Barriers to Utilization of Harm Reduction and Drug Rehabilitation Services among Female Drug Users in Kenya

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Abstract

There are an estimated 3.2 million women who inject drugs (WUD) globally, constituting 20% of all people who inject drugs. Notwithstanding the significant proportion of female drug users (FDUs) in Kenya, anecdotal reports from harm reduction and drug rehabilitation facilities have continued to record low utilization rates of the existing support services. Despite these alarming reports, there is limited data attempting to understand the barriers facing FDUs in need of harm reduction and drug rehabilitation services (HRDRS) in Kenya. The study therefore endeavored to investigate the barriers hindering access to HRDRS among FDUs in Kenya. A cross-sectional study was conducted using triangulation of multiple data collection methods. Findings showed that FDUs were primarily exposed to systemic barriers; socio-economic barriers; cultural and societal barriers. The most commonly reported systemic barriers were inadequate female friendly facilities; unavailability of baby friendly needs; recruitment challenges; and access challenges by pregnant or breastfeeding FDUs. The key socio-economic barriers were parenting responsibilities; challenges of physical access; lack of opportunities for income generation; and high cost of drug rehabilitation. The cultural and societal barriers were manifested through stigma associated with the family, community, religion as well as the healthcare personnel. The study therefore concluded that the complex interplay of the systemic barriers; social economic barriers; and cultural and societal barriers were the main underlying risk factors impeding utilization of HRDRS in Kenya.

Key words: *Harm reduction and drug rehabilitation services (HRDRS), female drug users (FDUs); and women using drugs (WUDs)*

Introduction

In 2019, an estimated 275 million people globally aged 15–64 years had used drugs at least once in the past year. Between 2010 and 2019, the estimated number of users of any drug in the past year globally increased by 22 percent from 226 million to 274 million. Among the estimated 275 million users of any drug in the past year, approximately 36.3 million (13%), are estimated to suffer from drug use disorders. Among opioids users, nearly 31 million had used opiates in the past-year in 2019. Further, an estimated 20 million people had used cocaine in the past year in 2019 (UNODC, 2021). There are an estimated 3.2 million women globally who inject drugs, constituting 20% of all people who inject drugs (Degenhardt et al, 2017).

Despite a clear need for harm reduction services (HRS) targeting women, they continue to face "masculinist" concerns and do not meet the needs of women (Ettorre, 2004). In Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicates that women make up approximately 25 percent of all people with drug dependence (EMCDDA, 2017).

Women who use drugs (WUD) are extremely hard to reach and they maintain a relatively inferior position to men in the drug-using sub-culture (Roberts, Mathers and Degenhardt, 2010). WUD face greater stigma and other harms at levels higher than men who use drugs (Roberts, Mathers and Degenhardt, 2010). The effects of entrenched gender inequities and norms are reflected in the support of services existing in the harm reduction and addiction treatment facilities (Azim, Bontell and Strathdee, 2015; Kushner, Chappell and Kim, 2019; Braitstein et al, 2003; Greenfield et al, 2007). With the responsibilities of parenting disproportionately falling to women, support services that fail to meet their needs including childcare facilities presents a significant access barrier for WUD (Pinkham and Malinowska-Sempruch, 2008; Malinowska-Sempruch, 2015; Otiashvilli et al, 2013; Copeland, 1997; Flavin, 2002; Esmaeili et al, 2018). Therefore, the lack of comprehensive and integrated HRDRS hinders access by FDUs (Malinowska-Sempruch, 2015). Another barrier relates to the limited availability of women-only spaces and services which help to guarantee the personal safety of women and reduce the impact of imbalanced gender power dynamics leading to improved health outcomes (Iversen et al, 2015).

Globally, studies exploring barriers to utilization of existing support services among FDUs have placed emphasis on harm reduction programs. Whereas HRS are offered mainly through drop-in centres, few studies have attempted to examine the barriers related to utilization of cessation programs implemented through drug rehabilitation facilities where clients are confined over a 90-day period. Notwithstanding the significant proportion of FDUs in Kenya (NASCOP, 2019), anecdotal reports from harm reduction and drug rehabilitation facilities have continued to record low utilization rates of existing support services. Despite these alarming reports, there is limited data on utilization barriers facing FDUs in need of HRDRS in Kenya. Further, there is limited data on utilization barriers specific to FDUs accessing drug rehabilitation services (DRS). Finally, context specific data is desired to inform tailored interventions addressing utilization barriers related to HRDRS among FDUs in Kenya. The study therefore endeavored to investigate the barriers hindering access to HRDRS among FDUs in Kenya.

Methodology

Study design

A cross-sectional study was conducted using triangulation of multiple data collection methods where both qualitative and quantitative data was generated.

Study area

The study was conducted in the Coast region, one of the eight (8) regions of Kenya. The region is Kenya's most popular international tourist destination characterized by a wide and porous border extending across the counties of Mombasa, Kwale, Kilifi and Lamu.

Sample size

The study targeted a purposive sample size of 110 respondents. Data was collected in the month of December 2021. The primary respondents were FDUs in program and FDUs out-of-program. Key informants

included centre managers; community members namely – women leaders, youth leaders and religious leaders; and NASCOP/ Ministry of Health (MOH) officials. Table 1 presents the sample size distribution:

Table 1: Sample size distribution

Category of respondent	Proposed sample size
FDUs in program (focus group discussions (FGDs))	35
FDUs out-of-program (FGDs)	35
FDUs in program (in-depth interviews (IDIs))	7
FDUs out-of-program (IDIs)	7
Centre managers (key informant interviews (KIIs))	7
Community members (KIIs)	10
MOH officials (KIIs)	7
Total	110

Sampling procedure

The study relied on non-probability sampling methods given the hidden and criminal nature of narcotic drug use. Coast region was sampled purposively with evidence showing that the region has continued to record the highest prevalence of narcotic drug use over the years in Kenya (NACADA, 2017). Within the Coast region, Mombasa, Kilifi and Kwale counties were purposively selected with available data listing them as key hotspots for drug use in Kenya (NASCOP, 2019). The first stratification was conducted where all the facilities providing HRDRS were mapped. Given that the mapped facilities were few in number, all the seven facilities were purposively selected. The second stratification involved allocation of the mapped facilities by the three sampled counties. In each facility, two focus group discussions (FGDs) were conducted targeting FDUs in program and FDUs out-of-program. The potential respondent was either a current drug user (FDU out-of-program) or a recovering drug user (FDU in program). The study was also limited to current or past users of narcotic drugs especially heroin or cocaine. Each FGD comprised 5 participants. For FDUs in program, the sample was selected through a simple random sampling method from a pool of FDUs currently in the programs. In addition, one FDU in program was also sampled to participate in the in-depth interview (IDI).

For FDUs out-of-program, community health workers were used to recruit the potential respondents. After identification of the seed respondent (FDU out-of-program) meeting the inclusion criteria, snow balling sampling method was used to identify the next respondent within their network through peer referral. Each respondent was allowed to recruit one respondent from their networks until a threshold of 5 FDUs was achieved.

The recruitment was only limited to FDUs. Besides, one FDU out-of-program was recruited to participate in the IDI. The sampled facility was also used as the study centre where key informant interviews (KIIs) were conducted with purposively selected centre manager of the facility, community member (women, youth and religious leaders) and the MOH official. The same procedure was replicated in all the seven sampled facilities.

Research instruments

The primary data collection methods were FGDs and IDIs targeting FDUs in program and FDUs out-of-program; as well as KIIs with the key stakeholders including community, youth and religious leaders. These qualitative methods explored the in-depth understanding

of barriers hindering utilization to HRDRS as well as examining gaps and weaknesses in the existing legal framework. Quantitative data was captured using a structured questionnaire that was meant to document the demographic characteristics and drug use behavior of FDUs recruited into the study. The responses from FGDs, KIIs and IDIs were tape recorded.

Data analysis

Descriptive statistics particularly frequencies and percentages were used to describe and summarize the background characteristics and drug use behaviour of the FDUs. FGDs, IDIs and KIIs were transcribed and translated into English. All interviews conducted were transcribed verbatim including the removal of individually identifiable information for the respondents so as to safeguard privacy and anonymity. Content analysis of the interview data was conducted using the qualitative software program NVivo 10. Content analysis of qualitative data is a research method employed for the subjective interpretation of data through systematic classification process of coding and isolating emerging themes (Hsieh and Shannon, 2005). For analysis of the interviews and coding them in a similar pattern, each of the two researchers developed a coding tree. The two coding trees were then compared and discussed in detail exploring similarities and variations in order to develop a final common coding tree. This approach assisted to isolate a number of key themes and patterns in the data. During coding of the interviews, categories were linked to their sub-categories and were then arranged around a common cluster. Finally, the major theme was extracted. Direct quotes were also generated to capture mood, opinions and experiences of the respondents.

Ethical consideration

Ethical approval to carry out the study was granted by the Institute for Security Studies Research Ethics Committee. Informed consent was sought from all the study participants and centre managers. Anonymity, confidentiality and privacy of the study participants were also safeguarded.

Results

According to Table 2, analysis of FDUs in program and FDUs out of program showed that majority were aged 25 – 35 years; affiliated to the Muslim religion; unemployed; divorced; and with a primary level education.

Table 2: Background characteristics of FDUs

Characteristic	Category	In-program (n=32)	Out-of-program (n=32)
		Percent (%)	Percent (%)
Age	18 – 24 years	9.4	9.4
	25 – 35 years	62.5	56.3
	36 – 45 years	28.1	25.0
	46 years and above	-	9.4
Religion	Protestant	28.1	15.6
	Catholic	18.8	18.8
	Muslim	53.1	62.5
	Others	-	3.1

Education	No formal education	6.3	6.3
	Primary level	68.8	65.6
	Secondary level	18.8	25.0
	Post-secondary level	6.3	3.1
Employment status	Unemployed	50.0	81.5
	Employed	21.9	-
	Self-employed	15.6	14.8
	Others	12.5	3.7
Marital status	Married	22.6	21.9
	Single	29.0	31.3
	Widowed	6.5	6.3
	Divorced	41.9	40.6

Drug use behavior

Analysis of drug use behavior among FDUs out-of-program showed that 96.8% were current users of heroin and 3.2% were current users of cocaine. For FDUs in program, findings showed that 100% were former heroin users. Data on injecting drug use also showed that 61.3% of FDUs out-of-program were injecting with the main drug while 43.8% of the FDUs in program were formerly injecting with the main drug. The median age of injecting with the main drug among FDUs out-of-program was 24 years while FDUs in program was 29 years.

Onset age for the main drug

Data showed that majority of FDUs out-of-program initiated drug use at the age of 18 – 24 years (58.1%) with a median initiation age of 21 years. For FDUs in program, the onset age for the majority was 18 – 24 years (34.5%) with the median initiation age of 20 years.

Data on onset age of injecting among FDUs out-of-program showed that the age of 18 – 24 years was the most critical age to initiate injecting of drugs (52.6%) while for FDUs in program, age 25 – 35 years was most vulnerable age of injecting drugs (64.3%).

Barriers to utilization of HRDRS

The barriers to utilization of HRDRS were classified into four broad categories namely systemic barriers; socio-economic barriers; and cultural and societal barriers.

Systemic barriers

This category of barriers was responsive to policies, procedures and practices hindering FDUs from accessing HRDRS. The main systemic barriers reported were inadequate female friendly facilities; unavailability of baby friendly needs; recruitment challenges; and access challenges by pregnant or breastfeeding FDUs.

Inadequate female friendly facilities

Inadequate availability of female friendly facilities was reported as a barrier to utilization of HRDRS. It was reported that female friendly drug rehabilitation facilities were almost non-existent thereby hindering FDUs seeking to access these support services.

"The other challenge is that we only have one female rehab if I am not wrong in the entire Coast region. One thing we need is to have these female rehabs like as soon as yesterday" (Key informant, MOH)

Recruitment challenges

The study observed that the complex and long recruitment processes for FDUs seeking enrolment to HRS was a key utilization barrier. In some cases, the harm reduction facilities were only admitting cases of relapse due to over-utilization of the available support services. This resulted to a long waiting time for intake of new clients leading to attrition of FDUs seeking admission to these facilities.

"Patience for drug users is low and therefore long procedures result to low enrolment for methadone program" (Key informant, Centre Manager)

"I hope that all those who are in the dens can also be taken into the methadone program. We have all been abandoned. Right now, they are taking defaulters only. What do we do?" (FDU out-of-program)

Further, unavailability of MAT services for children below the age of 18 years was another commonly reported recruitment barrier due to the exiting policy requirement.

"We cannot reach to children below 18 years because of the legal implications. Linking them for HRS is a challenge because that is considered not a legal age yet. So I think we need to have laws to reach out to this age group, because we are seeing a lot of children getting into drug use" (Key informant, MOH).

Access challenges by pregnant or breast-feeding FDUs

The study also revealed unique challenges facing pregnant and breastfeeding FDUs who were already enrolled in the methadone programs. It was reported that these FDUs have to present themselves in person in order to access methadone assisted treatment (MAT). In case it reaches a point where these women were so challenged to present themselves, there was no option of getting treatment through a third party. Majority of the FDUs were therefore defaulting treatment when faced with the challenges of pregnancy and breastfeeding.

"When you are sick or maybe you've just given birth, you are not given medicine until you come here yourself to take. Maybe you are in so much pain but you have to get to the centre yourself" (FDU in program).

Unavailability of baby-friendly services

FDUs expressed challenges related to unavailability of baby friendly HRDRS. There was limited provision of safe spaces for babies and young children when the mothers were seeking support services.

"Children are interacting with addicts attending the methadone program. I don't like what they are witnessing because they will end up being addicts" (FDU in program)

Socio-economic barriers

This category of barriers was limited to the aspects of income, employment or occupation. The key social-economic barriers to utilization of HRDRS reported were parenting responsibilities; challenges of physical access; lack of opportunities

for income generation; and high cost of drug rehabilitation.

Parenting responsibilities

One of the emerging social-economic barriers relates to the gender roles associated with women as caregivers. The findings showed that majority of the FDUs were single and therefore they were the sole bread winners for their children. This vulnerability of single headed families was identified as a key barrier to accessing support services meant for FDUs especially the in-patient programs.

"You are a parent, you want to wash clothes, you want to look for food for your children, you want to do this you want to do that. When you take me for rehab, who will look after my children?" (FDU out-of-program)

Challenges of physical access

The study established that some facilities were inaccessible due to the long distances that FDUs were required to cover in order to access HRS. In this case, lack of daily transport facilitation was a barrier to utilization of HRS. Majority of the FDUs resulted to covering long distances by foot to access support services due to the high cost of meeting daily transport needs.

"Mine is just to ask the government to build us another hospital because for us to access the facility we have to pay fare which is close to Ksh. 500 in a day" (FDU in program)

Safe spaces

Due to the stigma and rejection facing FDUs, it was reported that they only sort refuge in the drug dens.

"There is nowhere that is safe because in short, we are not loved. So the only place you will feel safe is in the dens. That is where my friends are" (FDUs out-of-program)

Lack of opportunities for an income generation

Generally, the FDUs reported that facilitation to engage in an income generating activity was a crucial component of relapse prevention. Idleness was reported as a major risk factor associated with relapse after completing a harm reduction or drug rehabilitation program. It was reported that most of the FDUs enrolled to support programs had returned to the drug dens and relapsed for lack of employment or income generating activities. This was therefore reported as the main barrier why FDUs fail to utilize available support programs.

"After 3 months of recovery, you go back to stay idle with nothing to do. So there is no benefit with this program because I will end up being an addict again" (FDU out-of-program)

"Some of my friends have been on methadone program for 6 years because they have nowhere to go. They fear that if they leave and they have nothing to do, they will relapse again" (FDU in program)

Cost of rehabilitation services

The high cost of addiction treatment charged by drug rehabilitation facilities was a major barrier for FDUs in need of these services. The study noted that majority of the FDUs had no identification cards to facilitate them to access the National Hospital Insurance Fund (NHIF) in order to acquire cheaper rehabilitation

services. In addition, majority were not formally employed to allow them to access other health insurance schemes.

"The programs that are available especially for the rehabilitation of women are meant to be paid for. So I see no need to go because I do not have money to pay for the program" (FDU out-of-program)

Cultural and societal barriers

Cultural and societal barriers were restricted to myths and misconceptions, attitudes and perceptions of FDUs. Results showed that cultural and societal barriers were manifested through stigma associated through the family, community, religion as well as the healthcare personnel.

Family related stigma

The family is the primary source of hope, encouragement, strength and comfort. Family rejection may therefore lead to the worst form of stigma. Most of the FDUs acknowledged that family related stigma was as a result of misconceptions about addiction.

"The family I have, first of all, they call me insane. Even now I don't know how my father will get counselling in order to understand. Because he knows that an addict is an insane person who cannot change" FDU out-of-program)

Community related stigma

FDUs also reported that stigma perpetrated by the community was the most difficult to cope with and this rejection had led even to loss of lives of FDUs manly through mistaken identity just because they were known drug users.

"There are challenges in the community. If something gets stolen, "it is the addict. Our children have no friends. They are usually called children of drugs users and prostitutes" (FDU out-of-program)

"You will hear people say, "we have seen two people and one addict". So an addict is not a human being, or an addict is an animal?" (FDU in program)

Healthcare personnel related stigma

Another form of stigma facing FDUs was that perpetrated by the healthcare personnel. It was reported that FDUs were perceived as criminals and people who deserve being in jail.

"And I think attitude amongst our healthcare personnel is that these are offenders. Even when they come to the facility, we will hide our things, because they're going to steal them" (Key informant, MOH).

Religion related stigma

Although it was expected that churches were safe spaces, the study established that they were indeed perpetrators of stigma targeted at the FDUs where drug addiction was viewed as a curse.

"We don't go to church. They always tell us that we are cursed" (FDU out-of-program)

Partner influence

The study also reported that many FDUs drop out of enrolment due to partner disapproval of the treatment program. Partner influence was a major barrier to utilization of support services.

"We have seen many women being drugged out of a program because it is against the will of their boyfriends and

they never come back again" (FDU in program).

Discussion

Drug use behaviour among FDUs in Kenya

The study examined the drug use behaviour among FDUs in order to identify risk factors associated with drug use. Findings revealed that majority of the FDUs were aged 25 – 35 years, had a Muslim religious background, with a primary level education, and were divorced, single or widowed. Data on employment showed that majority of FDUs were unemployed. According to a previous study conducted in Kenya, findings showed that FDUs had a mean age of 28.4 years; majority had a primary level education; and mostly single or not living with a partner (Ayon et al, 2018). Findings on drug use showed that heroin was the most commonly used drug. Similar findings were reported by Ayon et al (2018). The onset age of drug use was 18 – 24 years with a significant proportion of FDUs initiating drugs below the age of 18 years. In addition, majority of the FDUs were currently injecting with the onset age of injecting being 18 – 24 years. Findings also showed evidence of FDUs initiating injecting of drugs before the age of 18 years. These findings lay emphasis on the need to focus on programs targeting under-age children with the ultimate goal of delaying early initiation to drugs.

Barriers to utilization of HRDRS

Systemic barriers

Systemic barriers were the most commonly reported factors hindering utilization of HRDRS among FDUs. They included inadequate female friendly facilities, unavailability of baby friendly needs; recruitment challenges; and access challenges by pregnant or breastfeeding FDUs.

Inadequate female friendly facilities

Unavailability of female friendly facilities was one of the most commonly reported systemic barriers especially inadequate female only drug rehabilitation facilities providing in-patient services. Access to in-patient DRS was extremely challenging for FDUs given that majority were the sole providers for their families. Further, majority were residing in the drug dens and without a family, relative or rescue centre, and there was nobody to look after their young children. It has been established by Iversen et al (2015) that spaces and services exclusive for women guarantees the personal safety of women, reduce the impact of imbalanced gender power dynamics leading to improved health outcomes. In addition, other studies have demonstrated that treatment programmes centered on women may translate to improved treatment outcomes (Greenfield et al, 2007; Kissin et al, 2014).

Unavailability of baby friendly needs

Findings showed that most FDUs accessing HRDRS were either breast feeding or in the company of their young children. These facilities were not designed to provide safe spaces for children leaving them to interact with other drug users seeking HRDRS. In a similar study, it was noted that fear and lack of trust by FDUs towards childcare welfare services was a barrier to accessing and utilizing substance use services (Wolfson et al, 2012). Another study showed that the threat of FDUs losing custody of their

children was a major barrier to treatment (Schamp et al, 2021). Similarly, a study investigating women seeking addiction treatment identified childcare concerns as a barrier to access (Copeland, 1997). Other studies reveal that mothers who use drugs are unwilling to access health and HRS due to the risk of losing custody of their children (Boyd and Faith, 1999; Olsen et al, 2012; Taplin and Mattick, 2015). These findings therefore imply that support programs that intend to separate the FDUs and their babies may experience serious utilization challenges.

Recruitment challenges

Problems relating to recruitment of FDUs to HRDRS were reported as another barrier hindering FDUs from utilizing support services. First, there were limited spaces for admission of new clients with priority being accorded to FDUs with a history of relapse. Secondly, the recruitment process was so long and elaborate making FDUs to make several trips to the facility before securing an admission. Part of the recruitment process also involved presenting of a family member, relative or guardian to give consent for enrolment of FDUs. However, majority of FDUs were homeless and living in the drug dens and had been rejected by their families. Similar findings show that multiple appointments and parental consent requirement were barriers to accessing HRS (Ayon et al, 2018; Krug, Hildebrand and Sun, 2015). In contrast, a study on "open-access model" for rapid enrolment of people with opioid use disorder in methadone treatment showed improved treatment access without evidence of harmful effects on treatment outcomes (Madden et al, 2018). Therefore, there was need to review the threshold of recruitment procedures in order to realize higher enrolment and retention rates of FDUs to available support services.

Another recruitment barrier was unavailability of MAT services for children below 18 years. The study findings showed that a significant proportion of FDUs were initiating drug use as well as injecting drugs before the legal age. This therefore presented a major barrier to utilization of HRS for FDUs below the age of 18 years. Comparable findings have shown that age restriction was a key barrier to accessing support services by drug users (Krug, Hildebrand and Sun, 2015).

Access challenges by pregnant or breast-feeding FDUs

Another systemic barrier revealed by the study relates to the limitation of experienced FDUs who were either pregnant or breastfeeding. It was reported that in circumstances where a FDU was unable to present oneself to collect their daily methadone ration because of pregnancy or during breastfeeding, they ended dropping out of the program. Similar results showed that FDUs were likely to skip or avoid treatment or appointments during their pregnancy (Stone, 2015).

Socio-economic barriers

To a large extent, socio-economic factors were reported as key barriers to accessing HRDRS. They included parenting responsibilities; challenges of physical access; lack of opportunities for income generation; and high cost of drug rehabilitation.

Parenting responsibilities

Parenting responsibilities was reported as a major barrier for utilization of services by FDUs. This therefore meant that FDUs have to navigate through a delicate balance of parenting and meeting the daily needs for their families as well as utilizing support services. Therefore out-patient services tailor made to meet the needs of FDUs would be a better alternative compared to in-patient support services unless adequate mechanisms were put in place to address the challenges of parenting. With the responsibility for parenting disproportionately falling to women, HRS that do not meet the needs of mothers including lack of childcare facilities presents a significant barrier to utilization of HRS (Pinkham and Malinowska-Sempruch, 2008; Malinowska-Sempruch, 2015; Otiashvilli et al, 2013; Copeland, 1997; Flavin, 2002; Esmaeili et al, 2018). Parenting obligations by women also imply that they may be unable to utilize services during fixed hours of operation or at fixed intervals, underscoring the importance of flexible services (Olafsson et al, 2018).

Challenges of physical access

The study showed that harm reduction and drug rehabilitation facilities were skewed towards urban centres and were also very few in number. This therefore resulted to FDUs walking for long distances to access the services. Others who relied on public transport in order to access the services were vulnerable to relapse or reported higher attrition rates for lack of finances to meet their daily transport needs. A Kenyan study has also showed that the issue of long distances to harm reduction facilities was a major utilization barrier (Ayon et al, 2018).

Lack of opportunities for income generation

The most commonly reported social-economic barrier was lack of opportunities for one to engage in an income generating activity. This led to fear of leaving treatment or support services thereby opting to overstay in the programs. There was no existing post treatment programs meant for FDUs including training skills and facilitation of earning a living so as to reduce the exposure for relapse and retreating to the drug dens. Lack of an income generating activity has also been acknowledged as a risk factor for drug addiction treatment (Henkel, 2011).

High cost of drug rehabilitation

Whereas drug cession would be the ultimate goal of any support program, the study showed that DRS were unaffordable. This barrier was further complicated by the fact that most FDUs had no national identification cards which could facilitate them to acquire the NHIF card to enable them acquire cheaper and more affordable services. A comparable study has reported that the cost of recovery services was a key barrier to uptake of DRS (McQuaid, Jesseman and Rush, 2018). In addition, the cost of residential treatment among women seeking addiction treatment was also identified as a major utilization barrier (Copeland, 1997).

Cultural and societal barriers

Stigma was the most widely reported cultural and societal barrier. Stigma was manifested from the perspective of the

family, community, religion as well as the healthcare personnel. The study revealed that rejection of FDUs by the family, community and religion was the major motivation to move to the drug dens as the only available safe space for existence. Other studies have also identified stigma and discrimination as barriers to positive health seeking behaviour, engagement in care and compliance to treatment (Stengel, 2014; Stangl et al, 2019; Chaudoir, Earnshaw and Andel, 2013; Williams et al, 2019). Qualitative studies in Georgia, Indonesia, South Africa and Tanzania have concluded that women face greater stigma related to drug use than men leading to fears of disclosure and engaging with treatment (Zimudio-Hass et al., 2016; Myers, Carney and Wechsberg, 2016; Otiashvili et al., 2013; Spooner et al., 2015).

The study showed that healthcare personnel perceived FDUs as criminals and people who deserved to be incarcerated. It has been shown that one of the barriers women and young girls face regarding access to health facilities is stigma and discrimination from healthcare workers (Nyblade et al, 2019). A systematic review of stigma towards people who use drugs from health professionals established that the negative attitudes are pervasive making people who use drugs to avoid health and HRS (van Boekel et al, 2013). Evidence also shows that women face more restrictions than men, including hostile and judgemental attitudes and perceptions from healthcare professionals (Esmaeili et al, 2018).

Conclusion and recommendations

The study has provided evidence that indeed FDUs were being confronted with multiple barriers hindering utilization to HRDRS. The complex interplay of the systemic barriers, social economic barriers, cultural and societal barriers were the main underlying risk factors impeding utilization of available support services targeting FDUs. Therefore, towards achievement of better outcomes leading to improved access, utilization, enrolment and retention rates of FDUs into harm reduction and drug rehabilitation programs, there is need for integration with female friendly services. Further, given the delicate balance between the need for support services and fulfilment of parenting responsibilities, there is need to tailor an out-patient program that would be attractive and adoptable to FDUs. Finally, there is need to integrate harm reduction and drug rehabilitation programs with a strong component of supporting FDUs with skills and linking them with opportunities for income generation.

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