BARRIERS ENCOUNTERED BY PEOPLE WITH SUBSTANCE USE DISORDER IN ACCESSING MEDICATION ASSISTED TREATMENT IN DODOMA MUNICIPALITY

A CASE OF ITEGA MAT CLINIC-DODOMA

DISSERTATION SUBMITTED TO THE INSTITUTE OF SOCIAL WORK IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER'S DEGREE IN SOCIAL WORK

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CERTIFICATION

The undersigned certifies that they have read the entire work and recommend for acceptance by the Institute of Social Work (ISW) a dissertation titled ***Barriers Encountered by People with Substance Use Disorder in Accessing Medication Assisted Treatment (MAT) in Dodoma Municipality,*** in partial fulfillment of the requirements for the Award of Master's Degree in Social Work.

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Dr. Peter Mgawe
Supervisor

Date…….…….

DECLARATION

I, VENANT MLIGO, declare that this dissertation is my own original work and that the technical assistance I received is detailed and acknowledged. No part of this dissertation is being submitted to any university or institution. References have been provided where the work of others has been used.

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Signature

ACKNOWLEDGEMENT

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ABBREVIATIONS

AU	:	Africa Union
CDC	:	Centers for Disease Control
COWs	:	Community Outreach Workers
DCEA	:	Drugs Control and Enforcement Authority
HBM	:	Health Belief Model
IDI	:	In–Depth Interview
MAT	:	Medication-Assisted Treatment
NACADA	:	National Authority for the Campaign Against Drug Abuse
NGO	:	Non-Governmental Organization
SAMHSA	:	Substance Abuse and Mental Health Services Administration
SUD	:	Substance Use Disorder
UN	:	United Nations
UNODC	:	United Nations Office for Drugs and Crime
WHO	:	World Health Organization
MoH	:	Ministry of Health
FGD	:	Focused Group Discussion

ABSTRACT

The aim of this study was to explore the barriers encountered by people with substance use disorders (SUD) in accessing Medication-Assisted Treatment (MAT) services in Dodoma Municipality by assessing their awareness, examining perceptions influencing treatment-seeking behaviour, and identifying systemic obstacles associated with treatment delivery procedures. Methodologically, the study adopted an interpretivist philosophy and employed a qualitative research approach with an exploratory design. The study was conducted in Dodoma Municipality and targeted individuals with SUD and healthcare providers involved in MAT service delivery. Purposive sampling was used to select eighteen participants (18). This included fifteen (15) people with SUD and three (03) healthcare providers. Data were collected through in-depth interviews and focus group discussions, while secondary data were drawn from clinic reports, MAT guidelines, and clinical procedure documents. Thematic analysis guided the interpretation of data. The key findings revealed that MAT awareness was generally low and mostly acquired through peers rather than formal education. Misconceptions were widespread, including the belief that methadone substitutes one addiction for another. Procedural barriers such as lengthy registration processes, strict eligibility criteria, and limited-service points discouraged treatment initiation and contributed to high dropout rates, while stigma and mistrust of formal healthcare services further reduced MAT uptake. In conclusion, access to MAT is hindered by informational, attitudinal, and systemic challenges. The study recommends expanding MAT clinics to underserved areas, strengthening community sensitization, simplifying enrolment procedures, and enhancing government-NGO partnerships to improve MAT uptake, retention, and long-term recovery outcomes.

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CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE PROBLEM

1.1 Introduction

This chapter includes a background of the study, the statement of the problem, the objectives of the study, the research questions, and the significance of the study.

1.2 Background of the Problem

The problem of substance use disorder (SUD), in particular, opioid dependence, has already turned out to be a worldwide health crisis, with an increasing number of victims and associated deaths. Worldwide, over 296 million individuals took drugs in the year 2021, and 60 million were indicated to be experiencing opioid dependency (UNODC, 2023). Medication-Assisted Treatment (MAT) is a scientifically established treatment method of substance use disorder (SUD), especially opioid dependence, which involves the use of approved medications like methadone, buprenorphine, and naltrexone, together with counselling and behavioural treatments. Despite being a globally recognized evidence-based intervention, the accessibility and consistent uptake of Medication-Assisted Treatment (MAT) remain critically low across international, regional, national, and local contexts. The goal of MAT is to decrease the withdrawal symptoms, to prevent the relapse, and assist in long-term recovery and rehabilitation (Substance Abuse and Mental Health Services Administration [SAMHSA], 2022). It is generally accepted as an evidence-based intervention that enhances the survival of patients, retention of treatments, and social functioning (SAMHSA, 2022).

Globally, Medication-assisted Treatment (MAT) is established as an evidence-based intervention for SUDs; improving treatment retention and reducing health and social harms associated with opioid dependence. Yet, despite solid clinical support for MAT, access to the treatment is severely limited. Barriers, including stigma, regulations of drugs, limited treatment capacity and coverage and infrastructure, the scarcity of qualified service providers and financial barriers as well as geographical access continue to be responsible for a failure in delivery effective MAT services to people in need in many parts of the world (Mancher & Leshner, 2019; United Nations Office on

Drugs and Crime & World Health Organization, 2020). This means there is a large worldwide treatment gap between MAT's demonstrated efficacy and the number of people who can access it and remain in the MAT service uptake until totally recovered.

Nationwide implementation of MAT programs has been adopted by such countries as the United States and Canada to decrease the opioid crisis, though with obstacles concerning overdose fatalities and fentanyl abuse (CDC, 2023; Government of Canada, 2023). Opioid dependence is especially high in Asian countries such as India and China because both countries are close to regions that produce heroin. Approximately 8.5 million users of opioids are estimated to be in India, 3 million of whom are heroin dependents (India Ministry of Social Justice and Empowerment, 2022), and approximately 2.3 million users are registered in China (Ministry of Public Security, China, 2022). Medication-Assisted Treatment (MAT) programs have been implemented by both governments, but their availability is still scarce, particularly in rural and underserved regions. Across India, opioid agonist maintenance treatment (OAMT) centers offering buprenorphine-based treatment are estimated to be 67 percent, which cover approximately 5,800 individuals who inject drugs, as well as 11 government hospital-based centers offering MAT through NGOs. India has also pioneered five methadone maintenance clinics in the major cities (Ambekar et al., 2013).

By 2009, the China government had put in place approximately 680 methadone maintenance treatment (MMT) clinics in 27 provinces with over 242,000 enrolled opioid users (Yin et al., 2010). Despite this tremendous growth, the total coverage is low. The global harm reduction monitoring data show that 18 of every 100 persons with SUD can get opioid agonist therapy (Stone et al., 2023). Although South Asia demonstrates a bit more than average MAT coverage than other areas, systematic issues like underdose, stigma, low retention, and low integration with psychosocial services remain a barrier to effective and equitable delivery of MAT (Larney et al., 2017).

In Africa, the number of MAT services is scarce, and 1 in 18 individuals with SUD can only be found in large urban centres because of the lack of proper healthcare facilities, policies, and stigma (WHO, 2020; UNODC, 2022). Despite some countries providing OST, MAT clinics are scarce throughout the continent and are largely concentrated in limited metropolitan centers (Harm Reduction International, 2016). Political reticence,

regulatory constraints, suboptimal pharmaceutical supply lines, and an adherence to a punitive approach to drug use all maintain supply and uptake of MAT programmes at lower levels.

Approximately 60 million individuals in Africa are estimated to have issues related to drugs, with cannabis and opioids being the most frequently used drugs (African Union, 2022). According to Nigeria, 14.3 million individuals (14.4% of the population aged 15-64) are drug users, with 4.6 million opioid users (UNODC, 2022). South Africa has one out of five patients in rehabilitation centers who are addicted to heroin or synthetic opioids (South African Network of People Who Use Drugs, 2022). MAT programs are new; a few countries, like Tanzania, Kenya, South Africa, and Morocco, have them. Even though the number of individuals experiencing drug-related issues throughout the continent has been estimated to be 60 million, the coverage of MAT is incredibly low (African Union, 2022). As an example, in Nigeria, where it is estimated that there are 14.3 million drug users, 4.6 million of them opioid users, the MAT programs have yet to be launched (UNODC, 2022). South Africa is among the most developed countries of the continent in terms of the delivery of the MAT; approximately 12,000 patients are served in the country (Market Growth Reports, 2024). Nevertheless, systemic issues such as a low level of the health systems, shortage of trained staff, and stigma are serious constraints to MAT accessibility within the region (WHO, 2020; UNODC, 2022). Access to MAT in Africa is very limited because of both structural and policy challenges. Even though several countries have implemented opioid substitution therapy, the number of clinics providing MAT in Africa is very limited, and services are mainly concentrated in a few large urban centers (Harm Reduction International, 2016). The supply of medicine is affected by political hesitancy, regulatory limitations, weak medicine supply chains, and the predominance of punitive rather than health-based responses to drug use, which, together, cause a further decrease in the availability and utilization of MAT programs. Besides that, a large proportion of stigma and fear of being penalized prevent many people from going to treatment, thus maintaining low coverage rates and leading to a high prevalence of SUD that is not treated in the region (United Nations Office on Drugs and Crime & World Health Organization, 2020).

In Tanzania, the government developed MAT in 2011, which first started in the coastal areas, including Dar es Salaam and Zanzibar, as a harm-reduction measure against

increasing heroin consumption and HIV transmission (DCEA, 2021). The use of substances in Tanzania, especially heroin, has been on the rise in the country, especially in the coastal parts of Tanzania, including Dar es Salaam, Tanga, and Zanzibar. According to the Drug Control and Enforcement Authority (DCEA), the shipment of heroin has risen as a result of the geographical position of the country in the drug trafficking route along the Indian Ocean (DCEA, 2021). Nevertheless, 1 out of 10 have used medical help or rehabilitation (Mbwambo et al., 2020). Dar es Salaam has around 12 MAT clinics nationwide, including Mwananyamala, Temeke, Tanga, and others (Kidia et al., 2022; Mbwambo et al., 2020). For example, as of 2023, the Tanga clinic alone had more than 500 clients (UNODC, 2023). The retention rates differ from one clinic to another.

In Dar es Salaam, some clinics had shown a retention rate of 64 to 73 percent in the past 12 months (Kidia et al., 2022). Even with this development, MAT services are still mostly urban-oriented and have several issues, such as congestion, excessive waiting time, stigmatization, insufficient awareness, and absence of integrated services like mental health or HIV care (Mbwambo et al., 2020; MedCrave, 2023). In Tanzania, over the last ten years, the implementation of MAT services has been a gradual process, and these services have been extended to different areas, but there are still problems of access to them. The majority of MAT clinics are located in big cities, mainly in Dar es Salaam, and therefore people living in the other regions of the country have hardly any access to these services (Mlaki et al., 2022). The problem of going to the clinic every day, the money for the means of transport, the lack of psychological support, and the low number of addiction specialists even among those who live close to the facilities and visit them regularly are the reasons for which access to treatment and its continuity constitute great challenges (Mlaki et al., 2022; Ubuguyu et al., 2016). The stigma that has always been associated with drug use influences the demand for care and thus many people who are dependent on opioids in Tanzania and have not been given any treatment, although there are effective interventions, remain invisible.

Dodoma Municipality is a fast-developing urban center and the political capital of Tanzania, and substance use is also increasing. Every 1 in 10 people is diagnosed with SUD on average, and the use of heroin increases (Kalungi, 2022). In reaction, the government created the Itega MAT Clinic in Mirembe National Mental Health Hospital,

which was supposed to be a strategic facility in the country to deliver MAT and aftercare programs. Despite such an intervention, the area still has high dropout, low uptake, and systemic and individual-level barriers to access MAT.

This research is thus based on the context of rising SUD epidemiology and the lack of use of MAT services in Dodoma. The study is timely and adequate to fill the gap in knowledge of awareness and perceptions, as well as procedural issues, on the way to improving access to and retention of MAT treatment.

1.2 Statement of the Problem

Tanzania introduced Medication-Assisted Treatment (MAT) in 2011 as a national strategy to address the growing problem of substance use disorders (SUD), particularly opioid dependence, which has been increasing in urban areas such as Dodoma Municipality. Through this initiative, the government has established MAT centres, including the Itega MAT Clinic in Dodoma, to expand treatment access and support recovery efforts (DCEA, 2022). Despite these interventions, the utilization of MAT services remains very low, with less than 10% of people who use illicit drugs enrolled in MAT programs nationwide, and many individuals discontinue treatment prematurely (DCEA, 2022).

Relevant studies on MAT services have focused more on examining MAT service providers' performance and the effectiveness of the service, with limited attention to the MAT service accessibility for people with substance use disorder themselves (Kayungi, M., & Pessa, J. C., 2025). This raises questions about the accessibility of MAT services in meeting the treatment needs of people with SUD. It is unclear why service uptake remains low despite the presence of a national MAT programme and specialized treatment at Itega MAT Clinic. Furthermore, there is limited understanding of how people with SUD in Dodoma municipality perceive MAT services, the factors that influence their decision to seek or avoid treatment, and the reasons behind the high dropout rates observed in MAT programs.

Therefore, the study explored the key barriers affecting the accessibility and continued use of Medication-Assisted Treatment services among people with substance use

disorders in Dodoma Municipality, to generate insights that can inform policy and strengthen MAT service delivery and accessibility.

1.3 Objectives of the study

1.3.1 General Objective

To explore barriers encountered by people with substance use disorder in accessing Medication Assisted Treatment (MAT) in Dodoma Municipality.

1.3.2 Specific Objectives

i. To examine the awareness of MAT among individuals with substance use disorder in Dodoma Municipality.

ii. To explore the perceptions of people with substance use disorder toward MAT service in Dodoma Municipality

iii. To analyse the procedural challenges in MAT service provision that hinder the accessibility of MAT for people with substance use disorders in Dodoma Municipality.

1.4 Research Questions

i. How does the awareness of MAT influence the treatment of individuals with substance use disorders in Dodoma Municipality?

ii. How do people with substance use disorder perceive MAT in Dodoma Municipality?

iii. What are the challenging procedures governing MAT service that hinder the accessibility of MAT to people with substance use disorders in Dodoma Municipality?

1.5 The Significance of the Study

The research can make a significant contribution to several stakeholders. To the administrators of the MAT clinic, the program coordinators, and frontline service providers, it shows the difficulty experienced by clients in accessing and staying in

treatment, the service gaps and dropout factors, and what can be done to improve service quality, schedule flexibility, and follow-up process in patients. The results of this study provide evidence-based suggestions on the assessment and reconsideration of national substance use treatment strategies, the expansion of MAT in underserved areas like Dodoma, and the implementation of MAT in the context of the general public health policy. The research is also relevant to the literature on addiction treatment in Tanzania because it gives background data and guidance to future research, especially on treatment efficacy, policy execution, and community-based interventions to address addiction.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter defines the key terms that help guide the study. It also presents a theoretical review of substance use disorder (SUD) concerning medication-assisted treatment (MAT) services. The discussion has demonstrated that, in the context of the Health Belief Model, patients with SUD experience several obstacles that limit access to MAT services. Also, the available empirical evidence based on past research has always highlighted issues in the usage of the service and has highlighted significant gaps in literature. The current study was founded on these gaps.

2.1 Definitions of Key Terms

2.1.1 Substance Use Disorder

The United Nations Office on Drugs and Crime (UNODC) defines substance use disorder (SUD) as the harmful pattern of drug use that leads to clinically significant damage to a person's physical or mental health, or results in behavior that harms the health of others (UNODC, 2021). In this study, substance use disorder is defined as a chronic medical relapsing brain disease characterized by compulsive use of psychoactive substances such as alcohol, prescription medications, or illicit drugs, despite the presence of significant negative consequences in an individual’s social, physical, or psychological functioning.

This definition is used in the study because it aligns with internationally recognized public health and clinical standards, ensuring conceptual clarity and consistency with global research on substance use. The UNODC framework provides a comprehensive understanding of SUD by emphasizing both the behavioural and health-related consequences of substance use, which is essential for examining treatment needs and barriers to accessing care. Furthermore, defining SUD as a chronic, relapsing brain disease reflects current scientific evidence and supports the study’s focus on medication-assisted treatment as a legitimate clinical intervention rather than a moral or social issue. This definition is therefore appropriate for guiding the study’s analysis of

treatment-seeking behaviour, service accessibility, and recovery outcomes among individuals with SUD.

2.1.2 Medication-Assisted Treatment (MAT)

The World Health Organization (WHO) defines Medication-Assisted Treatment (MAT) as the use of medications, in combination with counseling and behavioral therapies, to provide a 'whole-patient' approach to the treatment of substance use disorders (WHO, 2021). In this study, Medication-Assisted Treatment (MAT) is defined as an evidence-based therapeutic approach for the treatment of substance use disorders (SUDs), particularly opioid use disorder, that combines the use of approved pharmacological medications with therapies.

This definition is adopted because it reflects the internationally accepted and evidence-based understanding of MAT as endorsed by the World Health Organization. It emphasizes the integration of medication with counseling and behavioral therapies, which aligns with the comprehensive treatment model currently implemented in Tanzania's MAT program. Using this definition ensures conceptual clarity by highlighting MAT as a clinically validated and holistic intervention rather than a medication-only approach.

2.1.3 People Who Inject Drugs (PWID)

The World Health Organization (WHO, 2016) defines People Who Inject Drugs (PWID) as people who use syringes to take psychoactive substances for non-medical purposes that include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives, and hallucinogens through intravenous, intramuscular, or other injectable routes. In this study, People Who Inject Drug (PWID) is defined as individuals who administer psychoactive substances by injection for non-medical purposes.

This definition is used because it is internationally recognized by the World Health Organization and provides a clear, precise, and measurable understanding of the target population for the study. Focusing on individuals who inject psychoactive substances for non-medical purposes, the definition captures the specific group most at risk of health complications, including infectious diseases and overdose, and who are typically

eligible for Medication-Assisted Treatment (MAT) programs. Using this definition ensures consistency with global public health standards, facilitates comparability with other studies, and clearly delineates the population under investigation for barriers to MAT access and retention.

2.3 Theoretical Framework

2.3.1 Health Belief Model (HBM)

In this research, the Health Belief Model (HBM) was used, a psychological theory created in the 1950s by Hochbaum, Rosenstock, and Kegels when employed in the U.S. Public Health Service (Rosenstock, 1974). The model is applied to explain why individuals do not participate in disease prevention and health promotion measures, such as seeking treatment services. The health belief model (HBM) presupposes that people tend to more actively take up health-related practices when they feel they are susceptible to a critical condition (perceived susceptibility and severity). There will be clear benefits of action that exceed the resistance or difficulty (perceived benefits and barriers (Rosenstock, et al.,1950). Also, individuals require certain stimuli or reminders to act (cues to action) and should believe that they can successfully perform the behavior (self-efficacy). According to the model, individual beliefs and perceptions drive health behaviors instead of objective facts (Rosenstock et al, 1988).

The people in the aspect of perceived susceptibility must feel that they are subject to adverse consequences, including overdose or chronic health issues, unless they seek treatment. Unless they realize how serious their addiction is and feel that the outcomes of their drug consumption will affect others but not them, they can experience no necessity to receive MAT service. Using this assumption, it is possible to conduct interventions aimed at raising awareness of the dangers linked to unaddressed substance use to make people more willing to seek assistance. Perceived severity entails what a person believes is the extent of seriousness of the consequences of their substance use problem. This encompasses medical results, e.g., damage to organs or an overdose, and social results, e.g., losing a job, a break-up of a family, or legal troubles. The individuals can underestimate the severity of their condition in the context of SUD. Provided that they are unaware of the long-term health, social, and psychological effects of addiction, they may not consider MAT a necessity. The HBM focuses on

realizing that one believes a health problem is severe enough to act on it (Chimbindi, 2022).

Patients with substance use disorder must understand that treatment can provide them with actual benefits, including relief of cravings, better health, and control over their lives to respond to MAT. The wrong beliefs that MAT only replaces one addiction with another or that it does not work can discourage a person from seeking help. With the help of the HBM in resolving misconceptions and communicating the established positive effect of MAT, including the success rates of recovery and enhanced well-being, individuals might be more inclined to seek treatment. HBM defines and deals with the perceived treatment barriers (Venes et al, 2024). The HBM proposes that, if people acknowledge the seriousness and advantages of treatment, they might fail to act if they see too many barriers.

Under HBM, cues to action refer to stimuli that make individuals seek treatment. These prompts might be a health-related alarm, recommendations by a physician, or the witnessing of the outcome of their use of the substance by the person with SUD. Expectant and peer support groups, held regularly, should act as strong triggers to action, helping individuals to think of MAT as an option. According to the model, individuals require reminders or encouragement to act, and this could assist in overcoming inertia or reluctance to seek treatment. Among SUD people, the lack of self-efficacy can be caused by previous unsuccessful experiences of sobriety or fear of the new MAT difficulties. Unless people think that they can cope with their treatment and eliminate withdrawal symptoms, they might be less willing to adopt MAT (Mbwambo et al,2019). Using the HBM, the treatment programs would be able to address the confidence of people in their ability to achieve success, support, and set attainable goals, and encourage them continually during the treatment process. These can enable them to seek and continue MAT (Kidia,2022)

Self-efficacy is also the model's priority as it aims to identify whether the individuals can participate in and undergo treatment successfully. In individuals with SUD, low self-efficacy can be the result of previous unsuccessful experiences of abstinence or fear of the difficulties of MAT. Unless people feel that they are capable of self-treating and overcoming the withdrawal symptoms, they will be less willing to attempt MAT. The

application of the HBM, in this study, assists in comprehending treatment programs that can facilitate the development of confidence among individuals to succeed in the treatment due to a sense of support, goal setting that is not too hard, and reliable encouragement along the treatment procedure, something that can make people do and continue with MAT.

HBM is applicable in this research since it can be used to investigate individual and organizational obstacles to MAT adoption. It assists in forecasting and interpreting the psychological and systemic mechanisms that prevent individuals with SUD from receiving/remaining in treatment. Thus, it is a useful model in informing interventions and policy suggestions on how MAT service access can be enhanced.

The Health Belief Model (HBM) was applied to explore barriers to MAT access by explaining how people with SUD perceive their risk of harm, the benefits of methadone treatment, and the obstacles that discourage them from seeking care. It helps uncover how misconceptions, stigma, low awareness, and fear of side effects reduce perceived benefits while increasing perceived barriers. The model also highlights how limited outreach, gendered information gaps, and negative community attitudes weaken cues to action and self-efficacy. By identifying these psychological and structural factors, HBM guides the design of targeted interventions and policies that can improve MAT uptake and retention.

2.4 Empirical Review

2.4.1 The Awareness of MAT among Individuals with Substance Disorder

The MAT clinic services awareness in the context of this study means how well people with substance use disorder, their families, and the community in general understand MAT as a treatment option. This ensures that it is well-informed on its existence, the advantages it will bring, and how it can be obtained. A low awareness might cause misconceptions, stigma, or the absence of motivation to seek treatment. In contrast, a high one can lessen these barriers, and more people will be willing to receive the required support to recover (Kidia et al., 2022). Awareness has a direct influence on the way people sense and approach MAT services. The degree of awareness directly determines the treatment and interaction of people with MAT services (UNODC, 2019).

The survey by McGinty et al (2020) was on Medication for Opioid Use Disorder: A National Survey of Primary Care Physicians in the United States. The survey also indicated that many primary care physicians are unaware of or untrained in MAT, affecting their capability to educate patients. The substance abuse cases were treated just like normal cases by the primary physicians, as there is no clear and detailed awareness of MAT services, particularly in the primary health care facilities. Minor focus on awareness of physicians, not directing the level of patient awareness, has restricted the implementation and use of MAT services as a significant element of healthcare in the treatment of individuals with substance use disorders.

According to the report of the European Monitoring Centre of Drugs and Drug Addiction (EMCDDA) in 2018 on the drug trend and development, there is variability in MAT awareness and availability in different countries in Europe, with some regions reporting low patient awareness and a lack of information dissemination. This demonstrates that the information on the availability and accessibility of the MAT was not discussed in the country, and the majority of the population, as well as those who have substance use disorder, do not know about the existence of such services. Based on the report's recommendation, it was clear that standardizing the MAT information campaign in Europe could provide uniformity in substance users' awareness. The report is quite general, but there are no country-specific measures of personal awareness on the utilization, availability, and accessibility of MAT services.

The study of World Health Organization (2019) on access to Medication-Assisted Treatment in Europe: Barriers and Facilitators is accompanied by the research results, which found that 45% of people with substance use disorder knew about MAT services. This indicates that half of the population in Europe did not realize the MAT services offered in primary health facilities and other rehabilitation centers. The obstacles to this lack of awareness were misinformation, stigma, and inadequate public health campaigns. The research also found that national MAT campaigns in countries provided a higher awareness rate. The study suggested the creation of multilingual culturally sensitive awareness and incorporating one MAT education, ie, primary healthcare services, to heighten individuals ' and communities ' awareness of MAT.

The article by Karamouzian et al (2020) is titled Awareness and Willingness to Access MAT Among People Who Inject Drugs in Iran. The researchers indicated that one out of every three individuals who inject drugs (PWID) knew about MAT, mainly because there was no outreach program. There was more awareness among those with prior contact with the healthcare providers. Through this study, the individuals without contact with health providers were not informed about the existence, availability, and accessibility of MAT services. Conversely, in the regions where the outreach activities and campaigns on substance abuse and use disorder are performed, people know how to access the services, what their effects are, and what the benefits of using or utilizing the services are. In another study conducted by Matseke et al (2019) on Awareness and Utilization of MAT Services among Substance Users in South Africa, it was found that awareness of MAT programs was at its lowest among the rural areas, with only 25% of the substance users aware of MAT programs. The language barrier and the absence of transportation were among others. This study found that more than 75 percent of the rural substance users are unaware of these services, and most of the centers are located in towns and semi-urban sections, leaving most of the drug abuse in rural societies unattended by MAT services. The research also suggested that more mobile clinics should be employed and that MAT education should be offered in the local languages.

One of the aims of the study Effect of Medication-Assisted Treatment on Psychosocial Wellbeing among Patients with Opioid Use Disorder in Kenya by the National Authority for the Campaign against Alcohol and Drug Abuse (2020) was to determine the degree of community awareness on the use of MAT. In the given work, it was found that the awareness of MAT services among the opioid users was significantly low, which resulted in underutilization. Non-priority of the treatment and rehabilitation services applied to people with substance use disorders is the cause of the lack of awareness. The research also suggested decentralizing services and implementing a community outreach program to raise awareness.

The study by Massawe et al (2014) on Challenges in Accessing Medication-Assisted Treatment among Opiate Users Attending a Methadone Clinic in Dar es Salaam, Tanzania: A Qualitative Assessment determined that the research reported formidable barriers to accessing MAT, such as a lack of awareness of the existence and benefits of methadone programs among opiate users. Based on this research, the researcher found

that there is less awareness of the availability and accessibility of MAT as an alternative medicine for substance use disorder patients. The low awareness has posed a problem in using these services, thereby people with substance abuse do not use these services. It also advocated the adoption of specific awareness interventions to create awareness among substance users on MAT services as a means of filling the current gap in the scarcity of extensive data on the general awareness rates of MAT among the general population of substance users in Tanzania.

This research has presented empirical findings of different studies, which indicate how awareness plays a critical role in determining the use of MAT. It shows that lack of knowledge regarding MAT is a major obstacle to treatment. The awareness programs, decentralization of treatment services, and community-based education are stressed to increase MAT uptake.

2.4.2 The perceptions of people with substance use disorder toward MAT in Dodoma Municipality

The 2020 Medication-Assisted Treatment of Opioid Use Disorder in the United States report by the Substance Abuse and Mental Health Services Administration. This study has discussed the perceptions of MAT among people with substance use disorder. It was discovered that MAT was thought to be a good medication by some people, but many of them did so with skepticism because they feared that they would remain dependent on the medication. The participants indicated that they would prefer complete abstinence from substances and feared that MAT would substitute one dependency with another. The research also proposes the use of MAT with counseling and psychological support to tackle the issues related to long-term dependence and to recommend MAT as a component of a more holistic recovery strategy. Moreover, they need to train more to eliminate myths and minimize the stigmatization of MAT.

This study by Van de Glind et al (2017), The Influence of Perceptions of Medication-Assisted Treatment on Its Uptake: A European Study, examined the effect of cultural variations on the perceptions of MAT in several European nations. The moral views on addiction had a great influence on the perceptions in societies, where the cultural taboos of addiction are strong, such as in Eastern European regions. In these countries, MAT was considered by many to be ineffective or dependence-producing. These cultural

perceptions led to a reduction in service uptake in high-stigma countries. Instead, the study suggested that MAT programs should include cultural competency training of providers and create culturally sensitive and localized interventions that would facilitate awareness and acceptance of MAT. It also promotes social campaigns to combat the social stigma of addiction and MAT.

In addition, according to a qualitative study carried out in South Africa by Kohli (2021) on the Perception of Medication-Assisted Treatment of Opioid Addiction in South Africa, the findings of the qualitative research were that, in general, healthcare professionals were enthusiastic about the MAT, but people with opioid use disorder were reluctant to undergo the treatment. Most people considered MAT substances, such as methadone, as addictive and were afraid of the stigma surrounding the treatment (Kohli, 2021). In addition, individuals thought that MAT was a simple solution and decided to follow rehabilitation programs with the focus on abstinence (Kohli, 2021). The work by Kohli suggested that focused public health interventions should be conducted to sensitize communities on the advantages of MAT. It additionally emphasized the need to combine MAT with holistic treatment methods like counseling and peer support to make it more acceptable.

The study by Mburu (2018) is on the topic of treating substance use disorder with medication-assisted treatment: the South African experience. The researchers determined that individuals who had substance use disorder in South Africa were initially sceptical about MAT. There was a popular feeling that MAT was not a long-term treatment plan but just a short-term form of therapy. The long-term medication use was also an area of great concern. The MAT was frequently considered a worse choice in comparison with rehabilitation services, which could guarantee a complete abstinence (Mburu, 2018). The authors suggested combining MAT services with other sources of treatment, including group therapy and counseling, to offer a more holistic approach (Mburu, 2018). The study that was conducted by Simba (2019) is called Barriers to Medication-Assisted Treatment in East Africa: Evidence from Kenya, Uganda, and Tanzania. The research found there was increased acceptance of MAT in urban regions where, as in rural areas of East Africa, especially Kenya, Uganda, and Tanzania, people were less aware of MAT. The patients were usually terrified of the outcomes of such treatment and considered MAT an addiction. The study suggested that

more awareness of MAT in the rural setting should be developed through community gatherings and educational outreach. It also proposed training healthcare providers to facilitate MAT as an evidence-based and legitimate treatment option.

Mixed-Methods Study by Mugisha et al (2020) of the perceptions of MAT of People with Substance Use Disorder in Uganda. The substance use disorder patients had the notion that MAT failed to work and could only replace one addiction with another. Nevertheless, the current stigma by the family members and the community members also played a role in the unwillingness to use MAT services and the rising negative perception of the use of MAT services. The researcher also proposed that further research and awareness campaigns should be carried out to clarify misconceptions about MAT. They also suggested the incorporation of family members and community leaders in the talks on MAT to help decrease the stigma and augment acceptance because there was a current disparity in the understanding of SUD concerning the use of MAT services.

Kasirye (2019) has presented the research on an investigation about the topic of Medication-Assisted Treatment and its Role in Opioid Recovery in Uganda: Client Perceptions and Challenges. This study has indicated that patients already accessing MAT services in Uganda believed that it was an effective method of managing opioid addiction. Still, many people were unable to initiate treatment because of the stigma of taking medication as a form of addiction management Kasirye, 2019). The emphasis was on the clean recovery by means of abstinence, and MAT was regarded as a type of continued dependence. The author suggested that healthcare providers should be trained more to enable them to deal with the concerns and misconceptions of the patients. They were also the promoters of former patients' participation in awareness campaigns to illustrate the effectiveness of MAT in the long-term recovery (Kasirye, 2019).

Research by Okeyo (2021) about Perceptions of Medication-Assisted Treatment of Opioid Dependence in Kenya: Barriers and Opportunities. The study identified that individuals with opioid use disorder in Kenya had ambivalent views about MAT. Although there were people who considered MAT an effective intervention to deal with opioid addiction, not everyone was eager to use it because of addiction stigma and difficulties with methadone. It was feared that, over time, a heavy dependence on

methadone would be employed and that full dependency on all substances was preferable. The study suggests that more needs to be done to educate the masses about the advantages and safety of MAT. MAT needs to be portrayed as a long-term recovery tool, and stigma against MAT should be minimized by creating awareness at both the community and national levels. The research suggests raising awareness on the advantages and safety of MAT, encouraging MAT as a long-term recovery option, and reducing stigma by stimulating awareness at both the community and national levels.

The other research was carried out by Mwaisaka (2017) under a study titled "Perceptions and Attitudes towards Medication-Assisted Treatment for Alcohol Use Disorder in Tanzania. Generally, in Tanzania, the views towards MAT regarding alcohol use disorder were quite negative since the culture dictated that addiction must be cured not by medication, but by abstinence. The other major obstacle was stigma because individuals were afraid that those using MAT would be socially rejected. The study's recommendations included creating culturally relevant education that explains how MAT may become a component of an overall recovery strategy. It even proposed the establishment of community-based support groups to assist in eliminating the stigma attached to MAT.

2.4.3 The procedural challenges in MAT service that hinder the accessibility to MAT for individuals with substance use disorders in Dodoma Municipality

The study of Barriers to Retention in Medications to Treat Opioid Use Disorder was carried out by Vanessa et al (2024). This research has shown that logistic issues, including the distance to the treatment facilities and transportation complications, play a significant role in retention in MOUD programs. Treatment length of stay is related to longer distances to outpatient treatment. Elmang (2018) carried out another research on the barriers to Availability and Accessibility of Controlled Medicines in Sub-Saharan Africa: A Report on Field Assessments of Selected African Countries. The regulatory structures and policies restrict access to MAT. Implementing MAT in existing healthcare is hampered by bureaucracies, and the government is not committed to scaling up pilot projects. The lack of special treatment facilities and staff training is a limitation to access MAT, as shown by the sampling of several studies by Samuel et al (2024), "Residential and Inpatient Treatment of Substance Use Disorders in Sub-

Saharan Africa: A Systematic Review. The high cost of treatment and dependence on out-of-pocket payment also worsen the accessibility problem.

The article by Mongi et al (2023) of Medication Assisted Treatment Program in Tanga: A Potential Weapon in the War on HIV Among PWID. Disclosed that stigmatization and availability of the MAT services are some of the challenges involved. Nevertheless, the research concluded that combining MAT with HIV services has demonstrated potential in dealing with the two issues of SUDs and HIV. Nonetheless, the feasibility of such programs is conditional upon the long-term funding and support, the efforts to decrease the stigma, and to make them more accessible.

Mburu (2020) published an article where he experimented with the title of Barriers to Accessing Medication-Assisted Treatment Services to People with Opioid Use Disorder in Kenya. In the research, it was identified that healthcare practitioners and the community were so stigmatized that people with opioid use disorder (OUD) could not have access to MAT services. The participants said that they were called people with an addiction and not patients. The research also indicated that the number of MAT clinics was minimal, especially in Nairobi. Thus, many were forced to cover a long distance to acquire the treatment. This was particularly challenging for the rural population since the participants mentioned transportation cost as an important setback, which was exacerbated by their joblessness. These results show that such structural problems as the poor distribution of MAT services and socioeconomic barriers are crucial challenges. Further, the problem is aggravated by stigma from society and the healthcare workers.

Research by Chimbindi (2022) on Challenges to Sustained Access to MAT Services to people with Substance Use Disorder in Sub-Saharan Africa found that numerous countries had been dependent on donor funding to implement MAT programs. Thus, when their funding shrank, it affected the provision of these services. The other hand had inadequate training on how to manage addiction, as many healthcare providers offered patients poor experiences. The author identifies the systemic issues that need policy-level responses and more resourceful MAT services.

Otiende and Muganda (2021) investigated the policy framework in MAT programs in a study on Challenges of Implementing Medication-Assisted Treatment Programs in Sub-Saharan Africa: The Case of Kenya and Tanzania. Through the study, it was discovered

that strict government policies, the necessity of various approvals, and insufficient integration of MAT services into primary healthcare were the factors that led to low accessibility. It further reported that the continuity in the treatment process was hampered by frequent stockouts of methadone caused by ineffective management of the supply chain. The researchers suggested aligning MAT policies with the wider national policies on healthcare to enable the delivery of services with ease.

The research by Mbwambo et al. (2018) is called Structural and Systemic Barriers to the Utilization of Methadone-Assisted Treatment in Tanzania: A Qualitative Analysis. The researchers established that access to MAT by persons with substance use disorders was hampered by the bureaucratic processes that comprised high eligibility requirements, long enrollment procedures, and repetitive documentation requirements. Also, healthcare providers noted that it was not easy to cope with administrative regulations, which caused discrepancies in service delivery. The study suggested policy change to make the MAT enrolment easier and more accessible.

Nyandindi et al. (2019) examined Barriers to Medication-Assisted Treatment of Opioid Use Disorder in Tanzania: A Policy and Institutional Perspective, which addressed the most essential issues of procedures that influence the access to MAT. The researchers developed complicated enrollment processes, bureaucratic delays, and tough eligibility requirements as key factors that leave many people out of MAT services. Also, internal factors like staffing, shortage of trained staff, and lack of funds to fund the services were cited as limiting the efficiency of the services. The research offered policy changes to make registration easier and enhance institutional capacities.

Chiduo et al. (2020) have published a study on the effects of restrictive legal policies on the MAT service provision in urban centers in Tanzania titled The Role of Legal and Policy Frameworks in MAT Accessibility: A Case Study of Tanzanian Urban Centers. The research article indicated that a significant number of people who have substance use disorders are discriminated against by the law, such as being arrested and imprisoned, thus making them unwilling to seek treatment. Moreover, the study found no intersectoral cooperation between the criminal justice and the health institutions, resulting in an uncoordinated strategy towards reducing harm. The research proposed

decriminalizing substance use and using a human rights approach to enhance the performance of MAT services.

Such empirical researches indicate the main barriers in providing MAT services, such as hard eligibility criteria, bureaucratic enrollment processes, weak institutional support, limited legal policies, and ineffective intersectoral cooperation. To make such access more positive and provide people with substance use disorders with effective treatment, it is essential to address these challenges.

2.5 Research Gap

Although some of the studies have investigated the awareness of Medication-Assisted Treatment (MAT) among people with substance use disorder (SUD), there is still a clear gap in the research on the overall awareness rates within the specific communities, especially in the environment of Dodoma Municipality, Tanzania. Past research, including the works of Massawe et al. (2014) and NACADA (2020), proposes insufficient awareness of MAT services as a key factor that affects the adoption of treatment options, along with the stigma and misconceptions. These studies have, however, been mainly concentrated on Dodoma Municipality. Additionally, although the role of awareness campaigns and decentralized service in the context of global reports (e.g., WHO, 2019; Karamouzian et al., 2020) is also emphasized, there are no thorough country-specific data that will examine the factors that mediate awareness on the local community level in Tanzania. The gap encompasses the awareness and particular obstacles, i.e., MAT belief, socio-economic, perception, and service complex procedures that make people with SUD unwilling to use MAT services.

Furthermore, the perception and barriers have been studied in the past, usually looking at the perception of healthcare providers or a particular demographic. The limited research that combines the views of the substance use disorder patients themselves, as it concerns the effectiveness, safety, and benefits of MAT as a component of the holistic method of treatment, is insufficient.

Thus, this gap will require further studies to address it by undertaking a more detailed evaluation of the degree of awareness of MAT services in people with substance use disorders to identify specific impediments in Dodoma Municipality. The study

examines the interaction between social and economic variables which influence the awareness, perceptions, and MAT service processes, and the effectiveness of specific awareness-raising programs and community-based intervention in enhancing service utilization. This would be of good value in formulating locally acceptable measures to expand access and utilization of the MAT services.

CHAPTER THREE
RESEARCH METHODOLOGY

3.1Introduction

The chapter presents the research methodology. It specifically presents the study area, research design, and study population. The study includes a sampling procedure in which purposeful sampling is explained, including sample size, data collection methods, data analysis, validity, reliability of the research issues, and ethical considerations (Kothari 2008).

3.2 Research Philosophy

This research used an interpretivism research philosophy. It is a philosophy that Wilhelm Dilthey and Max Weber created in the 19th century. Creswell (2024) notes that interpretivism is a perspective according to which reality is socially constructed, that is, objective and influenced by the views and relationships of people. This philosophical research is based on people's definitions and explanations for their experiences and social realities.

Interpretivism is very appropriate in the research on issues facing individuals with substance use disorder (SUD) to access medication-assisted treatment (MAT) in Dodoma Municipality due to several reasons:

Knowledge of the personal experience: As the present study is based on the individual experience and perceptions of people with SUD, it is possible to consider interpretivism as the option to gain a better insight into how they see obstacles to receiving MAT.

Contextual knowledge: Interpretivism allowed the researcher to investigate the social, cultural, and emotional aspects that affect access to MAT by the individuals in Dodoma Municipality. It highlights that the local context is important and may differ and influence access to healthcare and treatment.

Detailed data gathering: The qualitative approach applied in this study, including interviews and focus groups, is consistent with the research philosophy that is supposed to learn the lived experiences and narratives of the people with SUD.

Interpretivism allows the researcher to interact with the participants through a flexible, empathetic, and reflective approach to data collection. The researcher can establish rapport, build trust, and establish a safe environment where open conversations can be made with the subjects due to the participants' subjective experiences. In the study, the focus groups or in-depth interviews would have been used, allowing the participants to share their thoughts, feelings, and opinions regarding the issues they encounter.

This philosophy promotes the researcher to be a good listener, to ask open-ended questions, and to allow the participants to express their personal interpretation of their experiences. This assisted the researcher in collecting in-depth data, rich in content, and the participants' voices are represented, and their views are not ignored.

3.3 Research Approach

This study used a qualitative research approach. According to Creswell and Poth (2018), qualitative research refers to a method in which the complex phenomena of social life are studied and interpreted, and non-numerical information is gathered. It enabled the researcher to know the participants' perceptions, beliefs, behaviors, and interactions in their natural situations. The author selected the method since it helps the researcher immerse themselves in the participants' world, discover the details of their experience, and give a comprehensive insight into the obstacles to MAT access. It enabled the researcher to modify the questions during the research process, depending on the participants' answers and the themes that emerged during the study. Such flexibility is especially applicable to identifying unforeseen impediments to the access of MAT services among individuals with substance use disorder. The researcher became able to understand further how the factors in the local community (i.e., stigma, healthcare access, socio-economic barriers, etc.) affect the ability of people to access MAT services. This may give useful data to carry out context-specific interventions.

3.4 The Study Area

The study area was the Itega Methadone clinic, Dodoma Municipality, Tanzania. The Itega Methadone-Assisted Treatment (MAT) Clinic is chosen as the center of interest in this study because of its strategic role in the nationwide approach of dealing with substance use disorder, and specifically among individuals who inject drugs (PWID).

The Itega Methadone-Assisted Treatment (MAT) Clinic in Dodoma Municipality was selected because it provides services to individuals with substance use disorders (SUD), particularly People Who Inject Drugs (PWID), making it an appropriate location to study treatment-seeking behaviours, service access, and retention patterns. The clinic has recently introduced an aftercare program to address high dropout rates, yet reported a highest rate of default at 40% in the past year (Itega MAT Clinic Annual Report, 2024), offering an opportunity to examine the effectiveness of interventions aimed at sustaining treatment and reducing relapse.

3.5 Research Design

Creswell (2024) suggests that research design is a strategy or a plan that defines how a research study is to be done. Creswell also adds that the research design is subject to the nature of the research problem, the research questions, and the assumptions about knowledge (epistemology).

In this research, the design adopted was exploratory, which best fits the exploration of phenomena where there is already little research or when the topic aims to gain insight into an issue in its initial phases (Creswell, 2024). Exploratory designs would enable the researcher to venture into new or uncharted fields, including the challenges people with substance use disorders (SUD) encounter when seeking Medication-Assisted Treatment (MAT). This method helped the researcher gather information across different points of view, reveal new meanings, and identify the personal, social, and systemic aspects that influence access to MAT services. This design enabled the researcher to be closely involved with the participants and dig into their lives, inspirations, and difficulties. It also helped to single out themes and patterns of the societal perceptions, personal experiences, and systemic problems like stigmatization, accessibility to healthcare, and logistical issues that could result in clients not completing the treatment.

3.6 Study Population

A population may be a cluster of people with one or more common characteristics that interest the researcher (Bryman, 2001). In this study, the study population was adult people above 18 years, and older, with substance use disorders, who have been diagnosed with SUD and those who actively seek and/or have sought MAT services.

The group gave firsthand information regarding the challenges and barriers experienced in the treatment process. The study also included the health professionals who were directly involved in the provision of MAT services and the administration of MAT services. It included a physician, the administrator of the MAT clinic, and a social welfare officer. They had a faint outlook on systemic barriers and operational issues in the healthcare environment.

3.6.1 Inclusion and exclusion criteria

The study population consisted of individuals diagnosed with substance use disorders (SUD) who are actively seeking or have previously sought Medication-Assisted Treatment (MAT) services, as well as medical professionals directly involved in the administration and delivery of MAT at the Itega MAT Clinic in Dodoma Municipality. Individuals with SUD were selected because they can provide firsthand information regarding the barriers and challenges experienced during the treatment process, including factors that affect service access, treatment retention, and dropout. Medical professionals, including clinicians, nurses, and counsellors, were included because they have knowledge of the operational and systemic aspects of MAT service delivery, such as program procedures, implementation challenges, and patient management.

Participants were obtained from the Itega MAT Clinic, which serves as a key center for MAT services in Dodoma. Purposive sampling was used to ensure that participants met the inclusion criteria, allowing the study to gather rich and relevant information from both the clients' and service providers' perspectives. This approach enabled a comprehensive understanding of the factors influencing the accessibility and effectiveness of MAT services in the study area. Selecting both patients and service providers ensures that the study captures complementary perspectives, combining experiential insights from service users with professional observations from providers, which is essential for generating a comprehensive understanding of the factors influencing MAT accessibility and retention.

3.7 Sampling Procedures

The study used purposive sampling. Purposive sampling was used to obtain adequate information from the key informants regarding the study under investigation.

3.7.1 Purposive Sampling

Kamuzora (2008) says that judgmental sampling, or purposive sampling, is a non-probability type of sampling, where the researcher selects the subjects they believe will give the most pertinent and accurate information to the research. In the study, purposive sampling was used to choose the sample of individuals with direct experience of substance use disorder (SUD) and individuals whose previous and/or current use of Medication-Assisted Treatment (MAT) services at Itega Clinic.

This approach would be very appropriate in the context of qualitative exploratory research because it guarantees that the respondents possess personal experience with the obstacles under research. The study achieved its objectives by basing the survey on people who know MAT, including service users and health care providers directly involved in MAT services. It assisted in revealing the variety of viewpoints and systemic, social, and individual-level issues concerning the accessibility of MAT. Purposive sampling is therefore vital in facilitating the researcher to gain deep information on the lived experiences, perceptions, and institutional barriers to the accessibility of treatment services by people with SUD in Dodoma Municipal.

Purposive sampling was done by first formulating the target population as individuals with Substance Use Disorders (SUD) in Dodoma Municipal who were receiving or had received treatment services. The researcher then developed inclusion criteria and selected the respondents who could give rich and relevant information, namely, the participants diagnosed with SUD, and those treated or who had been treated were willing to give their accounts. Participants were purposely identified by treatment centers, clinics, and community networks familiar with individuals with SUD seeking services. The researcher sampled until data saturation was achieved; no new themes or information emerged due to the new participants. Ethical considerations during the process were upheld, such as taking voluntary informed consent and providing confidentiality.

3.8 Sample Size

The sample size of the study is 18 informants, comprising fifteen (15) informants who are clients of MAT services at the Itega MAT clinic and who have substance use

disorders, and three (3) health professionals who visit the clients who have substance use disorders at least six months. Data saturation was used to determine the sample size. Data saturation happens when the data gathered does not provide further information or a theme that can restate the research efforts. This implies that the researcher would interview the participants until the information obtained by the researcher became redundant and no new ideas came out. The sample size was large enough to answer the research questions (Kingston et al., 2017). It was reasonable to use data saturation to enable the researcher to be receptive to the quality and completeness of the information instead of adhering to a predetermined sample size.

3.9 Methods of Data Collection.

3.9.1 In-depth Interview

The in-depth interviews in this study were carried out by asking the participants to be interviewed individually and privately, and in a neutral environment within the Itega MAT Clinic, after agreeing to do so privately to make them feel comfortable and secure. The interviews were conducted using the main language of the participants, Kiswahili, so there was clear communication, and the interviewees could communicate freely. The semi-structured interview guide was employed, facilitating the respondents to go into detail and respond in their own words. The researcher could also ask them follow-up questions and seek clarification when clarity regarding the demographics of informants will be provided, according to the type of substance use disorder, age, sex, and education level. To capture all the participants' responses accurately and obtain all the information they had to provide, all the interviews were audio-taped with the informed consent of participants, and field notes were taken to capture all the details regarding non-verbal messages and expressions, as well as context-related observations. The transcriptions after the interviews were word-for-word translated into English and cross-checked to maintain all the words and the interpretation of the words used by the participants. This enabled the researcher to identify patterns, themes, and variations in the participants' experiences with access to medication-assisted treatment (MAT) in a systematic way.

3.9.2 Focus Group Discussion

The use of Focus Group Discussions (FGDs) was effectively aimed at collecting the collective views and experiences of people with substance use disorder (SUD) of Medication-Assisted Treatment (MAT) services. The participants were divided into three groups; each group consisted of six people, which made discussions manageable, and all the members could participate in the debate. The FGDs were conducted in the Itega MAT Clinic, as it has sufficient space and a place where interruptions were minimal and open dialogue was facilitated. The sessions were scheduled at about 35-45 minutes, which is enough time for all the participants to express their views, discuss the challenges, and share their experiences with the MAT services.

3.9.3 Document review

Document review is a useful qualitative research technique that entails the methodical review and study of the existing records or written documents about the research topic. Bowen (2009) defines document review as analyzing printed or electronic materials to get useful information for research. The data collection method, documentary review, was implemented in this research and entailed a systematic investigation of the available records, reports, and written materials to obtain information about Medication-Assisted Treatment (MAT) and the issues of its accessibility to individuals with Substance Use Disorder (SUD) in Dodoma Municipality. A checklist was used to conduct the review process systematically and to ensure that the key documents included in the checklist were the clinical records and treatment registers (e.g., patient I, intake forms, MAT attendance logs, dropout records and relapse reports), the Ministry of Health guidelines and protocols on MAT, and past research reports and program evaluations conducted by NGOs and civil society organizations. In each document, a particular information was pursued: clinical records offered patterns of the service uptake, retention, and dropout; policy documents were analyzed concerning compliance between guidelines and actual practice; research findings revealed issues and effective use of interventions in MAT provision. The data collection was done by systematically searching through all the documents on the checklist, retrieving the relevant information, and documenting it in a structured format to enable thematic analysis with

the interview and FGD data. The trend of MAT service provision was identified in the review of the documents.

3.10 Data Analysis Methods.

Hatch et al (2002) revealed that a data analysis involves building answers to questions by examining and interpreting. The thematic analysis was used in this research to analyze the data collected from the participants. The process consisted of six steps: Familiarization with the data. The first one is a comprehensive reading and re-reading of the data to be very familiar with it. This is to immerse in the data and have a general picture of what is collected. Creating preliminary code is the stage where interesting aspects of the data are coded in an organized manner throughout the whole dataset.

This is to arrange the data into significant categories and determine patterns. In this step, a search was done for the theme, and codes were analyzed to obtain broader themes. This is meant to initiate data analysis and meaning-making by grouping similar codes. Defining the theme entailed narrowing down the themes to capture the data properly, hence allowing the articulation of a thorough comprehension of the theme and setting up a coherent discussion. Review the theme. It included a critical analysis to examine the details of each theme, the general narrative they portray, and report writing. This is the last step of writing the analysis in a structured format. This aims to give the study results in a manner that conveys the information acquired from data to others.

3.11 Rigor and Trustworthiness of Data

According to Saunders B (2017), credibility and validity are part of the measures to identify the rigor and trustworthiness of the research data. Rigor and trustworthiness play a crucial role in qualitative research because they need to guarantee that findings are correct, dependable, and significant. Credibility, dependability, transferability, and confirmability are the major criteria for assessing qualitative data's rigor and reliability. In this research, the researcher has used the following strategies to maintain these standards:

3.11.1 Credibility

Credibility refers to the confidence in the truth and accuracy of the data and findings. It includes the following aspects used by the research in this study.

Triangulation: Data collected from multiple sources, including in-depth interviews, document review, and observation, allowed the researcher to cross-check and validate the information.

Prolonged engagement: The researcher spent adequate time in the field at Itega MAT Clinic to build rapport and ensure authentic participant response. C**hecking:** After interviews are transcribed, summaries are shared with participants to verify the accuracy of their responses and ensure that their views have been captured and interpreted.

3.11.2 Dependability

Reliability in qualitative research guarantees consistency and reproducibility of the results due to the systematic description of the research process (Saunders et al., 2017). Dependability is a concept that relates to the permanency and congruence of the research process. To guarantee the consistency and reproducibility of the results, the researchers did the following:

Audit trail: A log was maintained, documenting all steps of the data collection and analysis process and methodology changes. Preferred semi-structured interview directions: These guarantee continuity in questions and give the participants freedom in narrating their experiences.

Peer debriefing: The results and the interpretations are shared with fellow research peers or supervisors to ensure no conclusions are made on the researcher’s bias.

Confirmability: Confirmability was done to ensure the results are based on the participants' opinions and experiences, not the researcher's viewpoint and prejudice. The study employed feedback from the participants in the determination of data.

Reflexivity: The researcher kept a reflexive journal during the study to contemplate their assumptions, decisions, and reactions during the research process.

Verbatim transcription: Interviews are transcribed word-for-word to maintain the original meanings, and those that are to be analysed as data are based on the words of participants.

Transferability

Transferability is the degree to which the study results can be transferred to other settings or populations.

Thick description: The researcher has been quite descriptive of the study setting, the participants, and the setting so that readers and future researchers can know how the findings apply to other settings and whether they are relevant.

3.12 Ethical Considerations

The research followed all the set ethical guidelines used in research involving human subjects. Necessary ethical considerations were made by treating all the respondents with respect, dignity, and fairness during the research process. The participants were informed of the research's aim and extent, and only those who had voluntarily consented were recruited. Participants were assured confidentiality and anonymity, and no identifying information was provided to ensure the participants' privacy. Moreover, the research was conducted in accordance with professional standards, stating that the minimum level of harm should be avoided, and the well-being of involved participants should not be endangered, which is part of the professional recommendations regarding the ethics of social work research (Hadi et al., 2016):

The research instruments were administered along with the consent form, which the informants were informed of after receiving the notification of the purpose of the research; therefore, the respondents had the choice and could give or even withdraw their consent at any time.

The researcher observed the subjects' right to privacy, and the information provided by that individual was kept in confidence. A researcher maintained the duty of confidentiality to assure the informants that the information provided would not be disclosed to anybody. Also, a researcher was involved in the security and storage of information that the respondents supplied by ensuring it was not disclosed. In the report,

names and personal identities were not attached to any information details shared voluntarily and given by respondents.

The researcher received a clearance letter from the Institute of Social Work before visiting the field. It is through the letter that the researcher was introduced to the Mirembe National Mental Health Hospital, and permission to collect data was granted. Moreover, in guaranteeing the privacy of the informants and their information, the researcher guaranteed the anonymity throughout the entire data and report gathering by using numbers or letters in place of the participants.

CHAPTER FOUR

DATA PRESENTATION ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Introduction

The chapter presents data, analysis, discussions, and interpretation of the findings obtained from the field. The study aimed to explore barriers encountered by people with substance use disorder (SUD) in accessing medication-assisted treatment (MAT). The specific objectives were to assess awareness and understanding of MAT among individuals with SUD, to explore their perceptions of MAT and how these influence treatment-seeking decisions, and to analyses procedural and structural constraints within MAT service delivery. The document review provided secondary data, while the in-depth interview provided primary data, complementing a focus group discussion.

4.2 Participants overview

This section provides a contextualized account of the eighteen informants who participated in the study. Fifteen informants were individuals receiving Medication-Assisted Treatment (MAT) at the Itega MAT Clinic, and three were health professionals involved in service delivery. Their demographic characteristics are presented concerning age, sex, education level, and type of substance use disorder, emphasizing contextual understanding rather than numerical generalisation, consistent with qualitative research principles.

4.2.1 Age, Sex, Education Level and Type of Substance Use Disorder

In this study, informants representing various age groups were involved. There were four aged 24-30 years, ten aged 31-35, and four aged 36 and above. This variant shows that most respondents were early to middle-aged adults, with the greatest number of respondents aged thirty-one to thirty-five. This age distribution is in line with accepted trends of service utilization in people with long histories of substance use.

Regarding sex, twelve people reported being male and six people said they were female. Although the representation of both sexes was equal, men were the majority of MAT service users. This is in line with the wider gendered trends in substance use and treatment-seeking behaviours in the same socio-cultural setup.

The educational level of the participants also differed. Five were self-educated, four were primary-educated, 5 were secondary-educated, and four were tertiary-educated, including one service user and three health professionals. Such trends also indicate that even though a minority had attained higher education, most service-users were poorly educated, with the highest secondary education.

The substance use histories of the participants were also lacking. The most common was heroin dependence; seven people reported it as their main drug. Two informants had reported alcohol use disorder, four had reported marijuana use, and two had reported cocaine use. This diversity allowed gaining an understanding of the varied experiences of the ways people access MAT services and the diversity of experience that they bring to treatment and recovery.

A combination of these demographic features identified a valuable account provided by the participants. The differences in age, sex, educational attainment, and profile of substance users, along with the fact that the majority of service-users were men, added a fine dimension to how people access and utilise MAT services at the Itega MAT Clinic.

4.3. The trend of MAT services provisions as revealed by the reviewed document

An overview of clinical records and other documentation at Itega MAT Clinic has shown that there have been developing trends in offering Medication-Assisted Treatment (MAT) services in 2021-2024. The MAT programmes in the clinic are aimed at helping individuals who have substance use disorders to achieve independence and move towards recovery. Enrolment requires registration, which is followed by information given to clients on the eligibility criteria, conditions of service, and treatment expectations.

4.3.1 Gender Disparity in Access to MAT Services

Clinic records indicate that 160 patients were registered during this period. Of these, 97% were male and 3% female, reflecting a notable gender disparity in treatment uptake. This reflects on one of the MAT clinic reports, which adds that;

> *"The data clearly shows that the service users are almost entirely male; female enrolment remains exceptionally low, indicating a*

> *critical gap in gender-responsive outreach and low women's accessibility to MAT services."* (clinic record/2025)

4.3.2 Polysubstance Use and Dependence Complexity

Reports of the clinic indicated that there was a vast array of substances consumed to strengthen or increase intoxication, including illicit drugs and prescription drugs. This shows a tendency towards adaptive or compensatory substance use behaviours. Several substances were reported, though heroin, tobacco-related substances, alcohol, marijuana, and cocaine were the most commonly reported. In addition to these, prescription drugs, which have a psychoactive or addictive effect, like diazepam (Valium) and tramadol, were also found to be used in the study. These drugs were also allegedly used to extend or duplicate the action of the primary drugs of addiction, especially during transition or withdrawal.

Document revealed that:

> "*Patients often combined prescription sedatives like diazepam or tramadol with heroin to sustain the desired effects, especially during transition or withdrawal phases."* (clinic report, 2025)

This weakens treatment adherence, which leads to missed doses and dropouts of the MATA service.

4.3.4 Comorbidity of mental health and other illnesses: Limit Access and Retention

The clinical notes were used to outline various mental health conditions that were co-occurring. Commonly reported issues were anxiety, depression, post-traumatic stress disorder (PTSD), panic disorder, personality disorders, and other cognitive or psychosocial impairments. It was reported that clients who received treatment earlier mentioned having acquired some features of self-identity and personal agency as a part and parcel of their recovery process.

The document review also discovered an increased susceptibility to communicable and chronic health conditions amongst service-users. The common diagnoses were hepatitis B, skin infections, sexually transmitted diseases, and tuberculosis, implying the

compounded health burdens linked to the extended use of the substance. In the study, it was revealed that some clients missed a single dose due to illness.

As the document statement revealed:

> *"Addiction does not arrive alone; it brings illness, trauma, and exhaustion, and MAT services are not always equipped to respond to all that complexity. Most people with SUD have no health insurance card for treatment of other illnesses associated with addiction."* Social welfare officer report on MAT service challenges at Itega MAT clinic/2025

The review of the documents made it possible to state that although MAT delivery in Itega Clinic corresponds with the national guidelines, it is limited by the real-life barriers related to the accessibility of the services. Knowledge on MAT is also attained in a structurally organized manner with formal registration and induction protocols. However, gender inequalities and polysubstance trends show that understanding and acceptance of the treatment is still not on par among critical groups. The views of MAT as an additional type of substance replacement undermine compliance and determine the rates of dropout. Moreover, comorbid conditions of mental and physical health greatly deter a long-term engagement, and they expose the lack of a coherent system of care. Even though MAT provides a well-organized recovery route, its influence is mediated by procedural inflexibility and the complexities of life among the users. The ability to handle the issues of awareness, perception, and delivery is thus crucial to fair and efficient access to MAT.

4.4 The awareness of MAT among individuals with substance use disorder in Dodoma Municipality.

In this research, MAT awareness among people with SUD means how people with substance use disorder know the existence, purpose, and meaning of MAT services for treatment. The study examined how individuals describe and make sense of MAT on their own words, including the understanding of methadone as a treatment for opioid dependence and eliminating cravings and withdrawal symptoms, and how they believe it is an effective treatment. People with SUD revealed their understanding of the MAT

service procedure, such as programme qualification, enrolment procedure, requirements during enrolment, and expectations. In this exploration, the following sub-themes emerged:

4.4.1 Limited awareness about MAT

In this study, it was reported that patients with substance use disorder (SUD) in the study area have poor knowledge about Medication-Assisted Treatment (MAT). Most participants had heard about MAT services via the news, most of whom were already clients of the services, had friends or other persons who had enrolled in the services, and sometimes gave their testimonies about the services. This secondary exposure usually gave partial or even incorrect information, and many of the prospective clients had wrong ideas based on the purpose, process, and benefits of medication-assisted treatment. In interviews, the participants expressed the inability to have a clearer picture of MAT, including the mechanism of the program, eligibility criteria, dose regimens, pre-treatment training, and the anticipated results. Some were unaware of how to begin the treatment or which support services were offered in the clinics. This was quoted by the informant as follows;

> *"I don't know much about MAT. I just heard from friends, but the purpose of substance use disorder is not clear to me. So, it becomes difficult for me to make an early decision until the NGO's provide training for me (IDI/Persons with SUD/2025).*

Through IDIs, the impression was that most participants had only a faint understanding of what MAT entails. They stated that it was only after they had to take a path to the MAT Clinic due to their deteriorating health or their social life that they actually had the chance to know about methadone. Generally, the idea of MAT came across to most people through friends, who had already enrolled for MAT services, or randomly through NGO announcements, but this information was mostly partial and ambiguous.

Another informant revealed the following;

> *"I have very little understanding of MAT. No one was there to tell me what it is in detail until I came to seek the services myself. I used to hear people mention methadone, but nobody explained how it works or why it helps. We only come when things get bad, not because we understand the treatment. If someone had told me earlier, I mightn't have wasted so many years struggling. They expect us to accept the treatment, but first we need to understand it." (IDI/persons with SUD /2025)".*

Moreover, the researchers have also discovered that the lack of awareness is aggravated by the deficiency of community education and outreach activities and the selective delivery of information by the health facilities or non-governmental organizations. Consequently, the individuals with SUD have not received sufficient information to choose whether they need to be treated or not, which has resulted in delays in enrolling in the program, misunderstandings about methadone, and withholding participation in the program being offered in some cases. The researcher concluded that the majority of the SUD clients received information once the addiction had influenced them. Health professionals revealed this when they said;

> *"There is limited awareness of MAT services, and most of the SUD clients never come of their own free will unless they are recruited through NGO's. No pre-information was disseminated to clients. Therefore, MAT services are not clear to most of our clients (IDI/health professional /2025)".*

The response indicates the lack of awareness amongst people with substance use disorder. A low risk of awareness of MAT services implies that the affected population might not be well exposed to information about the purpose of existence and the benefits of such services. Nonetheless, the researcher discovered that the low awareness has also been subject to negative perception and rumors that those with substance use disorder hold about methadone treatment. The research indicated that patients have absorbed the myths and speculations about MAT services and consider methadone to be another addictive substance. This ignorance led to the fact that misconceptions made

the people with substance abuse disorders perceive MAT as being equal to psychoactive substances such as heroin. This has been commented by an informant who was quoted as saying;

> *"I think methadone is the same as heroin. I did not want it, even though I did not know much about MAT, I did not want to trade one addiction for another. To me, it sounded like just another dependency, only this time given at the clinic. No one clearly explained how it is different or how it helps people recover. I was scared they just wanted to control us in another way." (IDI/Person with SUD/ 2025).*

Another informant commented;

> *"Nobody told me how long I would be on methadone. Someone told me methadone will destroy my liver. I heard stories from other users and got scared. I kept thinking, what if I get stuck on this for life? I didn't know whether I was getting healed or trapped in another problem. Without clear information, it's hard to trust the treatment." (IDI/Person with SUD/ 20e25).*

These utterances indicate fear and uncertainty regarding the aim, security, and the length of the methadone therapy. The results show that the erroneous beliefs about MAT are widespread among people with substance use disorder. Poor knowledge is reflected in the misinterpretations made, like equating methadone to illicit drugs or thinking that it has severe side effects. This is in line with research that indicates that misinformation is a major obstacle to treatment uptake. In most societies, people get to know information based on rumors or street-level stories instead of health professionals, hence the continuation of fear and non-adoption of MAT services.

It means that there is a direct influence of the lack of awareness and misconceptions on the willingness to enroll in MAT programs. Practically, this implies the dire need to have standardized pre-treatment education and community sensitization programs involving the transparency of the role, safety, and monitoring of methadone. Policy requires investment into communicating public health strategies to counter the stigma and misinformation. Research shows that the various health education models (peer-led,

clinician-led, multimedia) are needed to determine the most effective methods to correct the misconceptions.

Although there is little information regarding MAT, the research established that, before patients access MAT services, they should receive one to two weeks of training on MAT and its mechanism of action. As per the patient's knowledge, however, in the Itega MAT clinic, the training was offered for only a week in cooperation with NGOs, which had merged to create DARO (Drug Abuse and Recovery Organization). The study discovered that DARO educates patients to take daily doses, avoid medications, and modify lifestyles. The Patient may also begin the methadone dose in the clinic after training. This has been exposed by one of the informants who quoted as saying:

> *"We provide them with training first before giving them methadone. The focus is to enrich them with knowledge about methadone treatment so that they can create awareness among the drug users (IDI/health professional/2025).*

A person with a substance abuse commitment complimented on the quote of a health professional saying;

> *"They said that before starting the methadone dose, we were required to undergo a preparatory training period lasting more than a week. During this time, they were oriented on clinic procedures and expected behaviors to change; only after completing this introductory phase allowed to begin methadone dosing. While some acknowledged its usefulness, others felt the waiting period delayed access to treatment. I myself found it difficult to continue using heroin. This highlights the mixed reception of pre-induction protocols among service users." (IDI/person with SUD /2025)".*

This demonstrates that there are concerted attempts to ensure the community possesses adequate knowledge regarding MAT and the associated services. The existence of these trainings is an indication that the individuals with substance use disorder are provided with methadone willingly, once informed about the character of the services offered and their corresponding impact on them.

4.4.2 Limited Community Outreach and Public Information MAT Dissemination

Participants from various data sources have pointed out that there were no community-level campaigns about MAT. The promotion of the use of MAT was mostly carried out by NGOs, health workers, and by word of mouth, and there was no recourse to public health messaging on a regular basis.

A health professional revealed that;

> *"Public education is at a very low level. The majority of people only get to know about MAT when they are already in a situation of crisis." (IDI/ Health professional/2025)*

Also, the review of the MAT clinic's daily operation reports did not find a budget allocation specifically for community awareness of the use of MAT.

Due to such limited structured outreach, many people in the community got to know little or nothing about MAT as a method of treatment.

4.4.3 Unreliable Pre-Treatment Orientation and Education

It is implied in the standard MAT protocol that one or two weeks of orientation should precede induction; however, the research revealed that this was a different story in different places. Some clients described a well-organized preparation conducted by NGOs, while others only saw the waiting time as their treatment being delayed. A health worker said:

> *"We conduct training before methadone so that clients know and understand the treatment and, in turn, can explain it to others." (IDI, Health professional, 2025)*

On the other hand, a service user commented:

> *"The waiting time before methadone was really hard, especially when I was still using heroin. Some people left while waiting." (IDI/Person with SUD/2025)*

Document review, MAT service guideline revealed that there were standardized training procedures for which the implementation was sometimes shortened or adjusted due to allocation of resources, thus leading to a situation where patients had different experiences as far as their treatment was concerned.

4.4.4 Lack of Family Participation in the Awareness Campaign

As a matter of fact, families were mostly responsible for deciding how the treatment should be done; nevertheless, only a handful had the opportunity to be educated formally about MAT. The study showed that the families of people with substance use disorder only linked substance use with punishment and moral failure and therefore, rejected the idea of treatment.

One participant revealed:

> *"My family didn't know methadone was a way of treating the disease. They thought discipline was the only solution." (IDI, Person with SUD/2025)*

The scarcity of family-targeted awareness has resulted in less encouragement to patients who are on the verge of using MAT. Also, the document review has disclosed that there are no regularly scheduled sessions for families to be engaged in program plans to support the recovery of their family members with SUD.

4.4.5 Lack of Family Involvement in Awareness Efforts

The family influence was very strong, especially when it came to making treatment decisions, but hardly any of them had the opportunity to be educated formally on MAT. A few participants mentioned that their families only saw substance use as something that needed to be punished and that it was a sign of moral failure, and they didn’t see it as a disease that needed to be treated. One participant shared:

> *“My family didn’t consider methadone as treatment. They thought that the only way to recover from heroin was to be punished.” (IDI, Person with SUD/2025)*

The lack of awareness among the families of the patients led to a lessening of the patients' support from their families when they were thinking about MAT, and the review of documents has shown that there were no regular family engagement sessions in the program plans.

4.4.6 Awareness through Lived Experience and Peer Networks

The research found that respondents understood MAT through peers or by observing others. It was found in the field that the awareness of MAT is best derived through the peers who initiated methadone and turned out to be a testament to others. The research found that other people are motivated when they see positive changes in others. One of the female patients exposed this by saying;

> *"I heard from my neighbor, who is on the program, that he stopped stealing and now works. That made me think about it and consider enrolling myself because seeing someone close to me change their lives gave me hope that I could also overcome my challenges. It showed me that the program is effective and that recovery is possible if I commit to it (FGD Participant/2025)."*

Another commented;

> *"We share tips in the group; some say it helped them, and others say it made them sleepy. You hear a bit of everything. This creates confusion. They should teach whole communities from the family so that everyone understands how the treatment works and how they can support us better instead of spreading half-truth or misconceptions (FGD Participant/2025)."*

The research established that peers tended to provide early information about methadone and gave out success stories on one hand, and mixed reports on the other, which subsequently served as entry points to other addicted drug users. These results explain that peer networks are a key avenue of MAT awareness. On the positive side, observing evident peer changes (better health, less crime, and employment) develops credibility and prompts others to consider treatment. Nevertheless, informal sharing

also brings contradictions and half-truths, which may leave people bewildered or skeptical.

This denotes that peer networks are a threat and an opportunity. They are credible channels of information, and at the same time, they are spreaders of misinformation. To practice, MAT programs involve peer educators and recovery ambassadors formally to direct the right information through it. In policy terms, acknowledging peer-led interventions as an acceptable part of MAT outreach may enhance the program's legitimacy.

4.4.7 Gender Differences in MAT Awareness

Consciousness about MAT Clinic services was also found to be different between males and females with SUD. Men from the selected locations where street-level interactions happen in “hot points” could have heard about MAT the most since a lot of details were made public. A health worker shared:

> *“Men gather in places where drugs are used openly and hear from peers who have received the treatment so they get more information than women.” (IDI, Health Professional, 2025)*

On the other hand, women resorted to drug use in more secretive places due to stigma, social demands, and their safety. This also limited their access to the provision of the services and information they could get from fellow users. A female participant said:

> *“I don’t meet other users openly like men. Because of that, I rarely hear information about where treatment is or how to begin.” (IDI/ person with SUD/ 2025)*

The document review also concurred with this finding that the implementation of outreach activities deeply depended on the locations of the drug-use “hotspots” that were well known and thus, mainly targeted men who used drugs in public.”

The researcher established that male respondents tended to come across details about methadone services through peer-to-peer communication, outreach efforts, or in their social circles when in socialized areas where the details about MAT are shared. This

exposure helped the men be better informed about MAT's availability and purpose. This is uncovered in informants who say;

Another commented;

> *Men have more knowledge about MAT than women because they spend most of their time in Vijiweni, where their peers who benefit from the MAT service visits. This informal sharing of experience exposes them to more information about treatment options, while women, who often remain at home or engage in household responsibilities, may miss out on such discussions, leaving them with limited awareness of MAT services"* (Health professional/2025)

Conversely, most women with substance use disorder (SUD) were not much aware of treatment with methadone and, in other cases, did not fully understand the mechanism of its action, as well as who can receive this medication. This difference could be attributed to several interconnected factors. To begin with, the male gender is more noticeable in the street-based drug use setting, and consequently, they are the main target of the outreach initiatives and sharing of information among peers. Second, women with SUD usually face more stigma and social judgment. This factor compels them into the hidden or private use patterns, limiting their exposure to information regarding treatment. Third, women have cultural and gender roles that tend to confine them to domestic settings, and this exposes them to fewer awareness campaigns. Lastly, in most settings, outreach programs often target the male drug-using population to the disadvantage of women whose needs are even less conspicuous.

This was revealed by one female patient who said;

> *"As a woman with SUD, I have a very limited network compared to men. Most of the time, I smoke in hidden or private places because it is unsafe or shameful to use openly. Men gather in groups and share information quickly, but women like me stay isolated. That means I rarely hear about services like MAT unless I accidentally meet someone who knows. Even when I want help, I don't know where to start or who to ask. The fear of being judged or exposed keeps many of us silent.*

> *Now, you see, while men access treatment through their connections, women remain invisible. Lack of information becomes another barrier added on top of stigma to women."* (IDI/person with SUD/2025)

Other informants revealed the following;

> *"Women have limited awareness because most outreach programs are conducted in drug-using hotspots, commonly known as vijiweni. Men mostly occupy these places, and it is rare to find women there due to safety concerns and social stigma. As a result, men receive information about MAT services more easily through peer interactions. Women, on the other hand, remain hidden and disconnected from such networks.* (IDI/health professional/ 2025).

4.4.8 Socio-Cultural Stigma as a Barrier to Awareness

The stigma attached to drug use and treatment has caused a decrease in the number of people who are seeking help. Participants were so terrified of being branded or judged that they did not ask for information openly. A lady shared her experience this way:

> "*People dare not to ask about treatment because they stereotype drug users as criminals."* (IDI/ person with SUD/2025*)*

The discouragement resulting from this was so great that people were hardly willing to go to clinics to get information about the treatment. The program documents also referred to stigma as the most significant issue at the community level that impedes the uptake of MAT.

These results show that individuals with substance use disorder encounter several obstacles to accessing Medication-Assisted Treatment (MAT). Low awareness and common misperceptions concerning MAT represent a major obstacle to seeking treatment. People often see methadone as another addictive drug, similar to such illegal drugs as heroin. Poor information and the lack of thorough educational programs are sources of such misunderstandings. Without adequate understanding, people will become less likely to learn about MAT as a valid and efficient treatment method. However, people will become more likely to know about MAT due to others' first-hand

experience. Even though this may be good, it implies that misinformation may propagate if peers do not have correct knowledge about MAT clinic services. This highlights the need for formal processes to ensure that the information is accurate and reliable. Gender inequalities also serve as a burden on the awareness front. Men are more exposed to outreach programs and peer-based discussions on MAT, being more visible in the areas of drug use since they are more visible.

On the other hand, women tend to consume drugs in more confidential places because of the stigma that surrounds this in society, exposing them to minimal such information. This lack of balance illustrates the necessity of specific awareness campaigns that would attract everyone, irrespective of gender. Lack of awareness and misconceptions are the main issues that prevent access to MAT, but not the treatment itself.

The relatively little awareness of MAT in people with substance use disorder affects their health behaviors at various levels, given the insights of a Health Belief Model (HBM). Most of the participants had no knowledge of the purpose, benefits, and safety of methadone, a fact that lowered their perceived vulnerability to the damages of further drug abuse, and it also generated a misleading perception of the extent of addiction. Their beliefs in the benefits of the treatment were lowered due to misconceptions, including assuming that the treatment is comparable to heroin or having worries about serious side effects. Peer networks and outreach programs prompted action, yet the inconsistency or incorrect information sometimes prevented their usefulness. Lack of awareness also negated self-efficacy, whereby people were unsure of their capacity to comply with treatment.

The results of the research by Woo et al. (2017) on the misconceptions about MMT are consistent with the present study, as they point to critical obstacles to accessing Medication-Assisted Treatment (MAT). According to Woo et al. (2017), people often have a negative perception of methadone because they think that it has the same effect as other opioids and thus are unwilling to be treated. This is in line with the findings of this study, as the participants said they were afraid of methadone as a substitute for heroin and feared the side effects that it produces, including liver toxicity. Also, the observation of the study that males are more aware of MAT than females is in line with

the results of the 2022 National Survey on Drug Use and Health, which found that there were differences in awareness of substance use treatment between men and women.

Interpretatively, the triangulated evidence from IDIs, FGDs, and document review shows that, although MAT services are available in Dodoma, knowledge about them is still low, very uneven, and mainly influenced by informal sources of information. There are limited public awareness campaigns, differences between men and women, stigma, and irregular education that all lead to wrong ideas about the disease and late getting of the treatment. Enhancing well-organized community education, including the family and using gender-responsive outreach methods, could be instrumental in clearing up awareness gaps and facilitating access to MAT services in Dodoma Municipality.

4.5 The perceptions of people with substance use disorder toward MAT and their influence on service uptake

The researchers discovered that the picture regarding Medication-Assisted Treatment (MAT) is both positive and negative among people with Substance Use Disorder (SUD). Individual experiences with treatment, peer pressure, attitudes of the community, availability of credible information, and the level of family and social support determine such perceptions. Successful recovery was commonly perceived positively through observing peers' successful recovery, improving their health and stability, and acquiring a hope of reentering society. Indicatively, one of the participants stated that on realizing that neighbors or friends, upon joining the program, ceased committing crimes and instead got a job, they felt compelled to treat themselves. Negative perceptions, on the other hand, were affected by misinformation, side effects, stigma, and the perplexity of mixed stories shared in peer groups.

4.5.1 Negative perception towards MAT and their influence on service uptake

The study concluded that there are negative perceptions about Medication-Assisted Treatment (MAT) by some individuals with substance use disorder (SUD) that deter them from joining and sticking to the program. These attitudes are usually due to misinformation, fear of side effects, community stigma, and conflicting opinions, which are exchanged among peers, diminishing confidence in the treatment and limiting uptake of the services, as discussed below:

4.5.1.1 MAT as Replacing One Addiction with Another

The study has found that individuals affected by SUD saw methadone not as a treatment but as a type of addiction. They were afraid that by taking methadone, they would not stop their dependency, but rather would be substituting one drug for another. Based on the discovery, it was found that this perception generates a significant number of MAT service defaulter because some of them miss a dose due to being scared of continuing their addiction.

This was revealed during the interview by informants who said;

> *"I believe that Methadone is identical to heroin. I cannot give up one addiction to substitute it with another one, since to me it sounded like an exchange of names with the same drug. I fear that methadone would keep me in the loop of dependency, and I would never be free of the drug. This causes me to be reluctant to go on with the program, as I thought the treatment was more of a change than of recovering, but not changing the substance in use."* (IDI/person with SUD/2025)

Another informant said;

> *"I was scared to take it because it seemed like I was just changing one drug for another. I was worried that instead of helping me to recover, it would only make me dependent on a different substance. This fear kept me trusting the program at first as I felt that true recovery should mean living completely without drugs"* (IDI/person with SUD/2025)

Persons with SUD considered methadone as a replacement for one addiction with another. Both men and women widely expressed this perception in the study. Persons who have SUD tend to evaluate methadone in the context of their existing experiences with illegal opioids and the apparent psychoactive impact of these substances. Since Methadone is not a drug that is completely devoid of opioid effects, individuals with SUD regarded it as closer to the last drug of choice that they used, which contributed to their unwillingness to participate in MAT programs. It means that there is a lack of knowledge about the aim of methadone, which is to stabilize and suppress cravings, not to achieve euphoria. The statements of the participants were also of a moral nature and

not of fear only, as they also showed their judgments about keeping up any form of drug use. The community narratives, anecdotal experience, and the absence of formal pre-treatment education reinforce such perceptions.

The understanding that methadone is another addictive drug largely determines the uptake and adherence to the MAT services. The fear and moral consideration about the need to proceed with any drug use decreases readiness to participate in treatment and causes treatment default among the participants. People have fewer reasons to believe that MAT is a real recovery method, and they even miss doses out of fear of long-term dependency. This shows that poor knowledge of the therapeutic purpose of methadone is a significant obstacle to MAT service utilization. The findings indicate that misconceptions must be rectified with pre-treatment education and community sensitization. When people with SUD get clear and correct information regarding how methadone works to stabilize cravings and harm, the fear of substituting one addiction with another may be reduced, and it will enhance the level of adherence to treatment and the uptake of the service in general.

In terms of the Health Belief Model (HBM), the belief that methadone is merely another form of replacement of addiction with another implies that the individual has a high perceived barrier and a low perceived benefit, as per the people affected by the substance use disorder. They consider the persistent reliance on methadone to be a serious implication that raises the level of fear and non-compliance to initiate or comply with treatment. The myths and storytelling of communities are pointers to action, yet they tend to support negative ideas instead of appealing to action. This belief also compromises self-efficacy, as people do not believe in their capability to successfully go through MAT and become cured.

The understanding that methadone is simply a replacement of one addiction by another is a widely held misconception among persons with a substance use disorder (SUD). Such a belief is a frequent cause of opposition to entering or maintaining the Medication-Assisted Treatment (MAT) program. Frank (2020) explains that this assertion has been applied to deny the efficacy of methadone maintenance treatment (MMT) as an effective approach to treat opioid use disorder. Moreover, a research performed by Jaffe (2024) emphasizes that the perception of opioid use disorder

medications, such as methadone, can contribute to the treatment choice to a considerable degree. Unfair assumptions, including the idea of methadone as an alternative addiction, may discourage people from starting or continuing treatment.

4.5.1.2 Fear of side effects and health risks

The research found that a large number of people with substance use disorder (SUD) consider methadone to be potentially disastrous to their health. The participants raised the issue of liver damage, long-term complications, or other unpredictable side effects of using methadone. These fears were widely reported in various age groups and gender and oftens, acted as a hitch to initiating or sticking to MAT.

During interviews, participants shared statements such as:

> *"Nobody told me how long I would be on it, or if it would destroy my liver. I heard stories and got scared. Without clear information from professionals, I kept doubting the safety of the treatment and wondered whether it might cause more damage than good in the long run."* (IDI/person with SUD/ 2025)

This statement shows that participants were not well learnt about the pharmacological effects of methadone. Rather, their knowledge was formed mostly by personal experiential information provided by their peers or community-based stories, which, in most cases, emphasized the dangers more than the therapeutic opportunities. This contributed to reluctance or evasion of treatment due to a lack of accurate information.

Fear of side effects is perceived to influence uptake of MAT. The concerns of people with SUD about liver damage or unspecified health outcomes indicate the greater problem of misinformation and lack of pre-treatment counseling. The less certain people are about the safety and purpose of methadone, the more they consider it a risk, and this may decrease their compliance with the prescribed dosing schedules or even fail to enroll at all. This observation is consistent with those of other researchers, who claim that the myths surrounding medication safety tend to be a barrier to participation in substance use treatment programs. To illustrate, the lack of full knowledge of the period of treatment and continuous monitoring, rumors surrounding the community, and

anecdotal fears can only increase anxiety regarding the side effects, which ultimately cripples the efficacy of the MAT interventions.

The attitude towards methadone as something harmful shows that the fear of side effects is a psychological barrier to the uptake of the service. Patients with SUD might be more concerned with what appears to be their avoidance rather than the potential advantages of treatment, which leads to late start of or inconsistent compliance with MAT programs. It is against this background that organised pre-treatment education, which is simple to understand about the mechanism of action, safety monitoring, possible adverse effects, and anticipated results of methadone, is necessary. Evidence-based information and counseling can alleviate fears and build confidence in MAT services and adherence, ultimately improving the success of the treatment.

In the HBM perspective, perceived severity and perceived susceptibility are at a high level among people with SUD, as reflected by the fear of side effects and the possibility of being affected by some health problems. The participants think that taking methadone may kill their liver or lead to other long-term complications; hence, they feel very susceptible to adverse health consequences. This attitude is also a perceived obstacle, where fear of harm is more important than the perceived utility of the remedy, a detriment to taking or sticking to MAT. The lack of knowledge about the safety of methadone and dependence on anecdotal narratives only reduces the self-efficacy level, as people do not know whether they are capable of overcoming the treatment with no negative consequences. This feeling suggests that focusing on fears through specific education and counseling is necessary to reduce perceived barriers and enhance perceived benefits and MAT uptake.

The present results are congruent with the results of Hosseini, Ahmadi, and Rezaei (2024), who found that long-term patients of methadone maintenance reported the fear of physical injuries and fatigue due to the treatment, which thus impacted their engagement and compliance. On the same note, the research is consistent with that of Khazaee-Pool et al. (2018), who established that patients with opioid use disorder believed that methadone is potentially harmful. Side effects are also the reason why they do not want to start or continue taking treatment.

4.5.1.3 Mistrust toward MAT Services and providers

The research found that there are people with substance use disorder (SUD) who find MAT clinics to be controlling or untrustworthy instead of helpful. Those interviewed complained that the services were created to spy on, chain, or incarcerate them instead of assisting them to heal. This feeling usually caused them to be reluctant to participate in the treatment or the prescribed protocols.

For example, one participant noted:

> *I think health workers would like to see who we are heroin users with the view of arresting or reporting those who sell us drugs. This is the reason why most individuals fear visiting the MAT clinic. The opinions of some of the members of my community are based on a belief that MAT is not actually a treatment, but that it is a method of collecting evidence and following up drug users. They say that after registering, the authorities will begin to follow you. Due to the belief, individuals do not utilize the service even when they require assistance. They do not find it a safe place but a pitfall. At least until trust is established, many of them will not be part of the system."(*IDI/person with SUD/2025)

Another participant commented;

> *"Most of SUD think that we want to arrest them so that they can show us dealers. This creates mistrust towards our services and even our health professionals. However, when they realize that we have good intentions, they start trusting us again*" (IDI/Health professional /2025)

The analysis showed mistrust was strengthened by gossiping in the community, prior bad experiences with healthcare providers, and a lack of clear information on the work of MAT programs. The distrust of MAT services is one of the most prominent psychological and social challenges to treatment attendance. Whenever patients feel that medical workers control or scold them, they will hardly accept the treatment or follow dosage schedules. This observation is in line with other research that claims perceived

coercion or the absence of transparency during substance use treatment will discourage involvement. These mistrust perceptions are usually reinforced by peer stories and community narratives, which pose more barriers to healthcare workers trying to educate and enroll patients.

This indicates that a perceived mistrust hinders uptake of MAT since patients might not want to use services they are not sure are supportive and safe. Building trust by being open in communication, handling it with respect, and consistently providing patient-centered care is important. Explicit descriptions of the treatment objectives, observational practices, and patient rights may be used to decrease fear and promote readiness to participate in the MAT programs.

According to the HBM lens, the mistrust of MAT services indicates a high perceived barrier, decreasing the chances of people participating in treatment. The respondents feel that the clinics are either controlling, restrictive, or not, and are not sincerely supportive, heightening the perceived risks of joining MAT. This distrust reduces self-efficacy, since the individual might not be confident in going through the treatment process effectively or feel unsafe in the clinical setting. There are also low perceived benefits as the participants doubt that methadone treatment actually helps in their condition improvement. Rumors and anecdotal stories within the community trigger action, but in this instance, the clues tend to strengthen negative stories instead of making people participate.

The results are in accordance with the research of Gibson et al (2008) *on Methadone maintenance treatment: Patient perceptions and barriers to treatment engagement.* This research established that distrust of treatment providers and fears of coercion or judgment were the most important barriers to involving patients in methadone maintenance programs. It also aligns with McHugh et al. (2017). Differences in sex and gender as a substance use disorder: A literature review. This paper has indicated that perceptions of stigma, absence of provider transparency, and mistrust of treatment settings among patients hurt the initiation and adherence to substance use disorder treatments such as MAT.

4.5.2 Positive perception towards MAT and their influence on service uptake

4.5.2.1 MAT as a Pathway to Stability and Recovery

The field data showed that the people who had SUD considered MAT to be an efficient method to reclaim their lives and to get their cravings under control and relapse averted. It was discovered that MAT is seen as a means of being stable and on a road to recovery. The researcher found that the physical and psychological stability of people with Substance se Disorder (SUD) improved once the program was initiated, and they were able to organize their future and take part in everyday activities without experiencing terrible cravings.

This is revealed by a participant who stated:

> *"Although we do not know how, to many of us, MAT is a pathway to recovery. After I started MAT, I stopped craving heroin all the time. Now I feel more stable and can think about my future. I can sleep properly and even plan for my work without feeling the constant urge to use drugs."* (IDI/Person with SUD/2025).

Another informant revealed the following*;*

> *"There has been a positive perception towards MAT services in recent years. Some of the clients have felt that MAT is the solution for all forms of addiction. This has motivated many to come voluntarily when there seems to be no hope. However, despite the positive response, some still drop out of the service when no clear information is provided when they need it."* (IDyI/health professionals/2025).

This quote demonstrates that MAT is not only effective in minimizing the physical symptoms of addiction, but it also gives the participants a sense of control in their lives, and this increases their confidence and willingness to comply with the program.

The fact that MAT is viewed as a way of getting stability and recovery emphasizes the suitability of the program in tackling the physical and behavioral elements of substance use. This decrease in cravings and lack of relapse shows that MAT offers a systematic way of managing addiction, which promotes care continuity and long-term remission.

The program that results in the achievement of stability enables individuals to re-establish daily lifestyles, remain employed, and involving in social and community engagement that are vital in the continuation of recovery. The fact that MAT is perceived as a stabilizing intervention also indicates that the program is one of the causes of better overall well-being. The treatment creates the feeling of normality and control of life situations by alleviating the effects of withdrawal and limiting the physiological and psychological weight of addiction. This will create a conducive atmosphere where recovery will be possible in the long term, which will boost the chance of compliance with treatment regimes.

Additionally, the discovery highlights the wider effects of MAT, ie, society. By allowing people to operate efficiently and be reintegrated into social systems, the program minimizes the social and economic impact of drug use, i.e., crime, absenteeism, and social exclusion. The awareness of MAT as a useful channel of stability underlines the value of the persistent availability of full-fledged treatment services and the incorporation of supportive interventions to reinforce the recovery outcomes.

Direct implications of the service intake are the concept of MAT as a source of stability and recovery. As the program becomes known to be effective in the reduction of cravings, prevention of relapse, and overall stability, the chances of individuals with substance use disorder seeking enrollment will rise. Good perceptions serve as a driving force, and the prospective clients will be more eager to undergo treatment and follow the intake process. In addition, a perception of MAT as a recovery method will foster confidence in the program, and this may diminish the anxiety or fear over seeking services. This implies that the approach will result in increased participation and better rates of first adoption once the advantages of MAT are adequately publicized and realized. Practically, the strategies to focus on the stabilizing effects of MAT can be employed in any effort to offer outreach or counseling services to more individuals in the community, thus making more people engage in service intake and spreading the program.

Through the prism of HBM, this result indicates that the perception of MAT as a route to stability and recovery is a strong incentive that encourages people with substance use disorders to pursue and participate in treatment. The benefits of MAT, such as a decrease in cravings, relapse prevention, and the possibility of gaining control over life daily, are acknowledged. However, more people must pay attention to initiating services, treating the condition according to the ice, and maintaining recovery. The result demonstrates that favorable attitudes toward effectiveness promote service uptake and support further visitation, which qualifies MAT as an important instrument to clinical management and social reintegration.

The observation that Medication-Assisted Treatment (MAT) is identified as a way to stability and recovery correlates with the recent research by Jason et al. (2021), who concluded that access to better housing and recovery assistance contributes greatly to people who use MAT to maintain their recovery. Furthermore, Minauro (2025) notes that MAT is not only a medical treatment; it is a means of restoring stability, meaning, and dignity in the struggle against addiction. Moreover, the 2023 National Survey on Drug Use and Health results have shown that MAT is a well-known and commonly used treatment modality, which supports the need to drive stability and recovery. All these studies help to believe that not only is MAT a physiological approach to addiction, but it also helps to make a person more stable in the whole psychosocial sense, thus promoting the desire to get and persist with therapy.

4.5.2.2 MAT as the place where social functioning and family relationships are improved

The study results showed that the subjects of a substance use disorder (SUD) perceived MAT as the place where social functioning and family relationships are enhanced. According to the research, MAT has been said to assist persons with SUD in regaining trust with their families, reestablishing respect, and becoming members of their respective communities again. The positive change positively transformed the participants and made them take up services easily.

This has been revealed by the informants who revealed that;

> *"My family trusts me again since I joined MAT. They see that I don't steal or disappear from home anymore. I feel respected and supported, making me want to continue the program. This sense of acceptance and encouragement motivates me to continue with the program to stay on track and work towards fully rebuilding my life."* (FGD Participant/2025).

Another informant quoted saying;

> *"Most of our clients regain family relationships after starting MAT services. In a real sense, their respect and sense of independence have been restored after treatment. This makes it easy to do family reintegration for those their family rejected."* (IDI/Health professional/2025)

This means that these positive experiences were observed to serve a more positive self-image, which, in turn, leads to acceptance and compliance with treatment services. The more participants gained respect and recognition in their families and communities, the more they were willing to stick with treatment, less prone to relapse, and willing to obtain supportive services. The recovery of dignity and social belonging served as a psychological reinforcement and a practical facilitator of long-term recovery.

The results show that MAT helps in the enhancement of social functioning and strengthening of family bonds among substance users with substance use disorders (SUD). By participating in MAT, the families can trust and reintegration into the community is boosted. Such changes not only enhance self-image but also provide a positive environment where continuity in treatment is promoted. The reinstatement of esteem and acknowledgement in the family and social situations brings the psychological and social support required to maintain recovery. Increased self-image leads to dignity, confidence, and a sense of belonging, decreasing relapse and promoting treatment service adherence. This indicates that MAT effects go beyond clinical care and cover more social and relationship elements of healing that are fundamental to long-term well-being.

The results imply that MAT does not have a pharmacological role, as the concept can treat larger social, psychological, and relational dimensions of recovery. Reintegration into the community and re-establishing trust in the family help people with SUD to rebuild their respect, dignity, and recognition. The process leads to a better self-image, which enhances a stronger drive to go through treatment and decreases the chances of relapse. These findings align with the previous studies, which point out that the efficacy of MAT is not only in reducing drug use but also in enhancing social functioning and interpersonal relationships. Indicatively, De Maeyer et al. (2011) have pointed out that recovery is a multidimensional process in which social connectedness and quality of life play as important a role as abstinence.

Equally, Mitchell et al. (2016) determined that by being involved in MAT, it was possible to restore some trust in families and enable a better level of acceptance in communities. In addition, research by Wogen and Restrepo (2020) highlights the necessity of stigmatizing less and improving self-image to encourage compliance with treatment services. In this respect, MAT may be regarded as a clinical and a social intervention. Although the medication is known to stabilize the biological factors of the addiction situation, the progress in self-perception and social acceptance is what sets an enabling milieu, which further strengthens the long-term recovery. In this way, the study shows the role of MAT in rehabilitating patients with SUD as it is a holistic approach that addresses the patient's medical, psychosocial, and relational needs.

Viewed through the prism of the Health Belief Model (HBM), the results indicate that MAT can make people with substance use disorders realize that the treatment is beneficial, can restore their family trust, self-image, and social relationships, which makes them feel motivated to continue their engagement. Meanwhile, MAT is less stigmatizing and socially rejecting, and individuals are more inclined to take and comply with treatment. The adverse impact of substance use will make them more aware of the severity of their situation. In contrast, the positive response of the relativists and the community will act as an incentive to remain involved. Optimism and dignity boost their confidence in their capabilities to sustain recovery.

4.5.2.3 MAT as a place where hope and self-efficacy can be restored

The researchers discovered that MAT has been viewed as a location where hope and self-efficacy are reinstated. The statistics indicate that the participants were rejuvenated and had a sense of purpose through participation in the program. With the help and framework of MAT, people could once again trust themselves and one another, reinforce their faith in their capacity to take control of the recovery process, and envisage meaningful and productive futures. The hope restored encouraged the participants to proceed with treatment and other positive life decisions. In contrast, the increased self-efficacy gave them greater confidence to overcome the obstacles, and the likelihood of relapsing was minimized.

This was reported by informants who quoted saying;

> *"Before MAT, I thought my life was finished. I was tired of using heroin; drugs ruined my life. Now I see I can work and live like other people. It gave me hope and made me believe I can recover fully if I follow the program properly."* (FGD, participants with SUD/2025)

Another informant said;

> *"We have observed that clients who regularly attend MAT sessions start believing in their ability to recover. They become more motivated to rebuild their lives, reconnect with their families, and plan for their future."* (IDI/Person with SUD/2025)

These quotes mean that the restoration of hope encouraged the participants towards treatment and positive life decisions, and greater self-efficacy led them to feel more confident that they could overcome the challenge, and they were less likely to relapse.

The analysis demonstrates that MAT offers a setting that helps to restore hope and self-efficacy in a person with substance use disorders. The results imply that the program has a structure, guidance, and support that allows participants to build confidence and envision positive futures. This renewed hope and motivation in treatment, along with improved self-efficacy, enable people to cope with difficulties better and comply with program demands. The findings demonstrate the need to take into account both

psychosocial and clinical outcomes in substance use treatment because the support and empowerment of individuals are the enhancing factors of recovery processes and stability in the long term.

The fact that MAT is the setting where hope and self-efficacy can be revived shows that the program has a strong psychosocial effect on individuals with substance use disorders (SUD). MAT assists individuals with SUD to have confidence that they can cope with recovery and rebuild their lives, which strengthens the desire to continue to attend treatment. By restoring hope, they can all see productive futures and meaningful goals to be pursued, and enhanced self-efficacy makes them believe they can get over any challenges and stick to the program. This two-fold effect of psychological empowerment and medical care develops the atmosphere that, in addition to responding to the physical realities of substance dependence, leads to long-term behavior change, stability, and long-term recovery.

According to the HBM perspective, the result is that MAT can affect the determinants of health-related behavior of individuals with substance use disorders (SUD). MAT improves perceived benefits through revitalizing hope and self-efficacy as individuals with a SUD become aware that by participating in treatment, they will make a significant change in their lives. Concurrently, the perceived barriers (stigma, social exclusion, or fear of relapse) are minimized as the program makes its involvement and adherence to treatment easier. Progress and positive reinforcement experiences served as stimuli to action and encouraged SUD people to keep participating in MAT. Empowered self-efficacy improves their belief in self-efficacy to handle recovery and overcome difficulties even further.

The results of the present study are consistent with the current research showing that MAT enables the recovery of hope and self-efficacy in patients with substance use disorders (SUD). Indeed, an example could be the article by Bernardo and Cunanan (2023), who have found that the levels of hope positively interplay with self-efficacy to reinforce the outcomes of abstinence and recovery in therapeutic communities. Likewise, Amura et al. (2022) have discovered that MAT resulted in reduced substance use, better physical and mental health, and increased motivation, proving effective in regaining confidence and a sense of purpose. Shourabi et al. (2025) mention that hope

fostering is a highly effective way to increase self-efficacy that decreases psychological distress. Yang et al. (2025) indicated that increased self-efficacy decreases the probability of drug intake and is more likely to lead to a successful recovery.

4.6 The procedural challenges in MAT service provision that hinder the accessibility of MAT for individuals with substance use disorders.

The researchers discovered that before the initiation of Medication Assisted Treatment (MAT) among clients with substance use disorder in Tanzania, they must undergo a preparatory measure that qualifies them to be ready and safe. Community-based organizations and outreach workers (COWs) identify clients and sensitize them by educating them on the purpose of MAT, its benefits, obligations, and potential side effects. The research also determined that the concerned customers are registered in a Pre-MAT program. They are provided with comprehensive training regarding the importance of attending day-to-day classes, the need to adhere to requirements, and the significance of psychosocial support. Following this process, the clients will be officially referred to a MAT clinic to undergo thorough examinations, such as medical history, physical examination, and lab tests for diseases like HIV, hepatitis, tuberculosis, and liver checks to determine whether to be on methadone and at what dose.

It also provided results that psychosocial assessments are done to measure the mental health, housing stability, and social support systems, and clients are encouraged to identify treatment supporters to facilitate their recovery process. Lastly, the research established that the clients should give informed consent and make pledges to clinic rules like attending and testing drugs regularly, which helps the involved parties to be ready and the service providers to be effective towards a safe treatment process. The processes have been reported to be troublesome in availing MAT services to SUD clients. These issues are elaborated under four emergent themes.

4.6.1 Lengthy and Bureaucratic Enrollment Process

The authors discovered that access to substance use disorders (SUD) was impeded by bureaucratic and lengthy procedures during the enrollment process into MAT services in Tanzania. Treatment required the clients to go through a series of administrative

processes in which community outreach workers made referrals, took medical exams on several occasions, visited the clinic several times, and had to complete a lot of paperwork before receiving treatment. The results also indicated that the process took quite some time in most cases, spanning several weeks, and in the process, many of the potential clients got frustrated or lost interest. The research also concluded that the requirements delayed enrollment and locked out vulnerable people who could not easily manufacture the required documents. As a result, several prospects are identified during the enrollment phase. It failed to comply with recurrent requests or visit the clinic regularly, because of financial issues, stigma, or unstable housing conditions. These bureaucratic obstacles were identified to counter the main aim of MAT, which was to offer timely and readily available treatment by screening out those who need immediate treatment.

During the interview, informants revealed the following, as quoted;

> *"They told me to come many times with a form from the NGO, and I did not understand it. It took weeks before I could even start methadone. Before I started methadone treatment because of the delay in the initiation of treatment, I continued to take heroin."* (IDI/person with SUD/2025)

Another informant revealed the following;

> *"It took too long to qualify for starting medication, and by the time I finished the forms and tests, I had already gone back to using heroin several times; it was too long. If the procedures were within a few days, then I would start methadone dose, I think I would not go back to taking heroin."* (IDI/person with SUD/2025)

The research also found that bureaucratic enrollment processes conflict with the realities of most people with substance use disorder (SUD), who lead very unstable lives, have limited financial means to get transport, and have no capability of making repeated appointments. Every other necessity, be it the generation of documentation, a follow-up clinic visit, or paperwork, offers an instance of disengagement or relapse. The results indicated that these administrative requirements not only extend the enrollment

process, but also raise indirect costs, including transport fares, loss of income-generating time, and childcare, which adds to the barriers on top of clinical considerations. Furthermore, the intricacy of the consuming process was identified to convey to the clients that the system values formalities rather than quick and caring service, which consequently undermines their trust and the desire to get treatment. This means the prolonged bureaucracy slows access to life-saving services and decreases the number of clients who can start MAT. Notably, the study was keen to note that vulnerable people, including unstably housed persons, unemployed, and those constrained by family-related duties, are disproportionately excluded, thus making what ought to be a treatable moment of preparedness a scene of deflection.

Besides, the researcher discovered that men and women residing in drug addiction bases (also referred to as vijiwe) are adversely impacted by lengthy and bureaucratic tedious processes of the MAT enrollment, but women face compounded problems. Although in Vijjiwe, the major challenge men face is financial limits and unstable lives, females not only deal with the same economic issues but also have to take care of children. In some cases, their partners are also drug users.

One female participant explained,

> *"I cannot leave my children with their father or any other person to visit the clinic to make frequent visits. With the responsibilities of childcare, it becomes extremely hard to travel consistently. As a result, I occasionally skip planned appointments and the doses of methadone. This is because of the effect of missing doses that impact my treatment progress and make it difficult to keep up. I am afraid of lagging in the process of meeting family demands. Caregiving issues are not reflected in the clinic schedule. This forms another obstacle, particularly for the ladies in recovery. It is very difficult to continue regular treatment without the support of services."(IDI/ Person with SUD/2025)*

This single poverty burden, coupled with childcare issues, complicates the lives of women who have to fulfill numerous visits or participate in the enrollment process. Men, in turn, though also being financially limited, are not as exposed to the childcare responsibilities, so they can slightly better afford to go to clinic appointments regularly.

This fact implies that the mechanism of MAT enrollment is highly unfavorable to individuals with Substance Use Disorder when it comes to individuals who are ready and willing to begin treatment. Still, it is extremely hard to do so. The frequent check-ups, the Facilities, the Administration, and the visits cost both time and resources that the client usually lacks. They thus may either cause dropout or may revert to drug use even before starting the treatment. It has a special impact on women since, besides being impoverished and living unstably, they have to take care of children whose parents are also involved in drug use, complicating the process of attending multiple appointments. Men also have a hard time, but when they do not have the childcare burdens, they can occasionally cope with repeated visits.

Using the HBM-influenced approach, the results indicate that the MAT enrollment process is long and bureaucratic, which influences the perception of the clients regarding the barriers and self-efficacy as some of the most important health behavior determinants. The perceived barriers include the repeated clinic visits, medical checks, and administrative demands, and make the effort to obtain a treatment appear high when compared to the benefits, even in cases where clients are aware of the severity of their substance use disorder and the potential benefits of MAT. In the case of women, the perceived barriers are further augmented by caregiving responsibilities, which decrease the initiation of treatment. Also, because the life of individuals with SUD and financial limitations is unstable, it decreases self-efficacy levels among clients, i.e., they perceive themselves as unable to complete the enrollment process successfully. The perceived barriers and self-efficacy are high, discouraging action, hence why most clients disengage before commencing treatment. When referring to HBM, the bureaucratic procedure unintentionally decreases the likelihood of converting the willingness and awareness of MAT benefits into the actual health-seeking behavior among the clients.

The research is consistent with the results of Lawala et al. (2025), who have determined that there are major obstacles to MAT enrollment in Mbeya Zonal Referral Hospital. Their study identified obstacles like long administrative procedures, multiple checkups, and frequent visits to the clinic, which, in most cases, resulted in a lack of client engagement. Moreover, Gooden et al. (2023) investigated obstacles to HIV care, such as the logistical problems and the lack of awareness of treatment, which may also be used in the context of access to MAT services.

4.6.2 Limited and Inflexible Pre-Treatment Training

This study discovered that MAT clients in Tanzania receive little and rigid training on pre-treatment, which is set on Wednesday and Friday per week; further obstructing access to treatment. It requires clients to undergo one to two weeks of pre-treatment training before they can receive their first dose, and this training is usually the education about substance use, advantages and side effects of methadone, adherence, and psychosocial support. These sessions are, however, traditionally provided on a very sporadic basis due to a lack of clinic capacity or on the timetables of collaborating NGOs. Consequently, the customers who cannot attend the particular planned sessions will have to wait until the next training cycle, and occasionally, they are under a lot of waiting time before they can commence treatment.

The contacted informants revealed the following;

> *"We had to wait for training, but sometimes training only happens when NGOs are around, so it takes a long time to start. This delay often makes it difficult for us to begin the program on time, and sometimes people lose motivation or face challenges continuing with the treatment because the support is not consistent. It feels like progress depends on the availability of external organizations rather than on our own readiness to improve"* (IDI, person with SUD, 2025).

Another informant revealed the following;

> *"Many clients have jobs or other responsibilities, so asking them to dedicate a full week to training can prevent them from participating fully. This creates a barrier to accessing the program and may delay*

the start of their treatment or reduce engagement, especially for those who rely on daily income to support themselves and their families."
(IDI/health professional /2025)

The results have shown that such inflexibility is disproportionately applied to individuals with substance use disorder, who commonly experience unsteady lives daily, financial limitations, and mobility issues. For example, clients might not be able to afford to be present on consecutive training days or might be too busy trying to get food and shelter, and therefore, strict schedules are not easy to adhere to. Thus, the time between enrolment and the start of dosage taking may take several weeks, and clients are still at risk of relapsing. The research has pointed out that restricted and rigid pre-treatment training not only slows down a client's timely initiation of MAT, but also compromises client motivation and engagement, thus eliminating the number of people who successfully pass through the path of readiness to active treatment.

However, such pre-treatment education is relevant as it ensures that the clients have informed consent, comprehend the advantages and dangers of the MAT, and are more likely to follow the treatment regimens. Meanwhile, the study also established that block-scheduled training with rigidness produces a bottleneck. In cases where training programs are only provided at specific hours or require visiting NGOs, clinic capacity is the limiting factor to initiating treatment. Full-week attendance is not always down-to-earth when the patient has a substance use disorder and does not have social support, inconsistent income, or is going through withdrawal and needs quick stabilization. Consequently, the timely initiation of MAT is minimized by lengthy, infrequent, or inflexible forms of training.

It implies that even though pre-treatment education is the most important step of making sure clients know about MAT, agree to treat, and are willing to follow through and comply with treatment properly, the manner in which it is now being provided in the form of long, sporadic, and strictly scheduled sessions works against actually getting many clients and timely access to care. Individuals who are in dire need of treatment, do not have social support, or have other pressing commitments are unable to fulfill these inflexible requirements, which all contribute to the possibility of delays, disengagement, or relapse. Stated differently, such a system, which helps to protect and

prepare clients, is counterproductive, as it demonstrates that even the required safeguards can hinder when they are not adjusted to the realities of the client's lives.

According to the HBM, rigid pre-treatment education adds perceived barriers among the clients, which is one of the fundamental determinants of health behavior. Although clients might be aware of the severity of their substance use disorder and the advantages of MAT, strict training programs establish objective challenges that complicate action. As an illustration, the long and block-scheduled sessions could be against their immediate needs, daily survival, or caregiving roles, decreasing their self-efficacy and belief in their ability to finish the enrollment process. Clients are less willing to start treatment when they feel the perceived benefits outweigh the perceived barriers. In the HBM perspective, therefore, the strict training is an unwanted barrier to action, which makes the treatment process overwhelming or inaccessible, transforming the treatment process into a tangible and psychological barrier to care. This education protection has been intended as a practical and psychological barrier to care.

Equally, Mosha et al. (2022) discovered that rigid clinic hours and insufficient pre-treatment education were barriers to client engagement and a rise in the likelihood of dropout in MAT programs in Dar es Salaam. Cooke et al. (2019) further pointed out that strict training conditions and administrative difficulties were crucial barriers to the commencement and maintenance of clients under methadone treatment. Together, these pieces of evidence confirm the existing result that pre-treatment education is a necessary factor, but rigid and inaccurately planned training may accidentally slow access and decrease treatment adherence in individuals with substance use disorder.

4.6.3 Daily Clinic Attendance Requirement (Observing Dosing)

The research discovered that clients under MAT programs must visit the clinic daily to receive directly observed dosing, which does not allow diversion of methadone because of adherence. On the one hand, this method is clinically significant in ensuring treatment compliance, but on the other hand, according to the participants, it poses a serious practical challenge. The field evidence has demonstrated that financial burdens are created by commuting daily to the clinic, since not all clients can afford transportation expenses regularly. Travelling long distances and work or money-earning conflicts also restrict their regular opportunities to attend the sessions. In addition, the

study has mentioned that physical disability or illness may render day-to-day attendance difficult. The fact that social stigma was experienced in the queues when the community members recognized some clients as a methadone clients also discouraged other clients from attending regularly.

A health professional revealed the following during the interview, saying;

> *"Every day they must come here, even if they are sick or have no bus fare. Sometimes they miss. These challenges affect their consistent attendance and can interfere with treatment progress, highlighting clients' difficulties in adhering to the program requirements"* (IDI, health professional/2025).

Another informant revealed the following, as quoted;

> *"I have to attend the clinic every day. If I miss one day because I have no money, then I feel ashamed to come back, as the social welfare officer will punish me. This makes it difficult for me to maintain consistent attendance, and sometimes I delay returning to the program due to fear of reprimand"* (IDI, person with SUD/2025).

The researchers found out that these requirements of attending school every day help lead to dose omissions, inconsistent therapy, and even therapy abandonment, especially in clients who experience financial instability, diseases, and conflicting costs. Although observed dosing is aimed at assuring safety and compliance, it has the inadvertent effect of punishing clients who cannot achieve the strict daily dosage, thus showing a misalignment between clinical procedure and the reality of the clients' lives. In this respect, the daily attendance regulation could be viewed as a structural obstacle, particularly when it comes to persons with substance use disorder whose livelihoods are unstable, with health problems, or social commitments.

This means that although daily attendance policies are designed to guarantee compliance and diversion prevention of methadone, they put more emphasis on controlling the program rather than caring for clients at the expense of access and equity. The policy presupposes that each client possesses the time, finances, and

physical capability to drive to the clinic daily, something that is hardly possible in the case of a substance use disorder patient. Most clients are in poverty, irregular/informal income earners, or must travel distances to access the clinic, which makes it imposing both financially and physically to attend the clinic daily. Also, some clients have caregiving duties for children or ill family members, not to mention those with employment or income-generating employers and jobs incompatible with the strict clinic timetable. Respondents did not skip their doses because they did not want to or felt unmotivated to do so, but because attending classes every day was logistically and financially impossible.

Moreover, the policy puts clients at social stigma, whereby attending sessions daily makes them noticeable in the community and can be labeled publicly as users of methadone, leading to non-attendance. Disease, tiredness, or withdrawal symptoms may also hinder the daily schedule compliance of the clients. All these aspects together impose structural obstacles that in turn discriminate against the most vulnerable clients in favor of those who have a steady income, social support, or proximity to the clinic, and against those who are marginalized in terms of their vulnerability but who may be at more risk and require more treatment. Practically, a measure established to facilitate safe drug use is a counter product, creating marginalization to lower treatment adherence and increasing disparities in access to healthcare.

According to the HBM, hard and fast policies on attendance aid in increasing perceived barriers, which is one of the determinants of health behavior. Although the clients can be aware of the severity of their substance use disorder and the utility of the MAT service, attendance requirements face practical and psychological barriers. Financial issues, distance, caregiving, work, illness, and stigma decrease the self-efficacy or confidence of clients in their stance of being able to maintain consistent adherence to treatment. Clients are less likely to commence or continue with MAT despite being aware of its benefits when they perceive more barriers than benefits. Effectually, the daily attendance rule unconsciously discourages engagement by rendering treatment inaccessible or uncontrollable, especially to the most vulnerable. The policy creates the opposite effect on action-taking. It increases the levels of default, which can be seen

through the lens of HBM, showing how the structural elements may influence the health behaviors even when the subject is aware of the risks and benefits.

These results are consistent with the study of Knight et al. (2023), who carried out a qualitative research in Dar es Salaam, Tanzania, to investigate the economic, social, and clinical variables that influence retention in methadone maintenance therapy. The study established that attending the clinic on a daily basis was a financial strain as it involved transportation expenses, and female clients were challenged by income-generating activities operating against the clinic's timings. On the same note, Laswai and Nsimba (2017) examined the issue of MAT access among opiate users visiting a methadone clinic in Dar es Salaam. The researchers cite logistical problems, such as transport and unemployment, as major discouraging factors in treatment. Moreover, misunderstanding of methadone and the fear of being discriminated against were cited as challenges.

4.6.4 Limited-Service Points.

The research indicated that MAT services are highly concentrated in a limited number of clinics, posing many operational and structural problems. The centralized services saturate the few available infrastructure and staff, causing a high patient-to-staff-to-ios ratio. The field data indicate that clients are not paid as much attention to individually during counseling or psychosocial assistance, which negatively influences their knowledge of treatment, adherence, and involvement. Prolonged waiting, less counseling, and poor conditions in the clinic reduce client morale and motivation and lead to higher chances of missing doses or dropping out of treatment. The most vulnerable customers such as those with unreliable income, irregular work hours, caring duties or poor health are strongly affected since the centralized design does not fit their respective logistical and social conditions.

This has been explained by the informant, who revealed the following;

> *I always have to travel from Gairo, my district, and if I am late, I miss the dose. It feels like punishment. The distance and strict dosing schedule make it challenging to adhere consistently to the program. Traveling long distances daily is physically and financially*

> *demanding, and any delay or disruption, such as transport issues or personal commitments, can prevent timely attendance. This situation creates stress and discouragement, potentially affecting motivation to continue with treatment and compromising the overall effectiveness of the program"* (IDI, person with SUD/2025).

Another informant was quoted as saying;

> *"There is only one clinic in Dodoma, and people with SUD are many from different parts of the region. This causes challenges, especially when they come from a location that is far from the MAT Clinic Centre, and causes dropout from the MAT service* (IDI/health professional/2025)

These results indicate that centralized services make the client travel very long distances in different districts, making it costly to reach the MAT clinic center. Although this might be resource-efficient at the system level, centralization, in a way, leads to structural barriers that undermine access, equity, and retention in MAT programs. This implies that service concentration is detrimental to accessibility, acceptability, and continuity of care. Absences due to bus fare shortage will deter attendance, demoralize, and diminish retention, with an unequal impact on those with unstable lives.

According to the HBM, the perceived barriers, mainly the centralization of MAT services and consequently the long distance to MAT services, are the central determinants of health behavior. Although clients might be aware of the extent of substance use disorder and the advantages of methadone treatment, structural factors like long travel distances, long queues, low counseling rates, and open queues posed significant barriers to action. These impediments may lower the self-efficacy or confidence of clients to go to the clinic regularly and comply with treatment, particularly for patients with unstable income or work status, caring duties, or health issues. By increasing perceived barriers, decreasing self-efficacy, and reducing supportive cues as a result of centralized services, awareness of severity and benefits will be discouraged, and ultimately decrease treatment uptake and retention among individuals with substance use disorder.

The results are consistent with those obtained by Lawala et al. (2025), who measured barriers to adopting contingency management to manage methadone treatment patients in a tertiary hospital in Tanzania. The analysis has pointed out that the large number of patients served by the clinic due to the existence of limited-service points, resulting from the lack of MAT centers, resulted in a long waiting time with an overcrowding default rate of 38, thus suggesting an adverse effect on treatment outcomes.

Irrespective of these obstacles, the research study established that some clients have undergone MAT services and regained, while others fully recovered. To ensure the complete attendance process and recovery process, the study identified the following;

4.7 Effects of Stopping Medication-Assisted Treatment (MAT) for Substance Use Disorder

The field data show that some SUD individuals have dropped out of MAT services due to several factors. The termination of addiction treatment, specifically, the Medication-Assisted Treatment (MAT), bears serious consequences for people with substance use disorder (SUD). MAT that usually incorporates medication like methadone offers physiological stabilization, decreases cravings, and aids psychological and social functioning. By discontinuing or diversifying the treatment, the clients are deprived of the protective benefits of MAT, putting them at risk of various negative consequences. These are the relapses into the use of illegal substances at a very fast rate, serious withdrawal signs, the heightened risk of overdose, the worsening of mental condition, and social and occupational instability.

4.7.1. Relapse to Illicit Drug Use

The results of the study show that the immediate continuation of MAT is directly related to the capacity of persons with Substance Use Disorder (SUD) to continue abstinence from illicit drugs. The removal of the effects of the stabilizing medications, such as methadone or buprenorphine, known as the MAT, leads to the recurrence of cravings and withdrawal symptoms when clients discontinue them. These are usually strong and psychologically uncomfortable desires whereby individuals find it highly challenging to deny the urge to consume opioids or other drugs.

As one participant explained:

> "*After I stopped methadone, the cravings became unbearable, and I went back to using heroin within a week. This demonstrates how critical continuous access to MAT is, as interruptions in the program can lead to relapse. The rapid return to substance use highlights the physiological dependence on opioids and the need for consistent support and monitoring to maintain recovery"* (IDI, person with SUD/ 2025).

Health providers commented on the following during the interview;

> *"We often notice that when clients miss doses or are unable to attend daily due to travel or financial constraints, they struggle with increased cravings and are at higher risk of relapse. Consistent attendance is essential for MAT to be effective, but many external factors make this challenging"* (IDI/health professional/2025)

This quotation shows that the relapse may be extremely fast, as soon as a person stops taking opioids, and it can take just several days, which proves physiological dependence and alterations in the neurochemical processes. Lack of control of the cravings without medication assistance enhances the chances of relapsing into the past behaviors of substance abuse. The effects of relapse are not just the immediate relapse into drug use. The use of unsafe substances, overdose, or transmission of infectious diseases may pose physical health risks to the clients in the case of injecting drugs. On a social level, relapse might create tension in family and friendship relationships. On a legal level, individuals might be arrested or suffer other criminal repercussions related to attempting to seek substances. Moreover, relapse undermines prior achievements in recovery, such as mental health improvement, work, and social functioning, which further complicates future efforts to achieve treatment.

The results suggest that not only is the end of MAT depriving the person of a fundamental protective mechanism against cravings, but also the person with SUD is subjected to an increased cycle of physical, psychological, and social risk. The quick relapse, as reported by participants, is an expression of the neurobiological fact of

opioid dependence in the absence of pharmacological stabilization; the brain returns rather fast to compulsive seeking of substances. This reveals the significance of MAT as not only a treatment but also a life-saving intervention that breaks the relapse processes.

4.7.2 Severe Withdrawal Symptoms

The study results indicated that a sudden stop of MAT results in serious physical and psychological symptoms of withdrawal since the body has become physiologically addicted to the drug. Symptoms like nausea and vomiting, diarrhea, aches, insomnia, nervousness, and irritability are usually commonplace. These symptoms are not only pains but also mentally draining to the extent that they cause a strong urge to obtain illicit opioids to help alleviate pain.

> "*When I stopped the treatment, I could not sleep, and my body hurt so much that I almost gave up on everything. The withdrawal symptoms were extremely severe, which made it very difficult to maintain recovery without ongoing support. This experience highlights the importance of continuous MAT adherence and close monitoring to prevent relapse and manage the physical challenges associated with stopping treatment"* (FGD with participant/2025)

Another informant revealed the following;

> *We often observe that when clients interrupt their methadone treatment, they experience severe withdrawal symptoms such as insomnia, body pain, and intense cravings. These physical effects make it very difficult for them to continue recovery, and some even relapse if adequate support is not provided"* (IDI, health professional/ 2025).

Based on the findings, the withdrawal symptoms were found to affect the ability of clients to abstain adversely. The excessive lack of comfort usually frustrates them to pursue further recovery and may even deter re-admission into the treatment programs. Clients might be desperate or despairing, and they may think that the only solution to their problems is to relapse. Such symptoms may also aggravate comorbid mental

health problems, including anxiety and depression, and may complicate the recovery process even more, leading to worse health and social outcomes.

It means that individuals who have a substance use disorder experience the strongest reaction in the case of abrupt MAT disappearance since they have been accustomed to the drug. The withdrawal symptoms (such as pain, sleeplessness, and anxiety) are severe to such an extent that they can hardly remain drug-free. The pain is so excruciating that most people find they are not given an option other than to resort to drug use to help alleviate the pain. This demonstrates that it is not only the cessation of treatment that leads to the relapse, psychological difficulties, and surrender of the recovery effort, but that it is also putting people in a danger. It supports the significance of ongoing therapy and care to keep them on track and not relapse into drug abuse.

4.7.3 Increased Risk of Overdose

The field data demonstrated that the end of MAT decreases opioid tolerance in the body in the long run. In case clients relapse and take the same dose of opioids as they took before treatment, their bodies might not be able to process it, and the risk of overdose becomes high, and it is lethal. The pharmacological stabilizing effect of MAT, which protects the opioid receptors and avoids both harmful increases and decreases in drug exposure, is lost upon discontinuation of the treatment.

> *“I relapsed after stopping methadone and almost overdosed because my body could no longer handle the dose I used before. This shows how interruptions in MAT can lead to dangerous consequences, including increased risk of overdose. Continuous support and careful dose management are essential to prevent relapse and protect clients from severe health risks"* (FGD with SUD participant/2025).

Another informant quoted saying;

> *We have seen several clients return to substance use after stopping methadone, and in some cases, they nearly overdose because their tolerance has decreased. This emphasizes the need for continuous monitoring, counseling, and support to ensure clients safely maintain recovery"* (IDI, health professional/2025).

These results have unveiled the intolerance loss that presents a specific weakness in individuals with SUD who withdraw from MAT. It was also discovered that the risks of overdose are multiplied by the psychological and social strains of relapse, such as stress, cravings, and potential exposure to high-potency illegal opioids. This supports the life-saving attribute of MAT because it not only controls the cravings and withdrawal but also ensures that the clients are not exposed to the potentially fatal consequences. Discontinuation of treatment eliminates these protective mechanisms and subjects individuals to an urgent and severe threat.

This means that, with the withdrawal of a substance use disorder subject, the stabilization of the methadone or buprenorphine effect is compromised. These drugs maintain the balance of opioid receptors in the brain and eliminate the extreme change in the exposure to drugs, and reduce the number of cravings. The tolerance to opioids starts decreasing once MAT is discontinued. This implies that the body has become unable to accommodate the large amount of heroin or other opioids that the client might have been taking before treatment. In case the individual relapses and consumes the same level as previously, the tolerance will be low against overdose. The result points out that the occurrence of relapse following cessation of MAT is not merely a reversion to drug use, but also a life threat. The risk is increased by the fact that the illegal opioids that are available in the market can be combined with more potent substances that the person's organism, who has just been released after treatment, cannot resist. Besides this, relapse tends to occur when the persons are under stress, craving, or when they are in hopeless conditions that expose them to be less cautious, leading to the use of harmful dosages.

4.7.4 Mental Health Deterioration

The study further revealed that discontinuing MAT can negatively impact psychological well-being because the medication provides both physiological stabilization and a sense of security in recovery. Without this support, clients often experience heightened anxiety, depression**,** irritability, and emotional instability, which can intensify drug cravings and make abstinence more difficult. The loss of routine, structure, and support provided by MAT clinics further exacerbates mental health challenges.

Informants revealed the following saying;

> "*When I stopped the treatment, I became anxious and depressed, and it was harder to control my urges. The emotional and psychological challenges made it very difficult to maintain recovery without ongoing support"* (FGD /Participant with SUD/2025).

Other quoted saying;

> "*The combination of physical withdrawal symptoms and psychological stress often discourages clients from continuing treatment. Flexible support systems are needed to improve adherence"* (IDI, health professional/2025).

MAT has an essential part in assisting in mental health by alleviating the pressure related to withdrawal and drug cravings, providing counseling opportunities, and creating a well-organized environment of treatment. Clients lose these psychological stabilizers when therapy is discontinued, which exposes them to emotional dysregulation. This decline can have a direct link to relapse because clients might indulge in the use of substances to help deal with the increased negative emotions. Loss of mental health also diminishes the interest to participate in the activities aimed at support, in the counseling sessions, or in the recovery plans.

It means that, as an individual with substance use disorder quits MAT, he loses not only the medication that helps suppress your cravings, but also the psychological safety net, which treatment offers. When under MAT, a client can enjoy a sense of structure (daily or frequent clinic visits), counseling, and relief from not having to fight with withdrawal continuously. These aspects contribute to stabilizing the emotions and minimizing stress. As soon as MAT ceases to exist, this stability is lost. This is the reason why clients are likely to have deteriorated mental health, which consists of anxiety, depression, irritability, and emotional instability. In the absence of MAT, there is an increased craving, and the emotional pressure makes it difficult to withstand a relapse. Most clients revert to substance consumption as a coping mechanism for these crushing emotions. Lack of routine and support from supportive personnel is also a factor. The absence of these outside anchors will leave clients alone, discouraged, or

demotivated to proceed with recovery. Consequently, they have fewer chances of attending counseling, recovering family relationships, working, or socializing.

4.7.5 Social and Occupational Instability

The study results showed that termination of MAT interferes with the social and occupational functioning of the clients. Without the stabilizing influence of treatment, most individuals do not manage to continue employment, their duties in the family, or positive social relationships. Job loss, family conflicts, and rejection of the community are some of the most common results of relapse, withdrawal symptoms, and emotional distress. This imbalance of the situation makes clients get into the dependency, poverty, and marginalization circles that kill their ability to obtain long-term recovery.

The informants who were contacted by the study revealed the following;

> "*After I left methadone, I lost my job and had constant conflicts with my family. Everything became chaotic again. Without the structure and support provided by MAT, both personal and social aspects of my life deteriorated, making it difficult to maintain stability. This illustrates how interruptions in treatment can have broad consequences beyond physical dependence, affecting employment, family relationships, and overall well-being"* (FGD/Participant with SUD/2025)

Another informant said;

> "*We often observe that when clients stop methadone, they struggle to maintain employment and experience frequent conflicts with family members. The absence of structured treatment support can lead to social instability and increase the risk of relapse"* (IDI, health professional/2025).

These results indicate that MAT assists clients to achieve stability through decreasing the use of drugs, enhancing the physical and mental well-being, as well as engagement in family and work life. This progress is reversed when treatment is terminated. Employers, colleagues, and people in the community stigmatize clients should they

relapse, and this excludes them further from constructive involvement in society. The ensuing instability is a vicious cycle: because of relapse, one loses the job, and puts strain on the family, consequently, causing stress and more drug use. As time passes, this decays clients' social capital and heightens their reliance on risky survival tactics, such as petty crime or transaction relationships to satisfy their daily needs.

This points to the discovery suggesting that MAT is not a purely medical intervention, but also a stabilizing element in the social and occupational life. Being on MAT, clients can more effectively cope with cravings, retain their mental health, and engage in family, work, and community life. The therapy assists them in restoring the routine, responsibilities, and social relationships that, in most cases, have been interfered with by the substance use. Clients lose these stabilizing supports when MAT is discontinued. Emotional strain, relapse, and withdrawal symptoms may cause job loss, family strife, and social rejection, leading to further destabilization of their lives. This forms a vicious cycle, where social and occupational issues gain momentum and leave people vulnerable, which leads to substance use, which in turn deteriorates social and occupational functioning. This destroys clients' social networks and resources, and they rely more on dangerous survival tactics, including petty crimes or transactional relationships, to fulfill basic needs.

CHAPTER FIVE

DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the findings, conclusions, and recommendations based on the findings obtained from the field. The recommendations play a crucial role in fostering favorable conditions for People with SUD accessing MAT services.

5.2 Discussion

This research aimed to explore the barriers that individuals with substance use disorders face when trying to access Medication-Assisted Treatment (MAT) in Dodoma Municipality. Specifically, the study was driven by three objectives: to assess the knowledge level of MAT among addicted individuals, to find out the perceptions of people with substance use disorders towards MAT and how these influence the uptake of the service and to review the procedural issues in the provision of MAT that make it difficult for individuals with substance use disorders to access MAT in Dodoma Municipality.

The study found that the addicts to substances (SUD) hardly knew about the MAT services offered. Most of the knowledge comes through someone's own experience with the program and hearing or seeing a friend who has gone through the MAT and witnessed health improvements. Thus, peer influence is highly instrumental in shaping not only the knowledge but also the perception of the treatment. Nevertheless, the degree of knowledge varies and is influenced by gender differences. In particular, women tend to have less knowledge of MAT services because they are more bound by the home chores like taking care of the children, washing, and cooking which limit their capacity to seek information or participate in awareness sessions. These gender-specific barriers bring about differences in access, as men generally have a higher chance of getting information and engaging in MAT services than women. As a result, the unequal distribution of knowledge contributes to differential access to treatment, which can have an impact on the involvement and the results that men and women with SUD achieve.

While people with SUD do not have sufficient knowledge of the services offered by MAT, their attitudes to the program are a combination of both extremes, less frequently positive and more often negative, which, in turn, affect the uptake of the service. Some clients, focusing on minimal or delayed benefits, hold negative perceptions and hence discontinue the program, as they also underestimate the effectiveness of MAT. On the contrary, some clients realize the positive effects of a program, such as improved physical health, social adjustment, and diminished cravings, and this can be a strong incentive for them to continue their engagement.

Moreover, the research uncovered that the provision of MAT is fraught with procedural obstacles, which include requirements for daily attendance, long travel distances, scarcity of transport services, irregularity of training and counselling sessions, and reliance on foreign NGOs to initiate the program. On top of that, the complicated registration processes and conflicting personal or socioeconomic commitments make it difficult for one to get to the MAT clinic on time and follow the treatment. Nonetheless, the Itega MAT clinic, in collaboration with some NGOs, is doing everything possible to facilitate access and ensure that clients agree with the treatment despite all these procedural problems. The measures that they take entail, among others, regular counseling, creating awareness, and flexibly providing support wherever it is possible, as well as emphasizing the voluntary nature of enrolment, which are all intended to engage, retain, and general treatment outcomes for people with substance use disorders.

An examination of the findings of this investigation through the perspective of the Human Belief Model, which was the guiding framework for the study, shows that the results correspond closely with the components of the model of health belief. The results reveal that individual beliefs and situational barriers determine involvement in MAT. The issue of limited knowledge raised in the paper reflects an area where understanding is insufficient and the need for cues to action arose - the exposure to a peer being the main impetus for seeking help. Differences in awareness related to gender further point to disparities in getting cues, hinting that women have to overcome social and structural barriers that lower their perception of access and confidence in treatment.

Perceptions of the treatment program (MAT), being either positive or negative, correspond with respective perceived benefits and perceived threats. Those patients who

recognize better health and functioning as a result of treatment show a greater conviction of the advantages brought about by MAT, thus leading to stronger adherence. On the other hand, the people who are sceptical about its efficacy show low perceived benefit and higher perceived barriers, thus they are more likely to discontinue the treatment. According to the model, these perceptions have a direct impact on the decision and ensuing behaviour.

Among the procedural issues hindering treatment are the need to travel long distances, attendance at strict procedures, and socioeconomic restrictions that serve as external barriers to lower patients' self-efficacy and make them reluctant to seek therapy. While health workers' and NGOs' supportive efforts can give the needed cues to action, the continued existence of structural barriers lessens their effect. In sum, the intertwining of belief systems, contextual hurdles, and healthcare delivery methods illustrates how the Health Belief Model can be used as a consistent explanatory framework to understand MAT access for individuals with SUD in Dodoma Municipality.

5.3 Conclusion

Using the data gathered in the field, it can be explained that individuals with substance use disorder (SUD) in Dodoma Municipality have several obstacles related to access to Medication Assisted Treatment (MAT). It was also discovered that men were more aware of MAT than women, because men were more involved in peer networks where information on treatment is disseminated. Instead, women are limited by social, cultural, and economic factors like the need to take care of children, limited movement, and stigmatization, which deny them access to information and awareness programs.

The attitudes of people about MAT in relation to SUD are still highly adverse, as most of them consider the advantages of treatment and the perceived inconvenience or insignificance of the side effects. These perceptions are also caused by procedural challenges that hinder the use of the services. These consist of bureaucratic and administrative policies at the time of enrolment, obligatory pre-treatment training and counseling, and daily attendance to take medication, which may be challenging for people with unstable jobs or other obligations. Lack of follow-up and monitoring is also a risk to treatment continuity. It will result in discontinuation and its consequences, which include risks of overdose, social and occupational instability, and worsening

mental health. Consequently, it has become necessary to consider methods of diminishing these barriers in the procedure, creating awareness among women, and seeking to change the attitude towards MAT by employing specific educational, counseling, and communal support initiatives. Enhancing outreach and offering a favorable environment in which sustained treatment is possible will ensure that SUD sufferers can make the most out of the MAT services and have improved health and social outcomes.

5.4 Recommendations

Based on the study findings, the following recommendations are proposed to improve MAT services and address the revealed barriers. These recommendations are directed to different stakeholders as follows:

5.4.1 To the Tanzanian Government through the Ministry of Health and Social Welfare

The Government, through the Ministry of Health and Social Welfare, should increase the number of Medication-Assisted Treatment (MAT) service points in Dodoma Municipality and other underserved districts. Expanding the number of clinics will decrease the travelling distance and transportation expenses, simplifying access for people with substance use disorders (SUD) to daily dosing sessions and follow-up appointments. Special care must be taken of those people who live in remote regions, breastfeeding women, and disabled people with disabilities.

In addition, the Ministry must offer sufficient resources, including trained personnel, counseling services, and flexible work hours, to meet the socioeconomic status of clients. Ensuring that procedural requirements in the MAT program are client-focused and context-sensitive to the client's needs will improve the engagement, retention, and general effectiveness of the MAT program.

In consultation with the local government, the non-governmental organisation (NGO), and community-based organisations, the Ministry should carry out specific awareness campaigns to sensitize the communities to MAT services. Such campaigns must provide clear information on where the services are provided, the fact that they are

voluntary, and show good results, such as improved health, fewer cravings, and social reintegration.

5.4.2 To Itega MAT Clinic.

Itega MAT Clinic ought to enhance awareness of MAT services by introducing peer-led education programs, where persons who have received MAT clinic service will share their experiences and positive outcomes. Also, neighborhood, religious institutions, and social group community workshops can target individuals who are unaware of the services. The materials on how MAT works, its advantages, how it can be used to minimize withdrawal symptoms, relapse prevention, and social and occupational stability should also be widely distributed so that the community will have their own information on the program.

Moreover, the clinic must aggressively publish success stories of its clients who have enjoyed MAT. There should also be an effort to correct the myths and misconceptions through counseling, workshops, and awareness creation. It is imperative to encourage the creation of a conducive and non-judgmental atmosphere so that fear, mistrust and negative attitude towards substance use disorder would not be experienced, thus motivating clients to participate and comply with treatment.

Itega MAT Clinic ought to introduce flexible working schedules that will suit the clients' work, school, and domestic life. Clients could engage in the treatment process without affecting their personal or professional commitments by giving them some flexibility in their daily dosing or counseling sessions. This model improves accessibility, reduces missed doses, enhances adherence and retention, and overall treatment outcomes of people with substance use disorders.

5.4.4 To People with SUD

Individuals with SUD are expected to attend psychosocial support and counseling sessions, awareness sessions, and peer support groups to gain a clearer idea about the advantages of Medication Assisted Treatment (MAT). Those sites will inform about the mechanism of MAT, its efficiency to decrease withdrawal symptoms and relapse, and how to cope with the side effects. The use of awareness and education will also

contribute to busting myths and misconceptions, as well as the confidence in the treatment and a voluntary participation.

MAT depends on consistency in dose sessions and follow-up appointments daily. The clients' main priority should be to keep participating in regular attendance to enhance better health outcomes, relapse prevention, decrease the risk of overdose, and improve social and occupational stability.

Individuals experiencing SUD are expected to freely share their challenges that they face, including side effects, transport challenges, or personal limitations, with health professionals or any support organizations. There is early communication that can result in effective interventions, changes, or encouragement that may eliminate treatment discontinuation.

Personal determination and hardiness should be developed among individuals to withstand the procedural and social boundaries, such as daily attendance, pre-treatment stipulations, and social stigma. Developing these skills will maintain a long-term engagement in MAT and enhance the overall recovery rates.

5.4.5. To the Community

The research advises the community to actively minimize stigma to increase the acceptance and use of MAT services. This should be achieved by arranging sensitization discussions in churches, mosques, mass gatherings, and even the local media to help make MAT appear to be a sound health intervention and not an expression of moral weakness. This project can be realized by mobilizing the leadership of the local community leaders.

5.5 Area for Further Studies

As the study aims at investigating the barriers faced by individuals with substance use disorder when seeking Medication Assisted Treatment (MAT) within Dodoma Municipality, the study population is primarily people with SUD disorders and not other populations. Thus, the study recommends that other researchers consider looking at:

(i) “The Role of Peer Networks in Shaping Uptake of Medication-Assisted Treatment (MAT) Among Individuals with Substance Use Disorders.”

(ii) "Family Support and Its Influence on Access and Retention in Medication-Assisted Treatment (MAT) Among Individuals with Substance Use Disorders."

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Appendices

BARRIERS ENCOUNTERED BY PEOPLE WITH SUBSTANCE USE DISORDER IN ACCESSING MEDICATION ASSISTED TREATMENT (MAT) IN DODOMA MUNICIPALITY

TOOLS FOR IDIs- PEOPLE WITH SUD

INTERVIEW GUIDE QUESTIONS FOR AN INDIVIDUAL WITH SUD.

Introduction and Consent

I am a Master's Degree student at the Institute of Social Work. I am conducting this interview as part of my research study to gather insights and opinions on the Barriers Encountered by People with Substance Use Disorders in Accessing Medication-Assisted Treatment (MAT) in Dodoma Municipality**.** This study is for academic purposes aimed at understanding your experiences and perspectives related to the topic, which will help to inform policymakers, researchers, educators, social welfare officers, and parents. Your honest feedback is very important and will contribute to the success of this study. The information collected from this study will be kept confidential and will not be shared contrary to the study's purpose. In this study, participation is voluntary, and you may withdraw at any time without consequences. With your permission, I will be recording this session so that we don't miss any details.

Since participation is voluntary, you can accept (YES) or reject (NO)

Part I: Demographic characteristics of informants

1. Sex.....
2. Age.....
3. Educational level.....
4. Marital status.....
5. How long are you attending MAT.....
6. Types of SUD (Alcoholism, drugs, etc) .....

PART 2 QUESTIONS

SECTION A: Awareness of MAT

(Objective i: To examine the awareness of MAT among individuals with SUD)

1. What do you remember about how you first became aware of MAT services?

   Client 1 Answer:

   .....

2. What were your initial thoughts or feelings about MAT when you first heard about it?

   .....

3. What did you know about MAT before you started the program?

   .....

4. Describe what MAT means to you and how you understand its role in treatment.

   .....

5. Explain your awareness and understanding of the type of medicine used in MAT before you joined the program

   .....

6. Describe any experiences of receiving information or education about MAT from health workers or other outreach teams?

   ……

7. Describe how people with substance use disorder in Dodoma understand MAT?

   .....

8. Can you describe your confidence and understanding of MAT when you decided to start treatment? what factors influenced your confidence in your understanding of MAT before starting treatment?

   .....

9. Looking back, what more information would have helped you before starting MAT?

   .....

10. In your opinion, what would be the best way to raise awareness about MAT among people with substance use problems in your community?

    .....

Objective ii: The perceptions of people with SUD toward MAT and how these perceptions affect service uptake

1. What were your expectations when you first started MAT?

   .....

2. Can you describe how your treatment experience compared with your expectations

   .....

3. Can you describe how people in your community or peer group perceive or experience MAT

   .....

4. Can you describe any experiences of stigma or negative reactions you have encountered from others while using MAT?.....

5. Do you personally believe MAT is an effective way to manage substance use?

   …….

6. What are some common fears or concerns people have about starting MAT?

   .....

7. What helped or encouraged you to begin and stay in the MAT program?

   .....

8. Has anyone tried to discourage you from continuing with MAT?

   .....

9. Can you describe how your opinion or perspective about MAT has changed since you started treatment, and what influenced that change?

   .....

10. Can you describe the factors that influence people with substance use disorders to either seek out or avoid MAT services??

    ……

(Objective iii: To analyze procedural challenges in MAT service provision that hinder access to MAT for individuals with SUD)

1. Describe your experience with the registration or enrollment process for the MAT program, including any challenges or difficulties you encountered.

   .....
   .....

2. Can you describe any delays, paperwork issues, or other challenges you experienced during the registration or enrollment process for MAT?

   ……

3. Describe challenges in reaching the clinic for your daily MAT treatment, including any obstacles you face.

   .....

4. Can you describe how the clinic's operating hours affect your ability to access MAT services and fit your daily schedule?

   .....

5. Can you describe any experiences of missing a MAT dose due to medication shortages or system-related challenges?

   .....

6. Can you describe your experiences with clinic staffing and how it affects your access to MAT services??

   .....

7. How would you explain the challenges you face when waiting for your MAT treatment at the clinic?

   .....

8. How would you explain how privacy and dignity are maintained or compromised during MAT service provision?

   .....

9. Apart from medication, are you receiving other services like counseling or health check-ups?

   .....

10. What changes or improvements would you suggest to make MAT services better in Dodoma?

    .....

Thanks for your cooperation

CHECKLIST FOR SECONDARY DATA DOCUMENT REVIEW

Itega Methadone-Assisted Treatment (MAT) Clinic

A. Administrative & Strategic Documents

☐ Itega MAT Clinic Strategic Plan

☐ Annual Clinic Reports (past 3–5 years recommended)

☐ Partnership Agreements & MoUs with supporting organizations

☐ Operational Policies and SOPs (Standard Operating Procedures)

☐ MAT Guidelines (National MAT Guidelines, Clinic-Level Guidelines)

☐ Quality Assurance & Quality Improvement (QA/QI) Reports

☐ Facility Performance Assessment Reports

☐ Staffing Plans and Human Resource Deployment Schedules

B. Patient Demographic & Clinical Data

☐ People with SUD Annual Demographic Report

☐ Client Admission and Enrollment Registers

☐ Daily/Monthly Clinic Attendance Logs

☐ Patient Follow-up and Retention Records

☐ Methadone Dispensing Logs (daily dose records, stock usage)

☐ SUD Diagnostic Assessment Forms

☐ Counseling and Psychosocial Support Records

☐ Referral Records (inbound and outbound referrals)

☐ Clinic-Level Client Satisfaction/Feedback Reports

C. Treatment & Program Performance Data

☐ **Annual MAT Performance Reports**

☐ **Service Delivery Statistics**

- Number of clients enrolled
- Retention rates
- Dropout/interruption rates
- Relapse cases
- Comorbid conditions (HIV, TB, mental health)

☐ **Pharmacy and Drug Supply Records**

- Methadone stock cards
- Procurement and supply reports
- Inventory reconciliation reports

☐ **Overdose Management Records** (if available)

☐ **Emergency Response/Incident Reports**

D. Monitoring, Evaluation & Reporting Documents

☐ M&E Framework for MAT Program

☐ Data Collection Tools and Templates

☐ Monthly, Quarterly, and Annual M&E Reports

☐ Reports submitted to the Ministry of Health / DCEA / Regional Authority

☐ Data Quality Assessment (DQA) Reports

☐ Supervision and Inspection Reports

E. Financial & Resource Management Documents

☐ Annual Budget and Expenditure Reports

☐ Funding Allocation Documents for MAT Program

☐ Resource Mobilization Reports

☐ Financial Audit Reports

F. Community & Partnership Information

☐ Community Engagement Reports

☐ Stakeholder and Partner Contribution Reports

☐ NGO/CSO Support Documentation

☐ Training and Capacity-Building Records

G. Additional Supporting Documents

☐ Research Studies Conducted at the Clinic

☐ Ethical Approval Documents for MAT Services and Research

☐ Facility Infrastructure and Equipment Inventory Reports

☐ Digital Health/EMR Reports if the clinic uses an electronic system

☐ Any Policy or National Framework Documents related to SUD or MAT

Final Review Section

After reviewing each document, complete the following:

Document Review Summary

☐ Document relevance to research

☐ Data completeness

☐ Data accuracy/consistency

☐ Timeframe covered

☐ Limitations identified

☐ Key insights extracted

FOCUSED GROUP DISCUSSION (FGD)

BARRIERS ENCOUNTERED BY PEOPLE WITH SUBSTANCE USE DISORDER IN ACCESSING MEDICATION ASSISTED TREATMENT (MAT) IN DODOMA MUNICIPALITY

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Since participation is voluntary, you can accept (YES) or reject (NO)

1. Opening and Welcome (5 minutes)

Good [morning/afternoon], everyone. Thank you for taking the time to join this discussion today. My name is …… and I am an MSW student from the ISW I want to understand people's experiences with Medication-Assisted Treatment, or MAT, here in Dodoma.

The purpose of our discussion is to learn about your views, experiences, and challenges related to accessing MAT services. There are no right or wrong answers—I am interested in your honest opinions. Everything you say will remain confidential, and your names will not appear in any report.

With your permission, I will be recording this session so that we don't miss any details. If you feel uncomfortable with any question, you can choose not to answer, and you are free to leave at any time.
Since participation is voluntary, you can accept (YES) or reject (NO)

Let's also agree on some ground rules:
- Only one person speaks at a time.
- Everyone's opinion is valuable, so please give each other a chance to talk.
- What is shared here stays here—we respect each other's privacy.

2. Section A: Awareness of MAT (30–45 minutes)

Objective: Explore participants' awareness of MAT.

1. When did you first hear about MAT services here in Dodoma?
2. What do you understand about MAT? How would you explain it to a friend?
3. Where do most people in Dodoma get information about MAT—through friends, family, healthcare workers, media, or other sources?
4. In your opinion, do people with substance use problems here have enough information about MAT?
5. What information do you think should be shared to make MAT easier to understand and more accessible?

3. Section B: Perceptions Toward MAT (30–45 minutes)

Objective: Understand how perceptions influence MAT uptake.

6. What do people in your community usually say about MAT—positive or negative?
7. Have you or people you know had any experiences, good or bad, with MAT services here?
8. What are your personal feelings or beliefs about using MAT as a treatment option?
9. Do you think stigma, shame, or fear affect people's willingness to start or stay in MAT? Can you give an example?

10. What do you think could change people's perceptions so that more people use MAT services?

4. Section C: Procedural and Service Challenges (30-45 minutes)

Objective: Identify barriers in service delivery.

11. How easy or difficult is it to reach the MAT clinic? For example, distance, transport, or clinic hours?

12. What challenges have you or others faced when trying to register or enroll in MAT?

13. How would you describe the services at the MAT clinic? For example, waiting times, number of staff, and how patients are treated?

14. Do financial issues affect people's ability to access or stay in MAT?

15. What kind of support do people on MAT receive—such as counseling, follow-up, or family involvement?

16. If you could change one thing about how MAT is provided here in Dodoma, what would it be?

5. Wrap-Up and Closing (10–15 minutes)

Thank you so much for your openness and honesty today. Before we finish, I'd like to ask:

- Is there anything we haven't talked about that you think is important regarding MAT services in Dodoma?
- If you had the power to change one thing about MAT services, what would it be?

Closing Remarks:

Your contributions today are very important. Once again, everything you shared will remain confidential.

Thank you again for your time and valuable insights.