Makerere University
College of Health Sciences
SCHOOL OF PUBLIC HEALTH

"Life is not built from blue-prints"
Insights into Substance Use Disorder Treatment Journeys, Quality of Life and Recovery in Sub-Saharan Africa, Uganda– Qualitative Exploration

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Study team

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Global burden of disease attributable to alcohol and drug use

- World Health Organization Report highlights:
  - 2.6 million deaths per year were attributable to alcohol consumption
  - 0.6 million deaths to psychoactive drug use.
- 400 million people (7% of global population > 15 years) have alcohol use disorders.
- GBD 2021
  - High alcohol use contributed 72.3 million DALYs and ranked 11th among 88 Level-2 risk factors.
  - Drug Use ranked 6th among Level-2 risk factors for DALYs in 2021

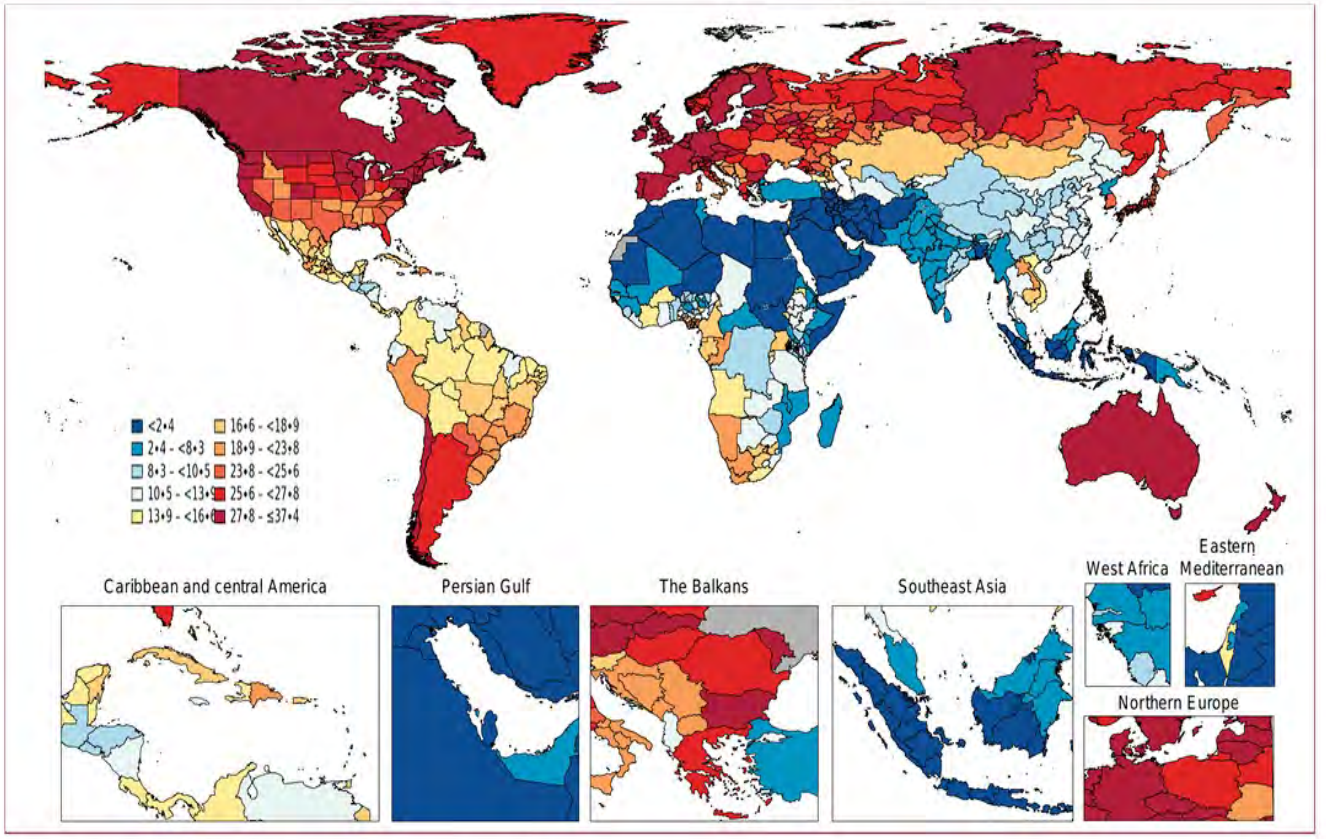


Figure 3: Age-standardised all-cause SEV by location, both sexes combined, 2021

Source: GBD 2021, Global Health Metrics

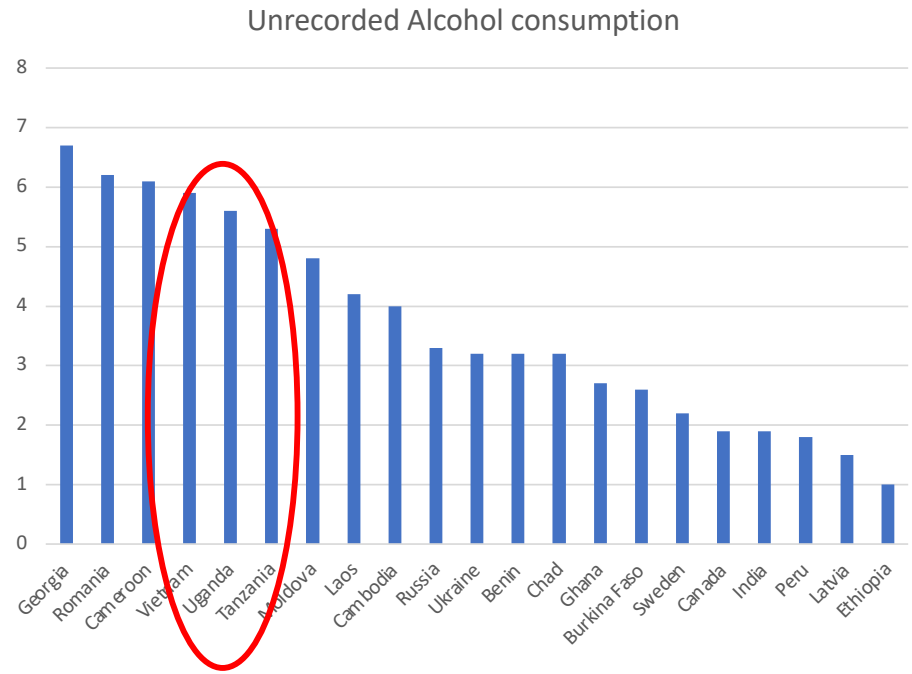
Alcohol Use in Africa, Uganda

- Alcohol use is socially acceptable and is embedded in social,and cultural life
- Most of alcohol consumed is “unrecorded”
- Production by fermenting malted grains, fruits, sugar cane or by distilling them

CRIME

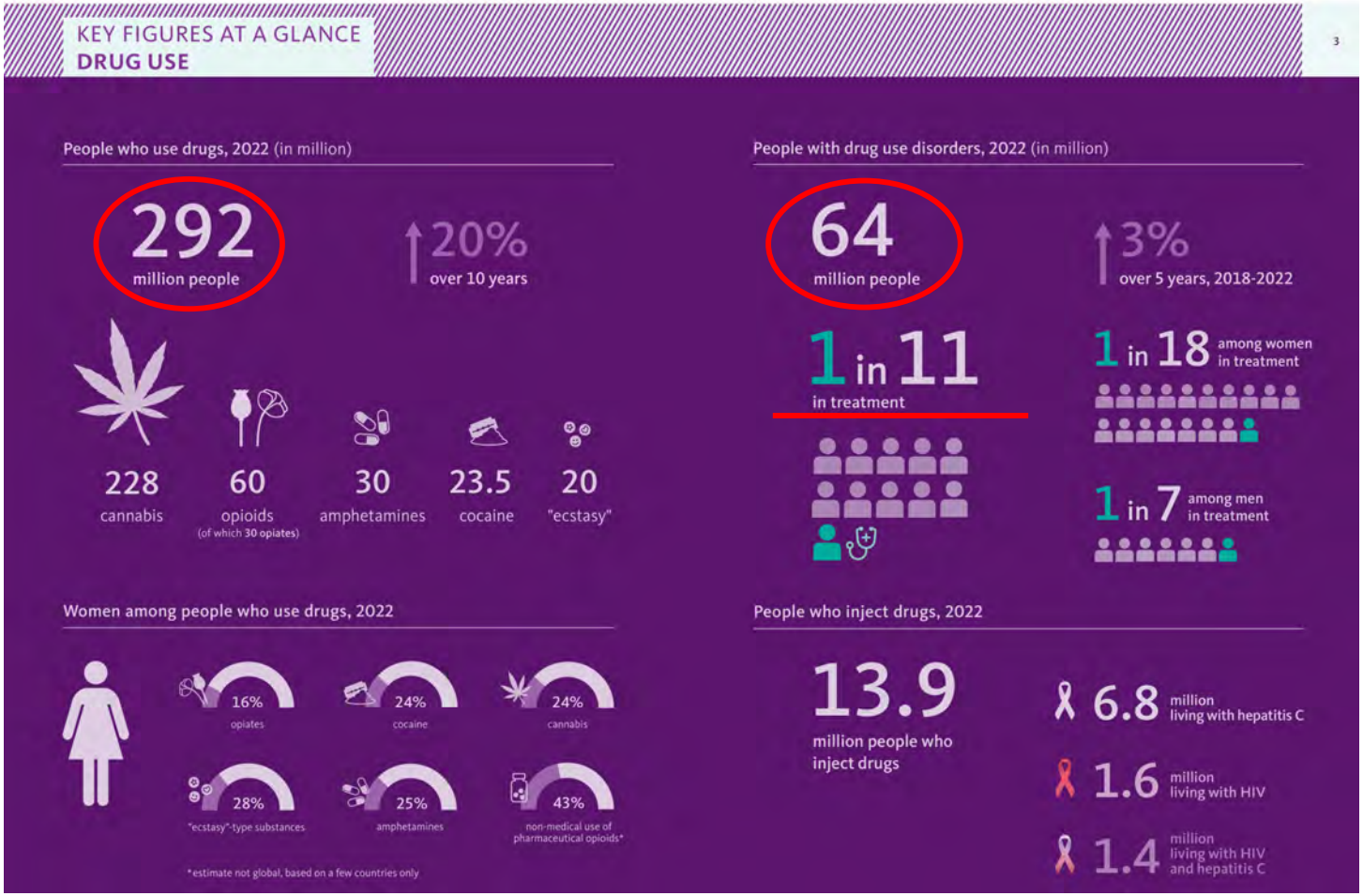
Enjoyment Gone Wrong; Locally Manufactured Waragi Kills 12, Leaves 20 Hospitalised...

Published 2 years ago on August 22, 2022
By **Grapevine News**



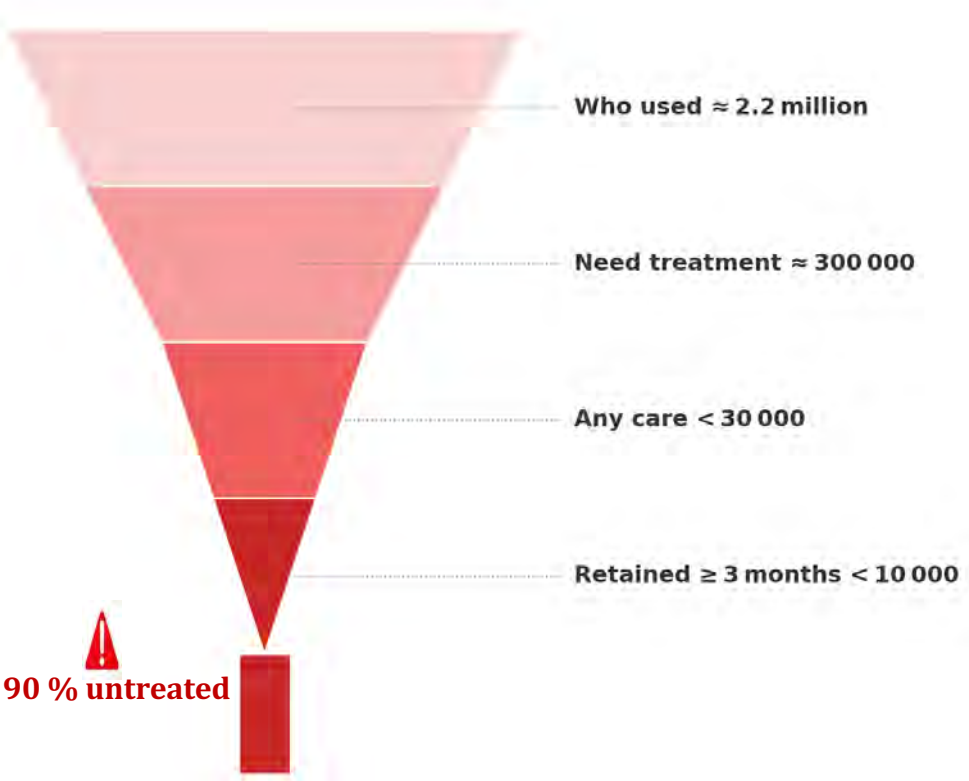
UNODC World Drug Report 2024: Global snapshot on burden of drug use

- 292 million people ≈ 1 in 18 adults worldwide use drugs
  - up 20 % increase in ten years
- 64 million people live with a drug-use disorder
- Only 1 in 11 receives evidence-based treatment



Treatment Coverage in Africa and Uganda

	TREATMENT COVERAGE	PRIMARY DRUG	PATHWAY OF REFERRAL
Africa	2.8% of people with Drug Use Disorders in treatment in 2022	Cannabis is most common, followed by Opioids	Referral by friends and family and self referral are most common
Americas	10.7% of people with Drug Use Disorders in treatment in 2022 – 7.5% for women, 13.1% for men	Opioids is most common, but ATS and cannabis are also significant	Varies across subregions but referral from other health care service is more common than in other regions
Asia	5.1% of people with Drug Use Disorders in treatment in 2022 – 1.9% for women, 10.5% for men	Amphetamine-type stimulantsis most common, followed by Opioids	Criminal justice system is the most common pathway of referral
Europe	25.9% of people with Drug Use Disorders in treatment in 2022 – 13.6% for women, 29.9% for men	Opioids is most common	Self referral and referral by friends and family are the most common
Oceania	14% of people with Drug Use Disorders in treatment in 2022 – 12.5% for women, 14% for men	Amphetamine-type stimulants is the most common, followed by Cannabis	Different pathways of referral observed

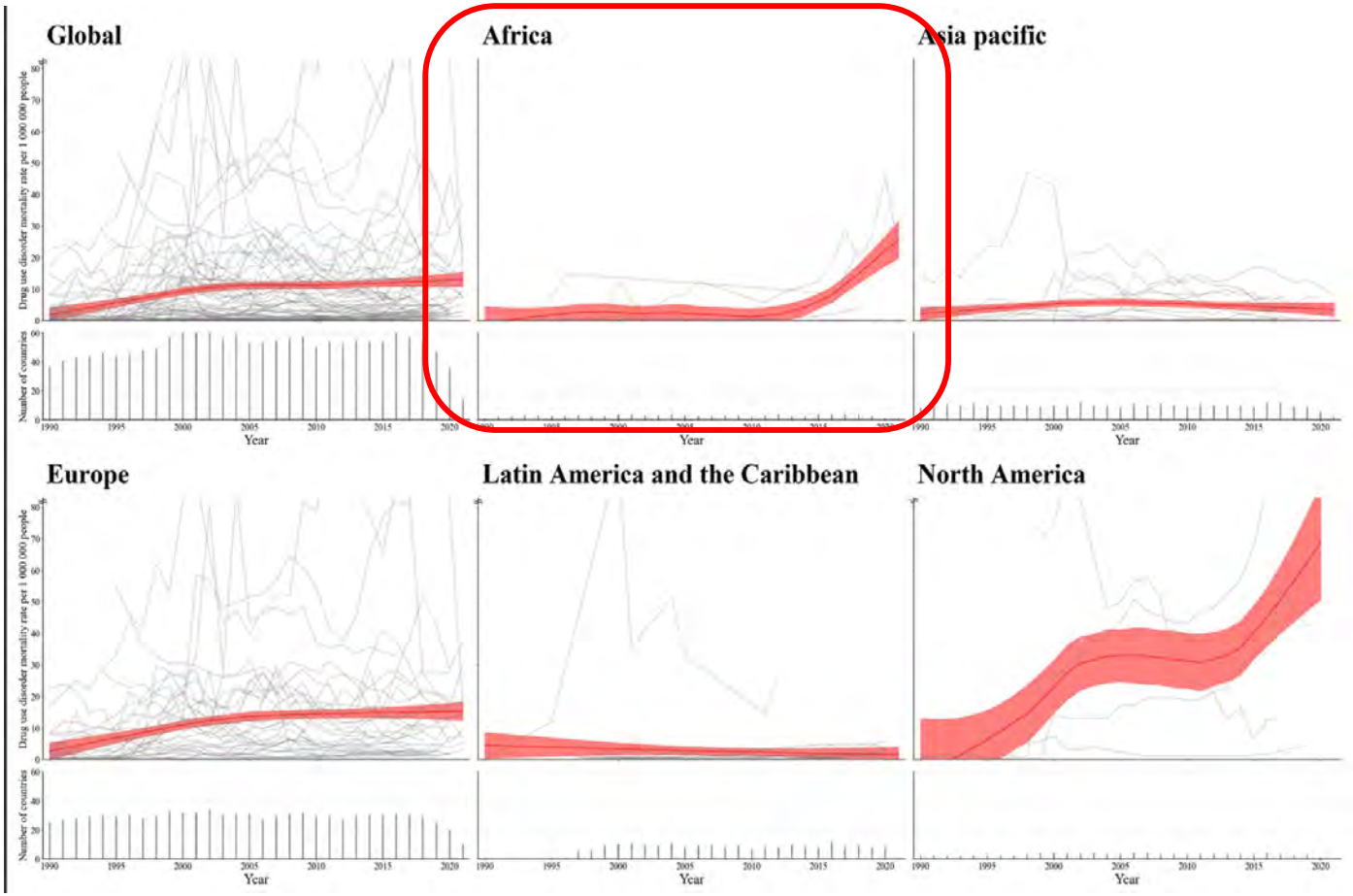


Uganda's treatment coverage **≲ 10 %** of need

World Drug Report 2024

† Estimates derived from STEPS 2014 prevalence national mentalhealth programme data

Age-standardised DUD mortality rate across the globe



- Drug DALYs have risen in Africa since 1990 and currently higher than global average
- Number of drug users in SSA expected to increase by nearly 150% by 2050
- Main drivers: opioid dependence, unsafe injecting & stimulant use disorders.

Drug harm is no longer "low" in Africa; it rivals malaria for young-adult mortality in some areas

Source:
Global, regional, and national trends in drug use disorder mortality rates across 73 countries from 1990 to 2021, with projections up to 2040: a global time-series analysis and modelling study Kim, Soeun et al. eClinicalMedicine, Volume 79, 102985
IHME. Global Burden of Disease 2021 – Drug-use disorders

Emerging drug trends in Africa

Sierra Leone declares emergency over drug kush - made from human bones

5 April 2024

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Umaru Fofana
BBC News, Freetown

The silent epidemic of drug abuse in Uganda

Wednesday, April 16, 2025

A man smokes marijuana during the informal cannabis holiday on April 20, 2017. A new Monitor investigation reveals that narcotic drugs get into different university gates through drug dealers called plugs. PHOTO/REUTERS

SOUTH AFRICA

Pregnant mom hooked on nyaope

BY ZOE MAHAPO - 25 May 2018 - 11:23

'Bluetooth' nyaope addicts ask for help to get off the drug

BY TMG DIGITAL - 01 March 2017 - 19:05

Nyaope addicts with syringes in their arms Picture credit: Judas Hlongwane

Chemical profiling of the street cocktail drug 'nyaope' in South Africa using GC–MS I: Stability studies of components of 'nyaope' in organic solvents

P.M. Mthembi [a b], E.M. Mwenesongole [a c], M.D. Cole [d]

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https://doi.org/10.1016/j.forsciint.2018.08.001

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Highlights

- Nyaope, is a major drug of abuse unique to South Africa.
- The major components of nyaope are, cannabis, heroin and antiretrovirals.
- Major components, in combination, are more stable in *t*-butanol for up to 72h.
- Chemical profiling of the major components of nyaope using GC–MS is possible.

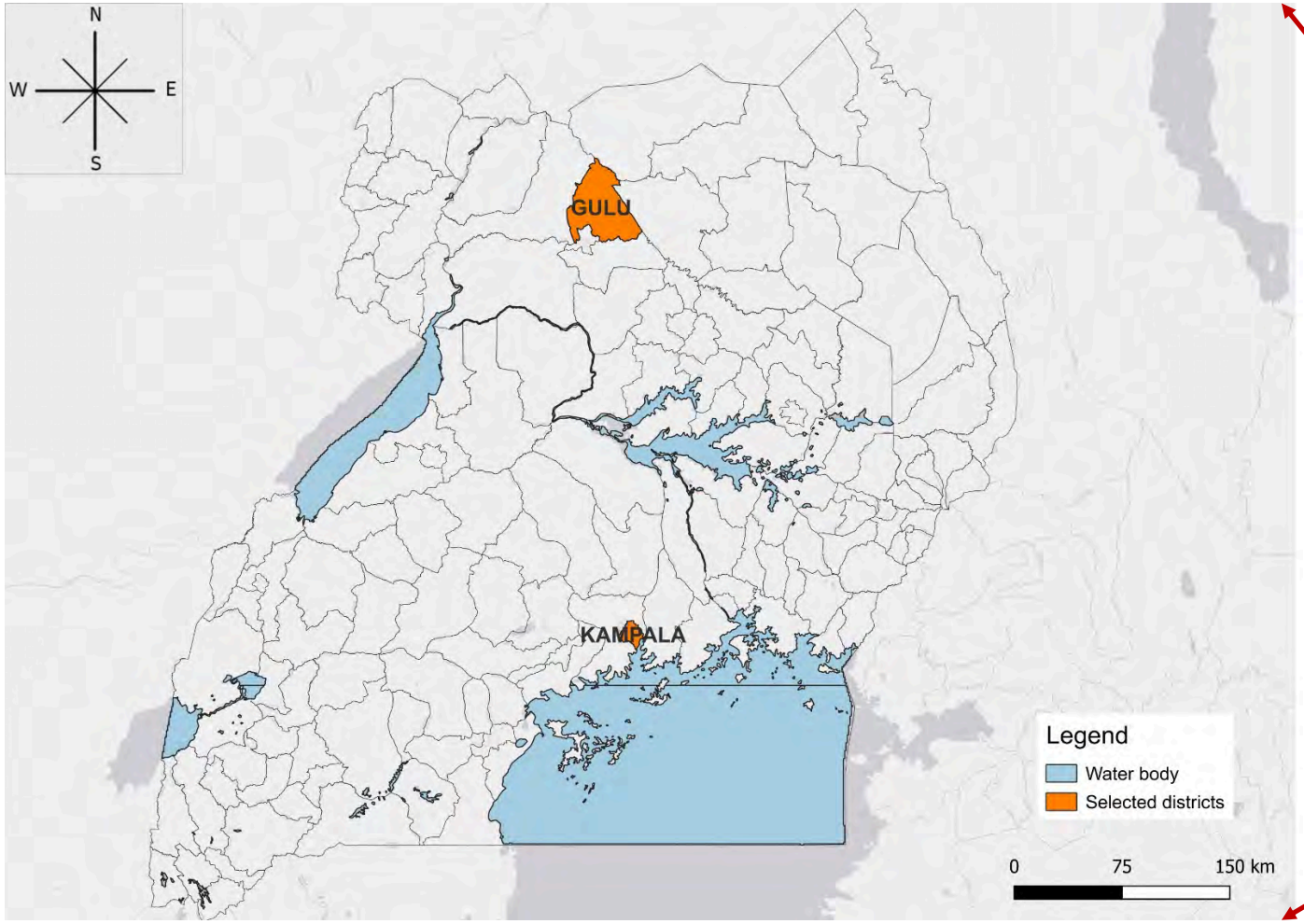
Objectives of our study

Aim: Explore and synthesize how individuals with substance-use disorder (SUD) and their health-care providers experience, and navigate treatment in Uganda focusing on recovery capital, quality-of-life change, and the multilevel factors that shape treatment outcomes

Specific objectives

1. To explore clients' lived experiences along the SUD treatment pathway in Uganda, covering entry into care, the quality and continuity of services received, and perceived changes in everyday functioning and quality of life.
2. To identify factors that participants and their health-care providers perceive as precipitating relapse or, conversely, sustaining long-term recovery.
3. To generate context-specific recommendations for a more holistic SUD-care model by analysing gaps in current services (e.g., counselling, medication supply, spiritual support) and highlighting practices that participants view as most helpful.

Study Area - Uganda



Methods: Overview

Aspect	Key Details
Design	Qualitative, constructivist-grounded approach using 18 in-depth interviews (IDIs) with service-users and 10 key-informant interviews (KIIs) with frontline staff. Analysis guided by Interpretative Phenomenological Analysis (IPA).
Sampling & frame	Drawn from a parent cohort of 443 SUD clients attending 3 Ugandan treatment centres (Kampala & Gulu).
Eligibility	Service users eligible: ≥ 18 yrs, DSM-5 SUD diagnosis, engaged with treatment ≤ 12 m ago. Excluded acute psychosis / severe cognitive impairment. Service providers: Employed a purposive sampling strategy to recruit healthcare workers directly involved in the treatment and care of individuals with SUD at the study sites
Sampling	Computer-generated random list from parent cohort : invited 20 → 18 service users consented (90 %). Eight face-to-face interviews were conducted with healthcare workers
Approach	Explorative, semi-structured in-depth interviews (IDIs / KIIs) at 2 public facilities. ▪ 45–60 min, private rooms, audio-recorded, verbatim transcripts; field notes for context

Data Analysis

- Data were analyzed using a thematic analysis approach (six-step framework by Braun and Clarke.)
- Transcripts read multiple times by two independent researchers with backgrounds in psychology and public health
- The two researchers then independently coded the transcripts.
- Interviews from service users and healthcare workers were analyzed separately in the initial stages to preserve context-specific meanings.
- Initial codes were generated manually and with the aid of qualitative data management software NVivo.
- A structured coding tree was developed collaboratively and refined through discussions to generate codes and sub-themes and themes derived inductively from the data
- Researchers engaged in integrative mapping to identify cross-cutting meta-themes that spanned both participant groups

Participant Characteristics & Substance Use Profile

	Service-users (n = 18)	Providers (n = 10)
Sex	Male ♂ 15 (83 %) Female ♀ 03 (16 %)	Male ♂ 7 (70 %) Female ♀ 3 (30 %)
Age	Mean 31 yrs (range 19 – 41)	Median 34 yrs (range ◆–◆)
Primary substance	Alcohol 11 (61 %) Cannabis 4 (22 %) Sed-hypnotics 1 (6 %) Illegal opioids 1 (6 %) Legal opioids 1 (6 %)	—
Role	—	Clinical psychologist 4 Psychiatric nurse 2 Counsellor 2 Community-health worker 2

Theme 1: "Running on Empty": Structural & Resource Constraints

Sub-theme	Key points	Quote
Human-resource gaps	▪ Shortage of providers VS large SUD patient population ▪ Lack of specialized staff ▪ Dual responsibilities ▪ Inadequate training	*"* *"Human Resource is one of major challenges we face here at the unit, for example, there is no attached counsellor or psychologist at the unit. So as the clinical team we try to fill up these gaps but haphazardly. (28 year old Male, HCW7)*
Structural and Security limitations of treatment facilities	▪ Absence of therapeutic areas hinders comprehensive care ▪ Lack of security or perimeter control causing unrestricted access to external environments ▪ Poor sanitation infrastructure	*"Our unit here is an open space, patients come in and go out whenever they want. Some of them actually sneak in these substances and so we are trying to do detoxing, but the person is taking in more of the substances." HCW* *"The toilets keep blocking and they become very dirty, so it is very uncomfortable to be admitted here…." (SU)*

"Running on Empty"

Theme 1: Structural & Resource Constraints

"Running on Empty"

Sub-theme	Key pain-points	Quote
Medication & supply stock-outs	▪ Frequent Drug Stockouts & unreliable availability of essential SUD medications. ▪ Treatment Discontinuation due to unmet pharmacological needs.	*"It becomes hard when you do not get medication from here, you go away when you feel like you have not been helped at all"* *"Sometimes drugs get over and we struggle to buy them." (SU)"*
Weak district health-system capacity	▪ Lower-level facilities lack skilled providers ▪ SUD treatment is centralized at regional hospitals ▪ Rural populations face barriers due to distant services and high transport costs ▪ Many patients seek treatment only at advanced stages of substance use disorders	*" From general hospital right to Health Centre II are not helping. People by-pass all those levels and come to the regional referral and yet the distance and transport costs are very high, they come from far villages."*

Theme 2: Fragmented, Symptom-Focused Care

Sub-theme	What it looks like	Quote
Symptom Centered Care and Gaps in Comprehensive SUD Management	▪ SUD care primarily focuses on acute withdrawal, detoxification, and stabilization ▪ Treatment is symptom-based, overlooking root causes of substance use	*"They told us the doctor would counsel us, I waited in vain." (SU)* *"….so, all we do is wait for her (patient) to come back to the facility and continue managing the psychotic symptoms. (HCW)*
One-size-fits-all	▪ "One Size Fits All" similar protocol used regardless of patient variability. ▪ Uniform treatment fails to address root causes, leading to incomplete recovery and relapse cycles.	*"We fail to classify and treat them in the one-size-fits-all way." (HCW)*

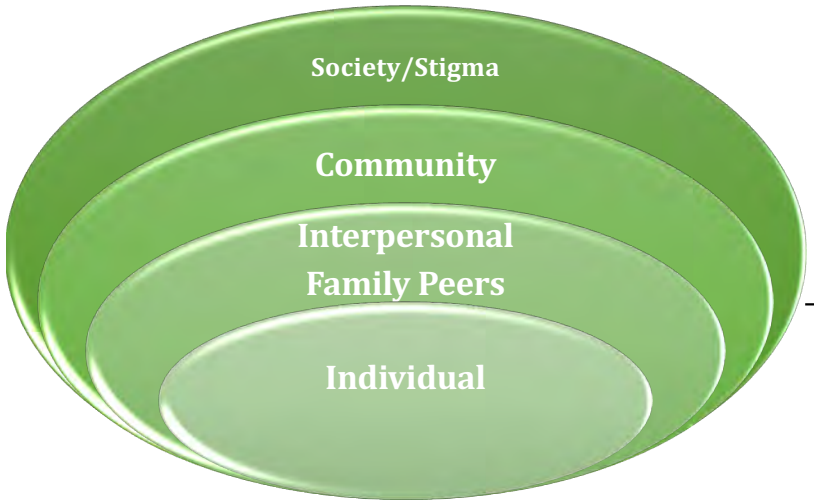
"Patching the Leaks, Not the Roof

Theme 2: Fragmented, Symptom-Focused Care

Sub-theme	What it looks like	Quote
Insufficient In-Patient Duration and Lack of Post-Discharge Follow-Up in SUD Care	▪ Patients discharged prematurely ▪ Limited recovery planning for psychological and behavioural intervention ▪ No follow-up or monitoring of patient recovery after discharge ▪ Aftercare systems are passive, relying on patients to return on their own	*"Two weeks is not sufficient… we just have wait for them to come back." (HCW)*
Unmanaged side-effects & medicine dependence	▪ Non-adherence to treatment plan ▪ Side effects; Erectile Dysfunction, Difficulty sleeping, Sedation, Forgetfulness, etc ▪ Requests for 'drug holidays'	*"I feel addicted to these tablets … they make me forget." (SU)*

"Patching the Leaks, Not the Roof

Theme 3: "Life Beyond the Ward": Social Ecology of Use, Stigma & Support "



Sub-theme	What it looks like	Quote
Stigma & moral labelling	▪ Use of stigmatizing terms (e.g., "addict," "abuser") reinforces harmful stereotypes ▪ Self stigma, leading to shame, isolation ▪ Health workers' moralistic attitudes and language worsen patients' self-stigma ▪ Individuals with SUDs seen as moral failures ▪ Language in support programs like AA may discourage participation	*"When you have people who are generally, judgemental, then you wish to have a beer first. You reach home and your wife starts shouting... Now you've gone back to drinking and others are just there discouraging you, your mother says... I knew you didn't want to do it, you would not make it. This is my thing now. So it is a very complicated... it is a very very complicated... It is a very complicated thing."*
Inconsistent Family Support and Lack of Structured Family Involvement in SUD Care	▪ Family support (some are supportive, others withdraw or disengage_ ▪ Feelings of judgment, rejection, and negative family dynamics discourage patients ▪ Family members (e.g., children, spouses) can motivate recovery efforts ▪ Families lack education on SUDs, and no structured family sessions are provided	*……Some are even brought in by good Samaritans and for some the families have already taken in enough of the addiction that they only drop them here at the facility."* *"Children are the reason I decided to stop." (SU)*

Theme 3: “Life Beyond the Ward”: Social Ecology of Use, Stigma & Support ”

Sub-theme	What it looks like	Quote
Environmental and Peer-Driven Triggers	▪ Easy availability of substances in the community ▪ Some individuals rely on substance-related livelihoods ▪ Peer influence and social circles normalize substance use and provide access to drugs ▪ Lack of community-based relapse prevention programs	*““I have a patient who is always coming back to the facility with alcohol induced psychosis… her employment is brewing local alcohol brew where she earns a living and pay for school fees for her children. She usually tells me that you cannot sell what you have not tasted.”* *“After leaving the hospital, I started taking alcohol because of ….. being around people who drink also just encouraged me to drink” SU*
Social and psychological triggers	▪ Social isolation and lack of supportive relationships hinder reintegration ▪ Employment and financial instability ▪ Daily stress reinforce triggers ▪ Interpersonal conflict	*“…So the alcohol I drink is not because I want but because there is nothing I can do about it. The situations have forced me to resort to it. Because I am tired, I am very stressed.” SU*
Comorbid mental & physical illness	▪ Co-occurring mental health conditions ▪ Chronic medical conditions complicate SUD management ▪ Multiple addictions, but treatment typically addresses only one substance	*“Medical comorbidity, if overlooked, creates complicated situations.” (HCW)* *And I have a pre-existing condition so it also stressed me out too….”SU*

Theme 4:– Social, Spiritual, and Community Anchors of SUD Recovery ”

Instrinsic and spiritual motivation

- Religious practices and spiritual identity are key motivators
- Weak psychosocial and spiritual support systems are linked to relapse rates
- Involvement of pastors in recovery support

“...I started spiritual counselling, pastors really helped me, and gave me advice, and I continue to receive this spiritual counselling because I am now part of the church”

Active Coping and Lifestyle Change

- Staying busy through physical activity
- Adopting new, structured routines that replace substance-related behaviors
- Purposeful work such as farming, small businesses

“...I go running in the morning and in the evening so I forget about everything that was going on, like if you were thinking about going and taking opium, I will now not take but continue doing my own things and just keep myself busy.

Family Engagement for SUD Recovery

- Sense of responsibility toward family, especially children drives recovery
- Incorporate family counselling into the care of the patients

“...I feel the medical team should provide more education to the family of patients who come to hospital to understand the dangers of taking alcohol and its negative effects in a person’s life

Community

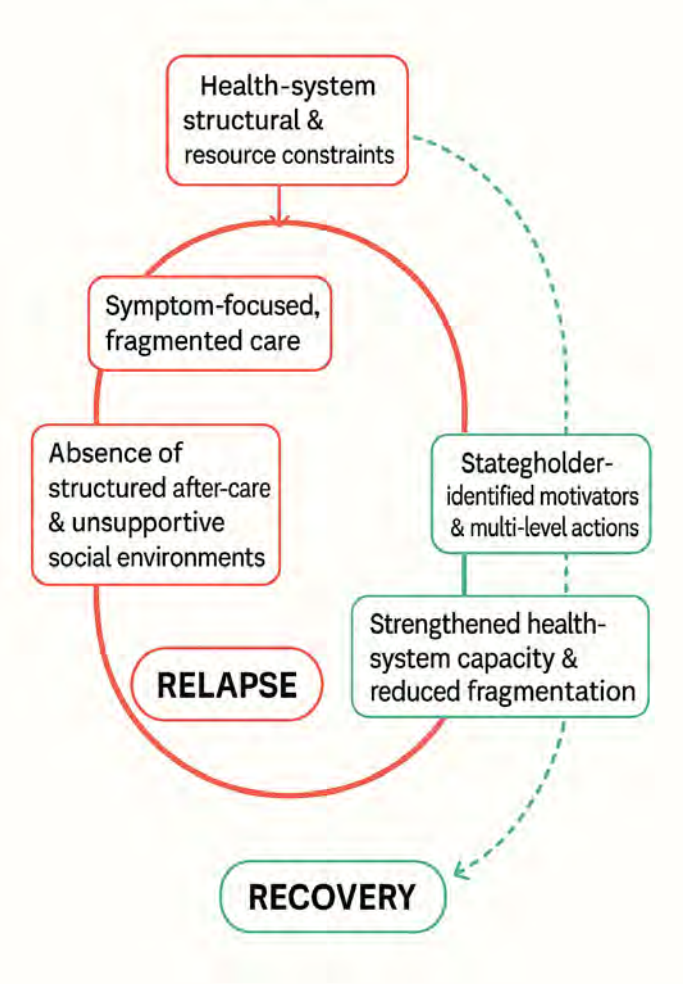
- Engage VHTs and CBOs to enhance recovery and outreach support
- Leverage community support groups led by expert clients
- Launch anti-stigma campaigns to support reintegration

“Have ambassadors go out from the ones that recover.“

Systems

- Create Safe Therapeutic Environment
- Need for trained addiction professionals to provide evidence-based care.
- Ongoing education for existing healthcare staff to manage SUD complexities
- Effective referral system essential
- Holistic Care Models also integrating mental and physical health services into SUD care plans

Conclusion: Self-reinforcing Cycle for Relapse



- Structural and resource constraints lead to;
- Symptom-focused, fragmented care;
- Patients then re-enter unsupportive social environments
- Stakeholder-identified motivators and multi-level actions suggested as having the potential to interrupt this cycle and support sustained recovery

Limitations

- Findings illustrate lived realities in two Ugandan treatment centres; they are transferable, not statistically generalisable.
- Men were over-represented (83 % of SUs); women and stimulant users may face different barriers.
- Potential socio-desirability bias mitigated by private interviews, reflexive probing and triangulating SU vs HCW narratives
- Language translation (Luganda/Acholi to English) may have caused some subtle details to be missed.


THANK YOU