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Background

Methadone maintenance treatment (MMT) started in the 1960s in the United States and has now expanded to more than 150 countries in the world (World Health Organization, 2017). Using methadone for maintenance treatment revolutionised the field of addiction treatment by redefining therapeutic success as patient stability and functioning rather than abstinence

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(Newman, 2009). MMT has been promoted by many who are in favour of treating addiction as a disease (Volkow, Frieden, Hyde, & Cha, 2014). Abundant literature, mostly quantitative, has proved its effectiveness in reducing illicit opioid consumption, improving social security, and reducing public health harms related to opioid injection (Fullerton et al., 2014; Sun et al., 2015). This serves as a rationale for global methadone expansion, especially in low- and middle-income countries. However, for those who oppose the model, prescribing methadone is merely "trading one drug for another" (Volkow et al., 2014). For this reason, many Asian countries only reluctantly authorised MMT in the early 2000s to reduce HIV infection related to unsafe injecting drug use (Reid, Sharma, & Higgs, 2014). Still, multiple barriers, including stigma and discrimination against former drug users, criminalisation of drug use, lack of a favourable legislative framework, and preference for non-evidence-based interventions such as compulsory abstinence and rehabilitation, have all hindered MMT's diffusion on the continent (Degenhardt et al., 2014; Reid et al., 2014).

Context: the introduction of MMT in Vietnam

After the country adopted a market-oriented economic model in the early 1990s, Vietnam's drug market changed. Heroin was smuggled into Vietnam from neighbouring countries and replaced opium as the drug of choice (Windle, 2015). This market change also transformed drug administration patterns. While smoking was the preferred mode of drug use in the mid-1990s when opium was the norm, injection became the more popular method in the early 2000s as heroin took over the market (Nguyen & Scannapieco, 2008). As users began to share injection equipment, HIV transmission escalated among people who inject drugs (PWID) and increased risks that the epidemic would spread into the general population (Hammett et al., 2007). In 2001, even as the government supported needle and syringe exchange programmes, PWID accounted for 60% of identified HIV cases (Nguyen & Scannapieco, 2008; Windle, 2015).

This situation pushed Vietnam to endorse MMT. From 2008 to 2010, the government piloted MMT in two provinces, with the hope of curbing the HIV epidemic (Edington & Bayer, 2013). Vietnamese methadone programmes have three objectives: 1) to reduce illegal opioid use in society, 2) to address health issues, including mortality and blood-borne diseases and 3) to improve individuals' social functioning (Ministry of Health, 2010). The pilot data not only showed only one new HIV case among almost 1000 patients followed over two years, but it also revealed a decreased proportion of patients who reported engaging in criminal activities from 40.8% to 1.3% in the same period (Ministry of Health, 2012). With these results, Vietnamese policymakers were convinced not only of MMT's effectiveness in controlling the HIV epidemic but also of its significant impact on crime rates (Ministry of Health, 2012). In December 2013, the Vietnamese government declared that addiction was a chronic disease, which brought it under the purview of the medical sector rather than that of social affairs and public security while also limiting the scope of compulsory detention centres (Government of Vietnam, 2013).

While the government has revised regulations to make it easier for opioid users to enter MMT if they so desire, take-home methadone is still not allowed for fear of diversion. Patients must visit their MMT clinics daily (Ministry of Health, 2015). Although MMT is

the only evidence-based addiction treatment available in Vietnam, methadone programmes cover an unexpectedly small number of patients, and have expanded slowly. Of the government's 2015 target of 80,000 patients (estimated at 40% of all opioid users), only 52,054 were following treatment in July 2017, a 5,600 increase from the previous year (Social Republic of Vietnam, 2014; Vietnam Administration of AIDS Centre, 2016, 2017a). Meanwhile, overdose deaths, police arrests for drug-related crimes, side effects, and lack of motivation to continue with treatment raised dropout rates as high as 33.3% at 36 months (Khue et al., 2017). While this figure is similar in other countries (Huissoud, Rousson, & Dubois-Arber, 2012; Zhang et al., 2013), it is important to understand why participants decide to drop out in the specific context of Vietnam, where MMT has received strong support from the government.

Factors influencing retention in methadone treatment

While there is strong evidence of MMT's effectiveness in improving health outcomes for opioid users (Fullerton et al., 2014), studies on the lived experiences of patients revealed the more nuanced impacts of treatment on patients' lives. For example, studies have questioned MMT's mode of delivery (Fraser, 2006; J. Harris & McElrath, 2012), interrelations of MMT with personal and structural barriers for PWID — such as underlying beliefs about addiction and treatment —(Bojko et al., 2016; Edington & Bayer, 2013), or the socio-economic status of PWID (Rhodes, Ndimbii, Guise, Cullen, & Ayon, 2015). Studies have also questioned the ability of MMT to meet patients' needs and to help them reach the level of social stability and functioning that many MMT supporters had led to expect (Bourgois, 2000; Reisinger et al., 2009).

Studies have also pointed to multiple factors influencing retention, which may be related to perceptions of methadone as a substance (Fischer et al., 2005; Goldsmith, Hunt, Lipton, & Strug, 1984; Malvini Redden, Tracy, & Shafer, 2013) or to experiences with services structured around methadone (Bojko et al., 2016; Fraser, 2006; J. Harris & McElrath, 2012). Many PWID considered methadone to be halfway between drug and medication (Langlois, 2013; Malvini Redden et al., 2013; Neale, 2013). As a drug, it could be purchased on the black market to replace heroin and sometimes to procure pleasure. As a medication, it would be prescribed by a doctor in a clinic with the aim of relieving opioid withdrawal and then taken by patients under close supervision. Seeing methadone as a drug might lead to unconventional treatment management strategies like self-discharge (Langlois, 2013).

Some patients appreciate methadone because it protects them against relapse and provides them with the daily stability, but they also fear the potential harm and addictiveness it could cause. (M. Harris & Rhodes, 2013; Malvini Redden et al., 2013). Relief from drug dependence is thus the immediate motivation pushing many opioid-addicted individuals to enter into and continue MMT (Mitchell et al., 2011). At the same time, many consider MMT to be the last resort after multiple failures to go drug-free (Bojko et al., 2015; Grønnestad & Sagvaag, 2016).

For many patients, the ambivalence arises more pronouncedly from the conditions of service. These may include inconvenient treatment conditions (Fraser, 2006; Rhodes et al.,

2015), negative therapeutic relationships (Bojko et al., 2016), and challenges in the patients' daily lives (Bourgois, 2000; Conner & Rosen, 2008). Taking daily dosages is universally considered a key factor preventing patients from securing the employment necessary to afford a decent lifestyle, hence damaging their sense of agency (Bojko et al., 2016; Fraser, 2006; M. Harris & Rhodes, 2013; Lin, Wu, & Detels, 2011; Rhodes, 2018). Furthermore, methadone clinics are criticised as sites of interpersonal and institutional stigmatisation (Bojko et al., 2016; Bourgois, 2000; Fraser, 2006; J. Harris & McElrath, 2012). Patients from various facilities reported being treated as "subhumans" by methadone providers (Bojko et al., 2016; Hayashi et al., 2017). Arbitrary regulations in some clinics such as "feetox," which discharged patients who were unable to pay treatment fees (p.289, Reisinger et al., 2009), or treatment contracts that listed punishable behaviours only for patients and not for providers, held patients in a vulnerable position (J. Harris & McElrath, 2012).

The poor reputation of methadone services stems especially from the relationship between patients and providers. Methadone providers often failed to appreciate patients' different treatment expectations. They failed to see that patients needed more than just achieving abstinence to return to a "normal life" (p.5, Mitchell et al., 2011). When patients did not receive support for their goals from the programmes, they often self-discharged (Reisinger et al., 2009). Multiple life challenges that MMT could not affect, such as intersecting stigma towards addiction, HIV or poverty, lack of social support or damaged health could also lower treatment continuation rates (Conner & Rosen, 2008; Vigilant, 2008).

Most of the existing literature is from studies of Western methadone programmes. Little is known about how opioid-dependent individuals in Asia experience MMT. This represents a major gap in policy literature, given the fact that the region is known for its tough drug policy and nascent harm reduction and drug treatment programmes. This paper draws on the accounts of current and former MMT patients and current heroin users without experience with MMT (MMT-naïve users) in Haiphong, Vietnam. It seeks to provide a detailed description of the barriers and motivations influencing users to start and continue MMT.

We describe patients' MMT experience in a temporal sequence. We start with impressions from the beginning of their treatment. We then inquire into retention barriers as patients' initial feelings fade out. Finally, we cover the most important motivations that kept patients in care. Although this paper relies primarily on the accounts of individuals who have experience in MMT, we sometimes use testimonials of MMT-naïve users to illustrate the popularity of the issue in question.

Methods

We collected data between August and October 2016 and in June and July of 2017. This qualitative study is part of an intervention research programme to reduce HIV incidence among PWID in Haiphong (known as DRIVE). DRIVE recruited PWID in the community using respondent-driven sampling and carried out assistance initiatives (harm reduction, referral to treatment, social support) through community support groups (Des Jarlais et al., 2016).

Haiphong is an industrial city in Northern Vietnam with 16 methadone clinics serving about 4,000 patients (Ministry of Health, 2018). The clinics open during working hours, from 7:30 am to 4:30 pm. Since 2014, Haiphong methadone programmes, as per national guidelines, require a monthly treatment fee of VND 300,000 (≈ U.S.$15). Previous assessments showed that patients thought this was an acceptable price (Tran, 2013).

This study draws on 58 in-depth interviews with both MMT-experienced and MMT- naïve heroin users and two focus group discussions (FGD) with young injectors and street methadone users. We first conducted FGDs, which informed interviews with ideas to be explored further. The information from FGDs and from interviews with MMT-naïve users served to solidify our findings from interviews with current and former MMT users on the perceived challenges of following MMT. Two researchers conducted FGDs in peer support group offices and interviews in the same offices as well as in hotel rooms for privacy.

We selected potential participants from the DRIVE cohort database based on age, sex, HIV status, hepatitis C virus (HCV) status and MMT status. Peer outreach workers contacted and recruited participants and brought those lacking transportation to the study sites on motorbikes. Each encounter lasted one to two hours. FGDs and interviews were audio-recorded and transcribed verbatim. Names and other personally identifiable information were omitted from the transcripts. Participants signed an informed consent form prior to the interview and received VND 200,000 (≈ U.S.$10) for their participation. The study was approved by the Institutional Review Board of the Haiphong University of Medicine and Pharmacy.

Data was investigated and coded with NVivo11.0 using a thematic analysis approach. A codebook of the topics of interest was first developed from the literature. Initial codes included: administrative barriers, methadone perception, time conflict, staff, and finance. As additional topics of interest emerged during the coding process, we included them into the codebook: stigma, drug management strategies, life projects, and family. The first and second authors coded the first five transcripts independently and discussed all differences in coding until we reached a consensus. To give context regarding social status and MMT experience, we noted the gender, age, marital and MMT status of quoted participants. The first author translated the quotes. The translation and original quotes were then reviewed by a Vietnamese-American collaborator who is fluent in both languages. Insights from the peer outreach workers on the preliminary findings confirmed our interpretations. In our analysis, we aimed to gain a more subtle understanding of MMT perceptions by relating the social experience of PWID to the Vietnamese social and political context. Working from a social science perspective helped us overcome the naturalistic view of MMT promoted by biology and public health and reveal the more complex and contradictory nature of MMT (Neale, 2013).

Table 1 shows the participants' socio-demographic characteristics. Participants were primarily male (72.4%) and in their late thirties, and 44.8% reported being married or living with a partner. People living with HIV made up one third of the sample. Among male participants, 17% were recruited through men who have sex with men (MSM) peer groups. Although most female participants were recruited through female sex worker peer groups,

only a few women confirmed that they were sex workers. Some reported doing it occasionally to make ends meet.

Results

Initial experiences of success: regaining decency and feeling hope

Current and former methadone patients in our sample all appreciated regaining control of their life as an immediate treatment benefit. As they stopped experiencing morning withdrawal or pleasure from heroin, participants felt confident in their ability to break up with the drug. Although some could keep doing heroin, they felt that this behaviour was decided through their own free will rather than compulsive.

> "I still use heroin sometimes when I feel bored. But if I don't feel like it, I don't take it."
>
> (Male, 46 years old, married, currently under MMT)

Relief from heroin dependence freed drug users from the daily burden of seeking money for drugs. This carefree feeling after decades of addiction was an intense experience of freedom. They did not have to worry when they did not have "100,000 dongs in my pocket before going to bed at night" (the price of one or two heroin doses for the next day). Some participants declared that they felt happy all day. They had the opportunity to work when they felt like it. They said that they felt more secure as they did not have to risk their lives and the lives of their loved ones while going out in bad weather to seek drugs.

Another effect of MMT was that PWID reported radical changes in self-perception and others' perception of them. As patients became more financially stable without drugs, they did not need to ask others for money. This made them feel they were being positively perceived. MMT helped users see themselves as more decent persons.

> When I was using drugs, I didn't want to do anything. Just to earn quick money. I was afraid to talk to people. I always thought they were looking down on me. When I was using drugs, looking at my daughter made me feel ashamed. When I stopped, I felt much more dignified and confident, totally different.
>
> (Female, 30 years old, divorced, currently under MMT)

With money in their pockets, patients did not need to avoid acquaintances or to lie to them to get money. Everyday gestures of politeness such as buying others drinks became easy and helped them regain normalcy. Once unthinkable habitual pleasures like beer drinking now could be savoured when patients wanted to.

One participant gave a vivid description of the contrast between heroin addict and methadone patient:

> A guy on methadone looks clean, has good clothes, good shoes and a watch. He goes out for breakfast. An addict doesn't even have a bicycle.
>
> (Male, 57 years old, married, currently under MMT)

This newly gained confidence gave participants hope for a conventional life: getting married, building their own house, and having children. One participant proposed to his girlfriend after he entered MMT and felt like he would be able to take care of her. As they no longer had to pay for their habits, participants could save money for their families. Some reported that they experienced regaining their family's trust.

> Since my family sees me getting methadone daily, they trust me more. For example, they trust me with money to perform family tasks, tens or even hundreds of millions of dongs.
>
> (Male, 27 years old, married, currently under MMT)

Men and women participants reported similar experiences with respect to their positive perception of methadone. We found no difference between HIV-positive and HIV-negative participants nor among participants of different levels of education.

Challenges to achieving a "normal" life

When the excitement of methadone faded away, participants came to realise the downsides of treatment, including fear of addiction to another drug, constraints for a functioning life, and lack of a trusting relationship with MMT providers. These inconveniences interfered with their daily life to different degrees.

Fear of methadone as another harmful drug—Patients actually had mixed feelings about methadone. On the one hand, the main motive to enter treatment was methadone's protective property against heroin. Methadone was the last resort when participants were exhausted from the cycle of detoxification and relapse, and accepted they could not quit heroin by themselves. On the other hand, there are widespread beliefs about methadone's harmful effects across all participant groups. Methadone was considered "hot," meaning in traditional Vietnamese medicine that it caused constipation and acne. Most current and former patients reported side effects including tooth decay, tooth loss, worsened memory and reduced sexual desires. Sedation interfered with work and daily functioning. One participant almost got into an accident on his way home from the clinic as he was feeling extremely sleepy. These side effects were common but not insurmountable; many of them waned over time. One HIV-infected participant dropped out of antiretroviral treatment (ART), fearing the potential harms caused by the interaction of the two drugs. Another stopped taking methadone after he started ART for the same reason.

Methadone-naïve participants displayed similarly negative though less specific perceptions of methadone. Most methadone-naïve participants learned about such side effects from word of mouth. Methadone in their mind was "harming," "making people gain weight," "worsening memory" and "if you do heroin while you are on methadone, you will die." One woman who quit heroin unassisted looked up the medication online and tried to persuade her husband to give up the treatment since "its consequences are not less than heroin's."

Both methadone-naïve and more experienced participants also reported being afraid that they would be unable to get off methadone. Drug users unanimously equated a drug's addictiveness with the length and severity of the withdrawal it induces. From this

perspective, it was widely reported that methadone was more addictive than heroin. Since tapering from methadone takes months or even years, some patients tried to keep their doses low or to decrease them, even if they had not yet planned to quit methadone.

Addiction to heroin or dependence on methadone programmes?—Despite the widespread rumour about methadone's long-lasting and difficult withdrawal period, most patients in our study had never experienced it. Only three people had undergone full methadone withdrawal when they were sent to compulsory rehabilitation. Another few participants had experienced mild symptoms after missing a couple of doses. Current and former methadone patients got frustrated with methadone programmes because they were unable to live the lives they expected to live when they entered treatment. Participants used the word 'nghiện' (addiction) exclusively to refer to heroin habits and 'phụ thuộc' (dependence) to indicate methadone treatment. 'Phụ thuộc' refers to the external forces and constraints inherent to following a methadone programme; in 'nghiện,' the forces at play are rather related to the internal, compulsive nature of drug-using acts.

The feeling of 'phụ thuộc' came from the inability to travel and from the time constraints that prevented patients from securing stable employment, therefore causing treatment fatigue. Heroin still allowed users to travel and work. Methadone treatment, however, requires patients to trade job opportunities against the ability to obtain daily medication from clinics during office hours. Although participants accepted this trade-off, they still experienced regret:

> I can't travel far. I had a good opportunity to go to work in Saigon but I can't take it since I depend on methadone. The clinic opens at 7:30 for dosing and medical examination. And it closes at 11. If I worked, I would work during the same time. How could I ask to go out every day? And if I told them I was on methadone, I for sure wouldn't be able to keep that job, so I decided to stay at home.
>
> (Male, 42 years old, single, currently under MMT)

Participants were rarely able to hold a job while following treatment. Only participants with flexible work schedules who worked for a family business or took night shifts managed it. Securing employment became more challenging as patients anticipated stigmatisation if they told employers about their addiction treatment. In fact, it is the explanation one of the four dropout participants gave for leaving treatment. The inability to coordinate a suitable work schedule with the rigid dosing window resulted in many patients losing their employment. During interviews, our participants estimated 70% to 80% of methadone patients were unemployed. Since they had nothing else to do, many hung out at tea stalls the whole day after receiving treatment.

The main reason MMT-naïve users chose not to enter into treatment was that they believed they were in control of their drug use. The majority (10/14) mentioned detoxification as a solution in case they wanted to quit. Among them, four had high-paying jobs that could support their habits. This, along with the belief that the procedures to enter MMT were complicated and costly, kept them away from treatment.

Our group discussions with PWID under 30 also suggested that those with a stable job were reluctant to get into MMT. Truck or ship drivers had to travel for several days and only stayed in Haiphong for a short period. Participants who did not follow treatment believed that MMT made patients dependent on others to make a living. This perspective was especially unappealing to younger people. They often opted for street methadone to control their drug habits.

> When my heroin dose increases and I can't afford it, I stop it for a while so it stabilises… I ask my friends to bring me some methadone. They leave me a bit from their doses. I buy some hundred thousand dongs' worth to treat heroin withdrawal.
>
> (FGD with PWID under 30 who had used street methadone)

The difference between women and men regarding time constraints reflected gender roles in Vietnamese society. Women felt less pressured than men to get a job. While nearly one fourth of participants were women (16/58), most of them described themselves as housewives or as self-employed. Their treatment fatigue originated from difficulties 'going on errands', 'going to pagodas', 'visiting family,' or 'having to go out in bad weather.' The majority of women wanted to get off methadone, but many accepted the idea of staying in treatment for an indefinite period of time. Men, on the other hand, were more frustrated by this kind of dependence. Patients often spoke of quitting methadone if they got a good job and mentioned patients who missed doses because of work commitments. Some male patients voiced a clear plan to taper off treatment.

> Sometimes I have offers to work far from home, but methadone doesn't allow me to take them […] But next year, I will try to reduce my dose. I am at 75 mg, this month I will reduce it to 70, next month to 65, then 60, and so on. Or if I get another opportunity, I will stop methadone.
>
> (Male, 39 years old, married, currently under MMT)

This frustration intensified with the feeling of being manipulated by methadone programmes. Dosing schedules were irregular, but unfavourable to patients. Many wishfully mentioned a methadone clinic in a neighbouring province that opens at 5:30 am since they could not get treatment there.

> Before they [Haiphong MMT clinics] delivered doses at 6 am … but now they open at 7:30. They treated patients better before, they brought methadone home to us if we couldn't come. But now they don't care whether you get methadone or not.
>
> (Male, 37 years old, single, dropped out for 8 years)

One clinic in Haiphong asked patients to pay an additional sum on top of their monthly treatment fee to get dosed earlier in the morning. Some patients who had more financial means found this request reasonable while others saw it as the clinic's attempt to "rob" them.

Lack of a trustful relationship with MMT providers—Methadone patients in our study declared that they did not receive good support for their personal treatment goals

within methadone clinics. They had a rather problematic relationship with their medical setting. The relationship was already complicated before the first day of care, since a popular assumption circulated that patients had to bribe clinic staff to receive treatment. While some participants had to pay to get into methadone programmes, this was not the case for the majority of our participants, for whom DRIVE made referrals. This belief, however, had transformed participants' perception of therapeutic relationships into a business transaction. Scepticism about the transparency of methadone programmes led patients to question clinic requirements such as lab test prices or the additional fees they were asked to pay.

> I don't understand the 50,000 dongs extra they asked us to pay. They said it was for security guards and daily hygiene of the clinic like washing cups. But these people already receive salaries from the government. They don'tt only work for this clinic, they work for the whole healthcare centre. They didn't hire extra security guards because of us.
>
> (Male, 34 years old, single, dropped out for 2 years)

In participants' stories, methadone staff were described as irresponsible, inconsiderate, and inhumane providers with inadequate expertise. Patients often got angry when staff did not seem to care about their needs. One described his frustration with the administration staff when the clinic opened its doors and patients rushed in to get their medication and start their work day.

> They were like… walking around, doing nothing. First they washed their hands, then dried them… then they wiped the table, wiped the glass. Only after a while did they start their work and give us doses. Patients were all in a hurry. We had to go to work on time. They were irresponsible. We have to pay for our treatment. They have to give us medication on time, so we can work. Otherwise how can we pay for the treatment?
>
> (Male, 37 years old, single, dropped out for 8 years)

Others complained about missing their doses just because they came minutes after closing time.

> These people shouldn't be allowed into care. They are inhumane. Some of us have jobs. They close at 11 am. But even if we are just one minute late and we tell them, 'Could you please give me my dose? I am just one minute late.' You see, it is just about sympathy. The dosing window opens at 7:30 but the staff also come at 7:30. They do their things and only start dispensing methadone at 7:45. We have never complained about it… But when it comes to us, we are just one, two minutes late and they lock the medication away.
>
> (Male, 42 years old, single, currently under MMT)

The rule of 'money first' requiring payment before medication delivery was considered too strict and unreasonable. This caused quarrels between staff and patients every month at the time of payment. One patient warned about the potential consequences of this rule:

> I think late payers will pay for their treatment anyway. They might not be able to make payment on the 5^{th}, but on the 10^{th} or 15^{th}. Staff are government officials,

> they should be more flexible. Without medication, patients would have to do heroin. So the staff facilitates patients' relapse. And when they relapse, they leave treatment. So why can't the staff wait a few more days?
>
> (Male, 34 years old, single, dropped out for 2 years)

Participants rarely complained about baseline fees; they knew that 300,000 dongs a month was much less than the amount they had been spending to maintain their heroin consumption. They explained that they experienced difficulties paying for treatment on time or at all because they struggled to maintain employment under the constraints of methadone programmes.

Participants described the tense atmosphere of methadone clinics, where staff-patient communication mostly included 'yelling,' 'blaming,' 'punishing,' and 'threatening to kick out of treatment' when patients screened positive for drugs or when they missed doses. In relation to the lack of transparency in methadone programmes, one patient who was discharged against her will because she had missed too many doses interpreted this treatment termination as an attempt to get rid of her to then sell her spot to another candidate. Some patients reported no communication at all with staff, except when they were late settling their co-payment. One woman explicitly criticised the staff for caring only about money rather than about patients' well-being.

Patients reported being subjected to stigmatisation by providers. Some physicians, for example, displayed a suspicious and humiliating attitude when patients requested a dose change, as one participant angrily reported:

> I told my physician I wanted a decrease of 5 or 10 mg. […] He said: 'You want a decrease to get high faster?' And so on, it was so mean, you understand? I replied: 'It's our responsibility to control our drug use. You don't need to encourage us, but don't say so.' I know it's good for us not to do drugs. Of course since we are addicts, people won't say nice things to us. But we all have our self-esteem. We have got in here, we are now a member [of the clinic]. We also pay for our treatment. They aren't giving us anything for free, right? So we have our rights. […] But sometimes what they tell us is so mean. That's why people don't really feel like being in treatment.
>
> (Female, 39 years old, divorced, currently under MMT)

Patients did not feel respected when spoken to by the providers. Young staff spoke to older patients without the politeness required by Vietnamese age hierarchy culture. This disrespectful attitude pushed away patients and thwarted any attempt to build a good relationship.

> We clearly feel the distinction they make between them and us, through their attitude and their way of addressing us. Although they are younger than me, they call themselves 'anh' (older brother), 'chị' (older sister). They don't respect us. They distinguish themselves from us and they are unwelcoming.
>
> (Male, 39 years old, married, currently under MMT)

While these negative opinions regarding methadone clinics and their staff were prevalent, a minority of patients (8/44) described methadone providers on more positive notes such as ‘devoted’ and ‘welcoming.’ These patients appreciated the help they received from their physicians and counsellors. All of these patients were currently on treatment, except for one who was forced to leave for deliberately missing his co-payment and was looking to re-enter treatment.

Factors of patient retention?

Methadone programmes retained patients for two reasons: methadone offered its users assistance in coping with an environment where drugs are ubiquitous; and patients wished to protect their recently regained happiness in the context of their families.

Since for many methadone was the last resort after numerous attempts to stay away from heroin, participants were dedicated to remaining in care until they felt confident that they could keep away from heroin. They reported feeling ‘safe’ with methadone and revealed fears of relapse without it. Some considered using methadone ‘until they died.’

> I will keep getting dosed in the coming time. I guess it would take a few more years… But I will only stop methadone if I am really confident … it means I would feel nothing, be totally indifferent when others offer me drugs. Now I am still struggling with this desire each time, although I haven’t accepted their offers, because I think of my wife and children.
>
> (Male, 37 years old, married, currently under MMT)

The importance of the family as patients’ anchor in treatment was echoed in the narratives of most participants. Being on methadone fit in their plan of caring for their families. Single participants prioritised taking care of and making their parents happy. Married participants thought about the needs of their spouse and children to get them through the hardships of treatment. They wanted to keep “bringing smiles back into the family.”

> First it was for me, second it was for my wife and children. They were miserable. My wife didn’t dare spend money on her food but gave me two, three hundred thousand dongs every day. That’s why I felt ashamed in front of her and my kids. I had to confront the reality. I couldn’t run away any more. So I got on methadone. Before, I didn’t dare to disclose my treatment, but now I tell my employer upfront, and say if he accepts my treatment, I will work for him. Otherwise, I won’t.
>
> (Male, 39 years old, married, currently under MMT)

Discussion

Patient attrition threatens the clinical and public health achievements of Vietnamese methadone programmes. Little information on PWID’s treatment experience is available. To our knowledge, this is the first qualitative study drawing on a large sample of PWID with and without MMT experience in the country. During Vietnam’s major shift from compulsory rehabilitation to the rapid implementation of MMT, understanding patient experience in care settings from their perspective is crucial to improve service quality.

Our findings point to evolving patient experiences of MMT. The immediate positive changes that methadone brought to our participants at the beginning of treatment are impressive. Individuals resumed control of their lives as methadone liberated them from heroin addiction. Heroin withdrawal was no longer a fear, and patients did not have to avoid it at all cost. This advantage was the very justification for methadone maintenance treatment (Gomart, 2002). The significance of MMT for Vietnamese drug users must be measured within a context traditionally characterised by compulsory detention as a punishment for drug use. The arrival of MMT then marks a new era when living a decent life becomes possible for drug users. MMT may be more significant to Vietnamese users than to users in high-income countries where it is just one option among other evidence-based interventions.

Although patients were satisfied with the pharmacological effects of methadone, it did not lead to the straightforward outcomes that patients had imagined when entering treatment. Patient experiences were affected by their negative perceptions of the substance. Despite the spreading biomedical discourse of addiction that advocates for methadone as a medication, the majority of our participants, regardless of their methadone experience, continued to perceive it as just another drug whose properties they could not trust. Indeed, some studies reported that methadone patients seem to attribute any physical discomfort they may feel after starting treatment to methadone (Bojko et al., 2015; Goldsmith et al., 1984). Goldsmith (1984) explained this belief system by pointing to drug users' autonomy in managing their physical condition, which encourages close attention to the effects of drugs in their body. Interpreting the effects of methadone by comparing it to known drugs helps individuals deal with the anxiety of unknown treatment experiences. Besides constipation, tooth decay, or reduced sexual drive, existing clinical research suggests that these symptoms may indicate undiscovered medical or living conditions (Leavitt, 2003). Over-sedation could be a symptom of inappropriately high dosages.

Patients' anxiety that they would be unable to escape methadone seemed more compelling than their fear of side effects. Many PWID believed methadone was more addictive than heroin (Bojko et al., 2015; Langlois, 2013). This concern explained the attempt by some participants to get the lowest dose possible by asking to be tapered off even when they had no immediate plan to quit treatment. While this practice has not been commonly reported, it remains worrisome, as an inadequately low dose is a risk factor for abandoning treatment in many programmes (Khue et al., 2017; Proctor et al., 2015).

Langlois (2013) proposed a typology of medication-assisted patients based on the combination of high/low motivation to fight addiction and the perception of the substance as a medication or as a drug. Perceiving the substance as a medication produces conformist (high motivation) or ritualistic (low motivation) users who comply or seem to comply with treatment requirements. Perceiving the substance as a drug leads to 'therapeutic craft' (high motivation), where participants deliberately adjust their doses as they see fit (whether secretly or overtly); or choose to terminate treatment or divert the substance (low motivation). Although other factors such as desire to take care of oneself and treatment constraints also influence patients' compliance, and 'therapeutic craft' does not necessarily stem from a perception of methadone as a drug (M. Harris & Rhodes, 2013), we find Langlois's typology useful in understanding the reactions of our participants. Unlike

Langlois's French sample, who mainly perceived opioid agonists as treatment, the majority of our participants fit into the quadrant of patients who are highly motivated to quit heroin and who think of methadone as a drug. Their attempts to get the lowest possible dose could be an outcome of their patient profile. This difference might reflect social conceptions of addiction in the two countries. France adopted the biomedical model of addiction as a chronic brain disease in the early 1990s and currently has one of the best medication-assisted treatment coverage in the world (Jauffret-Roustide & Cailbault, 2018). In Vietnam, the perspective of addiction as a chronic disease only officially appeared in 2013 (Government of Vietnam, 2013) and recently became more popular. "MMT as a medication-assisted therapy," started to replace "MMT as a substitution therapy" in Vietnamese medical discourse around the same time. However, the conception of addiction as a moral fault probably remains prevalent in Vietnamese society. Yet, other factors should be taken into account to explain the different conceptions of addiction.

Using 'nghiện' (addiction) and 'phụ thuộc' (dependence) – two words with similar meanings – to describe their conditions with heroin and MMT respectively, our participants restated the common "trading one addiction for another" view of MMT (Volkow et al., 2014). Patients revealed their frustration by highlighting external forces in their descriptions of 'phụ thuộc.' As it allows patients to shift from addiction to dependence, the current methadone programme relieves the compulsive element of using drugs, but does not offer a radical solution to the quandary that heroin users face. Interestingly, it is the treatment programme, rather than the medication, that patients compare to heroin. Patients felt trapped by the programme's requirements of daily dosing within office hours, which prevented them from working and becoming self-reliant. This finding expands on the works of Khue (2017), who explains that one reason for methadone patient attrition is the financial burden of treatment fees. Our study shows that complaints about treatment fees might be rooted in patients' deeper frustration at being unable to support themselves and their families under MMT. This finding adds to the previous literature that opioid users consider treatment and abstinence not as ends in themselves but as means to achieve a functioning life (Mitchell et al., 2011). While the Confucian society of Vietnam expects men to be providers for the family, its market-oriented economy encourages autonomy. Under such pressures, the inability to achieve financial independence might threaten participants' sense of self-worth.

Following Gomart (2002)'s argument that the perception of a substance is inseparable from the context of its practices, we believe that the feeling of dependence on methadone is inseparable from the contexts of methadone programmes. When patients reported being 'detained' by methadone, or when potential patients stayed away from treatment for fear of dependence, it was less about the pharmacological effects of the product itself and more about the daily observed dosing practices.

The reputation of methadone programmes as lacking transparency stems from the early days of MMT. At the time, MMT was reserved for the most severely addicted individuals who had failed multiple detoxification attempts, including compulsory rehabilitation. The admission procedures spanned different governmental levels and used to last up to several months. At the time, bribing providers to get a spot in the programme was common practice

among better-off drug users. The expansion of MMT starting in 2012 allowed people with an opioid addiction to enter treatment more easily. But bad first impressions remain.

The rule of ‘money first’ is quite comparable to the relationship patients had with drug dealers. This strengthens the already negative reputation of methadone programmes among PWID. Moreover, this business-like policy excludes the most vulnerable patients, who cannot pay treatment fees on time; which could possibly push them back into drugs.

The actual practice of methadone programmes appears to go against its third objective of improving individuals’ social functioning (Ministry of Health, 2010). It echoes the observation of Edington & Bayer (2013) that the ultimate objective of Vietnamese methadone programmes is “to make people’s lives drug-free, not to make them better.” Our participants, similar to other Vietnamese methadone patients, were in their mid-thirties when they entered treatment. The majority of them had only completed primary or middle school (Khue et al., 2017). The industrial city of Haiphong provides factory jobs to people with low education. Our participants, however, could not arrange to receive treatment within the traditional eight-to-five job schedule. Other offers such as construction work and truck or ship driving positions require frequent travel, which is incompatible with daily dosing practices. Additionally, there is no supportive mechanism in place to facilitate social integration. As a consequence, for unemployed patients, seemingly reasonable treatment fees can represent a significant enough burden to quit the programme (Hammett et al., 2018; Khue et al., 2017). Moreover, since having a job is critical to individuals’ sense of ‘normalcy’ (Rhodes et al., 2015), such constraints negatively impact the transformation of patients’ identity and their re-entry into what might be understood as a ‘normal’ life.

The problematic staff-patient relationship is common in many methadone programmes, where stigma and discrimination have been rampant (Bojko et al., 2016; J. Harris & McElrath, 2012; Lin et al., 2011; Reisinger et al., 2009; Wolfe, Carrieri, & Shepard, 2010). Their vulnerable socio-economic status and high HIV prevalence put PWID at risk of becoming targets of addiction stigma, but also of poverty and HIV stigma (Conner & Rosen, 2008). Vietnamese society traditionally views drug use as a ‘social evil’ opposed to cultural virtues. Unsurprisingly, stigma and discrimination towards people who display this behaviour are prevalent (Windle, 2015). Conflicts arise when patients do not feel respected by providers. Challenging the credibility of methadone programmes by criticising the inhumanity of their staff and lack of transparency of their operations could be a way for patients to defend themselves against the negative treatment they receive.

Looking at the issue from the staff’s perspective, a study in China reported most methadone staff felt discouraged in their work (Lin et al., 2010). Heavy workload coupled with low incomes, lack of recognition compared to professionals in other medical specialties, and inappropriate training to cope with daily work issues all contribute to staff burnout and dissatisfaction. Many providers consider methadone clinics only as launching pads towards better jobs (Lin et al., 2010). These negative feelings could be projected on the patients they serve.

This study's findings are in line with some of the issues found in other methadone programmes in the Asian Pacific region, including widespread belief in abstinence as the ultimate goal of addiction treatment, complaints about methadone's side effects, and a negative relationship between patients and providers. Still, logistical issues (e.g., ID requirements, distance) and police crackdowns in methadone clinics that were reported in other Asian countries (Hayashi et al., 2017; Lin et al., 2011; Yin et al., 2010) seem to be less problematic in Haiphong.

The global issue of stigma and discrimination in MMT programmes manifests itself differently in high-income versus lower-income countries. While in high-income countries, stigma towards patients translates into stigmatising institutional practices like queuing, unequal treatment contracts, or intrusive urinalyses (Fraser, 2006; J. Harris & McElrath, 2012), methadone patients from low/middle-income countries in South-East Asia and Eastern Europe experience more interpersonal and overt stigma through the negative attitudes of healthcare staff toward them. (Bojko et al., 2016; Hayashi et al., 2017; Wolfe et al., 2010).

In comparison with recent work done in Kenya, where MMT was established more recently (Rhodes, 2018), our study highlights other challenges of treatment in helping individuals to manage addiction. Vietnamese drug users no longer doubt the potential of methadone to help them to change. Today, they find it more challenging to figure out how to fit treatment into their quest for a normal, meaningful life.

Recommendations

This study's findings suggest that we need to develop addiction medicine, with specific training in medical schools. Addiction treatment professionals must learn that caring for people with substance use disorders requires more skills than just prescribing methadone. The development of addiction medicine as a specialty would offer possibilities for professional development and career advances for current methadone providers. Investing in methadone programmes (lighter workload, increased support and incentives) would alleviate work-related stress for professionals and reduce the conflict of interest between professionals and patients.

Since employment directly impacts quality of life and treatment engagement (De Maeyer et al., 2011; Jackson et al., 2014), Vietnamese methadone programmes should apply a more patient-friendly dosing schedule to attract and retain service users, especially to accommodate those with traditional eight-to-five work schedules. As M. Harris & Rhodes (2013) argued, 'generous constraints' would be beneficial in improving patients' sense of control, in assisting their self-sufficiency, and in reducing risks. Vietnam can learn from other countries and allow take-home medicines for stabilised patients. This would also help significantly decrease the workload at the clinic. Other effective medications like buprenorphine or extended-release naltrexone, which require looser supervision, might also be helpful to improve the convenience of addiction treatment.

Widespread negative beliefs about methadone are not easy to transform. However, clear communication during treatment initiation on what methadone can do (reducing medical and social complications related to heroin) and cannot do (curing patients from addiction), in consideration of patients' treatment goals, would reduce misunderstanding and prepare patients to better cope with the constraints of treatment. Properly addressing methadone's side effects is important to promote a better image of treatment among potential patients (Lin et al., 2011).

Methadone programmes would benefit from understanding the elements that retain patients in care given the daily struggles they face. Patients were committed to ending their relationship with heroin and to protecting their family's happiness. This finding reflects a specificity of Vietnamese collectivism by which fulfilling family obligations is critical to individual identity (Burr, 2014). It also confirms the sociological view of drug users as conformist citizens rather than offenders of established norms (Jauffret-Roustide, 2009). Such recognition is important to reduce stigma and enable more support for PWID to achieve their life goals. We should remain aware that being on MMT could place the patient's identity in a 'limbo' where they are viewed as 'not quite junkie' but 'not quite conventional' (Neale, 2013). This unintended outcome of treatment might have a negative impact on patients who wish to recover a 'normal life' within their family. Programmes should invest more efforts to strengthen patients' family support and to enhance the connection between clinics and families to improve treatment retention.

Future research could provide more insights into how significantly changing PWID's perception of methadone and addressing time constraints and office-based stigma and discrimination would affect treatment retention. Longitudinal studies following methadone patients over the course of their treatment might help understand how the challenges mentioned above develop over time, and how patients pursue their life goals despite adverse conditions.

Limitations

Our peer-based recruitment compensates for PWID's usual mistrust of official institutions and facilitates open exchanges, which in turn generates rich data. PWID seemed open and willing to share their experiences. Still, the findings should be examined within our limitations. Since DRIVE referred most of our participants to methadone programmes, their MMT experiences were relatively short (1–2 years). They might have different profiles than users seeking treatment on their own in terms of commitment to care. Their experience could also differs from that of patients with longer MMT experience regarding treatment fatigue. Additionally, male voices dominated our results. While the male – female ratio among current methadone patients is acceptable (28/12), we have too few women in the two groups of users who dropped out of MMT (3/1) and of users who had never followed MMT (11/3). This reflects the commonly difficult recruitment of female drug users for research, especially those who are not in care. The fact that most of our female participants were recruited through FSW peer groups but only few confirmed that they sell sex implies that their accounts may suffer from potential social desirability bias.

Conclusion

This paper showcases the experiences and perceptions of PWID towards MMT in Vietnam. The beginning of treatment brings about a significant feeling of success as heroin use gradually ceases to be a compulsive act. However, being in treatment also poses challenges for patients to lead a functioning life. The desire to break up with heroin and the pursuit of family happiness constitute the anchors that keep patients in care. This study's findings advocate for patient-centred changes in treatment delivery and for the development of addiction medicine as a medical specialty to improve the quality of addiction care.

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Table 1:

Characteristics of sample

	Currently under MMT (N=40) N (%)	**Dropped out (N=4) N (%)**	**Never been under MMT (N=14) N (%)**
Men	28 (70)	3 (75)	11 (78.6)
Recruited through MSM peer groups	5 (12.5)	1 (25)	1 (7.1)
Women	12 (30)	1 (15)	3 (11.4)
Recruited through FSW peer groups	10 (25)	1 (25)	3 (21.4)
Age (median)	37.5	35.5	39
Married/Cohabited	20 (50)	0	6 (42.9)
Having a job	34 (85)	4(100)	11 (78.6)
HIV positive	8 (20)	3 (75)	10 (71.4)
ART	7 (87.5)	2 (66.7)	7 (70)
Median length of MMT (years)	1.25	2	1
Median length of drop-out (years)		3	
Reasons of drop-out		Fear of methadone side effects	
		Time conflict with work with work	
		Being discharged for missing too many doses	
		Being discharged for not paying treatment fees	