UNIVERSITY OF NAIROBI

FACULTY OF ARTS

DEPARTMENT OF SOCIOLOGY AND SOCIAL WORK

FACTORS THAT HINDER ADDICTION TREATMENT AMONG WOMEN WHO INJECT DRUGS (WWIDs): A CASE OF WWIDs IN KILIFI COUNTY

BY: ZAINAB NGUVU

ADMIN: NO: C50/61606/2013

A research project submitted in partial fulfilment of the requirements for the award of the degree of Masters of Arts in Sociology (Rural Sociology and Community Development), University of Nairobi

2017

DECLARATION

This research project is my original work and has not been presented for award of a degree in any other University.

ZAINAB NGUVU

CSO/61606/2013

Signed..... Date.....

Declaration by Supervisor

This research project has been submitted for examination with my approval as the University Supervisor.

PROF. EDWARD. K. MBURUGU

Signed..... Date.....

DEDICATION

This work is dedicated to my family, without whose caring support it would not have been possible. My husband Dr. Raphael Lwembe for setting high expectations and always pushing the best out of me no matter the circumstances. My sister Khadija Nguvu for never giving up on me. Your support and encouragement can never be valued. My mother Sophia Nguvu for loving me unconditionally and being my pillar of strength, resilience and discipline.

To my son Jayden, you give me so much strength. I hope this project will help you believe in yourself and help you realize that you can do anything if you set your mind to it.

ACKNOWLEDGEMENTS

This research work has been a success due to the immense support I received from various groups of people.

I wish to acknowledge in particular my supervisor Professor Edward.K.Mburugu for his exceptional effort, support and encouragement throughout the course. His critique and firmness gave me self-confidence and courage to work hard.

I also acknowledge Mr. Zawadi Baya a health worker from Malindi District Hospital and Ms. Lilian Nyamawia community health volunteer in Malindi Sub County for sharing their expertise and knowledge on women who inject drugs in Kilifi County. A heartfelt thank you goes to Saumu Lwembe, Nicki Thorogood and all the participants without whose time this research would not be possible.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMNS AND ABBREVIATIONS

CHV – Community Health Volunteer

CHW – Community Health Worker

CSO – Civil Society Organization

CSW – Casual Sex Worker

HIV– Human Immunodeficiency Virus

IDUs – Injecting Drug Users

KANCO – Kenya Aids NGO Consortium

MAT – Medical Assisted Treatment

NSP – Needle and Syringe Programme

WWIDs - Women Who Inject Drugs

ABSTRACT

Injection drug use at the Kenyan coast is posing a great danger to the communities and the country at large due to the risks involved and rising number of youth affected in their most productive age. This study sought to examine factors that hinder women who inject drugs from accessing treatment in Malindi Sub County of Kilifi County in the Republic of Kenya. The study was guided by the following objectives: To establish if there are support mechanisms that exist for WWIDs, to identify if there are personal and community based factors that hinder access to treatment for WWIDs in Kilifi County and to determine if there are gaps in existing structures and support mechanisms that discourage WWIDs from accessing treatment in Kilifi County. A semi-structured questionnaire was administered to a sample of 60 respondents. A response rate of 83.3% was achieved. Interview schedules were distributed to 10 key informants. A response rate of 70% was achieved. Qualitative data results are presented in narrative form while quantitative data results have been presented in charts and tables. Data from the research showed that treatment centres and support structures for injecting drug users in Kilifi County are not gender based. There also exist personal and community based factors that hinder women who inject drugs from accessing treatment. These include lack of finances, discrimination, victimization and lack of legitimate sources of income. The study showed that other than socio cultural and personal barriers there also exist systemic barriers in addressing drug use problem. Although several WWIDs are aware of treatment facilities and enroll for treatment, the retention and completion rates are low. This can be attributed to several factors including absence of appropriate gender based and affordable treatment models, judgement and stigma. The study recommends that treatment programs in addition to pharmacotherapy and counseling adopt a holistic and comprehensive approach that addresses the most important areas of the lives of WWIDs which include employment, safety and acceptance. Interventions for women who inject drugs should also be long term and comprehensive. The interventions should not only focus on the WWIDs abandoning drugs but also the environment and behavior that puts them at risk.

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

The number of injection drug users in Kenya and the effects to society can no longer be ignored. According to the 2014 Kenyan AIDS Response Progress Report, Kenya has approximately 18,327 Injection Drug Users (IDUs). IDUs face a number of challenges including social exclusion and stigmatization, incarceration brought by the punitive legal environment, higher risk to disease, absence of or inadequate treatment facilities, poverty among others (Kageha, 2015; Nieburg, 2011; Musyoki, 2012; Roberts et al., 2010; Anderson, 2007; Guise et al., 2016).

Data from the World Health Organization (World Drug Report 2015) shows that only one out of six drug users globally has access to treatment out of an estimated total number of 16 million people who inject drugs. While one out of three drug users globally is a woman, only one out of five drug users in treatment is a woman (World Drug Report, 2015). In low income or resource constrained countries, global data holdings do not disaggregated by gender and age. The data also shows that low income countries generally fail to disaggregate data based on gender when providing HIV prevention, treatment, care and support services for people who inject drugs. This makes the assessment of the degree to which available services respond effectively to women's needs difficult (Pinkham et al. 2012; Roberts et al., 2010).

Locally, while WWIDs are few, their HIV prevalence is estimated to be 3 times higher (44.5%) compared to men who use drug injections. Many reasons have been recommended as to why WWIDs are exposed to a high risk of being exposed to HIV than male. Women stand a high chance of being isolated by the society while they stand a high chance of using injections particularly on exposed body parts in order to hide use of drug injections. Engaging in unsecure injections practices could be popular amongst women considering the hindrances involved in accessing syringe or generally, the medication for dependence on drugs and absence of services that are meant to specifically address needs for women. Recent surveys have reported high predominance of sex workers amid WWIDs and inconsistent use of condom, including high levels of sharing needles amid WWIDs who do not take part in sex work. Unsafe use of injections and unsafe sex significantly increases the risks of exposure to HIV amidst WWIDs (World Drug Report 2015).

Precise data on WWIDs in Kenya is not available and their exact number is currently unknown. There is also no clear distinction amongst women and men especially when conversing issues to do with prevalence, the risks involved and the impacts of injection. drug use which could help policy makers and care managers formulate relevant policies and subsequently accord the WWIDs the treatment and support they need. In 2012 Kenya adopted cost effective harm reduction strategies as intervention to cut down the number of HIV infections by and among injection drug users. These strategies included opioid substitution therapy needle and syringe exchange programmes. There is a major generalization of injection drug users as a homogenous group even when dispensing these services. Current proposed strategies and interventions do little to cater for the unique

needs of WWIDs. One of the reasons might be because these interventions are being tried out in Kenya for the first time and the need for urgent interventions gives no time to segregate by gender and age. It is nevertheless very vital to segregate IDUs according to gender and age; which will help reveal the specific and unique needs of each group. Understanding the needs of each gender and age will also help in formulation of effective policies on strategies that will help to effectively solve the problem. This study highlights the factors hindering WWIDs from accessing treatment and provides baseline information which might be key in the provision of proper interventions, care and treatment for WWIDs at the Kenyan coast.

1.2 Problem Statement

Extant research depicts most women who use injections are mostly from the U.S., Europe and Australia. Even though a reasonable body of growing research on WWIDs among low and middle income economies, today there lacks a logical analysis concerning prevalence and use of drug injections among women globally. However, the statistic on women who use drug injections is scarce. In 2012, Kenyan government in conjunction with the National AIDS and STI Control Program (NASCOP) recommended that Needle and Syringe programs among the communities were affected in Nairobi, Malindi and Mombasa.

This was to help reduce HIV infections among injection drug users transmitted through the sharing of needles. In 2014, the U.S. government together with the Kenyan government launched a Medically Assisted Therapy (MAT) treatment program at Mathari Teaching and Referral Hospital in Nairobi and at Malindi Sub County Hospital.

The program aimed to help people who inject drugs (PWIDs) reduce or stop injecting, decrease risks to their health, and return to productive lives. The treatment programs however fail to segregate men and women who inject drugs and do not offer gender based treatment.

In Kenya, there exists very little information concerning women with problems of substance-use and there is absence of concrete evidence on women who abuse drugs using injections (Word Drug Report, 2015). Women who participate in gender-related programmes and pharmacotherapy that focuses on their specialized treatment needs received better treatment results in critical areas of their lives unlike those that do not participate in gender programmes.

While studies have been conducted on injecting drug use in Kenya, scanty research from the literature reviewed showed significant gap on the gender based addiction treatment. Furthermore, factors hindering women who inject drugs from accessing treatment have also not been addressed. It is likely that policy is formulated and treatment intervention adopted without putting into consideration the needs, experiences and risks of women who inject drugs during and after treatment. The findings from this study aimed to inform the development of strategies that can be used to support women who inject drugs as well as provide baseline data for the measuring and evaluation of the proposed strategies if adopted.

1.3 Research Questions

i. What are the characteristics of women who inject drugs in Kilifi County?

ii. Are there any health facilities that cater specifically for women who inject drugs in Kilifi County?

iii. What factors hinder women who inject drugs from accessing health facilities in Kilifi County?

1.4 Objectives

1.4.1 Main Objective

The main objective of this study is to examine the types of challenges that hinder access to treatment for women who inject drugs in Kilifi County.

1.4.2 Specific Objectives

The specific objectives of this study are;

i. To establish whether there are existing support mechanism for women who inject drugs in Kilifi County.

ii. To identify personal and community based factors that hinder women who inject drugs from accessing treatment in Kilifi County.

iii. To examine factors in the existing structures and support mechanisms that discourage women who inject drugs from accessing treatment in Kilifi County

1.5 Justification of the Study

Focusing on WWIDs would be of vital because of several reasons particularly following the high rate of mortality, high chances of injection problems, high rate of growth from introduction to dependence, high rates of new HIV infections, involved risks of injection and sex behaviours (Roberts et al. 2010; Tuchman 2015; Rhodes et al. 2015).

Among the best treatment practices that have been identified from the developed countries around MWIDs, a huge gap has been left in knowledge regarding the treatment modalities and the essential traits that are desirable for women and the difference the they have in their cultural settings that can match different kinds of treatment. Paucity in female-specific researches creates a key hindrance in designing treatment programmes that are meant to address the needs of women.

The study offers valuable contributions from both a theoretical and practical standpoint by identifying the systemic, structural, social, cultural and personal barriers that hinder the access to addiction treatment for women who inject drugs at the Kenyan coast. This study is important because it puts local context into consideration in guiding policy makers and treatment centres on the need for gender based comprehensive treatment models that address the needs of WWIDs when offering support and treatment.

1.6 Scope and Limitations of the Study

The research was carried out in Kilifi County. The following were the specific objectives of the study: To establish whether there are existing support mechanisms for women who inject drugs; to identify personal and community based factors that hinder addiction treatment of women who inject drugs and to examine factors in the existing structures and support mechanisms that discourage women who inject drugs in Kilifi County from accessing treatment. The researcher identified the systemic, social and personal barriers that hinder WWIDs in Kilifi County from accessing drug treatment. The study helps determine effective solutions in the treatment and rehabilitation of WWIDs in Kilifi County and help in the fight against drug addiction in general. 50 women who inject

drugs in Kilifi County were identified as the respondents. The study had anticipated limitation in time however the researcher had a good working schedule that enabled her to work efficiently within the specified time. Some key informants were hesitant to participate in the research for fear of victimization. In such cases the researcher provided official document to convince them to participate.

1.7 Definition of Terms

Addiction treatment: A comprehensive treatment model that helps drug addicts able to function normally without any drug influence.

Harm reduction methods: These are strategies and ideas that are practically aimed at reducing the negative consequences associated with drug use.

Medically assisted treatment: This is treatment using medications, counseling and behavioral therapies to treat substance use disorders.

Gender based treatment: Treatment programs that are designed to treat a specific gender.

Needle syringe program: A social service that provides hypodermic needles and associated paraphernalia at little or no cost to injecting drug users.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Introduction

This chapter reviews literature on key study variables. It is intended to identify the research gap. The literature review more precisely examines the existing literature on the consequences of drug use and challenges that hinder access to addiction treatment for WWIDs.

2.1 Literature Review

2.1.1 Drug Use and Gender

Women who are multiple users of drug injections experience gender specific issues which prevent them from access drug facilities. However, only in few countries where you find gender disaggregated records on use of drug injections which provide customized drug treatment to women. Researches acclaims on the need for interventions for women who use these form of drug injections and their experiences with programs that work with this populations indicating the need for effective management and community support as the procedure for drug initiation, social factors and traits linked to substance abuse, biological responses and progress and development of these problems among men and women might be different (Pinkham et al. 2012). Kenya as a country has not yet provided such programs that are designed specifically for WWIDs when offering drug treatment services.

Females who inject drugs are lured into sex due to poverty and inability to afford basic needs, lack of education and unemployment while they need to support themselves and their family (Roberts et al. 2010). Those who venture into commercial with the goal of supporting their drug addiction behaviours, sex work had similar traits as transactional sex with a lack of choice on selecting clientele, persistence on safe sex practices as well as geographical location and the time to exchange in face-to-face urgent needs. Theories that revolve around the nexus between IDU and commercial sex focuses on the need for money for procuring drugs as a key determinant to engage in commercial sex. However, WWIDs have documented that sex is being used as an exchange for earning a livelihood; catering for basic needs and health care.

2.1.2 Access to care for PWIDs in Kenya

Overcoming addiction has been portrayed by addiction narratives as a process of self-change and identity transformation (McIntosh & McKeganey, 2000). Injection drug users in Kenya view overcoming addiction as the recovery of self and a return to normalcy and have a strong desire for treatment and social inclusion (Rhodes et al. 2015). This desire is severely constrained by the context in which these PWIDs live where there is extreme poverty and treatment facilities are scarce. The cost of local rehab is approximately 10,000KSh per month. This is prohibitive, as according to official estimates the monthly minimum wage in Kenya is at 9780.95 (Kenya Institute for Public Policy Research and Analysis, 2013).

Social environments are strongly linked and affect accessibility of treatment and the capacity of individuals and affected communities to engage (Rhodes, 2009). In cases

where the basic need for survival competes with the desire for treatment most PWIDs would opt to continue with their injection practice. WWIDs who are exposed to poverty, have strong desire to get treated and recover but are inevitably exposed to competing demands in daily survival activities (McCurdy, 2014). Food access, drugs and access to funds enable the victims to take care of themselves as well as improve their lives and have the capacity to access quality healthcare. An environment where social stigma is high practiced, criminalization of drug abusers creates a barrier to access health care and food. There is weak or completely no social support and this creates a huge barrier towards accessing healthcare (Bourgois, 1988; Rhodes & Sarang, 2012).

2.1.3 WWIDs and their vulnerability to HIV

A myriad of researches have been explored on the contribution of use of drug injections and HIV transmission as well as Hepatitis C (Lindenburg 2006; Hagan et al. 2001; Hagan et al. 2000). In Sub-Saharan Africa; where women are highly affected by HIV as compared to men, HIV amongst WWID in comparison to MWID. Locally, despite WWID population being few, prevalence for HIV is more than 3 times high (45%) compared to MWID (16%) (UN World Drug Report, 2015).

Some fundamental reasons have been put forward as to why WWIDs is exposed to high risks of infection of HIV as opposed to the male. WWIDs stand a high chance of being stigmatized as well as marginalized by the society and are likely to conceal their injecting dug usage behaviours. The practices are most common amongst women considering that challenges that they go through trying to access needle and syringe programs including treatment and lack of customized services to cater for women needs. Surveys depict that high percentage of sex workers among WWID are lured into this business to support their

families. Exposure to infections is brought about by inconsistent use of condom, sharing of needles and syringes among WWID, these exposures highly exposes WWID to risks of contracting HIV for women.

There is need to understand and study WWIDs in their local context so as to provide effective support and interventions as a blanket approach and generalizing might only do very little to help. Taking into account the local context in the implementation of treatment programmes might be key in catering for the specific needs of IDUs where these needs are different.

2.1.4 Barriers that hinder access to treatment for women who inject drugs

Several impediments which are socially and structural in nature deter women from accessing treatment for use of drugs: globally, huge evidence has demonstrated that there is a significant difference between men and women when discussing social and biological factors that related to substance abuse and continued use of substance as well as development of problems relating to substance use.

2.1.4.1Types of Barriers

UNODC groups these challenges to women treatment into various categories: systemic, structural, social, cultural and individual.

Systemic barriers entail lack of power to make key decisions regarding women treatment, Lack of awareness in gender differences among factors determining the health status, paucity of knowledge on women with problems of substance use and their treatment requirements that are relevant to dissimilar social-cultural situations, failure to have

suitable gender responsive mechanism and low-cost models for treatment, variances in funding health services among organisations and stigma.

Structural barriers are failure to have: childcare, services for expectant mothers, and affordable costs of treatment, bureaucratic schedules, efficient response mechanism, harm minimization programmes, coordinated services, referral and efficient intervention.

Social, cultural and personal barriers are fear of loss of custody, lack of support from the family, unprivileged life circumstances and failure to have effective treatment options. Risks that the partner might have violent behaviours might drive women into drugs.

2.2 Theoretical Framework

2.2.1 Social Exchange Theory

The Social exchange theory was introduced by George Homans in his work "Social Behavior as Exchange" in 1958. He defined social exchange as the exchange of tangible or intangible activity, and more or less rewarding or costly between at least two persons. Other theorists that made significant contributions to the exchange perspective in sociology include Peter M. Blau and Richard M. Emerson.

In social exchange, relationship decisions are driven by rewards and costs. Both parties depend on one another and take responsibility for one another. Costs reduce value for example the effort put into a relationship. Rewards are the elements that increase value for example sense of belonging or identity, acceptance and support.

According to Thibautt and Kelley's (1959) comparison level for alternative. Social Exchange theory predicts that people will stay in a relationship if they have no other option and fear being alone more than being in the relationship. The Social Exchange Theory emphasizes on the search for rewards and minimization of costs. The reward for substance abusers is often the euphoria that comes with the drug, the sense of belonging and companionship among fellow drug users and escapism from the harshness of reality. The costs can be punishment, disease, stigmatization and inability to function normally and take care of oneself among others. The Social Exchange Theory can be used to explain why substance abusers find keeping the habit more rewarding than seeking help. It can also help us understand why families of substance abusers find it difficult to get help for their loved ones. This is because the theory helps explain the reasoning behind those taking drugs and those around them.

According to Homans' success proposition, people tend to repeat an action when they are rewarded for their actions. It is typical among injection drug users to continue with the abuse in anticipation for the high after injecting themselves. This is because of what they feel every time they inject themselves with drugs. The shorter the interval of time between the action and the reward the more likely the person is to repeat the action. Injection drug users prefer to inject themselves rather than other means of drug use because the drug travels faster when injected producing the desired effects more quickly. This makes the short term reward for injecting the drug outweigh the longer term risks involved for the drug user.

Injection drug users have a strong desire to fit in and to be accepted. They have a great fear of isolation and independence (Homans, 1974). Every time they inject themselves in the company of other drug users they feel accepted and a sense of belonging. This is more rewarding to them than trying to seek for help especially in countries like Kenya where facilities, resources and support systems are limited The frustration-aggression proposition explains why it is difficult for injection drug users to quit the habit because as much as society firmly asserts that there is benefit in quitting, it is difficult for the abusers to see the benefits due to withdrawal symptoms and lack of proper support systems. Lack of immediate acceptance back to society for those trying to quit or those who have quitted might also discourage those in the habit and lead them back and deeper into substance abuse.

The acceptance and unconditional love and support by family members explains the deprivation-satiation proposition. The reward being the love and support irrespective whether the substance abuser keeps up the habit or not becomes less valuable and does not motivate them to quit. Family members can therefore be used to provide the support that does not fuel the habit but rather helps WWIDs to recognize the importance of quitting.

The high and the escapism provided as an effect produced by injecting drugs is the stimuli that encourages substance abusers to keep injecting the drugs. The discrimination, stigmatization and labeling by society may also influence the WWID to keep the habit as that is what they know themselves to be. That's their identity.

In the value proposition, WWID find it more valuable to inject themselves than to quit and experience withdrawal symptoms. It is also more valuable for them to continue with the habit and have a sense of belonging with fellow drug users than stop and find themselves a lonely recovering addict. Many might argue that we cannot apply the social exchange theory when explaining the behavior and relationships of substance abusers and other parties because the Social Exchange Theory strongly asserts that human beings are capable of making rational decisions and yet substance abusers are most of the time unable to make rational decisions. It is important to note that as much as humans are emotional beings before the substance abuser decides to take up the drug they make a rational choice to alter their state of mind and influence their behaviour and so the theory very much applies. Another risk within IDU relationships is difficulty in reducing or stopping drug use for fear of terminating the partnership. The emotional benefits they received from the partnership were more important as compared to the risks they faced from injecting for many women. This shows that, injecting partners can present a significant barrier to abstinence or reduction (Roberts et al. 2010).

2.2.2 Symbolic Interaction Theory

Symbolic interactionism, developed by George Herbert Mead in mid-20th Century focuses on the symbols we ascribe to language, objects, events and behaviour that give meaning to experiences in our lives. We tend to behave differently based on the meaning we give social interactions. We also adjust our approach depending on how we believe others perceive us. Social interactionists believe that reality is created by conversations, thoughts and ideas.

Some injection drug users might at times use society's lenses to determine actions and behavior. They sometimes internalize negative labels applied to them and might persist in deviant activities because of the negative social reactions from society. IDUs might engage in criminal activity just because they think that is what is expected of them. WWIDs sometimes have little sense of self-worth due to abuse from past experiences. They feel that injection drug use is the only solution to forgetting what happened to them. Drugs and injecting practice symbolize escapism from reality. IDUs are more comfortable with their drug problem as they feel a sense of acceptance and belonging as society tends to stigmatize and look down upon them. Their experiences in their daily interactions with their peers and society in general tend to shape their thought process, language and meaning to life.

A US study of non-injecting heroin users who transitioned to injection (Roberts et al. 2010) found that one of the strongest individual indicators of initiating to injecting included having friends who thought it was acceptable to inject drugs and one of the independent predictors of initiation injecting included exposure to current IDU and having friends who thought that was acceptable behavior. WWIDs might have a great fear of being viewed differently both by society and former associations who are still in the habit. This can at times make it difficult for some WWIDs to seek treatment so as not to lose their sense of belonging and established connections with those still injecting. Some couples share injecting equipment as a symbol of trust or intimacy (Pinkham et al. 2012). It can be difficult for women in such relationships to seek

help because of the bond that exists in their injection practices. Seeking treatment might be seen as a sign of betrayal and is therefore unacceptable.

2.2.3 Labeling Theory

Labeling theory is how terms used to describe or classify individuals influence and determine the self-identity and behavior of individuals. It suggests that people obtain labels from how others view their tendencies or behavior. The theory had its origins in 'Suicide' by Emile Durkheim (Durkheim 1897) individuals began adopting drug addict and alcoholic roles and identities with continued drug use and acceptance of the deviant label. This transition indicates that drugs have become more than substances one can choose to use. Drug addict and alcoholic roles and identities suggest that substances have become a more all-encompassing activity around which the self is organized (roles) and defined (identities). Thus a redefinition of the self and adoption of dramatically different roles is required for one to terminate drug use (Anderson et al. 2007). Most injection drug users tend to have defined roles in their social structures that help ensure their daily survival. It is not uncommon to find a WWID engaging in prostitution in order to provide for her family or partner. The MWID might also choose to engage in criminal activity in order to support his habit and family. In such cases it becomes difficult for the injection drug user to stop his/her substance abuse as it would mean a major shift in roles and identities.

The labeling theory has played a major role in the punitive war on drugs largely criminalizing those involved. The war on drugs has conferred a derogatory label and heavy social stigma on substance abusers and those involved in the sale of the same. In

most cases this label is not reversible as it marks one's record and exacts other social consequences. In Kenya one needs a certificate of good conduct from the criminal investigation department (CID) so as to apply for some jobs. This might cause lack of employment and lead to social death for those who have ever been incarcerated because of injection drug use or crime committed while under the influence. Some injection drug users find it difficult to accept that there is hope and a chance for social inclusion and normalcy. The Kenyan government in an effort to curb substance abuse asked those affected to come out and get help in 2015. Such a move would help lessen the fear of incarceration but needs a lot of preparedness and resources to execute.

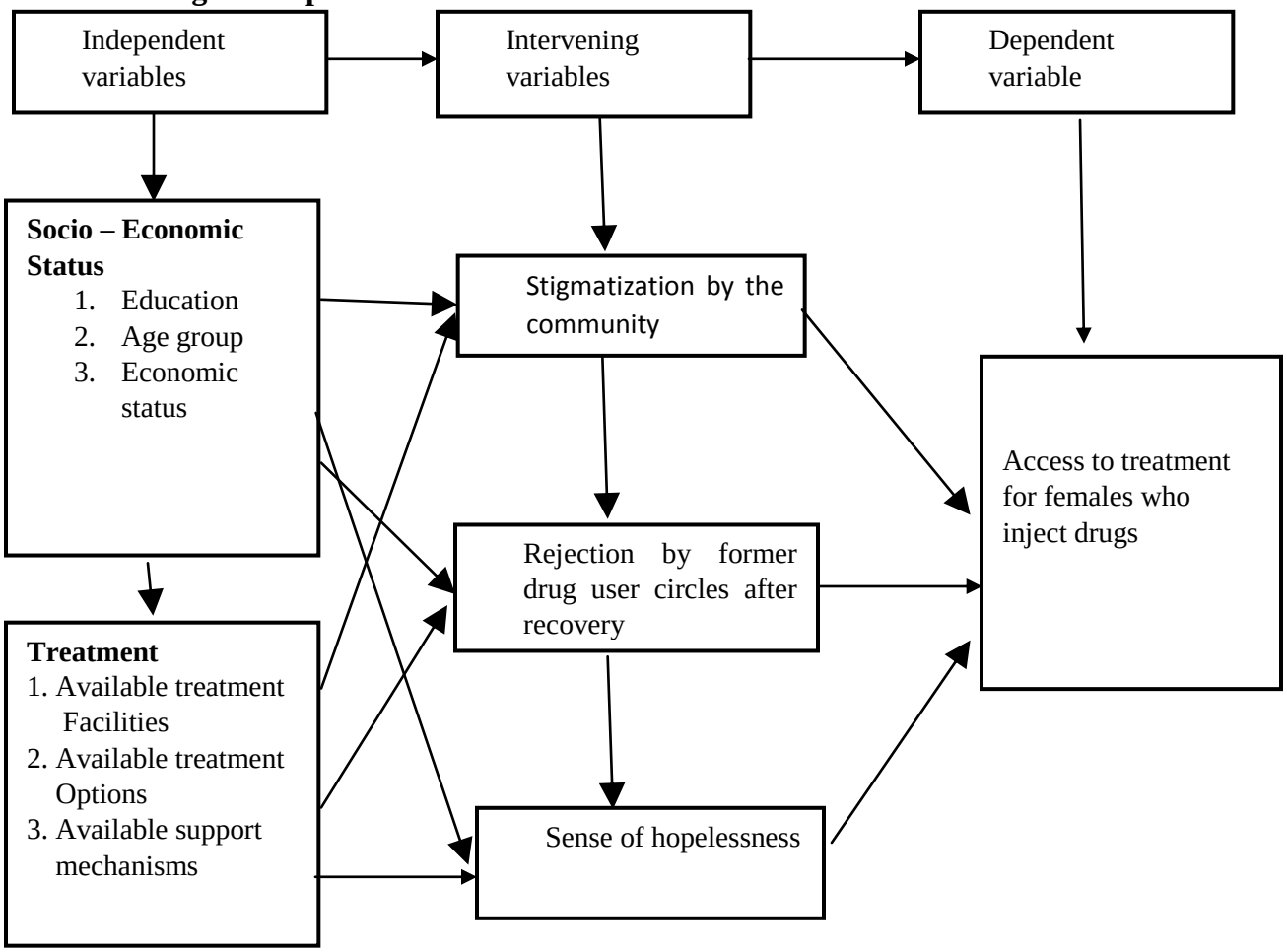
Edwin Schur 1973 notes that "It becomes extremely difficult for one to shed the new identity once branded as a wrong doer." Injection drug users tend to live under heavy social stigma because of the labels given to them to the extent that they embrace these levels and act in accordance to what society perceives of them. They tend to make poor decisions due to the pressure from labels given and not what their state of mind informs them to do. For example WWIDs might choose not to go for treatment because she thinks she is less of a human being or an outcast who does not deserve treatment or a place in society. The low status of WWIDs within general society and within the IDU community may hinder them from accessing treatment and prevention services (Roberts et al. 2010).

2.3 Conceptual Framework

The conceptual framework in figure 2.1 below guided this study. The dependent variable was access to treatment by females who inject drugs. The independent variables are treatment options and support mechanisms provided for females who inject drugs in

Kilifi County. The intervening variables are sense of hopelessness and fear of stigmatization by the community.

Figure 2.1: Conceptual framework showing linkages between independent, intervening and dependent variables



2.4 Summary of Empirical Literature and Research Gap

The literature reviewed above has presented the theoretical and empirical perspectives on challenges that might hinder access to treatment for women who inject drugs. The review clearly shows that there is scant research on women who inject drugs in Kenya and Africa as a whole. This study hopes to fill this gap in an effort to understand the factors hindering WWIDS at the Kenyan coast from accessing drug treatment in order to inform policy on proposed strategies and interventions and provide baseline information for effective treatment programmes.

CHAPTER THREE: RESEARCH METHODOLOGY

3.0 Introduction

The chapter outlines how the research was carried out. It entails the site description, research design, unit of analysis and units of observation, the target population, sample size and sampling procedures. It also looks at the methods of data collection, the quantitative and qualitative data, and ethical considerations.

Kothari (2004) describes research methodology as a way of systematically solving the research problem. He further explains that research methodology is a science of studying how research is scientifically carried out. It gives the various steps that are generally adopted by a researcher in studying a research problem along with the logic behind them (Kothari 2004). This chapter therefore sets out to focus on the research design, target population, description of the sample and sampling procedures, data collection procedures and instruments, validity and reliability of the research instruments as well as the data analysis procedures.

In-depth interviews with WWIDs explored experiences with drug use and access to treatment and other issues as raised by respondents. Interviews started with open questions on WWIDs general lifestyle and history of drug use and concerns before investigating factors that hinder access to drug treatment. The researcher carried out the survey by administering questionnaires to WWID and interview schedules to key informants in the target area. She then analyzed the data from the surveys to compare and contrast similarities, differences and trends on the population being studied.

3.1 Study Area

This study was carried out in Kilifi County of the Republic of Kenya. Kilifi County was formed in 2010 when Kilifi and Malindi Districts were merged. Its capital is Kilifi and its largest town is Malindi. The population is estimated to be at 1,237,892 with 587,719 males and 630,172 females (Kenya population and Housing census 2009). It also had about 200,000 households. It has 7 Sub counties namely; Ganze, Kaloleni, Kilifi North, Kilifi South, Magarini, Malindi and Rabai. The major economic activities in this county are tourism and fishing due to its proximity to the Indian Ocean. The county is strategically placed with good transport networks and a cosmopolitan culture making it accessible and hospitable.

The researcher focused on Malindi Town of Malindi Sub County because of the drug use problem in the area. Malindi is the largest town in Kilifi County and a popular tourist destination. It is situated about 120Km north of Mombasa and has a population of 207, 253 (Kenya population and Housing Census 2009). Tourism is a thriving business and a major income earner in Malindi. Residential villas that house foreigners, beach hotels and other luxury hotels are common around the town totally transforming the once agricultural town into a popular tourist destination. Malindi is strategically placed with a domestic airport and a highway between Mombasa and Lamu. The good transport network and cosmopolitan culture due its mixed population makes it easily accessible and hospitable to both tourists and Kenyans from all other parts of the country.

Malindi is one sub county that is heavily burdened by drug use among its population with no treatment facilities catering specifically for WWIDs.

3.2 Research Design

This study used descriptive design. According to Kisilu and Tromp (2004), descriptive survey is a method of collecting information by interviewing or administering a questionnaire to a sample of individuals. A researcher can use this design to collect information on people's attitudes, opinion, habits on any social issues. The researcher has chosen this design because it is appropriate in identifying the factors that hinder addiction treatment among women who inject drugs in Kilifi County. In this study the research object is WWIDs in Malindi Sub County. The researcher used questionnaires and structured interviews so as to understand the trends, attitudes and opinions WWIDs have towards access to treatment in finding answers to the research questions.

3.3 Units of Analysis and Observation

The units of analysis for this study are the factors hindering addiction treatment among women who inject drugs in Kilifi County. The units of observation are the women who inject drugs in Kilifi County. The women provided the researcher with quantitative data while key informants provided qualitative data.

3.4 Target Population

Busha & Harter (1980) defined a population as a set of objects or persons possessing at least one common characteristic, while Kombo and Tromp (2006) indicated that a population is a group of individuals, objects or items from which samples are taken for

measurement. Malindi town has an estimated number of about 500 women who inject drugs. The study targeted women aged between 15-45 years who qualified as either young adolescents and adults. Areas included; Shela, Maweni, Mwembe tayari in Kisumu ndogo, Mtangani, Myeye. A total number of 7 health workers, community health volunteers and community elders in Malindi Sub County served as key informants for the purpose of the study.

3.5 Sampling and Sample Size

Mugenda and Mugenda (2003) define sampling as the systematic process of selecting individuals or subjects from an entire population. The aim of sampling out certain individuals from the entire population is to get a representative sample whose characteristics can be objectively generalized on the entire population. Simple random sampling was used to identify the areas where the study was conducted. Snowball sampling was used in identifying respondents. The study aimed to get 60 women who inject drugs from this exercise with 12 women being drawn from each area. Structured questionnaires were used to collect information on socio-demographic backgrounds, experiences, and attitudes of the participants towards treatment. Different factors were put into consideration in determining the sample size. This included research cost, time, human resource and accessibility.

3.6 Data Collection

The researcher relied on both primary and secondary data sources. Primary data was obtained directly from respondents through questionnaires and key informant interview guides. Secondary sources of data included the review of published materials.

3.6.1 Collection of Quantitative Data

Quantitative data was collected using structured questionnaires administered face to face with the female who inject drugs. Community outreach staff helped to establish rapport and act as an entry point when accessing IDU dens. To be interviewed respondents were asked if they had injected in the past six months or more. This information was verified through self-report and proof of injection through looking for injection marks. Respondents were interviewed using structured questionnaires exploring their life style, attitudes and experiences. This included history of injection, age, employment status, education levels, family/dependents among others.

3.6.2 Collection of Qualitative Data

Qualitative data was collected using an interview guide administered face to face with key informants who are community elders, religious leaders, community health volunteers and health workers. A total number of 7 key informants were interviewed. Key informants were selected by virtue of their position and the knowledge they have on women who inject drugs, their challenges, attitudes and gaps in treatment services.

3.6.3 Sources of Data

Both primary and secondary data was collected for this study. Primary data was collected through the questionnaire survey and the key informant interviews. The

questionnaires were used to survey women who inject drugs and the key informant interview guide was used for community health volunteers, health providers and community elders. Secondary data was retrieved from UNODC reports as well as other literature available in books, journals and the internet that relate to the subject of study.

3.6.4 Validity and Reliability of the Research Instruments

Reliability refers to the degree to which a research instrument will yield consistent result after repeated trials while validity is the degree to which the results obtained from data analysis actually represent the phenomena under study; thus, how accurate the variables in the study are (Mugenda and Mugenda, 2003). The research study was piloted first whereby the researcher will administer the questionnaires herself. This exercise helped to revise questions that needed clarity.

3.6.5 Data Analysis

Mugenda and Mugenda, (2003) state that data analysis refers to the process of examining the collected data from the research instruments with the aim of making deductions and inferences so as to uncover the underlying assumptions. The data analysis involved ensuring that all questionnaires are collected and examined. The researcher then cleaned up the data in order to detect any anomalies in the responses and assign specific numerical values to the responses for further analysis.

Data analysis was done using the Statistical Package for Social Sciences (SPSS) which is preferred because of its flexibility, speed and accuracy. Descriptive statistics and analyses such as frequencies and percentages were used to summarize the available data. Frequency tables as well as pie charts were generated and used. The qualitative data was

organized into themes, describing the behavior and context in which they occurred. This was in accordance with the research objectives and was reported in narrative form along with quantitative frequency tables. SPSS was also used to code the quantitative data from the questionnaires.

3.7 Ethical Considerations

Ethical consideration was observed throughout the study through the principle of autonomy which implies the right to self-determination and right to full disclosure (Polit & Hungler 1999:136) Participants had a right to decide whether they would like to participate in the study and terminate their participation at any point during the study. They were also informed about what will become of the findings one research is completed. The research and its findings will in no way be harmful to the respondents and the community at large but will be beneficial in the fight against injection drug use. Respondent's real names were not published so as to ensure anonymity and confidentiality. The researcher obtained permission from the University to proceed to the field.

CHAPTER FOUR DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.0 Response Rate

The researcher intended to interview 60 WWIDs but managed to conduct 50 interviews which translated to a response rate of 83.3%. The researcher also targeted to interview 10 key informants but managed to interview 7 which translated to 70%.

4.1 Social Demographic Characteristics of Women Who Inject Drugs

4.1.1 Age distribution

The respondents were asked to indicate their age. The results show that majority of the respondents (54%) were aged 26-35 years while 28% were aged 15-25 years. Only 18% of the respondents were aged 36-45 years. This shows that most WWIDs are in the productive age bracket to acquire knowledge and engage in meaningful employment and if treated they might be able to improve their economic situation and that of the country at large. Table 4.1 shows these results.

Table 4.1: Respondents' distribution by age

Age	Frequency	Percent
15-25 years	14	28.0
26-35 years	27	54.0
36-45 years	9	18.0
Total	**50**	**100.0**

4.1.2 Level of Education

The respondents were asked to indicate their highest education level. The results show that majority of the respondents (70%) indicated their highest education level was primary school while 26% indicated secondary school as their highest education level. Only 4% of the respondents indicated their highest education level as technical/vocational institute. This shows that majority of the respondents have a low level of education and might be unaware of the dangers of injection drug use and the importance of seeking treatment. Their level of education might also be hindering them from acquiring well-paying jobs due to lack of the necessary skills as stated by several key informants. Table 4.2 shows these results.

Table 4.2: Highest education level

Education Level	**Frequency**	**Percent**
Primary school	35	70.0
Secondary school	13	26.0
Technical/vocational institute	2	4.0
Total	**50**	**100.0**

4.1.3 Respondents' Occupation

The researcher sought to find out what the respondents do for a living. The results show that 22% of the respondents were sex workers while another 22% indicated they were not engaged in any income generating activities. The results also show that 12% of the respondents combined casual work with peddling drugs while 8% combined casual work with sex work. Respondents who combined sex work and peddling drugs were 6% while

those engaged in peddling drugs alone were also 6%. Respondents who indicated what they did for a living as casual work alone and bar maid were 6% each while 4% indicated they steal or pick pocket people. Those respondents who indicated that they combine bar maid work and sex work were 2% and a similar proportion indicated they are salonist and peer educator each. This means that a high number of WWIDs are not engaged in any meaningful income generating activities and yet the fall into the productive age bracket. It is also important to note that most treatment facilities require payment for one to be enrolled. Table 4.3 summarizes these results.

Table 4.3: Occupation

Occupation	Frequency	Percent
Sex worker	11	22.0
Casual work	3	6.0
Peddling drugs	3	6.0
Peddling drugs and sex work	3	6.0
Peddling drugs and casual work	6	12.0
Casual work and sex work	4	8.0
Nothing	11	22.0
Bar maid	3	6.0
Salonist	1	2.0
Thief/pick pocket	2	4.0
Peer educator	1	2.0
Bar maid and sex work	1	2.0
Missing	1	2.0
Total	**49**	**100.0**

4.1.4 Duration lived in the area

The researcher sought to know the duration that the respondents had lived in the locality. Respondents were asked to indicate how long have they lived in the area. The results show that 36% of the respondents had lived in the area for 1-5 years while 30% had lived

there for 6-10 years. Respondents who had lived in the area for over 10 years were 22% while 12% had lived in the area for less than a year. This shows that most WWIDs have been residents in the area for an extended period of time that is sufficient enough for one to complete drug treatment and recover fully. This gave the researcher more reason to probe further as to why the respondents are still in the habit. The researcher established from several key informants that WWIDs sometimes are unable to complete treatment or interrupt treatment due to being put behind bars or due to stigmatization and fear of victimization. Table 4.4 shows these results.

Table 4.4: Duration lived in the area

Duration	Frequency	Percent
Less than 1 year	6	12.0
1-5 years	18	36.0
6-10 years	15	30.0
Over 10 years	11	22.0
Total	**50**	**100.0**

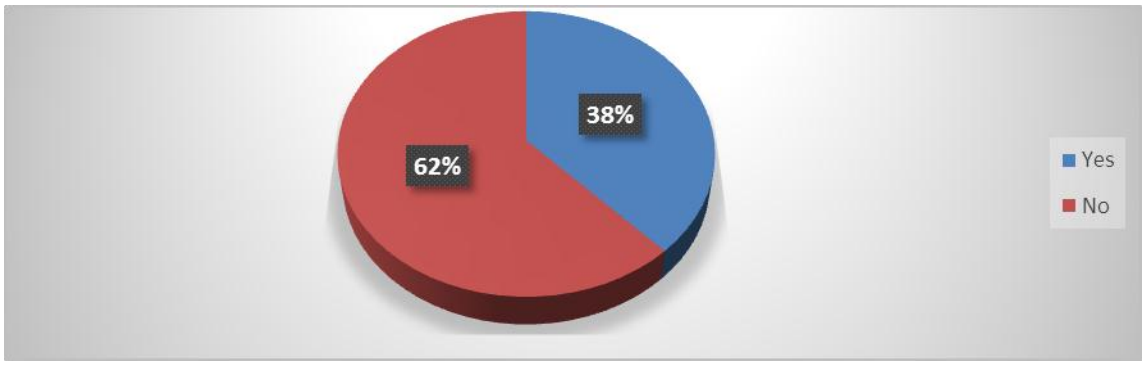
4.1.5 Whether respondents live with family

The respondents were asked to indicate whether they lived with family. The results show that majority of the respondents (62%) did not live with family while 38% indicated that they lived with family. One key informant referred to WWIDs as people who are unpredictable with very erratic behavior. *'They are very dishonest, erratic and constant on the move. Their behavior is also not acceptable in a family setting and so might find it difficult to live in a family'.* Some respondent confessed that they didn't want their family

members to know that they inject drugs and so ran away from home. This can be some of the reasons as to why it is difficult for them to live in a family unit.

Figure 4.1: Distribution by whether respondents live with family

(N=19)



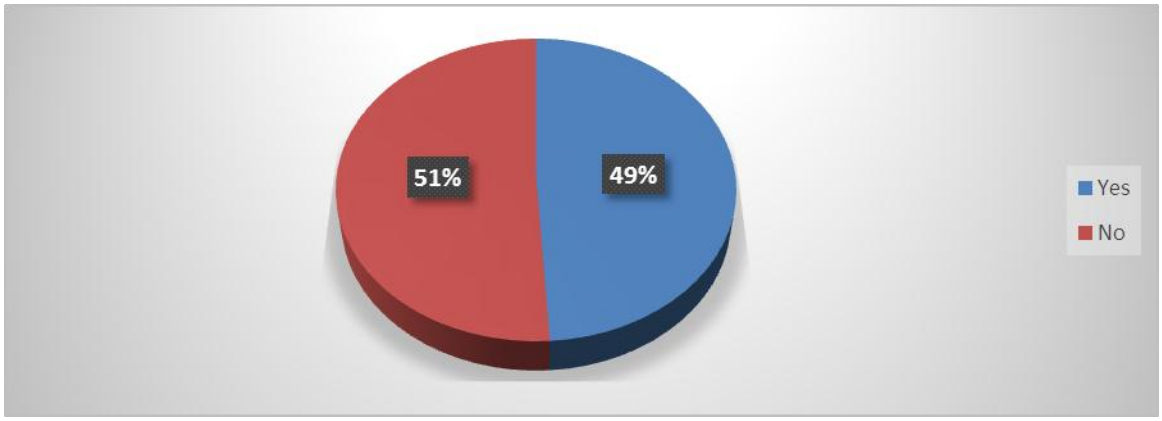
4.1.6 Respondents and Dependents

The respondents were asked to indicate whether they have any dependents. The results show that majority of the respondents (51%) did not have dependents while 49% of the respondents indicated that they have dependents. Almost half the respondents have dependents meaning this a children growing in an environment where the parent is addict. This poses a great danger as according to several respondents WWIDs are already in great danger of victimization, mob justice, sexual abuse and arrests. 'Sometimes we get high and men take advantage of us.' 'We get physically abused through mob justice.' 'It's not easy because we don't love ourselves.' 'We are vulnerable to many bad things.' They also do not have stable sources of income. This might inhibit them from being able to provide basic needs and the required love and protection to their young ones. The psychological stress and pressure to provide might also create a cycle where they use

drugs as an escape from reality and also to be able to find illegitimate sources of income. Figure 4.2 shows these results.

Figure 4.2: Respondents with dependents

(N = 24)



4.1.7 Marital status

The researcher sought to know the marital status of the respondents.38% of the respondents were single while 28% indicated that they were separated. 22% of the respondents are cohabiting while 6% and 4% indicated they were widowed and divorced respectively. Only 2% of the respondents indicated that they were married. A large percentage is not married with a huge number confessing to be casual sex workers putting them at risk of disease and stigmatization. A high proportion are either divorced or separated which could be partly contributed by their drug habit whereby family does not approve and in some cases where WWIDs do not want family to know that they inject drugs. Table 4.5 shows these results.

Table 4.5: Marital status

Status	Frequency	Percent
Married	1	2.0
Co-habitating	11	22.0
Single	19	38.0
Widowed	3	6.0
Separated	14	28.0
Divorced	2	4.0
Total	**50**	**100.0**

4.1.8 Religious Affiliation

The researcher sought to know the religion of the respondents. The results show that majority of the respondents (56%) were Christians while 32% were Muslims. The results also show that 6% of the respondents indicated their religion as traditionalist while another 6% did not have a religion. This indicates that majority of WWIDs have a religious affiliation making more involvement of religious leaders an approach worth considering in the recovery of WWIDs and acceptance in the community. Respondents believed that churches and mosques are the alternative places where they could go to get help. Table 4.6 shows these results.

Table 4.6: Respondents' distribution by religion

Religion	Frequency	Percent
Christian	28	56.0
Traditionalist	3	6.0
Muslim	16	32.0
None	3	6.0
Total	**50**	**100.0**

4.2 History of Injecting Drugs

4.2.1 Drugs injected and duration

The respondents were asked to indicate what drugs they inject. All of the respondents (100%) indicated that they inject heroine. The researcher sought to know the duration respondents have been using heroine. The results show that majority of the respondents (59.2%) have been injecting drugs for 1-5 years while 30.6% indicated 6-10 years. Only 10.2% of the respondents indicated that they have been injecting drugs for less than a year. Table 4.7 shows results on duration respondents have been injecting drugs. This shows that most respondents have been injecting drugs for an extended period of time and have not been able to quit the habit despite the existence of treatment centres in the area. This begs for an explanation as to why.

Table 4.7: Duration injecting drugs

Duration	Frequency	Percent
Less than a year	5	10.2
1-5 years	29	59.2
6-10 years	15	30.6
Total	**49**	**100.0**

4.2.2 Accomplices in injecting drug use

The researcher also sought to know people the respondents used the drugs with. The results show that majority of the respondents (60.4%) indicated that they used drugs with their friends while 18.8% indicated they used with family. The results also show that 12.5% of the respondents indicated that they used drugs with colleagues while 4.2% indicated they used drugs with sex partner. Respondents who used drugs with sex clients were 2.1% while another 2.1% indicated that they used drugs with friends and sex clients. Table 4.8 shows results on people the respondents used the drugs with. A majority indicated that they abused drugs with friends meaning that they have close knitted links with people who influence their behavior and might view those who do not inject drugs as people not within their circles of influence. This shows that peer influence plays a major role in sustaining the habit and could be instrumental in addressing the issue.

Table 4.8: People respondents used the drugs with

Person	Frequency	Percent
Friends	29	60.4
Family	9	18.8
Sex partner	2	4.2
Colleagues	6	12.5
Sex clients	1	2.1
Friends and sex clients	1	2.1
Total	**48**	**100.0**

4.2.3 Reasons for initiation to injecting drugs

The respondents were asked to indicate the reasons why they started injecting drugs. The responses were varied but the most common were influence from friends, family member or spouse and that the respondents wanted to feel intoxicated or as they put it *'to get high'*. For many of the respondents, this largely came from influence by friends or spouse. Some of the respondents indicated that they started injecting drugs because of nature of their work and especially those that were engaged in sex work. They claimed that when they were intoxicated they were able to perform in their work. One of the respondents said the drugs enable her *'to negotiate for sex'* while another one indicated that she wanted *'to get high when selling sex'*. Some of the respondents seem to have gone through prison as they cited inability or difficulty to smoke in prison as their reason for starting injecting drugs. One of such respondents said that *'in prison you can't smoke'*

while another one indicated that *'it was difficult to smoke in prison'*. There are some respondents who started injecting drugs for fun while others chose it due to the high cost of smoking other drugs. This was illustrated by one of the respondents who said that *'I thought it was fun'* while another one indicated that *'I was told it's fun'*. On the cost of other alternatives, one of the respondents indicated that she '*couldn't afford high cost of smoking drugs'* while another one indicated that *'smoking was expensive with little effect'*.

The quantitative data analysis results confirmed that 34.1% of the respondents indicated influence from friends, family or spouse as a reason for starting injecting drugs while 25% indicated that it is the easiest way to get high or intoxicated. The results also show that 13.6% of the respondents indicated that they started injecting drugs to maneuver in sex work while 9.1% indicated for fun and it was not possible to smoke in prison. Respondents who indicated that other drugs are expensive as the reason for starting injecting drugs were 4.5% while another 4.5% indicated that other drugs do not get them high. This shows a lot of escapism from the harshness of reality be it life in general or towards earning a living. It portrays a picture where for WWIDs to feel normal, to earn a living or feel a sense of belonging they have to inject drugs. Table 4.9 shows the results for reasons why respondents started injecting drugs.

Table 4.9: Reasons for starting injecting drugs

Reason	Frequency	Percent
It is the easiest way to get high	11	25.0
To maneuver in sex work	6	13.6
Other drugs are expensive	2	4.5
Not possible to smoke in prison	4	9.1
For fun	4	9.1
Other drugs do not get them high	2	4.5
Influence from friends, family or spouse	15	34.1
Total	**44**	**100.0**

4.2.4 Initiators

The researcher sought to know who introduced respondents to injecting drugs. The results show that 44.9% of the respondents were introduced to injecting drugs by friends while 38.8% were introduced by their sex partners or spouse. The results also show that 16.3% of the respondents were introduced to injecting drugs by a relative. This shows that peer influence play a major role in the initiation to injecting drug use and might be instrumental in the call for treatment and fight against drug use as a whole. Table 4.10 shows results on people who introduced respondents to injecting drugs.

Table 4.10: Person who introduced respondents to injecting drugs

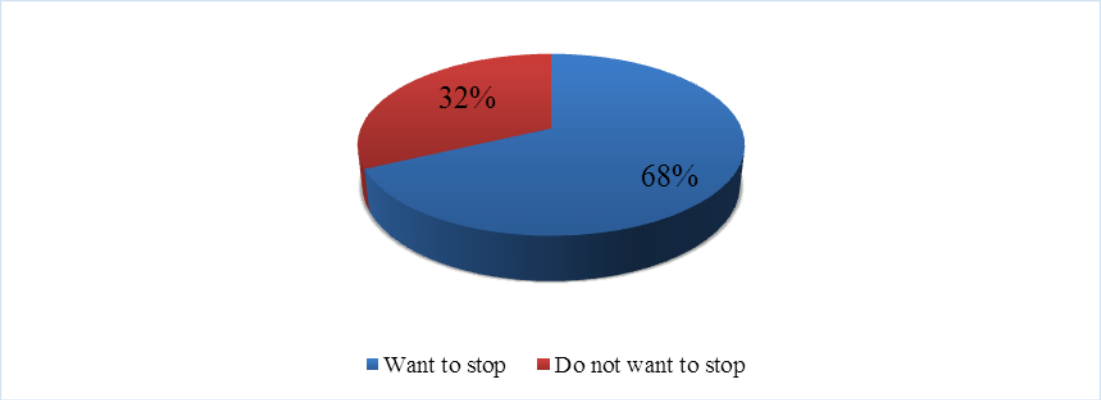
Initiator	Frequency (n)	Percent (%)
Relative	8	16.3
Sex partner/ spouse	19	38.8
Friend	22	44.9
Total	**49**	**100.0**

4.2.5 Willingness to stop injecting drugs

The respondents were asked to indicate whether they would want to stop injecting drugs. The results show that majority of the respondents (68%) would want to stop injecting drugs while 32% indicated that they do not want to stop. This shows willingness and a cry for help towards getting treated but there are underlying factors that make it almost impossible for it to be done. Unless these factors are addressed then treatment will always remain a dream that might never be achieved by this group in society. Figure 4.3 shows the results on whether respondents want to stop injecting drugs.

Figure 4.3: Whether respondents want to stop injecting drugs

(N=34)



The researcher sought reasons for the answer on whether respondents wanted to stop injecting drugs. The reasons for many respondents who wanted to stop injecting drugs included rebuilding and changing their life for the better while others want to stay drugs free and save money as they focus on other things in life like furthering their education and family. Some respondents sought to stop injecting drugs to avoid family members they hold dear from knowing that they use drugs especially parents and children. This was illustrated by a response from one of the respondents who indicated that *'my kids have grown and I don't want them to know I use drugs'*. Another respondent asked whether she would want to stop injecting drugs said *'yes, I'm getting old and my son is growing'*. Similar sentiments were expressed by another respondent who indicated that '*I want to stop* (injecting drugs) *before my mom finds out'*. The results also show that some respondents want to stop injecting drugs because they have realized that they have been wasting their lives and they want to become better people. However, there were some respondents who preferred smoking to injecting drugs while others indicated that injecting drugs have put them into pain and problems including being jailed. This was

clearly captured by one of the respondents who indicated that '*I sometimes don't have money and it is too painful'*. Similar sentiments were expressed by a respondent who termed injecting drugs as '*…expensive and painful'*.

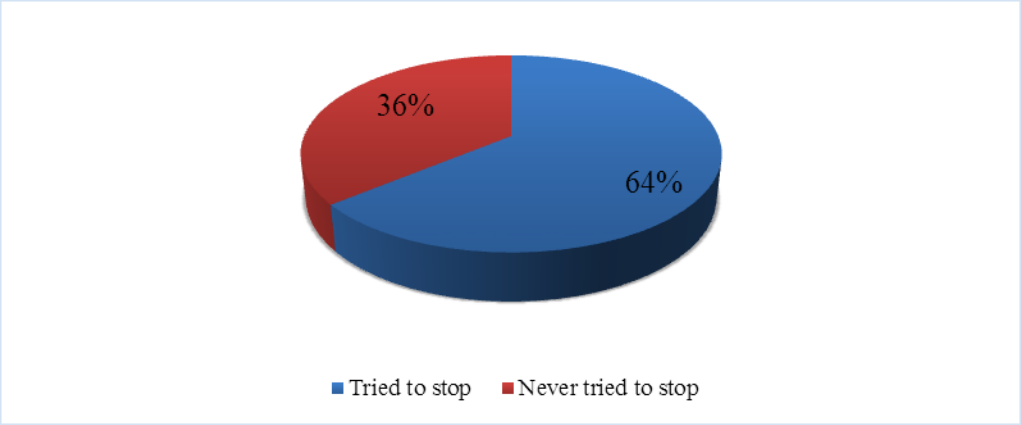
For those respondents who did not want to stop injecting drugs, their reasons more of questions on what and how they can benefit if they stopped. This was captured by one of the respondents who asked *'why should I stop'* while another one asked *'how will I benefit even if I stopped'*. Some wondered how they could manage in their work (commercial sex work) without injecting drugs while others felt they were not ready to stop since they feel good doing it and they were okay with it. This was demonstrated by one of the respondents who asked *'how will I do my job if I am not high'*.

4.2.6: Attempts to stop injecting drugs

The researcher sought to know whether respondents have ever tried to stop injecting drugs. The results show that majority of the respondents (64%) had tried to stop injecting drugs while 36% indicated they had never tried to stop injecting drugs. Several key informants confessed that enrollment to treatment is high but retention and completion rates are low due to the erratic nature of WWIDs. This is also a lot of disruption due to WWIDs getting arrested or moving from one place to another due to victimization and law enforcement. WWIDs are also not able to function without the drugs, they use drugs in sex trade among other ways of earning a living. The results imply that a comprehensive approach that touches on WWIDs livelihood is needed in addressing the problem. Figure 4.4 shows results for respondents who have tried to stop injecting drugs.

Figure 4.4: Had attempted to stop injecting drugs

(N=32)



4.2.7 Methods of stopping injecting drugs

The respondents were asked to indicate how they tried to stop injecting drugs. Many of the respondents who had tried to stop injecting drugs indicated that they went for rehabilitation while others indicated that they abstained from the drugs for some time. One of the respondents illustrated this when she mentioned that she '…*went for rehab at Omari project'* to try and stop injecting drugs. There were some who tried to stop injecting drugs when they were in prison while others went away from their friends and colleagues who they use drugs with by remaining indoors or travelling out of town. This was captured well by one of the respondents who indicated that in order to try and stop injecting drugs she *'remained indoors and avoided* (her) *friends who introduced* (her) *to drugs'.* Another respondent indicated that she '*went to live in* (her) *rural home for three months'* to try and stop injecting drugs. There are some who tried to stop injecting drugs by switching to smoking. To illustrate this one of the respondents indicated that she *'... switched to smoking but it didn't work'.* This clearly shows attempts to stop most of

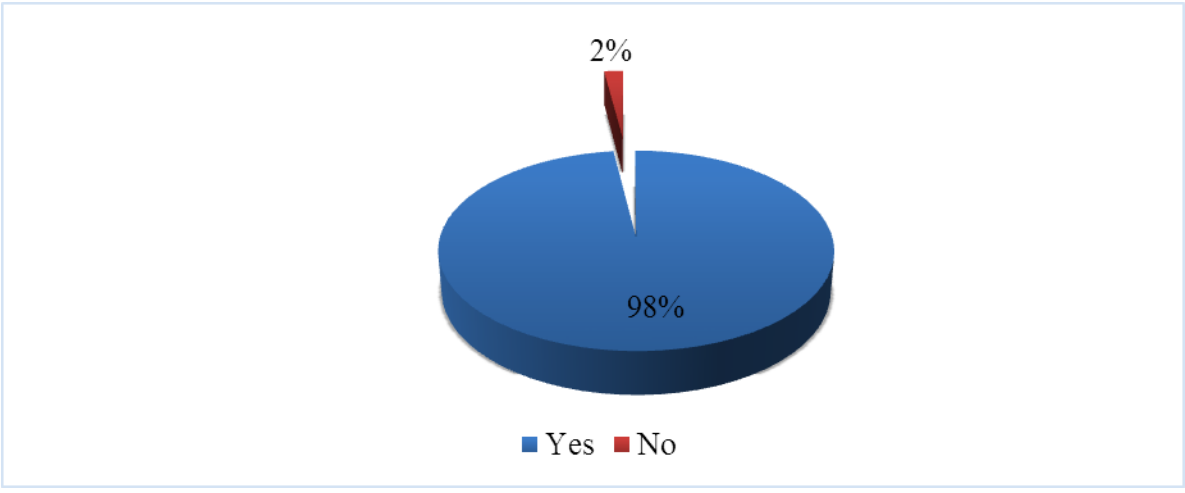
which are not effective. This calls for education and the provision of the necessary resources that can accord those who desire to change the opportunity to do so.

4.3 Support Mechanisms and Access to Treatment for Injecting Drug Users

4.3.1 Knowledge of support services and treatment centres

The researcher sought to establish whether respondents knew any support services or treatment centres. The results show that majority of the respondents (98%) knew support services and treatment centres. Only 2% of the respondents indicated that they did not know any support services or treatment centres. Figure 4.5 shows results for respondents' awareness on support mechanisms and access to treatment. The results imply that there is enough awareness of treatment services but this has not translated to the WWIDs getting treated. This implies that they could be other underlying factors that hinder treatment.

Figure 4.5: Respondents awareness on support mechanisms and access to treatment (N=49)

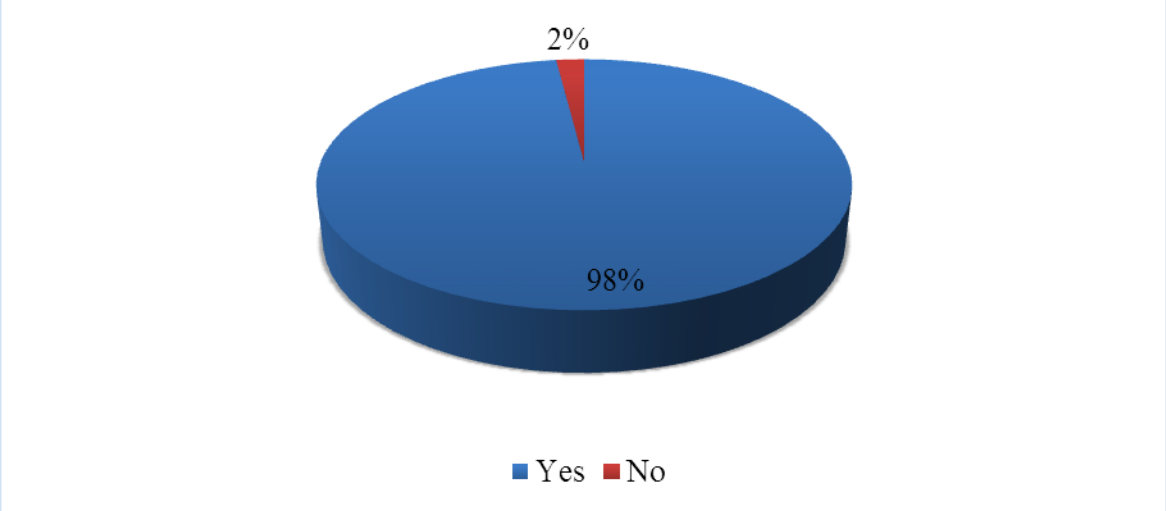


4.3.2 Accessing treatment

The respondents were asked to indicate whether anyone has ever asked them to access treatment. The results show that majority of the respondents (98%) have been asked to access treatment while 2% indicated that they have not been asked to. This shows that WWIDs are aware of treatment options but they are still not going to help meaning there are factors that hinder their access to treatment. Figure 4.6 shows results on whether anyone had asked respondents to access treatment.

Figure 4.6: Efforts advocating that WWIDs access treatment

(N=49)



4.3.3 Agents in advocating for treatment

The researcher sought to know who had asked respondents to access treatment. The results show that 45.8% of the respondents were asked to access treatment by outreach workers while 16.7% were asked by peer educators. The results also show that people

from Omari project asked 10.4% of the respondents to access treatment while community health volunteers and recovered addicts asked 8.3% and 6.3% of the respondents respectively to access treatment. Other people who asked respondents to access treatment included parents (4.2%), friends (4.2%), Kadhi (2.1%) and DIC (2.1%). Outreach workers have played a major role in reaching out to WWIDs and asking them to go for treatment. This clearly shows that as much as the message reaches the intended recipients it has proven to have very little impact. This was captured by one key informant, a service provider who said *'There is high enrollment but WWIDS do not normally complete our engagements'* There is need for more research that will unearth a change of strategy and approach in the whole process so that it works effectively and the terminal objectives are achieved. Table 4.11 shows the results on people who asked respondents to access treatment.

Table 4.11: People who asked respondents to access treatment

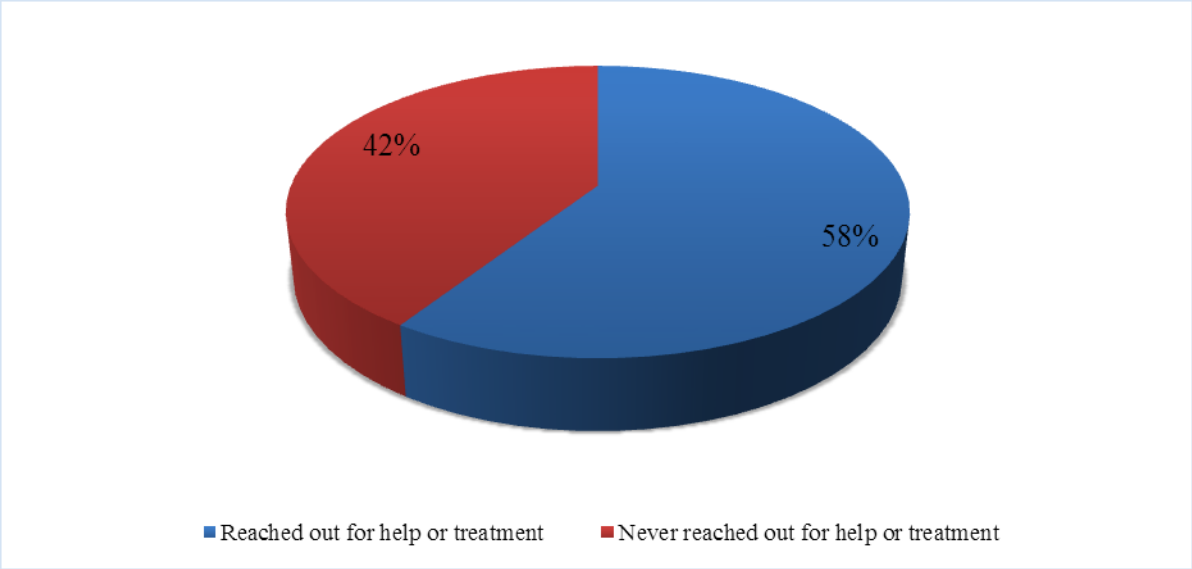
Agent	**Frequency**	**Percent**
Peer educator	8	16.7
Outreach worker	22	45.8
Recovered addict	3	6.3
Community health volunteer	4	8.3
Kadhi	1	2.1
DIC	1	2.1
Omari project	5	10.4
Parent	2	4.2
Friend	2	4.2
Total	**48**	**100.0**

4.3.4 Whether respondents ever sought help or treatment

The respondents were asked whether they have ever reached out for help or treatment. The results show that majority of the respondents (58%) reached out for help or treatment while 42% have never reached out for help or treatment. Figure 4.7 shows the results on respondents' reach out for help or treatment. A majority have sought help but are still addicts meaning there is a gap in the process that fails to contain this population throughout the entire period of time and ensure that they complete treatment. This might be because of disruptions due to arrests by police or a need to move to a different place because of victimization and law enforcement. In the words of one key informant a community elder *'One of the reasons for not completing treatment could be victimization of WWIDs that causes them to be on constant move and arrests by police that put them behind bars.* 'There is also the issue of finances and the experiences at treatment centres. Respondents confessed that they cannot afford treatment. One key informant confirmed a need for more training by serving providers at treatment centres saying *'We need more training on how to handle injecting drug users'*

Figure 4.7: Reached out for help or treatment

(N=29)



4.3.5 Treatment centres visited

The researcher wanted to know place where those who reached out for help or treatment went for it. The results show that 29.6% of the respondents sought help or treatment from rehabilitation centres while 25.9% sought it from methadone clinics. Respondents who sought help or treatment from Omari project and Kanco dropping center were 22.2% each. Table 4.12 shows results on place where respondents reached out for help or treatment. The results show that rehabilitation centres play a major role in addressing the problem.

Table 4.12: Place where respondents reached out for help or treatment

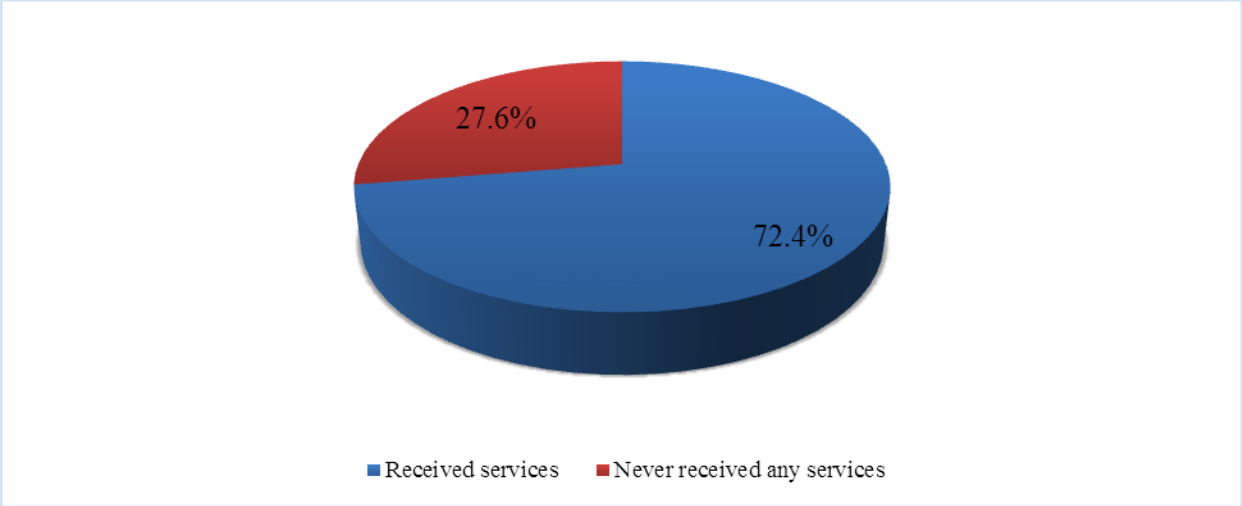
Place	Frequency	Percent
Rehabilitation center	**8**	**29.6**
Omari project	**6**	**22.2**
KANCO dropping center	**6**	**22.2**
Methadone clinic	**7**	**25.9**
Total	**27**	**100.0**

4.3.6 Services received

The respondents were asked to indicate whether they received any services. The results show that majority of the respondents (72.4%) who sought help or treatment received services and only 27.4% indicated that they did not get any services. Figure 4.8 shows results on whether respondents received services. This again shows high enrollment rate but very low completion rates as confirmed by several key informants.

Figure 4.8: Whether respondents received services

(N=21)



4.3.7 Length of time respondents received services

The researcher sought to know for how long respondents received services. The results show that majority of the respondents (71.4%) who reached out for help or treatment got services for a period of less than a year while 23.8% got it for a period of 1-3 years. Only 4.8% of the respondents who reached out for help or treatment got services for a period of 4-6 years. This shows that majority of WWIDs were only able to stay in treatment for less than a year and a few who stayed for a longer period were still not able to kick out the habit. This introduces a key aspect which is a need to follow up after they drop out of treatment and ensure completion of the program. There is a need for investigation on the causes and what can be done to address the issue. Table 4.13 shows results on duration respondents who reached out for help or treatment got services.

Table 4.13: Duration respondents who reached out for help or treatment got services

Duration	Frequency	Percent
Less than a year	15	71.4
1-3 years	5	23.8
4-6 years	1	4.8
Total	**21**	**100.0**

4.3.8 Experience at treatment centres

The respondents were asked to describe their experience with the services. The results show mixed reactions where some respondents described their experience as good or fair while others described their experience as not good or challenging. Respondents who described their experience as good further elaborated that they found the service providers who were accommodative and supportive. This was illustrated by one of the respondents who describing her experience indicated it was '*…good. They give us needles, syringes and tourniquet'*. However, there were some respondents who described their experience as good but lamented about the cost. One of the respondents described her experience as '*good but expensive'*.

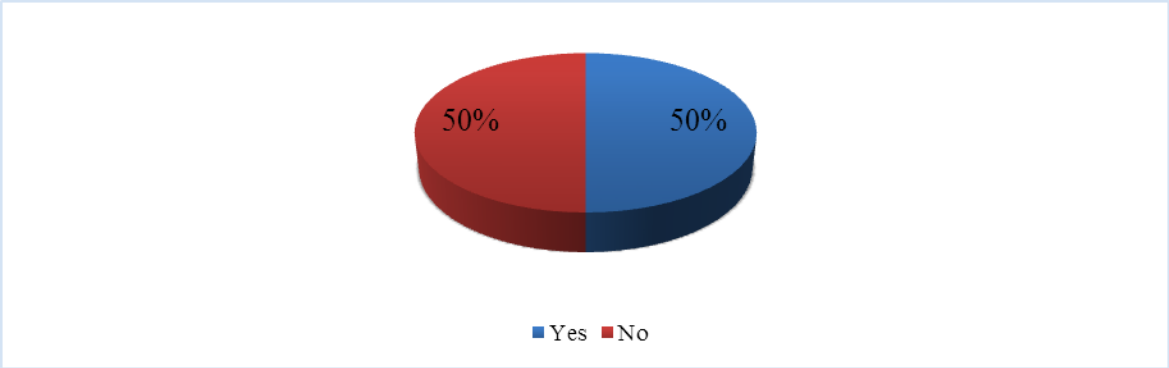
Respondents who described their experience as not good and challenging cited that service providers were not accommodative. This was captured by one of the respondents who indicated her experience as *'...not good. They said no walk in clients must be recruited through CSO'*. They also accused them of being judgmental. One of the respondents describing the service providers said, *'they are very judgmental'*.

4.3.9 Retention and completion of treatment programs

Respondents were asked to indicate whether they are still receiving help or treatment. The results show that half of the respondents (50%) who sought help or treatment were still receiving services while the other half (50%) was not. Figure 4.9 shows results on whether respondents were still receiving treatment services. This confirms the high dropout rates and calls for remedial measures by stakeholders.

Figure 4.9: Whether respondents were still receiving services

(N=14)



4.3.10 Reasons for not seeking help

The respondents who indicated that they had not reached out for help were asked to indicate their reasons. The results show that there were many reasons why respondents have not reached out for help where 26.7% of the respondents indicated that they were not ready. The results also show that 23.3% of the respondents did not want to stop injecting drugs, were not interested and were okay with their situation that is why they did not reach out for help. Respondents who did not reach out for help because it will cost

them were 13.3% while those who saw it as a procedure they were not prepared to undergo were 10%. Other reasons for not reaching out for help included unfriendly service providers (6.7%), time and distance from where they can seek help (6.7%), and having no one like a CSO to introduce them (6.7%). Respondents who indicated that they have not decided by now and those that relapsed were 3.3% each. Table 4.14 shows results on reasons for respondents not reaching out for help. A huge proportion of WWIDs indicated that they have not sought treatment giving reasons that are superficial but with deeper meanings for those who have lived with them and truly understand them e.g. 'I am not ready or why should I'. According to key informants WWIDs need to be given alternatives and a way to integrate back to community for them to confidently say they are ready or willing to stop injecting drugs.

Reason	Frequency	Percent
Not ready	8	26.7
It needs money	4	13.3
Service providers not friendly	2	6.7
Have not decided for now	1	3.3
Do not want to stop, not interested and okay with it	7	23.3
Time, distance or both	2	6.7
No one like a CSO to introduce them	2	6.7
It is a procedure	3	10.0
Relapsed	1	3.3
Total	**30**	**100.0**

Table 4.14: Reasons respondents have not reached out for help

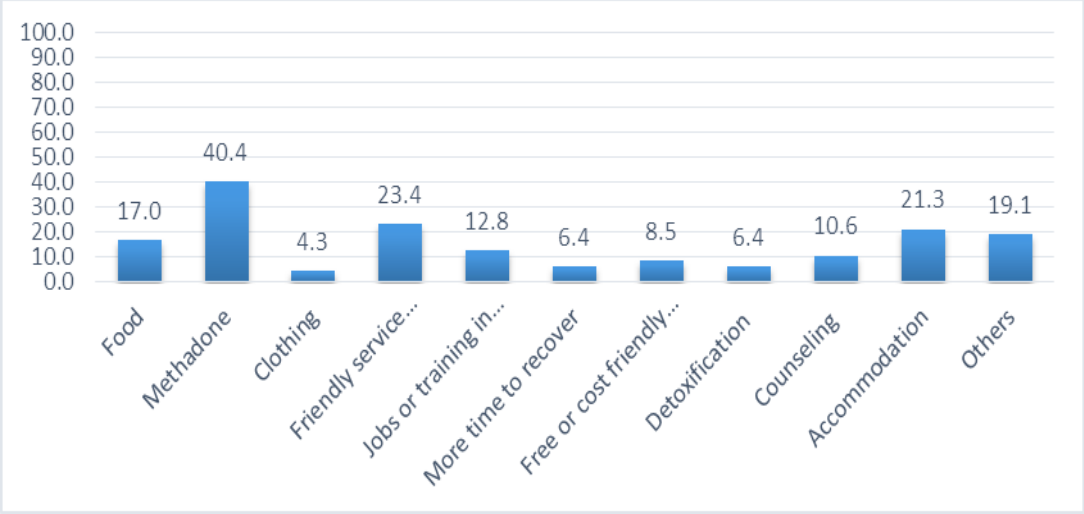
4.3.11 Provisions desired at treatment centres by WWIDs

The researcher wanted to know what treatment centres should provide to help respondents stop injecting drugs. The results show that 40.4% of the respondents indicated that treatment centres should provide methadone while 23.4% indicated that they should have friendly service providers. Respondents who indicated that treatment centres should provide accommodation were 21.3% while 17% indicated that they should provide food. The results also show that 12.8% of the respondents indicated that treatment centres should provide jobs or training in income generating activities while 10.6% indicated that they should provide counseling. Respondents who indicated that treatment centres should provide free or cost friendly services were 8.5% while those that indicated that they should provide more time to recover and detoxification were 6.4% each. Only 4.3% of the respondents indicated that treatment centres should provide

clothing while 19.1% indicated others. Others included things like support for dependents, health, dropping centres, Mosques, resume centres, teach them about safe injection and supply the syringes. According to the findings methadone seems to be the most preferred mode of treatment. This is because of its less frequency of use and also ability for one to function normally under its influence according to the respondents. There is also a huge cry for friendly service providers with most WWIDs preferring recovered addicts or people trained in injection drug use showing a big systemic gap. WWIDs also prefer to be accommodated at treatment centres where they will be able to follow through and focus on treatment with minimum disruption. All the factors listed below show what is lacking but very necessary for and effective treatment program for WWIDs.

Figure 4.10: Things treatment centres should provide to help

(N=50)



4.4 Factors that Hinder Access to Treatment

4.4.1 Distance to treatment Facility

The researcher wanted to know the distance to the nearest treatment center from the respondents. The results show that the distance to the nearest treatment center for the majority of the respondents (52%) was not far. The results also show that distance to the nearest treatment center was far for 32% of the respondents while 6% indicated that they do not live in one place. Respondents who indicated that distance to the nearest treatment center was a walking distance and very close were 4% each. Only 2% of the respondents indicated that distance to the nearest treatment center has never been an issue. Table 4.15 shows results on distance to the nearest treatment center. Most WWIDs don't think that treatment centres are far from them. This means that lack of treatment centres might not be a barrier to accessing treatment but the gap between setting foot in the treatment centre towards staying until completion of the program and not returning to the habit is the big puzzle.

Table 4.15: Distance to the nearest treatment center

Distance	Frequency	Percent
Far	16	32.0
Not far	26	52.0
Walking distance	2	4.0
Very close	2	4.0
Do not live in one place	3	6.0
Distance has never been an issue	1	2.0
Total	**50**	**100.0**

4.4.2 Preferred gender of staff

The respondents were asked to indicate what gender of staff they would prefer when accessing treatment. The results show that 40% of the respondents were alright with any gender while 18% and 14% preferred male and female staff respectively. The results also show that 18% of the respondents were alright with any gender but they be trained to handle drugs abuse or be recovered addict. Ten (10) percent of the respondents indicated that they preferred female staff but they be trained to handle drugs abuse or be recovered addict. This shows that WWIDs need someone who they feel understands them and will be able to help them. Table 4.16 shows results on respondents' gender preference for staff when accessing treatment.

Table 4.16: Gender preference for staff when accessing treatment

Gender	Frequency	Percent
Any	20	40.0
Male	9	18.0
Female	7	14.0
Any but trained or a recovered addict	9	18.0
Female but trained or a recovered addict	5	10.0
Total	**50**	**100.0**

4.4.3 Financial affordability

The respondents were asked to indicate whether they have the required finances to access treatment. The results show that 32% of the respondents indicated that they do not have required finances to access treatment while another 32% indicated that they have not tried. The results show that 18% of the respondents indicated that they do not have enough finances required to access treatment while 2% indicated that they would like to stay longer for treatment but were unable to pay. Only 16% of the respondents indicated that they had the required finances to access treatment. Table 4.17 shows results on respondents having required finances to access treatment. This shows that majority lack the required finances to engage a treatment centre.

Table 4.17: Have required finances to access treatment

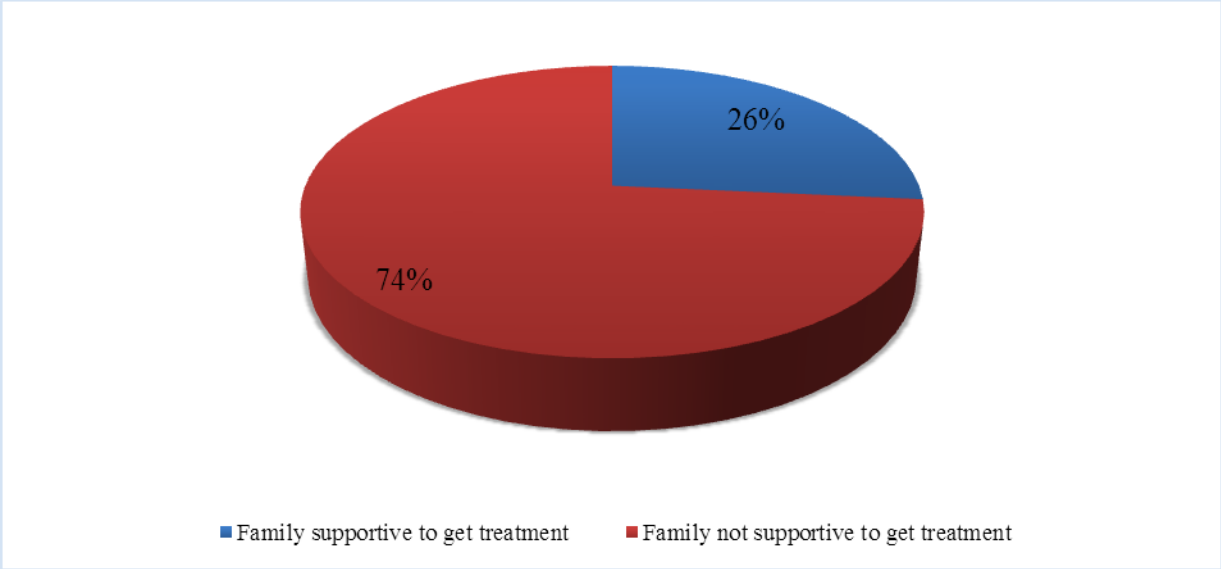
Have finances	Frequency	Percent
Yes	8	16.0
No	16	32.0
Have not tried	16	32.0
Would like to stay longer but unable to pay	1	2.0
Not enough	9	18.0
Total	**50**	**100.0**

4.4.4 Family Support

The researcher wanted to know whether family members were supporting respondents to get treatment. The results show that majority of the respondents (74%) indicated that their family was not supporting them to get treatment while 26% indicated that their family was supporting them to get treatment. Figure 4.11 shows results on family support to get treatment.

Figure 4.11: Family support to get treatment

(N=13)



4.4.5 Support and lack of it from family members

Respondents were asked to explain their answer on family support to get treatment. The results show that 28.9% of the respondents who indicated that their family supported them to get treatment elaborated that they contacted service providers or rehabilitation centres, paid and provided them with other items such as food, clothes and transport. The results also show that 26.7% of the respondents indicated that their family do not like them, they abandoned them or were not in good terms. Respondents whose family do not know that they inject drugs were 20% while those who indicated that they ran away from home, were not in touch with family and do not involve them in their life were 15.6%. 8.9% of the respondents indicated that some of their family members used drugs too. This shows a need to include families and the community at large on accepting WWIDs and

helping them towards recovery. Table 4.18 shows results for explanation of family support or lack of it.

Table 4.18: Explanation of family support or lack of it

Support or lack of it	Frequency	Percent
They do not know that I inject drugs	9	20.0
They do not like me, they abandoned me, not interested and not in good terms	12	26.7
Ran away from home, not in touch with family and do not involve them in their life	7	15.6
Contacted rehabilitation center, paid for rehab, food, clothes and transport	13	28.9
Some are drugs users also	4	8.9
Total	**45**	**100.0**

4.4.6 Whether law enforcement hinders access to treatment

The respondents were asked to indicate whether law enforcement has prevented them from accessing treatment. The results show that majority of the respondents (60.9%) indicated that law enforcement has not stopped them from accessing treatment while 8.7% indicated it has. The results also show that 30.4% of the respondents indicated that they have been victimized by law enforcement officers who perceive them as criminals, arrest them and some are even jailed. It is however key to note that there is a general fear

of police officers among WWIDs. Table 4.19 shows results on whether law enforcement stopped respondents from accessing treatment.

Table 4.19: Law Enforcement stopped respondents from accessing treatment

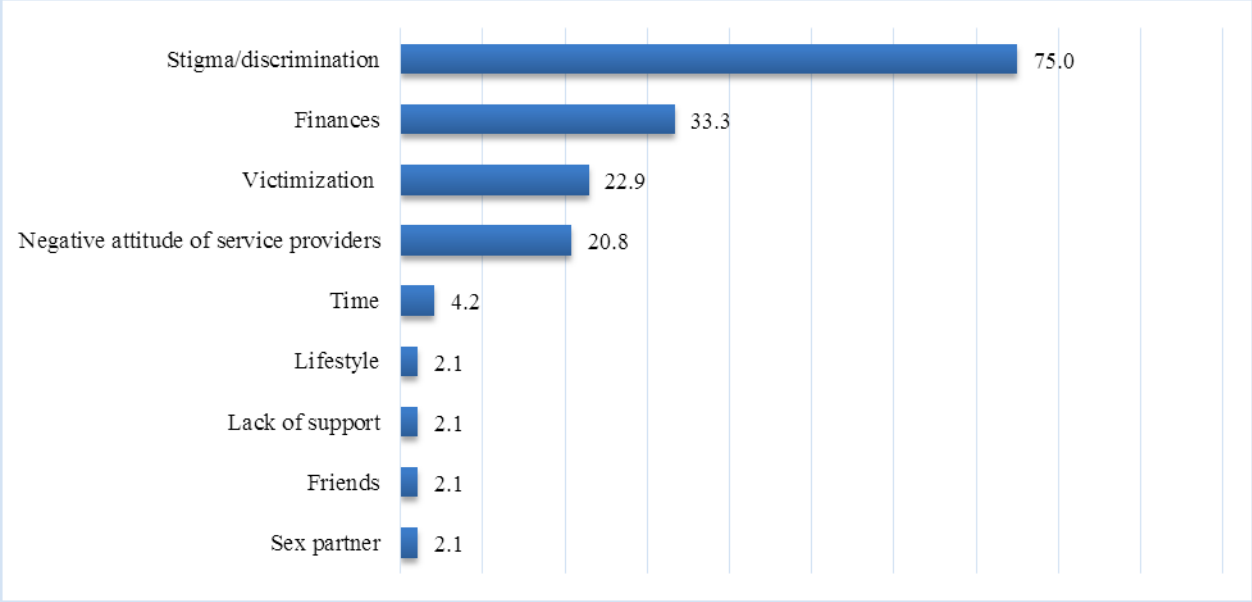
Stopped respondents from accessing treatment	**Frequency**	**Percent**
Yes	4	8.7
No	28	60.9
Victimized	14	30.4
Total	**46**	**100.0**

4.4.7 Barriers to treatment

The researcher wanted to know the greatest barriers to treatment from the respondents' perspective. The results show that stigma or discrimination is the greatest barrier for 75% of the respondents. Finances and victimization were perceived as greatest barriers by 33.3% and 22.9% respectively. The results also show that 20.8% of the respondents saw negative attitude of service providers as their greatest barrier to treatment while 4.2% indicated that time was their greatest barrier to treatment. Other greatest barriers cited by the respondents included lifestyle (2.1%), lack of support (2.1%), friends (2.1%) and sex partner (2.1%). Figure 4.12 shows results on greatest barrier to treatment from respondents' perspective. This elicits a need for acceptance and incorporation into the community for WWIDs. They feel like an unwanted lot and of no good to society. This perception needs to change for them to have a mental shift and see a need to get treated.

The healing process needs to be holistic starting from them accepting that they are a worthy and valuable segment in society.

Figure 4.12: Greatest barrier to treatment from respondents' perspective (N=50)

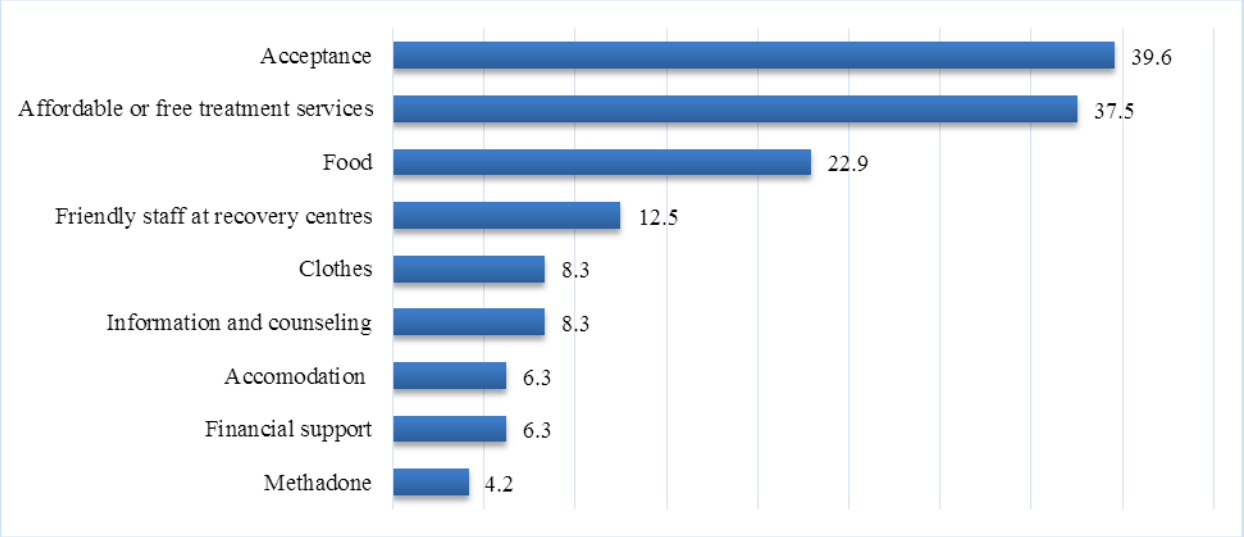


4.4.8 Motivation to seek treatment

The researcher wanted to know what would motivate respondents to go for treatment. The results show that acceptance (39.6%) and affordable or free treatment services would motivate respondents to go for treatment. The results also show that food and friendly staff at recovery centres would motivate 22.9% and 12.5% respectively. Respondents who would be motivated to go for treatment by clothing and information and counseling were 8.3% each while those who cited accommodation and financial support were 6.3% each. 4.2% of the respondents indicated that methadone would

motivate them to go for treatment. Figure 4.13 shows results on things that would motivate respondents to go for treatment.

Figure 4.13: Things that would motivate respondents to go for treatment (N=50)



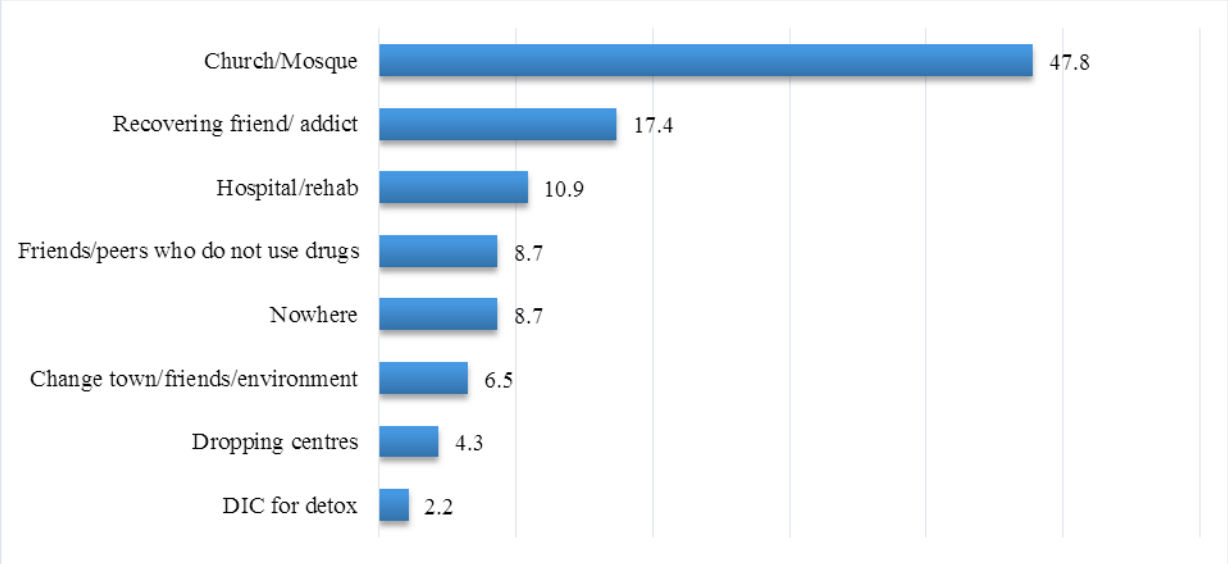
4.4.9 Other ways or places that could help

The respondents were asked to indicate where else they can go for help. The results show that 47.8% of the respondents indicated they can go to a church or mosque for help while 17.4% indicated recovering friend or addict. The results also show that 10.9% of the respondents indicated that they can go to hospital or rehab for help while those that indicated that they can go to friends or peers who do not use drugs for help were 8.7%. Another 8.7% of the respondents indicated that they have nowhere else they can go for help while 6.5% of the respondents indicated they can change towns, friends or environment. This means that religious centres seem to be a

credible source of help for WWIDs and should be involved towards helping them recover and re integrate back to society.

Figure 4.14: Where else respondents can go for help

(N=50)

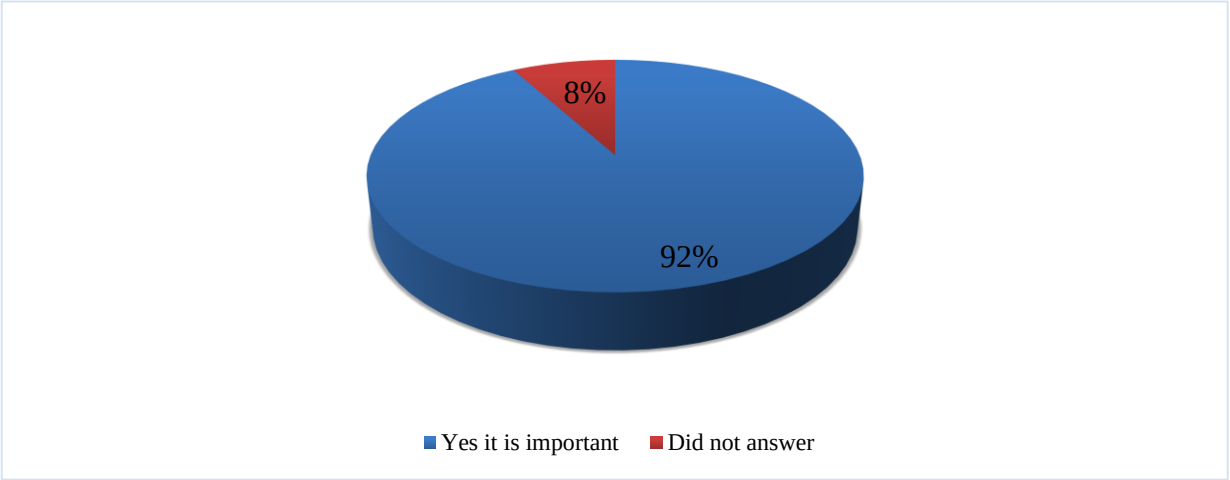


4.4.10 Importance of getting treatment

The respondents were asked to indicate their thoughts on importance of getting treatment. The results show that majority of the respondents (92%) indicated that getting treatment is important while 8% did not answer. Figure 4.15 shows results on respondents' take on importance of getting treatment.

Figure 4.15: Importance of getting treatment

(N=46)



The respondents were asked to explain their answer on the importance of getting treatment. The results demonstrated a recurring need for healthcare among the respondents. Many cited that they get infections, some are already sick and others are vulnerable to many other diseases like HIV. Another recurring theme in the responses was vulnerability to sexual abuse. Some respondents claimed to have undergone sexual abuse and need treatment as well as other intervention measures to prevent such experiences from occurring again. A section of respondents indicated that they have been battered and taken advantage of when they 'get high' and physical abuse and other bad things were meted on them mostly by men. Some of the respondents expressed their need for love, respect and acceptance which has been eroded by their situation. They saw treatment as the only way to regain love, respect and acceptance. There were some respondents who indicated that treatment is important to avoid death and live a long healthy life while others wanted a better life than they have now.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter covers summary of the key findings, conclusions made from the results and recommendations of the study. This study sought to establish if there are support mechanisms that exist for WWIDs and to identify if there are personal and community based factors that hinder access to treatment for WWIDs in Kilifi County. It also sought to determine if there are gaps in existing structures and support mechanisms that discourage WWIDs from accessing treatment in Kilifi County.

5.1 Summary of the Findings

The general objective of this study was to examine factors hindering addiction treatment among women who inject drugs in Kilifi County. The specific objectives of this study were: To establish whether there are existing support mechanisms for women who inject drugs in Kilifi County; to identify personal and community based factors that hinder addiction treatment of women who inject drugs in Kilifi County and to examine factors in the existing structures and support mechanisms that discourage women who inject drugs in Kilifi County from accessing treatment.

This study used a descriptive design to achieve these objectives. A semi-structured questionnaire was administered to a sample of 60 respondents. A response rate of 83.3% was achieved where 50 of the administered questionnaires were filled and returned for analysis. Seven interviews were also conducted with key informants using key informant guide. Qualitative and quantitative data analysis methods were used to analyze data.

Results of qualitative data were presented in narrative form while the results of quantitative data were presented in charts and tables.

The study showed that majority of WWIDs were introduced into injecting drugs by their friends, sex partners or spouse. Majority of WWIDs would want to stop injecting drugs for better healthy life and focus on other things in life like family and education. Indeed, majority of WWIDs had tried to stop injecting drugs by going for rehabilitation, abstaining from drugs for some time as well as changing friends and environment. The study established that majority of WWIDs were aware of available support services and treatment centres. Most had even been asked to access treatment mostly by outreach workers and peer educators. Majority of WWIDs reached out for help or treatment from rehabilitation centres and methadone clinics. Most of those who sought help or treatment received services but most got it for a period of less than a year and some for a period of 1-3 years. Their experience with the services showed mixed reactions where some WWIDs described their experience as good or fair while others described it as not good or challenging. Those who described their experience as good further found the service providers that were accommodative and supportive in the facilities that they sought help or treatment. On the other hand, those who described their experience as not good or challenging cited service providers that were not accommodative.

The study showed that majority of WWIDs were not far from the nearest treatment center. The study also found that WWIDs did not have a preference for gender of staff working in treatment centres. Many of the WWIDs did not have required finances or did not have enough finances to access treatment. The study found that majority of WWIDs'

family members were not supporting them to get treatment. The law enforcement has not stopped WWIDs from accessing treatment but victimization by police officers has had a negative effect on completion of treatment for WWIDs. The greatest barriers to treatment from WWIDs' perspective include stigma or discrimination, finances and victimization. The study showed that acceptance, affordable or free treatment services, food and friendly staff at recovery centres would motivate WWIDs to go for treatment. Alternative places that WWIDs can go to seek help include a church, mosque or a recovering friend or addict. The study showed that majority of WWIDs recognize the importance of getting treatment.

The study established that majority of WWIDs did not live with family. They either worked as sex workers, combined casual work with sex work or had no meaningful income generating engagements which means many of them were idle. Some WWIDs also combined sex work and peddling drugs and majority of them did not have dependents. The study also established that majority of WWIDs were either in their youth (15-25 years) or approaching middle age (26-35 years). Many of the WWIDs were either single or separated. Majority of them were either Christian or Muslim while their highest education level primary school.

All WWIDs used heroine and majority have been injecting drugs for a long time (1-5 years). The study also established that majority of WWIDs used drugs with their friends while some used drugs with family members. The reasons that WWIDs cite for injecting drugs were varied but the most common were influence from friends, family member or spouse and the need to feel intoxicated or *'to get high'*. Many of the WWIDs started

injecting drugs because of nature of their work and especially those that were engaged in sex work. The findings are in agreement that there are barriers hindering women who inject drugs from accessing addiction treatment. These barriers need to be addressed for the current treatment and interventions strategies to be effective.

5.2 Conclusions

Based on the findings above, the study came up with the following conclusions.

5.2.1 Existing support mechanisms for women who inject drugs

Although there exist several treatment and support centres, there is none that is gender specific and that caters solely for women who inject drugs. Current approaches that have been adopted do not put into consideration the needs and experiences of women who inject drugs.

5.2.2 Personal and Community Based Factors hindering treatment of women who inject drugs.

This study concluded that although there exist support mechanisms for women who inject drugs in Kilifi County, there impact is not felt and terminal objectives not fully achieved because of social cultural and personal barriers. These include stigmatization and victimization, disadvantaged life circumstances and lack of family support.

5.2.3 Factors in existing structures and support Mechanism hindering treatment of women who inject drugs.

The systemic barriers included lack of appropriate gender responsive and low cost treatment models. Judgment and stigma from service providers also play a key role in hindering access to addiction treatment.

5.3 Recommendations

5.3.1 Recommendations for policy action

This study recommends that:

1. In addition to pharmacotherapy and behavioural therapy, treatment centres and support systems should provide skills training and employment opportunities to women who inject drugs because majority of them depend on illegitimate sources of income that rely heavily on injection drug use.
2. This study recommends that intervention strategies by stakeholders should be comprehensive putting into consideration the needs of women who inject drugs during and after treatment
3. This study recommends that the government and other stakeholders should provide adequate training to service providers to ensure that WWIDs have a conducive environment free of bias at treatment centres.

5.3.2 Recommendation for Further Research

The study recommends that further research should be done on how to counter factors hindering addiction treatment among women who inject drugs in Kenya so as to develop comprehensive treatment models that cater for the needs of women who inject drugs in Kenya.

REFERENCES

Anderson, T. L. (1998). A Cultural Identity Theory of Drug Abuse. *The Sociology of Crime, Law, and Deviance,* 1: 233-262.

Anderson, T.L. (2005). Dimensions of women's power in the illicit drug economy. *Theoretical Criminology*, 9 (4), 371–400.

Anderson, T.L. (2007). *Sex, Drugs, and Death: Addressing Youth Problems in American Society*. New York: Routledge.

Ball, A., L, Rana, S., Dehne, K., L. (1998). HIV prevention among injecting drug users: responses in developing and transitional countries. *Public Health Reports*, 113, (1), 170-81.

Beckerleg, S, Telfer, M., Hundt, G.L. (2005). The rise of injecting drug use in East Africa: A case study from Kenya. *Harm Reduction Journal* 2: 12.

Blumer, H. (1962). *Society as symbolic interaction, in Rose, A. M. (Ed), Human behaviour and social processes: An Interactionist Approach.* Boston: Houghton Mifflin.

Bourgois, P. (1988). The moral economies of homeless heroin addicts: confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. *Substance Use and Misuse*, 33, 2323-2351.

Creswell, J. W. (2009). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches.* 3rd Edition, Los Angeles: Sage Publications, Inc.

Des Jarlais, D. C., Dehne, K., Casabona, J. (2001). HIV surveillance among injecting drug users. *AIDS,* 15(3): 13-22

Deshler, P and Sock, K. (2005). *Psychology and Community Change: Challenges of the Future*, 2nd edition. Homewood, II, USA: Dorsey Press.

Durkheim, E. (1897). Suicide: a study in sociology. New York City: The Free Press.

Freire, P. (1970). *Pedagogy of the Oppressed*. London: Penguin books.

Guise, A., Rhodes, T., Ndimbii, J. Ayon, S. & Nnaji, O. (2016). Access to HIV Treatment and care for people who inject drugs in Kenya: A short report. *AIDs Care*, 1-5.

Hagan, H., Thiede, H., Weiss, N., S. et al. (2001). Sharing of drug preparation equipment a risk factor for Hepetatis C. *Americal Journal of Public Health*, 91 (1), 42-46

Hagan. et al. (2000). HIV and HCV infection among injecting drug users. *Mount Sinai Journal of Medicine*, 67 (5-6), 423-428

Harris, M., Jolly, E., Martin, A., Wells, H., Rhodes, T. (2012). *Barriers and facilitators to hepatitis C treatment for people who inject drugs: A qualitative study*. Technical Report. Copenhagen: World Health Organization.

Homans, G. C. (1974). *Elementary Forms of Social Behavior*, (2nd Ed.), New York: Harcourt Brace Jovanovich.

Kageha, E, (2015). *Drug Laws and Human Rights in Kenya: Disharmony in the Law and Training Recommendations to Law Enforcement*. Amsterdam: Mainline.

KIPPRA (2013). *A Comparative Study on Public-Private Sector Wage Differentials in Kenya.* Nairobi: Kenya Institute for Public Policy Research and Analysis.

Kombo, D. K, and Tromp, D.L.A. (2006). *Proposal and Thesis Writing: An Introduction*. Nairobi: Paulines Publications Africa.

Kothari, C. R. (2004). *Research Methodology: Methods and Techniques*. New Delhi: New Age International (P) Ltd, Publishers.

McCurdy, S. (2014). *Heroin users strategies for survival in Dar es Salaam, Tanzania*. In C. Ambler, N. Carrier, & G. Klantsching (Eds.), *Drugs in Africa: Historical and Anthropological perspectives*, (pp. 145-160). London: Palgrave McMillan.

McIntosh, J. & McKeganey, N. (2000). Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science & Medicine*, 50, 1501-1510.

Meads, G.H. (1934). *Mind, Self and society*. Chicago: The University of Chicago Press.

Mugenda, M. and Mugenda, G. (2003). *Research Methods: Qualitative and Quantitative Approaches*. Nairobi: Acts Press.

Mugenda, O. M. and Mugenda, A. G. (1999). *Research Methods: Quantitative and Qualitative Approaches.* Nairobi*:* Acts Press.

Musyoki, H. (2012). *An Overview of Programs for People Who Inject Drugs: MARPs and Vulnerable Groups Program*. Nairobi: National AIDs/STI Control Programme.

NACC (2014). *Kenya AIDS Response Progress Report*. Nairobi: National AIDS Control Council.

NACC and UNAIDS (2014). *Kenya AIDS Response Progress Report of 2014 Progress towards Zero*. Nairobi, Kenya: NACC and UNAIDS.

Ndimbii, J., Guise, A., Ayon, S., Kalam, M., McLean, S., Rhodes, T. (2016). Implementing needle and syringe programmes in Kenya: changes, opportunities and challenges in HIV prevention. *African Journal of Drug & Alcohol Studies*, 14 (2), 95- 103.

Ngechu, M. (2004). *Understanding the research process and methods: An introduction to research methods*. Nairobi: Acts Press.

Nieburg, P. and Lisa C. L. (2011). *HIV Prevention among Injection Drug Users in Kenya and Tanzania: New Opportunities for Progress.* Washington, DC.: Centre for Strategic and International Studies.

Phelan, M., Nougier, M., and Bridge, J. (2013). HIV Prevention among People Who Use Drugs in East Africa: An International Drug Policy Consortium. *Briefing Paper*.

Pinkham, S., Stoicescu, C., Myers, B. (2012). Developing effective health interventions for women who inject drugs: Key areas and recommendations for program development and policy. *Advances in Preventive Medicine*, 269123, 1-10.

Republic of Kenya (2010). *Kenya Population and Housing Census of 2009*. Nairobi: Kenya National Bureau of statistics.

Rhodes, T., & Sarang, A. (2012). Drug treatment and the conditionality of HIV treatment access: A qualitative study in Russian city. *Addiction*, 107, 1827-1836.

Rhodes, T., Ndimbii, J., Guise, A., Cullen, C., Ayon, S. (2015). Navigating the poverty of heroin treatment and recovery opportunity in Kenya: Access work, self-care and rationed expectations. *Global Public Health*, 10(7):867-80.

Roberts, A., Mathers, B., Degenhardt, L. (2010). *Women who inject drugs: A review of their risks, experiences and needs. A report prepared on behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use.* Sydney, Australia: National Drug and Alcohol Research Centre (NDARC), University of New South Wales.

Stimson, G. and Choopanya, K. (1998). *Global Perspectives on Drug Injecting. In Drug Injecting and HIV Infection*. (Eds by Stimson, G., Des Jarlais, D.C. Ball, A.). London: UCL Press.

Tinker, T. (1990). *Persistent Inequalities, Women and World development.* New York: Oxford University Press.

Tuchman, E. (2015). Women's injection drug practices in their own words: A qualitative study. *Harm Reduction Journal*, 12(1), 6.

UNAIDS (2014). *Guidance Note: Services for People Who Inject Drugs*. Geneva: UNODC and UNAIDS.

UNODC (2004). *HIV prevention among young injecting drug users.* New York: United Nations Office on Drugs and Crime.

UNODC (2014). *World Drug Report 2014*. New York: United Nations Office on Drugs and Crime.

UNODC (2014). *World Drug Report 2015*. Vienna: United Nations Office on Drugs and Crime.

APPENDICES

APPENDIX 1: QUESTIONNAIRE

Dear Respondent

I am a student at the University of Nairobi pursuing a Masters of Sociology. As part of my study I am carrying out research and writing a report on the FACTORS THAT HINDER WOMEN WHO INJECT DRUGS FROM ACCESSING TREATMENT AT THE KENYAN COAST. I kindly request you to answer the questions in this questionnaire with ultimate honesty. I assure you that the information provided will be held in confidence and will be used for academic purposes only.

Thank you in advance for your support.

SECTION A

General Information:

1) How long have you lived in this area? /Umeishi hapa kwa mda gani?

   Less than 1 year ☐ 1- 5 years ☐ 6– 10 years ☐ Over 10 years ☐

2) How is it like living in this area? /Unayaonaje maisha ya hapa?

   ……

   ……

3) Do you have friends around here? /Una marafiki wanaoshi mtaa huu?

   Yes ☐ No ☐

4) Do you live with family? /Je unaishi na jamii yako? Yes ☐ No ☐

5) What do you do for a living? /Unajikimu vipi maishani?

   ……

   ……

6) Do you have any dependents? /Je una watu wanao kutegemea? Yes ☐ No ☐

10. How old are you? /Una umri gani? Less than 15 ☐ 15 – 25 ☐ 26 – 35 ☐

    36 – 45 ☐ 46 – 55☐ 56 and above ☐

11. What is your marital status? Umeolewa? Single ☐ Co habitating ☐

    Married☐ Separated ☐ Divorced ☐ Widowed ☐

12. What is your religious background? / Dini yako ni gani?

    Traditionalist ☐

    Christian ☐

    Muslim ☐

    Other (Please specify) ☐

13. What is your highest Education level/ Umesoma hadi kiwango gani?

    a) Primary and below ☐

    b) Secondary School ☐

    c) Technical/Vocation ☐

    d) University ☐

SECTION: B

History of Injection Drug use

14. What drugs do you inject? ☐

    a) Heroine ☐

    b) Cocaine ☐

    c) Morphine ☐

    d) Methaphythamine ☐

    e) Others (please specify)

15. How long have you been using these drugs?

a) Less than 1 year ☐ b) 1-5 years ☐ c) 6-10 years ☐ d) Over 10 years ☐

16. Who do you use these drugs with?"

a) Family ☐ b)Friends ☐ c) Colleagues ☐ d) Others (please specify)

17. Why did you start injecting drugs?

_____

18. Who introduced you to injecting drug use?

a) Parent ☐ b) Relative ☐ c) Spouse ☐ d) Friend ☐

e) Colleague ☐

f) Other (please specify)_____

_____

19. Do you sometimes stop injecting drug use? Yes ☐ No ☐

20. If yes why, if no why not?

_____

21. Have you ever tried to stop? Yes ☐ No ☐

22. If yes, how?

_____

_____

Support mechanisms and access to treatment

23. Do you know any support services or treatment centers that can help you stop?

Yes ☐ No ☐

24. Has anyone ever reached out to you and asked you to access treatment?

Yes ☐ No ☐

If yes who? _____

25. Have you ever contacted any support or treatment center for help?

Yes ☐ No ☐

If yes, please answer question 26 – 30. If no go to question 31

26. Which support or treatment center have you contacted?

_____

_____

_____

27. Did you receive any services when you contacted them?

_____

_____

_____

28. How long have you been receiving help and treatment?

a) Less than one year

b) 1 – 3 years

c) 4 – 6 years

d) Over 6 years

29. How long have you being receiving help and treatment?

a) Less than one year ☐

b) 1 – 3 years ☐

c) 4 – 6 years ☐

d) Over 6 years ☐

30. How would you describe your experience?

_____

_____

_____

31. Are you still receiving help and treatment from them? Yes ☐ No ☐

32. Why haven't you reached out to them for help?

_____

_____

_____

33. What should treatment centers provide to help you to stop using drugs?

_____

_____

_____

34. Apart from treatment centers who else can you go to for help?

a) Friends ☐ b) Family ☐ c) Religious centers ☐

e) Other (Please specify)

Appendix II: Key Informant Interview Guide – Community Elder

Dear Respondent

I am a student at the University of Nairobi pursuing a Masters of Sociology. As part of my study I am carrying out research and writing a report on the FACTORS HINDERING ADDICTION TREATMENT AMONG WOMEN WHO INJECT DRUGS AT THE KENYAN COAST. I kindly request you to answer the questions in this questionnaire with ultimate honesty. I assure you that the information provided will be held in confidence and will be used for academic purposes only.

Thank you in advance for your support.

1. Tell me about you, how long have you been living in this area?
2. How you have been working with female IDUs?
3. How long have you been doing this?
4. Are there any positive changes from the work you've been doing
5. Are there any challenges you face in working with these people
6. Are there any individuals or organisations that you work together with?
7. In relation to the current situation have you witnessed any reduction or increase in the number of female IDUs?
8. What in your opinion needs to be done to eradicate this problem? (Role of the community, role of the government, role of the treatment centers)
9. Are you aware of any government interventions to try to address this situation? (Needle exchange programmes, MAT clinics) What are your views about these interventions?

Appendix III: Key Informant Interview Guide – Service Provider

Dear Respondent,

I am a student at the University of Nairobi pursuing a Masters of Sociology. As part of my study I am carrying out research and writing a report on the FACTORS HINDERING ADDICTION TREATMENT AMONG WOMEN WHO INJECT DRUGS AT THE KENYAN COAST. I kindly request you to answer the questions in this questionnaire with ultimate honesty. I assure you that the information provided will be held in confidence and will be used for academic purposes only.

Thank you in advance for your support.

1. What is your current role in relation to IDUs?
2. How long have you been doing this?
3. What is your professional training?
4. What services does your organisation offer?
5. What is the enrollment, retention and completion rate of female IDUs to these services?
6. What challenges do you face in providing your services, how do you resolve them?
7. How do you reach out to those who do not come to access your services?
8. Are there any individuals or organisations you work with in delivering your services?
9. What would you say are the main successes in your work and how do you sustain these gains?
10. Any other comments?

10. In your opinion what are the challenges in reaching out and offering treatment to female IDUs
11. How do you go about identifying and recruiting female IDUs for treatment?
12. In your opinion how can the challenges be overcome?
13. Who are the influential people and decision makers in the lives of female IDUs?