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Qualitative Analysis of Community Support to Methadone Access in Kenya

James Ndimbii[a], **Andy Guise**[b], **Emmy Kageha Igonya**[c,d,e], **Frederick Owiti**[c,d], **Steffanie Strathdee**[f], **Tim Rhodes**[g,h]

[a]Kenya AIDS NGOs Consortium, Nairobi, Kenya;

[b]School of Population Health and Environmental Sciences, King's College London, London, UK;

[c]School of Medicine, University of Nairobi, Nairobi, Kenya;

[d]Kenya & African Population and Health Research Center, Nairobi, Kenya;

[e]School of Medicine, University of Nairobi, Nairobi, Kenya;

[f]Department of Medicine, University of California San Diego, San Diego, California, USA;

[g]centre for Research on Drugs and Health Behaviour, London School of Hygiene and Tropical Medicine, London, UK;

[h]University of New South Wales, Syndey, Australia

Abstract

Background: Methadone, as part of Medically Assisted Therapy (MAT) for treatment of opioid dependence and supporting HIV prevention and treatment, has been recently introduced in Kenya. Few low income settings have implemented methadone, so there is little evidence to guide ongoing scale-up across the region. We specifically consider the role of community level access barriers and support.

Objectives: To inform ongoing MAT implementation we implemented a qualitative study to understand access barriers and enablers at a community level.

Methods: We conducted 30 semi-structured interviews with people who use drugs accessing MAT, supplemented by interviews with 2 stakeholders, linked to participant observation in a community drop in center within one urban area in Kenya. We used thematic analysis.

Results: We developed five themes to express experiences of factors enabling and disabling MAT access and how community support can address these: 1) time, travel and economic hardship; 2) managing methadone and contingencies of life, 3) peer support among MAT clients

Declaration of interest

Dr Frederick Owiti has advised on development of standard operating procedures for methadone delivery across Kenya. As a clinician he provides private delivery of methadone within Kenya. All other authors declare no conflicts of interest.

Ethics statement

The study had ethical approval from the University of Nairobi, University of California San Diego and London School of Hygiene and Tropical Medicine. All participants provided informed consent to participate in the study. This article is original work and has not previously been published in any other journal.

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as treatment ambassadors, 4) family relations, and 5)outreach project contributions. Crosscutting themes address managing socioeconomic constraints and gender inequities.

Conclusions: People who use drugs experience and manage socio-economic constraints and gender inequities in accessing MAT with the support of local communities. We discuss how these access barriers could be addressed through strengthening the participation of networks of people who use drugs in drug treatment and supporting community projects working with people who use drugs. We also explore potential for how socio-economic constraints could be managed within an integrated health and social care response.

Keywords

Methadone; community; support; Kenya; HIV; opioid

Introduction and background

In response to the growing use of injecting drug use in Africa, harm reduction services are being developed across the region (Abdool, 2016; Harm Reduction International, 2018; Hunt et al., n.d.). Core harm reduction interventions being introduced in the region include needle and syringe programmes, anti-retroviral treatment, and more recently methadone (HRI 2018; Rhodes et al., 2016). Methadone is promoted as an effective intervention to support HIV prevention and treatment among people who use drugs (Low et al., 2016; MacArthur et al., 2012; Mukandavire et al., 2017; Tran et al., 2016). Methadone was introduced in Kenya in 2014, as part of Medically Assisted Therapy (MAT), where methadone is combined with psychosocial support (NASCOP, 2013).

As of early-2020, there are five operating methadone sites in Kenya, with two in Nairobi and others at urban areas on the coast. Methadone is delivered predominantly through stand-alone government-run clinics, with integrated HIV care and psychosocial support. Each site is also supported by separate community-based outreach projects. Such outreach projects have a long connection in many settings with people who use drugs, through providing harm reduction services and socio-economic support (Guise et al., 2015). Whilst such community based organizations can play a central role in enabling clinic based services their contribution is often less well understood (Ayon et al., 2018).

The use of methadone in many other settings globally has demonstrated potential social barriers to access (Deck & Carlson, 2004; Khampang et al., 2015), including the location and timing of services, perceptions about methadone among drug users beyond drug treatment, requirements of abstinence, police interference, and poverty and hardship (Guise et al., 2014; Philbin & Fujie, 2010; Rhodes et al., 2015; Rhodes & Sarang, 2012). Therefore, whilst methadone services might be available, a range of social factors can limit access to these services, with some of these being more pronounced in low income settings, such as food security and household income (Gari et al., 2013), transportation and unemployment (Laswai & Nsimba, 2017) perceptions of traditional medicine as an alternative (Isobell et al., 2015) and peer support in accessing services (Treolar et al., 2015). However, research on such community experiences, beyond clinics, in settings such as Kenya is limited (Laswai & Nsimba, 2017).

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Considering the potential range of social influences on clinic based MAT access we sought to explore community experiences of access to this new service in Kenya, and in particular the role of community support. Research in this area is essential to support the ongoing implementation of this novel service in Kenya and similar settings across the Africa region.

Materials and methods

The study was implemented in one city in Kenya (anonymous to ensure confidentiality). It was conducted within a 'Drop In Center' (DIC) run by a community-based outreach project for people who use drugs, that was supporting methadone implementation at a nearby clinic. The DIC had been working with people who use drugs before the introduction of MAT. Many of the MAT clients would frequent the DIC after going for MAT, and some had been recruited for MAT through the DIC. Clinic staff would visit the DIC for initial checks of client eligibility (i.e. age, use of drugs) and that there were others in their social network who would support them. After this initial check potential clients then visited the MAT clinic to receive their first dose. Whilst there was periodic monitoring and clinical appointments, clients received the majority of their daily doses of methadone through a window within the clinic site. The MAT clinic had fixed operating hours (open from 7am to 12noon during the week, which during the study extended to 1 pm; and open at the weekends with slightly shorter hours). Clients had to attend the clinic daily, Those who missed more than three sessions consequetively were denied MAT and referred to counselors for reorientation. Periodic checks of urine were used to check use of other drugs; use of drugs, including heroin, cannabis and alcohol, could be linked to counseling and then reinitiating on MAT. Treatment at the clinic was free. Other services, including HIV treatment and care, as well as TB and Hepatitis C care were also available at the site. The approach at the clinic can be described as 'high threshold', with a focus on abstinence from drugs, fixed routines for MAT attendance and requirements to maintain clinic rules (Mofizul Islam et al., 2013).

A combination of qualitative data generation methods were used. These included observation, in-depth interviews and stakeholder interviews (Paradis et al., 2016). The researchers used observation within the drop in center to familiarize themselves with the context being studied, and then understand and contextualize the experiences of people using drugs. Here, the researchers sat for up to three hours a day, observing interactions among and between clients and the community outreach staff. This also included sitting in open group sessions where MAT was discussed.

Based on the observations, initial discussions with clients and community project staff, and a literature review, the researchers developed a semi structured interview guide to facilitate in-depth interviews. Initial thematic areas in the guide included experiences of drugs use before and during MAT, the process of initial engagement with MAT, daily experiences of engaging with MAT, and HIV prevention and treatment. The interviews were conducted iteratively, with researchers discussing participants' accounts as a team and identifying emerging themes to further explore in later interviews (Moser & Korstjens, 2018).

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Interviewees were selected purposively in collaboration with the community-based outreach project in order to ensure a range of experiences according to age, gender and HIV status. 32 participants were purposively selected for interviews (30 participants who were currently engaged in methadone treatment during the time of the study (9 women and 21 men), and 2 participants working in community outreach projects). Among the clients on methadone treatment, the sample included people living with HIV ($n = 16$; 6 women and 10 men); clients interviewed ranged from 19 to 51 years of age, with an average of 34.7 and five of them 24 years and belowThe 2 participants from outreach projects both had extensive experience of working directly with people who use drugs, including before the introduction of MAT. Interviews were conducted in either English or Swahili, based on the preference of the participant. The inclusion criteria wereto have taken methadone for at least one month and be 18 years old and above (this age limit reflecting a threshold set by clinics for receiving methadone).

Thematic analysis was used (Nowell et al., 2017). Initial themes for coding were developed from the literature (Gari et al., 2013; Guise et al., 2015; Philbin & Fujie, 2010; Rhodes et al., 2015; Rhodes & Sarang, 2012) and emergent themes from respondents' accounts (Sutton & Austin, 2015). These initial codes were used to organize and categorize the data as it was collected, with this early analysis then informing on-going data collection. As data collection ended the researchers developed a coding framework through reading all the transcripts and sharing memos and analytical thoughts based on preceding coding. Detailed coding then explored specific aspects of MAT access, and through discussion of the coded data we developed the themes described below.

Ethical approval for the study was granted by three ethics bodies (names withheld for blinding). Participants provided written, signed informed consent, and food baskets were provided as compensation for the time taken by the study. All the names used in the results section are pseudonyms, and the study location anonymous, to ensure confidentiality.

Results

Participant ages were between 19 and 51 years. Most participants identified as either unemployed or doing casual work.

Whilst many welcomed MAT, being enrolled and attending the MAT clinic daily was described as dependent on a combination of community level factors and support. We developed five core themes that account for these experiences of MAT access- the first two highlighting barriers and the other three focusing on the role of community support: 1) time, travel and economic hardship; 2) managing MAT and the contingencies of life; 3) effects of family relations on MAT access; 4) community support among peer support among MAT clients; and 5) support from outreach projects. Two cross-cutting themes also emerged: managing socio-economic constraints and gender inequities in access. Socio economic constraints included day-to-day expenses needed for accessing MAT, but also daily living expenses such as food, shelter and support for family, whereas gender inequities revolved around aspects that made it even more difficult for women compared to men to engage with and stay on methadone.

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Time, travel and economic hardship

Whilst new experiences of MAT and managing drug dependency were welcomed, the daily socio-economic demands of being a MAT clientsoon became apparent. Some of the clients could walk to the MAT clinic, whilst others had to use public transport, involving costs of both time and money. Efforts often had tobe made on a daily basis to source money for transport, which included 'hustling'through begging or petty theft, or getting support from family and friends:

> 'Some of us we are living far.Some of us we don't have family. Some of us we don't have money for transport.Some of us we don't have jobs.So it is hard to get money, so we have to know, we have [to] hustle to search for the money, you have to work for the money.'
>
> (Morris)

For some clients, especially men with contacts within public transport services, they could ride for free with permissionfrom their conductor friends, in return for 'touting' for passengers (encouraging people to use that particular bus). Transport was more difficult for women, reflecting less potential for engagement in such male dominated networks. Women had to look for other sources of income and so faced greater challenges than those reported by some men. For example, Cathy's use of MAT was often interrupted while attempting to secure her access either by walking to the clinic, borrowing bus fare, doing casual work, engaging in sex work, or moving in with her friend closer to the MAT clinic; all this happening amidst disrupted relationships with her husband and child:

> 'In November I started MAT. I took it for two days then the third day I lost hope. I went back to [neighhourboodwhere she lives]. So coming to this place [MAT clinic] it is difficult [because] of lack of fare and my husband was not leaving any money for me. So I had to go and borrow money from someone so that I come, and then when I go back I look for something to do to refund the money back. Sometimes I would get men who would ask me for a shot [sex] and they pay for it.'
>
> (Cathy)

Income constraints and limited job opportunities led someback to using heroinor crime. Marvin and his friend stopped using MAT and started using heroin again because he was not able to provide for his partner while on MAT, and use of heroin was instead wrapped up in an illicit economy of theft that allowed an income. While Asha noted that despite MAT 'clearing the mind', occasionally she would resort to old 'behaviours' of getting money:

> 'You know MAT has started clearing our mind, helping us to see like we are normal human beings… I have taken MAT for over one year now, but I can't lie to you, that the behaviours I used to have for the last twenty years have cleared within one year. There are times I don't have even a shilling, I have tried to look for a job to no avail and then you have carelessly kept your phone, I will take it because I need money for food and I still have those old behaviours with me'
>
> (Asha)

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Time taken to get to, and be at, the clinic was also limiting, and had particular gender dynamics. Women engaged in sex work were also at a disadvantage here, and faced difficulties engaging with MAT at the prescribed opening times:

> ‘[it is] the women who are the greatestdefaulters. At least I'm very sure half of that number have defaulted or they are inconsistent. Currently you see, I think giving MAT to women, it is not just about giving MAT, it is also about looking at their other social issues that are affecting them because I think there are serious, social, affecting them, and one of things I know is that they are sex workers and they work at night.
>
> (Outreach Project Staff)

Having to work at night meant being at the clinic for the morning opening hours which was challenging. The opening times were especially restrictive for those who did not have regular jobs and were sometimes required to work, thus having to choose between missing MAT and going for work.

There were attempts by the MAT clinic to engage with clients' economic hardship through supporting skills building, income generating activities and distribution of clothes.

> ‘The doctors and especially social workers they promised us jobs and sometimes once in a blue moon you see them going to talk to the MCA [local politician] for this ward, and we tell them the problems we are going through. The social workers sometimes tell us if we have a hobby, for example soap making or making beads or hair dressings you can be coming to this place and then we can sell them and the money we get we share it among those who made the stuffs'
>
> (Asha)

However, this initiative did not last for long, as there were tensions regarding petty thefts at the clinic, which were attributed to the clients on methadone, prompting them to be asked to only take methadone at the clinic and leave.

Managing methadone and the contingencies of life

Overlapping with the constraintsof daily routines, was a frequent experience of managing methadone within emergent contingencies of life. Events – such as funerals - that were likely to occur only occasionally created tensions forclients. Eric talks about a funeral he had to attend (in most cases, funerals in Kenya mean traveling long distances, which might mean absences for up to a few days), which in turn made him miss his methadone, and in turn, he was expected to account for his absence:

> Yes, I told them [MAT clinic] I had gone for funeral. One client told me it is better next time so that they do not doubt you, you should be coming with that thing with a person's history [eulogy] just one, to prove to them where you were.
>
> (Eric)

Having to bring a eulogy as proof for an absence demonstrates the often strained relationships with the clinic and the doubts expressed by healthcare workers in explanations provided for missed appointments, to avoid discontinuation of one's dose.

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Again, gender inequities could arise focusing on child care responsibilities. Millie had to take her child to hospital, but despite making it to the MAT clinic after thisshe is not allowed to take her dose. Again, her account demonstrates the work that is being done to try and manage these contingencies:

> 'I feel bad because it is not [that] I refused and I wouldn't want to miss to take my child to the hospital because of MAT.I had gone to the hospital very early so I can be able to come and get it [MAT]. I mean, I keep time.'
>
> (Millie)

Family and intimate partner support to methadone access

Prior drug use wasoften reported to have broken down family relationships. In the course of enrolling in MAT, family ties were frequently repaired. A core part of this process was the requirements for starting methadone of having a family member come and 'sign' someone in for treatment. 'Signing in' is meant to ensure there is someone accountable for the treatment follow up of the individual. As a result, most clients had family members to accompany them during the initial visit to enroll for methadone:

> 'I got into problems with him [his father] and I got chased away from home. Anyways I have done so many bad things to him but when I stopped using this thing [heroin], I went back and asked him for forgiveness, I cried and begged him to come and sign so that I can give a try [at] this methadone. Hecame and signed for me.'
>
> (Arthur)

This rebuilding of family connection was the basis for material, social and psychological support to confront the challenges described above. Clients reported family members'happiness, and how this was effected through provision of resources to access MAT, based on trust that had been broken and was being rebuilt. Morris was able to get a place to stay from his brother when he joined methadone, after living on the streets while using heroin:

> 'R: You know my brother, when I started, when I start MAT, he saw me changing so I went to him, I saw him on the street, I asked him, he asked me 'what is going on? I can see you changing now, what problem…'. So I had to tell him there is a medication that has come out which is MAT, it has already changed me, yeh, so I have already… so I asked him if he could give me a place for sleeping so I can get more support. So he said like 'you are not going to use heroin any more. I can see truly your face, you have changed so far because of the medicine'. I told him about MAT so he had to trust me …… he is my brother, he accepted, he said okay, come home I will give you a place to sleep while you search for your own life.'
>
> (Morris)

As pointed out earlier, women experienced more difficulties than men. Apart from limited sources of income, it was easier for men to have support from their families than it was for women, as outlined by an outreach project worker:

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> 'We have those ones they have already defaulted and they defaulted because they said they are not accepted back by their families, that is what they told me. I was actually even talking to them yesterday, [they are] not accepted back by their families because they have their children and there is no income they are bringing to their families'
>
> (Outreach project Staff)

Peer support among methadone clients

People using methadone were often described as integral in enabling the access of others. This 'treatment ambassador' role functioned informally, but also had more formal connotations in the support of some peer outreach workers, discussed in theme 5 below. More informally, those who had joined methadone earlier through their actions or encouragement were a source of motivation for others to join. Eric observed a number of his friends who joined methadone. On approaching the ones who managed to stay on methadone, he was convinced that it was the right decision to make:

> 'When I saw how my two friends who didn't relapse after the other two relapsed, I asked them their opinion on methadone, how do you feel about it,'
>
> (Eric)

Observing others served to dispel initial hesitation from some clients, often based on rumors within the community of methadone being dangerous and an experiment on people who use drugs. Freedom had one of her friends join methadone, and she observed the changes he experienced. Despite her friend urging her to join, she remained hesitant, especially because of rumors of methadone killing people. Eventually, her friend managed to convince her of methadone's 'magic':

> 'I went to ask that guy, that guy told me you don't know, methadone is a magic, come you try and you will see. I tell him, I start thinking, heh this guy has told me this thing is a magic and when I take I won't feel nini arrosto [withdrawal]. I started thinking, thinking. At long last I decided to'
>
> (Freedom)

Support from outreach projects in managing access to methadone

Outreach workers and outreach organizations were tasked with a formal role of recruitment for methadone for the clinics, as well as providing information regarding methadone. The familiarity with staff from outreach projects made it easier for potential clients to get information from the centers:

> 'Yes, this to me it [outreach drop in centre] is a family, even they are more than a family. I don't even know how I will repay them, if they tell me to pay them back, because they have really, really helped me. They have brought me out from a dark pit and I love them with all my heart.'
>
> (Winnie)

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Outreach projects were described as supporting communication with both potential and engaged clients, working toward enhancing treatment by providing encouragement and psychosocial support. Evans almost stopped methadone, having tried up to four times and being unsuccessful at being enrolled, and it is through his engagement with an outreach worker, who followed up with him in the ‘drug den’ to find out what was wrong that made him attempt again:

> ‘when I arrived at [MAT clinic] I was already late and the people taking in clients for the day told me that I am late, I was mad with them, I left that place and went to [drug den] and I smoked heroin. Later they called me, I came to this place and [an outreach worker] asked me what happened, I told him I was told that I am late, they could tell that I am a hot tempered person, [the outreach worker] was the one who helped me. He told me don’t lose hope; just wait for us. After three weeks we will be taking new [methadone] recruits’
>
> (Evans)

Outreach projects also offered paid worktoa small number of methadone clients as peer educators. These positions were limited in number, with some clients upset at not also getting them. For those who did get them, they felt comfortable working with the outreach projects, because they felt understood by them, as opposed to other places of work where it would be difficult to convince potential employers of the change experienced after joining methadone. Evans identifies a number of MAT clients who were assigned roles at the outreach project, and the way this might have been beneficial to them avoiding mixing methadone and drugs or going back to heroin:

> ‘like the two who we left sitting here outside, they were given jobs in this place [outreach project], that way they can’t think about taking drugs.
>
> (Evans)

These roles in the outreach project were just one response to the hardship respondents described and the potential this generated for continued drug use (described above, under theme 1). Cognizant of the hardships faced by women, one of the outreach projects also attempted to specifically cater for the socio economic constraints faced by women by providing various forms of support. This worked for some of the clients, but it was also short of resources and so needed the beneficiaries of such programs to also put in individual efforts such as seeking customers:

> ‘…and our program [doesn’t] have anything for them.I, it is like the economic empowerment we try to do with them in the salon, they must get the customer for them to get the money.’
>
> (Stakeholder)

Whilst such opportunities allowed people to manage the socio-economic constraints they faced, it also generated tensions for how such opportunities were limited and so a focus for some competition amongst clients. In addition, despite efforts to implement economic empowerment initiatives, lack of resources would leave clients in a position of having to make extensive effort to make the initiatives work.

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Discussion

Our results demonstrate how people accessing methadone in one urban setting in Kenya experience and manage socio-economic constraints and gender inequities in seeking methadone; with time, costs and location of methadone in the context of clinic infrastructures and poverty being managed through combinations of social support and community organization.

Whilst our analysis details multiple challenges to access, we also note how community enabled MAT is proving accessible for some, and this within a setting constrained by few resources (Rhodes et al., 2015). We also note how policing is not reported as a community level barrier to accessing MAT, as in other contexts (Rhodes & Sarang, 2012; Laswai & Nsimba, 2017). This might be attributable to proactive engagement by multiple health authorities to engage with stakeholders interacting with people who use drugs. We suggest that this 'enabling environment' of policing and stakeholder support might be a context in which social and community support has such effects as we described (Rhodes, 2002).

A priority issue for future scale-up of methadone in Kenya and the region is to address the socio-economic constraints and gender inequities reported by respondents, and reported in other similar settings (Laswai & Nsimba, 2017) and to do this in ways that build on existing locally effective forms of community level action.That women especially experience constraints on access to services shaped by socio-economic constraints and gender inequities is already known (Ayon et al., 2018). However, interventions in response have been limited (Kelly et al., 2010). Our analysis provides specific insights into how the social environment interacts with MAT delivery in the Kenya setting, and how these community factors can be considered within clinic settings– in a gender sensitive way - to enhance access and support expansion of MAT treatment. Specific clinic level actions are needed as clinic operations in particular create tensions for clients in accessing MAT as evidenced in the strict operating times, and rules and regulations that frequently do not resonate with the daily realities of clients, and being more pronounced among women. In response, considerations should be made for greater clinic flexibility in operations, including adjusting opening hours, allowing for modes of care beyond daily attendance, incorporation of a women representative group to guide on considerate clinic operations and avoiding routines that seek to excessively control and monitor clients. This flexibility could also include forms of support to particularly enable women's attendance, including child care facilities and flexibility in dispensation which is not strictly recovery focused, and differentiated by various aspects including location of care, culture of delivery and social relations (Blackenship et al., 2015; Guise et al., 2019). Modes of delivery beyond fixed clinic infrastructure through the utilization of community based forms of care, such as mobile delivery of methadone and outreach to deliver MAT as well as prescription through physician approaches could also be explored, and would be of particular benefit to women constrained in travel, and especially those involved in sex work (Ayon et al., 2018; Keeney & Saucier, 2010).

Efforts should be made to intervene more directly in addressing social exclusion faced by people who use drugs, and to prioritize a gender sensitive response to this, building on

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the forms of support being initiated by local communities. In the setting just described there were some efforts by the outreach projects to address social need, by encouraging skills development and providing spaces for small businesses. The guidelines for MAT implementation in Kenya outline the need for creating and supporting new social networks that can enhance social and economic opportunitiesamong people in MAT, such as job placements and retraining (Ministry of Health, 2017). This should be approached in consideration of stigma against people who use drugs, and also within a sociopolitical context of poverty and hardship for the general population (Jennings et al., 2017). Reflecting the structural nature of socio-economic exclusion, structural interventions are needed that can challenge these community level conditions, such as linkage to work opportunities, skill development and seed capital, and other short and medium term support mechanisms such as social, emotional and material support from family and community (Luchenski et al., 2018). Interventions targeting structural issues are also likely to have more far reaching effects that are sustainable over time, as well as addressing the specific needs of women such as flexible options for accessing methadone (Blankenship et al., 2006). We note here that the challenges of socio-economic exclusion we report are also experienced in other, including high-income, settings (Bourgois, 2000). In most high income countries there may be government mandated social support available in the form of social security, which may help to ease these challenges, whereas in Kenya, none is available (Harris et al., 2013; Treloar & Rance, 2014). Future research should explore more these factors of poverty and employment and how they relate to specific contexts, and in particular if and how these challenges are heightened in resource-poor settings such as Kenya.

Outreach organizations in Kenya have been providing services to people who inject drugs, even before the introduction of methadone (Ndimbii et al., 2015). The role of outreach projects continues to be significant in the provision of methadone, and the projects attempt to address some of the structural challenges faced by the MAT clients, such as engaging them as peer educators and providing a space for them to work and develop small businesses. This happens within an environment of resource constraints. In addition, being close to the community of people who inject drugs, outreach projects are able to pick out the more subtle and less obvious constraints to accessing MAT, such as the extra efforts women have to make, barriers they face and organizing women specific networks. As outlined in the results, there have been small scale attempts to address these, although with resource constraints, and to some extent not able to cater for the needs of these women, such as providing the skills, but not being able to link them with the actual opportunities to utilize the skills to get income immediately. Outreach projects need to be supported in effecting this supportive role that is important for supporting psychosocial and socio economic efforts that ease access to methadone, and in working toward a holistic approach which goes beyond a narrow biomedical emphasis on methadone (Coyle et al., 1998; Needle et al., 2006).

Current methadone implementation arrangements should also build on the possibility of informal networks among friends and peers in promoting MAT, such as encuraging networks of people who use drugs to mobilize and organize. By providing a community within which experimentation with medication becomes possible, others are able to access care. It also allows for MAT to actively involve, as opposed to merely responding to the needs of, people who use drugs in Kenya. Even in the absence of paid engagement as peer

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educators, programs should consider having influencers among methadone clients who can be treatment ambassadors (Broadhead et al., 2002), and who can understand and help structure programs in such a way that they are responsive to the nuances of community members (Weeks et al., 2009). The support provided by families has been outlined above as important for those accessing MAT to stay on, and for those lacking this form of support, experiencing difficulties engaging with the intervention. As a way of strengthening retention on treatment, implementing organizations need to continue to actively reach out to families of PWID to foster family engagement in treatment and enhancing continuous education among people in recovery and their families in relation to understanding the experiences and challenges of addiction recovery.

This article is among the first to look at the community contexts for access to methadone in a low income setting (Bruce et al., 2010, 2014; Laswai & Nsimba, 2017) giving an in-depth perspective on social barriers and enablers of access. This qualitative approach was developed within the auspices of an exploratory study and limited by resource and time constraints. The contingencies of the setting of the drop in center sometimes curtailed interviews, e.g. clients had to leave before the end of an interview for reasons of transport, food or other needs. The study would have benefited from more follow-up and repeat interviews, as well as direct exploration - e.g. through observation and immersive fieldwork –of the community settings that shape MAT access such as settings for sex work or use of transport infrastructures. Further study, especially ethnographic study, could engage more with the combinations of social factors that we have described above, and so develop more the perspective we initiated of a community perspective on methadone access. Further study could also focus on exploring women centered service delivery as well as experimenting community led methadone delivery, through already existing community organizations.

Conclusion

Our findings highlight how the community context for methadone delivery – particularly the networks of people who use drugs, family and outreach based organizations – can be central to access. Such a clinic-community nexus could then be the basis for additional activities linking people to work, skills building and structural interventions such as housing that can help them manage the socio economic conditions they face, and specific gender inequities. Efforts to situate MAT closer to the community can also be experimented with. This article contributes to the developing body of literature on harm reduction in resource limited settings, and especially the implementation of MAT within a recently emerging drug epidemic in a resource constrained environment.

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References

Abdool R (2016). Policy change towards implementing harm reduction in Sub-Saharan Africa. International Journal of Drug Policy, 30, 140–142. 10.1016/j.drugpo.2016.03.001 [PubMed: 27017377]

Ayon S, Ndimbii J, Jeneby F, Abdulrahman T, Mlewa O, Wang B, Ragi A, & Mburu G (2018). Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: Role of community-based outreach and drop-in centers. AIDS Care Journal, 30(4), 480–487. 10.1080/09540121.2017.1394965

Blankenship KM, Friedman SR, Dworkin S, & Mantell JE (2006). Structural interventions: Concepts. Journal of Urban Health: Bulletin of the New York Academy of Medicine, 83(1), 59–72. 10.1007/s11524-005-9007-4 [PubMed: 16736355]

Blackenship K, Reinhard E, Sherman S, & Nabila E-B (2015). Structural interventions for HIV prevention among women who use drugs: A global perspective. Journal of Acquired Immune Deficiency Syndromes, 69 Suppl 2, S140–S145. [PubMed: 25978480]

Broadhead RS, Heckathom DD, Altice FL, Van Hulst Y, Carbone M, & Friedland GH (2002). Increasing drug users' adherence to HIV treatment: Results of a peer-driven intervention feasibility study. Social Science & Medicine, 55(22), 235–246. [PubMed: 12144138]

Bourgois P (2000). Disciplining addictions: The bio-politics of methadone and heroin in the United States. Culture, Medicine and Psychiatry, 24(2), 165–195. 10.1023/A:1005574918294 [PubMed: 10885786]

Bruce D (2010). Methadone as HIV Prevention: High Volume Methadone Sites to Decrease HIV Incidence Rates in Resource Limited Settings. International Journal of Drug Policy, 122–124. [PubMed: 19931444]

Bruce D, Lambdin B, Chang O, Masao F, Mbwambo J, Mteza I, et al. (2014). Lessons from Tanzania on the integration of HIV and tuberculosis treatments into methadone assisted treatment. International Journal of Drug Policy, 22–25. [PubMed: 24210295]

Coyle S, Needle R, & Normand J (1998). Outreach-based HIV prevention for injecting drug users: a review of published outcome data. Public Health Reports, 19–30. [PubMed: 9722807]

Deck D, & Carlson MJ (2004). Access to publicly funded methadone maintenance treatment in two western states. The Journal of Behavioral Health Services & Research, 31(2), 164–177. 10.1007/BF02287379 [PubMed: 15255224]

Gari S, Doig-Acuna C, Smail T, Malungo J, Martin-Hilber A, & Merten S (2013). Access to HIV/AIDS care: A systematic review of socio-cultural determinants in low and high income countries. BMC Health Services, 13, 198.

Guise A, Kazatchkine M, Rhodes T, & Strathdee S (2014). Editorial commentary: Successful methadone delivery in east Africa and its global implications. Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America, 59(5), 743–744. 10.1093/cid/ciu387 [PubMed: 24855151]

Guise A, Ndimbii J, Igonya E, Owiti F, Strathdee S, & Rhodes T (2019). Integrated and differentiated methadone and HIV care for people who use drugs: a qualitative study in Kenya with implications for implementation science. Health Policy and Planning.

Guise A, Tim R, Ndimbii J, & Ayon S (2015). The need for structural and community interventions to support HIV care and harm reduction for people who inject drugs in Kenya. Annals of Global Health, 81(1), 6. 10.1016/j.aogh.2015.02.527

Harris M, Rhodes T, & Martin A (2013). Taming systems to create enabling environments for HCV treatment: Negotiating trust in the drug and alcohol setting. Social Science and Medicine, 83(April 2013), 19–26. [PubMed: 23465200]

Harm Reduction International. (2018). The global state of harm reduction. Harm Reduction International.

Hunt N (n.d.). A review of the evidence-base for harm reduction approaches to drug use. Retrieved January 2, 2019, from Harm Reduction International. https://www.hri.global/files/2010/05/31/HIVTop50Documents11.pdf

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Isobell D, Kamaloodien K, & Savahl S (2015). A qualitative study of referring agents' perceptions of access barriers to inpatient substance abuse treatment centres in the Western Cape. Harm Reduction Journal, 12, 36. 10.1186/s12954-015-0064-z [PubMed: 26410817]

Jennings L, Mathai M, Linnemayr S, Trujillo A, Mak'anyengo M, Montgomery BEE, & Kerrigan DL (2017). Economic context and HIV vulnerability in adolescents and young adults living in urban slums in Kenya: A qualitative analysis based on scarcity theory. AIDS and Behavior, 21(9), 2784–2798. 10.1007/s10461-017-1676-y [PubMed: 28078495]

Keeney R, & Saucier E (2010). Lowering the threshold: Models of accessible methadone and buprenorphine treatment. Open Society Institute.

Kelly SM, O'Grady KE, Schwartz RP, Peterson JA, Wilson ME, & Brown BS (2010). The relationship of social support to treatment entry and engagement: The Community Assessment Inventory. Substance Abuse Jan; 31(1), 43–52.

Khampang R, Assanangkornchai S, & Teerawattananon Y (2015). Perceived barriers to utilise methadone maintenance therapy among male injection drug users in rural areas of southern Thailand. Drug and Alcohol Review, 34(6), 645–653. 10.1111/dar.12268 [PubMed: 25867927]

Laswai O, & Nsimba S (2017). Challenges in accessing medication assisted treatment among opiate users attending a methadone clinic in Dar Es Salaam, Tanzania: A qualitative assessment. Addiction Medicine and Therapy, 3(2), 44–50.

Low AJ, Mburu G, Welton NJ, May MT, Davies CF, French C, Turner KM, Looker KJ, Christensen H, McLean S, Rhodes T, Platt L, Hickman M, Guise A, & Vickerman P (2016). Impact of opioid substitution therapy on antiretroviral therapy outcomes: A systematic review and meta-analysis. Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America, 63(8), 1094–1104. 10.1093/cid/ciw416 [PubMed: 27343545]

Luchenski S, Maguire N, Aldridge RW, Hayward A, Story A, Perri P, Withers J, Clint S, Fitzpatrick S, & Hewett N (2018). What works in inclusion health: Overview of effective interventions for marginalised and excluded populations. Lancet (London, England), 391(10117), 266–280. 10.1016/S0140-6736(17)31959-1 [PubMed: 29137868]

MacArthur GJ, Minozzi S, Martin N, Vickerman P, Deren S, Bruneau J, Degenhardt L, & Hickman M (2012). Opiate substitution treatment and HIV transmission in people who inject drugs: Systematic review and meta-analysis. Bmj, 345(3), e5945. 10.1136/bmj.e5945 [PubMed: 23038795]

Ministry of Health. (2017). The national protiocol for treatment of substance use disorders in Kenya. Ministry of health.

Mofizul Islam M, Topp L, Conigrave KM, & Day CA (2013). Defining a service for people who use drugs as 'low-threshold': What should be the criteria?The International Journal on Drug Policy, 24(3), 220–222. 10.1016/j.drugpo.2013.03.005 [PubMed: 23567101]

Mukandavire C, Low A, Mburu G, Trickey A, May MT, Davies CF, French CE, Looker KJ, Rhodes T, Platt L, Guise A, Hickman M, & Vickerman P (2017). Impact of opioid substitution therapy on the HIV prevention benefit of antiretroviral therapy for people who inject drugs. Aids (London, England), 31(8), 1181–1190. 10.1097/QAD.0000000000001458 [PubMed: 28323752]

Moser A, & Korstjens I (2018). Practical guidance to qualitative research. Part 3: Sampling, data collection and analysis. European Journal of General Practice, 24(1), 9–18. [PubMed: 29199486]

NASCOP. (2013). Kenya national guidelines for standard operating procedure for medically assisted therapy for people who use drugs. Ministry of Health.

Ndimbii J, Guise A, Ayon S, Kalama M, McLean S, & Rhodes T (2015). Implementing Needle and Syringe Programs in Kenya: Changes, opportunities and challenges in HIV prevention. African Journal of Drug & Alcohol Studies, 14(2), 95–103.

Needle R, Kroeger K, Belani H, & Helge J (2006). Substance Abuse and HIV in Sub Saharan Africa:Introduction to the special issue. African Journal of Drugs and African Studies, 84–94.

Nowell LS, Norris JM, White DE, & Moules NJ (2017). Thematic analysis: Striving to meet the trustworthiness criteria. International Journal of Qualitative Methods, 16(1), 160940691773384. 10.1177/1609406917733847

Philbin MM, & Fujie Z (2010). Exploring stakeholder perceptions of facilitators and barriers to accessing methadone maintenance clinics in Yunnan Province, China. AIDS Care, 22(5), 623–629. 10.1080/09540120903311490 [PubMed: 20229375]

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Rhodes T (2002). The 'risk environment': A framework for understanding and reducing drug-related harm. International Journal of Drug Policy, 13(2), 85–94. 10.1016/S0955-3959(02)00007-5

Rhodes T, Closson E, Paparini S, Guise A, & Strathdee S (2016). Towards "evidence-making intervention" approaches in the social science of implementation science: The making of methadone in East Africa. The International Journal on Drug Policy, 30, 17–26. 10.1016/j.drugpo.2016.01.002 [PubMed: 26905934]

Rhodes T, Guise A, Ndimbii J, Strathdee S, Ngugi E, & Platt L (2015). Is the promise of methadone Kenya's solution to managing HIV and addiction? British Medical Journal, BMJ Open 2015, 5.

Rhodes T, Ndimbii J, Guise A, Cullen L, & Ayon S (2015). Navigating the poverty of heroin addiction treatment and recovery opportunity in Kenya: Access work, self-care and rationed expectations. Global Public Health, 10(7), 867–1706. 10.1080/17441692.2015.1046385 [PubMed: 26089184]

Rhodes T, & Sarang A (2012). Drug treatment and the conditionality of HIV treatment access: A qualitative study in a Russian city. Addiction, 107(10), 1827–1836. 10.1111/j.1360-0443.2012.03880.x [PubMed: 22404277]

Sutton J, & Austin Z (2015). Qualitative research: Data collection, analysis, and management. Canadian Journal of Hospital Pharmacy, 68(3), 226–231. [PubMed: 26157184]

Tran BX, Nguyen LH, Nguyen LP, Nguyen CT, Phan HT, & Latkin CA (2016). Methadone maintenance treatment promotes referral and uptake of HIV testing and counselling services amongst drug users and their partners. PLOS One, 11(4), e0152804. 10.1371/journal.pone.0152804 [PubMed: 27046029]

Treloar C, & Rance J (2014). How to build trustworthy hepatitis C services in an opioid treatmentclinic? A qualitative study of clients and health workers in a co-located setting. International Journal of Drug Policy, 25(5), 865–870. [PubMed: 24559604]

Weeks M, Convey M, Dickson-Gomez J, Li J, Radda K, & Martinez M (2009). Changing drug users' risk environments: Peer health advocates as multi-level community change agents. American Journal of Community Psychology, 43(3–4), 330–344. [PubMed: 19326208]