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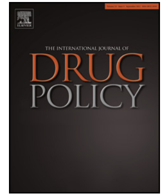

Research paper

Correlates of health care seeking behaviour among people who inject drugs in Dar es Salaam, Tanzania

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ABSTRACT

Background: People who inject drugs (PWID) suffer from a high burden of infectious disease. At the same time, they often have poor access to health care. As in other East African countries, the population of PWID is growing in Tanzania, but little is known about their contact with health care services. In this paper we examine patterns of health care use among PWID in Dar es Salaam and identify what factors are associated with regular contact with clinicians during illness.
Methods: We conducted a baseline cross-sectional study as part of a prospective cohort study involving PWID. We recruited 578 PWID, of whom 273 were newly enrolled on an integrated methadone-assisted treatment (MAT) program and 305 were community-recruited. At baseline, we interviewed the MAT program enrollees before they received services at the program clinics. We used bivariate and multiple logistic regression analyses to identify the factors associated with seeking medical care when ill.
Results: Only 25.4% of 578 participants reported seeing clinicians regularly when they needed medical care. Participants were more likely to see clinicians regularly if they were employed, (OR: 2.25, 95% CI: 1.28–3.98), had higher income levels (OR: 1.10, 95% CI: 1.00–1.22), were parents (OR: 1.71, 95% CI: 1.09–2.68), or knew where to seek affordable care (OR: 3.42, 95% CI: 2.12–5.52).
Conclusion: PWID in Dar es Salaam generally did not seek health care when needed. To improve their health care seeking behaviour, it is important to advise PWID about where to seek affordable health care and to increase their income-generating skills.

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Introduction

People who inject drugs (PWID) face various medical and social problems. Medical problems include illnesses resulting from HIV (Matiko et al., 2015), tuberculosis (Gupta et al., 2014), hepatitis, skin abscesses and infection, and pulmonary and cardiovascular diseases (Altice, Kamarulzaman, Soriano, Schechter, & Friedland, 2010). PWID also suffer from social problems such as sexual or physical abuse and unemployment (Neale, Tompkins, & Sheard, 2008). In addition, drug use may lead to overdose and an escalated risk of mortality (Mathers et al., 2013). Despite such disadvantages, the majority of PWID have poor access when in need of medical care (Chitwood, McBride, French, & Comerford, 1999; Cisneros, Douaihy, & Kirisci, 2009; Cronquist, Edwards, Galea, Latka, & Vlahov, 2001; Riley et al., 2002).

Factors influencing access to health care are well described by the Behavioral Model of Health Services Use (BHSU) (Andersen, 2001). This model comprises four domains: contextual characteristics, individual characteristics, health behaviours, and outcomes. The contextual and individual characteristics are further divided into predisposing, enabling, and need factors. Predisposing factors include demographics, social factors, and beliefs. Enabling factors are the means that enable or hinder an individual to use health care, while need factors are related to the state of an illness.

PWID have reported various barriers and facilitators affecting their access to health care. An example of a barrier is long duration

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of travel required to reach a health facility, which is one of the contextual enabling factors under the BHSU (Neale et al., 2008). Perceived stigma experienced at health facilities is another barrier, and an example of an individual predisposing factor (Day, Ross, & Dolan, 2003). High treatment cost is also an example of an individual enabling factor which may impair access to health care (McCoy, Metsch, Chitwood, & Miles, 2001). On the other hand, knowing where to seek care is an example of an individual enabling factor which may facilitate access (McCoy et al., 2001). Finally, health workers' negative attitudes to PWID is an example of a health behaviour which may impair access to health care (Brener, von Hippel, & Kippax, 2007).

PWID have poorer access to health care than the general population (Knowlton et al., 2001). However, evidence from high-income countries is inconsistent in this regard. Access is satisfactory for some (Islam et al., 2013; O'Brien et al., 2015) but poor for others (Chitwood et al., 1999; Riley et al., 2002; Sohler et al., 2007). Evidence is very limited about the level of access to health care among PWID in sub-Saharan Africa. In particular, in Tanzania, where the growing burden of drug use is evident (Mbwambo et al., 2012). This marginalized population is known to be vulnerable to HIV infection (Williams et al., 2009), tuberculosis (Gupta et al., 2014), and hepatitis (Nyandindi et al., 2011) and poor access to health care may result in poor health outcomes among PWID and increase the cost of medical care to an individual and the health system as a whole. It is therefore necessary to understand the level of access to health care among PWID and to identify ways to improve it.

In Tanzania, PWID may receive care from both publicly and privately run health facilities (Mtei et al., 2012). Health workers include medical specialists, general physicians, also known as medical officers, and mid-level providers. Mid-level providers include clinical officers and assistant medical officers. They provide health care to most populations in semi-urban and rural areas and are also referred to as doctors (Kwesigabo et al., 2012). The number of medical doctors is insufficient to cater to the health care needs of the population (Anyangwe & Mtonga, 2007; Kwesigabo et al., 2012). Therefore, mid-level providers assume tasks that medical doctors would typically undertake. They play a vital role in providing basic care, treatment, and preventive services to the general population, including PWID.

Patients cover health care costs through health insurance schemes and out-of-pocket payments in Tanzania (Mills et al., 2012). However, only about 10–12% of the population is covered by health insurance and the majority relies on out-of-pocket payments (Macha et al., 2012; Mills et al., 2012)—PWID are no exception. Several defined vulnerable populations are exempted from paying health care fees in public health facilities (MoHSW, 2003; Mtei et al., 2012). These groups include children under-five, pregnant women (de Savigny et al., 2004), those aged 60 years or more who cannot afford health care costs, impoverished individuals, and people with chronic diseases such as cancer, HIV, diabetes, tuberculosis, and mental illness (MoHSW, 2007). However, some of these eligible populations do not receive free health care because of various intervening factors, including lack of knowledge of their entitlements, informal payments, and lack of medications at the health facilities (Tibandebage & Mackintosh, 2005).

The objectives of this study were to examine the level of health care utilization and the factors associated with seeing clinicians regularly among PWID in Dar es Salaam. The cost of health care is one of the major challenges in accessing health care in Tanzania. Accordingly, we hypothesized that PWID would be more likely to see clinicians regularly when in need if they were employed, had higher income levels, and knew where to seek affordable medical care.

Methods

Study design, area, and population

This baseline, cross-sectional study was conducted as part of a prospective cohort study involving PWID in Dar es Salaam. Study objectives were to examine the roles of an integrated methadone-assisted treatment (MAT) program on improving high-risk injecting and sexual behaviours, criminal activities, and access to health care among PWID. The intervention group consisted of PWID newly enrolled in the MAT program and the control group consisted of community-recruited PWID not on methadone treatment. We applied the following inclusion criteria: reported use of drugs by injection at least once in the past 30 days, aged 18 years or older, and resident of Dar es Salaam. The exclusion criterion was having a severe mental illness. We assessed mental health status based on general observation and a brief interview conducted prior to data collection. This included looking for gross disorganization in behaviour and speech and being cognizant of time, place, and person. Among the participants we approached, none had a severe mental illness.

Dar es Salaam is the business capital of Tanzania, with a population of approximately 4.4 million (NBS & OCGS, 2014). The region has three municipalities: Kinondoni, Ilala, and Temeke. The main patterns of drug use in the region include smoking, sniffing, inhaling, and injecting (Dewing, Pluddemann, Myers, & Parry, 2006). The types of drugs used include heroin, cannabis, and valium (Williams et al., 2009). There are an estimated 30,000 PWID in the country, of whom 30–50% are thought to reside in Dar es Salaam (Dutta, Barker, & Makyao, 2014). They engage in high-risk behaviours such as sharing injecting needles, unprotected sex, and multiple sexual partnerships (McCurdy, Ross, Williams, Kilonzo, & Leshabari, 2010; Williams et al., 2009). As a result, HIV prevalence among PWID in Tanzania is 35.0% (Dutta et al., 2014) which is markedly higher than that observed among the general population (5.1%) (TACAIDS, ZAC, NBS, OCGS, & ICF International, 2013).

Sampling

We used convenience sampling to recruit participants. We recruited new integrated MAT program enrollees from the Muhimbili National Hospital and Mwananyamala Hospital located in Ilala and Kinondoni municipalities, respectively. These hospitals are the only public hospitals that offered the MAT program at time of data collection. We recruited PWID from the community using snowball sampling in all three municipalities of Dar es Salaam. We invited 600 PWID (280 new MAT program enrollees vs. 320 community-recruited PWID) to participate in the study, and only two refused to do so.

Data collection

We collected baseline data between January and April 2014. We recruited and trained five research assistants who were involved in service provision at the integrated MAT program clinics. Two researchers collected data from the hospitals and three collected data from the community. The research assistants received training in questionnaire content, data collection procedures, and ethics-related issues.

We used a pretested Swahili questionnaire for the face-to-face interviews. We interviewed new enrollees in consultation rooms at the program clinics. The clinics provide methadone, voluntary screening of various infectious diseases, medical care, and referral for further care when required (Bruce et al., 2014; Lambdin et al., 2013; Lambdin, Mbwambo, Josiah, & Bruce, 2015), psychosocial counseling, and training for income generating activities. At

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