Barriers to Hepatitis C Treatment among Women in Methadone Treatment: A Study from Iran, the Most Populous Persian Gulf Country

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Original Article

Abstract

Background: Untreated Hepatitis C Virus (HCV) has been reported among many Iranian female methadone patients. However, few of them report receiving HCV treatment. The present study is the first research from western Asia that explored the barriers to receiving HCV treatment among a group of Iranian female HCV-infected methadone patients.

Methods: This qualitative study was conducted in four main methadone treatment clinics in Tehran, Iran, in November 2016. Overall, fifty-six untreated HCV-infected women and eight clinicians from HCV and methadone treatment services were interviewed. Women either had not received HCV treatment or received HCV treatment but left it. Data were analyzed using NVivo software. This was based on the grounded theory of Strauss and Corbin.

Findings: Barriers to receiving HCV treatment included factors related to individuals and factors related to the system. Individual factors included the perception that untreated HCV infection was not a serious health concern, family responsibilities, and self-perceived discrimination against HCV-infected women. System-related factors included the lack of referral from methadone treatment staff, and a long distance between HCV treatment centers and methadone treatment centers. Interviews with the health professionals also confirmed the women' self-reports.

Conclusion: The results of this research confirm the necessity of providing HCV education and the delivery of comprehensive care for this group in methadone treatment clinics. Other services such as staff education and HCV treatment services at methadone treatment centers are suggested.

Keywords: Drugs; Hepatitis C virus; Iran; Methadone; Treatment

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Introduction

Hepatitis C virus (HCV) remains an important reason for death, affecting over 130 million individuals in the world.[1] HCV is estimated to be an important reason for liver cancer and cirrhosis,[1] and death from HCV-related liver disease has surpassed death from HIV in some parts of the world.[2] HCV is a serious health problem among drug-depepdents.[3] However, it is estimated that less than half of drug-dependents with chronic HCV have been offered treatment ever.[3-5] This is very important because untreated HCV among drug-dependents can affect people.[3-5]

Iran is an immense Persian country with a population of about 80 million in western Asia, and has a long eastern boundary with Afghanistan.[6] Afghanistan's opiates are smuggled to Iran on a massive scale.[6] Therefore, Iran has a serious opiate problem.[6] Opiate dependence in Iran is related to the HCV problem.[6] A large number of HCV infection occurs between addicted sex worker women.[7] The simultaneous engagement of female methadone patients in unprotected sexual relationships with multiple partners has been reported.[7,8] This can be associated with some adverse health impacts such as HCV.[7,8]

To reduce opiate dependence and associated harms, methadone substitution therapy has been developed in Iran.[9] This has been accompanied with providing antiviral therapy for HCV.[10] However, studies in Iran indicate that many methadone patients with HCV problem do not report willingness to receive treatment.[10] Therefore, the majority of HCV-infected methadone patients remain out of HCV treatment.[10] HCV treatment is an important issue,[11] because lack of receiving such services can have serious health problems for the patients and the community.[10]

Barriers to receiving HCV treatment have been documented in western countries and such barriers can have important health implication for the community.[11,12] At the patient level, unemployment, legal issues, poor knowledge of HCV problem and treatment, social and economic problems, and drug injection have been reported.[11,12] At the provider level, poor knowledge of practitioners, poor treatment referral, and poor communication issues have been reported. Lastly, at the systems level, poor treatment promotion, long waiting lists for treatment, poor educational initiatives, and excessive paperwork have been reported.[12]

To date, the factors which prevent receiving HCV treatment among Iranian female methadone patients have not been documented. This issue may prevent developing effective HCV responses and as a result, controlling HCV among others. The aim of this study was to explore the barriers to receiving HCV treatment among a group of female methadone patients at individual and system levels.

Methods

This qualitative study was designed based on the grounded theory of Strauss and Corbin.[13] The study settings included four methadone maintenance treatment (MMT) centers in Tehran, Iran. Three study sites were women-only services with high rates of reported HCV infection among their patients.

Inclusion criteria for eligibility of women's participation in study were: 1) eighteen years old (at least), and 2) medical diagnosis of HCV infection in the last two years. Re-check was done for women whose HCV was reported by physician of each study site. Participants must have been on MMT for at least two months and reported untreated for HCV at the time of the research. Exclusion criteria included severe drug dependence-related symptoms and/or psychiatric problems which can affect the interview procedures.

A subsample of 56 women who enrolled in MMT was recruited in this qualitative study in November 2016. Women were approached by the center managers or the psychologists for study participation. Two groups of women were recruited: first, those who did not have any engagement with HCV treatment (n = 30, 53.6%); second, those women who undertook HCV treatment but left the treatment incomplete (n = 26, 46.4%). Interviews with a range of eight HCV and methadone treatment staff involved in methadone or HCV treatment were also conducted. According to Strauss and Corbin's grounded theory, the sampling continued until no new theme revealed in four consecutive interviews.[13,14]

The eight clinicians who participated in the study included one nurse, four HCV treatment

providers, two doctors in methadone treatment clinics and the director of a HCV treatment setting.

First, the purpose of the study was explained to the participants, then in-depth and face-to-face interviews were conducted. Interviews were done in private interview rooms at the methadone centers in November 2016. Interviews took 60 minutes and were audio-taped with prior permission from each interviewee. Semi-structured interviews were designed for a set of core issues. Women interviews included a brief demographic and clinical overview (including drug treatment and HCV histories) and attitudes towards and/or experiences of HCV treatment (including barriers). The core set of issues raised with the health professionals included their initial expectations of working with HCV-infected women, client responses, and barriers to clients' HCV treatment entry. The health professionals were interviewed at the same time.

Data analysis was based on qualitative content analysis and thematic approach. Interviews were transcribed verbatim. Transcripts related to the interviews were translated from Persian into English for better analysis. The methodological approach was inductive and was based on the grounded theory.[14] We categorized barriers to HCV treatment in this framework to provide hierarchy and communication findings. All the data were checked for accuracy. Data summaries were presented to all authors for discussion. Data interpretation was done until we reached consensus. Data were imported into NVivo software (version 8) for qualitative management and coding.

The study was approved by Tehran University of Medical Sciences, Tehran, Iran. Contribution was completely voluntary and confidential. Consent form was obtained from each interviewee. Both women and staff were assured that the lack of participants would not have any impact on either their methadone treatment or their professional relationships. Women were reimbursed $10 for their time and expertise.

Results

Baseline characteristics: Fifty-six women participated in the study. The mean age of the women was 38 [standard deviation (SD) = 8] years (age range: 22-50 years)]. Most women (51.7%) were married at the time of interview. Overall, 38 participants were jobless and 18 participants had part-time jobs. The medium years of schooling were eight years. Overall, 31 participants reported stable housing at the time of interview. Length of opiate dependence was 10.6 (SD = 6.1) years. The length of the methadone treatment ranged between 4 and 31 months. No participant was in HCV treatment at the time of interview (Table 1).

Table 1. Baseline characteristics of the women (n = 56)

Characteristics	Value
Age (year) (mean ± SD)	38 ± 8
Age (year) (range)	22-50
Marital status [n (%)]	
Married	29 (51.7)
Separated	12 (21.4)
Divorced	10 (17.8)
Single	5 (8.9)
Job status [n (%)]	
Jobless	38 (67.8)
Part-time jobs	18 (32.2)
The medium years of schooling (n)	8
Living conditions [n (%)]	
Stable housing	31 (55.3)
Dormitories	17 (30.5)
Homeless	8 (14.2)
Length of opiate dependence (year) (mean ± SD)	10.6 ± 6.1
The length of the methadone treatment (months) (range)	4-31
Recent HCV treatment (n)	0

SD: Standard deviation; HCV: Hepatitis C virus

Barriers to receiving HCV treatment

Individual factors: The perception that untreated HCV infection is not a serious health concern.

This theme was common in the narratives that HCV was not a health concern. This was because women lacked HCV symptoms. Some of the women (n = 8) were co-infected and received antiviral therapy for HIV; they showed persistency to receive HIV treatment on a regular basis but they did not care about receiving HCV treatment. There was a common perception that HCV could be treated at any time and the antiviral therapy was an open choice with no time limit. In addition, there was a common perception that the treatment side effects and tolerability were concerning. Women expressed poor motivations for HCV treatment, partly because they saw their friends felt unwell after receiving treatment. This issue was risky because it led to

forgetting the long-term side effects of HCV, and prevented receiving HCV treatment. The health professionals raised the concern that HCV treatment remained an unattractive option for a considerable number of women, while lack of symptoms provided an opportunity not to think of liver damage and the potential risk of health complications and cancer.

'…Addicts don't die of HCV but HIV is very important for treatment. I can go to treatment for HCV at any time …Why should I really go for HCV treatment in the community?...' (A 42-year-old woman)

Family responsibilities: A theme that repeatedly emerged from the narratives confirmed that multiple housework chores such as cooking, cleaning, and washing hampered receiving HCV treatment. Some of the women had no children but they had to care of other family members. In some circumstances, this included taking care of elderly family members or close relatives. Some participants had children of less than fifteen years and they had to take care of them. Further thematic analyses of the qualitative data indicated that more than two thirds of the participants came to methadone treatment services every day and did not have adequate time to receive HCV treatment in the community because of multiple responsibilities at home while being in methadone treatment. This was finally misleading because participants perceived that the interplay of receiving methadone treatment and doing housework responsibilities did not leave an opportunity to receive HCV treatment, and this work was considered time-consuming.

'…I can't go out for HCV treatment because I have two kids and an old mother…I come to methadone treatment every day. I should go and pick up the kids at school every day… Most women take care of their kids and spend time in their kitchens…' (A 35-year-old women)

'…Most addicted women have lots of responsibilities in home and cannot go for HCV treatment. We should provide HCV treatment in methadone clinics for them…' (A medical doctor)

Self-perceived discrimination against HCV-infected women

A theme that gradually emerged from the narratives was discrimination. Interviewees frequently explained how social stigma encouraged them to ignore the adverse health impacts of HCV and hampered HCV treatment entry. The relationship between HCV and high risk behaviors such as sex work and drug injection was a significant barrier to receiving HCV treatment among one third of the participants. This concept that drug injection and high risk behaviors are against social norms in the Iranian community was common. This was both common at the levels of service providers and other patients in HCV treatment. However, stigma was found more common at the patient level.

'…People show stigma to women with HCV. Male patients think you are HCV-positive because of sex work and drug injection…' (A 28-year-old woman)

'…Most women think of being stigmatized and discriminated. This is right but we should develop HCV education…' (A medical doctor)

System-related factors

A long distance between HCV treatment centers and methadone treatment services

A theme that frequently emerged from the narratives indicated that there was a long distance between HCV treatment centers and methadone clinics. Because Tehran is a large populous city, it was difficult for many women to simultaneously move between methadone treatment centers and HCV treatment centers. The separate provision of HCV treatment from methadone treatment was cited as a barrier to receiving treatment by half of the women. Cost of transport for long distances, a lack of ability to pay for transport, the overlap of the time of taking methadone with antiviral therapy for HCV, and a lack of ability to be simultaneously in two treatment sites were frequently found in the women's narratives. The health professionals raised the same concern and demonstrated that how the lack of providing on-site methadone and HCV treatment services worked as a barrier to receiving HCV treatment by a considerable number of women.

'…There is a long distance between HCV treatment centers and this methadone clinic. I can't easily move between these two places in Tehran…' (A 33-year-old woman)

Lack of referral from methadone treatment staff

A theme that repeatedly emerged from the narratives confirmed that most methadone staff did not have adequate information about HCV treatment services. Therefore, they did not refer female methadone patients to these centers for

treatment. Some health professionals reported that methadone staff did not provide information about HCV which can be easily treated in the community treatment services. This concept was misleading because women did not take responsibility for HCV treatment.

'…I do not know where to go for HCV treatment. This methadone clinic does not refer me for HCV treatment…' (A 36-year-old woman)

'…Most methadone staff do not refer women to us. They should inform women about HCV treatment services. HCV education should be a must in methadone treatment…' (A HCV treatment provider).

Discussion

The low rates of HCV treatment entry among Iranian women may reflect specific barriers that they face. Such barriers refer to reasons that patients do not utilize specialized HCV treatment services.[15-17] To date, barriers to receiving HCV treatment among female methadone patients have not been studied in Iran. To our knowledge, the current study is the first research.

Analyzing the narratives indicated that the lack of perceiving untreated HCV as a serious health concern was the most reported barrier. The main obstacle among these patients was the perception of HCV as a harmless disease, the fact that women were not feeling unwell. The other reason may originate in this issue that HCV treatment is not as serious as HIV treatment among the Iranians. A qualitative study on 188 HCV-infected illicit drug users that sixteen percent of them had received treatment for HCV indicated that among those not having sought HCV treatment, the major reasons for not doing so included lack of information about HCV or knowledge that treatment was available, the absence of symptoms and the perceived side effects of treatment.[18] Special educational programs should be provided in methadone treatment clinics to inform women about the adverse health impacts of HCV and the necessity of treatment.

The thematic analyses of the narrative indicated that housework responsibilities were among the most important barriers to receiving HCV treatment among the study participants. This is consistent with a study which indicated that women were less likely to enter HCV treatment when they had multiple responsibilities at home.[19] Women should be specifically educated that HCV is a critical health concern and family responsibilities should not act as barriers to HCV treatment entry. HCV education should be an inevitable part of methadone treatment for these women.

Further qualitative analysis indicated that self-perceived discrimination was a main barrier to receiving HCV treatment. It has been reported that discrimination against people with blood-borne viral infections is common in HCV treatment services.[20] Previous research indicates that stigma is experienced acutely by many female drug users and can be a serious barrier to treatment seeking by them.[20-22] Special educational programs should be provided to reduce this problem among both the patients and the staff. The training of HCV specialists and patients, which focuses on insights into addiction medicine, could address moral-based misconceptions and stigma towards female HCV-positive methadone patients. This needs to be gradually addressed at both levels of service providers and patients.

Moreover, the study indicated that long distance between HCV and methadone treatment places was a serious barrier to receiving HCV treatment. Other studies indicated that comfort was one of the most important factors in receiving HCV treatment, and distance from the clinic discouraged HCV treatment.[23-25] This qualitative finding indicates that the optimal conditions for treatment delivery may comprise integrating care through multi-disciplinary teams. Free and high quality HCV treatment should be provided at methadone treatment centers.

The thematic analyses of the narratives indicated that the lack of referral from methadone treatment staff was another important barrier. This qualitative concept was misleading because women did not take responsibility for HCV treatment. This is consistent with a qualitative study of HIV among Iranian female methadone patients. In the study, qualitative interviews were conducted with 47 women at five drug treatment centers. The interview accounts showed a number of barriers to receiving HIV treatment including: 1) a considerable lack of knowledge about free HIV

centers in the community, and 2) a poorly referral supportive system among drug use treatment centers and HIV centers.[26] HCV education should be provided for these women. The updated list of HCV treatment services should be available for such women in methadone treatment services.

There are several limitations in this qualitative study. First, the study was about women. Therefore, the study findings should not be generalized to men. Sex differences in barriers to receiving HCV treatment may exist. This should be studied with conducting more research. The study was limited to patients in methadone treatment clinics. This may be different from untreated HCV among regular drug users in the community who do not receive treatment. Further qualitative studies are suggested.

Conclusion

In summary, this research notes the barriers to receiving HCV treatment among Iranian female methadone patients. There is not only one simple solution to reach proper HCV treatment among these patients. Delivering HCV treatment in methadone treatment settings should be considered. This should be followed by reducing stigma and providing more services. Yet, further research is needed to develop this concept beyond simply adding on HCV treatment to methadone treatment in the most populated Persian Gulf country.

Conflict of Interests

The Authors have no conflict of interest.

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موانع درمان هپاتیت در زنان تحت درمان با متادون: یک مطالعه از ایران، پرجمعیت‌ترین کشور خلیج فارس

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مقاله پژوهشی

چکیده

مقدمه: هپاتیت C درمان نشده در میان بسیاری از زنان تحت درمان با متادون در ایران گزارش شده است. با این وجود، تعداد کمی از آن‌ها درمان هپاتیت C را دریافت می‌کنند. مطالعه حاضر، اولین پژوهش از منطقه غرب آسیا بود که با هدف بررسی موانع درمان هپاتیت C در بین گروهی از زنان ایرانی تحت درمان متادون و مبتلا به هپاتیت C انجام شد.

روش‌ها: این پژوهش کیفی، در چهار مرکز بزرگ درمان متادون در آبان سال ۱۳۹۵ انجام شد. در مجموع، با ۵۶ زن مبتلا به هپاتیت C درمان نشده و ۸ متخصص سلامت شاغل در مراکز متادون و هپاتیت مصاحبه صورت گرفت. زنان مورد مصاحبه هیچ درمانی دریافت نکرده بودند و یا درمان هپاتیت C را شروع کرده، اما آن را نیمه‌کاره رها کرده بودند. داده‌ها در نرم‌افزار NVivo مورد تجزیه و تحلیل قرار گرفت. تحلیل داده‌ها، بر اساس نظریه Strauss و Corbin بود.

یافته‌ها: موانع دریافت درمان هپاتیت C عبارت از موارد فردی و موارد مربوط به سیستم بود. موارد فردی شامل باور به این که هپاتیت C درمان نشده مشکل جدی برای سلامت نیست، مسؤولیت‌های داخل خانواده و احساس فردی تبعیض علیه زنان مبتلا به هپاتیت C بود. موارد مربوط به سیستم نیز «عدم ارجاع بیماران برای درمان توسط کارکنان مراکز متادون و فاصله زیاد بین مراکز درمان متادون و مراکز درمان هپاتیت» عنوان گردید. مصاحبه کارشناسان نیز گزارش‌های زنان را تأیید کرد.

نتیجه‌گیری: نتایج به دست آمده لزوم فراهم‌سازی آموزش هپاتیت C و ارایه یکپارچه مراقبت‌های بهداشتی چند وجهی برای این گروه در مراکز متادون را تأیید می‌نماید. همچنین، انجام خدمات جانبی دیگر مانند آموزش کارکنان و خدمات درمان هپاتیت C در مراکز درمان متادون پیشنهاد می‌شود.

واژگان کلیدی: مواد مخدر، ویروس هپاتیت C، ایران، متادون، درمان

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