THE MSF KIAMBU PROJECT: **INSIGHTS ON SERVICE DELIVERY FOR PEOPLE WHO USE DRUGS (PWUD)**

Sharing key learnings, innovations, adaptations and achievements

MEDECINS SANS FRONTIERES

Acknowledgments

We sincerely thank all individuals and institutions whose contributions made the Kiambu PWUD Project and this Capitalization Report possible.

Special appreciation goes to the MAT clinic teams, Kiambu County MoH, NASCOP, LVCT Health, and the Kenya Prisons Service for their vital partnership in sustaining MAT services.

We are especially grateful to the PWUD community and other key populations whose lived experiences, resilience, and engagement have meaningfully shaped this project.

We also acknowledge the valuable support of all stakeholders and partners who shared their insights, experience, and commitment throughout the process.

This report reflects our collective commitment to client-centred service delivery, health equity, and inclusive care for all key populations.

Published by: Médecins Sans Frontières (MSF), Kenya. April 2025.

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ABBREVIATIONS AND ACRONYMS

ABT	Abstinence-based therapy
ART	antiretroviral treatment
CDC	Centers for Disease Control and Prevention (United States)
CHMT	County Health Management Team
CHW	Community health worker
CBO	Community-based organization
CME	Continuing medical education
CSO	Civil society organization
DIC	Drop-in centre
DOT	Directly observed therapy
EPTB	Extrapulmonary tuberculosis
HACK	Haven Addiction Centre Kiambu
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HCW	Healthcare workers
HIV	Human immunodeficiency virus
ICAP	International Centre for AIDS Care and Treatment Programs
ID	Identification
KENPUD	Kenyan Network of People who Use Drugs
KP	Key Population
KEMSA	Kenya Medical Supplies Authority
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
LTFU	Lost to follow-up
MAT	Medically assisted therapy
MoH	Ministry of Health
MSM	Men who have sex with men
MSW	Medical Social Worker
NASCOP	National AIDS and STI Control Programme
NSP	Needle and syringe programme
NHIF	National Hospital Insurance Fund
OPD	Outpatient department
OST	Opioid substitution therapy
PCR	Polymerase chain reaction test
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People living with HIV/AIDS
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
PWUD	People who use drugs
SHIF	Social Health Insurance Fund
STI	Sexually transmitted infection
SVR	Sustained virological response
TB	Tuberculosis
THD	Take-home dose
USAID	United States Agency for International Development
WHO	World Health Organization
WWUD	Women who use drugs

GLOSSARY OF TERMS

Addiction: A complex, chronic disorder involving the compulsive use of a substance or engagement in a behaviour despite negative consequences. It is characterized by loss of control, cravings, and continued use despite harm. Addiction affects brain function, particularly areas related to reward, motivation, and decision-making, leading to physical, psychological, and social impairments.

Opioids: A class of drugs that are commonly used to relieve pain. They work by binding to specific receptors in the brain, **spinal cord**, and other parts of the **central nervous system,** reducing pain and creating a feeling of euphoria. Opioids can be both prescription medications (like morphine, pethidine, tramadol, oxycodone, and codeine) and illegal drugs (like heroin). While they are effective for pain management, they can also be highly addictive and carry risks of fatal overdose.

Harm reduction: Policies, programmes, and practices that aim to minimize negative health, social, and legal impacts associated with drug use, drug policies, and drug laws. It is grounded in justice and human rights – it focuses on positive change and on working with people without judgment, coercion, discrimination, or **requiring that they stop using drugs as a precondition of support**. The World Health Organization (WHO) outlines key components of harm reduction for people who use drugs (PWUD) to minimize health risks and improve well-being. These include:

1. **Needle and syringe programmes (NSPs)** to prevent the transmission of blood-borne infections
2. **Opioid substitution therapy (OST)** such as methadone or Buprenorphine for opioid dependence
3. **HIV testing and counselling** for early diagnosis and treatment
4. Access to **antiretroviral therapy (ART)** for those living with HIV
5. **Prevention and treatment of sexually transmitted infections (STIs)** and **condom programmes** to help reduce transmission risks
6. **Targeted information, education, and communication** to promote safer behaviours
7. **Prevention, diagnosis, and treatment of viral hepatitis**, which is prevalent among PWUD
8. **Prevention, diagnosis, and treatment of tuberculosis (TB**)
9. **Overdose prevention and management**, including Naloxone distribution and training – essential in reducing drug-related fatalities

Additional interventions were added to the harm reduction framework to address the broader psychosocial and legal factors that contribute to the marginalization and vulnerability of individuals:

- **Mental healthcare interventions** to ensure PWUD have access to mental health support, including counselling and psychiatric care to address co-occurring disorders.
- **Socioeconomic reintegration** to provide or link to education, employment, family reintegration, and housing support to help PWUD rebuild their lives and reduce dependency on drug use.
- **Promotion of human rights** to advocate for **decriminalization**, equal healthcare access, and protection from stigma, abuse, and law enforcement violence against PWUD.

These measures form a comprehensive harm reduction approach that prioritizes both health and human rights.

Key population: Groups at higher risk of acquiring HIV, viral hepatitis, and other health challenges due to specific behaviours and social or legal barriers. According to WHO and UNAIDS, they include **PWUD, sex workers, men who have sex with men (MSM), transgender individuals**, and **people in prisons**. These groups often face stigma, discrimination, and criminalization, limiting their access to healthcare. Targeted interventions are essential to address their health needs and reduce vulnerabilities.

Medically assisted therapy (MAT): A comprehensive approach that combines prescribed medications like methadone or Buprenorphine with counselling and behavioural therapy to manage opioid dependence. It helps reduce cravings, prevent withdrawal symptoms, lower the risk of overdose, and support long-term recovery while improving overall health and social well-being.

MethaMeasure system: The MethaMeasure machine is a vital device used in MAT clinics to dispense and monitor doses of methadone for clients undergoing treatment for opioid use disorder. The system combines a computer with a dispensing machine to ensure accurate, consistent, and safe administration of methadone. It is a user-friendly design and efficient.

Key benefits include:

- **Accurate dosing:** Delivers precise doses of methadone, ensuring treatment effectiveness and client safety.
- **Consistency:** Standardizes methadone measurement, reducing human error in dosing.
- **Monitoring:** Tracks the amount dispensed to each client, facilitating monitoring of treatment progress and compliance.
- **Prevention of misuse:** Minimizes the risk of medication misuse or diversion by controlling the quantity dispensed.
- **Directly observed therapy (DOT):** Ensures clients receive their methadone dose accurately under supervision.
- **Off-site treatment packaging:** Facilitates the preparation of methadone doses for clients receiving care outside the clinic, maintaining continuity of treatment.

Drop-in centre (DIC): Also known as a 'safe space', this is a safe, accessible space where individuals can receive a range of harm reduction and support services. These may include health screenings (HIV/HBV/HCV or cervical cancer screening), addiction counselling, needle and syringe programmes (NSPs), condom distribution, education on safer drug use and injection, contraceptive services and access to medical treatment and psychosocial support. The DIC aims to reduce harm, improve health outcomes, and connect PWUD with necessary services in a non-judgmental and supportive environment. The DICs are usually community-based and in Kenya, they are run by civil society organizations (CSOs) or community-based organizations (CBOs).

A nurse attends to Michael Mburu, a client at the MAT clinic, which provides a one-stop-shop—integrating medical, psychosocial, and harm reduction services under one roof to improve access and continuity of care

EXECUTIVE SUMMARY

Introduction

This report reflects on Médecins Sans Frontières (MSF)'s journey, implementing a comprehensive package of care, including medically assisted therapy (MAT) services for people who use drugs (PWUD) in Kiambu County, Kenya. Working in partnership with Kiambu County Ministry of Health (MoH), National AIDS and STI Control Programme (NASCOP), LVCT Health and Kenya Prison Services, MSF documented the experiences, best practices, and lessons learned.

Opioid dependence has a significant impact on global public health, with 296 million drug users worldwide, 69 million of whom use opioids. Injecting drug use, which contributes to about 10% of new HIV infections and 39.4% of HCV cases, is a major driver of morbidity and mortality, with over 70% of drug-related deaths in 2019 attributed to opioid overdoses. The World Health Organization (WHO) advocates for comprehensive care to reduce the harm associated with drug use, including combating HIV, HCV, and HBV transmission, and opioid overdoses.

Drug use, particularly opioid use, has been a significant concern in Kenya since the 1990s, with a study of 336 heroin users in Nairobi showing that 44.9% had a history of injecting, and among injectors, 52.5% were HIV positive. In 2013, there were an estimated 18,327 people who inject drugs (PWID), and by 2021, 26,673 individuals were reported to use opiates. Despite harm reduction programmes, including needle and syringe programmes (NSPs) and MAT clinics, PWID continue to face logistical barriers to healthcare access, stigma and legal constraints.

The objective of the Kiambu PWUD Project, therefore, was to reduce morbidity/mortality associated with illicit opioid drug use. Morbidity rates were high due to delayed treatment access in case of drug overdose, mob justice, and HIV, TB, HCV and other co-morbid conditions. The Kiambu Project aimed to increase access of PWUD to adequate health services, ensure a holistic approach for PWUD, and increase different models of care and innovative treatment for opioid substitution therapy (OST) and client support.

The Kiambu PWUD Project is therefore a story of adaptations, innovation, and dedication to improving healthcare access for PWUD. The insights gained from this project will serve as a valuable resource for stakeholders, policymakers, and healthcare providers looking to replicate or improve similar programmes.

Project background

Before the Kiambu PWUD Project, accessing MAT services in Kiambu County was a major challenge. PWUD faced significant barriers, including the absence of MAT clinics, social stigma, and logistical obstacles. Many individuals had to travel long distances to access treatment in MAT clinics in Nairobi, which often resulted in treatment interruptions. In response to these challenges – and also guided by an initial assessment of the needs of PWUD that MSF carried out in 2017 across harm reduction implementers in Nairobi and the coastal region – the project was designed to provide a holistic service model that integrated medical, psychological, and social support in a single framework.

The first MAT clinic opened in Karuri Level 4 hospital in September 2019 and rapidly developed a cohort of 924 individuals, with many initially transferring from other sites; most from the Nairobi MAT clinics.

In May 2021, a round table review discussion was held with key stakeholders including NASCOP, Kiambu County Health Management Team (CHMT), LVCT Health, and the PWUD community. The objective was to review lessons from the initial phase and to identify challenges to access and adapt the programme, with a particular focus on increasing community engagement. The reviewed strategy focused on:

- **decentralizing MAT services** through mini-MAT clinics
- **increasing Buprenorphine uptake as an alternative OST**
- **building the capacity of healthcare workers (HCWs) and peer educators on overdose management and mental healthcare**
- **enhancing the peer model in the MAT clinics**
- **constructing an empowerment centre** for PWUD
- **creating a client-led community-based organization (CBO)**
- **enhancing further the collaboration with LVCT Health** through an MoU to strengthen the provision of harm reduction services at the community level
- conducting an **anthropological study** to further assess the needs of PWUD, to inform programming

A holistic approach to medically assisted therapy

The Kiambu PWUD Project transformed the delivery of MAT services by addressing the complex needs of the target population. By integrating medical and mental health, nutritional needs, and social services under one roof, the project simplified access and reduced stigma for PWUD. clients no longer had to navigate fragmented systems; instead, they received OST; treatment for any other comorbidities, counselling; SRH services (STI screening and treatment, contraceptives, cervical cancer screening); HIV, HCV, HBV and TB care, nutritional support; and social reintegration services under one roof.

Geographical barriers were another challenge, so the project introduced decentralized MAT services through mini-MAT clinics (which also increased access to incarcerated PWUD as they were based in prison) and satellite dispensing sites, making treatment more accessible. This approach improved retention rates and ensured that more individuals could continue their treatment with fewer interruptions.

Peer educators played a pivotal role in the success of the project, providing health education, supporting treatment adherence, and bridging the gap between the healthcare system and the PWUD community. Their involvement fostered trust, which was essential in ensuring continuity of care.

The project also introduced flexible delivery mechanisms for OST to ensure a continuum of care for PWUD. These strategies included take-home doses (THDs), home deliveries, delivery of OST to prisons, and hospital-based OST, accommodating the diverse needs of individuals with mobility challenges, facing incarceration, hospitalized or balancing work or educational commitments.

One of the most notable innovations was the introduction of Buprenorphine tablets as an alternative to methadone syrup. This provided clients with a more flexible dosing regimen and fewer side effects, making MAT more accessible and client-friendly.

Additionally, the project established an Empowerment Centre to offer vocational training, social support, and wellness activities. This facility aimed to promote the long-term reintegration of PWUD into society by equipping them with skills for employment and self-sufficiency.

Project outcomes and impact

By June 2024, the Kiambu Project had enrolled 1,619 individuals across three MAT clinics. Of the 1,619, 81.5% were newly inducted and 18.5% transfer-ins, with a median age of 28 years, predominantly male (92%), and most referrals coming from LVCT Health (81.2%). Cumulative adjusted retention in care was >70%, 8.1% were lost to follow-up, 2.9% deceased, and 4.9% relapsed. The prevalence of key comorbidities was relatively low: HIV (1.5 %), HBV (0.2%), HCV (2.9%), and TB (2.5%). Of the cohort, 5% accessed pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP) during follow-up.

This success is attributed to the project's client-centred approach and its ability to meet the diverse needs of PWUD. Notably, the project influenced national policy through:

- participating in the revision of national guidelines for harm reduction
- sharing experiences with county and national technical working groups for key populations
- contributing to increased awareness of the unique needs of PWUD through harm reduction, including the expansion of take-home dosing policies.

Through its comprehensive approach to client support and access to OST, the project helped reduce opioid-related deaths and medical complications, marking a significant public health impact.

Another milestone was the formation of a client-led CBO, which strengthened advocacy efforts and ensured that peer engagement continued beyond the project's initial phases.

The project was acknowledged by NASCOP as a centre of excellence due to its innovative strategies and adaptations. It became a key learning site for other countries, including South Africa and Burundi, among others, and served as a training resource for HCWs in non-MAT health facilities across the county on harm reduction. This contributed to a more supportive environment for PWUD and improved management of overdose cases within these facilities.

Challenges and lessons learned

Despite its successes, the project encountered several challenges. One major issue was the gender disparity in enrolment, with only 7.7% of participants being women. This highlighted the need for more gender-sensitive engagement strategies to address the unique challenges faced by women who use drugs (WWUD).

A significant challenge was recruiting counsellors with the appropriate qualifications for addiction counselling, as they needed six months of specialized training after recruitment, which MSF supported. This highlighted the importance of ensuring that MAT staff are adequately trained and equipped to handle addiction management.

Since harm reduction is a relatively new area for many HCWs, establishing such a programme required having a programme leader with prior experience in harm reduction from the onset and also ensuring continuous capacity building for all staff.

PWUD are a socially marginalized group, and many lack a steady income, which hampers their ability to access services. This highlights the need to offer free services and to include PWUD as a vulnerable population in various support programmes.

Resistance from HCWs to the introduction of new OST methods also posed a challenge. Extensive training, sensitization, and mentorship were required to overcome this initial reluctance and ensure that healthcare providers were equipped to deliver effective care.

Regulatory barriers, especially around the approval of THDs, required sustained advocacy efforts to streamline processes.

Community stigma against PWUD remained a significant challenge. Overcoming this societal bias required continuous community education and sensitization, which should have begun early, even before the project was launched. Engaging with stakeholders at all levels, from the county to the grassroots, is critical. Mapping these stakeholders and involving them from the very beginning ensures effective collaboration and a more supportive environment for PWUD. Ongoing sensitization efforts throughout the project's lifespan are essential for maintaining community support and addressing stigma.

The challenges faced by programmes reliant on external funding, as recently experienced with the USAID freeze, highlight the urgent need for greater government investment and support. This situation underscores the importance of building resilient systems that can sustain services for vulnerable populations without being overly dependent on financial aid.

While discussions about the handover began about a year and a half before the transition, it is essential to start the handover process earlier in the project cycle and implement it in phases to ensure continuous service delivery without disruption.

Strategic recommendations for future implementation

The lessons learned from the Kiambu PWUD Project have paved the way for several strategic recommendations for future harm reduction initiatives. Scaling up decentralized services through additional mini-MAT clinics and satellite dispensing sites would further reduce geographical barriers and improve treatment adherence. Additionally, decentralizing services to prison facilities would enhance access to MAT for incarcerated PWUD, ensuring they receive continuous care and treatment while serving their sentences.

Strengthening peer engagement by expanding the role of peer educators and supporting client-led organizations will enhance trust, encourage service uptake, and improve retention rates. Advocacy for regulatory reforms remains essential to streamline MAT processes, particularly for take-home dosing approvals.

Investing in digital health systems will also improve the efficiency of client tracking and service delivery, transitioning from paper-based records to electronic health information systems. Additionally, developing gender-specific interventions is crucial, particularly for addressing the unique challenges faced by WWUD. Strategies that include childcare support and gender-sensitive treatment models will ensure more inclusive care.

The anthropological study was conducted towards the end of the project cycle, which left insufficient time to fully implement its recommendations. Moving forward, it is essential to incorporate a midterm evaluation early in the project. This would allow for adjustments and improvements to service delivery, based on the findings, and help determine the most appropriate timing for project closure.

The last MAT clinic was initiated only 11 months prior to the project handover, which did not provide enough time to evaluate its stability. For future projects, it is advisable to plan for a 1 to 2-year period after the implementation of the strategy before considering the handover, ensuring that newly established activities are stable and operational.

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A client on take-home OST doses runs a small business near his home. This demonstrates how flexible MAT access supports socio-economic reintegration for MAT clients.

KEY RECOMMENDATIONS

The Kiambu PWUD Project, in partnership with Kiambu County MoH, NASCOP, LVCT Health and Kenya Prison Services, has set a strong foundation for delivering comprehensive,client-centred care for PWUD. Building on its successes, there are key steps to ensure sustainability, scalability, and adaptation to PWUD and other populations with similar needs. The way forward focuses on strengthening the existing model while exploring its applicability to broader groups facing health and social challenges.

1. Expand access and coverage

- **Overcome geographic barriers:** Despite decentralizing services, there are still geographic areas where MAT clinics and satellite dispensing sites are needed. Efforts must be made to reach remote and rural populations through partnerships with local health facilities.
- **Integrate services with existing health infrastructure:** Rather than starting from scratch, integrating the MAT services into existing clinics and hospitals will ensure better use of available resources, while promoting continuity of care.
- **Improve access for incarcerated PWUD**: Decentralizing services to prison facilities will enhance access to MAT for incarcerated PWUD, ensuring they receive continuous care and treatment while serving their sentences.

2. Broaden the scope of services for PWUD

Address poly-substance use: While OST has been a core component of MAT, the needs of PWUD who use other substances, such as alcohol, methamphetamines, benzodiazepines, etc, must also be addressed.

3. Increase Access to User-Friendly Naloxone

To effectively reduce opioid-related deaths, it is essential to make naloxone available in user-friendly formats—such as nasal sprays or prefilled syringes—that can be safely administered by peers, family members, police officers, and other first responders. These easy-to-use options ensure timely overdose intervention, especially in community settings where medical personnel may not be immediately available. Broad access to such formulations empowers communities to act quickly and save lives.

4. Include social reintegration support

Psychosocial support must be more deeply integrated into MAT services. The success of the Empowerment Centre model should be replicated in other regions to support the social reintegration of PWUD and provide them with opportunities for skills development, employment, and self-empowerment while collaborating with the right stakeholders. It also creates a safe space for holding the PWUD support groups.

5. Strengthen gender-sensitive approaches

- **Focus on WWUD:** Despite efforts to engage WWUD, their participation remains low. More targeted outreach and gender-sensitive programmes are required to ensure that women have equal access to care. This may include creating gender-specific safe spaces, offering or led by female peer educators, and addressing specific barriers that women face, such as caregiving responsibilities and social stigma.

- **Address gender-based violence and intersectionality:** A deeper understanding of the intersectionality of gender, substance use, and violence is needed to tailor services more effectively. Expanding outreach to address the unique experiences of women and marginalized groups will be essential to improving engagement and retention in MAT services.

6. Improve data collection and research

- **Develop comprehensive data systems:** Currently, many MAT clinics face challenges in data collection, relying heavily on paper-based systems that limit efficiency, accuracy, and the ability to monitor client progress effectively. To address these challenges, there is a need to transition to a comprehensive electronic medical record (EMR) system across all MAT clinics. Implementing an EMR system would enable real-time tracking of client progress, streamline service delivery, and improve the monitoring and evaluation process, ensuring better outcomes for clients and programmes.
- **Conduct ongoing research:** More anthropological studies are required to better understand the evolving needs of PWUD and other key populations. They should also be conducted early in the project to shape service design and ensure that interventions are continuously adapted, based on evidence.

7. Expand peer-led initiatives and community engagement

Increase the role of peer educators and CBOs: Peer-led initiatives were central to the success of the Kiambu Project. Expanding the role of peer educators and collaborating more with CBOs will help build trust and improve service uptake.

Additionally, providing competitive and consistent remuneration for peer educators is essential to boost morale, enhance retention, and ensure sustained focus on delivering impactful community-based services.

8. Engage key population sub-groups

Ensure equitable access to services by actively engaging key population sub-groups – such as sex workers, the homeless, and the Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) community – through collaborative programming with community actors. This approach will help reach high-risk individuals who may still be underserved.

9. Address stigma and legal barriers

Combat stigma through education and advocacy: Stigma remains a significant barrier to care for PWUD and other key populations. Continued efforts must be made to raise awareness, educate communities, and challenge discriminatory attitudes. This includes working with healthcare providers, paralegals from the PWUD community, law enforcement, and community leaders to foster a more supportive environment for individuals seeking MAT services.

10. Advocate for policy change

Current policies, particularly those around THDs and eligibility, need to be reviewed and revised. Continued advocacy, including from PWUD themselves, is required to push for more flexible treatment guidelines, particularly to ensure that PWUD who are stable and compliant with treatment can access THDs without unnecessary bureaucratic barriers.

11. Strengthen capacity for scaling the model

- **Integrating Harm Reduction into Professional Training Curricula:** To promote a more informed, compassionate, and effective response to drug use, harm reduction principles should be embedded in the training curricula of key professional sectors. This includes medical schools, law enforcement and prison officer training institutions, teacher training institutions, and all other relevant training bodies.
- **Invest in staff training:** Continuous, ongoing training for HCWs, peer educators, and CHWs is essential to maintain high-quality service delivery. Specifically, it is crucial to ensure that counsellors receive specialized training in addiction counselling, enabling them to effectively support PWUD with the complex challenges they face. Well-trained counsellors are integral to providing the compassionate, informed care necessary to address the unique needs of individuals struggling with addiction.

12. Strengthen government ownership and sustainable funding

- **Ensure government commitment to MAT services:** **In light of the USAID funding freeze,** it is critical for the government to take full ownership of MAT programmes by integrating them into national health priorities. This includes allocating dedicated funding in county and national budgets to cover essential medicines, operational costs, and harm reduction interventions. Additionally, providing competitive and consistent remuneration for peer educators is essential to boost morale, enhance retention, and ensure sustained focus on delivering impactful community-based services.
- **Institutionalize MAT within public health systems:** Integrating MAT services within existing MoH facilities will enhance sustainability by reducing reliance on external donors. This should include formal policy commitments, standardization of service delivery, and clear funding mechanisms.
- **Advocate for inclusion in universal health coverage (UHC):** MAT services should be recognized as an essential component of UHC, ensuring that PWUD can access treatment without financial barriers. This includes advocating for public insurance schemes like SHIF to cover MAT services comprehensively.
- **Strengthen public-private partnerships:** Leveraging partnerships between government, NGOs, and private sector stakeholders will help fill funding gaps, support innovation, and ensure the long-term success of MAT programmes.

Conclusion

The Kiambu PWUD Project demonstrates the effectiveness of a holistic, client-centred approach to MAT. Through innovative harm reduction strategies, the project has made a significant impact on the health and social outcomes of PWUD, setting a national standard for excellence in service delivery. The success of this project highlights the need to improve MAT programmes at national level – which is not only the delivery of OST. This approach requires community-driven approaches, strong advocacy agenda, and sustained investment in harm reduction services. Moving forward, the lessons learned from the Kiambu PWUD Project provide a framework for similar interventions across Kenya and beyond, ensuring that MAT services evolve in ways that prioritize accessibility, dignity, and client empowerment.

INTRODUCTION

This capitalization document captures the experiences, innovations, adaptations, and lessons learned from implementing MAT for PWUD in Kiambu County, Kenya. It demonstrates the Kiambu Project's unique approaches and alignment with existing standards. The report targets a diverse audience, including the MSF internal audience, healthcare providers, policymakers, and advocates, and serves as a resource for stakeholders and practitioners to improve care for substance use disorders, while contributing to advocacy and global dialogue on MAT implementation.

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The report describes how various care models have been tailored to meet the needs of PWUD at both the community level and within MAT clinics, with an emphasis on the challenges and benefits these approaches present to service delivery.

A key aspect of this document is the exploration of client-centred harm reduction approaches, which simplify access and prioritize the well-being of PWUD. It includes an examination of how peer-led initiatives have been integrated into the treatment process, and the impact of these programmes on client engagement and adherence to treatment.

The document outlines key advocacy priorities and milestones achieved through the Kiambu PWUD Project, highlighting its successful initiatives to promote harm reduction strategies.

Project background

The Kiambu PWUD Project was started by MSF in 2019 in partnership with Kiambu County MoH, LVCT Health, NASCOP, and later with Kenya Prison Services. This comprehensive initiative aimed to address existing gaps in healthcare for PWUD (identified in a benchmarking exercise by MSF in 2017) through an innovative, client-centred, harm-reduction approach. The project integrated medical, psychological, and social services, creating a replicable model of care that garnered recognition as a centre of excellence by NASCOP.

The project's primary focus was on providing comprehensive medical services, including harm reduction services through MAT clinics. It collaborated with LVCT Health, a CSO that provided outreach or community-level harm reduction services. This CSO prepared PWUD who were ready to start OST and referred them to the MAT clinics for enrolment. LVCT Health also worked closely with the MAT clinics to trace PWUD who dropped out of care and helped with family and social reintegration.

The implementation of MAT services in Kenya is guided by NASCOP's MAT National Guidelines on the use of medications and other interventions for the treatment of opioid use disorder. NASCOP stipulated that MAT implementers do not engage in community outreach and vice versa, but despite this division of responsibilities, MSF collaborated closely with LVCT Health to ensure seamless service delivery. A clinical officer was stationed at the LVCT Health drop-in centre (DIC) to offer medical care to PWUD not enrolled in MAT. Additionally, a one-year memorandum of understanding (2022–2023) formalized collaboration on community-level microplanning activities, including extensive training for peer educators and outreach teams from LVCT Health. The project, being very peer-led, depended on the peers who were recruited and incentivized by LVCT Health, although four peers were hired under an MSF contract as CHWs to be stationed in the MAT clinic.

The goal of the MAT National Guidelines is to reduce the harmful health, psychological, and socio-economic consequences of drug use and apply to all national and county health authorities and policy makers implementing programmes for PWUD. The Kiambu Project proved that goals within the guidelines previously seen as inspirational are, in fact, attainable. The project additionally made adaptations and innovations to improve service delivery and increase access for PWUD.

Objectives of the Kiambu Project:

General objective: To reduce mortality and morbidity associated with illegal drug use and common ailments among PWUD in Kiambu County.

Specific objective:

1. PWUD make use of adapted models of MAT services that ensure prevention, access, and continuity of care in Kiambu County.
2. PWUD make use of community activities, which include the creation of a PWUD-led organization active in Kiambu County that proposes harm reduction services.

What was the added value of MSF?

MSF implemented a number of adaptations to the existing service delivery guidelines and practices in other MAT clinics, introducing both modifications to existing approaches and new innovations. A summary of these adaptations is provided below, with more detailed descriptions in the following chapters.

One-stop-shop model:

Comprehensive treatment for HIV, viral hepatitis and tuberculosis (TB) was provided under one roof, enabling PWUD to receive direct observed therapy alongside OST. This included comprehensive SRH services; nutrition; mental health and psychosocial services with an optimum number of addiction counsellors and social workers according to the guidelines; psychiatrists and psychologists placed full-time in the MAT clinics; and drugs for mental health conditions available free of charge for PWUD at the MAT clinic. The psychosocial services included home visits, prison visits for incarcerated PWUD to enhance social re-integration, various thematic group therapies to facilitate recovery, and support from and for the caregivers of PWUD.

Introduction of Buprenorphine as an alternative OST option:

Kiambu MAT clinics were the first in the country to introduce Buprenorphine in October 2021. MSF ensured a consistent supply through buffer stock and established a 'Buprenorphine corner' to facilitate supervised dispensing for new PWUD. The clinics also introduced a sustainable solution for cleaning and reusing methadone dispensing cups, with a standard operating procedure shared nationally.

Nutritional support for PWUD:

About 20% of the PWUD enrolled in the MAT clinics were diagnosed with either moderate or severe malnutrition. Since PWUD were excluded nationally as a vulnerable population and hence did not benefit from free supplements, the Kiambu Project invented the MAT porridge and later provided a ready-to-use therapeutic food, BP-100. Finally, through advocacy to NASCOP, the project succeeded in having PWUD considered as a vulnerable population and therefore included as beneficiaries of nutritional supplements.

Decentralized MAT services:

MAT services were expanded through mini-MAT clinics and satellite dispensing sites to improve access for PWUD. Both mini-MAT clinics were based in prisons as being the most eligible sites, following the preference of PWUD. The satellite sites were based in MoH level 4 facilities.

Implementation of continuum of care:

Flexible approaches ensured support for PWUD who were unable to visit clinics daily. Innovations included THDs, home deliveries, and targeted delivery services for hospitalized or incarcerated clients.

Community engagement and implementation of peer-led models:

MSF worked closely with LVCT Health to implement microplanning activities at the community level and extend these to the MAT clinic. To further enhance community engagement, MSF supported the creation of a client-led CBO: Haven Addiction Centre Kiambu (HACK).

Anthropological study:

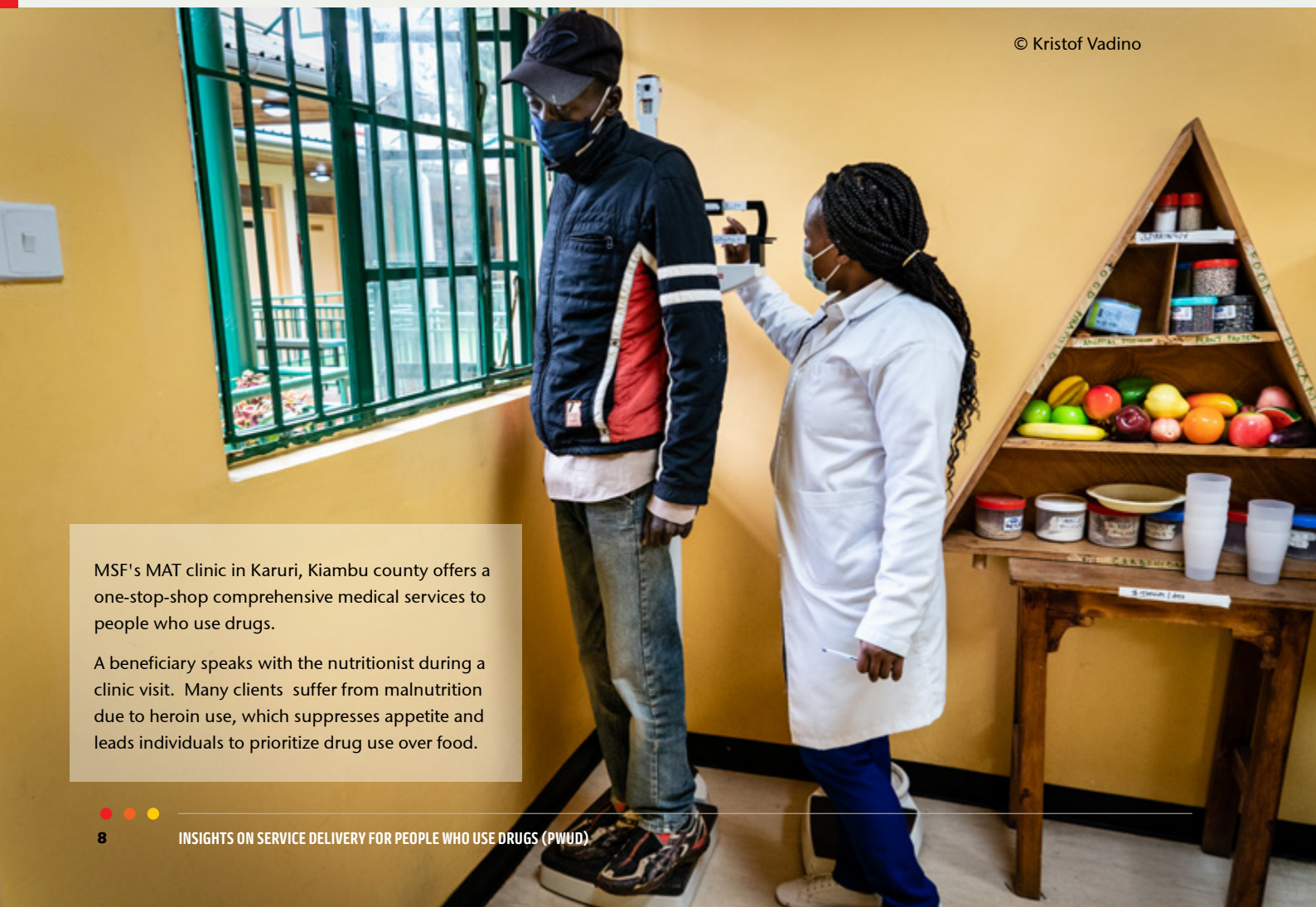
MSF also conducted an **anthropological study** to better understand the needs of PWUD and inform programming.

Implementation of the Empowerment Centre:

MSF constructed the Empowerment Centre next to the Karuri MAT clinic to provide a safe space for PWUD. The centre offered vocational training, wellness activities, and social reintegration programmes; fostering community engagement and reducing stigma.

Policy advocacy:

Due to the stringent measures instituted on OST as a controlled substance, the Kiambu Project implemented flexible guidelines promoting THDs and client-centred care. This was further enhanced through experience sharing with other implementers, both locally (technical working groups and committees of experts for key populations and PWUD) and internationally and through NASCOP identifying the MAT clinics as sites for benchmarking.



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MSF's MAT clinic in Karuri, Kiambu county offers a one-stop-shop comprehensive medical services to people who use drugs.

A beneficiary speaks with the nutritionist during a clinic visit. Many clients suffer from malnutrition due to heroin use, which suppresses appetite and leads individuals to prioritize drug use over food.

IMPLEMENTATION DETAILS OF THE PROJECT – PHASED ROLLOUT AND MILESTONES

Table 1 Key milestones of Kiambu PWUD Project

2018/2019	• MoU with county MoH – December 2018) • Construction of the 1st MAT clinic (March–Sept 2019) • Recruitment and training of staff (July–September 2019) • 1st client enrolled (19 September 2019)
2020	• Official launch of the Karuri MAT clinic • First take-home dose given
2021	• 1st client started on Buprenorphine in October • Strategy change with more focus on increasing access to PWUD and increasing support for community engagement
2022	• 1st satellite dispensing site in February • 1st decentralized MAT clinic in May • Operationalization of the Empowerment Centre • Start of the client/PWUD-led CBO (HACK) • 1-year MoU with LVCT Health to support community activities
2023	• Handover discussions commence with county MoH and PEPFAR/CDC • 2nd decentralized MAT clinic
2024	• Start of 2nd satellite dispensing site • Appointment by the Minister of Health, Kiambu of a transition Technical Working Group to oversee the handover process • Official handover to MoH – 5th July

Project staff composition

The project had over 70 staff – a mix of people hired locally and internationally by MSF and people hired by the MoH. The MSF staff included a project coordinator, medical managers, a logistics team including drivers, and CHWs. The MoH staff included clinicians, nurses, laboratory technicians, a nutritionist, health records officers, addiction counsellors, medical social workers, a clinical officer psychiatrist, pharmacy technicians and a pharmacist. The MoH staff were responsible for running the day-to-day activities of the MAT clinic, which was viewed as a good strategy to ease the process of handover to the county MoH.

MAT commodities

NASCOP provides methadone, HCV treatment, condoms, and some STI drugs free of charge to the clients, while HIV/TB medication is supplied by the HIV-funded programmes.

Results and impact

By June 2024, the Kiambu PWUD Project had enrolled 1,619 individuals across three MAT clinics, achieving an adjusted retention rate of 69%. Of the 1,619, 81.5% were newly inducted and 18.5% transfer-ins, with a median age of 28 years, predominantly male (92%). Most referrals came from LVCT Health (81.2%). Comorbidities were low, with only small percentages of clients affected by HIV (1.3%), HBV (0.2%), HCV (2.9%), and TB (2.5%), while 5% were not on PrEP. Of the remaining clients, 8.1% were lost to follow-up, 2.9% deceased, and 4.9% had relapsed.


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1. OVERVIEW

1.1 How did MSF begin working with People Who use Drugs?

MSF had been working in Kibera, Nairobi, providing services for people living with HIV/AIDS (PLWHA) since 1997, some of whom were coinfected with hepatitis C virus (HCV). In 2015, MSF began to screen and treat HCV among PWUD since the cases in the PLWHA were very few. Many of the PWUD were accessing harm reduction services at other sites and were travelling daily to access MAT services in Nairobi through the NASCOP-supported MAT clinics in Ngara and Mathari. Service delivery was fragmented, with PWUD required to visit separate sites for HIV/TB, HCV, and MAT services. The need for a more integrated approach was clear, and MSF, together with NASCOP and other partners, began to investigate ways to expand services. With the closure of MSF's project in Kibera in 2016, this led to the development of a concept for a new project for PWUD with 'one-stop-shop' peer-led/supported services for PWUD healthcare needs by MSF.

Before the project started, a benchmarking exercise was done in 2017 (see Appendix 1), including meetings with most stakeholders implementing programmes for PWUD in Kenya. The objective of this exercise was to identify the gaps that existed in the provision of services for PWUD, for MSF to be better informed on how to implement these services. One of the key highlights of the benchmarking exercise was the need to provide comprehensive one-stop-shop services for PWUD to facilitate their access to an often-fragmented healthcare, and to increase capacity and competencies in human resources and treatment for mental health and nutrition services.

1.2 Global overview of drug use

The impact of opioid dependence on public health is profound, contributing significantly to morbidity and mortality worldwide. In 2019, 296 million individuals engaged in drug use globally, with 69 million specifically using opioids. Of the reported 128,000 drug-related deaths in 2019, 70% were attributed to opioid overdose.[1] Particularly concerning is the fact that over 70% of drug users in Africa are under the age of 35. There are 11 million injecting drug users globally, 1.4 million of whom are living with HIV. Injecting drug use accounts for approximately 10% of new HIV infections globally.[2] Additionally, 39.4% of injecting drug users have an HCV infection.[3]

The WHO advocates for a comprehensive care and support package to reduce harms associated with drug use, including combating the transmission of HIV/HCV/HBV and reducing opioid-related overdoses.[4]

1.3 Drug use and the evolution of harm reduction in Kenya

Drug use, and opiate use in particular, has been a concern in Kenya since the early 90s. A study of 336 heroin users in Nairobi found that 44.9% had a history of injecting. Among current injectors, 52.5% were HIV positive, compared to a 13.5% HIV prevalence among non-injectors.[5] In 2012, as an initiative of harm reduction, Kenya initiated needle and syringe programmes (NSPs) through CSOs, supported by various international donors. These programmes not only complemented existing HIV prevention efforts but also offered a targeted approach to support individuals who inject drugs. Kenya had a population of over 1.6 million people living with HIV in 2014, and it was estimated that 18.3% of people who injected drugs (PWID) were living with HIV.[6]

In 2013, the estimated number of PWID was 18,327.[7] The establishment of MAT clinics began in December 2014, supported by entities such as PEPFAR, CDC, United Nations Office on Drugs and Crime (UNODC), The Global Fund, Open Society Foundations, USAID, ICAP, and University of Maryland, further emphasising Kenya's leadership within Africa in addressing substance use disorders. The MAT programmes offer opioid substitution therapy (OST) and other healthcare services. The MAT programmes are carefully regulated and only found in government healthcare facilities. They are monitored by NASCOP, and all must follow the national MAT guidelines. A regulatory body, the Pharmacy and Poisons Board, authorises the MAT clinics to start operations after meeting key set requirements.

In 2021, an estimated 26,673 individuals[8] were reported to use opiates in Kenya. **Despite these alarming figures, PWUD face significant barriers to healthcare access due to stigma and legal constraints, exacerbating the already high prevalence of HIV and HCV within this population.**

1 United Nations Office on Drugs and Crime. *World Drug Report 2023.*
2 UNAIDS. *UNAIDS Data 2020.*
3 Grebely et al., 2018.
4 World Health Organization (WHO) – Global HIV, Hepatitis and STIs Programmes. *People Who Inject Drugs.*
5 Beckerleg S, Telfer M, Sadiq A. A Rapid Assessment of Heroin Use in Mombasa, Kenya.
6 National AIDS Control Council. *Kenya AIDS Strategic Framework 2014/15–2018/19*
7 Kenya National AIDS Control Council. *Kenya AIDS Response Progress Report 2018.*
8 Ministry of Health, National AIDS and STI Control Programme (NASCOP). *Key Population Size Estimates – Kenya.* 2021

2. RATIONALE FOR SETTING UP THE FIRST MEDICALLY ASSISTED THERAPY (MAT) CLINIC IN KIAMBU

2.1 Background and need for the project

- In line with **MSF's 2016–2021 prospects**, the project was deemed necessary as **PWUD were marginalized**, **vulnerable** and considered as **excluded from comprehensive healthcare,** and the **prevalence of HIV and HCV was high** among this population.
- The support of **MoH and NASCOP** enabled the **development of comprehensive harm reduction programming and related innovation and advocacy,** which was not possible in many countries, including most of Africa.

Population size estimation (2018)

- A **PWUD population size estimate** conducted in **2018 by NASCOP and LVCT Health** found that Kiambu had an estimated **1,230 opiate users**, ranking it the **5th highest in the country**.
- This size estimate was conducted by **peer educators from LVCT Health**, using the following approach:
  - **Geographical mapping** of hotspots frequented by PWUD
  - **Key informant interviews** to understand operational dynamics and estimate numbers
  - **Validation of estimates** by **peers and outreach workers** from LVCT Health, following NASCOP's standard mapping process

Challenges before the medically assisted therapy clinic

- Before the establishment of the **MAT clinic in Kiambu, PWUD had to be referred to clinics in Nairobi**, limiting their access to **essential treatment and services**.
- The need to **bring services closer** to PWUD in Kiambu was therefore **critical** in ensuring effective service delivery.

Significance and learning opportunity

- This was the **first project of its kind for MSF-Operational Centre Brussels (OCB)**.
- Due to its **uniqueness**, the project was also expected to:
  - serve as a **learning platform** for MSF
  - provide an opportunity to **build capacity** for MSF staff on harm reduction
  - potentially become a **model service in Kenya**
  - along with the **companion project by MSF-Operational Centre Geneva (OCG) in Maputo**, **Mozambique**, act as a **pilot site** for new and **innovative approaches** that could later be expanded within **Kenya and beyond**

2.2 Establishing the first medically assisted therapy clinic in Kiambu County

Background

- In December 2018, MSF signed an MoU with Kiambu County, agreeing to support the establishment of a MAT clinic to serve PWUD.
- The MoU was initially set for three years (until June 2022) and extended to June 2024, ensuring continued partnership and smooth transition after MSF's handover.

Initial assessment and site selection

- MSF, in collaboration with LVCT Health and the Kiambu County team, conducted a thorough assessment of health facilities across Kiambu County (from Level 2 to Level 5 facilities).
- The goal was to identify the best location for a MAT clinic based on accessibility, available space for construction, and the willingness of staff to accommodate PWUD.
- **Karuri Level 4 hospital** was selected as the ideal location based on these criteria.

Construction of the medically assisted therapy clinic

- The clinic was built from scratch in **six months**, beginning in **March 2019**.
- The structure was a masonry (stone) building, completed as one of the fastest constructions for MSF projects.

Clinic operations

- **Opened:** September 2019
- **Services provided:** The MAT clinic offers a one stop-shop model for comprehensive medical services including OST, outpatient department (OPD) care, HIV/HCV/HBV/TB care, mental health and psychosocial services, SRH, nutrition, laboratory services, and assisted referrals.
- **Partnerships:** The clinic is a collaboration between MSF, Kiambu County, NASCOP, and LVCT Health.

2.3 What factors influenced the evolution of the project?

The early period of the project from September 2019 to mid-2021 was dedicated to learning and ensuring successful delivery of services at the Karuri Level 4 clinic, with transfer-in of clients from more distant centralised MAT clinics, and development of a cohort of PWUD in care at that site. Having run the clinic for about 1.5 years, MSF reviewed its approaches, including considering opportunities for innovation and examining gaps in care provision. These gaps were aggravated by the COVID pandemic. To address these needs, 11 months prior to the initial end cycle date of the project, a round table discussion was held in May 2021, where the strategy was reviewed. Key stakeholders were involved in the discussions and they included MSF, Kiambu CHMT, NASCOP, LVCT Health, PWUD and other stakeholders working with PWUD.

The outcome of the discussions was that the project was extended until the end of June 2024 and with a revised strategy.

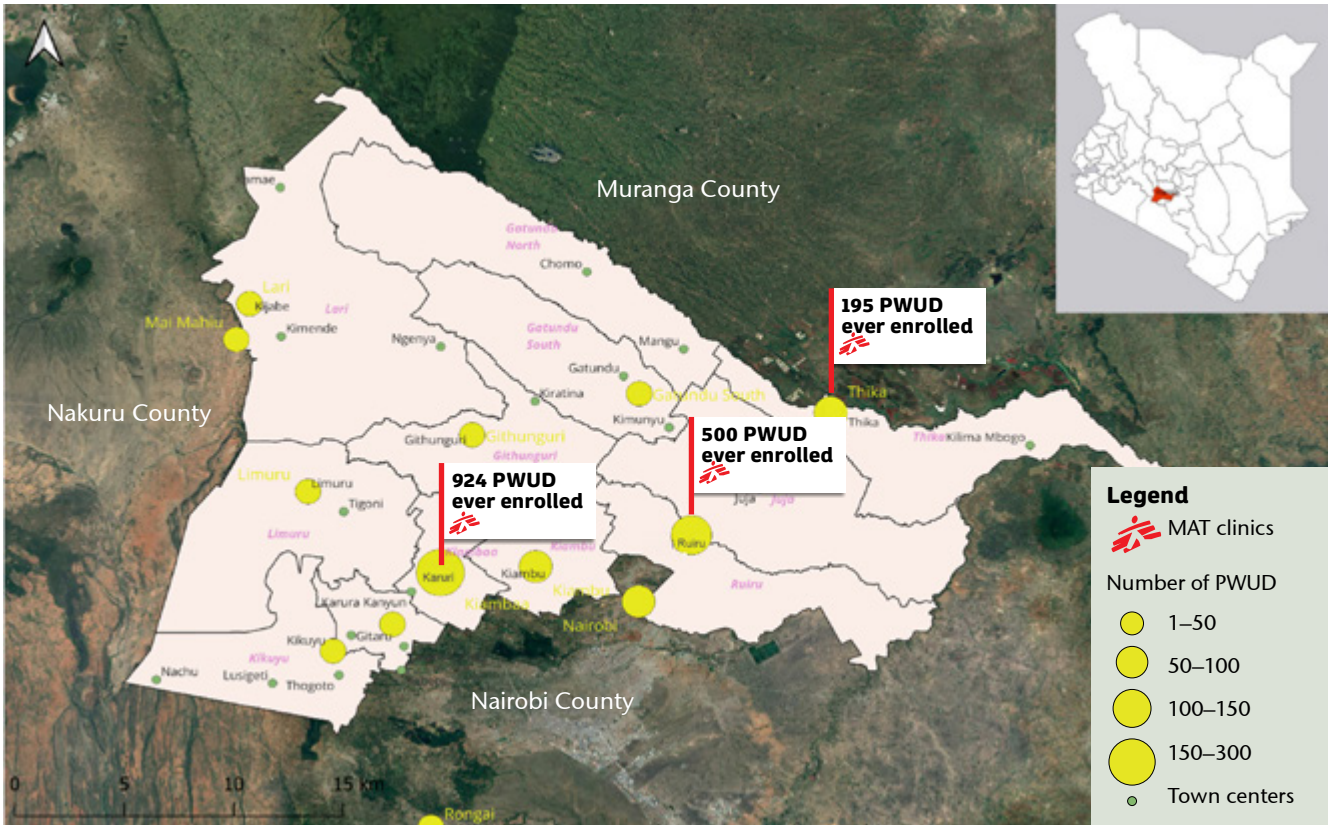
This included:

- decentralization of MAT services to increase access to PWUD
- increased uptake of Buprenorphine
- increased support and collaboration with LVCT Health:
  - to support the uptake of MAT services and community outreach
- to conduct an anthropological study to better understand the needs of PWUD, and
- to support the creation of a client-led CBO.

As part of the decentralization of services to increase access to PWUD, which was preceded by a second PWUD size estimate done by MSF and LVCT Health in August 2021 (described above), two decentralized MAT clinics were opened in Ruiru Prison and Thika Prison in May 2022 and July 2023, respectively. Two satellite dispensing sites were also started in Lusigetti and Kihara Level 4 facilities in February 2022 and April 2024 respectively.

By the end of June 2024, 1,619 PWUD (1,512 males and 127 females) had been enrolled across the three MAT clinics, with a gross adjusted retention in care of >70% across the three clinics. Notably, the project's innovations, adaptations, and **client-centred approach** have garnered the project **recognition as a centre of excellence** by NASCOP in providing innovative solutions to PWUD healthcare needs.

Figure 1: Map of MSF-supported MAT clinics in Kiambu County



Map created by msfocb-kiambu-datamanager@brussels.msf.org April 2023

3. MODEL OF CARE – THE ONE-STOP-SHOP APPROACH

3.1 What is the one-stop-shop model?

The **one-stop-shop** approach is an integrated service model that consolidates multiple services within a single location. In the context of the Kiambu Project, this approach provided comprehensive medical care within the MAT clinics, including OPD services, HIV, HCV, HBV, and TB care, nutrition support, laboratory services, as well as mental health and psychosocial support.

This model aims to provide a **comprehensive, accessible, and non-judgmental** environment where PWUD can access multiple services without stigma or unnecessary barriers.

3.2 Objectives of the one-stop-shop model of care

The one-stop-shop model of care was implemented in the Kiambu Project to achieve the following objectives:

1. **Enhanced access to services:** Bring together comprehensive health services and service providers to the same location and ensure that clients are assisted in accessing secondary and tertiary care when needed.
2. **Improved coordination and integration:** Reduce the waiting time incurred when a client must move from one area of service to another. PWUD are known to have poor health-seeking behaviours and tend not to seek services where care is fragmented.
3. **Holistic and client-centred approach:** Ensure access to medical and psychosocial services for clients with health conditions that impact mobility, such as fractured limbs, severe wounds, or hospitalization. Additionally, support incarcerated PWUD and those seeking social reintegration, such as employment or education opportunities, etc.

3.3 How was it implemented?

During MSF's benchmarking exercise before the MAT clinic started, and also when MSF was running the HCV project offering treatment to PWUD, it was noted from discussions with stakeholders that many clients dropped out of care from the fragmented services, predominantly due to the stigma and discrimination they faced. This had a negative impact on their quality of life.

The aim of the one-stop-shop model of care, therefore, was to ensure that all services were availed to PWUD under one roof, and when this was not possible, they were assisted by nurses who accompanied them to the referral facilities. Since the services outside the MAT clinic needed to be paid for, MSF paid the National Hospital Insurance Fund (NHIF) for the most vulnerable clients, which in turn reduced the overall cost of referral for MSF.

Holistic, one-stop-shop services available in the MAT clinic.

How is it structured?

Constructed inside MoH facility (**to ensure sustainability post MSF handover**) Built as stand-alone clinic in 3 sites: Karuri, Ruiru Prison and Thika Prison

MoH Staff: Running all the MAT activities
Clinical officers, nurses, pharmaceutical team, addiction counsellors, psychiatrist, lab technicians, medical social workers, security personnel

MSF Staff: Management team
Project coordinator, project medical referent, health promotion manager, mental health supervisor, medical activity manager, psychologist, psychiatrist, logistics supervisor, HR/finance manager, CHWs and logistics team, including drivers.

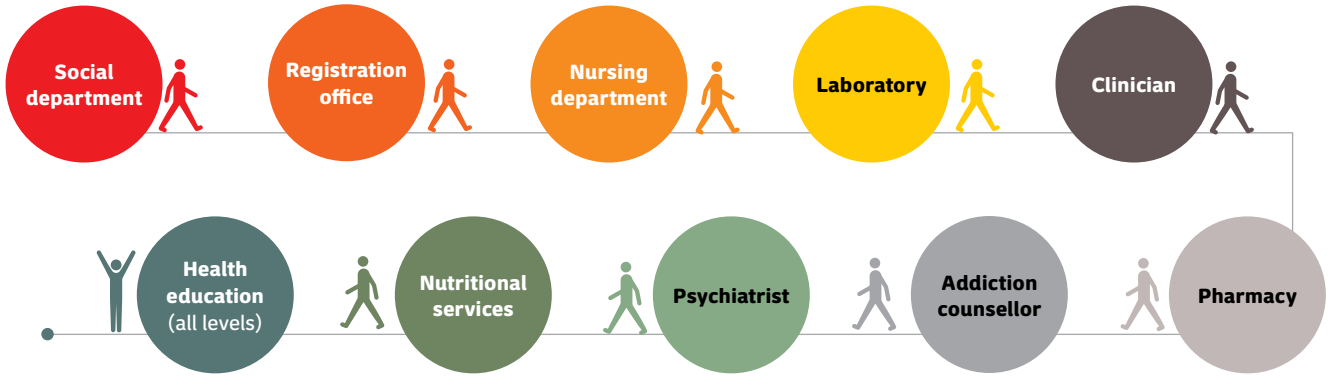
LVCT Staff: Peer educators

Open to all PWUD including their dependants (spouses and children)
Opening Hours: 7am – 1pm (7 days a week)

What is the Package of Care?

- OST: methadone and Buprenorphine
- Free OPD services, including wound care
- Integrated HIV, HCV, HBV, and TB services
- SRH services including STI care, contraceptives, cervical cancer screening, access to post-abortion care and antenatal services
- Mental health and psychosocial services, including individual and group addiction counselling
- Nutritional services
- Laboratory services
- Referral services to secondary and tertiary facilities for external lab, radiology services and admissions assisted by nurses and MSF ambulance
- Health promotion activities and dialogues, health education and other overall well-being activities led by the peers, such as yoga, art and gardening
- Peer engagement: crowd control inside and outside the MAT clinic, prevention of diversion of OST at the pharmacy, health education, microplanning activities in collaboration with the community peers – including tracing of PWUD who have dropped out of care.

Revised client flow in the MAT clinic for new PWUD



The client flow was redesigned to ensure that the first clients did not experience long waiting times to see the clinician for their OST prescription during the enrolment process. Instead, after triage, clients would first undergo a urine toxicology test and other baseline tests in the lab, followed by a consultation with the clinician to initiate OST, as clients are typically in withdrawal at this stage. Once the OST begins to take effect, clients can then be comfortably seen by the psychosocial and mental health teams.

Stable, ongoing clients would follow the standard client flow, starting with triage, followed by a consultation with the clinician, then proceeding to the lab, counsellor, or nutrition services as needed, and finally to the pharmacy for prescriptions.

3.4 What was different about this model of care?

Table 2 Service comparison: MSF supported Kiambu MAT clinics versus other MAT clinics.

Service	Package offered in other MAT clinics	Package offered by MSF-supported clinics (pre-handover)
Opioid substitution therapy (OST)	Methadone only	Methadone + Buprenorphine
General outpatient (OPD) services	Basic OPD services	**Free comprehensive** OPD services + integrated care (SRH, vaccinations, nutritional support, wound care, and assisted referrals)
OST access	Daily clinic visits are required	Flexible access: THDs, hospital/prison deliveries, daily home deliveries
HIV, HCV, TB integration	Available	Fully integrated, with active follow-ups, including direct observed therapy MSF supported PCR for HCV at Lancet Laboratories
Mental health services	• Limited availability on certain days • Mostly no resident psychiatrist • Mental health drugs are usually not always available	Dedicated mental health professionals: • clinical psychiatrist and psychologist • structured psychosocial support, including various group therapies • peer-led wellness activities, including yoga • mental health drugs are available, supported by MSF
Nutritional support	No dedicated nutritionist for the MAT clinic	Dedicated MAT nutritionist • Nutritional assessment and support are provided even in prisons • Introduction of MAT porridge for malnourished PWUD, followed by transition to BP-100 provided by MSF • **Advocacy success**: PWUD are now included in the national nutrition support programme through NASCOP.
Psychosocial support	Addiction Counselling, defaulter tracing through the CSOs	Structured psychosocial interventions, including: group therapies, home visits, prison visits, empowerment programmes (e.g., yoga, art, gardening, training on income-generating activities)

Laboratory services	Urine drug screening, HIV, HCV, HBV, and syphilis testing	Comprehensive free lab services covering all essential tests – those not available within the facility were outsourced, and MSF paid
Sexual and reproductive health services	Mainly STI screening	Available on-site: Contraceptive services, STI screening and treatment, cervical cancer screening, pregnancy support
Overdose prevention and harm reduction services	• NSP and basic education (if available) • Limited Naloxone distribution	Comprehensive harm reduction: • NSP in the MAT clinic through LVCT Health • Naloxone distribution – even to Levels 4 and 5 facilities near drug dens and hotspots – to facilitate quick response, in case they receive an opioid overdose client • peer-led health promotion • overdose prevention training
Continuum of care	No continuity of care, clients are expected to attend daily except for prison and hospital deliveries	Flexible care models: Take-home doses, home/hospital/prison deliveries, follow-up for defaulters
Buprenorphine corner	Not available	Innovation of MSF MAT clinics
Referral and assisted access to care	• Self-referrals to higher-level facilities • High cost of secondary/ tertiary care limits access	• Assisted referrals: nurses accompany clients to secondary and tertiary facilities • MSF ambulance available • MSF pay NHIF premiums for socially vulnerable clients • If NHIF is not available, MSF support clients in paying hospital bills where eligible • MSF pays for laboratory tests and diagnostic services
Home and prison visits	Not standard practice	• Regular home visits for psychosocial support and social reintegration • Prison visits to provide psychosocial care and support the social reintegration of incarcerated PWUD
Empowerment Centre	None	Dedicated Empowerment Centre with peer-led activities: vocational training, wellness programmes (yoga, art therapy, gardening)
Community and peer engagement	Minimal direct community involvement	Strong peer-led initiatives: microplanning activities through peer educators from LVCT Health. MoU signed between LVCT Health and MSF for one year to support these activities
Accessibility	Limited operational hours	Multiple access points (satellite dispensing sites)

3.5 What was achieved with our model of care?

1. **Easy access under one roof:** Easy access to services all under one roof improved the uptake of services, enhanced follow-up for mental health and other comorbidities, and improved retention in care. It also prompted several transfer-ins from other clinics and inductions of new PWUD to benefit from the services.
2. **Improved client outcomes:** Improved client outcomes were evident, with a notable reduction in opioid overdose-related mortalities over time. This improvement can be attributed to the increased accessibility of OST, comprehensive services including mental health support, and health promotion initiatives that empowered clients to make healthier choices.
3. **Peer engagement in international conferences:** The project seconded two peers to participate and present at the the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) conference in 2023 in Zimbabwe.
4. **Anthropological study for programme improvement:** An anthropological study (titled 'Perceptions and Experiences of People Who Use Drugs, Regarding Their Lives in Relation to Drug Use, and How It Impacts Enrolment and Retention in a MAT Programme in Kiambu County, Kenya') was conducted in 2022 to gain deeper insights and inform programming for PWUD.

Another smaller anthropological study was conducted in 2020 to understand the needs of WWUD and how to tailor service provision accordingly.

5. **Recognition as a benchmarking site:** Due to the comprehensive nature of the services provided and because the client-centred approach incorporated innovations and adaptations specifically for PWUD, the MAT clinics were recognized as benchmarking sites nationally and internationally.

3.6 What did not work well?

Dependency on MSF for financial and logistical support: The one-stop-shop service delivery model aimed to empower PWUD by encouraging stable clients to take ownership of their treatment, including paying their NHIF premiums and following up on their care. However, many clients demonstrated a continued dependency on MSF, expecting ongoing financial support for NHIF and frequently relying on nurses for transportation to appointments, even though they were capable of attending independently.

Limited enrolment of WWUD: Only 7.7% of the PWUD enrolled in the MAT clinics were WWUD, a figure consistent with other MAT clinics across the country. Despite several initiatives, including the involvement of female peer educators, a small anthropological study conducted in 2020 to assess their needs, and engagement through a women-only group, efforts to reach more WWUD were not successful.

Gender disparities in opioid use and stigma

The disparity between men and women using opioids is 85% men and 15% women.[9] Additionally, the intersectionality of drug use and transactional sex creates a dual layer of stigma, where WWUD face societal and institutional discrimination for their drug use as well as their involvement in transactional sex. This compounded stigma often leads to further marginalization, making it more difficult for WWUD to seek help or access essential services. The fear of being judged, criminalized, or rejected by healthcare providers and service organizations discourages many from coming forward, ultimately hindering their ability to receive the care and support they need. A strong recommendation, therefore, is that the CBOs should have a strong outreach package that also emphasizes the needs of WWUD.

9 United Nations Office on Drugs and Crime. *World Drug Report 2023*.

3.7 Lessons learned

1. **Holistic care improves health outcomes:** The MAT clinic's comprehensive service model allowed clients to address multiple health conditions in one location. This client-centred approach led to better overall health outcomes and improved treatment adherence.
2. **Peer-led engagement enhances continuity of care:** By implementing a structured peer-led approach, the peer educators were trained and incentivized in collaboration with LVCT Health. These peer educators became an integral part of clinic operations, participating in staff meetings and clinic planning, psychosocial team activities, defaulter tracing and client follow-ups. Their active role in clinic processes enhanced client engagement and trust, reduced stigma, and ensured that PWUD remained connected to care.
3. **Strategic partnerships strengthen implementation:** The collaboration with LVCT Health, formalized through an MoU, was key to sustaining peer-led initiatives. By co-funding peer educator incentives, this partnership effectively supported microplanning activities, improving outreach and service delivery.
4. **Involve PWUD in strategy design:** Initially, the project lacked meaningful input from PWUD in service design. Over time, it became clear that actively involving PWUD in decision-making, research, conferences, training, and networking opportunities greatly enhanced the effectiveness of the model.
5. **Effective care coordination prevents treatment gaps:** Ensuring integration across different services was crucial for the continuity of care. Strong coordination among healthcare providers, peer educators, and partners helped prevent treatment gaps, leading to better client outcomes and retention in care.
6. **A flexible model is essential for long-term success:** The needs of PWUD are diverse and change over time. A rigid system would not effectively address these evolving needs. A flexible and adaptive approach – capable of responding to new challenges – proved crucial in maintaining the project's relevance and impact.
7. **The anthropological study came too late:** An anthropological study (2022–2023) provided valuable insights into client behaviours and service accessibility. However, investing in such research earlier in the project would have strongly informed a more adapted service design from the beginning. This was a missed opportunity that could have shaped a more effective model earlier on.
8. **Gender-specific barriers limited access for WWUD:** Early outreach efforts focused on drug dens, which primarily served male PWUD. However, WWUD had different drug use patterns, often avoiding dens and obtaining substances through different networks. This limited their access to services, despite a small MSF study in 2020 exploring better outreach strategies for WWUD. Unfortunately, the study did not yield significant results, and service provision for WWUD remained a challenge.

9. **Opportunities for stronger CSO engagement were missed:** Although a partnership was established with LVCT Health, closer engagement with other experienced organizations, such as Support for Addictions Prevention and Treatment in Africa (SAPTA), which managed DICs in Nairobi and had extensive experience with community and peer-led harm reduction approaches – including outreach for WWUD – could have further improved service access and delivery.

10. **Early formation of a PWUD-led CBO would have strengthened the project:** The strategic vision of the project should have included the formation of a PWUD-led CBO from the beginning. Establishing this structure earlier would have enhanced client advocacy, self-governance, and long-term sustainability of peer-led initiatives.

Recommendations

Balancing recruitment and reintegration: When setting up a MAT clinic, it's crucial to focus on both PWUD recruitment and their reintegration into society. The Kiambu Project successfully implemented systems to attract new PWUD but faced challenges in encouraging their outflow.

Strengthening community-based services: When delivering services for PWUD, having a strong presence and engagement within the community is essential for improving outcomes. MSF could have enhanced its impact by directly providing community-based and outreach services tailored to the needs of PWUD.

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Dr. Elizabeth Muritu takes stock of medicines in the Karuri medically assisted therapy (MAT) clinic in Kiambu.

© Eugene Osidiana/MSF

A client during a laboratory consultation. All samples, including those referred to higher facilities, were collected at the MAT clinic.

4. CLIENT-CENTRED APPROACH

4.1 What is a client-centred approach?

A client-centred approach means putting the client at the heart of their own care. It involves listening to and understanding what each client needs and wants and then tailoring the care to fit those needs. This approach ensures that the care is respectful of and responsive to individual client preferences, values, and circumstances. During the project strategy design, a key consideration was addressing the fragmented care and the high threshold of MAT services, which required PWUD to visit the clinic daily for their OST doses.

A client-centred approach was encompassed in **decentralization of services, continuum of care, psychosocial interventions, nutritional support, creation of a client-led CBO**, among other interventions. These topics will be covered comprehensively in the chapters ahead.

4.2 Decentralizing MAT services

Decentralizing the MAT services is crucial in increasing the number of people able to access treatment, especially in settings where centralized care is limited by geographic or resource constraints.[10]

Rationale for decentralization

The decision to decentralize MAT services in Kiambu County was informed by various factors, including client access challenges, geographic barriers, and resource limitations due to daily transport requirements. The central MAT clinic was not adequately serving the widespread PWUD population, particularly those in remote areas. Furthermore, cohort analysis and client feedback during the COVID-19 pandemic emphasized the necessity of localizing services to reduce travel constraints and improve retention in care.

10 Harm Reduction International. *Annual Report 2021.*

Model of decentralization

The decentralization strategy was designed to optimize resource use and expand service coverage by establishing:

- **Mini-MAT clinics:** These smaller, fully functional MAT clinics ensured comprehensive care in targeted areas.
- **Satellite dispensing sites:** These sites focused primarily on dispensing OST while clinical and psychosocial follow-up continued at the main MAT clinics.

Collaboration with key stakeholders

The success of the decentralized model relied heavily on collaboration with multiple stakeholders, including:

- **County Ministry of Health (MoH)** led facility assessments in collaboration with MSF and LVCT Health and ensured buy-in from selected healthcare facilities.
- **MSF and LVCT Health** provided technical support, capacity building, and cohort analysis for informed decision-making.
- **Kenya Prison Services** demonstrated openness and cooperation by allowing the integration of MAT services within correctional facilities, ensuring that both incarcerated PWUD and PWUD from the neighbouring community had access to essential treatment and support.
- **PWUD community** gave direct input in focus group discussions to ensure site selection aligned with client needs.

Community support and acceptance: The project's success was further bolstered by the positive reception from the community, where local leaders and residents supported the programme, helping to foster trust and ensure its long-term effectiveness, albeit with continuous intensive sensitizations needed.

Implementation strategy for the decentralized MAT services

The decentralization of MAT services in Kiambu was implemented through a structured approach.

Table 3 Process of decentralization of MAT services in Kiambu

	Process	Details
Step 1	PWUD size estimates	• 2018: 1,310 PWUD mapped in Kiambu County by NASCOP and LVCT Health. • 2021: 3,312 PWUD mapped in Kiambu County by MSF and LVCT Health.
Step 2	Facility identification and mapping	Health facilities close to hotspots (where PWUD buy and consume drugs) were identified as the best fit
Step 3	Eligibility criteria for proposed decentralized sites	• Free access to services 7 days a week • Number of hotspots in the area and number of PWUD • Easy geographical access • Community safety • Availability of space to accommodate MAT services • PWUD preference • Adequate staff to support delivery of services to PWUD • CSO focused on PWUD
Step 4	Assessment and site selection	• Assessment conducted by Kiambu CHMT, MSF, LVCT Health and MAT staff. • Eligible health facilities selected based on the criteria above. • Site presented to PWUD, and a focus group conducted to identify the best site. • Final selection made based on PWUD preference.
Step 5	Implementation of the decentralized sites	• Construction done from scratch within an existing MoH health facility. • Staff recruited by the county and salaries supported through MSF. • HCWs trained on harm reduction strategies by MSF. • Continuous monitoring, supervision, and evaluation by MSF to ensure quality of care • MSF continued to provide the comprehensive package of care similar to the main MAT clinic

Impact of decentralization of MAT services

The decentralized model yielded significant improvements in MAT service access:

- Nearly 700 PWUD enrolled in Ruiru and Thika sites in just one and a half years.
- There was a reduction in stigma and increased acceptance of services, particularly among incarcerated PWUD.
- Integrated services optimized existing healthcare infrastructure and resource utilization.

What did not work well for the decentralization of MAT services?

While the initiative successfully expanded access to MAT services, challenges such as limited resources and infrastructure constraints were encountered at the host facility. Although the first site was proposed as an integrated model, it experienced staffing shortages and lacked the necessary equipment and space for comprehensive care.

Lessons learned

The first decentralized MAT site in Ruiru faced unexpected challenges due to an influx of prison officer trainees, which overwhelmed the facility. This led to a need for additional staff and space to accommodate MAT activities. The experience provided valuable lessons, prompting better preparation for the second site, which was equipped with adequate space and staff, primarily sourced from the Kenya Prison Services.

1. The key takeaway was the **importance of anticipating potential challenges**, such as increased workload and space limitations during busy periods, which had not been considered during the initial site assessment.
2. The importance of **stakeholder engagement, including clients themselves** – done through focus group discussions and input into decision-making processes – was paramount in identifying the best site for the decentralized MAT services.
3. While the objective of decentralization was to increase access and bring services closer to clients, some PWUD chose to go to other facilities due to stigma. This highlights the importance of remembering that **clients' choices matter.**

Recommendations

1. Key factors for success include **early involvement of the county MoH core team** to lead facility assessments and implementation, as this improves buy-in from the selected facilities, strengthening staffing and infrastructure for quality care, while building staff capacity to reduce stigma and create an enabling environment.
2. For ease of replicability and efficient resource management, the decentralized sites should be **integrated** into an existing MoH health facility.

4.3 Satellite dispensing sites

What informed the satellite dispensing sites?

Despite having two decentralized MAT sites, clients from other sub-counties in Kiambu County were still travelling long distances to access care at the three available clinics. Cohort data analysis revealed that these clients were dropping out of care for the same reasons previously identified. By mapping client origins, areas with the highest concentrations of clients were identified, using a similar process to the decentralized site assessments. Health facilities near drug-use hotspots were pinpointed. The goal was to establish satellite dispensing sites near these areas, allowing clients to access their OST at local hospital pharmacies, while continuing clinical and psychosocial follow-up at the main MAT clinics.

Key strategic considerations for satellite dispensing sites

1. **Facility assessment and eligibility:** A thorough assessment of the host facility was conducted, using criteria similar to those for the decentralized MAT sites. However, particular attention was given to the pharmacy's capacity and security to ensure proper handling of the medication.
2. **Pharmacy security and infrastructure:** The pharmacy required a secure environment, including a strong door with a lock system and reinforced windows to safeguard the OST stored. Additionally, a metal cabinet was provided for secure storage of the OST.
3. **Staff training:** Staff at the satellite site received training from the main MAT clinic team. This included an immersive one-week orientation, primarily in the pharmacy, to understand the operational procedures of the MAT clinic and the principles of dispensing OST effectively.
4. **Induction for PWUD:** PWUD were introduced to OST at the main MAT clinic, where they received comprehensive education about the treatment. They continued to attend their clinical, nutrition, and psychosocial appointments at the main clinic, while satellite dispensing focused on OST dispensing. Those with comorbidities also received their medication from the satellite sites.

Note: Satellite dispensing logistics: The satellite dispensing is mainly dependent on the host facility requiring the MAT clinic staff to deliver the OST from the MAT every 2 weeks.

What challenges did the satellite dispensing sites face?

- **Limited buy-in:** The progress of activities was delayed due to limited buy-in from some county and facility HCWs. In some cases, these challenges were also related to implicit bias and stigma among some facility staff, as satellite dispensing was seen as an additional task, and PWUD were seen as 'belonging to MSF'.
- **Disruptions from industrial strikes:** During industrial strikes by HCWs, dispensing services were suspended, and clients were asked to return to the main MAT clinic, leading to frustration and causing some to drop out of care.
- **Maintaining a holistic approach:** Although access to OST improved, PWUD were still required to visit the main MAT clinic for medical and psychosocial appointments. This additional effort sometimes led to reduced motivation and logistical challenges, weakening the significant role that psychosocial support plays in fostering long-term recovery and enhancing overall well-being.

Lessons learned

1. **Training and sensitization of facility staff on harm reduction**, including embedment in the MAT clinic played a big role in embracing and understanding PWUD hence reducing stigma.
2. A critical lesson learned was the **importance of fostering strong buy-in from both county and facility HCWs**. Without this support, even well-designed interventions can be delayed or misunderstood. Overcoming implicit bias and stigma is vital, and future initiatives must prioritize training, sensitization, and partnership-building activities to ensure healthcare staff view these activities as integral to the care of PWUD, rather than an additional task.
3. **Satellite dispensing sites can significantly improve access to OST** for PWUD with minimal resource requirements. During the MAT programme implementation phase, it is essential to carefully plan these sites from the outset, with the active involvement of PWUD, MoH and CSO. This approach, in the long term, enhances client retention, improves treatment outcomes, and supports clients' overall well-being.

Recommendations

1. **Ensure continuity of comprehensive care:** It is crucial to integrate both medical and psychosocial services at satellite dispensing sites to maintain a holistic approach to care. While OST access is improved, continued access to psychosocial support should be a key consideration to enhance motivation and long-term recovery. Efforts to reduce the need for clients to travel to the main MAT clinic for these services can be achieved by either training existing counsellors within the facility on the management of addiction or assigning dedicated counsellors to the satellite sites.
2. **Address institutional barriers:** Ensuring ongoing training and sensitization of facility staff to harm reduction and the unique needs of PWUD is critical for reducing stigma and bias. This will foster an environment where PWUD are treated with respect and where services are viewed as integral, not an additional task.

4.4 Continuum of care in the context of harm reduction: What the Kiambu Project implemented

What is continuum of care?

Continuum of care is a **comprehensive approach** that addresses the diverse needs of PWUD throughout their recovery journey. It acknowledges that effective treatment extends **beyond facility-based care** and includes alternative service delivery models to ensure continuity, improve health outcomes, and reduce barriers to accessing care.

As a result, **comprehensive health services and OST** are offered to clients who **cannot visit the MAT clinic daily** due to the following reasons:

- **Illness** (e.g., fractures, debilitating wounds, recent hospital discharge)
- **Employment** (difficulty commuting to the clinic without compromising work)
- **School attendance** (conflicting school schedules, boarding school)
- **Late pregnancy and post-delivery recovery**
- **Hospitalization**
- **Incarceration**
- **Travel/mobility** (work-related travel, social functions like weddings/funerals)

See our video:
Ensuring continuum of care for people who use drugs in Kiambu County - NO ONE IS LEFT BEHIND • https://bit.ly/4jhC0EI

To address these challenges, different strategies under **continuum of care** were implemented, including:

1. Take-home doses
2. Daily home deliveries
3. Hospital deliveries
4. Prison deliveries

What was the rationale for continuum of care?

The implementation of **continuum of care** aimed to:

- Ensure uninterrupted **daily OST doses** for clients unable to visit the MAT clinic.
- Provide **mental health** and **clinical care** to those needing continued support.
- Encourage **hospital staff (for admitted clients)** and **prison authorities** to liaise with MAT clinics for continuity of client care.

Detailed description of the continuum of care approaches

The table below summarizes the various strategies of continuum of care, including its objective, implementation, impact and challenges encountered. A detailed description of each strategy is provided later in the chapter.

Table 4 Summary of continuum of care services

Service type	Objective	Implementation	Impact	Challenges
Take-home doses (THDs)	Allow stable clients to receive OST without daily clinic visits, improving adherence and reducing disruptions in their daily lives.	• Patients assessed by a **multidisciplinary team** based on clinical and psychosocial stability. • Initial **client-initiated requests** later transitioned to **HCW-led recommendations.** • THD privileges were gradually increased based on need and stability	• Patients' **improved adherence** to OST. • **Reduced clinic congestion** and long wait times. • Patients had more flexibility to **work, study, or travel** without missing doses.	• Some **clients preferred daily visits** for social reasons (meeting peers, avoiding idleness). • **HCWs were hesitant** due to procedural concerns and client trust issues. • PWUD not disclosing opioid use to **family or supporters** made home storage difficult. • Regulatory constraints required **individual NASCOP approvals,** making implementation slow.
Daily home deliveries	Ensure **continued OST access** for clients unable to visit the clinic due to mobility challenges and for whom storage of OST at home was deemed unsafe.	• OST delivered **directly to clients' homes** by HCW or CHW. • **Target groups**: those with severe illness, mobility restrictions due to fractures, or high-risk situations, e.g. complicated pregnancy or post-partum.	• Immobile clients had **increased access to OST.** • Prevented **treatment dropouts** among those with health or mobility issues.	• **Logistical difficulties** – need for daily allocation of a car and staff daily. • **Distance** from the MAT clinic. • **Slow approvals from NASCOP** for each new client needing home delivery.

Service type	Objective	Implementation	Impact	Challenges
Hospital deliveries	Ensure **continuity of OST for hospitalized PWUD**, reducing withdrawal risks and improving recovery.	• **Coordination between MAT clinics and hospitals** for inpatient OST administration. • Liaison with **hospital HCWs** to ensure proper dosing and monitoring.	• Prevented **withdrawal symptoms in hospitalized PWUD.** • Improved collaboration between **MAT clinics and hospitals**.	• Some **hospital staff lacked training** on MAT protocols.
Prison deliveries	Provide **OST for incarcerated PWUD**, ensuring they do not relapse due to withdrawal.	• **MAT clinics collaborated with prison authorities** to continue treatment. • OST doses were **delivered directly to correctional facilities**.	• Improved **health outcomes** and prevented withdrawal for incarcerated PWUD.	• **Stigma and resistance** from some prison staff.

4.5 Take-home doses for opioid substitution therapy

Objective

Take-home doses (THDs) are essential for stable clients as they minimize disruptions in their daily lives, improve quality of life, and improve adherence to treatment. To qualify for THDs, a multidisciplinary treatment team evaluates clients at different treatment phases to assess clinical and psychosocial stability, determining eligibility.

Importance of take-home doses

The provision of THDs was critical for the success of the project and clients, reducing barriers to accessing OST for PWUD. MSF strongly advocated this approach, even within the framework of strict guidelines. Insights from the project will inform future programming, which will be guided by evidence-based practices.

Implementing take-home doses for opioid substitution therapy

- **Guidelines:** In Kenya, the MAT guidelines allow THD privileges to be gradually increased from one to a maximum of six doses over at least three months. Special considerations may be made for additional doses or accelerated increases.
- **Challenges:** Our experience showed that the prescribed measures were not always practical. For instance, clients may request THDs before the three-month guideline or may need more than the prescribed dose. Strict adherence to the guidelines could lead to clients dropping out of care. Therefore, the eligibility criteria were revised to best benefit the client.
- **Evolution of approach:** Initially, THDs were client-initiated and based on need. Over time, with more experienced staff and more stable clients on OST, the approach shifted to HCWs proposing THDs to PWUD.

Table 5 Stepwise approach for take-home doses

Step	Details
1. Request initiation	Provider/patient initiated for stable clients or based on client needs (e.g., job, travel, school, illness).
2. Initial evaluation	Conduct a thorough assessment to ensure the client is stable, not using heroin or other OST, and not cross-addicted to alcohol. (See Appendix 2.)
3. Home visit	Perform a home visit by a pharmacist/clinician and psychosocial team to assess eligibility: • Safe and lockable storage and a good living environment, not close to known drug dens or hotspots. • Presence of a reliable treatment supporter. • Treatment supporter is not an active heroin user or alcohol dependent. (See Appendix 3.)
4. Multi-disciplinary discussion	• Discuss client eligibility within the medical team. • Disqualify if there are safety concerns (e.g., past attempts at diversion).
5. Consent and documentation	• Patient and treatment supporter sign consent forms for THDs (see Appendix 4). • The treatment supporter provides a copy of their national ID or, if the ID is lost, a police abstract indicating that a replacement is pending, for inclusion in the client's file.

Step	Details
6. Initiation of take-home doses	• For stable clients, start with a 7-day dose, potentially increasing to 14 days. • Doses delivered using an ambulance or MSF car. • Provide a safe box for OST storage and transport.
7. Monitoring and control	• Patient must return to the clinic for review on the last day of the dose. • Conduct urine toxicology tests and psychosocial assessments. • Patients must return empty OST bottles and any missed doses with P4 forms.
8. Follow-up and adjustments	• If clients test positive for opiates (heroin) or fail to adhere to instructions, re-evaluate their case. • Continue daily OST delivery if the client is unable to come for review due to illness.

What did we achieve with take-home doses?

- **Increased access to treatment:** THDs were successfully provided to eligible clients, reducing the burden of daily clinic visits and improving overall accessibility
- **Improved client convenience and flexibility:** clients who opted for THDs were able to integrate treatment into their daily routines, allowing them to manage work, education, and family responsibilities more effectively.
- **Enhanced trust and client autonomy:** Offering THDs empowered clients to take responsibility for their treatment, fostering a sense of independence and trust in the healthcare system.
- **Reduction in clinic congestion:** THDs helped free up clinic resources, allowing HCWs to focus more on newly enrolled and high-risk clients.
- **Lessons for future implementation:** The initiative provided valuable insights into client preferences, healthcare worker concerns, and policy barriers, which can inform improvements in MAT programmes moving forward.

Challenges faced in implementing take-home doses for opioid substitution therapy

While significant progress was made and many clients benefited, this strategy did not achieve the desired outcomes for the following reasons:

- **Patient preferences:** Some stable clients did not want THDs and preferred attending the MAT clinic daily. Reasons included wanting to interact with peers and being idle at home due to a lack of employment.
- **HCW hesitation:** HCWs were sometimes hesitant to propose or initiate THDs for eligible clients due to concerns about procedural requirements and uncertainties regarding client readiness and trust.
- **Non-disclosure:** Lack of disclosure by PWUD to family members or treatment supporters regarding opioid use dependency made it challenging to initiate THDs.
- **Restrictive procedures:** Since THDs were not widely implemented in MAT clinics in Kenya due to control measures enforced by the Pharmacy and Poisons Board (PPB), significant advocacy was required to expand this practice through NASCOP. As a result, individual requests had to be submitted to NASCOP for authorization to deliver OST to each new client via email, along with weekly follow-up updates, making this a time-consuming task for the team.

Lessons learned from implementing take-home doses

1. **Patient-centred approaches are key.** Not all eligible clients prefer THDs. Some value daily clinic visits for social interaction and structure, highlighting the need for flexible, client-driven care models.
2. **Healthcare worker support is crucial.** Hesitation from HCWs due to procedural concerns and trust issues can slow down implementation. Training and clear guidelines are essential to increase confidence in recommending THDs.
3. **Family and community involvement matters.** Many PWUD do not disclose their opioid dependency to their families for fear of judgment or stigma, creating barriers to home-based treatment. Strengthening family education and support mechanisms could help.
4. **Policy and advocacy challenges hinder implementation.** The requirement for individual approvals from NASCOP and weekly follow-ups made scaling the programme difficult.

The Kiambu county-led advocacy in ensuring continuum of care:

The proactive role of the Kiambu CHMT in advocating for the continuity of THDs after MSF's handover demonstrates the county's commitment to ensuring uninterrupted client care. It also underscores the need for clear, supportive policies that facilitate service continuity, **reduce bureaucratic barriers**, and promote client-centred care in MAT programmes.

4.6 Recommendations for THD

Provide flexible treatment options with guided support. HCWs should actively discuss the benefits of THDs with eligible clients, highlighting how they can improve convenience, stability, and adherence. At the same time, clients should have the autonomy to choose between THDs and clinic-based care based on their individual needs and preferences.

5. **Strengthen HCW capacity and confidence.** Conduct targeted training for HCWs on eligibility criteria, client readiness assessments, and procedural requirements to encourage uptake of THDs.
6. **Enhance family and community awareness.** Develop strategies to support disclosure and reduce stigma around opioid use disorder, fostering a more supportive environment for clients.
7. **Streamline policy and approval processes.** Advocate for policy changes to allow wider implementation of THDs without the need for case-by-case approvals, reducing administrative burdens.
8. **Leverage digital tools for efficiency.** Explore digital platforms for submitting and tracking THD approvals, ensuring smoother communication with regulatory bodies like NASCOP and PPB.

4.7 Daily home deliveries

What was the objective?

Providing daily home delivery of OST was essential for clients, particularly those who were homebound due to illness or injury and not eligible for take-home doses. The key aspects of the implementation included:

- **Delivery process:** OST doses were packed in a secure box along with P4 forms for signing by both the client and the MAT staff upon dosing.
- **Delivery team:** The process was initially handled by the pharmacy team, but as demand increased, **the role was task-shifted to the psychosocial team, clinicians, and later to trained CHWs who were peer educators under an MSF contract.**
- **Transportation:** Deliveries were made using MSF vehicles or ambulances, ensuring accessibility for clients unable to reach the MAT clinic.
- **CHW involvement:** Expanding the role of CHWs to include home deliveries strengthened client-centred care and built trust within the community, demonstrating their valuable contribution to the healthcare system. This was the first time the CHWs were involved in OST delivery by MSF or MAT clinics in Kenya. Before starting, NASCOP had to be informed for approval.

Challenges faced by home deliveries

1. **Logistical constraints**: Daily home deliveries had to be incorporated into an already overloaded movement schedule. Balancing these deliveries with other daily activities required careful planning and prioritization, often stretching available personnel and transport capacity.
2. **Distance and resource limitations:**
    - Some delivery locations were far from the MAT clinic, leading to extended travel times.
    - Limited availability of vehicles and human resources sometimes delayed deliveries, as they were engaged in other essential activities.

Impact and lessons learned

1. **Improved recovery outcomes:**
    - Daily OST deliveries ensured consistent access to medication, reducing the need for clients to seek illicit substances.
    - Stable OST access contributed to better health outcomes and a more structured recovery process.
2. **Prevention of health complications:**
    - Patients with fractures previously resorted to removing casts to solicit financial aid for drugs, leading to complications like malunion and osteomyelitis.
    - With reliable OST home deliveries, these clients could remain at home, focus on recovery, and avoid further medical issues.
3. **Empowerment of CHWs:**
    - Task-shifting home deliveries to trained CHWs who were peers themselves enhanced trust and confidence in their abilities.
    - This approach reinforced a client-centred model and demonstrated the effectiveness of community involvement in healthcare service delivery.
4. **Strengthening community-based healthcare with OST delivery:**
    - Daily home deliveries of OST played a critical role in supporting client recovery and reducing reliance on illicit substances.
    - Despite logistical challenges, the initiative proved highly beneficial, offering key lessons for future MAT programme implementation, particularly in strengthening community-based healthcare approaches

4.8 Opioid substitution therapy delivery to hospitals

Hospital deliveries of OST were implemented:

1. To provide OST for clients who were admitted to the hospital.
2. To support clients who were not eligible for THDs and lived too far to benefit from daily home deliveries.

How was it done?

- The client or hospital staff would notify the MAT clinic via phone about an admission requiring OST.
- The pharmacy team would verify the MAT ID and client details using the MethaMeasure machine (a device used in MAT clinics to dispense and monitor doses of methadone for clients undergoing treatment for opioid use disorder).
- Upon confirmation, a seven-day OST supply would be delivered to the hospital pharmacy.
- The hospital pharmacist would dispense the OST as part of the client's treatment regimen.
- After the client's discharge, the hospital pharmacist would inform the MAT team to collect the empty bottles, P4 forms, and any leftover OST.

MAT clinic staff were permitted to review inpatients and document notes in their medical files and treatment sheets, facilitating follow-up care. This was possible due to prior sensitization efforts with HCWs at referral hospitals, who recognized the importance of continuity of care for PWUD.

Impact and lessons learned

1. Hospital deliveries were crucial in ensuring clients **remained on OST** throughout their admission.
2. Patients who were not on OST often **absconded from the hospital** or resorted to using heroin smuggled in by friends, which created conflicts with hospital staff.
3. By providing OST in hospitals, **client retention in care** improved, and hospital environments became more conducive to recovery.
4. Strengthening **collaboration between MAT clinics and hospitals** remains vital for sustaining this practice and enhancing client outcomes.

4.9 Delivery of opioid substitution therapy to incarcerated PWUD

Although two decentralized MAT clinics were established in Kiambu County at Ruiru and Thika Prisons, PWUD incarcerated in Nairobi Remand Prison and Kiambu Prison, which were distant from these clinics, required OST delivery at their locations.

How was it done?

The process involved:

- **Sensitization of police and prison officers:**
  - Police and prison officers were sensitized by the MSF team.
  - They informed the MAT clinic when a PWUD was in police custody or sent to prison.
- **Police custody process:**
  - PWUD in police cells (sometimes for up to **14 days** awaiting sentencing) were escorted by police officers to the MAT clinic for **daily dosing**.
  - MAT IDs given to clients during induction were crucial as proof of their follow-up at the clinic.
  - Initially, medical forms were provided to confirm the client's treatment status and need for daily dosing.
  - These forms were either given to relatives to deliver to the police station or taken by peer educators/social workers.
- **Prison incarceration process:**
  - Prison officers informed the MAT clinic of new PWUD incarcerations.
  - Patient details were verified using **MAT IDs** and **MethaMeasure** to prevent fraud (e.g., fake names or IDs).
  - Doses for verified clients were included in the next delivery.
- **Delivery frequency:**
  - Prison deliveries were made every **7–8 days** for incarcerated PWUD.
- **Comprehensive prison visits:**
  - A MAT clinic team (clinical, psychosocial, and nutritionist) visited the prison **every alternate Tuesday**.
  - Activities during visits included:
    - Comprehensive client reviews
    - Dose adjustments for OST
    - Provision of other necessary treatments, including **mental health medications**
    - Peers trained in para-legal support also visited to provide PWUD with para-legal aid.

Impact of delivery of opioid substitution therapy to incarcerated PWUD

1. **Continuity of care:** Most incarcerated PWUD continued OST, improving overall health and well-being.
2. **Reduced risky behaviour:** Providing OST in prisons minimized heroin use, reducing the risk of needle sharing.
3. **Post-release retention:** A significant number of individuals remained on OST after release, lowering the chances of relapse and overdose.

Challenges

1. **Increased logistical demands:** The growing number of incarcerated PWUD added to packaging and delivery requirements.
2. **Staff turnover:** Frequent changes in prison and police personnel required ongoing sensitization and training.
3. **Administrative barriers:** Efforts to transfer incarcerated PWUD to prisons with MAT clinics faced obstacles due to technical and protocol challenges from Kenya Prison.

Lessons learned

1. **OST can be re-initiated in prisons**. OST can be re-initiated in prisons with effective follow-up and education for both clients and treatment providers, ensuring that individuals who have previously disengaged or new to care are not overlooked during incarceration.

   Re-induction was done in prison, hospital and even for clients needing THDs, who had missed OST. This was crucial as it eliminated the need to wait for the client to return to the MAT clinic for re-induction, ensuring continuity of care. The re-induction doses were packed accordingly in different bottles and with the dates clearly indicated in each of the dispensing bottles, e.g. days 1–3, 30 mg, days 4–7, 35 doses, etc.

2. **Task shifting enhances continuity.** Implementing task shifting, supported by strong mentorship and training of the prison officers, is essential for enhancing continuity of care and reducing barriers to accessing OST.
3. **Harm reduction is facilitated.** Providing OST in prison facilitated harm reduction by preventing needle sharing among inmates.
4. **OST ensures a smoother transition post-release.** Many PWUD continued OST upon release, reducing relapse and overdose risks.

Recommendations

1. **Screening for opioid dependency:** Many PWUD may resort to crime to sustain their drug use, leading to incarceration. It is essential for prison health facilities to implement a screening system to identify individuals with opioid use dependency and connect them to MAT services. This approach can help mitigate drug use and reduce the sharing of needles within prison environments while also preventing opioid overdose upon release from prison.
2. **Enhanced sensitization:** Regular training for prison staff can improve service delivery.
3. **Policy advocacy:** Facilitating transfers to MAT-equipped prisons can improve access to OST.

A safe box and breathalyser machine that are key tools for take home doses at the Karuri MAT. © Daisy Okanga/MSF

4.10 Provision of opioid substitution therapy for school-going PWUD

Overview

For school-going PWUD who were unable to attend the MAT clinic daily, a flexible solution was implemented to ensure continued access to OST. Eligible clients were offered THDs as the first option. For those not eligible for THDs, an arrangement was made to deliver OST to a nearby hospital, where clients could access their medication at their convenience. The process was similar to that used in the delivery of OST to hospitals described previously.

Challenges faced in providing opioid substitution therapy to school-going PWUD

1. **Difficulty in coordinating OST delivery to boarding schools:** For students attending boarding schools located far from home, it was challenging to arrange the delivery of OST to the school infirmary by the MAT clinic team, especially if they had no reliable treatment supporter.
2. **Confidentiality concerns:** Disclosure of the client's condition was often a significant barrier, as many guardians were hesitant to share information about the client's treatment for fear of stigma and discrimination from both teachers and peers.
3. **Consent for minors under 16:** Some of the students receiving OST were under 16 years old, which required guardian consent for treatment decisions. This additional layer of complexity further hindered the smooth provision of care.

Impact and lessons learned

1. **Successful education completion:** Despite the challenges, the provision of OST enabled school-going PWUD to successfully complete their high school education, marking a significant milestone in their journey toward social reintegration.
2. **Confidentiality is crucial:** The importance of maintaining client confidentiality, especially when dealing with minors or school-going PWUD, was evident. The fear of stigma and discrimination could significantly hinder access to care and support.
3. **Flexibility in service delivery is key:** Providing flexible options for accessing OST, such as THDs and arrangements with local hospitals, helped ensure that school-going PWUD could continue their treatment without interrupting their education.
4. **Need for guardians' involvement:** For minors, it became clear that involving guardians in the treatment process was essential. However, the need for guardians' consent for those under 16 added complexity to the care process, highlighting the need for clear protocols in these cases.
5. **Barriers to access due to distance:** For students in remote or far-away boarding schools, logistical challenges in delivering OST highlighted the importance of proximity to healthcare facilities or the need for mobile or outreach services to ensure continuous treatment.

Recommendations

1. **Strengthen confidentiality measures.** Strengthen measures to protect client confidentiality, including training for teachers, caregivers, and health providers on how to manage sensitive health information for PWUD, particularly minors.
2. **Increase access to MAT services.** To address challenges related to distance and school attendance, consider more satellite clinics or decentralized sites that can bring OST directly to clients in remote locations.
3. **Create age-appropriate protocols for minor clients.** Develop age-appropriate protocols for managing the comprehensive treatment of minors, including for HIV and SRH, ensuring that the process of seeking guardian consent is streamlined, and that guardians feel supported in the treatment process without feeling exposed to judgment or discrimination.
4. **Consider alternative delivery methods for OST.** Explore the possibility of using alternative drug delivery methods (e.g., sublingual tablets like Buprenorphine, where applicable) that could reduce the need for frequent visits to clinics and support more flexible access for school-going PWUD.

4.11 Key takeaways from the continuum of care approach

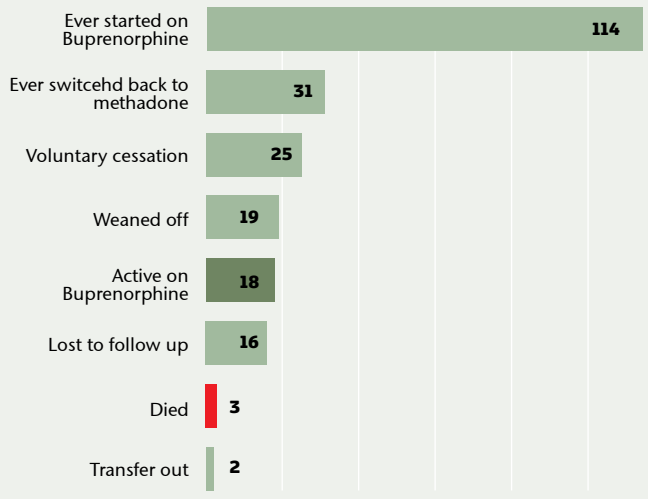
1. **Motivated MAT team:** The successful implementation of the approach relied on a highly motivated MAT clinic team committed to breaking barriers and extending care to PWUD while reducing stigma and discrimination.
2. **Sensitization of stakeholders:** Training and sensitization of HCWs, police, and prison officers were essential for effective implementation, as stigma and discrimination against PWUD were prevalent, and knowledge of harm reduction was limited.
3. **Peer involvement**: Engaging peers with lived experience of substance use and OST provided valuable insights and practical support for PWUD.
4. **Holistic care approach:** A comprehensive approach addressing physical health, mental health, social circumstances, and substance use-related challenges is crucial for the overall well-being of PWUD.

4.12 Use of Buprenorphine as opioid substitution therapy: Benefits, challenges, and implementation

Buprenorphine offers the advantage of reducing cravings and withdrawal symptoms while presenting a lower risk of misuse and overdose compared to methadone, making it a safer and effective option for OST. Additionally, as a sublingual tablet, it is more convenient for use as a take-home treatment option.

Buprenorphine was supplied to the MAT clinics through NASCOP via the Kenya Medical Supplies Authority (KEMSA). Initially, the project began by inducting PWUD on low doses of methadone (less than 40 mg) to Buprenorphine.

Outcomes of Buprenorphine



Challenges in introducing Buprenorphine as opioid substitution therapy

As the Kiambu MAT clinics were the first in the country to introduce Buprenorphine as OST, they encountered significant challenges.

1. **Hesitation among PWUD:** Initially, PWUD were reluctant to switch to Buprenorphine, particularly because it was a new drug and also due to the strict requirement of complete abstinence from methadone for 24 to 36 hours prior to induction. This was essential to avoid precipitated withdrawal, but many PWUD were concerned about the risks and discomfort associated with this process, which made the induction phase difficult for both clients and healthcare providers, leading some PWUD to request a switch back to methadone.
2. **Reluctance among HCWs:** As Buprenorphine was a new treatment option, there was initially a degree of caution in its adoption. This was largely due to the lack of familiarity with the medication, as well as the challenges of integrating a new treatment into existing practices. As a result, the uptake of Buprenorphine treatment was slower than anticipated. This led to the expiry of stocks both at the project and KEMSA.
3. **Stock shortages:** Once PWUD became accustomed to Buprenorphine and HCWs gained more confidence in its use, the clinic experienced a shortage in supply. The stocks from KEMSA were minimal and couldn't keep pace with the rising demand. To bridge the gap, MSF stepped in to provide a buffer stock of Buprenorphine for 20 clients within the Kiambu Project.

Lessons learned

1. **Comprehensive training for staff is essential**: Ensure that all healthcare providers, including doctors, nurses, pharmacists, and counsellors, are thoroughly trained on Buprenorphine's pharmacology, administration, dosing protocols, and potential side effects.
2. **Education and awareness for clients is crucial:** Educate clients about the role of Buprenorphine in recovery, its benefits, and potential side effects. This helps manage expectations and encourages adherence to treatment.
3. **Accurate quantification of Buprenorphine is essential:** Ensure that there is enough stock to meet the needs of clients while preventing shortages or excess inventory.

Recommendation

Based on our experience, once clients understood and began using Buprenorphine, it proved to be an effective and convenient THD option for OST. Buprenorphine particularly benefits PWUD with a shorter drug use history, assuming that this population is increasingly common in Kenya, as the most vulnerable populations have already been reached with methadone over the past 10 years of MAT implementation. Therefore, increasing the availability and stock of Buprenorphine should be prioritized to better meet the growing demand and support continued treatment success. Buprenorphine combined with Naloxone further reduces the risk of diversion, as Naloxone induces immediate withdrawal symptoms if the medication is injected.

4.13 The Buprenorphine corner

Buprenorphine is commonly available as a sublingual tablet, making it particularly well-suited for take-home use. Its sublingual administration makes it easy for clients to manage independently, which reduces the need for frequent clinic visits. This promotes autonomy, improves adherence to treatment, and reduces stigma associated with daily clinic visits. Additionally, Buprenorphine has pharmacological properties that make it safer for unsupervised use compared to other OST options.

The issue

It was important to observe clients who had newly started on Buprenorphine at the pharmacy, as they did not yet qualify for take-home. With the increasing number of PWUD started on Buprenorphine and with Buprenorphine still being administered as directly observed therapy (DOT), this made it difficult for both staff and clients, especially because Buprenorphine takes 5–10 minutes to dissolve. This led to crowding at the pharmacy window, as several clients waited for the tablet to dissolve.

The solution

With this challenge, the Buprenorphine corner was proposed – a small space next to the pharmacy with a table and chairs, and a screen for privacy. It was to be supervised by peer educators (CHWs) under MSF payroll; the first time peer educators were to oversee the administration of OST. The client would report to the pharmacy, then the pharmacy staff would give the drug at the 'Bup Corner'. The client would be observed by the CHW until the tablet dissolved.

> **"This setup has created more opportunities for peer-to-peer counselling sessions, which I found to be very useful."**
>
> A CHW's observation on the Buprenorphine Corner

4.14 Integrating nutrition into medically assisted therapy: A key component of recovery

Issue

Around 20% of PWUD – 337 (297 males and 40 females) enrolled in the three MAT clinics were found to be suffering from severe or moderate malnutrition. This was mainly due to heroin use, which suppresses appetite and leads individuals to prioritize drugs over food. Chronic opioid use also exacerbates gastrointestinal issues, loss of appetite, and mental health conditions, further affecting nutrition.

What support was provided?

Providing nutritional support to PWUD was challenging as they were not classified as a vulnerable group in national nutrition programmes. The nutrition department screened clients for malnutrition and offered counselling, while fortified porridge was introduced by MSF as a substitute for unavailable commodities from the MoH. The MAT porridge prepared by hygiene officers was enhanced with milk powder and peanut butter to meet caloric needs, and clients' consumption was monitored through a tracking system implemented by the nutritionist.

What was achieved?

While the "MAT porridge" was observed to have low treatment outcomes, the introduction of BP 100 which was provided by MSF, raised the introduction of BP-100, which was provided by MSF, raised the nutrition programme's cure rate from 52% to 62.85%, thus reducing the duration of treatment to between 2.5 and 3 months, with an average weight gain of 2.6 kg per client per month. However, some clients struggled to consume the required number of bars, leading to diversion. Additionally, the nutritionist collaborated with the social department to identify vulnerable clients, with MSF providing two meals a day for two weeks to stabilize them. As of April 2024, 337 clients had been enrolled in the nutritional support programme.

What were the challenges faced?

Relapse rates are high due to poor nutrition, dependency on clinic supplies, and food insecurity. Poly-substance use, such as inhalants, exacerbates feeding habits, prioritizing substances over food and worsening health. Opioid-related narcotic bowel syndrome complicates dietary tolerance. Additionally, inconsistent treatment follow-ups delay recovery, prolonging care duration and reducing programme effectiveness

Lessons learned

1. Issuing BP-100 as DOT was effective in minimizing diversion of commodities and improving outcomes, though it was time-consuming and challenging.
2. Health education on nutrition, both group and individual, was essential for adherence, as initial stigma surrounding porridge consumption led to dropouts.
3. Good treatment outcomes also relied on home nutrition, prompting the nutritionist to conduct home visits to educate families and treatment supporters.
4. Visits to prisons ensured adequate food rations for incarcerated PWUD with severe acute malnutrition (SAM) or moderate acute malnutrition (MAM).
5. While the BP-100 demonstrated positive outcomes and PWUD are now recognized and included as a vulnerable group in the nutrition programme by NASCOP, BP-100 is not part of the MoH standard list of supplements. Additionally, the availability of other nutritional supplements remains dependent on donor funding, which poses a challenge to the long-term sustainability of the programme.

Recommendations

1. **Dedicated nutritionist**: Each MAT clinic should have a dedicated nutritionist available to provide necessary services.
2. **Inclusion of PWUD as a vulnerable population**: Ensuring/advocating recognition of PWUD as a vulnerable group will facilitate their inclusion in budget allocations for nutritional supplements.
3. **Collaboration with MoH**: Strong collaboration with the MoH, supported by regular reporting, is essential for ensuring the availability of nutritional commodities.
4. **Home nutrition support:** Nutritional support is most effective when combined with home nutrition, which ensures that the clients eat a balanced diet at home, highlighting the importance of involving treatment supporters when necessary.

4.15 The Empowerment Centre

Overview

The Empowerment Centre (EC) within the Karuri MAT clinic offers clients a space for recreational, income-generating, and wellness activities. Originally called the Social Hall, it was renamed to reflect its primary focus on empowerment.

Coach Patrick standing, guides his learners as he trains them on Chess at the Karuri medically assisted therapy clinic empowerment center.

© Eugene Osidiana/MSF

Creation and need

- The Empowerment Centre was created in response to feedback from clients at the Karuri MAT clinic who were gathering outside after receiving their OST doses, which led to tensions with the local community.
- Many clients had nowhere else to go, which highlighted the need for a productive space within the clinic.

Management and activities

- The Empowerment Centre was constructed and supported by MSF and is now managed by the client-led CBO, HACK, which was supported by MSF.
- On average, the Empowerment Centre receives 50 to 60 visits per day as part of HACK's core activities.

Significance

- The Empowerment Centre has been described as part of therapy for clients, providing an essential space for wellness and social support.
- This investment is unique in that it is "like a drop-in centre close to the MAT clinic", offering integrated services for PWUD.

Recreational activities

Yoga, weightlifting, board games, darts, edutainment, hygiene services (facilities to shower and wash their clothes)

Trainings

- **MSF facilitated:** Farming, including hydroponic methods; production of soap, bleach and sanitizer; hairdressing, barbering and beauty
- **County facilitated:** General livestock management and animal husbandry; formation of self-help groups; rabbit and chicken rearing; bookkeeping and record keeping; group dynamics, including conflict resolution

Impact of the Empowerment Centre

- Reduced crowding, hence improved community perception of PWUD
- Observed behaviour changes as the Empowerment Centre was fully run by PWUD

Challenges encountered at the Empowerment Centre

- Did not fully solve the crowding outside the MAT clinic, as clients still did not have jobs.
- Albeit trained on Income generating activities (IGAs), they lacked the capital to start their own businesses.
- Lack of interest in training by some clients, so they acquired the skills but had no interest in developing them or starting a business.

What were the lessons learned?

1. To optimize the Empowerment Centre, additional strategies are needed to reduce client idling and overcrowding.
2. Involving clients in managing the Empowerment Centre empowers them and promotes personal growth.
3. It is crucial to engage stakeholders early to ensure alignment and support, while strong community backing is vital for sustainability.
4. Offering paid apprenticeships or incentives helps clients gain practical experience and develop sustainable businesses.

Recommendations for projects that consider having an Empowerment Centre

1. **Stakeholder involvement:** Engage experts in training and income-generating activities to enhance the Empowerment Centre programme.
2. **Structured curriculum:** Develop a well-organized, time-bound curriculum in collaboration with recognized Technical and Vocational Education and Training (TVET) institutions.
3. **Family engagement:** Involve clients' family members early to ensure continued support after training.
4. **Long-term sustainability**: Secure ongoing support from key stakeholders to maintain programme effectiveness.
5. **Multi-purpose functionality:** Establish the Empowerment Centre as both a safe space and a training centre.
6. **Safe space integration:** Where resources allow, establish a safe space alongside MAT clinics to provide PWUD with opportunities for socialization, peer interaction, and community support, enhancing their overall well-being.

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Clients during a Yoga Session in Karuri MAT clinic, Kiambu Kenya.

4.16 The anthropological study

Study overview

Title: 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 Programme in Kiambu County, Kenya.

This study, conducted in late 2022 and disseminated in September 2023, explored the lives, challenges, and resources of PWUD in Kiambu County, particularly in relation to MAT enrolment and retention. It examined perspectives on harm reduction, service provider collaboration, and programme expectations, generating key recommendations to enhance accessibility, holistic care, and community integration. A key lesson learned was the importance of conducting such studies early in the project cycle to better inform programming and service delivery.

See link for full report **https://evaluation.msf.org/sites/default/files/2024-11/anthropo_report_ke_kiambu_2023.pdf**

4.17 Contraceptive services for women who use drugs

Contraceptive services were made accessible to women who use drugs (WWUD) and the partners of male PWUD at the MAT clinic. While the MoH provided the commodities, accessing these services at the Level 4 hospital contraception clinic required a fee. Integrating contraceptive services within the MAT clinic with commodities provided by MSF ensured they were available free of charge, eliminating financial barriers and improving access.

One of the more innovative steps MSF took was piloting **self-injecting Depo-Provera** in 2022. We had hoped this would empower women by giving them more control over their contraception, especially for those who might find frequent clinic visits challenging. However, the response was more cautious than expected –**only five women opted in**, despite comprehensive education sessions for both **HCWs and WWUD.**

Through conversations with the women, we realized that **fear of self-injecting** at home was a significant barrier. Many preferred the reassurance of **HCWs administering the injection** at the facility rather than managing it on their own. This experience highlighted the importance of understanding client concerns before rolling out new interventions and the need for **more tailored support** when introducing self-managed care options.

Long-term opioid use can lead to hormonal imbalances, making the return of menstruation a significant achievement for WWUD when they started OST. For some women, the opportunity to conceive became a priority over contraceptive use, as many had longed for the chance to have children.

4.18 Innovative mental health and psychosocial care for PWUD

How psychosocial and mental health interventions were delivered

See our video:

How Psychosocial support was Implemented in the Kiambu Project for people who use drugs https://bit.ly/4ldK3UE

In Kiambu, psychosocial and mental health interventions were structured to address substance-related problems and or disorders. These interventions were applied at different stages of treatment based on the Kenya MAT guidelines of 2021 and MSF protocols. The primary goals were to identify and address the root causes of drug use, teach coping skills to reduce the risk of relapsing, and support clients' recovery and reintegration into society, fostering productivity and well-being.

According to the Kenya National MAT Guidelines of 2021,[11] evidence showed that a combination of specific pharmacological and psychosocial measures is more effective in reducing both illicit opioid use and harms related to drug use, improving quality of life. Psychosocial interventions at the MAT clinic were structured around pairing a medical social worker, addiction counsellor, and CHW with client cohorts, based on their MAT ID, to streamline follow-ups. Initially, having a full-time psychiatrist and psychologist was crucial for building clinician capacity, addressing mental health needs, and improving care. The addition of group therapies and mentorship for addiction counsellors further enhanced treatment quality, supporting the clinic's efforts in providing comprehensive care for PWUD.

11 Ministry of Health, Kenya. *National Implementation Guidelines for Medically Assisted Therapy for People with Opioid Use Disorders.* 2021.

Table 6 Comparison of psychosocial support in MAT clinics

Service	Psychosocial support (other MAT clinics)	Comprehensive psychosocial support (MSF-supported MAT clinics) – pre-handover
Mental health services	• No resident psychiatrist in most MAT clinics. • Patients referred externally for psychiatric care. • Mental health medications often unavailable.	• Dedicated mental health professionals, including a resident psychiatrist and psychologist. • Full-time clinical officer psychiatrist available on-site. • Mental health medication provided free of charge with MSF support.
Counselling and social services	Few trained addiction counsellors available.	• Addiction counsellors and medical social workers provided, as per the national guidelines' recommendation. • CHW paired with an addiction counsellor and a social worker work as a trio following the same cohort of clients. • Structured psychosocial support, including various group therapies. • Family therapy group, with champion parents identified to improve reintegration.

Service	Psychosocial support (other MAT clinics)	Comprehensive psychosocial support (MSF-supported MAT clinics) – pre-handover
Group therapy and peer support	Limited or not available.	• Various thematic group therapies provided for specific needs • Peer-led support supervision provided. • Support groups provided for caregivers and families of PWUD.
Home and prison visits	Not standard practice.	• Regular home visits to provide psychosocial support, even for those with mobility challenges. • Prison visits to provide psychosocial care and support social reintegration of incarcerated PWUD.
Empowerment and social reintegration	No structured vocational training or empowerment programmes – usually offered through the CSOs.	• A dedicated Empowerment Centre providing vocational training, wellness activities, and social reintegration programmes. • Life skills training, including financial literacy, entrepreneurship, and job placement support.
Medical insurance enrolment	Not available.	• Social workers identify socially vulnerable clients and propose their enrolment within the NHIF, covering costs associated with secondary/tertiary referrals and lab/radiology services. MSF paid medical insurance for socially vulnerable clients.
Prison and hospital deliveries	Not available.	• Mental health support provided during prison and home deliveries.
Registration for national ID cards in the MAT clinic	Done routinely	• Area chiefs invited to MAT clinics to assist PWUD in obtaining new or replacement national ID cards, addressing concerns about arrest fears linked to substance use and criminal behaviour.

Group interventions implemented in the medically assisted therapy clinics

Group therapies provide support for individuals facing addiction, fostering a positive self-image through shared experiences and affirmation. The Kenya National MAT Guidelines of 2021 recommend that MAT clinics offer various group therapies, including psychoeducation, early recovery skills, social support, relapse prevention, and self-help groups such as 12-Step facilitation. The project had 11 group therapies focusing on supporting the well-being of the PWUD and recovery.

Some of the group therapies that focused on PWUD recovery

Induction group

Provides support to newly inducted PWUD and orients them into the MAT programme.

Psycho-education group

Aims at providing PWUD with information and skills to understand and manage substance use, reduce associated risks, and support healthier coping strategies without necessarily requiring complete abstinence.

Retention group

Provides support to individuals lost to follow-up (LTFU) and collaborates with treatment supporters to help re-engage them in MAT.

Family therapy

Offers support to treatment supporters while ensuring they have a clear understanding of addiction, harm reduction, and their role in theclient's recovery process.

Other thematic groups

Based on the success and experience gained from the other groups, several more groups were formed:

Men's group, Ladies' group, Only-the-strong-survive, Narcotics Anonymous (a 12-step group facilitated by members)

Why group therapy matters in MAT clinics

- **Encourages peer support and shared learning** – fosters a sense of community and belonging.
- **Enhances treatment retention** – helps individuals stay committed to MAT.
- **Improves mental and emotional well-being** – provides coping skills and emotional support.
- **Reduces stigma and isolation** – creates a safe, non-judgmental space for open discussion.
- **Empowers families and caregivers** – strengthens support networks for long-term recovery.

Impact of group therapy in MSF-supported MAT clinics

- **Higher retention rates:** clients engaged in group therapies showed increased adherence to MAT.
- **Improved social reintegration:** Thematic groups facilitated better self-esteem and personal growth.
- **Strengthened family support:** Family therapy helped reduce stigma and improve understanding of addiction, hence improving family re-integration.

Social work core activities in MAT support

1. Reintegration and support services

Objective: To ensure clients have access to essential documents and services for successful reintegration into society.

Key activities:

- **National ID cards:** Social workers help ensure all enrolled clients obtain their national ID cards by referring them to the Registrar of Persons and the Area Chief (offices located near MAT clinics). The social workers coordinated with the area chief to visit the clinic and assist PWUD in obtaining the necessary documents, as many were afraid to visit government offices due to fear of arrest related to past offenses. However, for non-Kenyan citizens, drawing from the experience of MAT clinics in Nairobi, where a few non-Kenyan individuals access services, these clients are referred to the International Organization for Migration (IOM) to obtain an Alien ID. This is essential to facilitate access to services that require identification, including medical insurance registration, as non-Kenyan passports are generally not accepted.
- **NHIF registration:** Social workers ensure that clients are enrolled in NHIF, providing them with access to secondary and tertiary healthcare services.
- **Home visits:** The aim was to trace the LTFU and enhance family-reintegration which was integral to clients recovery.

2. Community engagement through the chief's barazas

Objective: To foster community acceptance and understanding of MAT services.

Key activity:

Social workers collaborate with the area chief to secure invitations to Chief's barazas (community meetings) held by the chief. During these meetings, social workers are invited to briefly talk about MAT services as part of the agenda, promoting awareness and acceptance in the community.

3. Lost to follow-up (LTFU) tracing

Objective: To track and re-engage clients who have defaulted on their treatment.

Weekly activity:

- **Team collaboration:** On Mondays, a team comprising the Health Records Information Officer (HRIO), social workers, CHWs, and peer educators, works together to review the client line list and identify clients who have defaulted from treatment.
- **Tracing priority:** Defaulted clients are prioritized for tracing. The team uses phone calls to trace clients, and those who cannot be reached are referred for physical tracing by LVCT staff.
- **Satellite clinics:** This tracing activity is also extended to clients receiving treatment at satellite clinics.
- **Documentation:** An Excel sheet is used to document the tracing process, including details of each tracing attempt and outcome.

4. Grassroots sensitization and social directory updates

Objective: To continually engage and update key actors in the community who are involved in the care and support of MAT clients.

Target audience: Police, rescue shelters, children's homes, vocational training institutes, rehabilitation centres, and other community actors near MAT clinics.

Key activities:

- Social workers carry out sensitization visits and gather updated information, and maintain an up-to-date **social directory**. The directory serves as a framework for client referrals to various community services.
- **Reporting:** After each visit, a report is generated before updating the directory with the latest contacts and resources.

Achievements and impact of the psychosocial interventions

- **Positive treatment outcomes:** One of the key results of psychosocial support is the improvement in overall treatment outcomes. This includes better engagement in treatment, reduced relapse rates, and an enhanced quality of life for the clients
- **Family support and reintegration:** Family visits and involvement are encouraged, strengthening emotional resilience and recovery.
- **Social reintegration:** Support is provided for clients to return to education, employment, or start businesses, aiding societal reintegration.
- **Legal and financial support:** Paralegal assistance and hospital waivers ensure access to legal rights and financial relief.
- **Access to identification documents:** clients are assisted in obtaining critical documents, enabling full participation in society.

Challenges in implementing the psychosocial and mental health interventions

- The **willingness of PWUD to engage with care**, particularly counselling services, was low, highlighting the need for the team to possess the appropriate skills, like motivational interviewing, to encourage their participation and maintain their involvement in the programme.
- **Some team members exhibited reluctance to follow up with their cohorts**, particularly as many of our innovative approaches, like social re-integration, required staff to step outside the MAT facility to engage with stakeholders and treatment supporters.
- **Strengthening the capacity of general clinicians in managing mental health disorders** is vital for providing comprehensive care to PWUD, even in the absence of a psychiatrist; however, despite training opportunities, some clinicians and nurses have shown reluctance to adopt these skills, often perceiving them as outside their job descriptions and without appropriate compensation.
- Some stakeholders involved with MSF expected **financial compensation**, while others **imposed their personal values**

on the clients. For instance, PWUD without stable housing were placed in shelters that insisted on abstinence from OST to maintain accommodation. This issue was addressed by providing sensitization on MSF's principles and values, as well as on harm reduction and recovery approaches.

Lessons learned

1. **Training on motivational interviewing:** Some healthcare providers typically use a 'top down' approach rather than a client-centred one, making it essential for all clinical and relevant non-clinical staff in MAT clinics to be trained in motivational interviewing, as this approach has proven most effective for individuals with addiction, highlighting the need for comprehensive training, especially for addiction counsellors and mental health team members.
2. **Socioeconomic reintegration** is vital for the recovery of PWUD as it offers essential support and resources to help them rebuild their lives, regain stability, and reduce the likelihood of relapse. Engaging a partner with expertise in developing skills for sustainable livelihoods from the outset would have been more effective than attempting to implement this on our own.
3. **Capacity of partner organizations:** The effectiveness of harm reduction services and psychosocial support at the community level is greatly influenced by the capacity of partnering organizations, impacting outcomes for PWUD both in MAT clinics and during aftercare.
4. **Psychoeducation for families:** Providing psycho-education to family members is crucial for ensuring their support of PWUD and for preventing relapse.
5. **De-escalation techniques training:** Regular continuing medical education (CME) on de-escalation techniques is important for managing anger or irritability in PWUD, related to opioid withdrawal or underlying mental health issues.
6. **Full-time psychiatrist for comprehensive mental healthcare:** Having a full-time psychiatrist within the MAT clinic is essential for providing holistic, one-stop-shop mental healthcare for PWUD. This ensures timely diagnosis and management of co-occurring mental health conditions, facilitates integrated treatment planning, and allows for immediate psychiatric intervention when needed.
7. **Integrated psychiatrist consultations:** Involving addiction counsellors in psychiatrist consultations can enhance treatment coordination for PWUD, ensuring a more holistic approach, while reducing the need for multiple appointments.
8. **Community engagement:** Establishing positive relationships with local stakeholders and creating referral systems can facilitate access to available services and opportunities for PWUD.
9. **Peer legal aid training:** Training peers as paralegals to accompany every prison visit can provide legal aid to incarcerated PWUD lacking access to legal representation and educate them on their human rights.

- The MAT clinic engaged with the judiciary to advocate for non-custodial sentencing for PWUD, allowing them to continue receiving care and facilitating their socio-reintegration; however, **some individuals violated the terms of their probation**.
- Due to the **absence of data collection tools** for mental health and psychosocial services in the MAT clinic, MSF developed a psychiatric intake form, which was subsequently adopted by NASCOP as a national standard.

Recommendations

1. **Training in motivational interviewing:** Equipping clinical and non-clinical MAT staff with training and skills in motivational interviewing is crucial for enhancing client engagement, improving treatment outcomes, and fostering a supportive environment that encourages individuals to actively participate in their recovery journey.
2. **Is a full-time psychiatrist a must?** Based on the Kiambu experience, having a full-time psychiatrist in the MAT clinic is valuable for ensuring a comprehensive approach to treatment. It allows for the timely identification and management of co-occurring mental health disorders, ultimately improving overall care and recovery outcomes for individuals with substance use disorders. In Kenya, clinical officers receive specialized training in psychiatry and are well-equipped to take on this role, helping to address the country's shortage of psychiatrists while improving the client-clinician ratio. Therefore, where resources allow, including a psychiatrist should be a key consideration.
3. **Collaboration with shelter providers:** Identify and work closely with actors providing shelter to support PWUD newly enrolled into the MAT programme and with no housing or social support.
4. **Engagement with livelihood partners**: Engaging a partner with expertise in developing skills for sustainable livelihoods for PWUD from the outset would have been more effective than attempting to implement this on our own.
5. **Ongoing engagement for medical access:** To maintain ongoing access to medical services, the social department should engage PWUD and their families or treatment supporters from the outset and consistently emphasize the importance of regularly paying for their medical insurance.

@ Kristof Vadino

MSF's MAT clinic in Karuri, Kiambu county offers a one stop-shop comprehensive medical services to people who use drugs. Peer educators are central to effective service delivery for PWUD.

5. THE PEER-LED APPROACH IN SERVICE DELIVERY FOR PWUD – WHY IT MATTERS

5.1 What is the peer-led approach?

A peer-led approach involves individuals with lived experiences leading the planning and implementation of interventions for their communities, tailoring their methods to meet the specific needs of key populations. Peer educators provide targeted support across different health programmes, such as HIV, HCV, HBV, TB, SRH and non-communicable diseases, and with key population groups such as MSM, FSW, PWUD, etc.

Why the peer-led approach works: The rationale behind the model

- **Building trust:** Peer educators play a critical role in harm reduction programmes by building trust, reducing stigma, and leveraging shared experiences to support PWUD.
- **"Nothing for us without us":** PWUD believe that no decisions should be made on their behalf without their active involvement. They believe that nothing should be done for them without their engagement. Peer educators empower communities by offering mentorship and lay counselling, and collaborating with HCWs to ensure that interventions are relevant and effective.
- **Advocacy and sensitization:** Peers are key in advocacy efforts, supporting with para-legal aid, partnering with organizations such as HACK and LVCT Health to raise awareness and implement harm reduction strategies in the community.

How peers were included

1. Involved in strategy and design of the programme

Peers played a significant role in decision-making and service design and improvement at the MAT clinics and within the community. They were involved in:

- Selecting decentralized sites through focus group discussions
- Conducting client satisfaction surveys
- Designing activities for the empowerment centre
- Participating in weekly/monthly feedback meetings to refine services
- Managing PWUD community feedback through suggestion boxes and complaint books for direct client input
- Hotspot mapping and estimating the PWUD population size

2. Involved in the implementation of activities at the community and MAT clinic

Peers were engaged and contracted by LVCT Health, which seconded them to the MAT clinic. LVCT Health played a key role in selecting, training, and incentivizing the peers. MSF also worked closely with LVCT Health peers and incentivized those seconded to the MAT clinics.

Roles of community-based peers

- Identified dens and hot spots.
- Mobilized PWUD to attend outreach services and MAT preparation sessions at the DIC.
- Supported the induction process by escorting PWUD to the MAT clinic, which was a requirement.
- Implemented the microplanning for peer-led outreach activities in collaboration with LVCT Health.
- Informed the PWUD size estimates conducted by NASCOP/LVCT Health in 2018 and MSF/LVCT Health in 2021.
- Worked in collaboration with the DIC and MAT clinic psychosocial team to trace the PWUD who dropped out of care.

Roles of MAT clinic-based peers

- Provided day-to-day support at the MAT clinic by:
  - Compiling the daily attendance register for all PWUD visiting the MAT clinic
  - Overseeing crowd control both within and outside the MAT clinic
- Worked in collaboration with the community-based peers to trace PWUD who drop out of care.
- In collaboration with the health promotion team, organized and facilitated health education activities on key topics within the MAT clinic and during World Health promotion days.
- Assisted in running the daily activities of the empowerment centre.

Innovations and adaptations in peer-led approach

Employment of peers as CHWs and provision of stipends

MSF hired peers as salaried CHWs to enhance peer support activities at MAT clinics and work in collaboration with the community peer educators and outreach teams. These CHWs were selected through an external advertisement. Their key roles were:

- Assisted with referrals, health education, home visits, and hospital support.
- Tracked clients who missed appointments and helped with client engagement.
- Worked closely with peer educators from LVCT Health.

The salaried model provided peers with stability, allowed them to focus entirely on support roles, and ensured sustained impact, without relying on external incentives or juggling other jobs. It also facilitated close collaboration with peer educators from LVCT Health.

Key lesson learned

Ensuring that a peer educator is fairly compensated provides stability and supports recovery by offering meaningful employment and fostering purpose, thereby reducing relapse risks; comprehensive support and ongoing education are essential to mitigate these potential issues.

5.2 Microplanning for PWUD peer-led outreach

What is microplanning?

Microplanning is a tool used by peer educators, with consistent support from outreach workers, to map and track individual PWUD and their partners within their communities. Outreach workers are also peers who are trained further to provide technical support to fellow peers. This tool helps plan and monitor service delivery actions on a regular basis, focusing on individual risk profiles and prevention service uptake based on each PWUD's needs.

Key feature: Facilitates individual-level planning and follow-up of prevention services tailored to the unique risks and profiles of PWUD.

Guidelines for peer educators

According to the **Kenya National Implementation Guidelines for Medically Assisted Therapy**, each peer educator is expected to oversee a maximum of **40 PWUD.** However, this ratio is often impacted by human resource limitations and organizational funding.

Objective of microplanning

The goal of microplanning is to achieve an efficient scale-up of service delivery by:

- Identifying PWUD with the greatest needs, such as higher risks and vulnerabilities, who have been underserved by the programme.
- Ensuring that targeted services reach those who need them most, enabling more personalized care and engagement.

Microplanning meetings for peer support in harm reduction

Objective: Microplanning meetings are designed to support peer educators in effectively addressing the needs of their assigned cohort, including understanding and addressing risks and barriers related to prevention, care, and treatment. The aim is to prioritize harm reduction strategies and ensure personalized, targeted interventions for each cohort.

Meeting structure and implementation

Frequency:

- **Weekly meetings:** Held every Thursday afternoon at the MAT clinic. These meetings bring together facility and community-based peers to share information, provide feedback, discuss day-to-day activities, and engage in capacity building with the support of clinic staff.
- **Monthly meetings:** Also known as reporting meetings, these are held at the facility where community-based peers report on the progress of their assigned cohorts, plan activities, and collect NSP supplies for distribution to the PWUD in the community. These meetings are primarily supported by LVCT Health.

Focus of weekly meetings:

- **Information sharing:** Peers share updates on their cohort's health and well-being, discussing any challenges or barriers to care.
- **Support and capacity building:** The meetings provide a platform for peers to receive ongoing training and guidance from clinic staff and their fellow peers.

- **Addressing challenges:** Peer educators discuss any operational difficulties and strategize solutions.
- **Transportation support:** To ensure participation, peers are provided with a KES 500 transport allowance for attending the meetings.

Monthly reporting meetings:

- Held at the facility, these meetings gather community-based peers to report on their cohorts' progress and to plan for upcoming activities.

Key goals and benefits of the meetings:

- **Peer empowerment:** The meetings provide an ongoing platform for peers to build capacity, collaborate, and receive guidance from both their fellow peers and the clinic staff.
- **Improved communication:** Regular meetings ensure that peers stay informed, share feedback, and stay aligned with project goals and community needs.

Strengthening peer educators' capacity and support

- Capacity-building sessions are also included, focusing on: **Recovery, behaviour change and life skills** development
- **Support supervision** is provided monthly by an external partner also working with PWUD.
- **Peer support for peer educators:** Peer educators are also navigating their own recovery journeys, so these sessions also aim to support them in their personal recovery. By supporting peer educators, MSF helps them enhance their capacity to effectively assist others in similar situations.
- **Incentives:** MSF provides **stipends** to peer educators to support their attendance at these meetings, supplementing the modest **monthly incentives** they receive from LVCT Health.

How was microplanning structured?

Figure 2 Peer-led approach to microplanning

Key Steps to peer-led microplanning

1. Discussions and engagement with the CSO (LVCT Health)

LVCT involved in the engagement and identification of peer educators. LVCT Health was responsible for recruiting and incentivizing the peer educators.

2. Training of peer educators, out reach workers and health promotion team

MSF, with support from the South Africa Medical Unit (SAMU), conducted training sessions.

Key focus areas included:

- Hotspot mapping
- Geographical profiling
- Risk assessment

3. Cohort allocation

Each peer educator was assigned a specific den.
The number of PWUD in each den varied based on location.

4. Implementation phase

The MoH contact form, used by peer educators and outreach workers, was revised through a collaboration between MSF and LVCT.

Training sessions were conducted for MSF staff, LVCT staff (including outreach workers), and peer educators on:

- The revised tool
- Simple data collection and reporting methods

Peer educators were provided with small booklets to support activity planning.

5. Cohort reporting

Weekly review and planning meetings. Peer educators and outreach workers from LVCT met with the MSF health promotion team every week at the MAT clinic.

These meetings focused on:

- Reviewing activities from the previous week
- Planning for upcoming activities
- Collecting harm reduction commodities (clean needles, syringes, condoms, etc.)

To facilitate access, LVCT Health maintained a stock of harm reduction commodities at the MAT clinic.

5.3 Health education by peer educators

Health education sessions were a vital part of the MAT programme, aimed at informing clients about essential health topics and promoting overall well-being. These sessions were conducted by peer educators, supported by the health promotion manager/ supervisor, and covered various health topics relevant to PWUD.

How health education sessions were organized

1. **Training for peer educators:** Peer educators were trained by clinicians and nurses on health topics such as: HIV/TB/HCV, opioid overdose prevention and management, contraceptive services and other relevant health topics.
2. **Health education manuals** were provided to peer educators after their trainings to guide them in delivering accurate and comprehensive sessions.
3. **Session locations:**
    - Health education sessions were conducted in high-traffic areas within the clinic, such as:
        - **The pharmacy waiting area**
        - **The counselling department** waiting area
        - **Buprenorphine corner:** clients provided feedback that the daily health education sessions were becoming overwhelming due to their frequency, as they would be in the Buprenorphine corner daily. In response to client concerns, the frequency of the health education sessions was adjusted to be **needs-based**, allowing for a more tailored and flexible approach that better suited the consistent client group.
    - These locations ensured that a large number of clients, who visited the clinic daily, could participate in the sessions.
4. **Maximizing engagement:**
    - Given the generally short waiting times (1-2 minutes per person at the pharmacy for dispensing OST), many clients were able to engage in the sessions.
    - To further enhance engagement, **visual health education** was introduced, with sessions displayed on a **TV screen.** A different topic ran continuously each day, allowing for more accessibility and interaction.

Key lesson learned

Peers needed to have a strong understanding of the subject matter to effectively communicate accurate information to clients, which was influenced by varying levels of literacy. This required multiple refresher sessions to ensure they grasped the content thoroughly. Additionally, the health education sessions had to be brief and to the point, as PWUD typically had short attention spans.

5.4 Impacts of the peer-led approach

- **Enhanced trust and engagement:** Shared experiences built trust and encouraged greater participation and uptake of services in the community and MAT clinic.
- **Improved health outcomes:** Peer-led initiatives such as health education and microplanning activities led to better health practices, such as safer injection techniques and decreased needle sharing. In turn, this ultimately reduced overdose and disease transmission rates. Two cases of overdose fatalities were reported in the project in 5 years, and were noted to be in the initial phases of the project and decreased over time. Only 60 HCV cases were reported out of 1,619 PWUD, most of which were reported in the initial year of the project. Microplanning activities where peers brought partners of HCV clients for screening played a significant role.
- **Empowerment and self-advocacy:** By involving peers in leadership roles, they are empowered to advocate for their needs, fostering a sense of agency and community ownership over harm reduction efforts. This was achieved through the creation of the peer-led CBO, HACK.
- **Tailored support and services:** Peers provided insight into the design of the strategy, e.g. decentralized MAT services, the anthropological study, and patient satisfaction surveys leading to more relevant and effective support services that resonate with PWUD experiences.
- **Stigma reduction:** Peer involvement during community sensitizations challenged stereotypes and misconceptions about drug use, promoting acceptance and understanding within the broader community and improving the overall community perception of PWUD.

5.5 Self-impact of the peer role

Peers in the MAT programme faced challenges in balancing their dual roles as both clients undergoing treatment and peer educators responsible for supporting others. This created conflicts of interest and emotional strain in certain situations.

Challenges faced by peer educators

1. **Dual responsibilities:** As clients, peers were managing their own recovery processes while simultaneously being expected to guide and support others. This created internal tension, as they had to navigate their personal struggles with substance use while fulfilling their responsibilities as peer educators.
2. **Emotional and psychological strain:** The weight of their dual role sometimes led to emotional and psychological strain, as peers were required to maintain a sense of authority and strength while working through their own recovery challenges.
3. **Stigma:** Peers often faced stigma related to their identity as PWUD, which made it difficult for them to be fully accepted, particularly by HCWs in their role as peer educators.
4. **Conflicts with counselling:** Addiction counsellors reported challenges when providing counselling to peers, as the peers would often adopt their 'peer educator' persona, making it

difficult for them to engage fully in the therapeutic process. This challenge was sometimes magnified by the counselling approaches discussed in earlier sections regarding psychosocial interventions.

Mitigation strategies

Strategies were developed to help peers navigate these challenges and ensure they could effectively support both their personal recovery and their role as educators.

- Peers were provided with **training on life skills** to help them manage their dual roles.
- Peers were **encouraged to attend individual counselling sessions** with their primary counsellors to ensure their personal recovery needs were addressed.
- Regular **group support supervision** sessions helped peers process their emotional challenges and gain insights into managing both their recovery journey and their educator responsibilities.

Table 7 Further challenges of the peer-led approach

Challenge	Action taken
Recruitment of peers through a CSO (LVCT Health) limited MSF's decision-making on peer management, causing delays on decisions.	MSF recruited four CHWs and signed an MoU with LVCT Health to support activities, including incentivizing peers, enabling weekly meetings instead of monthly.
HCWs demonstrated resistance to the involvement of peers in the process.	Sensitization meetings were held for staff to clarify the role and benefits of peer educators, while peers received training on behaviour change, workplace conduct, andclient confidentiality.
Stigma and discrimination from the community hindered peer recovery and well-being.	Peers remained actively involved in community activities, while stakeholders continued to be sensitized.
Pressure from drug peddlers on peers to return to drug use increased relapse risk.	Pushers were sensitized by LVCT Health on the importance of harm reduction and the need to prevent opioid overdose.
Mistrust among peers led to conflicts, negatively impacting team dynamics.	Training on conflict resolution, open discussions, and group support supervision helped peers address disagreements and improve communication.
Peers in recovery may have faced difficulties achieving objectives due to their own ongoing recovery needs.	Peers were supported through individual and group counselling and life skills education.
Strategies to attract WWUD were not fully successful.	Initial strategies, such as involving female peer educators and running a women's group, were continued, and a child play area was introduced at the Karuri MAT clinic.
National guidelines restricted financial incentives for peers, limiting MSF's ability to improve compensation.	Advocacy efforts through the Kenyan Network of People Who Use Drugs (KENPUD) are ongoing but progressing very slowly.

5.7 Lessons learned in peer-led model implementation

1. **Overcoming initial resistance to the peer-led model:** At the start of the project, there was an assumption that all staff would be open to collaborating with peer educators. However, many staff members, unfamiliar with peer-led programmes, exhibited implicit bias, distrust, and rejection. Some even refused to attend meetings with peers, citing confidentiality concerns, which created significant tension within the team.

   To **address this challenge**, the peer-led model was reintroduced to all staff by the project managers, who clarified the roles of peer educators and emphasized the importance of their support. While attitudes improved, valuable time was lost due to the initial resistance.

2. **Remuneration of peer educators:** Acceptable remunerated peer educators are more focused, motivated, and able to contribute effectively to the programme. Fair compensation ensures commitment and engagement from peer educators.
3. **Gender sensitivity in peer-led approach:** Gender sensitivity is essential when implementing a peer-led approach. Ensuring the needs and experiences of all individuals are respected and addressed improves programme effectiveness. Tailoring the approach to be inclusive helps in achieving better results and broadens participation.
4. **Patient feedback mechanism (complaint book):** The complaint book, as a feedback mechanism, which was manned by peers, was not effective due to confidentiality concerns. Alternative feedback mechanisms that better protect client confidentiality should be explored to ensure trust and effectiveness.
5. **The critical role of peer engagement:** Our experience highlights the importance of peer engagement at the community level, within the MAT clinic, and post-MAT. Peers bridge the gap between PWUD and healthcare services, ensuring access to treatment, adherence support, and harm reduction. Post-MAT, they play a key role in follow-up, relapse prevention, and reintegration, helping individuals sustain long-term recovery.

5.8 Recommendations for improving the peer-led model

1. **Introduction and orientation for staff:** Before engaging staff unfamiliar with peer-led projects, it is important to introduce them to the peer-led model. If possible, provide an internship opportunity in CSOs or MAT clinics to help them understand how to collaborate effectively with peers, as well as to comprehend their characteristics and lifestyles. A refresher on this should be conducted routinely to ensure a harmonious work environment and continuous support for the model.
2. **Continuous mentorship and capacity building for peers:** Continuous mentorship and capacity building for peer educators are crucial to improve the quality of peer-led activities. Regular training sessions and support structures should be in place to enhance their effectiveness.
3. **Proper remuneration for peers**: Peers should be well remunerated to help them focus on their roles and maintain high levels of motivation. Competitive compensation packages should be implemented to ensure commitment to their roles and programme success.
4. **Holistic support for peers:** Peers need support across all dimensions – emotionally, behaviourally, and psycho-socially – since they are clients and staff members who have their own recovery struggles. Ensure there are structures in place to provide them with support in all these aspects, including counselling and group supervision to aid their recovery and role fulfilment.
5. **Feedback mechanism for peer protection:** A robust feedback mechanism should be established to ensure that peers are not at risk of bullying, abuse, or exploitation by staff, providing them with a safe and supportive environment.


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MSF's MAT clinic, in Karuri town, Kiambu County, offers a one-stop-clinic with free comprehensive health care services for people who use drugs, in particular opioid users, including heroin.

5.9 The Haven Addiction Centre, Kiambu: a PWUD-led community-based organization

Overview

The Haven Addiction Centre Kiambu (HACK) community-based organization (CBO) is a PWUD-led, membership-driven organization aimed at strengthening harm reduction services at the community level in Kiambu County. It operates within three MSF-supported MAT clinics and supports all PWUD – on MAT or not. The CBO was formed in October 2022 and officially registered in May 2023, with MSF's support, and has established leadership structures.

Key achievements of HACK after the handover:

- Following the MSF handover, the CBO, HACK, has remained operational with minimal support from MSF.
- It continues to carry out community sensitization efforts and harm reduction activities within the empowerment center.
- Additionally, five CBO members have transitioned into roles as community health promoters under the Kiambu County MoH.

Lessons learned

1. **Timely formation of the CBO:** The autonomy of the CBO required more time than anticipated. The process should have started at the project's outset, and the chronogram should have remained flexible, based on milestones achieved and yet to be achieved and the availability of partners or donors, with sufficient investment and commitment from MSF, even as support was gradually scaled down.
2. **Stakeholder involvement:** Early engagement with all relevant stakeholders, including the county, was crucial to prevent challenges and delays later in the process.
3. **Building internal capacity:** Strengthening the CBO's internal capabilities was vital for ensuring long-term growth and sustainability.
4. **Human rights defenders training:** This training should be incorporated at the inception of capacity-building efforts, as it has been shown to enhance peers' self-reliance and empowerment.
5. **Focus on psychosocial support:** Emphasizing mental health and psychosocial support helped expedite the recovery of members and supported the CBO's path to autonomy.
6. **Local community engagement:** Engaging local stakeholders and government entities helped to amplify the CBO's impact in the community.
7. **Tailored services for PWUD:** Adapting services to meet the specific needs of the PWUD population was a key factor in the CBO's success.

See our video:
Haven addiction Center Kiambu Community based organisation
https://bit.ly/4lejJK9

Key achievements

- Achieved **behaviour changes** among members through advocacy and life skills training.
- Developed **organizational policies**, focusing on capacity building in areas such as administration and project planning.
- Successfully integrated activities with CSOs like LVCT Health, including LTFU tracing and health education.
- Actively supported the day-to-day operations of the **empowerment centre**, offering safe spaces for income-generating and recreational activities.
- Improved community perception and acceptance, and **reduced stigma**.
- Conducted a **SWOT analysis** to assess organizational strengths and weaknesses.
- Conducted **focused group discussions** with PWUD to better understand their needs.
- Carried out a **benchmarking exercise** to learn from other well-established CBOs in Kenya's coastal region, informing future strategy.

Some challenges

- **Group dynamics** affected by members' ongoing recovery.
- **Funding constraints** that limit the full realization of goals.
- **Limited integration** with county systems.
- **Stigma** from healthcare providers, families, and the community.
- **Time-bound support** from MSF, set to end in December 2024, while activities were not fully established.

Recommendation

- When forming a peer-led CBO, it's important to acknowledge the challenges it will face before achieving autonomy, including the fact that members are undergoing their own recovery. It is necessary to provide psychosocial support and capacity building, and have a flexible timeline to help the CBO reach its goals.
- Ensure that all stakeholders essential for the CBO's establishment and success are engaged from the outset.
- Ongoing efforts to combat stigma and improve acceptance of PWUD within communities and healthcare settings are essential.
- The human rights defender training can be introduced earlier in the project cycle, but it is most effective once group dynamics have stabilized, recovery has progressed, and CBO members have a clear understanding of the organization's objectives

The Karuri MAT Clinic, built by MSF within Karuri Level 4 Hospital.

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6. HEALTH PROMOTION

6.1 Objective

Health promotion is essential in supporting PWUD because it helps improve their well-being and quality of life. Instead of only treating illnesses, health promotion focuses on preventing health problems, reducing harm, and ensuring access to healthcare. It also helps reduce stigma and supports PWUD in making healthier choices. In the project, **health promotion was integrated into every activity**, ensuring a holistic approach to care and reinforcing positive health-seeking behaviours at every stage.

6.2 Approach to health promotion

In this project, health promotion was implemented through a collaborative effort involving **peer educators and CHWs** supported by outreach workers from LVCT Health and MSF. A dedicated manager from MSF oversaw these activities, ensuring their effectiveness and alignment with the project goals.

6.3 Key strategies and activities

Health education

In order to empower PWUD with the knowledge and skills needed to make informed health decisions:

- **Peer educators and CHWs** led health education sessions. These sessions were designed to address critical health topics relevant to PWUD.
- Peer educators were trained in health education topics and methods for delivering these services effectively.
- **Information, education, and communication materials** such as posters, flyers, and brochures were used as teaching tools. Some were designed by PWUD themselves to better reflect their language and everyday realities.
- Health education sessions were recorded in the **health education form** and updated in the **health education database** weekly by a computer-literate CHW.
- Each **peer educator** had a target of conducting five health education sessions per day. This was monitored during weekly meetings.

Stigma reduction and empowerment

- By integrating harm reduction concepts and access to services, the approach contributed to reducing stigma and improving health-seeking behaviour among PWUD.
- In every sensitization forum to stakeholders, a peer educator/ CHW would be involved to share a testimonial.
- These efforts aimed to create a supportive environment where PWUD felt empowered to seek services without fear of judgment.

6.4 Digital health promotion campaign

Concerns arose related to the handover of MAT clinics to Kiambu County. In response, a digital health promotion campaign was initiated to address rumours, reassure clients, and ensure continuity of care. This initiative used social media platforms to disseminate key messages and re-engage clients who had dropped out of care. Before the launch, the messages were first shared with the peers for their feedback, who then tested them with clients to ensure the content was clearly understood.

- **Challenge:** Upon hearing about the transfer of MAT clinic management to Kiambu County, rumours circulated that the clinics might close or that familiar staff would be replaced. These rumours led to an increase in premature weaning from OST among clients.
- **Response:** To tackle these concerns, the health promotion team, in collaboration with the project management, supported by peer educators, developed key messages to reassure clients and clarify that MAT services would continue uninterrupted under county management. Despite these efforts, the rumours persisted. This prompted the team to extend their communication efforts to a digital health promotion campaign to reach a wider audience.
    - A targeted **social media campaign** was launched on Facebook, linked to a WhatsApp number, to reach a broader audience within Kiambu County. The campaign aimed to inform PWUD, their treatment supporters, and the wider community.
    - The **core message** emphasized that MAT services would continue without interruption under the county's management, ensuring ongoing care and support for all clients.
    - A **health promotion officer** was recruited to manage client inquiries and respond to any questions raised on the platform.
- After one month of the campaign, several PWUD who had dropped out of care returned for re-induction into OST, and new inductees also joined the programme.
- The campaign ran after the project's closure, with the key messages hosted on the **Kiambu County Facebook page**.

Lessons learned

- **Proactive communication:** Key messages regarding the clinic handover should have been shared well in advance to avoid rumours, minimize client anxiety, and prevent dropouts from the service. Early communication would have helped build trust and reassured clients before misinformation spread.
- **Use of social media:** Although there were concerns that social media might not effectively reach the PWUD community as many did not have smartphones, it ultimately proved to be a valuable tool for reinforcing key messages, reassuring clients about service continuity, and even engaging the broader community.

Key recommendation

It is crucial to **incorporate digital health promotion strategies** from the start of the project lifecycle. Establishing clear communication channels early on will help reach wider audiences, address concerns proactively, and ensure continuity of care. It will lead to improved client engagement and retention, and reach the broader community.

A client visits the MAT clinic for review, with treatment supporters who play a vital role in their recovery journey.

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7. ADVOCACY AND POLICY CHANGE: INFLUENCING THE AGENDA OF HARM REDUCTION

7.1 Overview

With drug use and PWUD still highly criminaliz ed and stigmatized, advocacy in harm reduction aims to promote policies and initiatives that reduce the negative impacts of drug use. The project focuses on two objectives:

- creating an enabling environment through stakeholder engagement
- influencing harm reduction policies at the county and national levels

Key advocacy areas

- **Raising awareness about the importance of harm reduction:** Stigma remains a major barrier preventing PWUD from accessing healthcare. Targeted sensitization efforts engaged key stakeholders, including HCWs, law enforcement officers, probation officers, health management teams, religious leaders, political leaders, community members, local administration etc. **Activities** included:
  - sensitization sessions conducted in MAT clinics, including facility tours
  - testimonials from clients and their families to humanize PWUD experiences
- **Influencing policy on harm reduction:** MSF actively contributes to shaping harm reduction policies by participating in key national platforms such as the **National Harm Reduction Technical Working Group** and the **Key and Vulnerable Populations Committee of Experts.**

7.2 Key contributions by MSF

Policy contributions:

- Played a key role by participating in developing Kenya's National Guidelines for MAT.
- Expanded access to MAT services through decentralization, satellite dispensing sites, and THDs.
- Advocated for increased uptake of Buprenorphine as a user-friendly THD option.
- Facilitated the availability of Naloxone at the community level through peer educators.
- Standardized practices, such as the reuse of methadone dispensing cups through standard operating procedures.
- Conducted anthropological studies to provide evidence-based insights into the challenges faced by PWUD and inform programme improvements.

Contributions to access to care and service integration:

- PWUD were included in the national Nutrition Programme as a vulnerable population through NASCOP.
- Advocated for NASCOP to facilitate the provision of pre-filled Naloxone.
- Established satellite dispensing sites to expand access to MAT services.
- Introduced THDs and daily home deliveries of OST.
- Peer educators were included in harm reduction programmes, managing the first Buprenorphine corner in the country.
- MOH staff were integrated into MAT clinics, ensuring sustainability beyond donor funding.

Stigma reduction efforts:

Engaged PWUD (HACK members) in sensitization meetings to combat stigma by sharing testimonials.

7.3 Pending advocacy areas in harm reduction requiring further attention

1. **Cost of MethaMeasure licenses**

- **Audience:** NASCOP, harm reduction implementers, health policymakers, government regulatory agencies, and healthcare funders.
- **Focus:** Advocacy efforts should focus on reducing the £1,000 annual license fee and the high cost of purchasing MethaMeasure machines. These machines are critical for accurate and safe methadone dispensing in OST programmes. Lowering these costs would improve access to evidence-based harm reduction interventions.

2. **Urine toxicology costs**

- **Audience:** NASCOP, harm reduction implementers, public health authorities, insurance providers, and healthcare policymakers.
- **Focus:** At €6.43 per test, the cost of urine toxicology screening presents a significant barrier to MAT initiation. Some clinics cannot induct PWUD due to affordability challenges. Advocacy should push for government subsidies or insurance coverage to ensure that cost does not hinder access to lifesaving treatment.

3. **HCV treatment funding**

- **Audience:** NASCOP, harm reduction implementers, donor organizations, global health institutions, and national health ministries.
- **Focus:** Advocacy should call for donor-funded HCV treatment programmes to include coverage for PCR HCV confirmatory testing. This test is essential for diagnosing chronic HCV and initiating treatment, yet funding gaps often exclude it, delaying or preventing access to care for those in need.

Lessons learned

1. **Early stakeholder collaboration:** Early collaboration with the MOH, county government, and NASCOP was instrumental in integrating and transitioning the MAT project into the existing healthcare infrastructure.
2. **Strategic partnerships:** Working closely with LVCT Health ensured a comprehensive harm reduction care package, fostering a deeper understanding of PWUD needs and enhancing service delivery
3. **Dedicated advocacy leadership:** Having an advocacy manager would have enhanced efforts in raising awareness, challenging stigma, facilitating partnerships, pushing for policy reforms, and ensuring long-term integration of MAT services into the healthcare system.
4. **Dignified Representation in Visual Communication:** Visual representations significantly influence public perceptions of PWUD. To support destigmatization, images used in communication, as well as those depicting interventions and activities, should portray PWUD in a respectful and dignified manner.

7.4 Media engagement in support of advocacy efforts for PWUD

Role of media

In the Kiambu community, local journalists are trusted and influential sources of information, shaping public narratives on various issues, including health and social challenges.

Objective of media engagement

To enhance understanding of harm reduction services and promote solution-focused reporting that reduces stigma around issues related to PWUD.

Media engagement strategy

The project organized a **dedicated sensitization session for Kiambu-based journalists**, which included:

- a facility tour of the MAT clinic to provide journalists with first-hand experience of the services offered
- a focused discussion on harm reduction services and their importance in supporting PWUD

Key focus areas:

- **Inclusive language:** The session emphasized the importance of using inclusive and non-stigmatizing language in drug-related reporting to challenge negative perceptions and combat stigma.
- **Solution-focused reporting:** Journalists were encouraged to shift the narrative towards solutions, focusing on recovery, rehabilitation, and the positive impact of harm reduction programmes.
- **Amplifying PWUD voices:** Journalists were encouraged to report on project activities and share the personal stories of PWUD and their treatment supporters, ensuring their voices were heard and valued.

Importance of media engagement

- **Shaping public perception:** By equipping journalists with accurate information and resources, the project aimed to influence how the community views PWUD, shifting from judgment to understanding and support.
- **Challenging stigma:** The media plays a critical role in shaping attitudes. By promoting inclusive and solution-focused reporting, the project worked to reduce the stigma associated with drug use and increase acceptance of harm reduction interventions.
- **Increased community support:** Positive media coverage can help generate public support for harm reduction programmes and advocacy efforts, ensuring sustained funding, resources, and community buy-in for PWUD initiatives.

7.5 Community engagement in support of PWUD projects: Who and when to engage?

Objective

Promote acceptance of PWUD at the community level and improve their access to services at the MAT clinics.

Initial community engagement strategy

Extensive community outreach was conducted at the start of the project, targeting key stakeholders including Kiambu CHMT and sub county-CHMT, law enforcers, chiefs, religious leaders, and HCWs, including facility leads. This was done in hotels, away from the MAT clinics. However, the strategy did not achieve the desired results in terms of community acceptance.

Initial challenges

Despite initial efforts to engage the community, negative perceptions of PWUD persisted. The rise in the number of PWUD seeking services, especially at the Karuri MAT clinic led to growing resistance and misunderstanding at the community level.

Revised strategy for community engagement based on challenges faced

- **Engagement of grassroots leaders:** In response to challenges, the approach shifted to engaging the community at a deeper, grassroots level. Key groups included Nyumba Kumi (community leaders), local clergy, and community health promoters, who were initially overlooked.
- **Sensitization initiatives:**
    - Nyumba Kumi and local clergy were invited to participate in **sensitization meetings** to understand the goals and benefits of the programme.
    - **Community members were invited to visit the MAT clinic** to witness first-hand the services being offered to PWUD.
    - The **venue** for sensitization was shifted from hotels to MAT clinics, allowing participants to directly observe the services provided at the clinics. This hands-on approach helped demystify the treatment process and showcased the support available for PWUD.
    - People in recovery shared **personal stories** of their journey to recovery, fostering empathy and reducing stigma.

Outcome

Improved community acceptance: The revised strategy led to significant improvements in community perceptions, fostering a more supportive environment for PWUD seeking treatment at the Karuri MAT clinic.

County ownership: The county took responsibility for inviting stakeholders to sensitization meetings. By positioning the initiative as a MoH-led effort, rather than a partner-driven project, the county ensured that the activity was seen as a local, government-supported programme, which enhanced credibility and acceptance within the community.

Key lesson learned:

Starting community engagement from the onset is key: Early and ongoing community engagement is essential for building trust, fostering acceptance, and preventing resistance to MAT services. In the Kiambu experience, initial outreach efforts did not fully address community concerns, leading to misunderstandings and stigma. A delayed shift to grassroots engagement revealed that involving key community influencers – such as Nyumba Kumi leaders, local clergy, and community health promoters – early in the process could have helped shape more positive perceptions from the start. Additionally, positioning the initiative as a county-led effort from the beginning would have strengthened community buy-in and ownership, reducing reliance on external partners. This highlights the importance of integrating community engagement into the project design, ensuring that stakeholders are informed, involved, and supportive from the outset.

Michelle Wambui stands next to her family home in crutches, following a road accident. She began receiving hospital deliveries for methadone dose during her admission to the hospital for three months, due to injuries. Currently, she receives daily home deliveries done through a peer educator.

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7.6 Where are the women? Advocacy strategy for the inclusion and empowerment of women who use drugs (WWUD)

Background

- **Gender-specific barriers:** Women who use drugs (WWUD) encounter unique challenges that make them particularly vulnerable. Gender-based issues such as stigma, discrimination, economic dependency, caregiving responsibilities, engagement in transactional sex work, and experiences of gender-based violence further complicate their substance use and treatment access. These barriers isolate women from support networks and exacerbate mental health struggles, trauma, and drug use.
- **Kiambu situation:** Despite various interventions, such as engaging female peer educators and creating women-only groups, WWUD account for only 7.7% of the total number of people enrolled in MAT clinics in Kiambu, a statistic mirrored in clinics across the country. This highlights the need for stronger advocacy and targeted interventions to address the specific needs of women in the drug recovery process.

Key challenges faced by WWUD

- **Stigma and discrimination:** Gender-based stigma associated with drug use is more pronounced for women, discouraging them from seeking help.
- **Barriers to treatment access:** Economic dependency, caregiving roles, and societal expectations create additional hurdles for women trying to access harm reduction services.
- **Trauma and abuse:** Many women face trauma, including gender-based violence, which further complicates their mental health and substance use issues.
- **Engagement in transactional sex:** For many women who use drugs, the intersectionality of drug use and transactional sex creates additional challenges such as increased vulnerability to violence, stigma, discrimination, exploitation, and barriers to accessing harm reduction and healthcare services.
- **Lack of supportive services:** There is a lack of safe, women-only spaces that provide not only treatment but also emotional support, peer bonding, and trauma recovery.

What could have been done differently?

- **Tailored outreach and communication:** Collaborate with LVCT Health to develop targeted campaigns addressing barriers WWUD face, such as caregiving, economic dependency, and stigma, using female-specific messaging and platforms.
- **Gender-sensitive services:** Design services to be more accessible for women by providing childcare, offering flexible hours, and training staff in gender sensitivity and trauma-informed care.
- **Safe, supportive spaces:** Expand women-only groups and safe spaces to provide not only treatment but also emotional support, peer bonding, and a sense of community. Integrate mental health services to address trauma and abuse.
- **Integrated support services:** Provide comprehensive services that address the intersection of drug use, gender-based violence, mental health, and economic empowerment through partnerships with women's rights and domestic violence organizations.
- **Strengthening partnerships for inclusive support:** Collaborate with CBOs and CSOs providing services to sex workers to enhance engagement, ensure tailored support, and improve access to harm reduction services for women who use drugs while avoiding bureaucratic barriers that hinder service delivery.
- **Peer-led advocacy and mentorship:** Increase the role of female peer educators and mentors to offer guidance, break down stigma, and encourage other women to access services.
- **Engagement with families and communities:** Work with families and community leaders to reduce stigma and create a supportive environment, potentially identifying a female parent as a champion to address these issues.
- **Monitoring and evaluation:** Track challenges faced by WWUD in accessing services, gather feedback, and adapt services to ensure they meet women's needs

A pharmacy technician packages methadone doses to be delivered toclients in prisons and hospitals. Prison and hospital deliveries ensure continuity of care for them.

8. KEY CONSIDERATIONS FOR HEALTHCARE WORKERS IN HARM REDUCTION

8.1 Overview

Engaging healthcare workers (HCWs) in harm reduction services was critical to delivering compassionate and effective care to PWUD. This approach ensured that HCWs were well-trained in harm reduction principles, which focused on minimizing health risks and improving the quality of life for individuals, rather than solely aiming for abstinence. To achieve this, a structured team consisting of county MoH staff, MSF staff, and peer educators was put in place to ensure the successful provision of MAT services.

8.2 Staff structure

1. **County MoH staff:**

- County MoH staff were recruited specifically to work in MAT clinics.
- While the county directly paid their salaries, MSF reimbursed these costs. No additional incentives were provided beyond their regular salaries, except for a gratuity at the end of their contracts.
- Staff roles included clinical officers, nurses, lab technologists, medical social workers, addiction counsellors, clinical officer psychiatrists, pharmacists, nutritionists, hygiene officers, and security personnel.
- These staff members were supervised by MSF managers while remaining accountable to their respective departmental heads within the county management structure.
- Administrative and human resource functions were managed by the county office, with MSF's HR manager working closely with the county HR department to provide additional support.

2. **MSF staff:**

- MSF recruited and paid key personnel, including a project coordinator, project medical referent, medical activity manager, mental health supervisor, health promotion manager, psychologist, psychiatrist, CHWs (peer educators), logistics and supply staff, and drivers.
- These personnel played a pivotal role in overseeing the implementation and quality of the MAT services.

3. **Peer educators:**

- Peer educators, who had lived experience with drug use, were recruited and seconded to the MAT clinics by LVCT Health.
- LVCT Health paid their monthly incentives, while MSF covered their daily transport allowances.
- Peer educators were directly supervised by MSF's health promotion team but remained accountable to LVCT health outreach workers.

8.3 Training and capacity building – how was it done?

1. Initial training:

- Newly recruited staff underwent an intensive 2-week training facilitated by certified national training of trainers (ToTs), NASCOP.
    - **Week 1:** Five days of training focused on harm reduction principles and understanding PWUD and their vulnerabilities. Addressed stigma and discrimination towards the key population.
    - **Week 2:** Covered MAT service provision.
- Staff were then placed in a 6-week hands-on training experience at Nairobi MAT clinics.
- For new staff at Ruiru and Thika MAT clinics, a 2-week embedment at Karuri MAT clinic was conducted before transitioning to on-the-job training at their designated sites.
- Experienced staff at Karuri MAT clinic provided coaching and mentorship to newer recruits, reinforcing best practices in harm reduction service delivery.

2. Ongoing professional development:

- The MAT clinics operated from 7h00 to 13h00, allowing afternoons to be dedicated to CME sessions and staff meetings.
- CME sessions covered diverse topics such as mental health support for PWUD, motivational interviewing techniques, and de-escalation strategies for crisis situations.
- Weekly case discussions were held to review complex cases, assess challenges, and share best practices.
- Medical meetings focused on analysing client data, evaluating service quality, and addressing operational challenges while celebrating successes.

3. Sensitization for all staff:

In addition to clinical training, all non-medical staff, including security and hygiene personnel, were sensitized on harm reduction principles. This initiative aimed to foster a welcoming, non-judgmental clinic environment where PWUD felt safe accessing services.

4. Integration of staff:

To enhance awareness and service integration, staff from the main healthcare facilities (Kauri L4 hospital, Ruiru L3 health centre) hosting MAT clinics were encouraged to rotate through the MAT clinics. This approach ensured a broader facility-level understanding of harm reduction principles and fostered an enabling environment for PWUD beyond the MAT clinic setting.

Lessons learned and recommendations

1. Engaging MoH staff from the start facilitates sustainability.

The decision to involve county MoH staff from the outset, with the county taking responsibility for salary payments, significantly eased the exit strategy for MSF as an implementing partner. This approach, clearly stipulated in the MoU between Kiambu County and MSF, ensured the continued sustainability of MAT services after MSF's withdrawal.

2. Continuous training is essential.

Ongoing/continuous capacity-building efforts were crucial in maintaining a supportive and professional environment for both staff and clients. Training empowered HCWs with the knowledge and skills required to handle the complex needs of PWUD while promoting client-centred care.

3. Support supervision is crucial for staff well-being and service quality.

Continuous supervision and mentorship provided HCWs with guidance, ensured adherence to harm reduction best practices, and addressed challenges faced in service provision. Regular check-ins and structured support mechanisms helped prevent burnout, enhanced staff motivation, and promoted high standards of care.

4. Mental health specialists play a vital role in MAT clinics.

In addition to addiction counsellors, psychologists and psychiatrists play a vital role in addressing co-occurring mental health disorders, providing therapy, and ensuring a comprehensive, client-centred approach to MAT services.

5. Staff attitude is key.

- Despite significant investment in staff training and advocacy for their absorption as permanent and pensionable MoH employees, their commitment to providing quality services to PWUD declined after MSF's exit, resulting in reduced enthusiasm and engagement.
- Additionally, without ongoing staff support supervision, motivation and service quality can decline. The lack of regular mentorship, feedback, and accountability may lead to reduced staff engagement, ultimately affecting their commitment to providing quality care for PWUD.

Angela Thiong'o (right) MSF Kiambu project Medical Referent explains a concept during a walk through session with journalists during a media sensitization at Karuri MAT clinic.

© Daisy Okanga/MSF

9. STRATEGIC MEETINGS FOR ENHANCING CLIENT CARE AND SERVICE DELIVERY

9.1 Objective

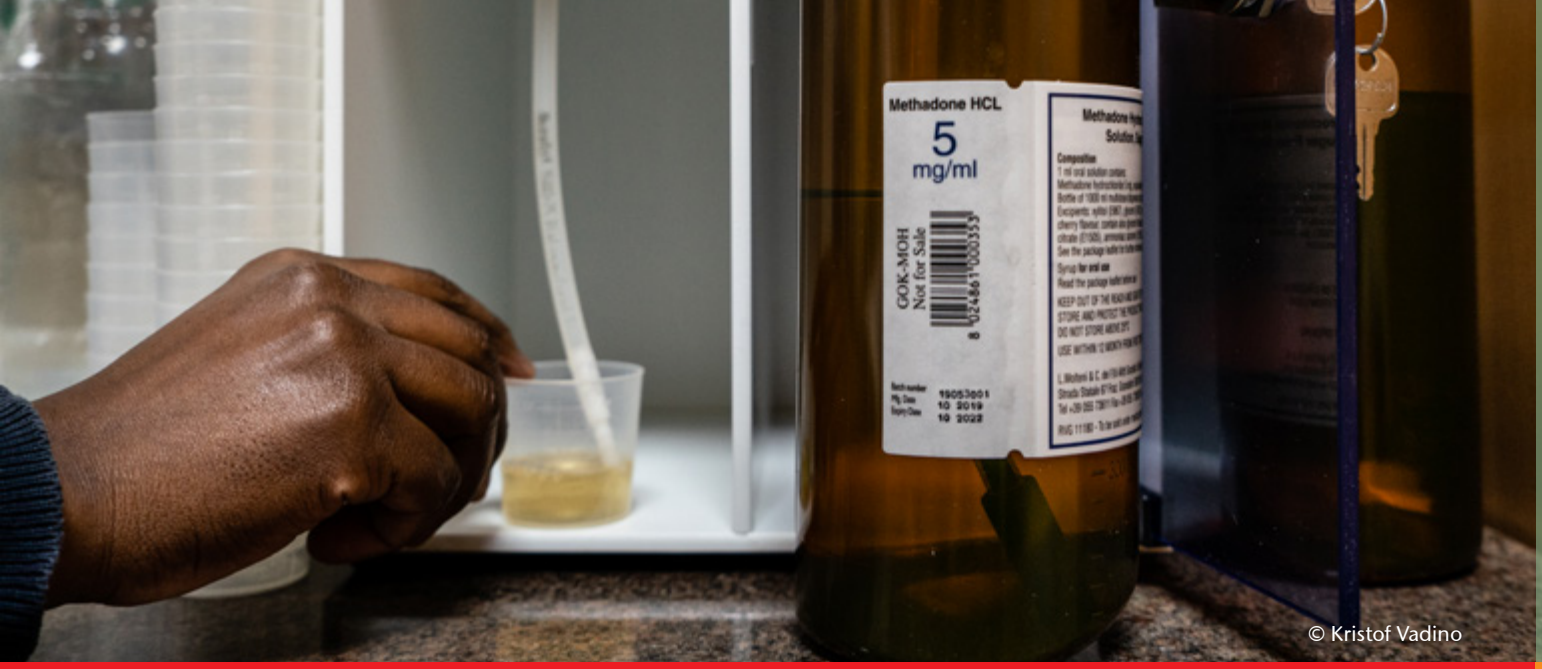
The primary goal of these meetings is to enhance the quality of care provided to clients and to improve overall client outcomes. By focusing on refining clinical practices, addressing challenges in service delivery, and strategizing for sustainable improvements, the meetings are an essential part of ensuring continued improved quality in care provision.

9.2 Meeting schedule

These meetings are held from 13h30 to avoid interfering with regular clinic hours, which run until 13h00. The timing allows for uninterrupted service delivery during working hours, while still providing a dedicated space for discussion and planning once client care has concluded for the day.

The meetings provide an opportunity to:

- Enhance quality of care: Regularly review clinical practices and explore ways to improve client treatment protocols
- Improve client outcomes: Analyse data and feedback to identify opportunities to boost client health outcomes and satisfaction
- Optimize operations: Review operational processes to ensure efficiency and identify areas for improvement
- Promote team collaboration and development: Offer a platform for staff to collaborate, share insights, and engage in continuous professional development.
- See Appendix 7 for the types of meeting, participants, frequency and objectives.



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10. STRENGTHENING MAT PROGRAMMES: THE ROLE OF TECHNOLOGY IN CLIENT CARE

Beyond accessibility and psychosocial support, improving the quality of care in MAT programmes requires leveraging technology and efficient systems. Two critical areas for advocacy are:

- the use of the MethaMeasure machine
- the integration of biometrics

Both have the potential to streamline services, enhance client monitoring, and improve overall programme efficiency. Below is a detailed discussion of their impact and necessity.

10.1 The MethaMeasure machine

Overview: The MethaMeasure machine is a vital device used in MAT clinics to dispense and monitor doses of methadone for clients undergoing treatment for opioid use disorder. The user-friendly, efficient system combines a computer with a dispensing machine to ensure accurate, consistent, and safe administration of methadone.

Key benefits:

- **Accurate dosing**: Delivers precise doses of methadone, ensuring treatment effectiveness and client safety.
- **Consistency**: Standardizes methadone measurement, reducing human error in dosing.
- **Monitoring**: Tracks the amount dispensed to each client, facilitating monitoring of treatment progress and compliance.
- **Prevention of misuse**: Minimizes the risk of medication misuse or diversion by controlling the quantity dispensed.
- **Directly observed therapy (DOT):** Ensures clients receive their methadone dose accurately under supervision.
- **Off-site treatment (OST) packaging**: Facilitates the preparation of methadone doses for clients receiving care outside the clinic, maintaining continuity of treatment.

Financial considerations as at March 2025:

- **Initial purchase cost**: €10,000 per machine.
- **Annual operating license fee**: Negotiated at £1,000 (reduced from £1,200).
- **Provider/host**: MethaMeasure UK
- **Clinic requirements**: A single clinic may require multiple machines depending on the client load.

Challenges observed with the MethaMeasure machine:

- **Incomplete data capture**: The machine does not capture all relevant data, such as missed doses for clients who do not have an updated prescription.
- **Inconsistent data retrieval**: It fails to consistently retrieve important client information, such as MAT ID and gender, even though these details are encoded during data entry.
- **Need for technical support**: The system requires reliable technical support to address potential failures. Without this, manual dispensing may become necessary, which can disrupt clinic operations.
- To mitigate this, key ICT teams from the county, subcounty level, and LVCT Health were trained on MethaMeasure machine handling and troubleshooting before the clinics were handed over. This training was conducted by Ecojoules, the local company licensed by MethaMeasure UK to provide technical support in Kenya.

Key lesson learned:

It was assumed for a long time that the MethaMeasure machine is almost 100% accurate in data reporting. However, during the capitalization process, it became evident that the machine has its own challenges in terms of extracting and reporting data.

Recommendations:

- It is important to have **contingency plans** in place for manual dispensing in case of system failure.
- Advocacy efforts should be made to negotiate a **more affordable operating license fee**.
- **Developing a localized, cost-effective software solution** could ensure the safe dispensing of OST while reducing reliance on expensive systems. This approach would make the system more accessible for clinics with limited resources. While this was identified as a key advocacy point, discussions with NASCOP and other partners were not initiated before the project handover.
- From the start, discussions on the machine's setup should have been prioritized to ensure it aligned with the clinic's needs. **Early engagement with the provider** could have allowed for necessary adjustments, **improving functionality in the local context**. Additionally, having a host that remains open to feedback and willing to adapt the system can enhance efficiency and data accuracy.

10.2 Use of biometrics in the MAT clinics

Overview

Biometrics were implemented in MAT clinics in Kiambu, like the approach in Nairobi, to verify client identity and ensure accurate dispensing of OST. Upon enrolment, clients registered their fingerprints and had a passport photo taken through the MethaMeasure system. Subsequent visits required clients to use their biometrics for identification at the pharmacy.

Experience during COVID-19 pandemic

- Biometric use was temporarily halted due to health concerns during the COVID-19 pandemic.
- Identification was instead carried out using MAT IDs and the passport photos in the MethaMeasure machine.
- For clients with damaged fingerprints (e.g., due to smoking), identification relied solely on MAT IDs or photos.

Implementation challenges

- **The case of the Kiambu Project:**
  - No significant opposition to biometrics by PWUD was reported.
  - Patients expressed concerns about using fingerprints in government processes, such as applying for a national ID card, fearing potential arrest due to past substance-related criminal activities but not for the MethaMeasure machine. To alleviate these concerns, the area chief facilitated a safe registration process at the MAT clinic.
- **The case of coastal MAT clinics:**
  - Biometrics were not introduced due to client concerns about human rights violations.
  - Past incidents, including the suspension of the Integrated Biological and Behavioural Surveillance (IBBS) study, highlighted strong opposition from PWUD and advocacy groups[12].
  - Concerns were raised late in the planning process, prompting intervention from organizations like The Global Fund and UNAIDS to halt biometric implementation.

Challenges and limitations of the biometric system

- **Encoding errors:** Occasional dosing errors occurred due to staff manually entering MAT IDs into the MethaMeasure system instead of using biometrics.
- **Lack of interconnectivity**: Biometric systems in MAT clinics were not interconnected, allowing PWUD to enrol in multiple clinics simultaneously. This led to:
  - Inaccurate national and regional enrolment counts.
  - Challenges in tracking client compliance and movement across the MAT clinics.

12 KELIN, and Kenya Key Populations Consortium. *"Everyone Said No": Biometrics, HIV and Human Rights, A Kenya Case Study.* 2018

Conclusion

Biometric systems in MAT clinics have improved client verification but face challenges, including:

- Public apprehension about data misuse and human rights violations in some regions, especially the coast.
- Regional differences in acceptance and implementation, reflecting varying levels of trust and advocacy efforts.
- Lack of interconnectivity, which allows duplicate enrolments, hinders client tracking across clinics, and leads to inaccurate national data, affecting resource allocation and programme efficiency.

Addressing these challenges will require a balanced approach to maintaining accurate records while respecting client rights and fostering trust within the PWUD community.

Methadone dispensing window with guidance for patients on use of biometrics in Karuri MAT clinic ©Daisy Okang/MSF

© Paul Odongo/MSF

An addiction counselor facilitates a family therapy group at the MAT clinic. Group therapies provide a safe space for shared experiences, strengthen family support, and play a key role in promoting sustained recovery for PWUD.

11. PROJECT OUTCOMES

The MAT clinic utilized all NASCOP tools for data collection and reporting, which were entirely paper-based. To facilitate data collection, the project developed an improvized Excel cohort list, as no electronic data system was in place. This manual approach posed challenges for data collection and reporting as the quality of the data was encoder dependent. Monthly reports were submitted to NASCOP through the sub-county health records officer, who entered the data into the KHIS system.

This section provides a summary of the data analysis and aims to provide an overview of the Kiambu project. The data was collected from various sources, including the MethaMeasure database, line lists, client records, and service utilization logs. The data was analysed to assess client demographics, retention rates, LTFU, service utilization, and treatment outcomes.

Figure 3 Overview of outcomes in Kiambu MAT clinics

September 2019–June 2024

Total PWUD and substances used

Total PWUD enrolled: **1,619**

Female: **7.6%**

Heroin: **97.3%**

Other opioids: **0.3%**

Not opioid dependent and ineligible for MAT: **2.4%**

Demographics and behaviours

Smoking prevalence: **81.7%**

Injecting: **3.7%**

Dual (smoking and injecting): **14.6%**

Median age: **28 years**

Health status

HIV positive: **1.5%**

HCV: **2.9%**

HBV: **0.2%**

Tuberculosis: **2.5%**

Type of OST

Methadone: **95%**

Buprenorphine: **5%**

Outcomes

Active in care **35.2%,** Abstinent at last contact **37.2%,** Transfer out **11.8%**

LTFU: **8.1%**

Relapse: **4.9%**

Deceased: **2.9%**

11.1 Uptake of MAT services and demographic data

Since September 2019, the Kiambu project has made significant strides in enrolling PWUD into MAT programmes across the county's three clinics, with 1,619 PWUD enrolled. These efforts underscore the transformative impact of outreach and decentralization of services in addressing substance use disorders and improving lives.

The majority of the enrolled clients were male (92.4%), with only 7.6% being female. The low percentage of women in MAT enrolment highlights the need for targeted, gender-sensitive outreach strategies.

The median age of participants was 28 years, highlighting that most who were struggling with substance use were young adults at the peak of their productive years.

Heroin use was overwhelmingly prevalent, with 97.3% of PWUD identifying it as their primary drug of dependence. The majority (81.7%) reported smoking heroin as their primary mode of use, while 3.7% exclusively injected heroin. An additional 14.6% engaged in both smoking and injecting. The remaining PWUD who were not using heroin primarily depended on other opioids, such as tramadol or pethidine.

The majority of the newly enrolled PWUD were referred by CSOs (96%) while the rest were either transferred in from other MAT clinics (18.5%) or self-referrals (0.2%). In Kenya, CSOs are generally responsible for offering harm reduction services at the community level. This includes referring PWUD who are ready for induction to the MAT clinic. Therefore, the MAT clinic cannot go directly to identify PWUD in the community. **This highlights the importance of CSOs role in service provision for key populations**.

Self-referrals for heroin users were not always encouraged, as it was observed that some individuals without opioid dependence would attempt to access the Kiambu MAT clinics in order to take advantage of the free comprehensive care package. This highlights the need to ensure availability of comprehensive medical services even for PWUD not enrolled on MAT. They were easily identified during the thorough screening process carried out in the MAT clinic before enrolment in MAT and induction to OST.

In July 2022, MSF signed a one-year MoU with LVCT Health to support community activities. This MSF-led support was instrumental in driving high induction rates in 2022, particularly in Karuri and Ruiru MAT clinics.

By the third quarter in 2023, enrolment trends across all clinics began to decline, driven by three key factors:

1. There was a growing assumption that the majority of PWUD in need of MAT services had already been reached. This left behind a smaller group who were still in the early stages of drug use. Despite intensified outreach efforts under the MoU with LVCT Health, and MSF's support for MAT preparation sessions in the community, new inductions remained low, reinforcing this perception.
2. Logistical and financial constraints following the end of the MoU with MSF significantly impacted outreach activities. With limited funding for LVCT Health's key population activities, peer educators and addiction counsellors faced challenges in engaging and preparing potential PWUD for MAT enrolment due to the lack of resources for transportation and allowances. As a result, outreach efforts were hindered, further contributing to the decline in new enrolments.
3. Some PWUD, particularly heavy drug users who never leave the dens, may have been missed due to the lack of regular and targeted outreach services. Additionally, relying on rented halls for outreach for PWUD and having limited strategies to engage WWUD may have further restricted reach.

The impact of these challenges is reflected in the data. By mid-2024, the three clinics had collectively enrolled 1,619 clients out of the 3,312 mapped by LVCT Health and MSF in August 2021: Karuri (924), Ruiru (500), and Thika (195). However, enrolment rates slowed significantly, with only 14 new inductions recorded in the second quarter of 2024 (Karuri – 1, Ruiru – 8, Thika – 5).

Services were brought closer to PWUD by decentralizing MAT services through two mini-MATs, satellite dispensing sites, and provision of THDs for OST. However, some individuals still preferred accessing MAT clinics located farther away.

Kiambu County has 12 sub-counties, and according to the 2021 size estimate (MSF and LVCT Health), the distribution of PWUD was as follows: 824 in Kiambaa Sub-County (home to Karuri MAT clinic), 760 in Ruiru, and 608 in Thika.

Given this distribution, Thika MAT clinic was expected to gain traction quickly. However, uptake remained slower than anticipated, indicating that **proximity alone was not the sole determinant of service utilization, and other factors such as stigma, individual preferences, and peers may have influenced clinic choice**.

Nonetheless, the majority of PWUD enrolled in each clinic were from the sub-county where the MAT clinic was located.

Figures 4, 5, and 6 below illustrate new enrolments per month at each MAT clinic (2019–2024).

- Karuri MAT clinic started in September 2019 and is located in Karuri L4 hospital.
- Ruiru MAT clinic was started in May 2022 and is located in the local prison.
- Thika MAT clinic started in July 2023 and is located in the local prison.

Figure 7 shows the cumulative uptake of services in the project between September 2019 and June 2024.

Figure 4 Monthly enrolments at Karuri MAT Clinic (2019–2024)

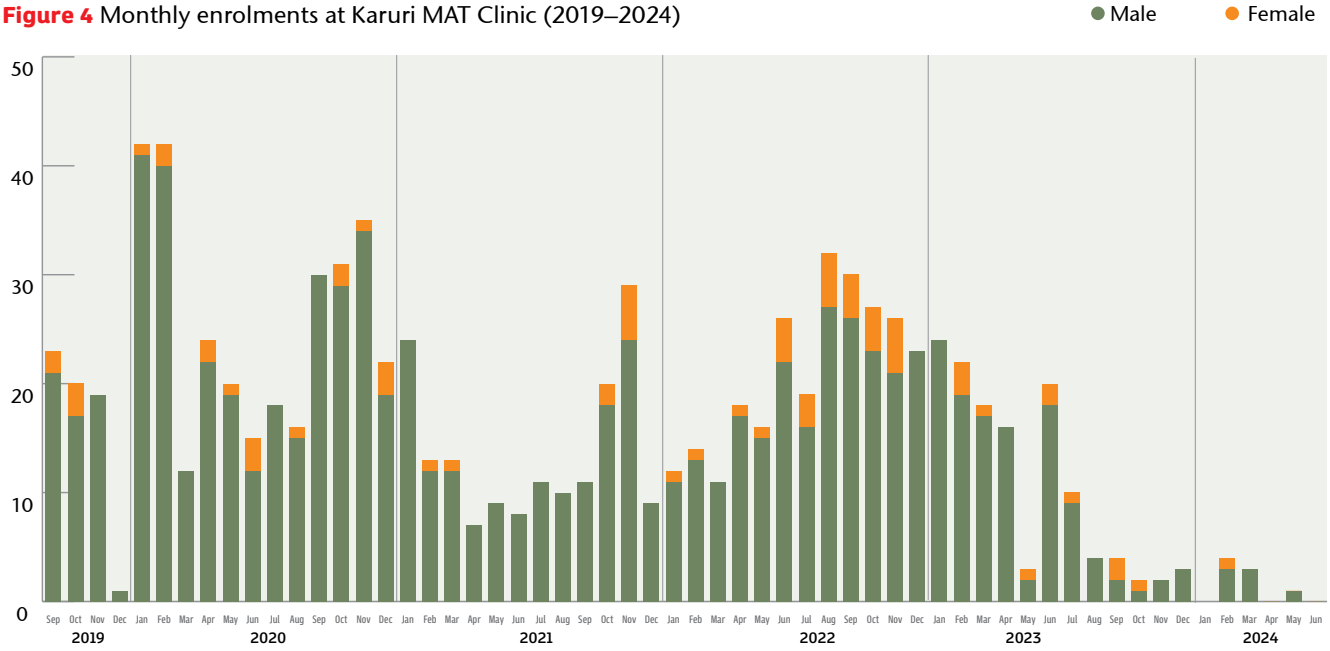


Figure 5 Monthly enrolments at Ruiru MAT Clinic (2019–2024)

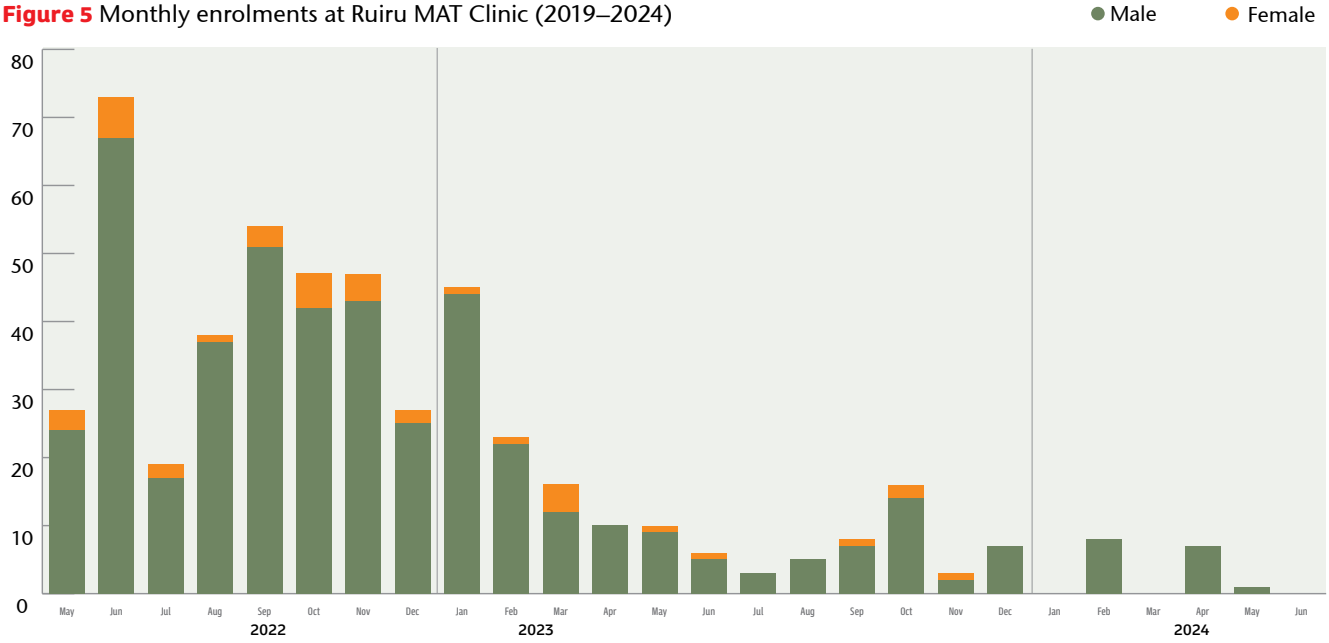


Figure 6 Monthly enrolments at Thika MAT Clinic (2019–2024)

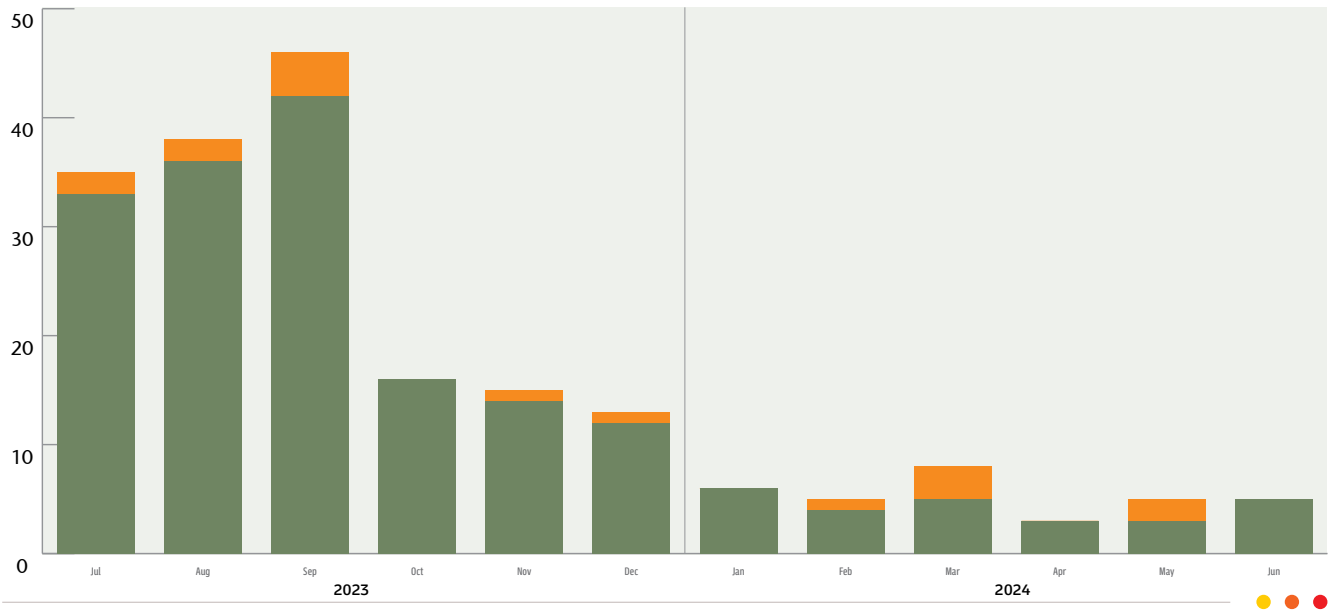


Figure 7 Uptake of project services (September 2019–June 2024) across the three sites

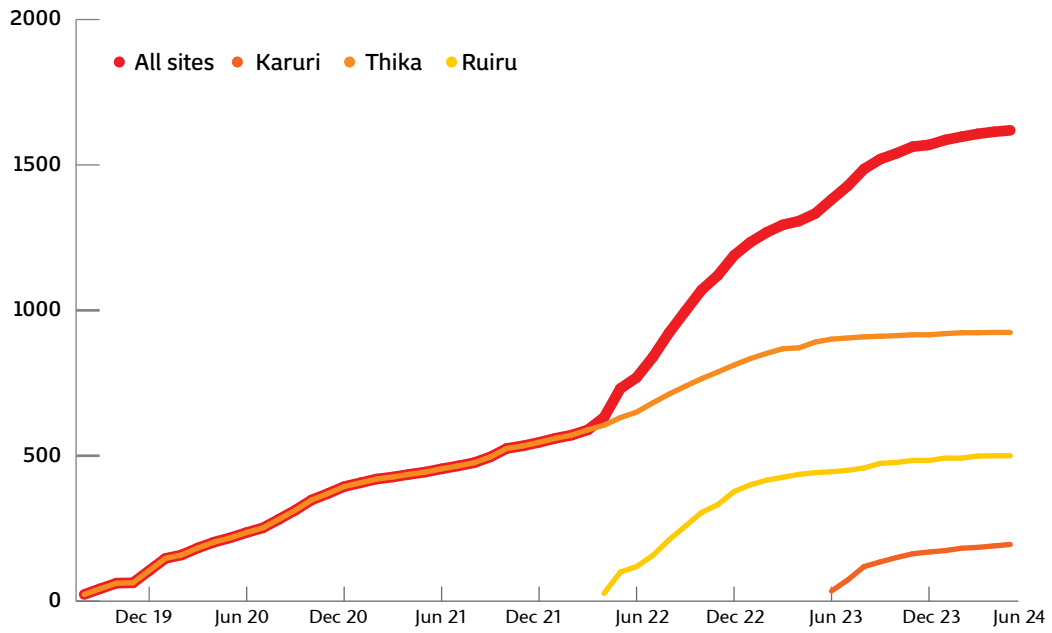
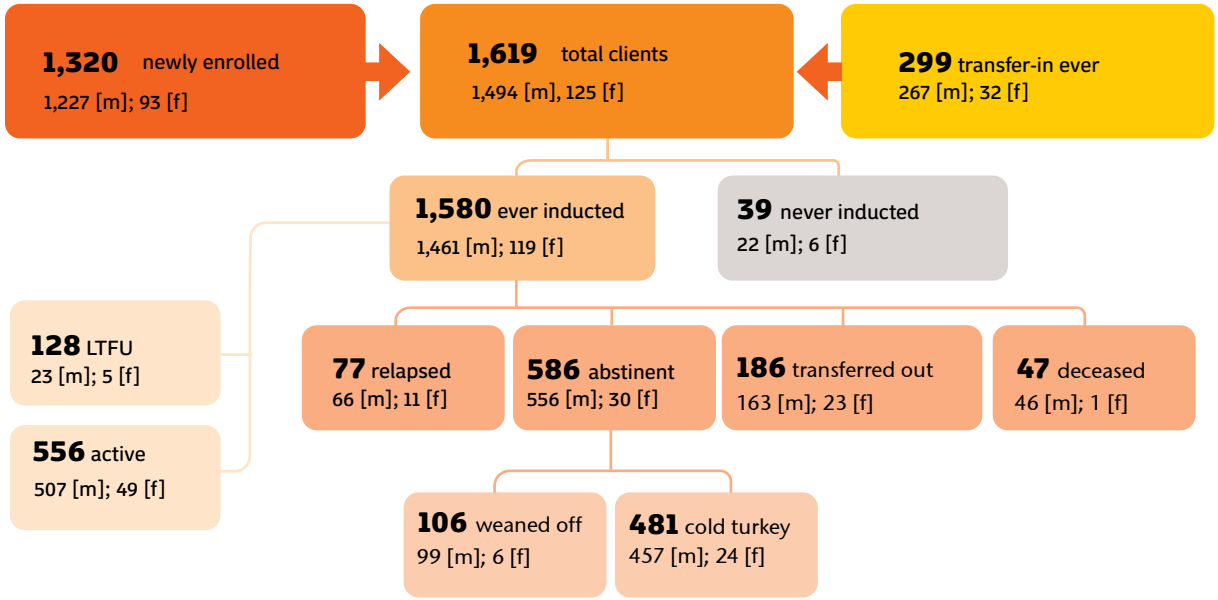


Table 8 General characteristics of the whole cohort across the three clinics.

Characteristics	Overall N = 1,580*	Female N = 119*	Male N = 1,461*
Age in years (median age = 28 years)	28 [25.7, 33.8]	26 [24.0, 30.3]	28 [25.8, 34.0]
Patient type			
Newly inducted	1,281 (81.1%)	87 (73.1%)	1,194 (81.7%)
Transfer-in	299 (18.9%)	32 (26.9%)	267 (18.3%)
Referral pathway			
CSO referral	1,277 (80.8%)	86 (72.3%)	1,191 (81.5%)
Transfers from other MAT clinics	299 (18.9%)	32 (26.9%)	267 (18.3%)
Self-referral	4 (0.3%)	1 (0.8%)	3 (0.2%)
HIV			
Never tested positive	1,556 (98.5%)	113 (95.0%)	1,443 (98.8%)
Ever tested positive	24 (1.5%)	6 (5.0%)	18 (1.2%)
HBV			
Never tested positive	1,577 (99.8%)	119 (100.0%)	1,458 (99.8%)
Ever tested positive	3 (0.2%)	0 (0.0%)	3 (0.2%)
HCV			
Never tested positive	1,534 (97.1%)	111 (93.3%)	1,423 (97.4%)
Ever tested positive	46 (2.9%)	8 (6.7%)	38 (2.6%)
TB			
Never tested positive	1,540 (97.5%)	116 (97.5%)	1,424 (97.5%)
Ever tested positive	40 (2.5%)	3 (2.5%)	37 (2.5%)
PrEP/PEP status at exit			
None	1,496 (94.7%)	114 (95.8%)	1,382 (94.6%)
Ever been on PEP	75 (4.7%)	5 (4.2%)	70 (4.8%)
Ever been on PrEP	9 (0.6%)	0 (0.0%)	9 (0.6%)
Outcomes			
Abstinent[13]	587 (37.2%)	30 (25.2%)	557 (38.1%)
Active	556 (35.2%)	49 (41.2%)	507 (34.7%)
Transfers out	186 (11.8%)	23 (19.3%)	163 (11.2%)
LTFU	128 (8.1%)	5 (4.2%)	123 (8.4%)
Relapse	77 (4.9%)	11 (9.2%)	66 (4.5%)
Deceased	46 (2.9%)	1 (0.8%)	45 (3.1%)
*Median [Quintiles 1, 3]; n (%)			

13 These are PWUD who had stopped OST either through a gradual wean-off process or abrupt cessation (cold turkey). See comment in section on abstinence.

Figure 8 Summary of the enrolment and outcomes data for the PWUD cohort as of June 2024. (Project cycle Sept. 2019–June 2024)



11.2 Outcomes of PWUD Enrolled in MAT Services

The overall outcomes of the PWUD enrolled in care are described in the figure 8.There is no good evidence on the optimal duration of treatment for opioid use disorder. It is recommended that this be tailored to the individual needs and specific clinical situation.[14] OST lasting at least 12 months improves retention, reduces relapse, and supports overall health, maximizing long-term benefits for opioid-dependent individuals.[15]

Of 1,580 PWUD ever enrolled in all sites:

- 186 (11.8%) transferred out
- 46 (2.9%) died.

Of the remaining 1,348:

- 556 (41.2%) were active at the time of analysis
- 587 (43.5%) had weaned off opiates
- 77 (5.7%) were known to have relapsed onto opiates
- 128 (9.5%) were lost to follow-up.

Table 9 Retention in care at months 3 and 6 across the three clinics

	Month three	Month six
Karuri	77%	71%
Ruiru	74%	61%
Thika	78%	72%

The reason for calculating retention at months three and six for PWUD is significant because these time points are critical for assessing the effectiveness of the treatment and the stability of the clients' engagement in care. By month three, individuals are expected to have adjusted to the treatment regimen, while month six provides a clearer picture of long-term adherence and potential challenges, such as relapse or attrition, that might affect ongoing care.

The average length of stay (ALOS) in the MAT clinic was 26 months. This figure is skewed by Karuri, which existed five years longer, and hence a higher population and longer follow-up duration were possible. The facility-specific ALOS were 32 months (Karuri), 12 months (Ruiru), and 7 months (Thika). Thika had only existed for 11 months at the handover.

Analysis of lost to follow-up and treatment interruption

LTFU was defined as missing out on care for >=30 days consecutively. Where such a client later returned to care, the episode of missed care would be reclassified as a treatment interruption.

Treatment interruptions were frequent among the 1,580 individuals enrolled in MAT. A total of 1,110 clients (71%) met the criteria for LTFU at some point during their care, with 839 of them (76%) recorded as LTFU only once since enrolment.

- Among the 1,110 clients who were ever LTFU:
- 123 (11.1%) eventually returned to care
- 561 (50.5%) were classified as abstinent from OST
- 75 (6.8%) had relapsed back to drug use
- 43 (3.9%) were confirmed deceased
- 183 (16.5%) had transferred out to other MAT clinics
- 125 (11.3%) remained LTFU as a final outcome

The remaining 446 clients (29%) of the 1,580 ever enrolled were never LTFU throughout their treatment journey. of these, 428 (95.9%) were still active on OST as a final outcome, 14 (3.1%) had been classified as abstinent, 2 (0.4%) were confirmed deceased, and 2 (0.4%) had transferred out to other MAT clinics.

There were no significant differences in eventual outcome when those with single episodes of treatment interruption were compared with those with multiple such episodes.

14 World Health Organization (WHO). "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence". 2009

15 Ministry of Health, Kenya. National Implementation Guidelines for Medically Assisted Therapy for People with Opioid Use Disorders. 2021

Some of the reasons for the LTFU and treatment interruption were treatment fatigue, peer pressure, lack of a high from the OST, abrupt travel, undesirable effects from the OST, lack of transport to the MAT clinic, and cross-addiction to alcohol.

Enhanced strategies to trace clients who were LTFU

An innovative strategy for tracing LTFU clients involved pairing CHWs with social workers and addiction counsellors to enhance defaulter tracing. CHWs were responsible for either locating LTFU clients or communicating their status to peer educators from LVCT Health, which significantly reduced the time needed to trace individuals. Early tracing proved beneficial in preventing severe relapse, as timely intervention improved client care and retention in treatment.

Additionally, a dedicated monthly meeting was introduced to specifically discuss LTFU cases. During these sessions, data officers projected the list of all LTFU clients, and HCWs – including peer educators – provided updates on their whereabouts or any known relapses. It was reported by the CSO and peers that some clients had left the area due to conflict with law enforcement or the community. Following the meeting, an updated LTFU list was shared with LVCT Health to enhance tracing efforts.

This approach not only improved tracking and follow-up strategies but also provided deeper insights into client choices, such as those who opted for cold turkey or experienced relapse. The approach enabled better support and more targeted interventions for PWUD in their recovery journey and strengthened data collection.

Abstinence

Over time, 37.2% (n=587) of clients (557 males and 30 females) were documented to be abstinent from OST, of whom 18.1% were gradually weaned off and 81.9% stopped abruptly (cold turkey), though many of these may later have relapsed as discussed below. The **high rate of abrupt cessation** was most pronounced in the **final year of the project**, largely driven by concerns about c**ontinuity of care post-handover**, despite efforts to inform clients about the transition.

Other causes of involuntary cessation included cross-addiction to alcohol, which was commonly observed during the OST dose reduction phase. While the clinical team assessed withdrawal symptoms using the Clinical Opioid Withdrawal Scale (COWS) some clients insisted on rapid dose reduction, wanting to "finish MAT fast and move on with their lives". It is well recognized that abrupt and unplanned cessation of OST is associated with frequent relapse.

The project's approach to tracking those weaned off OST was similar to that of the LTFU mentioned above, in addition to the reports from the after-care programmes where those weaned off continued to seek counselling.

Limited capacity at the community level made it difficult to track client outcomes over time, as tracing was dependent on the peer workers who were not always present or motivated. It is therefore not possible to describe what proportion remained abstinent versus those who relapsed, and it is likely that some may have relapsed to opiate use.

Better data collection systems and more investment are essential for effective **longitudinal client monitoring**, which remains a major challenge.

Relapses

As reported by peer educators or clients themselves through interactions with the psychosocial team, **8.1% (n=128)** of clients **relapsed to heroin use**. This cumulative figure was recorded by the end of the project in June.

Relapses occurred among those who had either dropped out of MAT due to various LTFU-related reasons or had been abstinent (mainly cold turkey) but struggled with withdrawal symptoms.

Since relapse data collection began **late in the project cycl**e, the findings are not conclusive, as it was unclear whether all abstinent clients remained abstinent or if some **LTFU cases had relapsed**.

Key lesson learned:

Relapse monitoring should be **integrated from the start** of MAT projects to provide a **more accurate understanding of long-term client outcomes**.

11.3 Transits in MAT clinics

Some PWUD transferred from other MAT clinics **temporarily** for reasons such as **work commitments** or **social events** near the clinic. These individuals were referred to as '**transits**'.

- The project recorded a total of **141 transits** (124 males and 17 females) across the 3 MAT clinics.
- It was also observed that some individuals **sought free medical care provided by MSF** at the MAT clinic before returning to their original MAT clinics.
- To track these individuals, they were assigned a **temporary unique identifier** in the new MAT clinic. The identifier included a prefix 'T' followed by a number (e.g., T001).
- Despite being temporarily assigned to the new MAT clinic, these individuals were **not included in the total count of PWUD**, as they technically remained r**egistered with their original MAT clinic**.
- During the transit, the PWUD was required to bring **a hard copy of the transit letter**, and a **soft copy** of the letter would be sent via email by the MAT lead or the pharmacy team of their original clinic to confirm the dose. **Earlier experiences** from other MAT clinics showed that sometimes **PWUD altered their OST dose** during transit, highlighting the need for careful verification.

11.4 Mortality rate and causes

- 2.9% (46 males, one female) of the PWUD cohort in the project were deceased.
- Main causes of death:
  - 23% due to road traffic accidents
  - 19% due to violence/mob justice
  - 11% attributed to opioid overdose, mainly at the start of the project. These fatalities were linked to the concomitant use of OST and alcohol.
  - 19% due to comorbidities, including 2 cases of disseminated TB (late presentation for treatment).
  - 28% of deaths had an unknown cause.

Lessons learned

Screening for drug use history at induction is critical.

- Proper drug use history screening is vital to identify which substance should be prioritized for treatment, hence the importance of the use of the ASSIST screening tool.
- Since both alcohol and OST are depressants, it is rare for PWUD to be heavily addicted to both substances at the same time.
- If heavy alcohol use or alcohol addiction is identified during induction, alcohol management should take priority before OST.

Address road safety for PWUD.

- PWUD were encouraged to attend driving school and obtain licenses to enhance safety.
- Defensive driving training was provided by MSF drivers.

Address challenges of TB diagnosis and management

- The lack of typical TB presentation in some PWUD led to delayed diagnosis and treatment initiation.
- HCWs were hesitant to start empirical TB treatment due to limited experience with such cases.
- These challenges highlight the importance of training HCWs to recognize non-typical TB symptoms and improve early diagnosis and treatment. The sub-county TB focal person was informed by the project, and as a result, a refresher training on the diagnosis and management of EPTB was conducted for HCWs to improve early diagnosis and treatment.

11.5 The HIV cascade

- **HIV prevalence and treatment**
  - Approximately 1.5% of the cohort was HIV positive, with around 60% receiving their treatment as DOT alongside OST.
  - Among those on DOT for ART, 91.6% achieved viral suppression, while 8.3% had a high viral load, linked to relapse into active heroin use.
- **Impact of DOT on adherence**
  - The integration of DOT for ART within the MAT clinic, along with group therapy for PLWHA, significantly enhanced adherence.
  - Some individuals hesitated to take treatment as DOT, as they were concerned about being judged for their HIV status, despite the provision of curtains for privacy in the dispensing area to ensure confidentiality and health education.
- **Continuity of HIV care**
  - 63% of PWUD on ART were later weaned off MAT and continued to receive HIV care through the MAT clinic, HIV clinics, or CSOs.
  - Only one client was on second-line treatment due to treatment failure.
- **Seroconversion and prevention measures**
  - At the start of the project, three PWUD seroconverted, prompting a rapid scale-up of HIV prevention efforts, including:
    - health education
    - provision of PreP
    - couple counselling and testing, even when the spouse was a non-PWUD
- The **seroconversions (all males)** were linked to improved sexual health following recovery on OST, as reported by the clients themselves.
- Since then, **no further cases** of seroconversion have been recorded.

HIV prevalence and risk in PWUD

- The **HIV prevalence** among PWUD is relatively low at 1.5%, suggesting that only a minority of the population is at high risk for HIV. According to our data, the majority of PWUD were smokers rather than injectors.
- The **low HIV risk** observed is also likely due to the **success of community education, NSPs,** and **OST access**, all of which play a significant role in **reducing HIV risk** among PWUD.
- The **low HIV prevalence** raises the question of how we can **better identify the most at-risk individuals** and ensure they are effectively accessing the programme. The project conducted **quarterly HIV testing** for PWUD in line with national guidelines. In addition, testing was extended to **partners of PWUD** at the MAT clinic, and **LVCT Health** tested PWUD not on MAT routinely.
- A key recommendation is to **collaborate more closely** with other **CSOs** providing services to different key populations, such as **sex workers** and **MSM**, to ensure **awareness** of harm reduction services, the **availability of NSPs**, and **OST access**.

HIV prevention uptake among PWUD

- Despite routine **health education** and counselling promoting the benefits of HIV prevention methods, only 7% of PWUD used **PreP**.
- **3.7%** of PWUD ever used **PEP**.

Contributing factors:

- **Treatment fatigue** was a significant barrier, with many individuals feeling overwhelmed by the need for daily medication.
- Despite regular health education, PWUD found PEP easier to manage than PreP. They stated that PEP provides a more **immediate, situational solution** to potential HIV exposure, whereas **PreP** requires ongoing commitment, which felt burdensome.
- **Routine education on proper condom use** for both male and female condoms was provided by **peer educators and counsellors**.
- While NASCOP provided free condoms, MSF **supplemented** the supply to ensure **consistent availability**, particularly during periods of stock shortages reported nationwide.

11.6 Tuberculosis care

TB Screening and diagnosis

- TB screening is conducted for all new inductees and routinely during medical consultations using the Intensified Case Finding (ICF) MoH tool.
- A high index of suspicion for TB in PWUD is crucial, as opioids suppress coughing, leading to atypical presentations and potential underdiagnosis.
- Undiagnosed TB can become **disseminated**, spreading beyond the lungs to affect organs such as the **liver, spleen, bones, and central nervous system**.

TB treatment outcomes

- **40 PWUD** were treated for TB, including **five cases of EPTB**.
- **Three relapse cases** (all male) were successfully treated.
- **Two males were LTFU** since project inception. Both individuals were experiencing homelessness at the time and residing on the streets.

Key lessons learned

- **High treatment success** rates can be achieved through **integrated care** and **targeted interventions**. The project involved treatment supporters and peer follow-up for PWUD with poor adherence, provided **TB medications** to clients unable to attend the MAT clinic due to illness, and implemented **DOT** for most clients. **Health education** was vital, especially in the early stages, when significant stigma towards TB was observed. Some PWUD reported being excluded by peers if they were known to have TB, leading to missed doses.
- **Addressing barriers to adherence**, particularly for **PWUD living on the streets**, is essential for improving outcomes. Follow-up for these clients proved challenging due to their constantly changing locations, making consistent care and monitoring more difficult. A recommendation would be to arrange for shelter for them, where feasible.

11.7 HBV management

- **HBV vaccination coverage was >85%** across the 3 MAT clinics.
  - **An accelerated vaccination schedule (**0, 7, and 21 days, with a booster at 12 months) was implemented to ensure **full coverage in a shorter timeframe** to prevent missed doses.
  - **Vaccination outside the pharmacy**, in coordination with the **nursing station**, proved to be effective. This approach was particularly helpful since:
    - Some PWUD expressed a **fear of injections**, which led them to avoid the nursing stations even when an appointment was scheduled.
    - Many PWUD were **unstable** within the first month after induction, meaning vaccination was not always a priority at that time for them.
  - The **MAT clinic staff** liaised with the DIC to track and verify vaccination status.
  - MSF provided a **vaccination card**, which was pinned at the top of the client's file to enhance follow-up and prevent missed doses.
  - A dedicated **HBV register** was maintained by the nursing station, and **clients who missed doses** were flagged and followed up by **nurses through peer educators**.
- **Testing results**:
  - Only **two male PWUD** tested positive for HBV on rapid test and PCR.
  - There was no **HBV/HIV coinfection**.

11.8 HCV testing and treatment

- By the end of the project, 65 (4.1%) of 1,580 clients had tested positive for HCV.
- For any new HCV-positive PWUD, LVCT Health was notified to organize outreach activities in the specific areas. These activities included distributing NSPs and testing other PWUD not on MAT for HCV.
  - Those testing positive were referred to the MAT clinic for induction and DOT treatment. Treatment was provided free of charge to clients through Global Fund support via NASCOP.
- HCV PCR testing was required before initiating treatment.
  - Initially, tests were sent to a private lab at a cost of $130 per test, covered by MSF.
  - Later, testing was supported by NASCOP at KEMRI, providing tests free of charge to clients.
- HCV cascade of care:
  - 1,580 tested and 65 PWUD tested positive for HCV antibodies.
    - 45 were PCR positive and therefore eligible for treatment
    - 39 initiated treatment, of whom:
      - 37 completed treatment.
      - 32 (82%) of those initiated achieved sustained viral response (SVR).
      - 2 were lost to follow-up.

A banner with handwritten messages by MAT clients during the commemoration of mental health day © Lucy Makori/MSF

11.9 Mental health services

Mental health issues and substance use disorders are closely linked, often exacerbating each other. All PWUD enrolled underwent baseline and quarterly mental health assessments. In 2 MAT clinics with a psychiatrist, 55% of PWUD had depressive disorders, 30% had sleep-wake disorders, and 8% were diagnosed with alcohol-related disorders, particularly during OST weaning, especially from methadone. **It was observed that although general clinicians received intensive training and mentorship on diagnosing and treating mental illness, they were reluctant to manage these clients, citing that it was not part of their job description and did not come with additional compensation**.

11.10 Family and social re-integration

Family and social reintegration play a vital role in the recovery of PWUD by providing emotional support, stability, and a sense of belonging. Strong social connections improve treatment adherence, reduce relapse, and enhance overall well-being. Rebuilding trust and fostering acceptance within families and communities creates a supportive environment for long-term recovery.

In addition to social support, securing a sustainable livelihood is essential. This included helping PWUD obtain national IDs, access job opportunities or income-generating activities, and enrol in the national health insurance scheme to ensure continued medical care after MSF's exit.

As a result of these efforts, the following number of PWUD clients were **reintegrated with their families**:

- 608 (65.8%) in Karuri MAT Clinic
- 314 (62.8%) in Ruiru MAT Clinic
- 109 (55.8%) in Thika MAT Clinic.

Additionally, the following number of PWUD clients had national IDs:

- 85% in Karuri
- 76% in Ruiru
- and 88% in Thika.

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A pharmacy technician packs methadone for take-home doses. This flexible model supports continuity of care, reduces daily clinic visits, and helps stabilize clients with work, family, or mobility challenges.

12. HANDOVER PROCESS OF THE KIAMBU PROJECT

The project handover, originally set for mid-2022 but extended to June 2024, was clearly defined in the MoU signed between MSF and the Kiambu County government. The handover process was designed to preserve essential healthcare services while addressing challenges associated with resource constraints and system integration.

12.1 Key achievements of the handover included:

MSF achievements:

- **Donation of medical commodities**: MSF provided essential medical supplies and equipment to ensure a smooth transition and continued client care.
- **Stakeholder advocacy**: MSF played a key role in advocating for the recognition of the unique healthcare needs of PWUD, fostering awareness and support among MoH, community and other key stakeholders.

MoH achievements:

- **Absorption of MoH staff**: MoH successfully integrated 49 MoH staff into the county government system, ensuring service continuity in MAT clinics.
- **Transition of operational costs**: MoH assumed responsibility for clinic operational expenses, aligning MAT services with the public healthcare system.
- **Technical oversight**: MoH contributed to the establishment of a technical working group to oversee the transition process and ensure adherence to best practices.

Kenya Prisons Service (KPS) achievements:

- Implementation of MAT services in correctional facilities: KPS facilitated access to MAT services within prison settings, improving care for incarcerated PWUD.
- Provision of KPS staff: KPS staff majorly supported the 2 MAT clinics based in prisons.

LVCT Health achievements (new implementing partner):

- Support for key MAT services: LVCT Health took over funding for essential services, including MethaMeasure license fees, urine drug screening tests, and transport support for the continuum of care.

LVCT Health officially assumed service provision in October 2024.

12.2 Evaluation of the handover process

A formal evaluation of the handover process was conducted by the Stockholm Evaluation Unit (SEU) through an external consultant, Silva Ferretti, and was commissioned by the MSF Kenya Mission Country Director, Dr. Edi Atte. The handover process began in May 2024 and was concluded in November following MSF's withdrawal. The evaluation aimed to assess the effectiveness and success of the handover process.

Please see the Handover Evaluation report.
https://evaluation.msf.org/sites/default/files/2025-03/evl_2024_kiamb_dis_summaryreport_0.pdf

13. FINANCIAL RESOURCES FOR MAT CLINICS

Funding for MAT programmes is essential for sustaining treatment services, covering costs for medications, operational expenses, and client support. Below are some of the basic commodities needed for a harm reduction programme and a snippet of the total cost that the Kiambu Project used to run the MAT clinics.

Table 10 Costing of basic MAT commodities as at April 2025

Type	Item	Price per single unit	Package/Remark
Harm reduction commodities	Methadone hydrochloride, 5 mg/ml, oral concentrate, 1 litre bottle (provided by NASCOP through KEMSA)	£ 16.58(per bottle)	Bisacodyl is for the management of constipation, a side effect of opioids.
	MethaMeasure dispensing machine	£ 8,970.00	
	Methadone dispensing cups	£ 0.029	
	Buprenorphine 2 mg, tablet, pack of 28 (provided by NASCOP through KEMSA)	£ 57.02 (per pack)	
	Buprenorphine 8 mg, tablet, pack of 28 (provided by NASCOP through KEMSA)	£ 152.04 (per pack)	
	Multi-drug urine toxicology test (locally purchased), per test	£ 6.44	
	Bisacodyl, 5 mg tab, pack of 1,000	£0.05	
	NSP kit	Usually donor-funded through the CSOs	The NSP kit is based on the number of PWID calculated on at least three kits per day.
Baseline and follow-up tests	Pregnancy test/HCG urine, pack of 50 strips	£ 0.16	Done quarterly per PWUD.
	Syphilis test kit, pack of 25	£ 0.63	
Naloxone	Naloxone hydrochloride 0.4 mg/ml, 1 ml. amp	£ 0.55	Has a short shelf life of 2 years. Consider the expiry date during purchase.
HCV commodities	HCV rapid test, pack of 25	£ 1.19	HCV test kits are quantified by at least three tests per PWUD per year.
	RNA PCR testing (viral load)	£128	Cost at Lancet Lab, otherwise done for free via KEMRI.
	Sofosbuvir 400 mg/Veltaspasvir 100 mg tablet	N/A	Available through The Global Fund.
HBV commodities	Tenofovir 300 mg tablet 30	N/A	Available through HIV funding.
	HBV rapid test		Cost at Lancet is $150, not partner-funded.
	DNA viral load – for HIV negative		
HIV commodities	HIV testing kits		HIV testing should be done quarterly for all PWUD.
	Male and female condoms	N/A	All included and available for free under HIV funding.
	ART drugs		
Human resources	Peer educators/CHWs, medical social workers, addiction counsellors, health records officers, clinicians/doctors, nurses, lab technicians, nutritionists, psychiatrists, pharmaceutical technologists, pharmacists, security personnel	As per job group and salary scale	Based on client volume, service model (integrated or standalone, task shifting and country-specific guidelines).
Medicines and medical consumables	Essential drugs	As per price guidelines	Wound care is a key need for PWUD. Availability of free essential medicines is key as PWUD are usually unable to purchase drugs.
Nutritional comorbidities	Food by prescription, BP 100, plumpynuts	As per price guidelines	Essential, as many PWUD present with either moderate or severe malnutrition on induction.

13.1 Overall funding of the MAT clinics

MSF served as the primary funder for all activities within the Kiambu PWUD Project. However, the success of the initiative was driven by collaboration among various stakeholders.

- LVCT Health played a key role by seconding peer educators to the MAT clinic, as well as preparing and referring PWUD for enrolment in MAT.
- NASCOP provided methadone, Buprenorphine, and HCV PCR testing and treatment free of charge to clients.
- KPS supported the project by staffing the two MAT clinics in Ruiru and Thika, alongside county staff whose salaries were covered by the county and county reimbursed by MSF. KPS also provided adequate space for the construction of the two MAT clinics based in prison, provided adequate 24-hour security and paid the utilities bills, such as electricity and water, similarly to MoH for the Karuri MAT clinic.

The Kiambu MAT programme successfully leveraged multi-stakeholder funding to enhance service access and integration. However, long-term sustainability depends on structured budget commitments, efficient resource allocation, and continued advocacy for government support.

Regarding resource allocation, a change of strategy in 2021 led to an increased budget for decentralizing MAT services, supporting the creation of a client/PWUD-led CBO and constructing the empowerment centre. Ruiru MAT clinic and an empowerment centre were built in 2022, followed by the Thika MAT clinic in 2023, enhancing service accessibility and community support.

Of the total £1,114,481.86 budget in (2018–2023)

- 10% was allocated to constructing three MAT clinics – an expense that could be avoided by integrating MAT services into existing MoH facilities.
- 39% was spent on hiring MSF project managers and specialized cadres such as psychiatrists and psychologists – a cost that could be reduced by training and utilizing existing MoH staff to serve PWUD and other key populations.

This demonstrates that the MAT model is replicable with fewer resources.

While NASCOP, through The Global Fund support, provided OST and HCV drugs free to MAT clinics, MSF covered the cost of essential medicines for clients. This was crucial, as PWUD often lack stable livelihoods, making treatment unaffordable. To ensure continued access, MoH should integrate these costs into annual budgets and advocate for dedicated funding for key populations as vulnerable population, particularly PWUD, under the national health scheme. This would enable them to receive comprehensive treatment at no cost to the client.

The long-term feasibility of MAT services hinges on sustainable county and partner funding, with key risks including reliance on external donors and inconsistent government commitment.

Figure 9 indicates the proportion allocated per budget family. Figure 10 provides a breakdown of the budget used per year.

Figure 9: Proportion of budget allocated per family

Kiambu PWUD Project cost 2022 per budget family (£1,114,481.86)

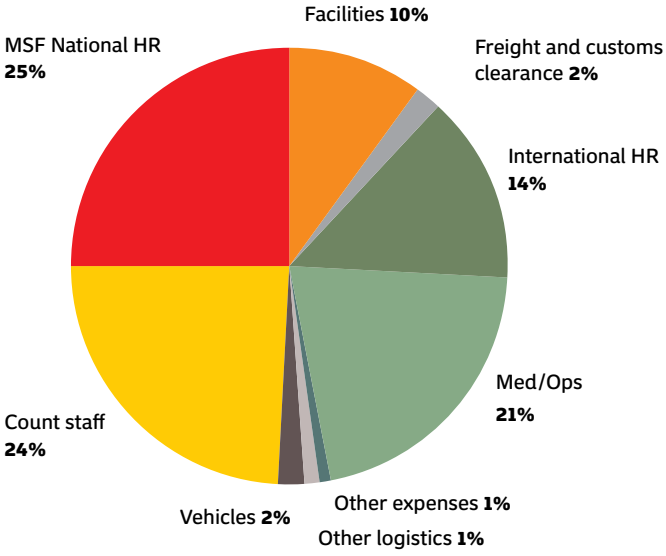
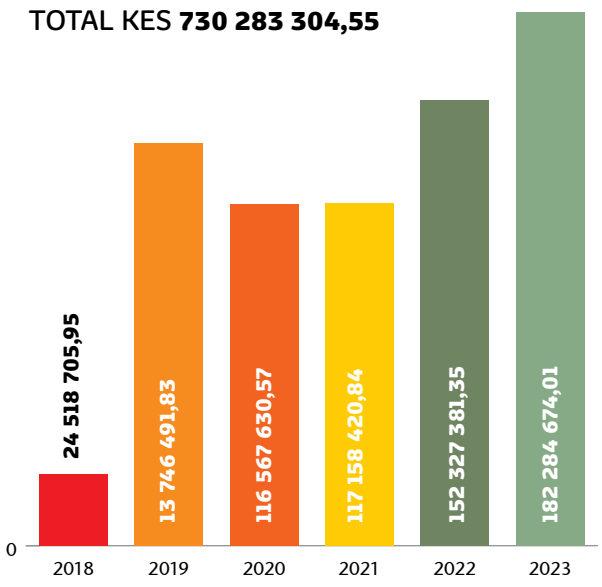


Figure 10: Budget per year (2018–2023)

Total six-year project cost (2018-2023)



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PWUD wait for their OST at the pharmacy. Sustained funding is essential to ensure continued access to MAT services.

14. IMPACT OF THE USAID FREEZE ON SERVICE DELIVERY

The USAID funding freeze, which came after the executive order of the US president on 24 January 2025, had widespread consequences for healthcare, particularly for programmes serving key populations, including PWUD, MSM, sex workers, and LGBTQI communities. The freeze led to disruptions in service delivery, loss of critical resources, and heightened vulnerabilities for already marginalized groups. Outreach programmes, MAT services and other harm reduction services including NSPs and community-based interventions including peer led activities faced operational challenges, threatening progress made in public health and harm reduction efforts.

14.1 How did this impact Kiambu County?

After the MSF handover, the Kiambu Project was managed through a partnership between Kiambu County, Kenya Prison Services, and LVCT Health. Kiambu County and Kenya Prison Services took responsibility for staff and facility utilities, with the county committing to support the provision of essential drugs. LVCT Health played a crucial role in sustaining operations, including covering the annual license fee for the MethaMeasure machine, purchasing urine drug screening tests, and ensuring continuity of care for PWUD by facilitating necessary logistics.

Additionally, LVCT Health provided harm reduction services at the community level, including distributing clean needles and syringes to PWUD and referring them to the MAT clinic. More than 95% of new PWUD in Kiambu's MAT clinics were referred through their efforts. They also supported the peer-led model by recruiting and incentivizing peer educators.

However, following the USAID freeze, all activities under key population funding for LVCT Health ceased. As a result, they could no longer support the MAT clinic or provide harm reduction services in the community. Without incentives, peer educators stopped their work, including distributing clean needles and syringes. This disruption increases the risk of rising HIV, HBV/HCV, and other bloodborne infections. Furthermore, the absence of peer educators makes it difficult to track and follow up with PWUD in the community through microplanning, as well as to trace those who drop out of care. These setbacks threaten to undo the progress achieved by the project over the past five years.

14.2 Key recommendations to mitigate future funding shocks

- **Government-led investment**: Strengthen domestic funding mechanisms to reduce over-reliance on external donors for key population services.
- **Policy and legal reforms**: Advocate for legal frameworks that prioritize harm reduction and key population health services within national budgets.
- **Strengthening health systems integration**: Integrated harm reduction and key population programmes into mainstream healthcare to ensure sustainability even in times of funding instability.
- **Community-led advocacy and engagement**: Empower affected communities to take a central role in policy discussions and funding decisions to safeguard their health services.
- **Diversification of funding sources**: Engage a broader range of international partners, private sector stakeholders, and philanthropic organizations to build financial resilience.

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15. CONCEPTS OF ABSTINENCE IN MANAGEMENT OF OPIOID DEPENDENCY DISORDER – THE KIAMBU EXPERIENCE

15.1 Objective

In 2022, an abstinence-based therapy (ABT) group was piloted with the goal of engaging PWUD who were on low doses of OST close to exiting the MAT programme, and motivated to stop using all other substances entirely.

The need for a comprehensive approach to the provision of group therapy was identified, particularly for clients suitable for an abstinence-based approach, abstaining from alcohol and other substances other than OST. This formed the basis of the development of the Abstinence-Based Therapy Group Programme.

15.2 Programme structure and phases of the ABT

The programme was conducted over a 6-month period and was divided into three phases:

- **Phase 1**: 21 days, with 3-hour sessions Monday to Friday; 90-minute sessions on Saturday and Sunday.
- **Phase 2**: 4 weeks, with 90-minute sessions on Monday, Wednesday, and Friday.
- P**hase 3**: 5 months, with one 90-minute session per week.

15.3 Programme components

The ABT group incorporated a comprehensive approach to support the recovery journey of participants. Participants who successfully completed the programme qualified for THDs and sponsored vocational training, which included mechanical and plumbing courses.

Table 11 Key elements of the ABT group

Element	Description
Group psycho-education	Educated participants on addiction, harm reduction, coping strategies, and healthy living.
Cognitive-behavioural therapy (CBT)	Helped individuals identify and change negative thought patterns contributing to substance use.
Relapse prevention	Equipped participants with skills to recognize triggers and develop strategies to prevent relapse.
Mindfulness practices	Encouraged self-awareness, emotional regulation, and stress reduction.
12-Step meetings	Promoted accountability to peer-led support groups and long-term sobriety.
Yoga and wellness activities	Provided physical and mental relaxation techniques to support overall well-being.
Homework assignments	Reinforced learning with self-reflection exercises and goal-setting tasks.
Urine toxicology testing	Monitored progress and encouraged accountability through regular drug screening.
Weekly family sessions	Involved family members to foster understanding, support, and strengthen recovery efforts.
Daily phone calls among group members	Created a support network to encourage commitment, accountability, and motivation.

15.4 Results of the abstinence-based therapy programme

A total of 19 participants were enrolled in the programme, with 14 successfully completing the required 45 hours of group attendance. Eight participants achieved the primary outcome of sobriety by the end of Phase 2. By the end of Phase 3, ten participants had attained sobriety at some point during the programme.

Many participants experienced significant improvements, including the ability to either cease or substantially reduce their OST dosage, and there was a noticeable reduction in other substance use. Only one client sought transitional housing and detox, though this was not necessary as he successfully tapered off and ceased OST.

Initially, sponsorship for vocational training was unavailable for eligible participants. However, an anonymous benefactor later offered to sponsor individualized vocational training, for all eligible participants, an opportunity extended to the nine group members who qualified.

Lessons learned

- Based on the results above, **consistent abstinence** for all PWUD may be **challenging** to achieve. A combination of harm-reduction and ongoing support through approaches like OST may be a more realistic path for recovery in this population.
- The **psychiatrist** had to dedicate the majority of each day to the group, which limited their availability to attend to other clients.
- Before the ABT group started, the **psychosocial team** was not comfortable running groups, but with experience gained during this process, they supported the leadership and formation of more groups and mentored their peers.

Conclusion

The ABT Group Program showed positive outcomes in helping clients achieve sobriety and reduce substance use, but its sustainability relies on resources, expertise, and capacity-building for clinicians, with potential for adapting less intensive interventions and strengthening collaboration with peer-led services and 12-step programmes.

16. CONTINUING THE MOMENTUM: WHAT'S THE WAY FORWARD?

The Kiambu PWUD Project, in collaboration with Kiambu County MoH, NASCOP, LVCT Health and Kenya Prison Services has set a strong foundation for delivering comprehensive, client-centred care for PWUD. Building on its successes, there are key steps to ensure sustainability, scalability, and adaptation to PWUD and other populations with similar needs. The way forward focuses on strengthening the existing model while exploring its applicability to broader groups facing health and social challenges.

Michael Karongo(right) and his wife Mary Wairimu(left) stand outside their home with their children. Mary has been Michael's greatest supporter in his recovery journey.

@Eugene Osidiana/MSF

1. Expanding access and coverage

- **Overcome geographic barriers**: Despite decentralizing services, there are still geographic areas where access to MAT clinics and satellite dispensing sites is needed. Efforts need to be made to reach remote and rural populations through partnerships with local health facilities.
- **Integrate services with existing health infrastructure**: Rather than starting from scratch, integrating the MAT services into existing clinics and hospitals will ensure better use of available resources, while promoting continuity of care.
- **Improve access for incarcerated PWUD**: Decentralizing services to prison facilities will enhance access to MAT for incarcerated PWUD, ensuring they receive continuous care and treatment while serving their sentences.

2. Broaden the scope of services for PWUD

- **Address poly-substance use**: While OST has been a core component of MAT, the needs of PWUD who use other substances, such as alcohol, methamphetamines, Benzodiazepines, etc, must also be addressed.

3. Increase Access to User-Friendly Naloxone

To effectively reduce opioid-related deaths, it is essential to make naloxone available in user-friendly formats—such as nasal sprays or prefilled syringes—that can be safely administered by peers, family members, police officers, and other first responders. These easy-to-use options ensure timely overdose intervention, especially in community settings where medical personnel may not be immediately available. Broad access to such formulations empowers communities to act quickly and save lives.

4. Include social reintegration support

Psychosocial support must be more deeply integrated into MAT services. The success of the Empowerment Centre (EC) model should be replicated in other regions to support the social reintegration of PWUD and provide them with opportunities for skills development, employment, and self-empowerment while collaborating with the right stakeholders. It also creates a safe space for holding the PWUD support groups.

5. Strengthen gender-sensitive approaches

- **Focus on WWUD**: Despite efforts to engage WWUD, their participation remains low. More targeted outreach and gender-sensitive programmes are required to ensure that women have equal access to care. This may include creating safe spaces, offering female peer educators, and addressing specific barriers that women face, such as caregiving responsibilities and societal stigma.
- **Address gender-based violence and intersectionality**: A deeper understanding of the intersectionality of gender, substance use, and violence is needed to tailor services more effectively. Expanding outreach to address the unique experiences of women and marginalized groups will be essential to improving engagement and retention in MAT services.

6. Improve data collection and research

- **Develop comprehensive data systems**: Currently, many MAT clinics face challenges in data collection, relying heavily on paper-based systems that limit efficiency, accuracy, and the ability to monitor client progress effectively. To address these challenges, there is a need to transition to a comprehensive electronic medical record (EMR) system across all MAT clinics. Implementing an EMR would enable real-time tracking of client progress, streamline service delivery, and improve the monitoring and evaluation process, ensuring better outcomes for clients and programmes
- **Conduct ongoing research**: More anthropological studies are required to better understand the evolving needs of PWUD and other key populations. They should also be conducted early in the project to shape service design and ensure that interventions are continuously adapted based on evidence.

7. Expand peer-led initiatives and community engagement

Increase the role of peer educators and CBOs: Peer-led initiatives were central to the success of the Kiambu Project. Expanding the role of peer educators and collaborating more with CBOs will help build trust and improve service uptake.

Additionally, providing competitive and consistent remuneration for peer educators is essential to boost morale, enhance retention, and ensure sustained focus on delivering impactful community-based services.

8. Engage key population sub-groups

Ensure equitable access to services by actively engaging key population sub-groups – such as sex workers, the homeless, and the Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) community – through collaborative programming with community actors. This approach will help reach high-risk individuals who may still be underserved.

9. Address stigma and legal barriers

Combat stigma through education and advocacy: Stigma remains a significant barrier to care for PWUD and other key populations. Continued efforts must be made to raise awareness, educate communities, and challenge discriminatory attitudes. This includes working with healthcare providers, law enforcement, and community leaders to foster a more supportive environment for individuals seeking MAT services.

10. Advocate for policy change

Current policies, particularly those around THDs and eligibility, need to be reviewed and revised. Continued advocacy, including from PWUD themselves, is required to push for more flexible treatment guidelines, particularly to ensure that PWUD who are stable and compliant with treatment can access THDs without unnecessary bureaucratic barriers.

11. Strengthen capacity for scaling the model

- **Integrating Harm Reduction into Professional Training Curricula:** To promote a more informed, compassionate, and effective response to drug use, harm reduction principles should be embedded in the training curricula of key professional sectors. This includes medical schools, law enforcement and prison officer training institutions, teacher training institutions, and all other relevant training bodies.
- **Invest in staff training**: Continuous, ongoing training for HCWs, peer educators, and CHWs is essential to maintain high-quality service delivery. Specifically, it is crucial to ensure that counsellors receive specialized training in addiction counselling, enabling them to effectively support PWUD with the complex challenges they face. Well-trained counsellors are integral to providing the compassionate, informed care necessary to address the unique needs of individuals struggling with addiction.

12. Strengthen government ownership and sustainable funding

- Ensure government commitment to MAT services: In light of the USAID funding freeze, it is critical for the government to take full ownership of MAT programmes by integrating them into national health priorities. This includes allocating dedicated funding in county and national budgets to cover essential medicines, operational costs, and harm reduction interventions. Additionally, providing competitive and consistent remuneration for peer educators is essential to boost morale, enhance retention, and ensure sustained focus on delivering impactful community-based services.
- Institutionalize MAT within public health systems: Integrating MAT services within existing MoH facilities will enhance sustainability by reducing reliance on external donors. This should include formal policy commitments, standardization of service delivery, and clear funding mechanisms.
- Advocate for inclusion in universal health coverage (UHC): MAT services should be recognized as an essential component of UHC, ensuring that PWUD can access treatment without financial barriers. This includes advocating for public insurance schemes like SHIF to cover MAT services comprehensively.
- Strengthen public-private partnerships: Leveraging partnerships between government, NGOs, and private sector stakeholders will help fill funding gaps, support innovation, and ensure the long-term success of MAT programmes.

HACK members and other stakeholders during the HACK inception meeting in Karuri MAT clinic, Kiambu. ©Lucy Makori/MSF

17. CONCLUSION

The Kiambu PWUD Project demonstrates the effectiveness of a holistic, client-centred approach to MAT. Through innovative harm reduction strategies, the project has made a significant impact on the health and social outcomes of PWUD, setting a national standard for excellence in service delivery. The success of this project highlights the need to improve MAT programmes at the national level – which is not only the delivery of OST. This approach requires community-driven approaches, a strong advocacy agenda, and sustained investment in harm reduction services. Moving forward, the lessons learned from the Kiambu PWUD Project provide a framework for similar interventions across Kenya and beyond, ensuring that MAT services evolve in ways that prioritize accessibility, dignity, and client empowerment.

BIBLIOGRAPHY

Beckerleg, Susan, Michael Telfer, and Abdirizak Sadiq. "A Rapid Assessment of Heroin Use in Mombasa, Kenya." *Substance Use & Misuse*, vol. 41, no. 6–7, 2006, pp. 1029–1044. https://pubmed.ncbi.nlm.nih.gov/16809185/

European Centre for Disease Prevention and Control. *Evidence for the Effectiveness of Interventions to Prevent Infections among People Who Inject Drugs. Part 2: Drug Treatment for Preventing Hepatitis C, HIV and Injecting Risk Behaviour.* ECDC, 2011

Frank, David, et al. "It's like 'Liquid Handcuffs': The Effects of Take-Home Dosing Policies on Methadone Maintenance Treatment (MMT) Patients' Lives." *Harm Reduction Journal*, vol. 18, no. 1, 2021, article no. 88, https://doi.org/10.1186/s12954-021-00535-y

Grebely, J., Larney, S., Peacock, A., Colledge, S., Leung, J., et al. "Global, Regional, and Country-Level Estimates of Hepatitis C Infection among People Who Have Recently Injected Drugs." *Addiction*, vol. 114, no. 1, 2018, pp. 150–166. https://doi.org/10.1111/add.14393

Harm Reduction International, 2022. https://hri.global/reports/2021-annual-report/

KELIN, and Kenya Key Populations Consortium. *"Everyone Said No": Biometrics, HIV and Human Rights, A Kenya Case Study.* KELIN, 2018, www.kelinkenya.org

KELIN, and Kenya Key Populations Consortium. *Geographic Mapping of Most at Risk Populations for HIV in Kenya.* KELIN, June 2012, www.kelinkenya.org/wp-content/uploads/2018/11/Geographic-Mapping-of-Most-At-Risk-Population-for-HIV-in-Kenya-June-2012.html

Kenya AIDS Control Council. "*Kenya AIDS Strategic Framework 2014/2015–2018/2019*". Kenya Government, 2014

Kenya National AIDS Control Council. "*Kenya HIV Prevention Response and Modes of Transmission Analysis*". Government of Kenya, 2009

Kenya National AIDS Control Council. *Kenya AIDS Response Progress Report 2018.* 2018. https://nacc.or.ke/wp-content/uploads/2018/11/Chairs-Remarks-during-KAPR-Report-launch-.pdf

Kenya National AIDS Control Council. *Kenya AIDS Strategic Framework 2014/15–2018/19.* Government of Kenya, 2014. https://nacc.or.ke/wp-content/uploads/2015/10/HIV_and_AIDS_score_card_for_Government_Ministries_Departments_and_Agencies.pdf

McLellan, A. T., et al. "An Improved Diagnostic Instrument for Substance Abuse Patients: The Addiction Severity Index." *Journal of Nervous and Mental Disease*, vol. 168, no. 1, 1980, pp. 26–33

Ministry of Health, Kenya. "*National Protocol for the Treatment of Substance Use Disorders in Kenya*". 1st ed., Mental Health & Substance Abuse Management Unit, 2017

Ministry of Health, Kenya. *National Implementation Guidelines for Medically Assisted Therapy for People with Opioid Use Disorders.* Government of Kenya, 2021

Ministry of Health, National AIDS & STI Control Program (NASCOP). "2010–2011 Integrated Biological and Behavioural Surveillance Survey among Key Populations in Nairobi and Kisumu, Kenya". Nairobi, Kenya: NASCOP, 2014

Ministry of Health, National AIDS and STI Control Programme (NASCOP) *Kenya MARPs Size Estimation Consensus Report 2012/2013.* Nairobi, Kenya: NASCOP, 2013

Ministry of Health, National AIDS and STI Control Programme (NASCOP). *Key Populations Programme Data Collection Tools: Revised Reference Manual.* Nairobi, Kenya: NASCOP, 2019

Ministry of Health, National AIDS and STI Control Programme (NASCOP). *Key Population Size Estimates – Kenya.* Nairobi, Kenya: NASCOP, 2021.

Ministry of Health. "*National Implementation Guidelines for Medically Assisted Therapy for People with Opioid Use Disorders*". Government of Kenya, 2021

National AIDS Control Council. *Kenya AIDS Strategic Framework 2014/15–2018/19*: Towards an AIDS-Free Kenya. Government of Kenya, 2014. https://nsdcc.go.ke/wp-content/uploads/2015/09/KASF_Final.pdf

National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide.* 3rd ed., NIH, 2018

National Syndemic Diseases Control Council**.** *Kenya Modes of Transmission Study: Final Report.* NSDCC, Nov. 2024, https://analytics.nsdcc.go.ke/estimates/KMoTReportNovember-2024.pdf

UNAIDS. *UNAIDS Data 2020.* 2020. https://www.unaids.org/sites/default/files/media_asset/2020_aids-data-book_en.pdf

United Nations Office on Drugs and Crime (UNODC), and World Health Organization (WHO). "Principles of Drug Dependence Treatment: Discussion Paper". UNODC & WHO, 2008.

United Nations Office on Drugs and Crime. *World Drug Report 2023*. 2023. **https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2023.html**

Wambugu, George M. *Uptake of Medically Assisted Therapy among People Who Inject Heroin in Mathare Low-Income Settlements, Nairobi County, Kenya*. Master's thesis, Jomo Kenyatta University of Agriculture and Technology, 2020

World Health Organization (WHO). Global HIV, Hepatitis and STIs Programmes. *People Who Inject Drugs* **https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/populations/people-who-inject-drugs**

World Health Organization (WHO). *The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Manual for Use in Primary Care*. WHO, 2010, **https://www.who.int/publications/i/item /9789241599382**

World Health Organization (WHO). "Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence". WHO, 2009, **https://doi.org/9789241547543**

World Health Organization (WHO). "Substance Abuse." *World Health Organization*, 12 Nov. 2019, **www.who.int/topics/substance_abuse/en/**

APPENDIX 1:

Assessment of needs and possibilities for an MSF-B intervention targeting PWUD in Kenya

Author: Ancella Voets
Date: 13th July 2017

Executive Summary

Introduction

In Kenya estimates on the number of people who use drugs (PWUD) don't exist. The estimates on numbers of people who inject drugs (PWID) in the country vary greatly and all stakeholders stress the need for updated and more reliable numbers. In 2011, during a national consensus meeting, the number of PWID in Nairobi has been projected at 6,216, while it was estimated there were 8,500 PWID in the Coast Province. 5-11% of PWID are believed to be women. By far the most injected drug in the country is heroin. Previous surveys have reported risky injection and risky sexual behaviour among PWID. And while the national HIV prevalence is 5.6%, the estimated HIV prevalence among PWID stands at 18.3%; HCV prevalence among PWID is estimated at 20%. Besides, more than 1/3 of PWID reported to have experienced an overdose (OD) in the past, while 90% state ever having witnessed an OD.

Findings

Currently Kenya has five operational methadone clinics: two in (East) Nairobi, two10 on the Coast (Mombasa and Kilifi counties) and one in Kisumu (Southwest Kenya), providing methadone to 1,674 PWUD, all through DOT. All clinics are PEPFAR-funded, with counties providing staff and GF participating in funding commodities. MAT is open for injecting and non-injecting PWUD and all clinics intend to offer comprehensive health care. However, some limitations to this aim are: 1) no services are offered to PWUD who don't take methadone; 2) HCV treatment is not available; 3) most MAT clinics have limited laboratory capacity and lack medication; and 4) not all clinics have a maternity ward, complicating care for new mothers and their infants. Though everybody agrees that scale-up and decentralisation of MAT services are urgently needed, MoH tries as much as possible to limit the private sector from providing methadone, while mobile distribution and take-home methadone doses are not (yet) allowed. Also, other substances to substitute heroin are not (yet) used.

Contrary to MAT, the implementation of NSP is not allowed in government institutions but delegated to civil society (though coordinated by NASCOP). Nine CSOs are implementing NSP in twelve sites in the country. For six organisations GF (through the Kenyan Red Cross) provides the safe injection kits; the British HIV/AIDS Alliance (through KANCO) supplies two others; and MdM purchases its own sterile injection equipment. Most CSOs receive funding from PEPFAR, GF, OSIEA and/or others for additional harm reduction services. More would be needed however to improve quality and coverage of these services.

According to stakeholders interviewed, the most urgent unmet health needs of PWUD in Kenya are:

- OST and other drug treatment
- Viral hepatitis C (and B) management
- Psychosocial support
- Mental health treatment
- Comprehensive HIV care and treatment
- TB management
- SRH services
- Nutrition and hygiene support
- Wound, abscess and skin care
- Access to general health services (including laboratory tests and medication)

Unsurprisingly, women who use drugs (WWUD) are more vulnerable and harder to reach than their male counterparts. Also access to health care services for PWUD in prison settings is extremely limited.

Although health care is a responsibility of county governments, the main government partner for issues related to PWUD is the National AIDS and STI Control Program (NASCOP) under the MoH. NASCOP would prefer MSF to start its intervention in Kilifi (on the Coast) or in Kiambu (north of Nairobi). Health needs of PWUD are undeniably more urgent in the Coast - especially in Kilifi and Kwale counties - than in Kiambu or Nairobi. In Nairobi county the largest population of PWUD is in Mathare, in the Eastern part of the city. However, if choosing for Nairobi, county health representatives urge MSF to focus on the Western part of the city, where fewer actors are working.

Recommendations

After the assessment, the first things for MSF to do are:
- Continue HCV treatment for PWUD, considering including PWUD from/in the Coastal region
- Carry out a situational assessment in Kiambu
- Carry out a needs assessment among PWUD (at least in the selected county of intervention)
- Consider contributing to the planned national KP mapping exercise

Meanwhile negotiations with NASCOP will have to take place to select a county for the planned intervention. Then MSF will have to select a public health facility together with the county authorities, all the time staying in contact with PEPFAR and its partners, with MdM and with the Kenyan Red Cross, making sure to have their support and to establish fruitful working relations.

It is recommended the initial intervention focus on HIV, HCV and TB treatment, OST, SRH, OPD, HBV vaccinations, psychosocial counselling and strengthening laboratory and pharmacy services of the selected facility. If a maternity ward is present, this should also be strengthened; if not, it is recommended to seek close collaboration with facilities close by that have maternity wards.

At the same time a civil society partner should be selected to link the clinic to PWUD. Together with this partner MSF ought to recruit and train peer educators and implement a peer-led micro-planning outreach method. PEs should be trained in using Naloxone and carry this on them to reverse overdoses. In outreach NSP, HIV, HB and HCV testing, TB and STI screening and accompanied referral to the clinic should be offered, next to detailed health information for PWUD. Ideally the CSO partner would have a DIC close to the clinic, offering the same services as in outreach, plus extended education and counselling, shower & laundry facilities, hygiene packs, meals and a place to be at ease. It is important that all services are also accessible for and tailored to WWUD and non-injecting PWUD.

It will take at least two or three years to implement and stabilise the intervention described above, before it can be safely handed over. If MSF would choose not to hand over but to continue instead, there is a range of options to expand services into a real centre of excellence that could serve as an example for the county, the country and possibly the East African region:

- Drug treatment (detox & rehab) for heroin, cocaine, alcohol, tranquilisers and/or cannabis users
- HBV treatment (at least for all HIV+ PWUD and for pregnant WWUD)
- Mental health services
- Extended SRH services
- NCD care
- Health care in prison settings (starting with PWUD who are MSF patients prior to incarceration)
- Prevention of violence (mob justice, domestic violence, GBV)
- Offering capacity building to third parties (training, internship, mentoring)

APPENDIX 2:

Step-wise approach for take-home doses

Take-home doses

The process

The request was either provider-initiated for the stable patients or on patient's request, based on a need, which could be job, travel, school, illness, etc.

INITIAL EVALUATION

- Once the team receives the request for take home dose, a thorough assessment is done to ensure that the patient requesting for Take home dose is stable, not concurrently using heroin and OST and not cross addicted to alcohol
- A home visit then follows conducted by a pharmacist and psychosocial team

WHAT TO LOOK OUT FOR DURING THE HOME VISIT (ELIGIBILITY)

- The patient is living in a safe environment and not close to a known den or hot spot.
- House is safe and lockable.
- Patient has a good treatment supporter.
- The spouse/partner or treatment supporter is not an active heroin user or with alcohol dependency.
- Has a lockable cabinet to store the OST.
- Can provide a safe box to carry and store the OST.
- **If the patient is deemed not eligible for take-home dose, based on the factors mentioned above, the OST is instead delivered to a nearby health facility that he/she can easily access daily for the defined period, or if this is not feasible, then a daily home delivery of the OST is done using an ambulance or car.**

PREPARATION FOR TAKE-HOME DOSES

- Once home safety is assured, the medical team has a multi-disciplinary team discussion about the patient, to be sure that he/she is a good fit for take-home doses.
- If some members of the team have some information that creates doubt in safety of OST once take-home dose is done, e.g., if the patient has ever been involved in a case of attempted diversion of OST in the clinic before, then at this point eligibility is disqualified.
- Once the patient is deemed eligible by the team for take-home doses, he/she signs a consent form (see Appendix X)
- The treatment supporter signs the consent form as witness and provides a copy of their national ID, which is kept in patient's file.
- The treatment supporter, together with patient, are taken through the process of taking the OST at home and signing the necessary P4 forms for documentation once they have taken the OST.

INITIATING THE TAKE-HOME DOSES

- For the stable patients, the dose can be given for 7 days to begin with and then increased to 14 days thereafter or as needed.
- The dose is delivered by the team using either an ambulance or car.
- To ensure safety, **patients are not allowed to use public transport to transport the OST but rather private means (car).**
- The OST is packed in the safe boxes for transit and one key remains with the pharmacy team.
- The doses are accompanied by the P4 forms for signing and accountability.
- The treatment supporter signs the P6 forms on receiving the OST doses, which indicate the total volume of the OST received.

MONITORING AND CONTROL

- The stable patients are required to come back to the clinic on the last day of their doses for review.
- This includes a urine toxicology test and psychosocial assessment
- They are required to bring in all the empty OST bottles with them or any missed doses plus the P4 forms.
- If they test positive for opiates (heroin) or are reported by the treatment supporter as not to adhere to the instructions, the multi-disciplinary team re-discusses their eligibility for take-home doses.
- Meanwhile, if not able to come for review due to illness, the team would continue to deliver the OST daily, until safety is established or otherwise
- The patient is expected to follow up on psychosocial or nutritional appointments as needed. If not able to come to the clinic, the team provides the services as a home visit.

APPENDIX 3:

Consent form for take-home doses (Kenya's MAT guidelines)

Methadone and Buprenorphine take-home dose consent form

I have been adequately informed by the treatment team on the requirements for ensuring methadone/Buprenorphine is safely used as it is a strong medication which, if not used as per the doctors' instructions, **can lead to harm/death**. For this reason, I agree to the following:

1. I will store my take-home doses safely, in a place where it is unlikely to be stolen or accidentally taken by another person.
2. I will consume my dose(s) on the day(s) they are prescribed only.
3. I will consume my Methadone/Buprenorphine dose in the appropriate manner as prescribed
4. I agree not to give, lend or sell my take-home doses to anyone.
5. I understand that selling methadone/Buprenorphine is a criminal offence as well as a danger to the community.
6. I will be required to collect my take-home doses in person at the clinic or through my trusted treatment support
7. Take-home doses are a **privilege and not a right**. My doctor and treatment team, in accordance with the clinic policies, MOH, NASCOP and Pharmacy and Poisons Board, grant these.
8. Take-home doses privileges are continued and increased once every 2 weeks, so long as I continue to remain clinically stable and able to be responsible for the care of my take-home doses. This is again at the discretion of the MDT treatment team.
9. Take-home doses may be cancelled or decreased if I do not remain clinically stable and able to be responsible for the care of my take-home doses.
10. Lost, spilled, vomited, or stolen take-home doses may not necessarily be replaced. Lost or stolen take-home doses must be reported to the clinic.
11. I will be required to return all my empty dispensing methadone bottles/Buprenorphine blisters to the clinic at my next appointment or as required by the MDT treatment team.
12. I will identify and provide to the clinic a treatment supporter to help me in my recovery.
13. I will advise the clinic of any change in my contact information (phone number or address).

My signature below indicates that I agree to follow the obligations and responsibilities outlined in this agreement. Should I fail to meet the terms of this agreement, I understand that this will affect my eligibility to partake in the take-home dose program.

I have had an opportunity to discuss and review this agreement with my prescribing clinician and counselor, and my questions have been answered to my satisfaction.

Client's Name ……Signature…… Date…….

Clinician's Name ……Signature…… Date…….

Counsellor's Name……Signature……Date…….

Treatment supporter

I have been adequately informed by the MAT treatment team on methadone/Buprenorphine safe use and I agree to provide support to …….. to ensure he/she uses his/her methadone/Buprenorphine safely at home as instructed by the clinician.

Name…… Signature …… Date……

APPENDIX 4:

Key meetings held in the project and their objective

KEY MEETINGS HELD IN THE PROJECT AND THEIR OBJECTIVE			
Meeting type	**Purpose of the meeting**	**Frequency**	**Participants invited**
Coordination meetings			
Project coordination meetings	Discuss project updates, challenges, and solutions, plans for the coming week and ensure alignment of activities across teams.	Initially was weekly, then bi-weekly	All project managers led by the Project Coordinator
Joint Management Team meetings (JMT)	Share project and CSO updates, including data. Plan, resolve issues or unforeseen difficulties that may arise.	Monthly	The county HIV coordinator, the MAT clinic leads, the MSF-B project coordinator, the MSF-B project medical referent, the MAT pharmacist, LVCT representatives, mental health / psychosocial specialist and ad hoc participants, experts, when determined by the JMT
County Health Management Team Meetings	Proposed by MSF to keep the county updated on MAT clinic activities and support needed from the county.	Initially, monthly, but later on basis of need, due to competing priorities from the county	County leads including Minister of health at the County (CECM), Chief Officer of health, County Director of Health, County Head of Programmes, Director of Public Health, County HIV coordinator, the MSF-B Project Coordinator, the MSF-B Project Medical Referent, MSF B HR, the Finance Manager and LVCT Health representatives.
Medical Meetings			
Medical managers' meeting	Discuss project medical updates, challenges, and solutions and ensure alignment with the project's logical framework and plans for the week.	Every Monday morning	Medical activity manager, pharmacist, data manager, mental health supervisor, health promotion manager and supervisor, psychiatrist
Medical meetings (thematic)	Different meetings every Wednesday, • LTFU (Lost to follow-up), • Case discussions on difficult medical cases • Strategies to increase Buprenorphine uptake • Main medical meeting – last Wednesday of the month to discuss the activities of the month, cohort analysis reports,	Weekly – every Wednesday; usually thematic	All clinic staff including peer educators and CHWs for some specific meetings like LTFU, Buprenorphine uptake and main medical meetings.

	achievements and challenges		
Psychosocial and mental health meetings			
Mental health and psychosocial departmental meetings	Plan for the week's activities as well as provide departmental updates.	Weekly	Addiction counsellors, psychiatrist and social workers, MAT lead and mental health supervisor
Peer educators' meetings			
Peer educators/ Microplanning meetings	Provide training and support for peer educators, discuss best practices, and share feedback.	Weekly	Health promotion manager, peer educators, CHWs, LVCT health outreach worker
Stakeholder engagement meetings			
MAT Linkage Forum	Engage stakeholders (LVCT Health, MSF, PWUD, County HMT) to assess project outcomes, share data, and align future plans.	Quarterly	MSF project managers, LVCT Health, County, PWUD community including peer educators
Patient management and compliance meetings			
Multi-disciplinary team (MDT) meetings	Discuss patients found to be violating clinic rules & regulations, including what is outlined in the consent form	On basis of need	A representative from every department including security personnel and peer educators. Usually led by the medical managers or project coordinator if case is linked to a security breach. (Refer to Appendix 5 for standard operating procedure on MDTs.)

APPENDIX 5:

Standard operating procedure on multidisciplinary team meetings

KIAMBU MAT CLINICS

Multi-disciplinary team meetings (MDT)

Standard operating procedure

1. Purpose

The purpose of this standard operating procedure (SOP) is to provide guidance on how multi-disciplinary team meetings (MDTs) are conducted in the MAT clinics, who is to attend, when, how the process should flow, and how documentation should be done.

2. Scope

The SOP is applicable for outlining the process of conveying an MDT for patients found to be violating clinic rules & regulations, including what is outlined in the Medically Assisted Therapy(MAT) clinic intake consent form.

3. Prerequisites

- Briefing of the incident that requires an MDT by the healthcare worker responsible to the respective manager as well as gathering relevant information from the patient's file, including but not limited to prior MDTs and any party who witnessed or reported the incident. Immediate documentation of the same should be provided.
- An Incident Form is also to be duly completed prior to the MDT by the staff member who received the report or observed the incident.
- The respective manager shall then send the Incident Form to the project coordinator (PC) via email and copy all managers for their information.
- The department involved in the reported incident shall take the lead in flagging the patient and informing the relevant departments of the planned MDT, including the date.
- Once the date of the MDT has been agreed upon by the relevant parties and the patient is well informed, a representative of the CSO shall be invited. The invitation shall be made by the social worker by phone through the CSO in charge of the respective DIC or the Addiction Counsellor, requesting their attendance by sending a representative on the set date. *Should a representative of the CSO be unable to attend physically, they can join via the virtual platform.*
- A mental health assessment should be done for the patient prior to their MDT, and the report should be filed accordingly. The addiction counsellor shall refer the patient to the Clinical Officer/ psychiatrist or psychiatrist who will be responsible for completing the Mental Health assessment form.
- Once the MDT has been conducted, the patient can be asked to step out briefly as the team deliberates on a way forward.
- Once the team has agreed on a clear way forward, the patient shall be called in and explained to on the way forward. The patient and the team attending the MDT shall all be required to sign the MDT form on completion of the discussions.
- In addition to the patient following up on the agreed-upon deliberations of the MDT, he or she shall also be required to re-sign a copy of the MAT clinic rules.

- Both the MDT form and the re-signed MAT clinic rules shall be filed in the patient's file indefinitely.
- In the event that the patient declines to sign the MDT form, the PC or PMR will make the final decision regarding the way forward for the patient.

4. Responsibilities

- Staff who witnessed or received the report of the incident will complete the incident form and brief the respective manager.
- The manager who receives the report will forward via email the Incident Form to the PC and PMR and copy in other managers.
- The primary social worker will call a representative of the CSO and invite them to the MDT.
- The social work or counselling department will flag persons involved in the incident with the help of the pharmacy department and peer educators/CHWs.
- Once flagged, the patient will be referred by the addiction counsellor to the psychiatrist or CO psychiatrist for a mental health assessment when feasible. The findings from this assessment will be presented to the MDT members prior to meeting with the patient.
- Once the person/s involved arrive at the social work department, the social workers will inform the respective manager, who will brief the PC and PMR. An MDT will be convened by the MH supervisor with a representative from every department.

5. Procedure

1. Once an incident is reported to a staff member, the staff member will document the incident on the Incident Form in hard copy. A soft copy will then be sent via email to the PC and PMR, and other managers copied in for their information.
2. The staff member will then brief the respective manager on the incident and share the Incident Form.
3. The manager will then give a brief on the incident to the PC, PMR and other managers, including the CSO. This could be done face-to-face or by email.
4. The MH Supervisor will be the convener of the MDT. A representative from every department will be notified of the MDT; they will be briefed on the incident prior to hearing from the persons involved in the incident.
5. Members present will be briefed on the MDT norms, including that only one person will talk at a time, even when someone disagrees with what is being said; everyone will get a chance to speak and share their views. It is the responsibility of the convener of the MDT to ensure the MDT is conducted in an orderly and calm environment.
6. The findings from the mental health assessment will be presented to the MDT prior to calling the patient or persons involved in the incident into the room.
7. Persons involved in the incident will be called in to recount what transpired in their own words after the introduction of members in the MDT. Persons involved in the incident will be notified that documentation of the entire process will be undertaken.
8. MDT members will then ask the person/s involved to wait outside as they deliberate on the way forward. The PC or PMR will then give feedback on the deliberations from the team to the person/s.
9. Should they not feel satisfied with the decision of the MDT, they can ask for clarification. Documentation of relevant forms is to be done before the MDT members disperse.
10. The hard copy of the MDT report will be filed in the patient's file. The patient will also be requested to write a letter of apology, which will be filed in his/her respective file.

11. The follow-up sessions are to be clearly explained to the patient. This will include explaining to the patient the status of whether a session was held & reasons for the same. This will be captured in the addendum of the MDT form and will require the signature of the primary counsellor once the session is held.

12. All mandated sessions as a result of the MDT are to be done within one week.

13. It is the responsibility of the primary counsellor and primary social worker to ensure adherence to the sessions and document the status of the findings.

14. **If the patient committed a gross misconduct e.g. violence within the MAT clinic with another patient or a staff member or diversion of OST and is transferred to another clinic, if he or she wishes to come back to the clinic to continue with his or her treatment, another MDT must be done, and steps repeated as mentioned above.**

6. References

Ministry of Health. *National Implementation Guidelines for Medically Assisted Therapy for People with Opioid Use Disorders* (2021).

MSF-OCB-KE. Incident Report Form.

7. Abbreviations

CHW	Community health worker
CSO	Civil society organisation
MAM	Medical activity manager
MAT	Medically assisted therapy
MH	Mental health
MHS	Mental health supervisor
OST	Opioid substitution therapy
PC	Project coordinator
PMR	Project medical referent
SOP	Standard operating procedure

APPENDIX 6:

Psychiatric form

The medically assisted therapy psychiatric encounter form, can be accessed here: https://bit.ly/44hC4jj

APPENDIX 7:

SOP for re-use of methadone dispensing cups

MSF-OCB MISSION	**PWUD Kiambu Project**
Guideline title	**CLEANING OF METHADONE DISPENSING CUP SOP**
Author	Logistics Manager and PMR
Status / Date	**Validated /** 17/10/ 2019

Function

The main function of this SOP is for hygiene officers to clean the methadone dispensing cups (thereafter called cups) and ensure they are re-usable with no cross-infection/contamination threat.

Collection of cups

MAT patients dispose of their empty cups into the bins facing the methadone dispensing windows of the pharmacy.
Cups are to be collected on a daily basis, after the dispensing stations have been closed for the day, and brought to the assigned cleaning area in the clinic.

Cleaning of cups

Cups are to be removed from the plastic bag from the bins at the dispensing windows.

Solution information
1% bleach solution is caustic. Avoid direct contact with skin and eyes. Prepare the bleach solutions in a well-ventilated area.
Bleach solutions must be prepared daily. They lose their strength after 24 hours. Anytime the odor of chlorine is not present, discard the solution.

Preparing the solution

PPE needed

1. **Face protection:** Wear chemical safety goggles. A face shield (with safety goggles) may also be used in cases where goggles are not available.
2. **Skin protection:** Wear chemical protective clothing, e.g., gloves, aprons, boots, coveralls or long-sleeved shirts and pants. Wear chemical protective grade equipment.
3. **Respiratory protection:** Up to 5 ppm mask.

Material and tools needed

1. 2 x 20-litre plastic buckets
2. Clean water
3. Chlorine (This will come with a 10g spoon)
4. Soap powder
5. Tablespoon
6. Stirring rod
7. Dedicated sponge

Mixing the solution

1. **Always add chlorine to water and not water to chlorine**, as it may cause a violent reaction
2. Add 4 x 10 grams of chlorine to 20 liters of water
3. Mix well at least 30 minutes before needed

Prepare soapy water

1. Add 5 tablespoons of soap powder to 20 liters of water in a bucket
2. Stir well until suds form

Washing procedure

1. Make sure to wear heavy-duty dishwashing rubber gloves
2. Soak the cups in the bleach solution for approximately thirty (30) minutes.
3. Scrub the cups with soapy water. Wet a clean sponge and gently scrub the cups.
4. Rinse the cup thoroughly under running water.
5. Let the cups air dry overnight to be used the next day.
6. After the cups are dried, stack them into each other and hand them over to the pharmacist.

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