

Access to HIV-related Health Services in Positive Women, Men Who Have Sex with Men (MSM), Transgender (TG) and Injecting Drug Users (IDU)

Research Finding Highlights

August 2009

REPORT

APN+

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asia pacific
network
of people living
with hiv/aids

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood - Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, colour, sex, language, religion, political opinion, social origin, birth or other status. Furthermore, no distinction shall be made on the basis of the political, jurisdictional or international status of the country to which they belong, whether it is independent, trust, non-self-governing or under any other limitation of sovereignty - Everyone has the right to life, liberty and security of person - No one shall be held in slavery or servitude; slavery and - No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment - No one has the right to recognition everywhere as a person before the law - All are

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ABOUT APN+

APN+ is the only regional network of people living with HIV and AIDS (PLHIV) that represents PLHIV individuals and groups throughout the Asia Pacific Region. It is an organization run by, and for, people living with HIV and AIDS. APN+ works to advocate for the rights of positive people including: access to treatment, care and support, to fight stigma and discrimination, and is involved in prevention interventions.

APN+ was established in 1994 and its network members have expanded to 29 countries throughout the Asia Pacific Region. Currently APN+ Regional secretariat is located in Bangkok. Today, APN+ is involved in many activities, with a diverse list of partners, to promote the health and well being of positive people. These include: PLHIV discrimination research, treatment access and preparedness and increasing the involvement of PLHIV in all facets of the HIV/AIDS response towards the epidemic.

ACKNOWLEDGEMENTS

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EXECUTIVE SUMMARY

Factors such as stigma and discrimination, poverty, criminalization of drug use, sex work and homosexuality, limited antiretroviral therapy (ART) service facilities and lack of trained healthcare professionals on HIV treatment have all been cited as barriers to HIV treatment access for people living with HIV (PLHIV). Although studies have also provided the frameworks for understanding and addressing how gender and sexuality, employment and drug use-based social status have impeded our goal of delivering treatment, care and support to the marginalized communities; progress in achieving equitable access on essential HIV healthcare services remains disappointingly slow.

In 2009, the Asia Pacific Network of People Living with HIV/AIDS (APN+) conducted a network-based research project aimed to explore the experience of women, men who have sex with men/transgender people (MSM/TG) and injecting drug users (IDUs) living with HIV in accessing ART and other HIV-related healthcare services. Specifically, the study examined the experience of PLHIV with linkages to PLHIV support organizations and services in areas of HIV counselling and testing, ART adherence, treatment for opportunistic infections (OIs) and healthcare providers' (HCPs) attitude toward the targeted marginalized groups.

Quantitative and qualitative measures were used to help assess the target groups' experiences. Over 3,000 PLHIV from 10 countries across Asia participated in the research. Participants were recruited through the APN+ national PLHIV networks, PLHIV support groups, local ART clinical centres, MSM and IDU drop-in centres, and drug treatment facilities. Data were collected during the second half of 2008.

Key findings of this research include:

- *HIV testing without informed consent reached as high as 37% among the women living with HIV respondents group*
- *One in three women did not know if HIV can be treated; one in three women also did not know the names of their ARV regimen*
- *Over 80% of women said they did not have adequate income to sustain their health needs*
- *59% of IDU and 46% of MSM/TG respondents reported to be in need of ART; of which, up to 60% of IDUs and MSM/TG in some countries do not have access to ART services*
- *An average of one in three MSM/TG and IDU respondents reported a lack of access to treatment for OIs*
- *IDU respondents reported an average of 1.24 missed ARV dosages in the past month – this suggests greater than 95% of adherence rate among IDUs who are likely to be on twice-daily ARV regimens*
- *Denial of medical services and physical assaults by HCPs were reported by more than 30% of the MSM/TG respondents in some countries*

The participants in this research study were composed of PLHIV who, despite being more likely to be informed and linked to available services, continue to confront significant barriers to accessing essential treatment. These results provide clear evidence of the enormous gaps that persist, particularly for people who do not have any links to PLHIV support networks and the challenges they face in navigating the HIV healthcare system.

RECOMMENDATIONS

1. **Provide treatment education** (include ART, OIs and HCV) and human/legal rights education to all PLHIV.
2. **Address stigma and discrimination** faced by PLHIV by implementing anti-discriminatory policies in healthcare settings and workplace, and through training of healthcare providers.
3. **Address individual barriers to ART initiation** *such as fear of side-effects and fatalism.*
4. **Develop mechanisms to provide free or affordable diagnostic** tests (CD4, viral load, HBV/HCV tests, liver and kidney function tests, etc.) and all necessary OI medications in the government centres.
5. **Improve ARV supply management system to eliminate drug stock-outs from occurring.**
6. **Develop plans and mobilize resources for providing second-line ART and treatment for HCV/HBV co-infected PLHIV**
7. **Link active drug users living with HIV to Oral Substitution Therapy (OST) programs** to assist them in initiating and adhering to ART.
8. Support PLHIV networks to **start sustainable income generation programs.**
9. **Develop and implement a national policy and action plan to ensure equity in ART** access for the marginalized communities.
10. Ensure women living with HIV are not coerced into sterilization, and have access to **quality and non-judgmental reproductive health services**; ensure that women living with HIV are educated about the risk of cervical cancer and the need for regular Pap smear; and **have access to Pap smear tests.**
11. Grant migrant workers access to HIV and health services regardless of their legal status.
12. **Involve PLHIV networks** and marginalized groups at all levels of decision making to ensure effective use of their experience and expertise in monitoring and reviewing the scale-up of ART programs and other treatment services.

BACKGROUND

Since early 2000, resources available for the scaling up of antiretroviral therapy (ART) and other HIV treatment, care and support services have grown significantly. Despite such growth, access to these services for people living with HIV (PLHIV) remains a challenge in Asia. It is estimated that only 26% of those in need of ART have access to such services¹; a vast majority of those who urgently need treatment but do not have access are members of marginalized communities and include HIV positive women, men who have sex with men/transgender (MSM/TG), and injecting drug users (IDUs) ¹.

Factors such as stigma and discrimination, poverty, criminalization of drug use, sex work and homosexuality, intellectual property rights and trade agreements on medicines, and limited ART service facilities have all been cited as key barriers to treatment access for PLHIV. Although studies have also provided the frameworks for understanding and addressing how gender and sexuality, employment and drug use-based social status have impeded our goal of delivering treatment, care and support to the marginalized communities; progress in achieving equitable access to essential HIV healthcare services remains disappointingly slow.

Specifically, there's a great need to help build a clearer picture on how policies condemning people's sexual and drug use practices have affected their rights to equitable health and HIV treatment services; how stigma and discrimination within the healthcare setting have affected the quality of healthcare they received; and what types of structural changes and social support services are needed to help increase the uptake and improve the quality of treatment and care to PLHIV regardless of their gender and behaviours.

STUDY OBJECTIVE

In July 2008, the Asia Pacific Network of People Living with HIV/AIDS (APN+) conducted a network-based research project aimed to explore the experience of women, MSM/TG, and IDUs living with HIV in accessing ART and other HIV-related healthcare services. Specifically, the study examined the experience of PLHIV with linkages to PLHIV support organizations and services in areas of HIV counselling and testing, ART adherence, treatment for opportunistic infections (OIs) and healthcare providers' (HCPs) attitude toward the targeted marginalized groups.

METHODOLOGY

Quantitative and qualitative research methods were used and included a literature review, surveys and focus group discussions (FGDs).

Three sets of questionnaires and FGD questions were developed collectively by the APN+ research consultant and the PLHIV-led country research teams. The questionnaires and the FGD questions contained both common and target group specific theme questions.

A quantitative statistical software tool (SPSS) was used for data analysis.

¹ Report of the Commission on AIDS in Asia. Redefining AIDS in Asia: Crafting and Effective Response. New Delhi, India: Oxford University Press, 2008

Survey and FGD respondents were recruited by the country research teams through the APN+ national PLHIV networks, PLHIV support groups, local ART clinical centres, MSM and IDU drop-in centres, and drug treatment facilities. Verbal informed consent was obtained from all survey and FGD respondents.

A survey (N=3,148) was conducted using a face-to-face, structured questionnaire. Respondents were categorized into three groups: women living with HIV (n=1,306; 41.5%), MSM/TG living with HIV (n=897; 28.5%) and IDUs living with HIV (n=945; 30%). In addition, 79 focus group discussions (FGDs) were also conducted (women: 38; MSM/TG: 14; IDUs: 27).

Table 1: Study method and sample size breakdown

Methods	Women living with HIV	MSM/TG living with HIV	IDUs living with HIV	Total
Quantitative (Survey)	N=1,306 Cambodia (n=268) China (n=334) India (n=236) Indonesia (n=180) Thailand (n=87) Vietnam (n=201)	N=897 India (n=424) Indonesia (n=128) Malaysia (n=83) Myanmar (n=44) Nepal (n=168) Singapore (n=50)	N=945 China (n=200) India (n=155) Indonesia (n=263) Myanmar (n=86) Nepal (n=100) Vietnam (n=100)	N=3,148 Women (n=1,306) MSM/TG (n=897) IDUs (n=945)
Qualitative (FGD)	38 FGDs Cambodia (4) China (2) India (12) Indonesia (8) Thailand (3) Vietnam (9)	14 FGDs India (3) Indonesia (4) Myanmar (3) Nepal (2) Singapore (1) and Malaysia (1)	27 FGDs China (4) India (7) Indonesia (2) Myanmar (4) Nepal (5) Vietnam (5)	79 FGDs Women (38) MSM/TG (14) IDUs (27)

Table 2: Demographic profile: women living with HIV (n=1,306)

Age (Mean)	Residency		Marital Status				Other Self-identifications		
	City/Capital (%)	Village/Town (%)	Single (%)	Married/Live-in Partner (%)	Separated/Divorced (%)	Widowed (%)	IDU (%)	Sex Worker (%)	Migrant Worker (%)
33.6 years	532 (43.0)	744 (57)	134 (10.5)	629 (49.4)	90 (7.1)	429 (32.9)	96 (7.7)	136 (10.9)	209 (16.9)

Table 3: Demographic profile: MSM/TG living with HIV (n=897)

Age (Mean)	Gender		Residency		Partnership		Live-in Partnership		Gender of Live-in Partner			
	Men (%)	TG (%)	City/ Capital (%)	Village/ Town (%)	Yes (%)	No (%)	Yes (%)	No (%)	Male (%)	Female (%)	TG (%)	Both Sexes (%)
32.47 years	688 (79.6)	179 (20.4)	504 (56.7)	385 (43.3)	712 (79.6)	182 (20.4)	592 (84)	113 (16)	258 (41.9)	147 (24.8)	44 (7.4)	153 (25.8)

Table 4: Demographic profile: IDUs living with HIV (n=945)

Age (Mean)	Sex		Residency		Accommodation					Drug Use	
	Male (%)	Female (%)	City/ Capital (%)	Village/ Town (%)	Rehab Centre (%)	Family/ Friends (%)	Homeless (%)	Alone (%)	Other (%)	Yes (%)	No (%)
31.09 years	757 (80.2)	187 (19.8)	629 (66.5)	316 (33.4)	116 (12.3)	660 (69.8)	23 (2.5)	130 (13.7)	16 (1.7)	387 (41)	556 (59)

KEY FINDINGS

1. HIV COUNSELLING AND TESTING

The question “where did you first receive your HIV test?” was asked in the questionnaires targeting women and MSM/TG living with HIV. Most participants (women: 88.4% and MSM/TG: 59.3%) received their HIV test from a government hospital. Specifically, over one-third (39.8%) of the women were tested for HIV due to their own illness and another one-third (32.9%) were tested due to their husband’s illness; 10.9% of the women were tested during their pregnancy.

HIV testing without informed consent was reported by respondents in both groups.

Nearly one-third of the women (37%) and 13.1% of the MSM/TG respondents reported being tested for HIV without informed consent. FGD participants expressed the need to employ peer counsellors in government HIV testing facilities in order to help improve the quality and appropriateness of counselling and the efficacy of the referral system.

“[Doctors] are not friendly and sometimes they use harsh or bad words to patients. I want to be counselled by someone who is also living with HIV.”
(Woman, Vietnam)

“Many issues that [MSM] encounter are different from those of straight guys. [MSM] may not feel comfortable talking to counsellors who are women or straight guys. There is a need for MSM-friendly counsellors.”
(MSM, Malaysia)

2. ACCESS TO ART

A variety of barriers deter people from starting or continuing ART.

These barriers include: lack of adequate knowledge about ART, availability of ART services in their area, fear of side-effects and drug interactions, affordability of treatment and laboratory testing costs, and transportation costs. Interactions between active drug use and ARV, distance to ART facilities, unfriendly provider attitude and denial of health services were also reported.

More than half (59%) of the IDU respondents and nearly half (46%) of the MSM respondents reported to be in need of ART.

Although the survey respondents were drawn mostly from HIV service delivery points where it is more likely that people are relatively well-informed and have access to available HIV-related health services, the study found that access to ART varies between groups from 57% to 71%. In particular, over 60% of those IDU in Myanmar and MSM/TG in Indonesia in need of ART indicated that they did not have access to treatment. Of the women who reported currently being on ART, one in three (33%) considered access to ART services either ‘difficult’ or ‘very difficult’.

One in three women reported not knowing if HIV can be treated.

“Interactions between ARVs and Methadone make us very confused whether or not to start ART.”

(IDU, China)

“Many MSM died while queuing for ART at the public health centre...still many are dying...ART availability is very poor...I am among one of those waiting for my turn to die. I am depressed a lot. I wish many other NGOs could give ART for MSM in the near future.”

(MSM, Myanmar)

“One doctor when I went for a check-up, commented that my CD4 and viral load levels didn’t change with ARVs, so he said that it wasn’t any use for me to take ARVs.”

(Woman, China)

Respondents who lived in the capital cities were significantly more likely to have access to ART than those in rural areas. The average travel time to the nearest HIV treatment centre is between 1.5 to 2.7 hours for the three groups (range: less than an hour to 30 hours).

The study also found that over 10% of the women respondents reported not knowing if ART services were available in their area.

“Since ARV stocks were low, they [ART centre] gave me [ARVs] for only two weeks.”

(MSM, Malaysia)

“I didn’t register for HIV treatment in my province because I am afraid that people will find out about my [HIV] status...I come to Ho Chi Minh City for health check every month. Each time, it takes me two days and I get so tired of travelling but I feel more secure here.”

(Woman, Vietnam)

Income related questions were included in the women living with HIV questionnaire. The study found that most women (79%) do not have adequate financial resource to access and sustain their HIV-related service needs. Three in five women said that they do not have sufficient income to maintain their health needs. Nearly 50% of the respondents also reported needing nutritional support for their children in the past six months.

“I was very sick and I had to stay at home. My kid asked me why I didn’t go to the hospital. I said I can’t go because I don’t have the money. (Crying) We are also human, why can’t we go to the hospital? No money. No food...”

(Woman, Thailand)

Operating hours of the government HIV health service clinics pose an additional challenge to some, including those who work as sex workers. MSM/TG respondents indicated that since many sex workers work at night, most have difficulty in attending clinics that are open only in the morning or during selected week days and hours.

3. CHALLENGES TO ART ADHERENCE

IDU respondents reported an average of 1.24 missed ARV dosages in the past month – this suggests greater than 95% of adherence rate among IDUs who are likely to be on twice-daily ARV regimens. For those who ever missed doses, more than 80% indicated that they simply “forgot” to take their medications. However, over 10% of the respondents from Manipur, India, identified “ARV stock-outs” as the reason for their missed doses.

Of the 865 women who had started ART, close to 40% said that they had, at sometime in the past, changed their regimen, and 18% reported that they had stopped taking their ARVs. Side-effects were the major reason for changing ART regimens (80.0%) or stopping ART (66.6%). In Vietnam, however, over one-third of the respondents had to change their ARV regimens due to drug stock-outs.

Lack of adequate knowledge on ART also impeded adherence. Among the respondents from China, more than 30% of them did not know why ARVs need to be taken every day and at regular intervals.

4. AVAILABILITY OF OI TREATMENT

An average of one in three MSM/TG and IDU respondents reported lack of access to treatment for OIs.

In particular, 68% of MSM/TG respondents in Nepal reported lack of access to OI treatment. The high cost of OI medications (49.8% of MSM; 39.1% of IDUs) and the low availability of services (41.9% of MSM; 37.7% of IDUs) were identified as the two major barriers to OI treatment services.

Obstacles to OI treatment include: frequent drug stock-outs, high cost of OI treatment, perceived poor quality of OI medicines and the limited availability of essential OI medicines in most public HIV treatment facilities.

“Whenever we go for OI treatment and medications, they provide us some cheap ointment and antibiotics. The stock seems to run out most of the time.”

(IDU, India)

“Not all OI drugs are provided free through the ART centres and in government clinics.”

(MSM, Indonesia)

5. ATTITUDE OF HEALTH CARE PROVIDERS (HCPs)

Among the respondents who disclosed their drug use or male-to-male sexual practice to their HCPs, most reported that their HCPs were neutral or friendly toward them. However, MSM/TG respondents also reported disclosure of their HIV status (12.4%) and sexuality (14.5%) to others by their HCPs without their consent. Fear of discrimination by HCPs for being ‘girlish’ also deterred some MSM/TG from accessing the healthcare system.

Denial of services and physical assaults by HCPs

Denial of services by HCPs was reported by both the IDU (15.4%) and MSM/TG (21.1%) respondents with over 30% of the MSM respondents from India and Nepal and 36% of the IDU respondents from Myanmar reporting the highest levels of such incidents. Specifically, the combined factors of being a ‘TG’ and being ‘out to HCPs’ about one’s gender identity exposed the respondents to the highest risk of refusal of healthcare services.

“HCPs are afraid that they might get HIV. When there was a need to give me an intravenous injection, the nurses asked my friends to inject instead. Even the doctors have an indifferent attitude.”

(IDU, India)

“Since the HCPs are not trained drug users’ issues, they treat us like aliens.”

(IDU, Nepal)

“The doctor said to me, ‘Maybe God doesn’t want you [MSM] on the earth any more.’ That statement was made after he knew about my HIV status.”

(MSM, Myanmar)

Furthermore, close to 10% of the overall MSM/TG respondents also reported physical assaults by HCPs. At close to 40%, respondents in Nepal were found to face the highest rate of such incidents. The survey, however, did not ask about the specific of physical assaults.

"I was so fed up of going to the [government] hospitals, as I had to wake up early and even if I reached the hospital, the doctors would speak very rudely. That was when I decided that enough is enough. I would rather spend money in some private hospitals but I do not want to go back to the government hospital."

(Transgender woman in sex work, India)

Discrimination within healthcare sector

One in two women (47.0%) faced discrimination in the public health system in the past two years (Indonesia 29.2%; Thailand 29.9%; India 31.4%; Vietnam 44.4%; Cambodia 47.4%; China 73.4%). Women in villages faced most discrimination (52.7% vs 43.3%).

Women not informed of being tested for HIV faced significantly more discrimination than women who knew they were being tested (58.9% vs 39.4%); significantly more women migrants and/or refugees said they faced discrimination compared to other women (62.0% vs 42.2%). Women who identified as sex workers did not face more discrimination than other women. Higher proportion of women who identified as injecting drug users said they experienced discrimination in health system compared to others but this difference was not significant.

6. ACCESS TO HIV SERVICES FOR MIGRANT WORKERS

Issues related to migrant workers were explored among the women living with HIV respondents.

Overall, migrant workers experienced added barriers in accessing HIV-related health services due to their migrant status. In Thailand, migrant workers who do not have a labour certificate are unable to get free ART and other HIV-related services. Although labour certificates can be obtained through registration with the village leaders, many are reluctant to do so due to their fear of authorities.

A similar labour registration policy was also reported in China. Registration with local authorities at their city of employment and an identification card are needed in order to obtain access to HIV services and treatment. However, in some areas, migrant workers can only receive free ART services by travelling back to their home city due to the differences in provincial labour policies. Fear of authorities due to their illegal status also limits migrants' usage of the public health services.

7. ACCESS TO ART FOR HIV-POSITIVE CHILDREN

Over 200 or 16.6% of the respondents from the women's group reported having at least one HIV-positive child; however, up to 20% of the respondents also reported not knowing about the HIV status of their children.

"I took my kid to the doctor. He was three then but the doctor wouldn't allow any test. He said that if the kid was sick, he will check it. When the kid reaches seven or eight and if he had been ill, bring him in for a check-up. Now my kid's eight and he's well, so I don't take him in"

(Woman, Thailand)

One in three women (36.2%) reported that paediatric ARV formulations were available in their area; however, another nearly one in three (31.8%) also reported not know about such formulations. As expected, in most countries, HIV-related services for children are limited to large urban centres.

"I also hear [about ARVs for children] but the quantity is still very limited. We have to register first, then we can't change from the regular ART [adult] to solution [paediatric] right away. The bureaucracy is too complicated. Maybe because the item is still rare, so it's a bit complicated. So [my son] still uses the adult form."

(Woman, Indonesia)

8. ADDITIONAL ISSUES: WOMEN LIVING WITH HIV

Pap smear testing and reproductive health services

Despite the increased risk of cervical cancer in women living with HIV, 35% of women do not know about cervical pap smear tests. FGDs further revealed that gynaecological services and treatment have been denied to women living with HIV by some HCPs and that referral services to reproductive health services were rarely provided. Women living with HIV in Thailand also reported being coerced into sterilization.

"My husband asked me to be sterilised because my womb was not so good but he didn't tell me that I had HIV. And the doctor told me not to breastfeed my baby..."

(Woman, Thailand)

Prevention of mother-to-child transmission (PMTCT)

Over half of the respondents (54.8%) did not know about the use of ARVs for the prevention of HIV transmission from mother to child and one in ten (10.5%) respondents did not have access to such services. Uptake of PMTCT services was especially low among migrant women due to fear of deportation.

9. ADDITIONAL ISSUES: MSM/TG LIVING WITH HIV

Discrimination within the MSM/TG communities

Fear of discrimination within the MSM/TG communities and rejection by their partners (male or female) due to their HIV status have prevented MSM/TG from getting HIV testing and seeking support for their HIV treatment. In addition, concerns about the side-effects of ART, including changes in body fat deposits (lipodystrophy and lipoatrophy) that could affect their physical appearance and reveal their HIV status have also discouraged some MSM/TG from accessing and/or adhering to their treatment.

The need for HIV-positive MSM support groups

The development of peer support groups for MSM/TG living with HIV can encourage timely testing and treatment to take place within the MSM/TG communities. MSM/TG-focused PLHIV support groups can also provide a safe space for HIV-positive MSM/TG to discuss sensitive issues, such as their sexual practices, which cannot be discussed openly and comfortably in support groups that are predominantly attended by heterosexual PLHIV.

“You have support groups for heterosexuals who are HIV-positive. We need such support groups for MSM too... But many HIV-positive MSM from rural areas do not know such groups [for HIV-positive MSM] exist and even if they do, they do not attend those support groups that are held in cities.”

(MSM, Malaysia)

Disclosure of MSM and/or HIV status to male and female partners

Of the 84% of the MSM participants reported to be living with a partner, 25% reported to be living with a female partner. Close to 40% of Indian MSM respondents indicated that they were living with a female partner. For some MSM, the difficulty surrounding the disclosure of their HIV status to their partners was compounded by the potential need to reveal their male-to-male sexual practice.

“My wife does not know that I am [MSM] or HIV-positive. I have stopped having sex with her since I learned about my [HIV] status. But I am afraid of what will happen if she comes to know. She doesn't even know that I am eating these pills [ARVs]. I have been pressed by the counsellors to bring my wife for counselling, I am scared but I need to do that one day or another.”

(MSM, India)

10. ADDITIONAL ISSUES: IDUs LIVING WITH HIV

Access to Hepatitis C (HCV) related services

Two-thirds (66.6%) of the IDU respondents reported knowing that HIV-positive IDU are more likely to be co-infected with HCV; however, less than half had been tested for HCV (41.9%). Nearly 60% of those who had been tested and received their test results on HCV reported positive HIV/HCV co-infection.

High costs of treatment (54.3%) and lack of knowledge about HIV/HCV co-infection (40.2%) were cited as the two key barriers for IDUs seeking treatment for HCV. Many expressed the need for the government to provide free, if not, affordable, HCV treatment options. The development of educational programs within IDU communities was also identified as key to further transmission reduction and increasing awareness about HIV/HCV co-infection.

“In government hospitals, we cannot access [free] HCV testing. In private hospital, we can test and we can get treatment – but the cost is very high. Cost of a 12-month course treatment is about 4 to 5 lakhs [10,000 – 12,000 USD].

(IDU, India)

“HCV treatment is not available here [a city]. We have to go to the capital city.”

(IDU, China)

Some respondents reported refusal by their HCPs to initiate ART due to their co-infection status.

“I have Hep-C. Doctor said that I need to first get treated for HCV before I could be started on ART. But I can not afford HCV treatment.”

(IDU, China)

Access to Needle Syringe Programmes (NSP)

NSP is a principal harm reduction measure that aims to curb the spread of blood-borne viruses such as HIV and HCV among IDUs; however, access to NSP for IDUs continues to be a challenge. Barriers to NSP include: limited service hours and locations, limited supplies, and police harassment.

NSP services are often offered through outreach workers or in drop-in centres only during the official working hours of NGOs. These working hours mostly do not coincide with the ‘peak drug-taking hours’ (That is, the time during which drug users mostly consume/inject drugs). For example, ‘peak drug-taking hour’ was reported as early morning in some Indian sites.

FGD respondents also indicated the gap in the frequency of injections (demand) and the supply of needles/syringes provided through NSP. Consequently, there are chances for needle sharing due to inadequate supplies of new needles and syringes.

In many countries police interference with IDU and NSP-related outreach activities was reported. Harassment from 'anti-drug' groups was also reported from the Indian state of Manipur.

"Needles/syringes are available at drop-in centres and outreach sites only and only during office hours. Our using [injecting drugs] behaviours do not depend on a particular time."

(IDU, India)

"Needle exchange programs are difficult to access. There only one [NSP] site [in his hometown] and the polices are always roaming around that site."

(IDU, China)

Drug dependency treatment services

IDUs seeking drug dependency treatment services also face similar barriers as those seeking NSP services. While oral substitution therapies (OST) such as the use of methadone and/or buprenorphine are available in some countries, access to such treatment is often limited to a number of sites and that most treatment facilities are located in the capital cities. Furthermore, although largely free, in some countries IDUs are required to pay a nominal fee for their daily OST dosages.

"Buprenorphine substitution services are available but the enrolments are always full. I am not able to get a slot in the substitution programme."

(IDU, India)

"Methadone substitution therapy centre at Medan is operating well but it is not available in Deli Sardang. Hence users from Deli have to travel a long distance. Excluding travel costs, clients need to pay 15,000 IDR (1.5 USD) for their daily methadone does."

(IDU, Indonesia)

Lack of good quality and low-cost/free drug rehabilitation centres were also cited by the FGD respondents from most countries as a barrier to utilizing drug dependency treatment services.

“When we were in the compulsory detox centre, there was very limited medical service. People won’t be referred to the hospital until they become very sick and people who were referred usually died within two weeks after being referred because it was too late.”

(IDU, China)

*“When we were in the compulsory detox centre, there was very limited
“Now I stay in a rehab centre where clients were treated using faith-based procedures. We don’t receive medical treatment. No nutrition. All we receive from the centre is spiritual counselling. It would be dream come true if there is at least one low-cost rehabilitation centre where we can receive good medical treatment and nutrition.”*

(IDU, India)

NEXT STEPS

This report aims to highlight some of the key findings from this research. While recognising that there are limitations to the design of this research study, our intention is to help highlight the ongoing challenges faced by women, MSM/TG and IDUs living with HIV in accessing essential health services. The respondents of our research are PLHIV who are more likely to be informed and linked to available HIV treatment and support services in their countries; however, many of them continue to face challenges in accessing essential health services for their HIV treatment. In exploring their issues, we are reminded of the plight of those without any linkage to a PLHIV supporting mechanism and the daily struggles they encounter in finding an entrance into this often complex world of HIV healthcare system.

In June 2009, APN+ organized a regional Treatment Summit to share the primary findings from the research with its country research teams. Dissemination of country-specific research findings have been planned for late 2009 in partnership with the APN+ national PLHIV network members. Country-level treatment advocacy plans also will be developed based on findings of this research.

The detailed research finding report from the ‘Women Living with HIV’ component of this research is available on the APN+ website (www.apnplus.org). Similar reports will also be published on the MSM/TG and IDU components of this research by late 2009.



Asia Pacific Network of People Living with HIV/AIDS
51/2 Soi Ruam Rudee, Ploenchit Rd.
3rd floor, Ruam Rudee III Bldg.
Bangkok 10330 THAILAND

T : +66 2 2557477
F : +66 2 2667479
www.apnplus.org