



**Treatment Access for
Injecting Drug Users (IDUs)
Living with HIV in Asia**

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ACRONYMS AND ABBREVIATIONS

APN+	Asia Pacific Network of People Living with HIV/AIDS
ART	Antiretroviral Treatment
ARV	Antiretrovirals
FGD	Focus Group Discussion
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HCP	Health Care Providers
HBV	Hepatitis B Virus
IDU	People Who Inject Drugs
OI	Opportunistic Infection
OST	Opioid Substitution Treatment
NSP	Needle Syringe Programme
PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV



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 marginalized communities; progress in achieving equitable access on essential HIV healthcare services remains disappointingly slow.

In 2008, the Asia Pacific Network of People Living with HIV/AIDS (APN+) conducted a network-based research project aiming 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 of opportunistic infections (OIs) and healthcare providers' (HCPs) attitude toward the targeted marginalized groups. This brief focuses on the findings in relation to IDUs living with HIV.

Quantitative and qualitative measures were used to help assess the target groups' experiences. 945 IDUs living with HIV from 6 Asian countries participated in the research. Participants were recruited through APN+ national PLHIV networks, PLHIV support groups, local ART clinical centres, IDU drop-in centres, and drug treatment facilities. Data were collected during the second half of 2008.

KEY FINDINGS

- *59% of IDUs reported to be in need of ART; of which, up to 60% of IDUs in some countries do not have access to ART services.*
- Of participants who are in need of ART, but currently not on ART (n=240), the following barriers were reported: Lack of adequate knowledge about ART (26.7%), lack of availability of ART (23.8%), active drug use (10.4%), fear of drug interaction (10%), fear of side effects (9.2%), and not able to afford treatment costs (7.1%).
- *An average of one in three IDUs reported a lack of access to treatment for OIs.*
- About two-thirds of participants (41.6%; n=126/303) currently on ART reported that they had missed taking some doses in the last month. *Among those, an average of 1.2 (range: 0.9-1.5) doses were missed.* This indicates that there is at least 95% adherence among most IDUs who missed ART in the last month (who are likely to be on twice-daily ARV regimens).

The participants of our research are IDUs living with HIV 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. In exploring their issues, we are reminded of the plight of those without any linkage to a PLHIV support mechanism and the daily struggles they encounter in finding an entrance into this often complex world of HIV healthcare systems.



INTRODUCTION

According to UNAIDS, 4.9 million people were living with HIV in Asia in 2007. This figure included the 440,000 people who became newly infected in that year. Approximately 300,000 people died from AIDS-related illnesses in 2007. Overall, an estimated 9 million Asians have been infected with HIV since it first appeared in the region more than 20 years ago.

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 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 marginalized communities; progress in achieving equitable access to essential HIV healthcare services remains disappointingly slow.

Building on the 2008 regional documentation of HIV-related discrimination in four Asian countries, which found that PLHIV with IDU backgrounds face significantly higher levels of discrimination, the Asia Pacific Network of People Living with HIV/AIDS (APN+) conducted a network-based research project which sought to further examine the impacts of discrimination in addition to the goal of Universal Access. Specifically, the study 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. It examined the experiences of PLHIV, identified through PLHIV support organizations and services, in areas such as HIV counselling and testing, ART adherence, treatment for opportunistic infections (OIs) and healthcare providers' (HCPs) attitude toward targeted marginalized groups.

This report shares research findings in relation to IDUs living with HIV. It highlights challenges faced by IDUs living with HIV across the region in accessing antiretroviral drugs (ARVs) and HIV-related diagnostic and treatment services in Asia. Conducted under the direction of the APN+ IDU working group, this study was designed and carried out by IDUs in the following six Asian countries: China, India, Indonesia, Myanmar, Nepal, and Vietnam.

Two other similar reports have also been published under this research project, one on HIV-positive women and a second on MSM/TG.

A mixed method (quantitative and qualitative) design was adopted for this study. The field research team consisted of people from both networks and agencies working with injecting drug users (IDUs). Research staff received intensive training about study objectives, design, data collection methods and research ethics. Data were collected during the last quarter of 2008. Details of the type of methods, sample size and countries involved are summarized in table 1.

Quantitative component: A survey (n=945) was conducted using a face-to-face structured questionnaire among IDUs. SPSS version-14 was used to undertake statistical analysis.

Qualitative component: 27 focus group discussions (FGDs) were conducted. Detailed notes were recorded during the FGDs including the documentation of quotes ad verbatim. These notes were expanded upon soon after the FGDs were completed, and themes and patterns identified from the focus groups were summarized.

Both the questionnaire and the FGD guide were developed collectively by the APN+ research consultant and the PLHIV-led country research teams. Survey and FGD participants were recruited by the country research teams through the APN+ national PLHIV networks, PLHIV support groups, local ART clinical centers, IDU drop-in centers, and drug treatment facilities. Verbal consent was provided by all survey and FGD participants.

Table 1: Study methods and Sample size

Country	Quantitative (Survey)			Qualitative (Focus Group Discussions)	
	No. of sites	Site name	No. of participants	No. of FGDs	Site name and No. of participants
China	4	Ruili, Yingjiang, Geiju, and Kaiyuan	200	4	Ruili city Yunan province (n=15), Yingjiang County Yunan Province (n=24), Kaiyuan city Yunan Province (n=26), and Geiju City Yunan Province (n=28)
India (Manipur and Mizoram)	6	Ukhrul, Chandel, Senapati, Thoubal, Imphal East & West Districts, and Aizwal city.	155	7	Saikul Bazar, Ukhrul Bazar, Usoipokpi, North AOC, Japhou Bazaar, and Aizwal City
Indonesia	6	Bali, North Sumatra, Jakarta, Java Timur, South Sulawesi, and West Java	263	2	South Sulawesi (n=16) and North Sumatra (n=16).
Myanmar	4	Mandalay, Lashio, Muse, and Yangon	86	4	Lashio (n=16), Muse (n=14), Mandalay (n=10), and Yangon (n=16)
Nepal	5	Kathmandu, Pokhara, Butwal, Chitwan, and Bhaktapur.	100	5	Kathmandu, Pokhara, Butwal, Chitwan, and Bhaktapur.
Vietnam	4	Ho Chi Minh City, Haiphong, Quang Ninh, and Hanoi.	100	5	Ho Chi Minh City, Haiphong, Quang Ninh, and Hanoi.

Table 2: Demographic profile: IDUs living with HIV

Age (Mean)	Sex		Residence		Accommodation					Drug Use	
	Male (%)	Female (%)	City/Capital (%)	Village/Town (%)	Rehab Center (%)	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)

A. CHARACTERISTICS OF THE STUDY PARTICIPANTS

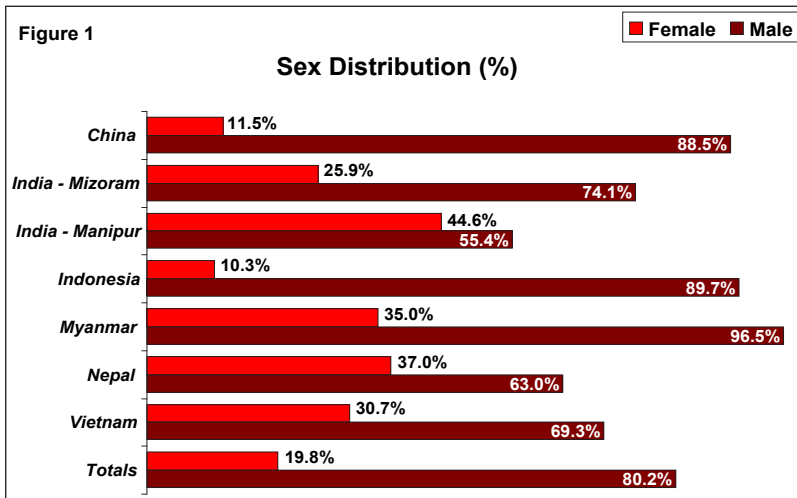
Characteristics of FGD participants

Almost all participants were recruited through the PLHIV networks and community organizations working with MSM/TG and IDUs. Most participants came from an environment of lower socio-economic status.

Characteristics of Survey participants

Sex and age of the participants

The majority of participants were males (80.2%; n=757/944). The sex distribution of participants across the six countries are demonstrated in figure 1.



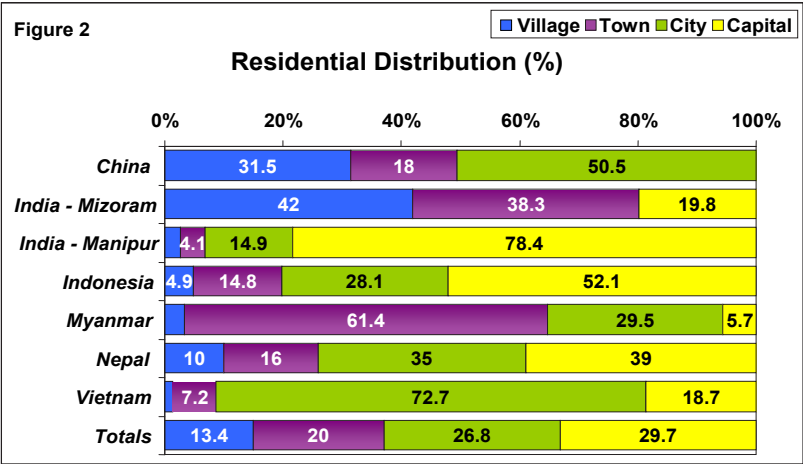
The average age was 31.09 years (with 95% of the sample group ranging from 30.7 to 31.5 years). While the average participant from China (36.74 years) was significantly older than all other country participants, the average participant from Nepal was youngest (27.06 years).

Participants were mostly from urban settings

About one-third (33.4%; n=316/945) of participants resided in rural settings such as villages and small towns, however two-thirds (66.5%; n=629/945) resided in urban settings such as cities and or the national capital. Where over 80% of participants from Manipur (India) resided in rural settings, about 92% of participants from Mizoram (India) resided in urban settings. Residential details of participants across countries are provided below.

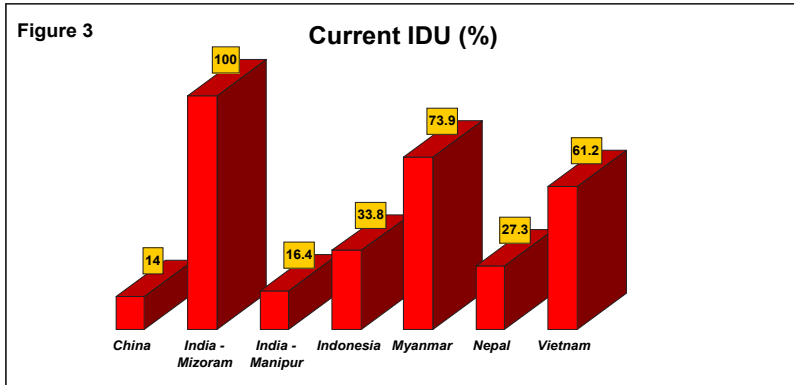
Most participants lived with their families or friends

More than two-thirds (69.8%; n=660/946) of the participants lived with their families or friends. About 14.8% (n=140/946) reported being homeless or living in rehabilitation centers.



A significant proportion self-reported that they were currently using drugs

In China, Mizoram (India), Indonesia, and Nepal, the drug use rates were nearly at, or lower than 33%, while in Manipur (India), Myanmar, and Vietnam drug use rates were relatively higher (100%, 73.9% and 61.2% respectively). The percentage of IDUs who self-reported that they were currently using drugs across the six countries is demonstrated in figure 3.



Overall, current drug users constituted about 40% of the participants.

B. INITIATION OF ART AND ADHERENCE

A significant proportion of participants who are in need of ART are currently not receiving ART

More than half (58.9%; n=554/ 941) of IDUs living with HIV are in need of ART. The estimated number of those in need of ART was arrived at after the number of people who reported they are currently on ART was added to the total number of those who did not report that they 'do not need ART'. The latter includes people who are eligible (as self-reported) to access ART but are currently not on ART since they could not afford it or because they had stopped taking it due to side-effects. While there are nearly, or more than, two-thirds of IDUs in need of ART in Myanmar (81.8%), Manipur (India) (79%), China (64.5%) and Vietnam (62.9%), less than half of participants in Nepal (43%) and Mizoram-India (26.8%) were in need of ART.

Among the IDUs who were in need of ART, only 56.7% (n=314/554) reported that they were currently on ART. While most participants in Nepal (79%), Mizoram (India) (78.9%) and China (62.8%) reported that they were currently on ART, a relatively smaller proportion in Manipur (India) (32.8%) and Myanmar (30.6%) reported ART uptake.

A variety of barriers hinder ART initiation

A variety of barriers deter people from initiating ART. Of participants who are in need of ART, but currently not on ART, the following obstacles were reported: Lack of adequate knowledge about ART (26.7%; n=64/240), lack of availability of ART (23.8%; n=57/240), active drug use (10.4%; n=25/240), fear of drug interaction (10%; n=24/240), fear of side effects (9.2%; n=22/240), unable to afford treatment costs (7.1%; n=17/240). Some (5%; n=12/240) reported that health care providers had denied any provision of health services.

Similarly, FGD participants across countries expressed a number of personal-level barriers to ART initiation; such as active drug use, fear of drug interaction whilst taking ART with other detoxification medicines, and an overall fear of side-effects.

Lack of information/counselling about ART side effects

“Side effects are the most important concern for us but medical doctors didn’t give us any information about it.” (China)

Fear of side effects deters ART initiation

“Many IDUs have not yet started ART as they are afraid of the side effects.” (Indonesia)

Reluctance in initiating ART due to a fear of drug interactions

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

ART adherence

About two-thirds (41.6%; n=126/303) of participants who were currently on ART reported that they had missed taking some of the scheduled doses over the last month. An average of 1.2 (range: 0.9-1.5) doses were missed in the last month. This indicates that there is at least 95% adherence among most IDUs who had missed ART in the last month.

In India (both in Manipur and Mizoram) and Vietnam, a relatively higher proportion of “ever missed more than one dose” cases were reported, 66.7%, 76.9%, and 66% respectively. Whilst in China and Nepal, about or less than one quarter of participants reported “ever having missed doses in the last month”. Of those participants who had reported “ever missed doses”, over 80% reported that they simply “forgot” to take their medications.

Slightly more than 5% reported a lack of adherence due to inadequate stocks at ART centers. However, in Manipur (India), 13.3% of the participants reported inadequate stock as the primary reason for having missed a dose.

Similarly, a lack of adequate stock in free government ART centers were reported during the FGDs in some countries, including China. This fact would significantly affect an individual’s ability to maintain adherence to ART. In addition, inadequate stock and subsequent interruption to treatment regimes would further compromise the overall efficacy of treatment.

Low stock means frequent visits to HIV treatment centers

“Since the stock of ART is running low, sometimes we have to go to the hospital [ART center] once every 3 days to get medication [ART].” (China)

C. ATTITUDE OF HEALTH CARE PROVIDERS (HCPs)

Most participants (85.3%; n=801/939) disclosed their drug using status to their health care providers. Among participants who had disclosed their status, half (51%; n=407/798) reported that their health care providers were neutral in terms of friendliness or had a friendly attitude towards IDUs. However, some (15.4%; n=144/937) reported experiencing refusal of services by health care providers.

During the FGDs, while participants across the six countries reported experiencing negative/unfriendly attitudes of health care providers (doctors, nurses, and support staff), exceptionally, very few expressed friendly service provision by health care providers. Also, some suggested there was a need to sensitize health care providers to offer non-discriminatory, as well as friendly services, to drug users visiting health centers.

Perceived discrimination - Longer Waiting time

“Since we are current and ex-drug users living with HIV, even if we came first to consult the doctor they always keep us waiting and see us last.” (India)

Fear of contracting HIV by HCPs

“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 me instead. Even the doctors have an indifferent attitude.”

(India)

Lack of adequate training on IDU issues to HCPs

“Since the HCPs are not trained about drug users’ issues, they treat us like aliens.” **(Nepal)**

“Health worker’s training is necessary to reduce the stigma & discrimination attached to them attending to IDUs in hospitals or clinics.” **(Indonesia)**

D. ACCESS TO OI TREATMENT

A significant proportion of participants (24.1%; n=227/940) reported a lack of access to treatment of OIs. While in Indonesia, Mizoram (India), China, Vietnam, and Nepal, more than 70% of participants reported access to treatment for OIs, in Myanmar and Manipur (India), 63% and 48% of participants respectively reported access to treatment for OIs.

In comparison with ex-drug users, current users have lower access to OI treatments and reported relatively more difficulties with using OI treatment.

Participants reported a variety of barriers for not accessing OI treatment: high cost of OI medications (39.1%); lack of availability of services (37.7%); and a lack of adequate knowledge and information (12.6%).

Issues related to cost particularly influenced participants in China (62.9%), Indonesia (55.6%) and Myanmar (40.6%). However, issues of availability have greater impact on participants in India (Manipur, 70.7% and Mizoram, 57.1%) and Myanmar (59.4%). Finally, issues of knowledge and information particularly impede Nepalese participants' utilization of OI treatments. During the FGDs participants also expressed some of these concerns, including lack of available, free OI medications.

Perceived poor quality of medicines and lack of adequate stock

“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”. (India)

Lack of free medicines in some centers

“Some of the government clinics do not provide certain OI medicines so we have to buy them by ourselves” (Vietnam)

“Some OI drugs are not provided for free.” (Indonesia)

E. ACCESS TO HEPATITIS C (HCV) RELATED SERVICES

Nearly two-thirds (66.6%; n=628/943) of participants were aware that HIV-positive IDUs are more likely to be co-infected with HCV. In Indonesia and Nepal, over 70% of participants were aware of co-infection, whilst in Manipur and Vietnam only slightly more than 50% of participants had this knowledge.

Over one-third (41.9%; n=394/941) had undertaken testing HCV. When participants in China, Mizoram (India), Indonesia, and Vietnam reported a relatively higher proportion of HCV testing, only less than one third of those in Manipur (India), Myanmar, and Nepal had tested for HCV. In comparison with ex-drug users, current users are less likely to have the knowledge about HIV/HCV co-infection and also less likely to know their HCV status.

Nearly 60% of those who had been tested and received their HCV test results reported a positive HIV/HCV co-infection status. Whilst HCV positive rates in China, Indonesia, and Vietnam were higher (all above 25%), those in Manipur (India), Myanmar, and Nepal were relatively lower (all below 20%). Of IDUs who reported that they were HCV-positive, only 27% reported having had access to HCV treatment.

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. Once current users are tested positive for Hepatitis C, they faced similar degrees of difficulty in accessing Hepatitis C treatment, and were equally likely to be on Hepatitis C treatments with their ex-user peers.

Many FGD participants expressed the need for governments to provide free, if not, affordable, HCV treatment options. The development of educational programs within IDU communities was also identified as key to reducing HCV transmission and increasing awareness about HIV/HCV co-infection. Some of the participants reported that their HCPs had refused to initiate ART due to their co-infection status.

Lack of free HCV testing in government centres

“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].” (India)

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

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

F. ACCESS TO NEEDLE SYRINGE PROGRAMS (NSP)

NSP is a principal harm reduction measure that aims to curb the spread of bloodborne viruses such as HIV and HCV among IDUs; however, access to NSP for IDUs continues to be a significant challenge.

Barriers to NSP include: limited service hours and locations, limited supplies, and police harassment. NSP services are usually offered through outreach workers or via drop-in centres however they are only available during official working hours. These working hours often do not coincide with 'peak drug-taking hours' (that is, the time during which drug users mostly consume/inject drugs). For example, the 'peak drug-taking hour' was reported to be most common during the early morning in some Indian sites.

FGD respondents also indicated a gap in the frequency of injections (demand) and the supply of needles/syringes provided through a NSP. Consequently, there is a greater chance of needle-sharing due to inadequate supplies of new needles and syringes. In many countries, police interference in both IDU and NSP-related outreach activities was reported. Harassment from 'anti-drug' groups was also reported from the Indian state of Manipur.

Limited service hours

"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." (India)

Police interference in NSEP

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

G. ACCESS TO DRUG-DEPENDENCE TREATMENT SERVICES

IDUs seeking drug-dependency treatment services also face similar barriers to 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 treatment facilities are mostly 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.

A lack of quality, low-cost/free drug rehabilitation centres was also cited by FGD respondents in most countries as a primary barrier to utilizing drug dependency treatment services.

In comparison with ex-drug users, current users are less likely to obtain appropriate information about drug substitution treatments and less likely to access such treatments. Moreover, current users reported experiencing relatively more difficulty with accessing such treatments.

Limited OST service outlets

“There is only one Methadone dispensing centre which is located together with a Drug treatment centre at a distance of about 20 miles away, down-town.” (Myanmar)

“Buprenorphine substitution services are available but the enrolments are always full. I am not able to get a slot in the substitution programme”. (India)

Need to travel and pay nominal charges to access OST services

“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 dose.”

(Indonesia)

Lack of quality services in Detox centres

“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.”

(China)

“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.” **(India)**

DISCUSSION

The research findings demonstrate an urgent need to increase community treatment literacy, to address the issue of stock-outs and the persistence of stigma and discrimination toward IDU's by health care providers. Specifically, more than one third of those in need of treatment, but not on treatment, indicated that their own lack of knowledge about ART, fear of drug interaction and side effects prevented them from seeking life-saving treatment. This is despite having access to critical ART entry points such as ART clinics, PLHIV support groups and PLHIV networks.

IDUs seeking drug-dependency treatment services also face similar barriers to those seeking NSP services. While 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 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.

The high level of treatment adherence, at least 95%, among most IDUs who missed one or more dosages in the last month is consistent with other studies on adherence among IDUs. However, it should also be noted that frequent stock-outs in local ART centres make up between five (5) to 13% of the rationale for missing dosages between the various studied areas.

Negative attitudes, including discriminatory comments from health care providers further impede and discourage health seeking behaviors by IDUs. Refusal to provide treatment and health services by health care providers based on one's drug using status, both prior and current, further violates the fundamental rights of all humans, including IDUs to health.

The efficacy and value of ART programs in improving the quality of life for IDUs living with HIV can be significantly impacted on by the limited access to OI treatment reported across all study sites. This issue is further compounded by a lack of access to hepatitis C treatment. High cost treatment and a lack of available services remains to be a key barrier to both OI and hepatitis C treatment.

NSP and access to drug-dependency treatment services constitute the core of harm reduction measures and are critical to the prevention of HIV and HCV among IDUs. However, access to such programs are frequently challenged by limited availability of service points, police interference and harassment in some countries. A lack of good quality and low-cost/free drug rehabilitation centers further contributes to limited utilization of such services in most areas.



CONCLUSION

The participants of this research included PLHIV who were more likely to be informed and linked to available services. Despite this, they continue to confront significant barriers to accessing essential treatment. These results provide clear evidence of the enormous gaps that persist, and the plight of those without any linkages to a PLHIV support system.

The following recommendations have been developed to provide strategic directions for both policy and program development and aim to achieve our collective vision of Universal Access.

RECOMMENDATIONS

- 1. Provide treatment education** to IDUs living with HIV (on ART, HCV, and OIs, as well as human/legal rights)
- 2. Develop and implement PLHIV treatment adherence interventions.** Consider providing a once-a-day dose to promote adherence among IDUs living with HIV.
- 3. Address stigma and discrimination** faced by IDUs living with HIV by implementing anti-discriminatory policies in healthcare settings and workplace, and sensitizing/training health care providers.
- 4. Address individual level barriers to ART initiation** such as a lack of self-efficacy in drug adherence, fear of side-effects and fatalism.
- 5. Link active drug users living with HIV to OST programs** in order to assist them in initiating and adhering to ART.
- 8. 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 government centres.
- 9. Develop plans and mobilize resources for the provision of second-line ART and treatment for HCV/HBV co-infected IDUs.**
- 10. Support PLHIV networks and community agencies working with marginalized groups to initiate and sustain income generation programs.**
- 11. Develop and implement a national policy and action plan to ensure equity in ART access** for IDUs living with HIV.
- 12. Ensure community involvement** 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.

Table 3. Comparisons between Former IDUs ('Ex-Users') and Current IDUs

Item	Drug Use Status			P	
	Former Users	Current Users	Total		
N (%)	556 (59)	387 (41)	943 (100)		
Demography					
Gender	Male	77.2%	84.9%	80.3%	$X^2 = 8.7$ $p = .003$
Age	Mean (95%CI)	31.5 (30.9-32.1)	30.6 (30.0-31.2)	31.1 (30.7-31.5)	$t = 2.139$ $p = .033$
Residency	Village	13.3%	13.4%	13.4%	$X^2 = 26.12$ $p = .000$
	Town	18.4%	22.5%	20.1%	
	City	32.4%	43.2%	36.8%	
	Capital	35.9%	20.9%	29.7%	
Access to ARV					
Need ARV	Yes	54.2%	65.7%	59.0%	$X^2 = 12.3$ $p = .000$
On ARV¹	Yes	71.7%	38.7%	56.6%	$X^2 = 68.3$ $p = .000$
	Never	24.3%	58.9%	40.1%	
	Dropout	4.0%	2.4%	3.3%	
Adherence to ARV²					
Frequency missed ARVs (General)	Never	60.0%	36.1%	52.6%	$X^2 = 15.8$ $p = .000$
	Sometimes	36.3%	59.8%	43.6%	
	Very often	3.7%	4.1%	3.8%	
Doses missed (Last month)	Mean (95%CI)	0.88 (0.54-1.22)	2.01 (1.39-2.63)	1.24 (0.93-1.54)	$t = 3.414$ $p = .001$
Reasons	Stock	6.7%	3.3%	5.1%	$\chi^2 = 2.9$ $p = .235$
	Forgot	77.3%	88.5%	82.4%	
	Others	16.0%	8.2%	12.5%	
Stigma among Health Care Providers					
HCP suspected/ knew drug use status of the participants	None	14.2%	15.3%	14.6%	$X^2 = 18.15$ $p = .000$
	Some	61.9%	48.8%	56.5%	
	All	24.0%	35.8%	28.8%	$X^2 = 5.14$

Item	Drug Use Status			P	
	Former Users	Current Users	Total		
N (%)	556 (59)	387 (41)	943 (100)		
<i>Stigma among Health Care Providers (continued)</i>					
HCP's friendliness³	Mean	3.43	3.09	3.29	t = 5.661
(1-5)	(95%CI)	(3.35-3.50)	(3.00-3.18)	(3.23-3.35)	p = .000
Refused Services	Yes	13.9%	19.9%	16.4%	X ² = 5.14 p = .025
<i>Opportunistic Infection Treatment</i>					
Access to OI treatment	Yes	82.4%	66.8%	76.0%	X ² = 35.54 P = .000
<i>Hepatitis C Treatment</i>					
Knowledge of Co-infection	Know	70.9%	60.9%	66.8%	X ² = 10.38 p = .002
Test for Hepatitis C	Yes	45.2%	37.1%	41.9%	X ² = 6.18 p = .015
Treatment for Hepatitis C⁴	Yes	28.7%	24.4%	27.0%	X ² = .5 p = .546
<i>Opioid Substitution Treatment</i>					
Heard about OST	Yes	85.6%	77.5%	82.3%	X ² = 10.17 p = .002
Access to OST	Yes	65.4%	38.2%	54.2%	X ² = .67.78
<i>Needle Syringe Program</i>					
Access to NSP	Yes	76.4%	80.6%	78.1%	X ² = 2.346 p = .128

Note:

1. Only among those who needed ARV
2. Only among those who were on ARV
3. Only among those who disclosed their IDU status to their healthcare providers
4. Only among those who were tested positive for Hepatitis C Virus

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