

# Audience Profile: People Who Inject Drugs

## Who They Are (and in the Context of HIV)

### **In a snapshot: struggling to stay afloat while bearing the heavy weight of drug addiction.**

The audience of people who inject drugs (PWID) includes any person who injects drugs for nontherapeutic purposes, irrespective of the type of drug injected, although heroin is the most common. PWID are discriminated against, criminalized, and often socially isolated because of their drug use. While unsafe injection practices put PWID at high risk for HIV, poor health is just one among many interconnected challenges they face—and dealing with their addiction almost always takes top priority. Engaging PWID in preventive health services is thus a difficult task.

### **There are few research-based generalizations about PWID in sub-Saharan Africa; the hidden nature of this population means that data vary widely among studies.<sup>1</sup>**

It is difficult to say which studies are truly representative of this population, but the greatest amount of research available is on PWID who are male, young, urban, and poor, and who are often involved in criminal activities.

For example, a 2014 report from the National AIDS Control Council of Kenya estimated that 80 percent of PWID surveyed were between the ages of 20 and 25, and 90 percent were male. Concentrated in urban centers, most PWID lived in poverty and lacked work, housing, or social support. About 14 percent engaged in petty crime (such as pickpocketing or shoplifting).<sup>2</sup>

A 2015 study from Nairobi, published in the journal *AIDS and Behavior*, also found that PWID surveyed generally lacked work. Only 11.4 percent of participants reported formal employment (compared with approximately 17 percent for the general population as of 2015<sup>3</sup>), while 18.8 percent earned income through illegal activities, including sex work. Many were also incarcerated or formerly incarcerated.<sup>4</sup> About half had a primary school education, and another 44 percent had been through secondary school.<sup>5</sup>

### **PWID lack community and family support networks.**

This may be because, as noted by the National AIDS and STI Control Programme (NASCOP) Key Populations Communications Strategy (2014-2017), PWID are often single, separated, divorced, or widowed, and very few have young children. (Those who do have children often have them out of wedlock).<sup>6</sup> Social stigmatization that results from their illegal behavior is also a contributing factor.<sup>4</sup>

## **But some PWID are connected to the general population via sexual activity with their non-injecting partners.**

While many drug users are socially isolated, the 2015 AIDS and Behavior study did find that more than half of sexually active PWID in Nairobi had non-injecting sex partners.<sup>4</sup> As their relationships with PWID put non-infected PWID at risk of acquiring HIV, any subsequent or concurrent sexual relationships the non-infected PWID enters into can be a bridge for transmission to the general population.

## **PWID populations are fairly small, but PWID are at high risk of HIV—and have an increasing impact on HIV rates. Rapid transmission is a hallmark of epidemics among PWID.**

The population of PWID in any country may be relatively small, though data may not reflect actual numbers given the challenges of identifying PWID. The 2014 Tanzania National AIDS Control Program, for example, in 2014, the Tanzania National AIDS Control Program estimated that there were 30,000 PWID in Tanzania (a country of more than 55 million people).<sup>1</sup>

Among populations of PWID in sub-Saharan Africa, HIV prevalence is estimated to range from 5.5 percent to about 43 percent.<sup>7</sup> More specifically, following are national HIV prevalences among PWID:

- Uganda: 16.7 percent (2014 estimate)<sup>8</sup>
- Kenya: 18.3 percent (2011 estimate)<sup>9</sup>
- South Africa: 19.4 percent (2015 estimate)<sup>10</sup>
- Tanzania: 35 percent (2014 estimate)<sup>1</sup>

However, while the population of PWID may be relatively small, their individual risk is extremely high; for each exposure to HIV infection via an infected needle, the probability of HIV transmission is twice as high as it is for exposure via vaginal sex.<sup>11</sup>

PWID may account for a comparatively low rate of new HIV infections; in South Africa, for example, a 2012 study found that just 1.3 percent of new HIV infections occurred among PWID.<sup>12</sup> However, injectors can exacerbate HIV epidemics—rapid transmission is a hallmark of the disease among PWID. This is due to ease of transmission via sharing of needles and drug equipment, but is also reinforced through criminalization and marginalization of drug use as well as poverty (which in turn decrease access to HIV prevention, testing, treatment, and healthcare).<sup>13</sup>

*The following is an overview of research among PWID, summarizing a broad array of recent studies conducted in communities and countries across sub-Saharan Africa. While this document references broad trends and similarities within this group, there are important distinctions between PWID in different countries and contexts—even from one neighborhood to the next. When used to inform a communications campaign, this overview can be a starting point for further investigation, including direct research and engagement with local PWID for whom PrEP is an option.*

## **Priorities, Worries, Dreams, Aspirations**

*When you are designing communications, you must understand your audience's complex lives. This section explores PWID's priorities (not specifically related to HIV), which generally reflect a struggle between ambitious dreams and urgent, day-to-day needs.*

## **PWID have ambitious long-term dreams.**

In 2017, the OPTIONS consortium conducted market research in Kenya and found that surveyed PWID generally cared about their health and valued having a job. Like other people in sub-Saharan Africa, many of the PWID said they hoped to run a business and start a family in the future. Most of them emphatically did not prioritize their own sobriety.<sup>14</sup>

## **However, their addiction and financial challenges are often obstacles to achieving their aspirations.**

When asked how they are working toward these goals, at least one in three PWID reported that they were saving money, working a second job, and/or not consuming drugs. However, almost a third reported that getting arrested, not earning enough money, and continuing to abuse drugs were barriers that prevented them from pursuing their goals.<sup>14</sup>

## Challenges

*Any person's risk factors for HIV acquisition are closely tied to the challenges they face. For PWID, the complex challenges that may accompany addiction (such as homelessness, financial insecurity, and violence) significantly shape their lives.*

## **PWID deal with homelessness, hunger, and violence, on top of the health and financial struggles associated with addiction.**

According to one global harm-reduction services organization, PWID in Kenya face multiple challenges, including homelessness, food shortages, and ill health linked to a lack of shelter. Many also suffer abscesses after injecting, which cause serious illness. For PWID, HIV and associated risks compete with these other urgent issues.<sup>15</sup>

PWID report victimization at the hands of community members in the form of “mob justice,” targeting them as criminals (whether their crimes are real or perceived).<sup>15</sup> For PWID, HIV and associated risks compete with these other urgent challenges.

## **They also face stigma and harassment from their communities and the criminal justice system.**

A 2015 study in Nairobi concluded that PWID face stigma from their community, both because drug use is criminalized and due to the perception that drug users frequently steal to support their addiction.<sup>4</sup>

In fact, 70 percent of PWID surveyed in the 2017 OPTIONS Kenya research reported experiencing stigma or being victimized by people in their own social circle. Respondents said they were frequently falsely accused of stealing, socially isolated (“no one wants to talk to you”), and often the subject of gossip. Eighty-two percent of

respondents believed that their peers experience the same.<sup>14</sup> The community's perception of PWID as criminals (whether their crimes are real or perceived) has resulted in some PWID being victimized.

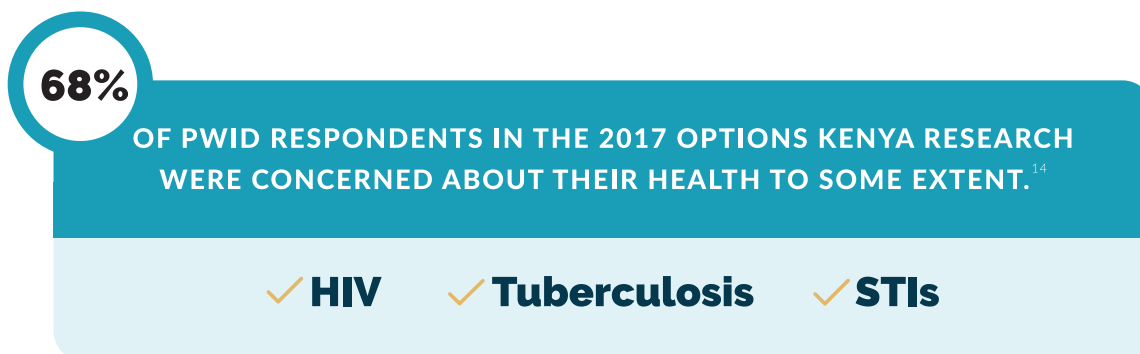
PWID living with HIV who responded to the 2017 survey also reported experiencing abuse and harassment connected to their HIV status, saying that people sometimes refuse to share objects with them.<sup>14</sup>

The criminal justice system presents additional challenges. Because drug use is criminalized, the police regularly harass and arrest PWID. The 2015 study from Nairobi showed that drug injection paraphernalia can be used as a basis for arrest, and that police often use injection track marks on the body as a basis for arrest as well.<sup>4</sup>

## Relationship to Health & Healthcare

*This section examines how PWID think about their health, especially with respect to preventive health practices (including HIV prevention). It also considers their access to and interactions with formal healthcare. Although PWID may know their health risks, they are less likely than the general population to have access to healthcare, and their addiction often interferes with their care.*

### **PWID are concerned about their health and are especially focused on disease transmission.**



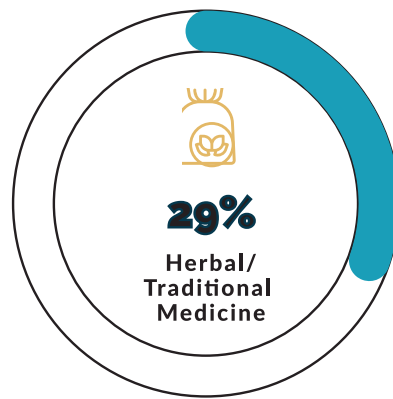
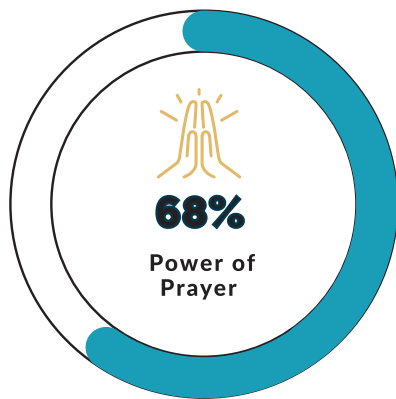
When asked about their peers' health concerns, the highest reported concerns were HIV, tuberculosis, and sexually transmitted infections (STIs).<sup>14</sup>

### **While they report practicing some healthy behaviors such as condom use, using clean needles was not mentioned as an HIV-prevention behavior.**

PWID respondents in the 2017 OPTIONS Kenya research reported using condoms, eating a healthy diet, and drinking water as ways to maintain their health. However, the extent to which PWID have opportunities to follow these practices is unclear, given their precarious financial and housing situations.<sup>14</sup>

### **A majority place faith in religious beliefs to keep them healthy, and use of traditional medicine is also common.**

In the 2017 OPTIONS Kenya research, 68 percent of PWID respondents (more than any other group surveyed) cited the "power of prayer" as a means of staying healthy. Additionally, 29 percent reported using herbal or traditional medicines to stay healthy. About one in four PWID surveyed did not rely on any religious or cultural beliefs when it comes to their health.<sup>14</sup>



## They may receive healthcare from government hospitals, nongovernmental organization hospitals, and/or drop-in centers when and if they can.

In the 2017 OPTIONS Kenya research, 75 percent of PWID surveyed received healthcare at government hospitals. Twenty-two percent of respondents said they seek care at nongovernmental organizations hospitals when possible, and 20 percent said they go to drop-in centers. Respondents were highly likely (88 percent) to go alone.<sup>14</sup>

## Stigma and the demands of addiction may act as barriers to seeking healthcare, and specifically stigma and discrimination from healthcare workers is an important impediment.<sup>16</sup>

A 2016 report from Kenya, published in the journal *AIDS Care*, explained that many PWID choose not to seek care because they fear discrimination and/or had a past experience of discrimination. As a result, some PWID hide their drug use from providers.<sup>16</sup>

Similarly, a study in Uganda suggested that discrimination against PWID leaves this group with inadequate health services.<sup>17</sup> A qualitative longitudinal study in Kenya in 2016 found that female PWID who engage in sex work may face additional discrimination connected to their sex work.<sup>16</sup>

**“When you go [to a healthcare provider] he tells you to go back and bathe first, then come back. You see? Sometimes he tells you, ‘Sit there.’ He segregates you from others, tells you to sit somewhere else, he will attend to you later, now you see, you start feeling like you do not belong in such a place. You see that, you go away.”<sup>16</sup> – Person who injects drugs, Kenya**

## The financial and opportunity costs of care that compete with the demands of addiction are often sacrificed in favor of dealing with withdrawal.

PWID may feel they must choose between their addiction and their healthcare, both in the monetary cost and the time investment required to seek care, especially when a clinic is located far away.<sup>16</sup> Time spent waiting in line at the clinic must be weighed against the need to invest time in securing drugs to prevent withdrawal symptoms. The need to prioritize addiction can thus be a barrier to care.<sup>16</sup>

**“If I need to go to hospital today and I have not dealt with withdrawal, I will not go to hospital, you see?... This stuff has taken control of my life.”<sup>16</sup> – Person who injects drugs, Kenya**

## Incarcerated people who use injected drugs may be blocked from healthcare.

The health of prisoners is often neglected because of the intense stigma that PWID in prison face and low levels of investment in their care. Budgetary constraints, along with legal and policy barriers and low political will to invest in prisoners' care, result in prison health services that are often far from optimal.<sup>18</sup>

The perception that PWID don't care about their own health is untrue. Despite the barriers PWID face, some advocates and service providers report that PWID are very receptive to healthcare when it is accessible.<sup>18</sup>

**“Drug users live on the edge of society where people want to do things to them and not with them. Our experience is that if you reach out to drug users and provide services to them in a safe and nonjudgmental way, they are very eager and willing participants...If they are given access to safer approaches, they will take them and they will use them. Starting with healthcare providers, humane treatment can make a world of difference.”<sup>18</sup> – Chris Beyrer, President of the International AIDS Society**

## Relationship to and Engagement in High-Risk Activities

*This section reviews the behavior and social norms that commonly put PWID most at risk of acquiring HIV: unsafe injection practices and unsafe sex practices.*

### Sharing injection equipment with others puts PWID at high risk.

Multiple studies across sub-Saharan Africa have found that PWID engage in high-risk injection practices, such as sharing syringes, needles, and other injecting equipment; using pre-filled syringes; sharing preparation water; drawing drugs from a common container; or drawing drugs from another user's syringe.<sup>4</sup> Several studies have found these practices to be widespread:

- In a 2015 study in Kenya, 67.3 percent of PWID surveyed had engaged in at least one risky injection practice in a typical month and 80 percent had done so in their lifetime.<sup>4</sup> A 2011 survey conducted by the Population Council similarly found that only 51.6 percent of respondents reported using sterile injection equipment at last injection.<sup>4</sup>
- In Tanzania, a 2015 study in Mwanza found that 67 percent of drug-injecting respondents shared needles.<sup>4</sup>
- A 2015 study of PWID in five South African cities found that 13 percent of male and 26 percent of female respondents regularly shared syringes and other injecting equipment and nearly half reused needles.<sup>19</sup>

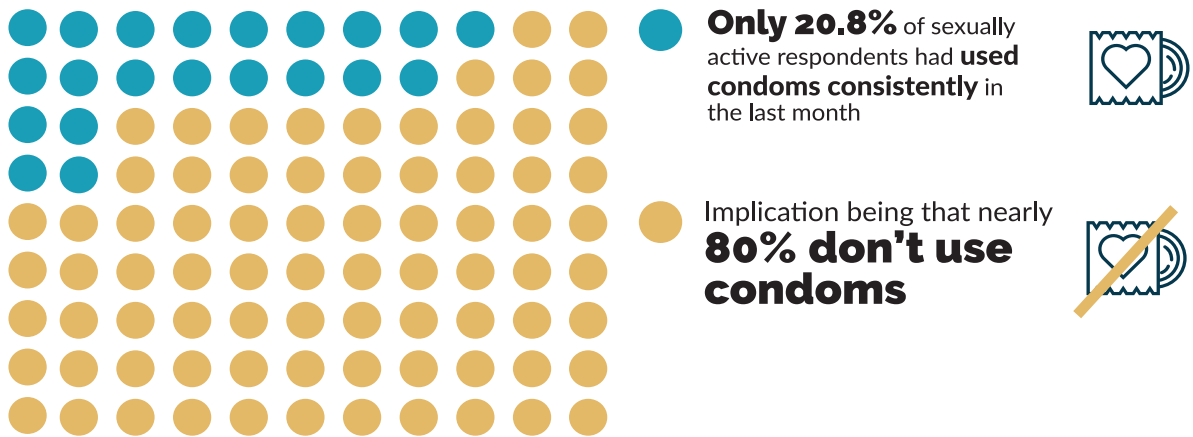
While its prevalence is undetermined, one extremely risky injection practice observed in Kenya and Tanzania is the use of “flashblood,” a secondhand method of drug use whereby a user draws the blood of another person who has recently injected, and then injects that blood to obtain some of the drug within it.<sup>20</sup>

### Many PWID engaging in these risky needle-sharing practices may be living with HIV.

In a 2015 Nairobi study published in the journal *AIDS and Behavior*, nearly one in four respondents who reported sharing needles was living with HIV. This high prevalence, combined with the risky behaviors noted above, underscores the high risk for HIV-negative PWID.<sup>4</sup>

## Overall, sexual activity among PWID has been found to be lower than among other high-risk groups; however, sexually active PWID are likely to engage in high-risk sexual practices.<sup>4</sup>

As with the general population, high-risk practices include having sex with more than one partner and inconsistent use of condoms. While the 2015 study in Nairobi found that only four out of 10 PWID reported sexual activity in the previous month, a majority of those were not using condoms—only 20.8 percent of sexually active respondents had used condoms consistently in the last month.<sup>4</sup>



Another survey from Kenya found that 29.8 percent of respondents had unprotected sex with their most current partner in the previous month.<sup>4</sup> (This is lower than the general population: Forty percent of Kenyan women aged 15-49 and 42 percent of Kenyan men aged 15-54 had used a condom at last sex).<sup>21</sup> Results of a bio-behavioral study revealed that 23 percent of PWID respondents in Kenya had more than one sexual partner in the previous year, which is higher than the general population<sup>4</sup> (12.6 percent of men and 1.4 percent of women reported having two or more partners in the preceding 12 months).<sup>21</sup>

A 2015 study in South Africa found that fewer than half of PWID surveyed there had used a condom during their most recent sexual encounter.<sup>19</sup>

## Female PWID may also engage in sex work, which steeply increases their HIV risk.

A multicountry survey found that 86 percent of female PWID were sex workers.<sup>22</sup> The 2014 UNAIDS Gap Report showed that global HIV prevalence among women who inject drugs was 13 percent, compared to 9 percent among men who inject drugs.<sup>13</sup>

## Many PWID underestimate their own HIV risk.

In the 2017 OPTIONS research in Kenya, 76 percent of PWID respondents were likely to perceive their peers as being at high risk of contracting HIV.<sup>14</sup> When asked to explain why, PWID cited sharing unsterilized needles and syringes; sharing other sharp objects with an HIV-positive person without knowing their status, having multiple sexual partners, sharing sexual partners, not using condoms, and having sex with someone whose status they do not know.

However, only 32 percent of respondents perceived themselves as being at high risk of contracting HIV. When asked to explain why they believed they were personally at risk, they cited their own practice of sharing needles as the primary reason.<sup>14</sup> The other respondents—the vast majority, who did not feel personally at risk—

explained that they did not share syringes (44 percent) or needles (38 percent), that they had only one sexual partner (39 percent vs. 25 percent of Kenyan men aged 15-54, who report only having one partner<sup>21</sup>), or that they always used a condom with their partner (32 percent).<sup>14</sup>

## Relationship to Sexual and Reproductive Health and HIV Testing, Prevention, Treatment

*This section examines PWID's access to and use of important HIV prevention practices. Prevention and care are difficult for PWID to access, even though many are aware of their own status.*

### Studies show that a majority of surveyed PWID know their HIV status.

One study from Nairobi in 2011 reported that 60.7 percent of PWID participants received an HIV test in the past 12 months and knew their results.<sup>23</sup> In the 2017 OPTIONS Kenya research, 96 percent of participants knew their status; 79 percent of participants had tested in the last one to three months, and 63 percent of those who had tested reported that they test every two to three months.<sup>14</sup> These respondents were most likely to get tested at a government hospital or dispensary.<sup>14</sup>

### HIV-related stigma and the silencing of HIV-positive people isolate PWID and prevent them from seeking care.

**"I'm afraid to go and... I'm afraid, I don't know why... I can go to the hospital to have some help. Then I go back... Why do you feel afraid of the treatment of the hospital? I don't know, I don't like so many people to see I'm sick."<sup>16</sup> – Person who injects drugs, Kenya**

The 2017 OPTIONS research found that some PWID in Kenya feared disclosing their HIV status to intimate partners and family, or even to outreach projects in the community. This fear limits them in seeking care. The study found that HIV is rarely discussed openly among PWID; many reported that they did not know which of their PWID acquaintances were living with HIV.<sup>16</sup>

**"I do not know any other sick person. These are discreet people. I can't tell...I do not know. Others are afraid, they cannot tell you that they are infected."<sup>16</sup> – Person who injects drugs, Kenya**

### Prevention methods that are top of mind for PWID include condoms and safe needle practices.<sup>14</sup>

When the 2017 OPTIONS research asked PWID about the known ways to prevent transmission of HIV, 87 percent of respondents cited using condoms and 66 percent cited not sharing needles.<sup>14</sup>

Similarly, when PWID were asked what "safe sex" meant to them, most (89 percent) cited "using male condoms."<sup>14</sup> PrEP was not mentioned as an HIV prevention method.<sup>14</sup>

## Relationship to PrEP



When you think about the best ways to influence an audience's behavior and encourage PrEP uptake, it is important to consider five factors: 1) awareness, 2) understanding, 3) benefits, 4) interest, and 5) barriers. This section looks at how PWID currently understand and consider PrEP across these five dimensions:

- Awareness is low.
- Understanding is high (once informed).
- Benefits for this audience (perceived) are focused on protection.
- Interest is very high.
- Barriers to uptake primarily include concerns about side effects and stigma of HIV.

## **PWID have a low awareness of PrEP.**

In the 2017 OPTIONS research in Kenya, only one in four PWID surveyed had heard of PrEP. Of those aware of PrEP, 51 percent said they knew a peer that uses it.<sup>14</sup>

When asked about ways to prevent the transmission of HIV, only 13 percent of respondents cited PrEP. Similarly, when asked what safe sex means to them, only 1 percent of respondents cited PrEP.<sup>14</sup>

## **PWID show high understanding of PrEP's efficacy once they receive information about it.**

After being shown an information sheet about PrEP, a majority of PWID respondents in the OPTIONS survey believed in its efficacy: 67 percent reported being "sure that [PrEP] would work" and 82 percent believed that it would lower the national HIV rates.<sup>14</sup>

However, when the OPTIONS survey asked PWID what worries they have about PrEP, 37 percent of respondents cited that there is "no proof that it works."<sup>14</sup>

Finally, like some other audience segments, some PWID may believe that PrEP can eliminate the need for condoms. Thirty percent of respondents said that one benefit of PrEP would be not having to worry about being drunk and not using condoms. Communications should emphasize that PrEP does not protect against STIs and pregnancy, and that condoms are still necessary.<sup>14</sup>

## **PrEP use may be fairly socially acceptable among PWID.**

Unlike other populations surveyed in the 2017 OPTIONS research, PWID in Kenya believe that PrEP use would be supported by their peers. Many PWID surveyed (44 percent) reported that their peers would be supportive of their decision to use PrEP.<sup>14</sup>

## **A majority of PWID surveyed either definitely or probably would use PrEP.**

In the 2017 OPTIONS research, the few respondents who did not express interest in PrEP gave reasons such as being "unfamiliar with the product."<sup>14</sup> This points to an opportunity to boost consideration through PrEP education.

However, interest varies by country and demographic. In another study from South Africa, just 35.4 percent of HIV-negative PWID surveyed expressed willingness to use PrEP.<sup>28</sup>

Local investigation is always needed.

## **There are a few barriers to overcome, many of which can be addressed through education, to increase consideration of PrEP use.**

In the 2017 OPTIONS research, surveyed PWID most commonly cited side effects as a concern with using PrEP.<sup>14</sup> Additionally, 51 percent of respondents expressed worry that people would assume they are HIV positive, and 41 percent were concerned it could be mistaken for HIV treatment.<sup>14</sup>

Other concerns included that:<sup>14</sup>

- PrEP is not 100 percent safe (i.e., PrEP is considered 90 percent effective in preventing HIV transmission).
- There is no proof that it works.
- It will increase the rate of STIs.
- People will forget to take it (including due to alcohol influence).

## **How to Reach and Connect with PWID: Best Channels to Connect**

*The following details primarily reflect the findings of the 2017 OPTIONS research in Kenya. Except where otherwise noted, these insights are specific to PWID in Kenya; like all information in this document, these are only a starting point for further investigation focused on a specific audience and context.*

### **PWID's main interests include:**

Listening to music, watching movies, spending time with family and friends, playing football, and going to the beach. Note that for PWID, the general interests and activities that most other audiences enjoy are much less commonly reported.<sup>14</sup>

### **While radio dominates at the country level, access to mobile technology is more widespread among PWID.<sup>14</sup>**

- 55 percent own a TV set.
- 78 percent own a radio.
- 80 percent have access to a cellphone, of which 77 percent have their own cellphone and 26 percent have access to a smartphone.
- 93 percent do not own a computer.

### **Channels they already engage with and turn to daily for information on healthy sexual practices and HIV prevention include:<sup>14</sup>**

- Community talks
- Churches
- Mobile doctors
- Friends
- Peer educators and peer educator programs
- Radio stations and TV
- Hospitals and health centers

## **Channels for communicating about PrEP include widely accepted mass media, as well as church and social-focused groups.<sup>14</sup>**

The 2017 OPTIONS research in Kenya asked PWID how they believe information about PrEP should be communicated to people like themselves. The results share some overlap with how and where they are currently receiving sexual health information, as well as places that could provide information if barriers were overcome.

These include:

- Mass media including radio, TV, and billboards
- Churches
- Seminars
- Social media
- Hospitals and health centers (when possible; note that a number of barriers, described previously, often block PWID from accessing these places)
- Friends

## **How to Reach and Connect with PWID: Best Tactics**

Word of mouth and interactions with trusted people are key to engaging PWID. In the 2017 OPTIONS Kenya research, of those PWID surveyed who had heard of PrEP, the majority became aware of it either through word of mouth or directly from a local nonprofit health service.<sup>14</sup>

Generally, information considered most credible is that which is endorsed by community, meaning fellow drug users and other people connected to access to drugs, or to the services PWID need.<sup>25</sup>

It may be useful to connect through organizations and programs that are already engaging PWID, including:<sup>25</sup>

- Peer education programs
- Medically assisted therapy (MAT, also known as opioid substitution therapy or OST) programs to reduce drug addiction
- Harm-reduction programs
- Support networks and community-based organizations

## **An approach focused on decentralized care and outreach—especially connected through trusted influencers and peers—may be most successful.**

PWID are strongly connected to and motivated by their peers. Anyone known to have a link with their drugs may qualify as a friend. When seeking to help PWID overcome barriers to clinic access, social and outreach support is helpful; however, clinic-based care may always be fundamentally challenging for some PWID.<sup>16</sup>

Thus it is worth considering developing stand-alone PrEP access for PWID, implementing, for example, mobile clinics. This decentralizes HIV treatment and care to community settings and involves peers in delivery. This would help address the challenges of cost of services, time waiting for services, and stigma PWID often face in clinics.<sup>16</sup>

## CASE STUDY

### Working with Harm-Reduction Services

Harm-reduction services are shown to be effective. These could be a channel to roll out PrEP.

According to the 2014 UNAIDS Gap Report, a combination prevention approach—including needle and syringe programs, opioid substitution therapy, HIV testing and counseling, condoms, and antiretroviral therapy—has the greatest and most cost-effective impact on the HIV epidemic among PWID.<sup>13</sup> For example, 155 clean needles and syringes were distributed to PWID in Uganda in 2016.<sup>26</sup>

Later that same year, UNAIDS found that nearly 90 percent of PWID had used a clean syringe last time they injected (compared to just 51.6 percent in 2012).<sup>26</sup> Further, 90 percent of PWID reported that they had acquired knowledge on how to prevent HIV through avoiding reuse of needles/syringes. Based on this success, the Ugandan Ministry of Health in 2017 authorized pilots for more needle and syringe programs.<sup>27</sup>

While the supply of harm reduction services is still far below demand, it may be on the slight rise. Since the introduction of harm-reduction in Kenya in 2012, for example, almost 10,000 PWID have been reached with clean needles and syringes, and with sexual and reproductive health information/services.<sup>28</sup>

Harm-reduction strategies could be effective methods for rolling out PrEP; aligning with harm-reduction services could be a useful tactic for engaging more PWID.<sup>29</sup>

### Another tactic may be to target “hotspots” where PWID may be buying drugs.<sup>4</sup>

A 2014 study conducted in Nairobi indicated that many PWID congregate at “bases,” which are typically outdoor public areas where drug dealers sell drugs. Some PWID also inject at these sites. The study suggests that these could serve as useful touchpoints for engaging PWID (while taking safety concerns into consideration). The study explains that even PWID who want to remain anonymous will often visit bases to buy drugs, even if they don’t linger.<sup>4</sup>

## To Keep in Mind for Engagement in Sexual and Reproductive Health and HIV Testing, Prevention, and Treatment

### Because needle sharing is the primary HIV risk, needle and syringe programs are an important part of a comprehensive prevention approach for PWID.<sup>4</sup>

Such programs have been found to be effective and cost-effective for reducing injection-related risk behaviors and the spread of HIV. Due to lower sexual activity among PWID, drug-injecting behaviors should remain the focus of any harm-reduction programs; for those within regular partnerships, condom use and PrEP can be incorporated into prevention.<sup>4</sup>

**Because PWID prioritize obtaining drugs, the time involved in healthcare and prevention is a significant cost to them. Community-based outreach that helps PWID overcome time-based barriers (such as having to wait in line) may be effective.<sup>16</sup>**

To avoid the symptoms of withdrawal, PWID often need to invest most of their time in obtaining money to buy drugs; any time spent in line at a clinic is thus a significant cost. To encourage PWID to seek care, some clinic routines give queue priority to PWID who are accompanied by an outreach worker, while others provide transportation assistance to clinics. These kinds of time-saving incentives may be effective in reaching PWID. That's also why community-based drop-in centers may provide the best ease of access.

The research for the PWID profile was largely based on three studies in Kenya conducted between 2011 and 2017. Most of the data were collected from urban settings. The number of participants in the studies varied from 100 to 169; all three studies included both men and women but were made up of a majority of male participants. The average age of the participants across the three studies was early 30s. Methods of data collection included both qualitative interviews and quantitative surveys. (Tun, W. et al. 2015 ; OPTIONS Market Intelligence Report: Kenya 2019 ; Guise, A et al. 2016)

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