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'Problematizing' health harms and policy responses for people who inject drugs in Kenya

REPORT

Background

The expansion of opioid pharmacotherapy (OPT; e.g., methadone and buprenorphine) for treating heroin addiction and preventing HIV among people who inject drugs (PWID) in low-resource settings has moved to the forefront of global public health agendas. In its presentation as an evidence-based public health technology, OPT is characterized as a technical solution that will have replicable effects across a range of settings. Yet OPT, its expectations and effects, are not as fixed or as detached from social relations as empirical research implies. OPT has a number of diverse, contested and situated meanings (e.g., a medical treatment, a crime reduction strategy, and a dangerous drug of dependence) and there are a myriad of factors—from policies to programme practices to community responses, that shape the way it is made meaningful in a specific place.

Over the past decade, Kenya has witnessed a steady rise in the number of people who use heroin and a growing HIV incidence attributable to heroin injection practices. In response to this emerging problem, Kenya launched a national OPT programme in 2014. This initiative marked a departure in Kenyan drug policy and will have lasting effects on drug treatment and harm reduction efforts at the national and regional level. A multitude of government and civil society stakeholders with different interests and values will likely play a role in the interpretation and reinterpretation of OPT in both policy and practice.

Aim and Research Questions

The purpose of the proposed project is to explore how meanings of OPT are constituted and negotiated in local discourse and in relation to local understandings of drug use in Kenya—in order to illustrate how a globally endorsed health intervention is 'made' according to local social and political dynamics. The project will be guided by three research question: (1) What are the claims made by stakeholders in support or resistance of OPT?; (2) How do these representations of OPT reflect and produce specific ways of understanding drug use as a social 'problem'?; and (3) How is OPT, and the claims made by stakeholders, negotiated as part of the process of its implementation?

Methods

The research project relies on a qualitative longitudinal design. The study is being conducted in Nairobi—one of the cities in Kenya where OPT is currently available. Three types of data sources will be used: **Longitudinal stakeholder interviews.** Up to 30 stakeholders will participate in two to three semi-structured qualitative interviews. The interviews are concerned with the language used to articulate understandings of OPT and the social context of how these ideas were formed and changed. Stakeholders are individuals in the policy realm but also members of the community who have a stake or perspective in OPT or its implementation. They will be recruited using a theoretical sampling strategy. As the analysis takes hold, cases will be recruited that are likely to generate data relevant to the emergent themes. **Observations of stakeholder interactions.** Observations focus on sites of social action where meanings of OPT are deployed and negotiated, including conferences, meetings, trainings, community forums and other types of similar events. **Analysis of written documents.** Written documents relevant to OPT in Kenya (e.g., official policy briefs and protocols, clinical guidelines, press-releases, meeting minutes, training materials, etc.) will supplement interview and observational data. The materials will be

identified through systematic internet searches, electronic databases), observations, and professional contacts.
All sources of data will be analysed using a thematic approach. It will be coded using Atlas ti qualitative software. Analytic memo writing will be used to explain codes, reflect on connections between cases, and develop ideas about emerging themes. The analysis will be guided by Carol Bacchi's *What's the Problem Represented to Be?* (2009) —a poststructuralist framework for policy analysis that is based on Foucault's Theory of Problematisations. It is used to examine the conceptual premises and underlying presuppositions of policies.

Progress
The London School of Hygiene & Tropical Medicine (LSHTM) upgrading report and seminar presentation for the research project were prepared from September to December 2015. The upgrading seminar was held in January 15, 2015 and was accepted without revisions. I obtained approval from the LSHTM Research Ethics Committee on March 4, 2015 and the Scientific Ethics and Research Unit at The Kenya Medical Research Unit on June 12, 2015. In April 2015, I accompanied my supervisor on a three-week orientation trip to Nairobi to meet with potential collaborators and learn more about the organisations and institutions involved in OPT implementation in Kenya. The first round of data collection began on June 15, 2015 and continued through September 15, 2015. During that time, I interviewed 22 stakeholders and completed 18 observations. Due to travel restrictions imposed by the UK Foreign Office, I was not permitted to conduct field work in Malindi, Kenya. Focusing on Nairobi proved advantageous. It gave me time to establish meaningful relationships with the stakeholder community and afforded a deeper, more thorough exploration of social and political factors shaping OPT implementation at the national and city-level. The second round of data collection is planned for December 2015.

Findings from Preliminary Analysis
The following is a summary of emergent themes based on a preliminary analysis of data collected up until this point.

- OPT as a temporary state of transition. Usually said to last up to two years before recovery is achieved and an equilibrium or normalcy restored. In terms of how the story of OPT is made, this state of transition is a visible effect, and can be seen. People transition: they are cleaner, healthier. The positive effects can be witnessed (and shown); they are beyond question.

- And in terms of how these narratives might cast OPT's potential, there might be a cultural tendency – according to some – for promises of 'breakthrough' linked 'quick fixes' to community problems for which 'outside' new technologies offer options. A counter narrative here then is concern that patients, as well as some clinicians, anticipate immediate and lasting results. The treatment of withdrawals, for instance, does not equate with long-term recovery, a distinction lost in expectations of a quick fix to addiction. As OPT's implementation progresses, there can be a revision (and a rationing) of expectation.

- OPT framed in relation to a narrative of addiction recovery hope rather than harm reduction or HIV prevention. Given the norm of relapse linked with rehab, OPT engenders hope as a better recovery alternative. Rehab is presented as failing to prevent relapse through its incapacity to stave off withdrawals, whereas OPT promises sustained recovery through its management of opiate withdrawals. An emerging narrative envisions recovery made "easier" by OPT.

- With addiction recovery envisaged as a return to normalcy and social inclusion realised through reintegration into work, family and social life, OPT is positioned as a technology of hope for enabling 'recovery of citizenship' where rehab has failed on delivering such promise. OPT as a hope for social inclusion, including via re-configuring relationships between people who use drugs and the State, is an extremely powerful narrative, especially among those for which the State is cast as having done nothing.

- For all its hopes, stakeholders too note the fragility of OPT's potential given the unpredictability of its social environment. Like would-be patients, they emphasise problems of the cost of transportation, the lack of work opportunity to prevent 'idleness' and a return to addiction, and the power of rumour to tell stories which undo the narrative of OPT promise so important to its success.

- Since its implementation, there has been considerable energy directed, especially among national stakeholders, to promoting and protecting a 'positive' OPT. A key tactic has been working through the television and press media on OPT related stories, documentaries and other features, as well as producing a promotional video supported by the Ministry of Health and managing a national launch.

- Some NGO stakeholders are critical of what they perceive to be an eagerness to story OPT as a success so soon after its delivery, and before other forms of evidence are made, as well as of the great efforts and resources being directed towards the media-making of OPT

Costs Covered by Award

The Phil Strong Memorial Prize funds covered costs associated with field work conducted in Nairobi Kenya, June-September, 2015.

Air travel	£530
Visa	£30
Accommodation	£670
Total	**£1200**

Benefits of Award

Conducting in-depth research in the field is an important aspect of my training as a public health sociologist. The Phil Strong Memorial Prize supported my ability to carry out this time- and resource-intensive endeavour. The experience of being in Nairobi was one of immense personal and professional growth. Through interviewing stakeholders and observing stakeholder events I have become more attentive to the nuances of social interactions such as conversation space, body language and word choice. It provided many tangible opportunities to gain insight into how my own values and perceptions transform the research interaction. Reflecting on one's role in the production of knowledge is an essential component of the qualitative research process. In working through some of the challenges associated with conducting research on a sensitive topic—illicit drug use, in a place where I am perceived as an outsider—Nairobi, I was able to learn strategies for managing social relationships, coping with logistical constraints, and navigating ethical considerations—all vital skills for life as well as for sociological research. I am very grateful for receiving the Phil Strong Memorial Prize, without which this seminal experience may not have been possible.