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Research Paper

"Can't you initiate me here?": Challenges to timely initiation on antiretroviral therapy among methadone clients in Dar es Salaam, Tanzania

Haneefa T. Saleem [a,*], Dorothy Mushi [b], Saria Hassan [a], R. Douglas Bruce [a,c,d], Alexis Cooke [e], Jessie Mbwambo [b], Barrot H. Lambdin [f,g,h]

[a] Pangaea Global AIDS, 436, 14th Street, Suite 920, Oakland, CA 94612, United States
[b] Muhimbili University of Health and Allied Sciences, Department of Psychiatry, P.O. Box 65293, Dar es Salaam, Tanzania
[c] Cornell Scott-Hill Health Center, 428 Columbus Avenue, New Haven, CT 06519, United States
[d] Yale University School of Medicine, 333 Cedar Street, New Haven, CT 06510, United States
[e] University of California, Los Angeles, Fielding School of Public Health, Department of Community Health Sciences, United States
[f] RTI International, 351 California Street, Suite 500, San Francisco, CA 94104, United States
[g] University of California San Francisco, San Francisco, CA, United States
[h] University of Washington, Seattle, WA, United States

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ABSTRACT

Background: Despite dramatic improvement in antiretroviral therapy (ART) access globally, people living with HIV who inject drugs continue to face barriers that limit their access to treatment. This paper explores barriers and facilitators to ART initiation among clients attending a methadone clinic in Dar es Salaam, Tanzania.

Methods: We interviewed 12 providers and 20 clients living with HIV at the Muhimbili National Hospital methadone clinic between January and February 2015. We purposively sampled clients based on sex and ART status and providers based on job function. To analyze interview transcripts, we adopted a content analysis approach.

Results: Participants identified several factors that hindered timely ART initiation for clients at the methadone clinic. These included delays in CD4 testing and receiving CD4 test results; off-site HIV clinics; stigma operating at the individual, social and institutional levels; insufficient knowledge of the benefits of early ART initiation among clients; treatment breakdown at the clinic level possibly due to limited staff; and initiating ART only once one feels physically ill. Participants perceived social support as a buffer against stigma and facilitator of HIV treatment. Some clients also reported that persistent monitoring and follow-up on their HIV care and treatment by methadone clinic providers led them to initiate ART.

Conclusion: Health system factors, stigma and limited social support pose challenges for methadone clients living with HIV to initiate ART. Our findings suggest that on-site point-of-care CD4 testing, a peer support system, and trained HIV treatment specialists who are able to counsel HIV-positive clients and initiate them on ART at the methadone clinic could help reduce barriers to timely ART initiation for methadone clients.

Background

Recent evidence highlighting the individual and public health benefits of expanded access to antiretroviral therapy (ART) has galvanized efforts to increase the number of people accessing treatment (Cohen et al., 2011; Kitahata et al., 2009; Sterne et al., 2009). Despite dramatic improvement in ART access globally, people living with HIV who inject drugs are less likely to receive ART compared with non-drug users as they consistently face barriers that limit the availability and accessibility of HIV prevention and treatment interventions (Gruskin, Ferguson, Alfven, Rugg, & Peersman, 2013). As a result, only four people who inject drugs receive ART per 100 HIV-positive people who inject drugs worldwide (Mathers et al., 2010).

* Corresponding author. Tel.: +1 2027250705.
E-mail address: hsaleem1@jhu.edu (H.T. Saleem).

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People who inject drugs and who are HIV-positive face multiple individual, social, and structural barriers to HIV care and treatment, including ART. At the individual level, active drug use, low self-efficacy, low motivation, and inadequate knowledge of ART, and untreated mental health illness have been identified as hindering access to HIV care (Batchelder et al., 2013; Chakrapani et al., 2014; Mimiaga et al., 2010; Wood, Kerr, Tyndall, & Montaner, 2008). Lack of family support, addiction and HIV-related stigma and discrimination, and instability of housing/food operate at a social level to limit access to HIV care and treatment for people who inject drugs (Chakrapani, Velayudham, Shunmugam, Newman, & Dubrow, 2014; Krusi, Wood, Montaner, & Kerr, 2010; Mimiaga et al., 2010; Wood, Hogg, et al., 2008). Furthermore, compartmentalized health care systems that are not conducive to comprehensive HIV care for people who inject drugs, enforcement-focused drug policies, and "conditional HIV treatment access," in which people who use and/or inject drugs are denied HIV treatment or delay seeking treatment until they are deemed reliable and deserving of treatment, i.e. not using drugs, are all structural problems that hinder ART initiation (Krusi et al., 2010; Rhodes & Sarang, 2012; Wood, Hogg, et al., 2008).

This failure to initiate ART among people who inject drugs represents a significant lost opportunity for HIV programs. Evidence suggests that enrollment of people who inject drugs in opioid treatment, such as methadone, contributes to improved ART adherence and resultant suppression of HIV-1 RNA and increases in CD4 cell count (Malta, Magnanini, Strathdee, & Bastos, 2010; Roux et al., 2009; Wood, Hogg, et al., 2008). Methadone clinics provide a unique opportunity to deliver comprehensive HIV care and treatment to people who inject drugs given that patients present on a regular basis for methadone dosing (Lambdin, Mbwambo, Josiah, & Bruce, 2015).

Since the late 1990s, the injection of drugs, mostly heroin, has become widespread in Dar es Salaam, Tanzania and is spreading throughout the country (McCurdy, Ross, Kilonzo, Leshabari, & Williams, 2006; McCurdy, Williams, Kilonzo, Ross, & Leshabari, 2005). Currently, an estimated 30,000 people who inject drugs live in mainland Tanzania (*Consensus estimates on key population size and HIV prevalence in Tanzania*, 2014). As is common in other regions of the world, people who inject drugs in Tanzania face high levels of HIV risk and burden, and in Dar es Salaam, 35% of people who inject drugs are estimated to be infected with HIV (*Consensus estimates on key population size and HIV prevalence in Tanzania*, 2014), compared to 6.9% in the general population of the city ((TACAIDS), (ZAC), (NBS), (OCGS), & International, 2013).

In response to the HIV epidemic among people who inject drugs, the Government of Tanzania opened the first publically funded methadone-assisted therapy (MAT) clinic on mainland sub-Saharan Africa at Muhimbili National Hospital (MNH) in 2011. To date, over 1000 clients have been enrolled into methadone at MNH with retention levels similar to other global programs (Lambdin et al., 2014). Similar to other settings that provide care for patients with HIV and addiction, failure to initiate ART is very common at the MNH methadone clinic. A recent analysis showed that 41% of ART-eligible methadone clients initiated ART within three months of being determined eligible for treatment (Tran et al., 2015), compared to approximately 59% estimated among the general population in 2012 (PEPFAR, 2014; Tran et al., 2015). This is despite daily encounters that methadone clients have with the health care system. These figures are particularly concerning given that, until recently, a CD4 count of less than 200 was required to obtain ART.

This study qualitatively examined barriers and facilitators to ART initiation among clients attending the methadone clinic at the Muhimbili National Hospital in Dar es Salaam, Tanzania. Findings from this study will inform the development of an integrated model of HIV and methadone services.

Methods

Study setting

This research was conducted at the Muhimbili National Hospital methadone clinic in Dar es Salaam between January and February 2015. As part of routine care, the clinic offers provider initiated HIV testing and counseling at enrollment for all clients followed by ongoing HIV testing every six months (see Table 1 on the HIV care and treatment management of methadone clients). Clients who test positive for HIV have blood drawn at the methadone clinic for CD4 testing and are screened for pulmonary tuberculosis to assess eligibility for ART initiation (*National guidelines for the management of HIV and AIDS*, 2012). Blood samples are taken to the MNH central laboratory for processing. Results are posted in the national electronic laboratory records information system, where clinical staff with access privileges can retrieve them. Clients are escorted by providers to the HIV care and treatment clinic (CTC) at Muhimbili National Hospital located approximately 500 meters from the methadone clinic, where they are started on ART according to national HIV treatment guidelines (Bruce et al., 2014). Once initiated on ART, methadone clients can continue to receive their treatment at the methadone clinic and further clinical assessments and consultation are conducted by clinicians at MNH CTC. MAT providers or community outreach workers affiliated with the methadone clinic escort clients from the methadone clinic to their appointments at the HIV clinic to facilitate attendance and support clients' HIV care and treatment. HIV-positive clients who are not eligible to initiate ART receive CD4 and opportunistic infection screenings every 6 months to monitor for eligibility. Clients receive their ART on a monthly basis or as directly observed therapy based on clinical and psychosocial indications. A few clients have also requested on their own to receive directly observed ART at the methadone clinic.

Table 1
HIV care and treatment management of methadone clients with service delivery location.

Procedure	Location
HIV counseling and testing	Methadone clinic[a]
CD4 testing	MNH central laboratory
Baseline lab testing	MNH central laboratory
TB screening questionnaire	Methadone clinic
Assessment of need for ART initiation	Methadone clinic
HIV care and treatment clinic registration and card dispensing	HIV care and treatment clinic[b]
ART initiation counseling	Methadone clinic + HIV care and treatment clinic
ART initiation: drug prescribing	HIV care and treatment clinic
Post-ART initiation:	Methadone clinic
Methadone dose change	
Post-ART initiation scheduled follow -up visits	HIV care and treatment clinic
Maintenance management:	Methadone clinic and HIV care and treatment clinic
CD4 retesting	
Monitoring	
ART drug changes when needed	HIV care and treatment clinic
Side effects	
Drug failure	
Special situations	HIV care and treatment clinic
Pregnant patients	
Significant psychiatric disease	
Comorbid diseases:	
- Hepatitis B	
- Hepatitis C	
- Renal failure	

[a] Methadone clinic at Muhimbili National Hospital.
[b] HIV care and treatment clinic at Muhimbili National Hospital.