

**National Study On Access of Drug  
Users To Treatment & Fundamental  
Human Rights  
In Pakistan**

Submitted to:

**Association of People Living with HIV  
(APLHIV)**

Submitted by:

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## **LIST OF ABBREVIATIONS.**

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AJK</b>	Azad Jammu Kashmir
<b>AP</b>	Asia and the Pacific
<b>APLHIV</b>	Association of People living with HIV
<b>APN+</b>	Asia Pacific Network of People Living with HIV/AIDS
<b>ART</b>	Anti-Retroviral Therapy
<b>ARV</b>	Anti-Retroviral
<b>CAT-S</b>	Community Access to Treatment, Care and Support Study
<b>CHBC</b>	Community and Home-Based Care
<b>COPC</b>	Continuum of Prevention and Care
<b>CSOs</b>	Civil Society Organizations
<b>FATA</b>	Federally Administered Tribal Areas
<b>FSW</b>	Female Sex Worker
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>HCV</b>	Hepatitis C Virus
<b>HIV</b>	Human Immunodeficiency Virus
<b>HSW</b>	Hijra Sex Worker
<b>IBBS</b>	Integrated Bio-Behavioral Surveillance
<b>ICT</b>	Islamabad Capital Territory
<b>IDU</b>	Injecting Drug-User
<b>KAPs</b>	Key at Risk Populations
<b>KPK</b>	Khyber Pakhtunkhwa
<b>LMIS</b>	Logistics Management Information Management System
<b>LTFU</b>	Loss to Follow-Up
<b>MATA</b>	Monitoring Treatment Access
<b>MIS</b>	Management Information System
<b>MSM</b>	Men who have Sex with Men
<b>NACP</b>	National AIDS Control Programme
<b>NGO</b>	Non-Governmental Organization
<b>NWFP</b>	North West Frontier Province
<b>OIs</b>	Opportunistic Infection
<b>OST</b>	Oral Substitution Therapy
<b>PACP</b>	Provincial AIDS Control Programme
<b>PKR</b>	Pakistan Rupees
<b>PLHIV</b>	People Living with HIV/AIDS
<b>PMTCT</b>	Prevention of Mother-To-Child Transmission
<b>PPTCT</b>	Preventing Parent to Child transmission of HIV
<b>PR</b>	Principal Recipient
<b>PWID</b>	People who inject Drugs
<b>SR</b>	Sub Recipient
<b>STIs</b>	Sexually Transmitted Infections

<b>SW</b>	Sex Worker
<b>TB</b>	Tuberculosis
<b>TG</b>	Transgender
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNGASS</b>	United Nations General Assembly Special Session
<b>VCTC</b>	Voluntary Counseling and Testing Centre
<b>WHO</b>	World Health Organization

## **ABSTRACT OF THE STUDY**

The study was conducted by the Association of People Living with HIV (APLHIV), in Pakistan. 545 were recruited for this study as participants / respondents, from 13 districts, across the country. The districts and study participants within each district were worked out, on the basis of in-country epidemiological reports, including the UNGASS report and the available data on Drug Users, in Pakistan. This has been a cross-sectional descriptive study using structure questionnaire to explore the accessibility among Drug Users to treatment related services delivery and Rights. The study population was men, women and TG who self-report injected / inhaled/ ingested drug due to non-therapeutic purposes for the past six months, prior to the date of interview.

The total sample size of 545 was decided in consultation with national stakeholders. A snow-ball sampling technique was used to enroll possible study participants. Gender specified seeds (initial respondents) were selected from different NGOs/CSOs; decided in consultation between APLHIV and the key stakeholders. 12 data collectors were recruited for varying period, ranging from a week to ten days. The National Coordinator and the Finance officer closely supervised the data collection, whereas the project officer entered the data into web portal after three (3) step checking. The data was collected between 22 December 2013 to 10 April, 2014.

A structured questionnaire was developed that was used for the face-to-face interview. The questionnaire was translated into the local languages (Urdu) and was translated back to English to ensure its consistency and quality. Each of the questionnaire was thoroughly reviewed for any missing data, first by the Finance Officer, followed by the national coordinator before entry and by Project Officer while entering the Data into online PHP MySQL. Using SPSS 19.0, data was analyzed. Descriptive analysis was used to summarize the socioeconomic, health, and other variables. Prevalence estimate for several variables were computed for the total sample and also separately by sex. Data were summarized using frequencies, proportions, mean, standard deviations and medians.

The key findings were recoded as; majority of the respondents were males (84.4%; n=460), 47.52 percent (N=259) had reported 'wages' as their mean for the financial support in the last six months, Mean monthly income of the study respondents came to PKR. 8253.39 (SD 4879.978, 38.3 percent of male respondents (N=209) were reported associated with some NGO/Network, overwhelming of the study respondents (75.4 percent; N=411) were reported living at their home, majority of drug users (44.7 percent; N=244) started taking drugs at the age group of 16 – 20 years, Poly-drug was observed among the study participants, with 30.5 percent (N=166), 65.3 percent (N=356) of the

study respondents, reported engaged in sex during the past six months, Condoms use was reported in 39.3 percent (N=214) of the study respondents; 39.4 percent (N=215) of the study respondents were found reported at any service delivery project for HIV treatment, 14.9 percent (N=81) conformed about the existence of detox, 53.8 percent (N=293) felt satisfied with the behavior of the health care providers; Slightly more than half of the study participants (50.1 percent; N=273) were found aware about the Hepatitis C Viral infection.

Over fifty percent of the study respondents (55.6 percent; N= 303) found aware of their rights, Over twenty five percent (25.3 percent; N=138) were denied access to medical care, 38.3 percent (N=209) of the study respondents were reported forced to live without food due to their drug use, 48.3 percent; N=263 got arrested / detained due to drug use, over eighty percent (82 percent; N=447) were reported insulted with derogatory words, 78.2 percent (N=426) reported perceived of being alone or feared; 72.8 percent (N=397) reported their personal space being invaded and 68.3 percent (N=372) felt being seen less than a human being and 18.5 percent (N=101) reported ever sorting legal support.

The study recommended that developing and implementing a national policy and action plan to ensure equity in ART access for DUs living with HIV, Initiating & rapidly scale-up OST program to ensure adequate coverage of all IDUs, sensitizing police (at all levels) and anti-drug agencies on drug dependency and need for NSP and OST – awareness campaigns with ANF and police authorities, developing close collaboration / coordination, between the Detoxification Centre and the Treatment Centre (ART Centre), ensuring early initiation of ART, mass awareness campaign on HCV/TB Co-infection, among drug users, ensuring integrated diagnostics & treatment facilities availability at ART centers, sensitization and training health-care professionals on an on-going basis on how to prevent, recognize and manage the non-medical use of prescription drugs and related consequences, implementing stigma reduction measures in the health care, combining legal and harm reduction measures for Drug Users, giving providers the space needed to treat drug users with respect and ensure access to health services, addressing stigma and discrimination, faced by Drug Users by implementing anti-discriminatory policies in healthcare settings and workplace, and sensitizing/training health care providers, community based campaigns, with Drug Users, creating awareness and knowledge about their fundamental and legal rights, with active involvement of APLHIV, strengthening APLHIV, through ensuring representation of all key at risk population (KAPs), among their board, supporting Drug Users support groups and community support mechanism, working with marginalized groups to initiate and sustain income generation programs, APLHIV may ensure such mechanisms in place, through awareness campaigns, advocacy at all levels and donor support for micro-financing, ensuring 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 preventive programs and other treatment services, developing

mechanism to ensure legal aid at the pretrial stage may help to persuade a judge not to detain a criminal defendant, thus averting the harmful effects of incarceration and reforming laws that authorize police surveillance and pretrial detention of drug users.

The study was confronted with some limitations. Most of the variables in the questionnaire are designed to assess the participants past exposure or experiences which may increase the risk of recall bias. All of the study participants were drug users which may result in non-differential recall of an exposure status or experiences. The study primarily reflects response of Drug Users community; yet the service providers i.e. civil society, health care providers and programme managers was not planned in the overall methodology.

### **KEY FINDINGS.**

The key findings of the study were as follows;

1. Majority of the respondents were males (84.4%; n=460). Approximately 76.88 (n=419) fall under the age bracket of 40 years;
2. Majority of the respondents were reported 'Single' (48.3 percent; N=263) followed by the married (41.7 percent; N=227);
3. 47.52 percent (N=259) had reported 'wages' as their mean for the financial support in the last six months;
4. The mean monthly income of the study respondents came to PKR. 8253.39 (SD 4879.978);
5. Some 38.3 percent of male respondents (N=209) were reported associated with some NGO/Network;
6. Overwhelming of the study respondents (75.4 percent; N=411) were reported living at their home;
7. Majority of drug users (44.7 percent; N=244) started taking drugs at the age group of 16 – 20 years;
8. Majority of the study participants use drugs twice a day (40 percent; N=218);
9. Poly-drug was observed among the study participants, with 30.5 percent (N=166) using Smoking, Charas, Hashish, Herion, Opium;
10. 65.3 percent (N=356) of the study respondents, reported engaged in sex during the past six months.
11. Condoms use was reported in 39.3 percent (N=214) of the study respondents; 39.4 percent (N=215) of the study respondents were found reported at any service delivery project for HIV treatment;
12. 14.9 percent (N=81) conformed about the existence of detox (Drug treatment services), at the service delivery points;

13. Very few study respondents 4.2 percent (N=23) were reported on ART, at the moment, among the study respondents;
14. 53.8 percent (N=293) felt satisfied with the behavior of the health care providers;
15. Mean waiting time to access to the Health Care Provider indicated as 64.17 minutes;
16. Slightly more than half of the study participants (50.1 percent; N=273) were found aware about the Hepatitis C Viral infection;
17. Out of the study respondents 56.1 percent (N=306) reported injecting drugs, with 45.7 percent (N=249) describing access to syringes as “easy”;
18. 39.1 percent (N=231) of the study respondents recoded knowledgeable about the Detoxification Services, for the drug users;
19. Over fifty percent of the study respondents (55.6 percent; N= 303) found aware of their rights as human beings and described them as dignity, right to treatment, independence, sovereignty, religious freedom, etc.
20. Over twenty five percent (25.3 percent; N=138) were denied access to medical care in the recent past, and some 28.1 percent (N=153) denied for admission in the hospital;
21. Over fifty percent (54.7 percent; N=298) got their HIV status tested;
22. Slightly over fifty percent (51.0 percent; N=278) denied being provided with information about VCCT; 61.3 percent (N=334); 42.6 percent; N=232) about HIV/AIDS and 53.4 percent (N=291) about HCV, of the study respondents;
23. 38.3 percent (N=209) of the study respondents were reported forced to live without food due to their drug use;
24. Just under fifty percent (48.3 percent; N=263) got arrested / detained due to drug use;
25. Over eighty percent (82 percent; N=447) were reported insulted with derogatory words;
26. Among those married, 45.7 percent (N=249) denied any difficulty in meeting their children;
27. 96 percent (N=523) of the study respondents felt of being perceived as a drug user only;
28. Majority 78.2 percent (N=426) reported perceived of being alone or feared; 72.8 percent (N=397) reported their personal space being invaded and 68.3 percent (N=372) felt being seen less than a human being;
29. 18.5 percent (N=101) reported ever sorting legal support and just 6.8 percent (N=37) confirmed being facilitated in sorting legal support.

## **A. INTRODUCTION.**

### **Background.**

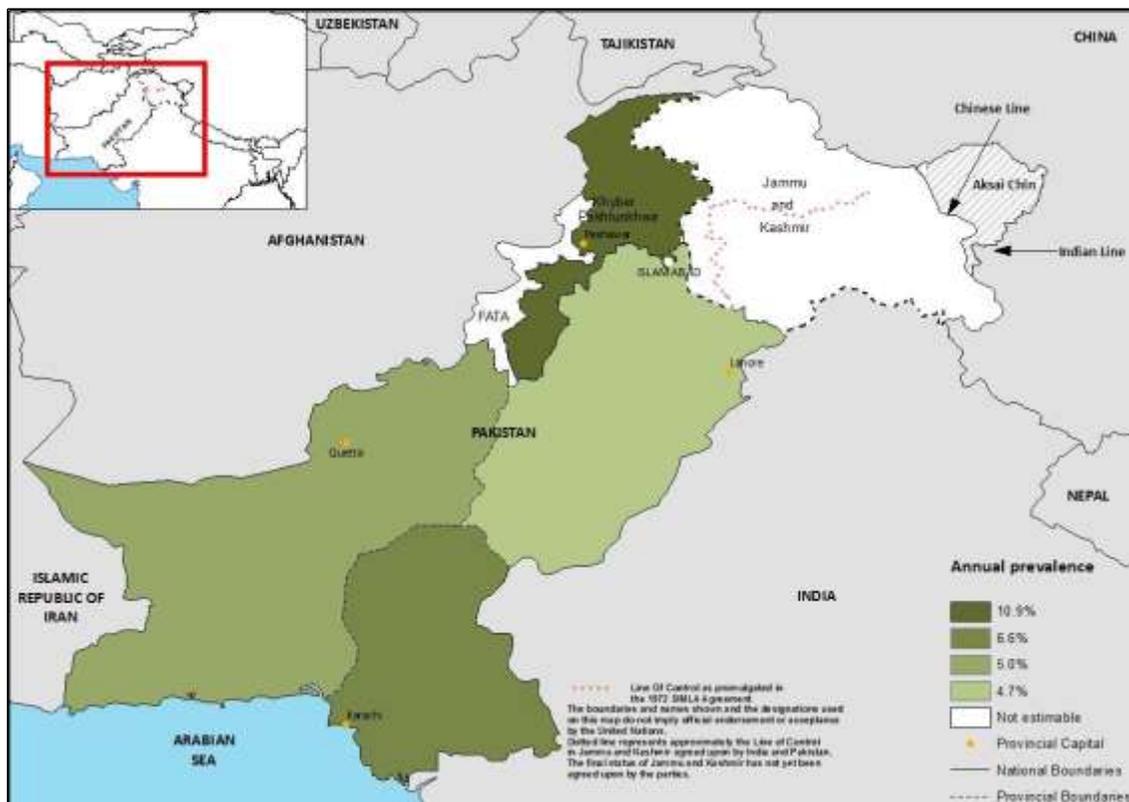
With around 180 million people<sup>ii</sup>, Pakistan is the sixth most populous country in the world. Pakistan continues to thrive as a key actor, politically and economically, in the south and southwest Asian region, despite facing a host of domestic social, economic, and political issues, responsible for hindering its continued development. The country is ranked 146 out of 186 countries by the 2013 United Nations Human Development Index<sup>iii</sup>, with nearly half of the population living below the poverty levels. According to the same report, almost a quarter of people are estimated to be living on less than USD 1.25 a day. Stark differences can be seen in literacy rates across gender as well as urban and rural sub-divides, as well as between provinces. Despite an overall literacy rate of 58 per cent, only 46 per cent of women in Pakistan are reported as literate. Pakistan's mean duration of schooling in a formal education setting is a mere 4.9 years.<sup>iv</sup>

The development of drug use in Pakistan can be seen in three successive as well as partially overlapping phases.<sup>v</sup> The traditional drug use, which still exists in some parts of Pakistan involves the use of opium, hashish (charas or cannabis resin) or bhang - a drink made from cannabis leaves. At the time of Enforcement of Hudood Ordinance in 1979, that put ban on the cultivation, sale and use of opium there were approximately 100,000 registered opium users in the country.<sup>vi</sup> Beginning in the 1980's, the heroin epidemic reached Pakistan spreading rapidly through the male population. Female heroin users were unusual, although regional pockets with high levels of heroin use among women were recorded. The misuse of prescription drugs has also existed at varying levels since decades, e.g., the misuse of pethidine and morphine, and tranquilizers and sedatives in urban centers along with use of substances such as methaqualone (Mandrax) - that was more popular in the seventies in Pakistan.<sup>vii</sup>

In addition to the historical and geographical context, socio-demographic, psychological, economic factors also play a role in determining drug misuse. Research conducted in Pakistan show that features of life such as unemployment<sup>viii</sup> and post-traumatic stress disorders<sup>ix</sup> are highly associated with substance use. In addition, cultural and environmental factors including the availability of both licit and illicit substances are likely to render many segments of the Pakistani population - from both urban and rural areas - increasingly vulnerable to drug use.<sup>x</sup>

Pakistan sits on one of the world's busiest drug trafficking corridors, largely due to the cultivation of opium poppy and cannabis in neighboring Afghanistan. According to UNODC

estimates 40 per cent of the drugs (heroin & charas) produced in Afghanistan are routed through Pakistan<sup>xi</sup>. This generates a considerable opiate supply for export but also for domestic use. Other than cannabis and opium poppy, available data points to an emerging supply of amphetamine-type stimulants (ATS), ecstasy, and cocaine. Law enforcement authorities in Pakistan have made seizures of methamphetamine in the last few years, as well as identifying irregularities around the import of related precursor chemicals such as ephedrine.<sup>xii</sup> Further, Pakistan has a developed pharmaceutical industry and a large network of pharmacies and medical stores that largely remain unregulated, around the country. These pharmacies and stores distribute and sell medicines, including controlled medicines, in nearly all parts of the country, in most instances without a requirement for a prescription from a medical practitioner.



**Figure 1. Annual prevalence of all illicit drug use, 2012**

The use of illicit drugs and the non-medical use of prescription drugs are established and widely recognized phenomena in Pakistan. The issue of non-medical use of prescription drugs has always remained a challenge for Health Administrators. The National Ministry of Health Reforms and provincial Health Departments never undertake any scientific study/research to identify the gravity of non-medical use of prescription drugs and its consequences. The psychological,

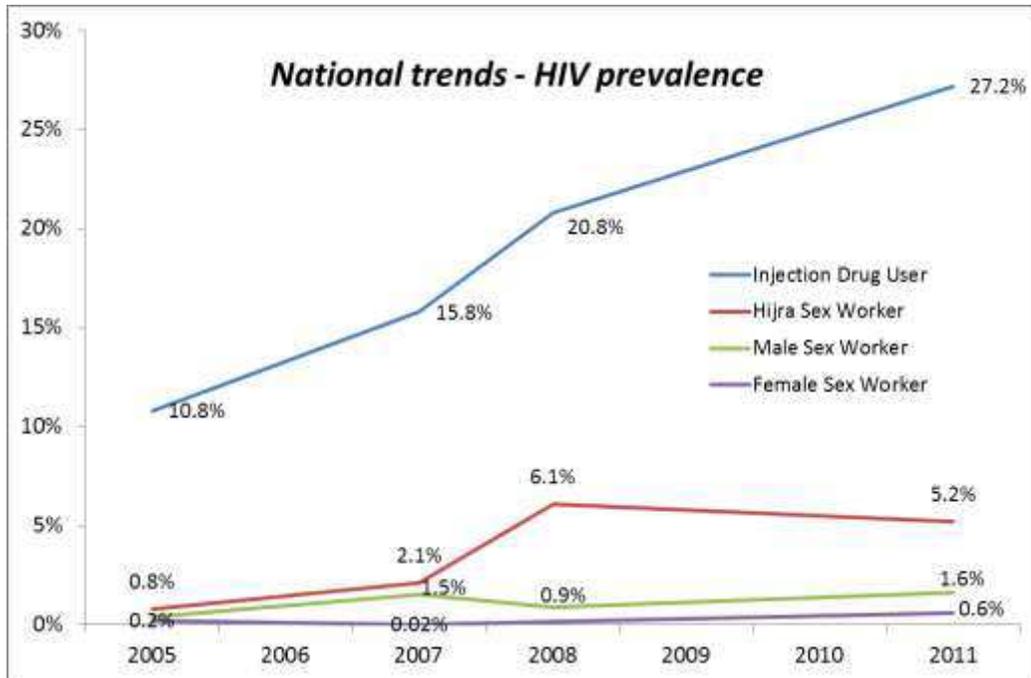
biological, social, as well the cultural factors (e.g. traditional use of cannabis and Heroin), combined with the easy access to an abundance of controlled substances within the country, have likely resulted in a large number of people experimenting or using drugs for recreational purposes as well as developing drug use disorders and dependence.<sup>xiii</sup> In addition to this geographical location of Pakistan with Afghanistan, the largest opium producer in the world has made Pakistan more vulnerable to the drugs (charas & heroin).

The Association of People Living with HIV (APLHIV) designed the said study to identify the hindrances faced by Drug User (DU) members and their community in accessing health care services, to document the violation of their human and legal rights, educate DU community about their fundamental human and legal rights and responsibilities, enable the DU community to unify their voices under the umbrella of the APLHIV and subsequently influence the policy makers at government level to pay an urgent attention to the needs of the DU community, through lobbying and advocacy.

### **HIV Situation Of The Country.**

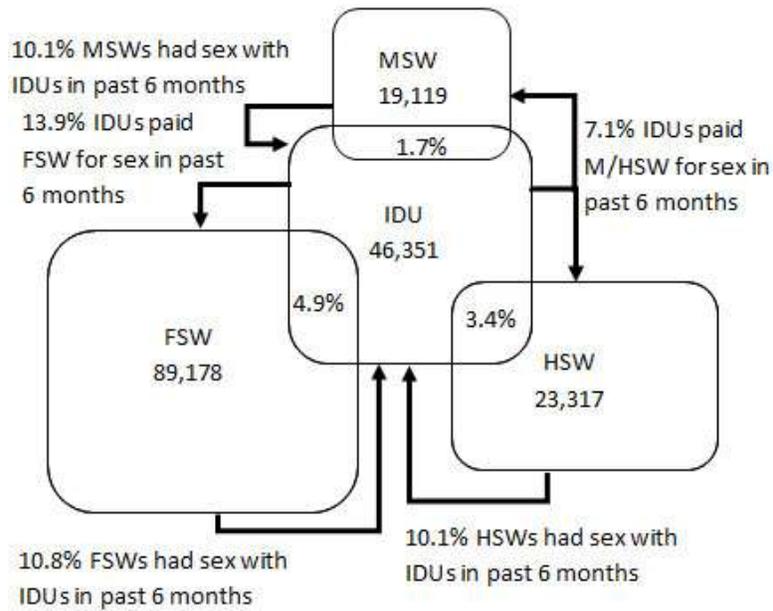
Like three Asian countries (Philippines, Malaysia, Indonesia), Pakistan is following a comparable HIV epidemic trend having moved from 'low prevalence, high risk' to 'concentrated' epidemic in the early to mid-2000s among key populations. The most recent estimate of HIV infected persons in Pakistan (EPP estimates) is in the order of 104,443 (median) for 2013<sup>xiv</sup>. HIV prevalence is still reported to be low (<0.1%) in the general population. The key concern however, is the rapidly increasing prevalence in several risk groups, with infection occurring largely through injecting drug use, followed by unprotected sexual contacts. PWID are driving the epidemic in Pakistan. Since 2003, a number of studies have indicated considerable on-going transmission among this group. Recent studies indicate a growing geographical spread as well with more cities emerging with significant PWID populations. Pakistan is one of three expanding epidemics in the Asia Pacific region along with Indonesia and the Philippines.<sup>xv</sup> The results of the 2011 IBBS also indicate significant network interactions among PWID and sex workers, among whom prevalence is rising. The overall prevalence of HIV among PWID was 27.2% (weighted= 37.8%). Among male PWID, it was 27.3% (1,341/4,914) and among female PWID it was 17.9% (7/39). As expected, prevalence increased with age (<20: 1%; 20-24: 6.6%; +25: 19.6%)<sup>xvi</sup>

The increasing HIV prevalence among risk groups is generally accompanied by worsening risk behaviors, according to IBBS surveys. Condom use remains low especially among Transgender Sex Workers (26%) and Male Sex Workers (13%), while needle sharing is also prevalent among Injection Drug Users (38% always using sterile injection).<sup>xvii</sup>



**Figure 2. National HIV Trends among Key at Risk Populations.**

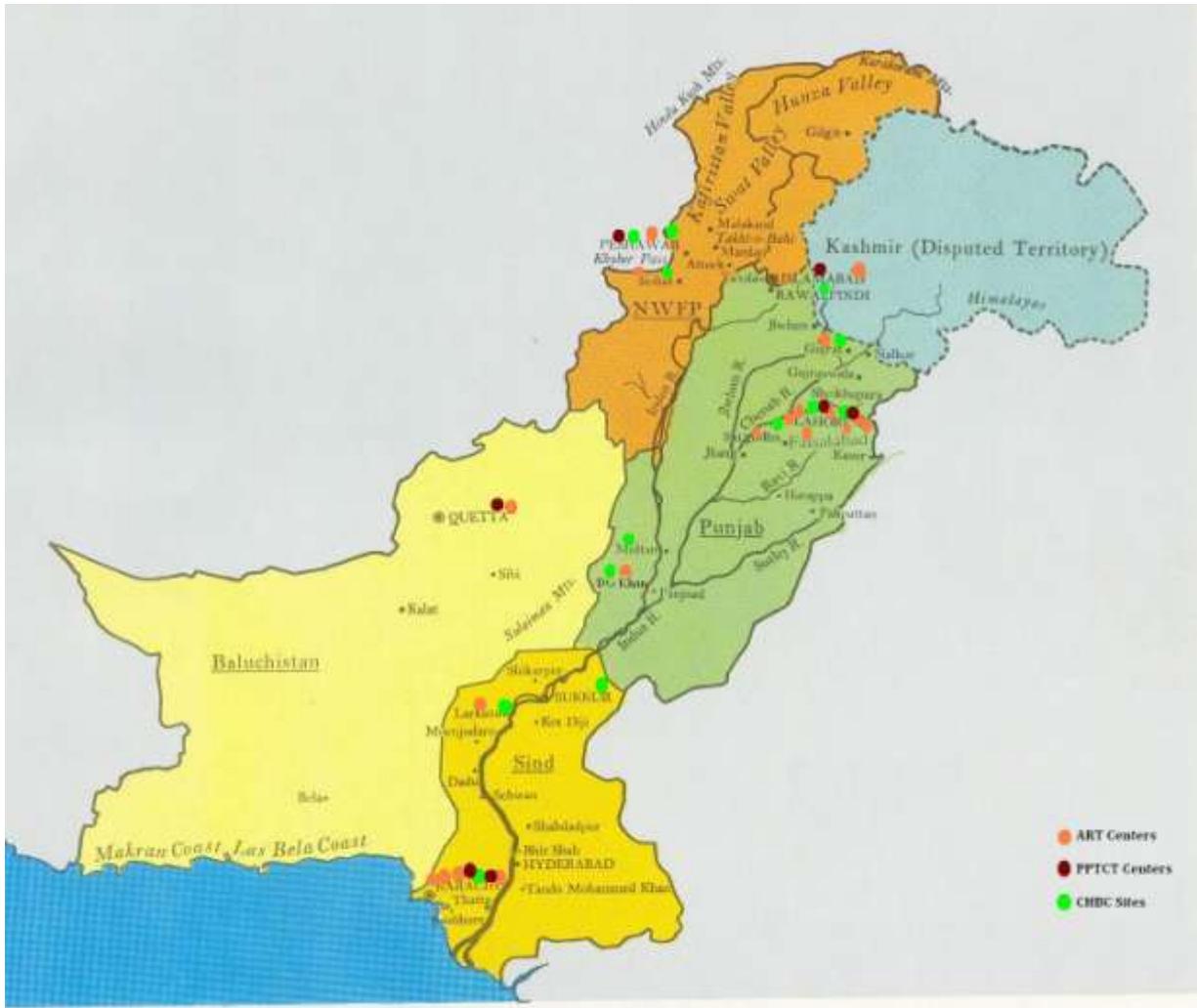
The high prevalence of HIV infection amongst PWID was found consistent with their frequent and risky injection practices: 71.5 percent report having 2-3 injections per day with 39 percent always using a new syringe in 2011<sup>xviii</sup>. Linkages with sex workers existed with around 14 percent and 7.1 percent reported paying for sex with FSWs and M/HSW respectively in the past six months, but only around 16% used a condom in their last sexual act. In Pakistan, as elsewhere, contextual and structural changes are occurring in sex work. Recent improvements in communication technology, especially the easy and wide availability of cell phones, has diminished street-based sex work as sex workers and clients can now directly interact without the need of going through a third person. While this has made female sex work diffuse and more difficult to access.<sup>xix</sup>



**Figure 3. Networking among the Key at Populations (KAPs).**

Other than the Key Affected Populations, evidence also exists of either HIV-related risk factors or infection among certain vulnerable populations, such as the spouses of at-risk persons, imprisoned populations, most at-risk adolescents and in certain occupational settings, including in some cases through nosocomial infection. While the evidence overwhelmingly calls for a focus on the Key Affected Populations, it is essential that prevention strategies and ‘low-threshold’ programs also be sustained for these larger segments of the population<sup>xx</sup>.

HIV treatment, care and support facilities are available to PLHIVs, in Pakistan, through 18 ART centres, 16 VCTC and 11 PPTCT sites. Under Global Fund Round 9 till now 13 CHBC sites has been established. Majority of the treatment, care and support facilities are confined to key cities<sup>xxi</sup>.



**Figure 4. Location of ART Centres, PPTCT & CHBC, in Pakistan.**

In Pakistan, proportion of reported to estimated PLHIVs is lowest in the region (3.0%); the ART coverage (%) is approx. 9.8 percent, Number of IDUs/PWIDs receiving ART per 100 HIV-positive IDUs/PWIDs (2009) is <1%; only 0.4% getting PMTCT coverage in 2009; while the data related to ART retention at 12 months and percentage of estimated HIV-positive incident TB cases who received treatment for TB and HIV, is not existent<sup>xxii</sup>. In addition, laws protecting PLHIVs against discrimination and preventing obstacles to access to HIV services for vulnerable subpopulations, are also not existent in Pakistan<sup>xxiii</sup>.

### **Global Fund**

Pakistan was awarded a Global Fund grant in round 9 focused on ‘Continuum of Prevention and Care’ (CoPC) for PWID, spouses and children as well as ‘Community and Home-Based Care’ (CHBC) for people living with and affected by HIV. In 2013 the grant was re-phased. Lessons learned from what worked and what did not in phase 1 were incorporated into phase 2 through the following

three adjustments: 1) increase coverage of PWIDs and PLHIVs with prevention, treatment and care services within the amount of resources available; 2) adopt more effective linkages between services for prevention, treatment and care for meeting the set targets; and 3) modify certain planned activities with little measurable impact in favour of those that respond to the needs of the population<sup>xxiv</sup>.

Two regional grants came to Pakistan under Global Fund since 2011: a R9 grant implemented by Naz Male Health Alliance (PR: UNDP) focused on HIV prevention and social justice among men who have sex with men (MSM) and transgendered persons; and a R10 grant implemented by the Association of People Living with HIV (APLHIV) (PR: APN+) aiming to document, monitor, and advocate issues related to treatment access for PLHIVs across 7 countries in Asia and the Pacific region, including Pakistan.

### **Role of NGOs and CSOs**

Since the beginning of the coordinated response to the HIV epidemic in Pakistan, service-delivery interventions have been implemented largely by NGOs and CSOs operating in a public-private partnership with Government. While GF funds NGOs directly, coordination with Government is still critical for an effective HIV response. The crucial and integral role of NGOs and CSOs is based on their comparative advantage of accessing and providing services to marginalized populations, most of the latter having have a quasi- legal status. The success of their service-delivery implementation hinges on establishing close contacts with concerned community members starting at the grass root level and extending to district, provincial and in some cases, national levels.

The number of dedicated AIDS-organizations, or those with a focus on HIV or specific populations across the country in the area of HIV prevention, treatment, care and support has increased substantially from initially a handful to currently over 50.<sup>1</sup>

### **The Association of People with HIV (APLHIV).**

The Association of people living with HIV [APLHIV] is a nationwide nonprofit network of the HIV community. Established in 2008, the APLHIV is to protect the rights of PLHIVs and associated population including PIDs/PUDs, sex workers and their families and ensure the dignity of their lives across country. Awareness, protection of the human rights of all the KAPs, provision of legal support, advocacy, lobbying, capacity building, policy dialogue, social mobilization, public private partnership, struggle for the empowerment of the community in accordance with universally acknowledged principles of greater involvement of PLHIVs (GIPA), meaningful

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<sup>1</sup> UNAIDS.

involvement of PLHIVs (MIPA), to make the members of our community productive members of the society, to give them a sense of belonging and to facilitate their access to treatment, care and support are the areas of the mandate of the APLHIV.

The APLHIV is the representative body of the community with ten (10) elected board members from across the country, with its general body of the registered members of over two thousand three hundred (2300) PLHIVs, (major bulk coming from the PID/PUD community, over 1300 PID/PUD form an integral part of our general body), a team of highly qualified professionals running the Federal secretariat and having elected provincial chapters across the country. Overwhelming majority of the board members (both federal and provincial) is from the PID/PUD community.

Since its inception in 2008 the APLHIV has battled the way to achieve its targets and attract the international bodies and the donors. Due to the performance, in the last two years, the HIV community bestows the confidence and trust in the APLHIV. Within a short span of four (4) years' time the APLHIV has successfully conducted many international, regional and national projects like a research based "Stigma Index Project" funded by IPPF, a regional research based multi country project funded by the Global Fund and a national project "to build the capacity of the community" funded by the Global Fund. In addition many small scale projects like toll free Helpline (Hello+) at national level and the institutionalization projects are in place to provide the services in accordance with the mandate of the APLHIV.

### **Significance Of The Study.**

There has been no study carried out, in Pakistan, on the access of Drug Users to their basic human, fundamental and legal rights. The study aimed to apprise with the obstacles faced by our DUs in accessing the treatment, care and support services, document the violations of fundamental human and legal rights, and to educate the DUs about their rights and responsibilities. The study will also help in organizing them to be able to raise a unified voice for their rights and organize themselves into effective networks within the fold of the APLHIV.

This being an important project which shall carry far reaching effects for any future programming for Drug Users community, in Pakistan, yet the financial resources might be a major obstacle to materialize any such effort.

### **Objectives Of The Study.**

In depth understanding of issues faced by DU's in everyday life, will enable APLHIV to advocate for improvement in treatment, care and support services, including rights related activities

provided to DUs. Such understandings will also help (NGOs, CBOs and others) in improving their work, help governments to provide better and accessible care to drug users in Pakistan.

1. The overall objective of this study is to monitor, document and advocate issues related to DU's access to treatment & other related services, and rights in Pakistan;
2. The specific objective of this study is to assess treatment & service delivery, fundamental human and legal rights-related issues, such as access to service delivery, initiation & ART adherence / OIs / HCV / TB, attitude of health care providers, discrimination, social exclusion, dignity violation and rights application etc.

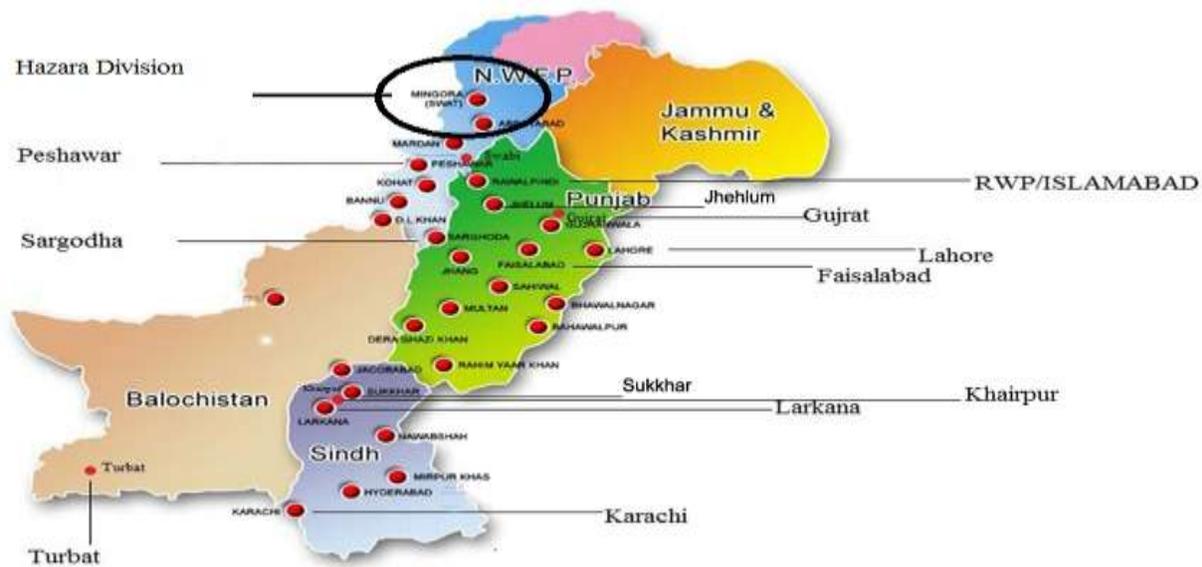
**Expected Outcome.**

1. Improved information on status of DU's access to treatment, care and support services in Pakistan;
2. Improved understanding of DUs access to fundamental human and legal rights.

**B. METHODOLOGY**

**Study Site And Sample Size.**

The study was conducted by the Association of People Living with HIV (APLHIV), in Pakistan. 545 were recruited for this study as participants / respondents, from 13 districts (Rawalpindi/ Islamabad, Lahore, Gujrat, Sagodha, Faisalabad, Jehlum, Karachi, Khairpur, Larkana, Sukkur, Peshawar, Hazara Division & Turbat) across the country. The districts and study participants within each district were worked out, on the basis of in-country epidemiological reports, including the UNGASS report and the available data on Drug Users, in Pakistan.



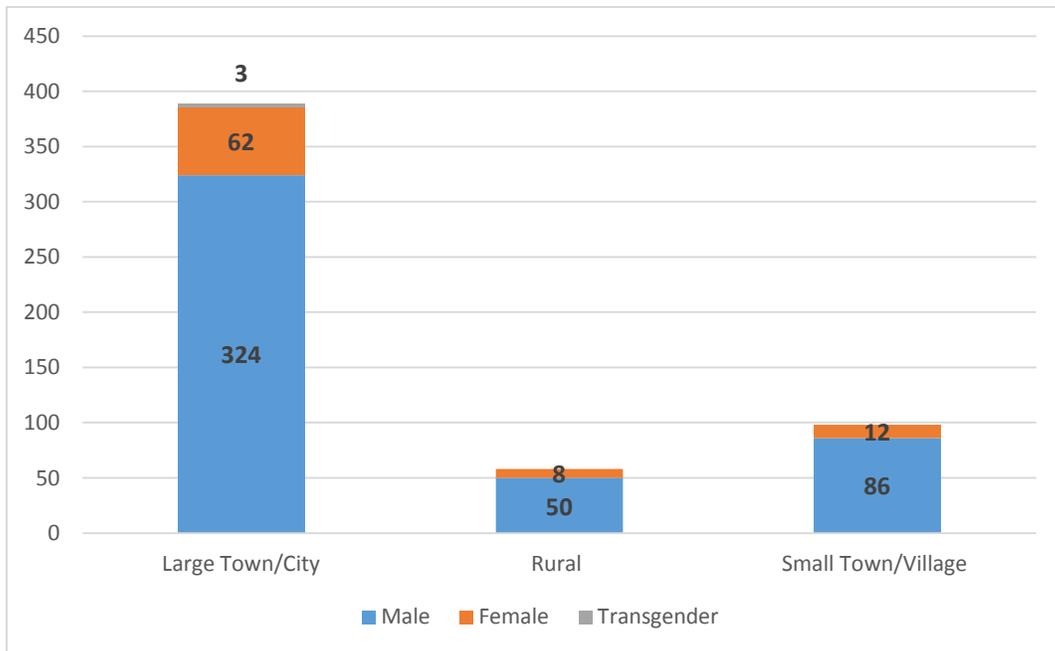
**Figure 5. Study Sites**

**Study Design.**

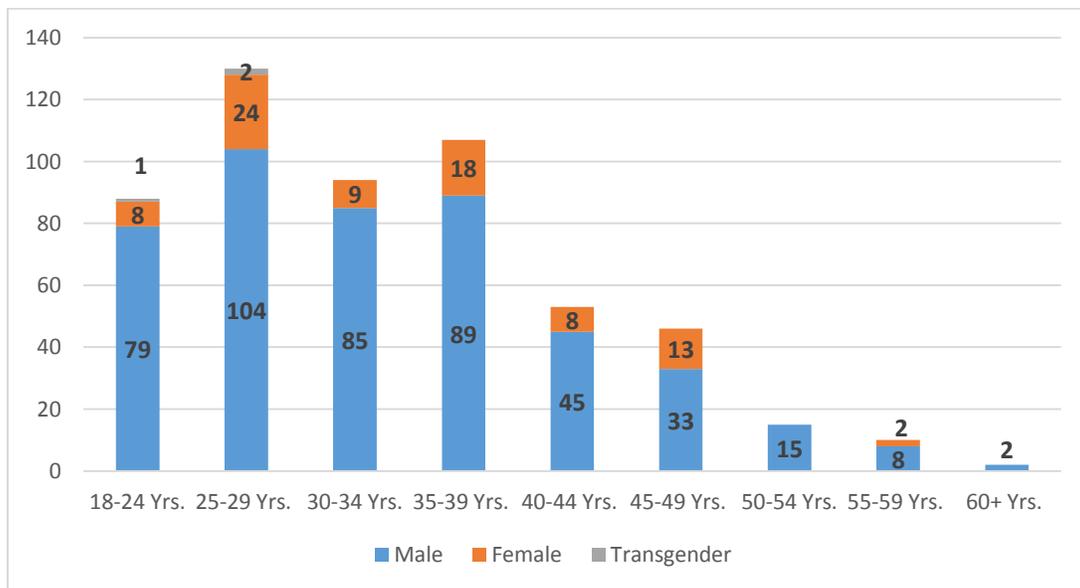
This has been a cross-sectional descriptive study using structure questionnaire to explore the accessibility among Drug Users to treatment related services delivery and Rights.

**Study Population And Study Period.**

The study population was men, women and TG who self-report injected / inhaled/ ingested drug due to non-therapeutic purposes for the past six months, prior to the date of interview.



**Figure 6. Number of study participants by Gender and Living Area (N=545).**



**Figure 7. Study Respondents by Age Categories and Sex (N=545).**

### **Inclusion Criteria For The Study.**

The criteria included:

1. Men and women who self-reported; injected / inhaled/ ingested drug due to non-therapeutic purposes for the past six months. prior to the date of interview;
2. Age between 18 to 60 years;
3. Giving written informed consent to participate in the study voluntarily.

### **Sample Size And Sampling Technique.**

Drug users in Pakistan frequently suffers from discrimination and marginalization, and their behaviors – drug use or sex work – are often illegal<sup>xxv</sup> making it even harder to enroll them randomly in a study. The total sample size of 545 was decided in consultation with national stakeholders. A snow-ball sampling technique<sup>xxvi</sup> was used to enroll possible study participants. Gender specified seeds (initial respondents) were selected from different NGOs/CSOs; decided in consultation between APLHIV and the key stakeholders.

### **Study Tools And Techniques.**

A structured questionnaire was developed that was used for the face-to-face interview (Please see the Appendix for the details). The questionnaire was translated into the local languages (Urdu) and was translated back to English to ensure its consistency and quality. The questionnaire was also pre-tested, among 10-15 participants, and modified accordingly. The questionnaire comprised of 3 main sections, with approximately 148 mostly closed ended questions.

### **Sample Size And Sampling Technique.**

Depending on the size of respondents (545), number of sites & geographical distribution, 12 data collectors were recruited for varying period, ranging from a week to ten days. The National Coordinator and the Finance officer closely supervised the data collection, whereas the project officer entered the data into web portal after three (3) step checking. The data was collected between 22 December 2013 to 10 April, 2014.

The National Coordinator trained field data collectors and supervisors, at a 3-day national training, held from 7 – 10 December, 2013, on overall study implementation, including study objectives, study procedure, rapport building, informed consent process, interview techniques, data-coding and reporting. After the training each data collector was required to fill five dummy interviews before initiating actual data collection in the field, to provide them with on the hand training.

The field implementation guideline for the use of data collectors and supervisors were developed and translated into local languages (Urdu).

While in the field, the data collectors first informed all the potential participants individually about the study procedures using an information sheet. All the participants then signed the informed consent form thus agreeing to participate in the study. The data collectors then conducted the face-to-face interview in a private/confidential and independent settings. Majority of interviews were held at places, thus ensuring independence and confidentiality. The fieldwork was supervised by the National Coordinator and Finance Officer, yet no field supervisors were recruited for the study. In addition both the APLHIV and data collector maintained close contact, with the respective Provincial Offices of APLHIV in the provinces. Both the data collectors and supervisors faced issues due to unstable political and law & order situation, in the country. A local courier was hired for transportation of filled questionnaires to the APLHIV office, at Islamabad.

### **Recruitment Of The Study Participants & Data Collectors.**

Association of People living with HIV (APLHIV) through its member NGOs/CBOs, working with Drug Users, employed snowball sampling method / multi-cluster targets setting. In addition a network analysis was conducted by the data collectors. The data collectors submitted their network plan to APLHIV. PLHIVs already registered or in contact of the NGOs/CBOs, were initially recruited and interviewed and then requested to introduce another participant who meets the inclusion criteria of the study. Again the same participant was requested to introduce another participant; the same process was repeated until the desired sample in each study site, was recruited. Among the respondents, 39.81 percent enrolled in the study, were already registered or in contact with NGOs/CBOs, while 60.18 percent were never registered anywhere. After interview, PKR. 700.00 were given to each of the participants as transportation cost.

12 Data collectors were selected either through NGOs/CBOs, or direct contacts of APLHIV, with adequate representation from the Drug Users (DUs), including two female. Each data collector was paid PKR. 600.00 per interview, once consistent with the data collection requirement, laid down in the study design. Each of the data collector was assigned specific site/sector; with two data collector assigned more than one site.

### **Study Tools And Techniques.**

A structured questionnaire was developed that was used for the face-to-face interview (Please see the Appendix for the details). The questionnaire was translated into the local languages (Urdu) and was translated back to English to ensure its consistency and quality. The

questionnaire was also pre-tested, among 10-15 participants, and modified accordingly. The questionnaire comprised of two main sections (Access to Treatment, & Access to Rights); each sub-divided into sub-sections (as indicated below).

### **Study Questionnaire Variables.**

<b>Predisposing Factors.</b>	
Age, Gender, Marital status, education level, occupation, risk group type (KAP), Income, living area,	
<b>Access to Treatment.</b>	<b>Access to Rights</b>
<ol style="list-style-type: none"> <li>1. Characteristics of Drug Use;</li> <li>2. Sexual Interactions;</li> <li>3. Access to Service Delivery;</li> <li>4. Initiation of ART and Adherence;</li> <li>5. Attitude of Health Care Providers (Doctor, Nurse, other support staff)</li> <li>6. Access to Opportunistic Infections Treatment</li> <li>7. Access to HCV-related Services</li> <li>8. Access to TB Services</li> <li>9. Access to Needle Syringe Programs</li> <li>10. Access to Drug-Dependence Treatment Related Services / Access to Detoxification Services.</li> </ol>	<ol style="list-style-type: none"> <li>1. Knowledge about Rights;</li> <li>2. Discrimination in health care setting.</li> <li>3. HIV/AIDS counseling, testing and treatment coverage and experience.</li> <li>4. Lack of health information.</li> <li>5. Inadequate living conditions.</li> <li>6. Arbitrary arrests;</li> <li>7. Torture and other degrading treatment.</li> <li>8. Social exclusion.</li> <li>9. Dignity violation.</li> <li>10. Application of Legal Rights.</li> </ol>

**Table 1. Study Variables**

### **Data Collection.**

Depending on the size of respondents (545), number of sites & geographical distribution, 12 data collectors were recruited for varying period, ranging from a week to ten days. Both the National Coordinator and the Finance Officer actively supervised the data collection process. The data was collected from 22nd December 2013 to 10th April 2014. List of data collectors and number of interviews conducted is attached as Annexure II.

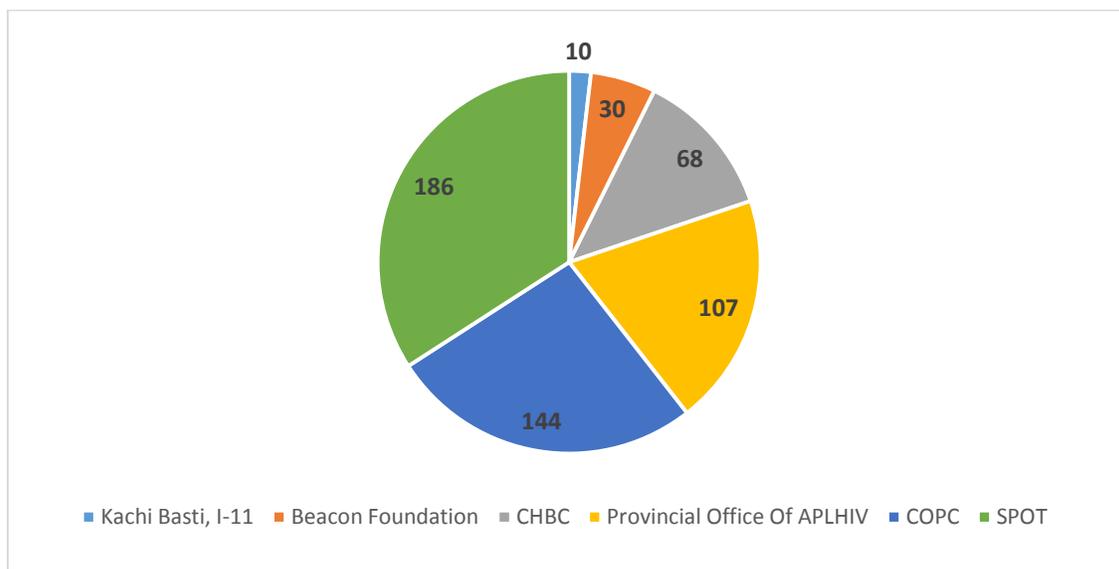
A 3-day national training, held from 7th to 10th December 2013, on overall study implementation, including study objectives, study procedure, rapport building, informed consent process, interview techniques, data-coding and reporting. After the training each data collector was required to fill five dummy interviews before initiating actual data collection in the field, to provide them with on the hand training.

The field implementation guideline for the use of data collectors and supervisors were developed and translated into local languages (Urdu).

While in the field, the data collectors first informed all the potential participants individually about the study procedures using an information sheet. All the participants then signed the

informed consent form thus agreeing to participate in the study. The data collectors then conducted the face-to-face interview in a private/confidential and independent settings. Majority of interviews were held at pre-designated places and on spots (where drug users use drugs), thus ensuring independence and confidentiality. The fieldwork was supervised by National Coordinator and Finance Officer, yet no field supervisors were recruited for the study. In addition both the APLHIV and data collector maintained close contact, with the respective Provincial Offices of APLHIV, in the provinces. Both the data collectors faced issues due to unstable political and law & order situation, in the country. A local courier was hired for transportation of filled questionnaires to the APLHIV office, at Islamabad.

Data on access to service delivery, initiation & ART adherence, attitude of health care providers, discrimination, social exclusion, dignity violation and rights application etc. was collected.



**Figure 8. Place for the Interviews (N=545).**

### **Data Management.**

Once the filled questionnaires were received at the APLHIV office. Each of the questionnaire was thoroughly reviewed for any missing data, first by the Finance Officer, followed by the national coordinator before entry and by Project Officer while entering the Data into online PHP MySQL. All questionnaire with missing data were referred back to the respective data collectors, with necessary instructions. The project officer entered the data in web-based server on daily basis. Data quality was ensured at three levels; first at the time of initial review by the Finance Officer, followed by second review by the national coordinator and at the time of data entry, by the project officer. The National Coordinators and Finance Officer, randomly crosschecked 10% of

questionnaires entered in the software. All questionnaire submitted were accepted by APLHIV, and no questionnaire was referred/rejected, due to data consistency issues.

All the information collected during the study will remain confidential. Data has been stored securely in at the office of Association of People living with HIV. The data was made available only to the authorized persons. A code number has been used to each of the questionnaire.

### **Data Quality Checks.**

APLHIV was primarily responsible for the data quality checks. The field work was thoroughly monitored by the staff of APLHIV. The filled questionnaire were thoroughly reviewed for any missing or data inconsistencies. Feedback was provided to the data collectors to address issues of missing values and any other inconsistencies. The filled questionnaire were entered into the web-based server by Project Officer and also reviewed by the National Coordinator and Finance Officer.

### **Data Analysis.**

Using SPSS 19.0, data was analyzed. Descriptive analysis was used to summarize the socioeconomic, health, and other variables. Prevalence estimate for several variables were computed for the total sample and also separately by sex. Data were summarized using frequencies, proportions, mean, standard deviations and medians.

For certain variables, data was analyzed based on the dichotomous (Yes/No) responses. For variables with responses were regrouped, into other categories, and responses were analyzed. Using Likert type scale, the relationship between some variables was measured through recoding scores: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly agree and total score used to calculate mean and SD.

### **Ethical Consideration.**

The study proposal was reviewed and approval by National AIDS Control Program, Islamabad, Pakistan.

The participants/respondents were adequately informed about the study objectives and the procedures before the initiation of the interview. Those willing to give written informed consent (thumb prints were obtained from those who wasn't able to sign) voluntarily, were recruited in the study. They were assured for their anonymity and confidentiality and were also allowed to skip questions and withdraw/ stop interview at any time, during the course of the interview. A code of conduct to ensure confidentiality during the interview and storage, analysis of was developed and used, during the course of the study.

## C. FINDINGS OF THE STUDY.

### I. Characteristics Of The Study Participants.

Majority of the respondents (60.18%; n=328) were recruited at various spots, followed by civil society organizations, working with Drug User (mostly Injecting Drug Users). Most of the respondents came from an environment of lower socio-economic status.

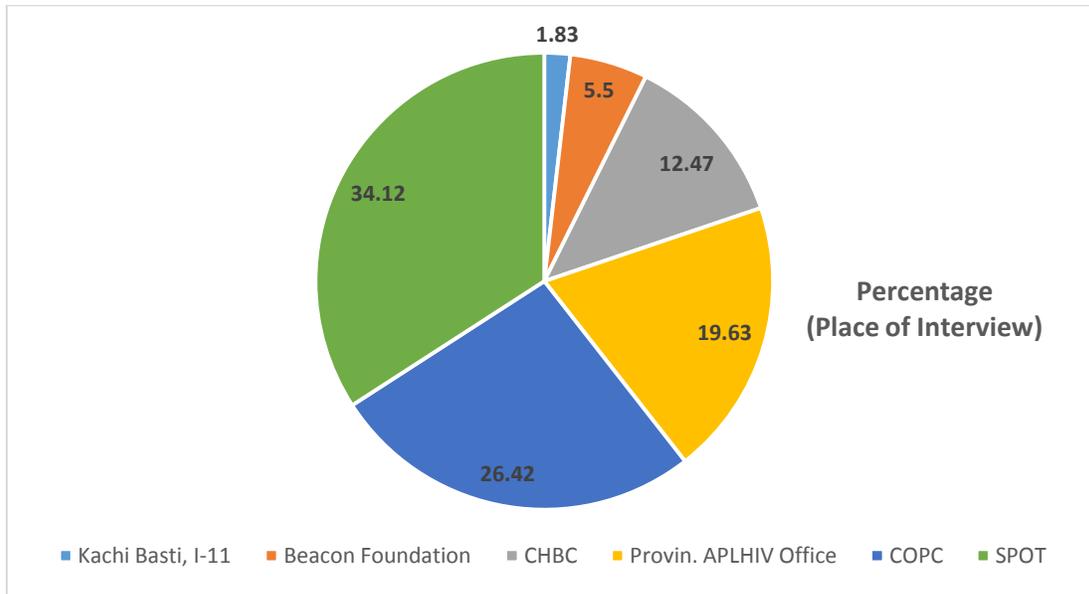
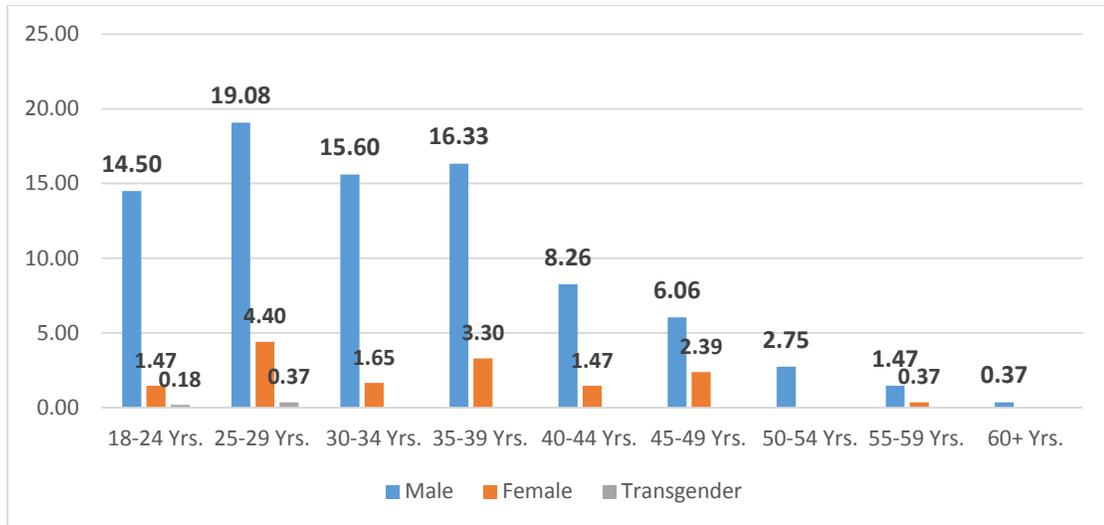


Figure 9. Place for the Interviews (N=545).

#### 1. Percentage Of Sex And Age Of Respondents.

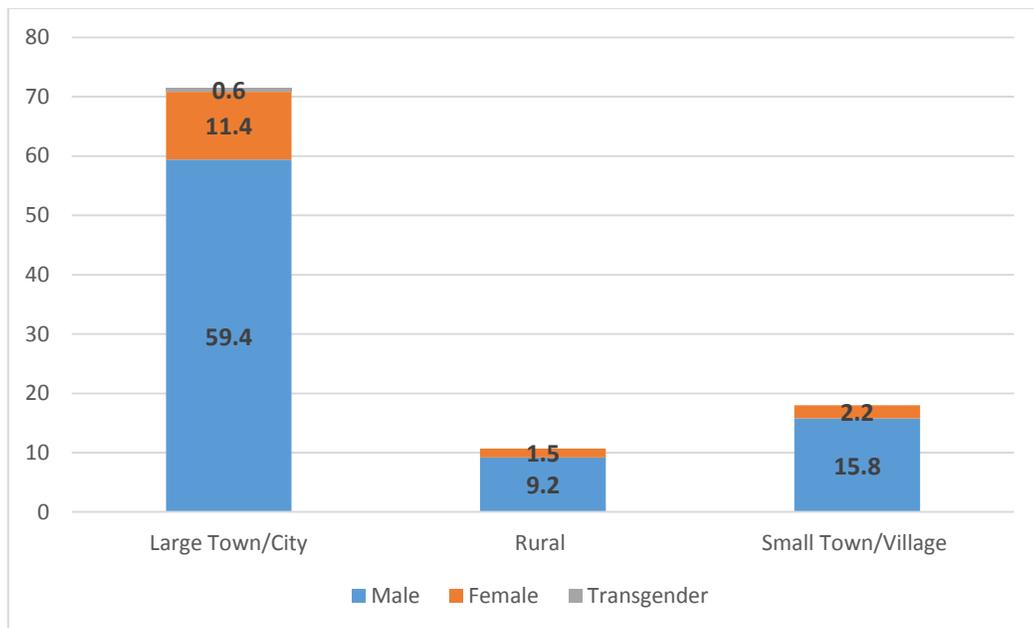
Majority of the respondents were males (84.4%; n=460). Approximately 76.88 (n=419) fall under the age bracket of 40 years.



**Figure 10. Study Respondents by Age Categories and Sex (N=545).**

## **2. Respondents Were Mostly From Urban Setting.**

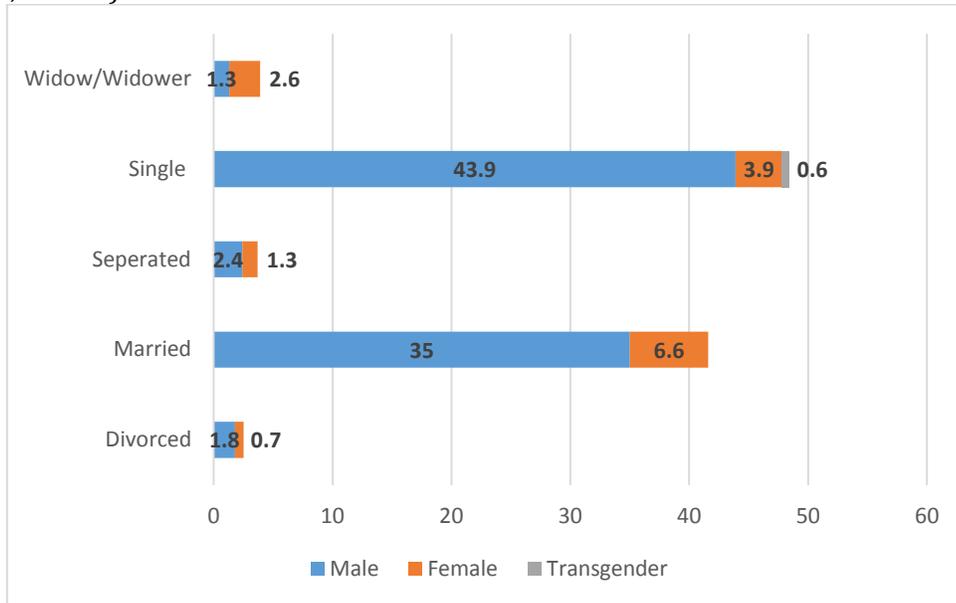
Majority of the respondents (71.37 percent; N=389) were reported to be from urban setting, only fewer numbers (10.64 percent; N=58) reported from the rural setting.



**Figure 11. Percentage of Study Respondents by Age Categories and Sex (N=545).**

### **3. Most Respondents Were Reported 'Single'.**

Majority of the respondents were reported 'Single' (48.3 percent; N=263) followed by the married (41.7 percent; N=227).



**Figure 12. Percentage of Study Respondents by Sex & Marital Status (N=545).**

### **4. Majority Of Respondents Had Some Formal Education.**

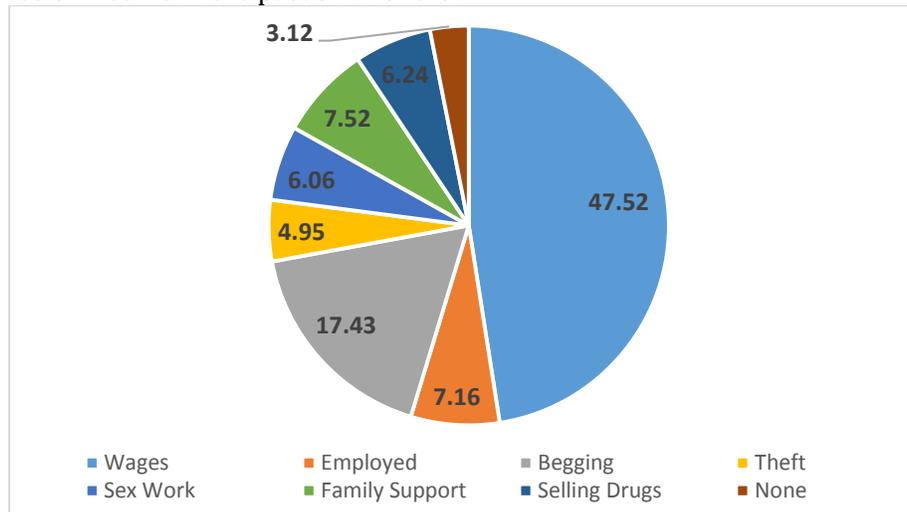
Majority of the study respondents has attained some degree of formal education (55.0 percentage; N=300). Among those reported 'illiterate' the male were reported 36.3 percent (N=198).



**Figure 13. Percentage of Study Respondents by Sex and Educational Status (N=545)**

## 5. Major Financial Support Was Through ‘Wages’.

47.52 percent (N=259) had reported ‘wages’ as their mean for the financial support in the last six months, while fewer (7.52 percent; N=41) got support from their family. Some 17.43 percent (N=95) rely on begging to get their financial support. Some of the study responded indicated more than one source of income in the past six months.



**Figure 14. Percentage of Study Respondents by Financial Support in last 6 months (N=545)**

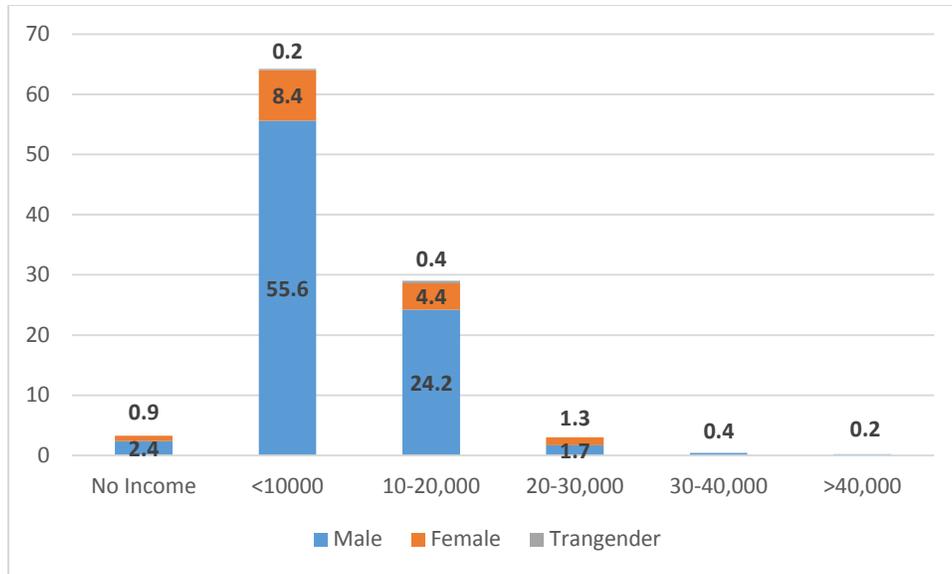
## 6. Average Monthly Income Of Respondents Was PKR. 8254.00.0

The mean monthly income of the study respondents came to PKR. 8253.39 (SD 4879.978; Min.=00.00; Max.=50,000.00; N=545). Majority of the study respondents were reported earning <PKR. 10,000.00 (64.2 percent; N=350).

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
What is your Average monthly income? (Rupees)	545	0	50000	8253.39	4879.978
Valid N (listwise)	545				

**Table 2. Average Monthly Income of the Respondents**

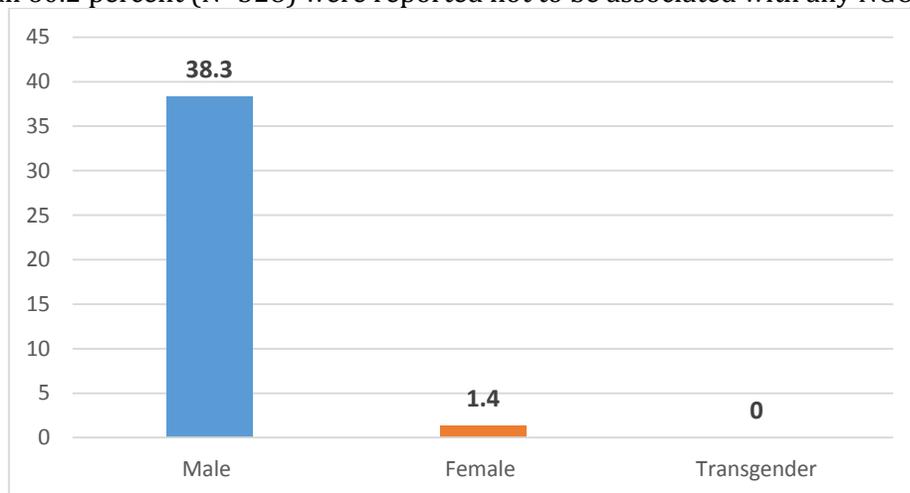
Majority of the study respondents (93.2 percent; N=508) were reported earning upto PKR. 20,000.00, very few (3.3 percent; N=18) indicated no income at all.



**Figure 15. Percentage of Study Respondents by Income Categories (N=545)**

**7. Majority Of The Respondents Were Member Of Some NGO/Network.**

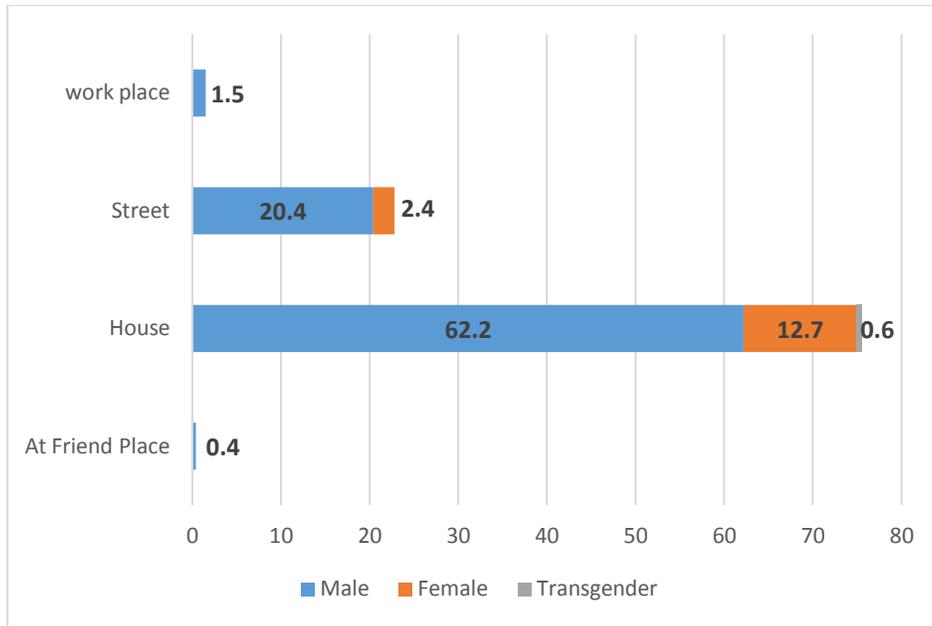
Some 38.3 percent of male respondents (N=209) were reported associated with some NGO/Network, while just 1.4 percent (N=8) of female respondents found working in NGO/Network settings. Overall 60.2 percent (N=328) were reported not to be associated with any NGO/Network.



**Figure 16. Percentage of Study Respondents by Sex and Association with NGO/Network (N=545)**

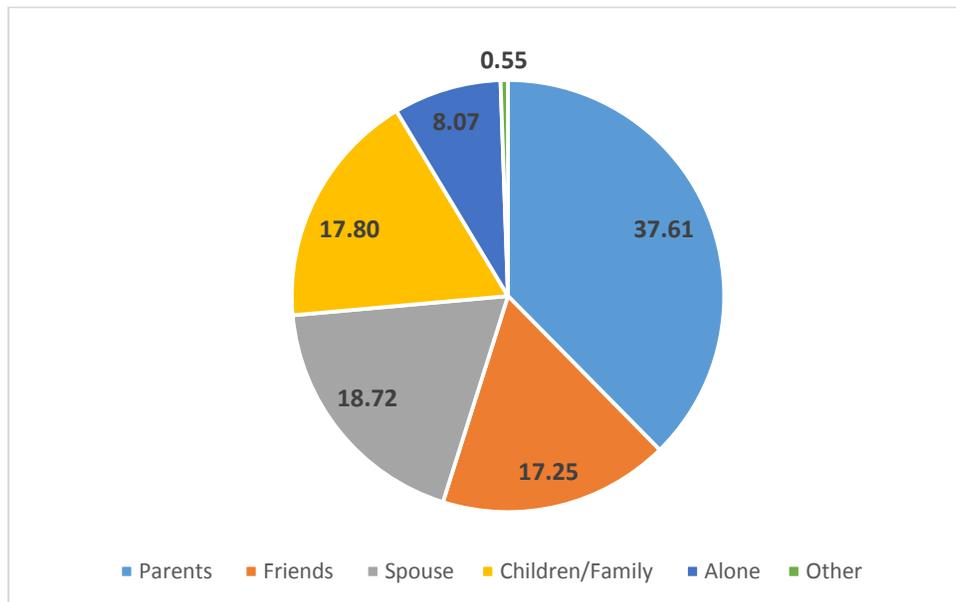
**8. Majority Of Respondents Lived At Their 'Home' With Their 'Parents'.**

Overwhelming of the study respondents (75.4 percent; N=411) were reported living at their home, followed by those living at street (22.8 percent; N=124).



**Figure 17. Percentage of Study Respondents by Sex and Place of living in past six months (N=545)**

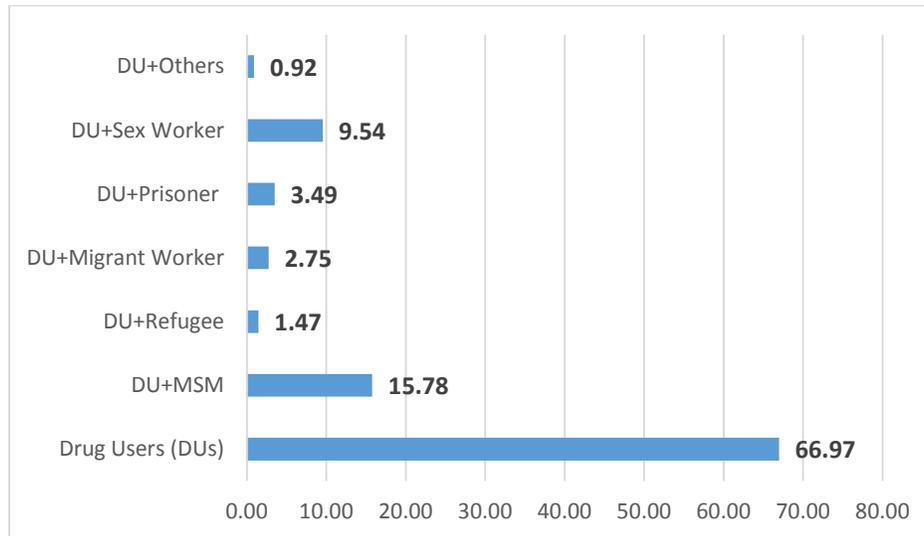
On further analysis, it was found that majority lived with parents (37.61 percent; N=205), followed by spouse (18.2 percent; N=102), Children/Family (17.80 percent, N=97) and Friends (17.25 percent, N=94) while 8.07 percent (N=44) remained alone in the past six months.



**Figure 18. Percentage of Study Respondents by 'Whom they lived with' in past six months (N=545).**

## 9. A Significant Proportion Self-Reported That They Were Currently Using Drugs.

Majority of the study respondents (66.97 percent; N= 365) reported themselves as Drug Users (Including Injecting Drug Users / PWIDs), while few identified themselves as MSM (15.78 percent; N=86), Sex Workers (9.54 percent; N=52), Prisoner (3.49 percent; N=19)etc., in addition to their DU status.



**Figure 19. Percentage of Self-categorization by the Study Respondents (N=525).** Multiple responses were allowed.

## II. ACCESS TO TREATMENT

### 1. Characteristics Of Drug Use.

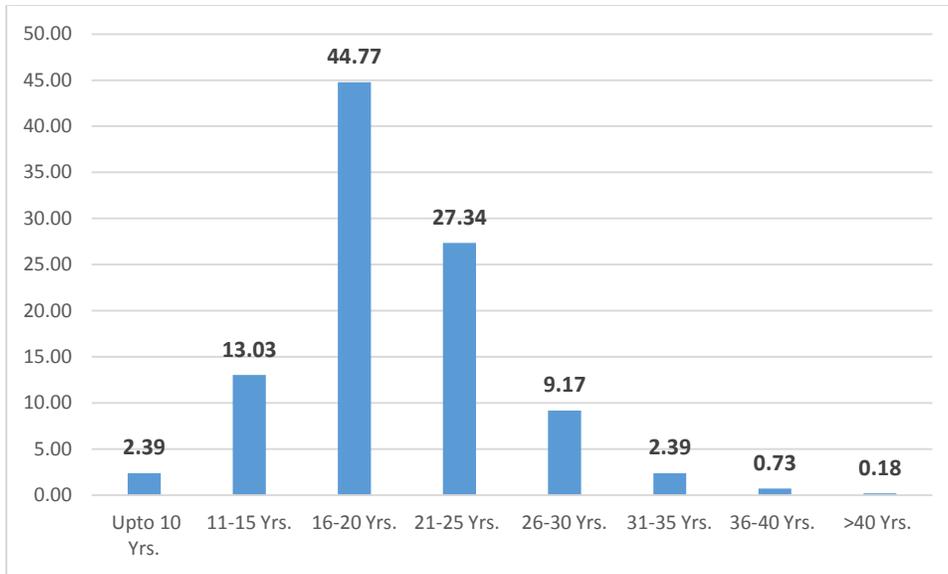
The mean age for initiation of drug use came out to 20.36 years (Minimum 7 years; Maximum 41 years; SD 5.223).

**Descriptive Statistics**

	N	Range	Minimum	Maximum	Mean	Std. Deviation
years	545	34	7	41	20.36	5.223
Valid N (listwise)	545					

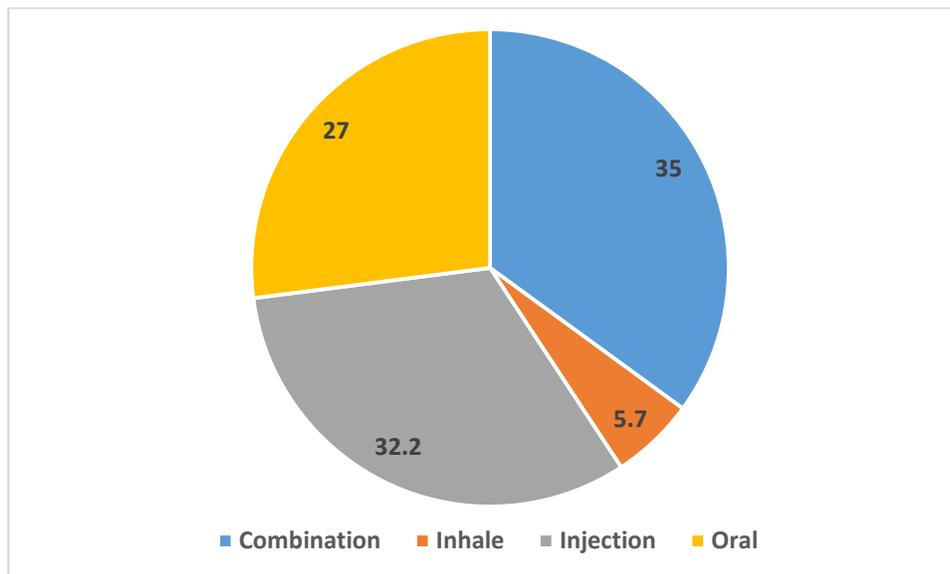
**Table 3. Mean age for Initiation of Drug Use.**

Majority of drug users (44.7 percent; N=244) started taking drugs at the age group of 16 – 20 years. Overall 85.14 (N=464) percent of drug user, started taking drugs in the age bracket of 11 to 25 years of drug use.



**Figure 20. Proportion of Start of Drug Use by Age Categories (N=545)**

Majority of the study participants use drugs twice a day (40 percent; N=218), followed by thrice a day (38.5 percent; N=210) and one daily (9.2 percent; N=50). 35 percent (N=191) administer drugs in combination (35 percent; N=191), while the injection drug use was reported in 32.2 percent (N=176) and followed by 27 percent (N=147) taking drugs orally.



**Figure 21. Proportion of Drug Use by Mode of Intake (N=545).**

Poly-drug was observed among the study participants, with 30.5 percent (N=166) using Smoking, Charas, Hashish, Herion, Opium; followed by some study participants, using Herion and Avil through Injection, Smoking, Opium, Hashish, Charas (21.3 percent; N=116). Among single drug use 11.2 percent (N=61) were reporting using Herion.

Majority of the study respondents (51.2; N=279) reported getting drugs through some supplier. Not much of a difference was observed among those taking drugs in group (54.7 percent; N=298) to those taking alone (44.4 percent; N=242). Of those injecting drugs some 25.7 percent; N=140) reported sharing of syringes with others, which is quite consistent with the HIV prevalence among the injecting drug users in Pakistanxxvii.

**Do you ever share syringe with others?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	405	74.3	74.3	74.3
	Yes	140	25.7	25.7	100.0
	Total	545	100.0	100.0	

**Table 4. Syringe Sharing with Others.**

## 2. Sexual Interactions.

65.3 percent (N=356) of the study respondents, reported engaged in sex during the past six months.

**Did you have sex in last six (6) months?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	189	34.7	34.7	34.7
	Yes	356	65.3	65.3	100.0
	Total	545	100.0	100.0	

**Table 5. Sex Interaction in last 6 months.**

The frequency of sexual interactions remained quite low as just 14.2 percent (N=77) had it twice and 7.7 percent (N=77) once in past one month. 29.2 percent (N=159) were engaged in husband/wife relationship, followed by sexual interaction with sex worker (10.9 percent; N=59) and their friends (7.0 percent; N=38). Some 26.0 percent (N=142) were reported in paid sex (buying/selling).

**Do you buy or sell sex?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	189	34.7	34.7	34.7
Buy	78	14.3	14.3	49.0
No	214	39.3	39.3	88.3
Sell	64	11.7	11.7	100.0
Total	545	100.0	100.0	

**Table 6. Buy/Sell Sex.**

Condoms use was reported in 39.3 percent (N=214) of the study respondents. 41.7 percent (N=227) purchased condoms from some shops/pharmacy, followed 24.2 percent (N=132), getting from some NGO/CBO.

**How often condom was used during the sexual interaction?**

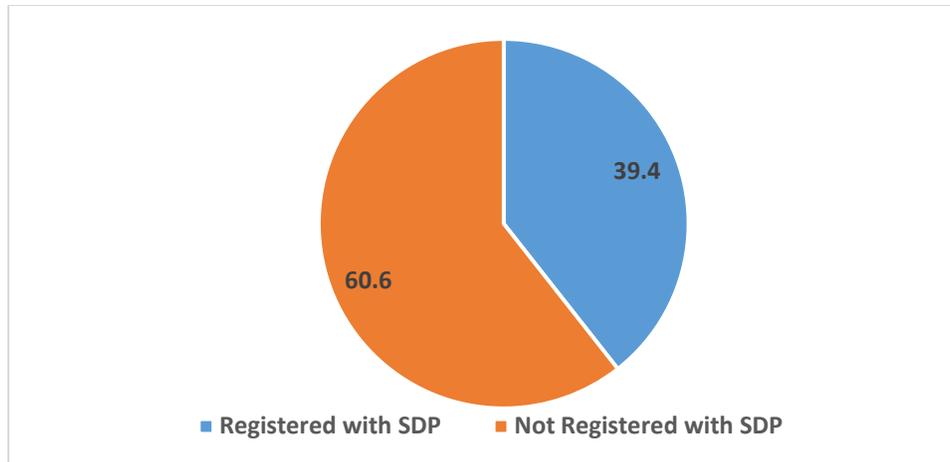
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	189	34.7	34.7	34.7
Always	45	8.3	8.3	42.9
Never	142	26.1	26.1	69.0
Often	25	4.6	4.6	73.6
Rarely	128	23.5	23.5	97.1
Sometimes	16	2.9	2.9	100.0
Total	545	100.0	100.0	

**Table 7. Condom Usage**

STIs were reported in 15.4 percent (N=84) of the study respondents; 14.3 percent (N=78) of the total responds got treatment for it. 5.3 percent (N=29) got treatment from some hospital, and 10.6 percent (N=58) completed their treatment. The data for issues / problems associated with treatment remained insignificant.

### **3. Access to Service Delivery.**

39.4 percent (N=215) of the study respondents were found reported at any service delivery project for HIV treatment.



**Figure 22. Access to Service Delivery (Registered with Service Delivery Projects) (N=545).**

Majority of services delivery at the service delivery included Syringe Supply, Detox Services, Wound Management, Condoms Supply and PHC etc.

More than half of the study respondents (54.7 percent; N=298) got tested with HIV; 23.3 percent (N=127) got them tested for HIV twice. 52.8 percent (N=288) reported aware of result of the HIV test.

**Have you been tested for HIV?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid No	247	45.3	45.3	45.3
Yes	298	54.7	54.7	100.0
Total	545	100.0	100.0	

**Table 8. Tested for HIV.**

HIV prevalence was reported 19.8 percent (N=108) among the study respondents.

**What was the result of HIV test?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Dont Know	12	2.2	2.2	2.2
Negative	178	32.7	32.7	34.9
Not tested for HIV	39	7.2	7.2	42.0
Not Tested For HIV	208	38.2	38.2	80.2
Positive	108	19.8	19.8	100.0
Total	545	100.0	100.0	

**Table 9. HIV Test Result.**

CD4 Count Test was conducted among 14.3 percent (N=78) of the study respondents, 10.6 percent (N=58) got it once.

**Did you get your CD-4 count tested?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	467	85.7	85.7	85.7
	Yes	78	14.3	14.3	100.0
Total		545	100.0	100.0	

**Table 10. CD4 Test.**

14.9 percent (N=81) conformed about the existence of detox (Drug treatment services), at the service delivery points.

**Are you being provided with detoxification services at the service delivery point?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	464	85.1	85.1	85.1
	Yes	81	14.9	14.9	100.0
Total		545	100.0	100.0	

**Table 11. Availability of Detoxification Services.**

#### **4. Initiation Of ART And Adherence.**

Very few study respondents 4.2 percent (N=23) were reported on ART, at the moment, among the study respondents.

**Are you currently on ART?**

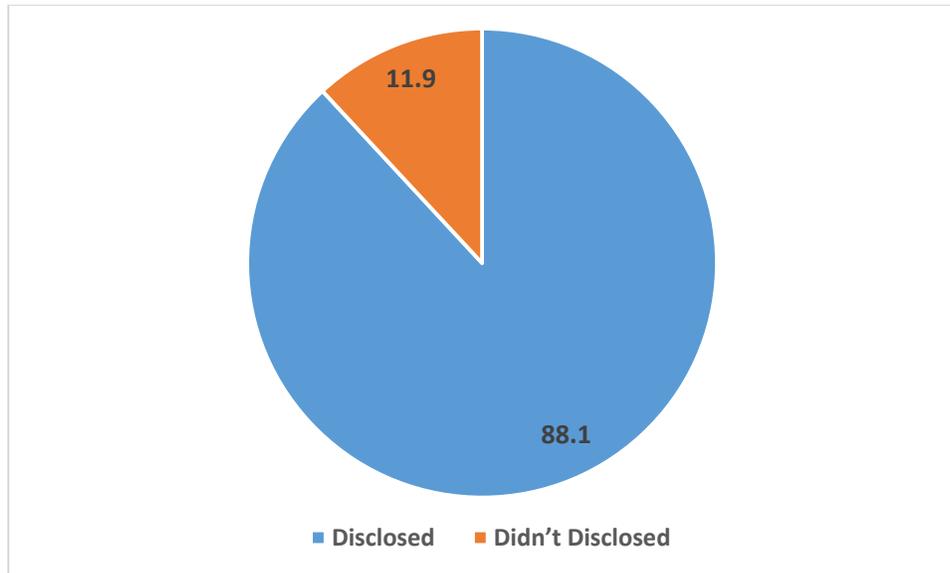
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	522	95.8	95.8	95.8
	Yes	23	4.2	4.2	100.0
Total		545	100.0	100.0	

**Table 12. Currently taking ART.**

Those on ART all were reported getting ARVs from the Government Hospitals. Only three study respondents disclosed issues related to getting access to ART, including fear of interaction, attitude of health care providers, travel cost etc. Of those taking ARVs 3.9 percent (N=21) reported taking ARVs regularly. Among those who weren't able to take ARVs regularly; active drug use, forgot to take ARVs were reported as the reasons.

**5. Attitude Of Health Care Providers (Doctor, Nurse, Other Support Staff).**

Majority of the study respondents (88.1 percent; N=480) reported disclosing their status to their treating physician and 44.4 percent (N=242) disclosed attitude of Health Care Provider as friendly.

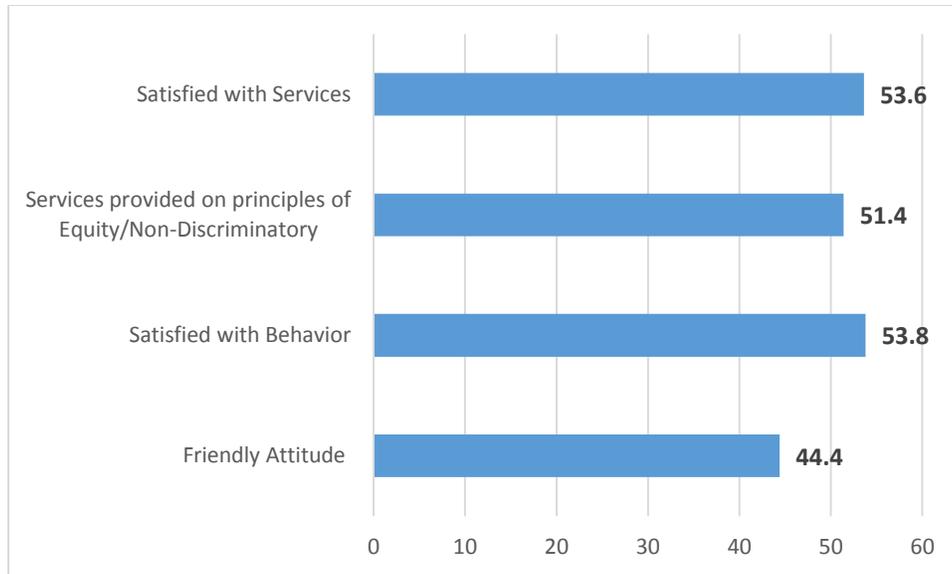


**Figure 23. Proportion of Study Respondents Disclosing their Status to HCPs (N=545)**

		If yes above, what is the attitude of HCP?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Discriminatory	118	21.7	21.7	21.7
	Friendly	242	44.4	44.4	66.1
	Negative/Unfriendly	92	16.9	16.9	82.9
	Neutral	93	17.1	17.1	100.0
	Total	545	100.0	100.0	

**Table 13. Attitude of Health Care Providers.**

53.8 percent (N=293) felt satisfied with the behavior of the health care providers; expressed services being provided following the principles of equity and in a non-discriminatory manner (51.4 percent; N=280); another 53.6 percent (N=292) described services provided by the health care provider (HCP) as satisfactory.



**Figure 24. Relationship with Health Care Provider (N=545).**

Mean waiting time to access to the Health Care Provider indicated as 64.17 minutes (Min. 0 Min.; Max. 300 Min.; SD 52.60). Study respondents described cost of treatment (19.2 percent; N=105) attitude of Health Care Provider (10.3 percent; N=56) and discrimination (9.5 percent; N=52), as three major hindering factors for access to treatment.

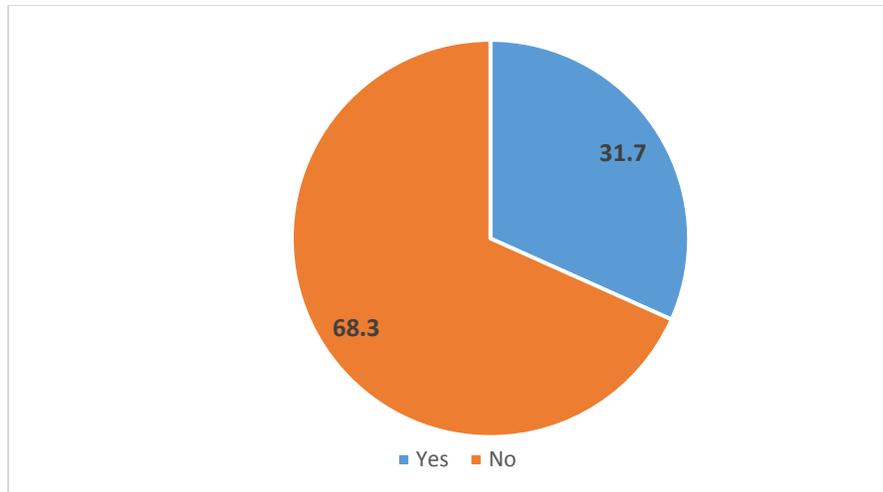
**Descriptive Statistics**

	N	Range	Minimum	Maximum	Mean	Std. Deviation
How much you will have to wait for getting services?	545	300	0	300	64.17	52.602
Valid N (listwise)	545					

**Table 14. Average waiting time.**

## **6. Access To Opportunistic Infections (OIS) Treatment.**

31.7 percent (N=173) indicated their awareness about the Opportunistic Infections (OIs).

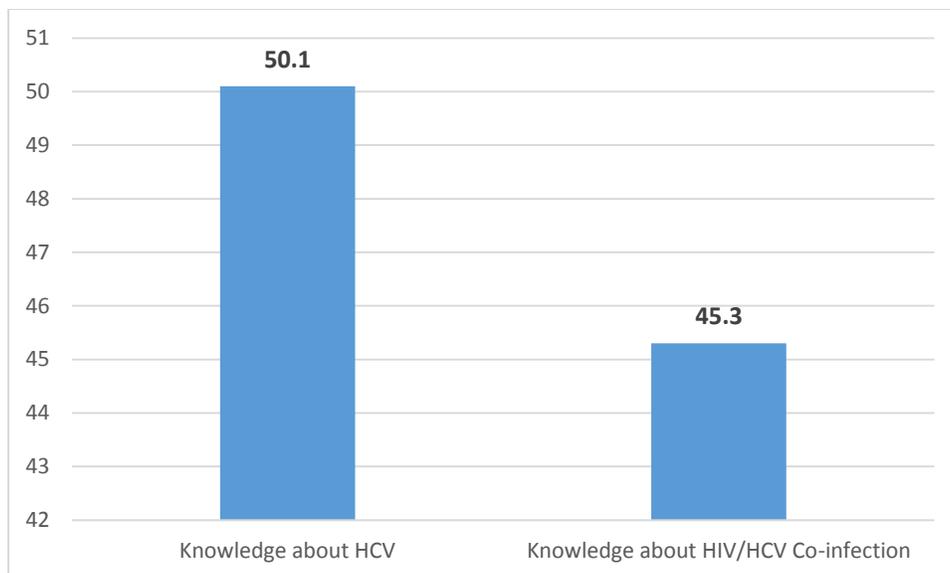


**Figure 25. Proportion of Study Respondents knowledgeable about Opportunistic Infections (N=545).**

Majority of the study respondents (11 percent; N=60) heard about OIs through NGOs. Some 24.4 percent confirmed access to OIs Treatment. Major causes for issues / problems faced in getting access to OIs treatment, were recorded as high cost of treatment and lack of availability of services.

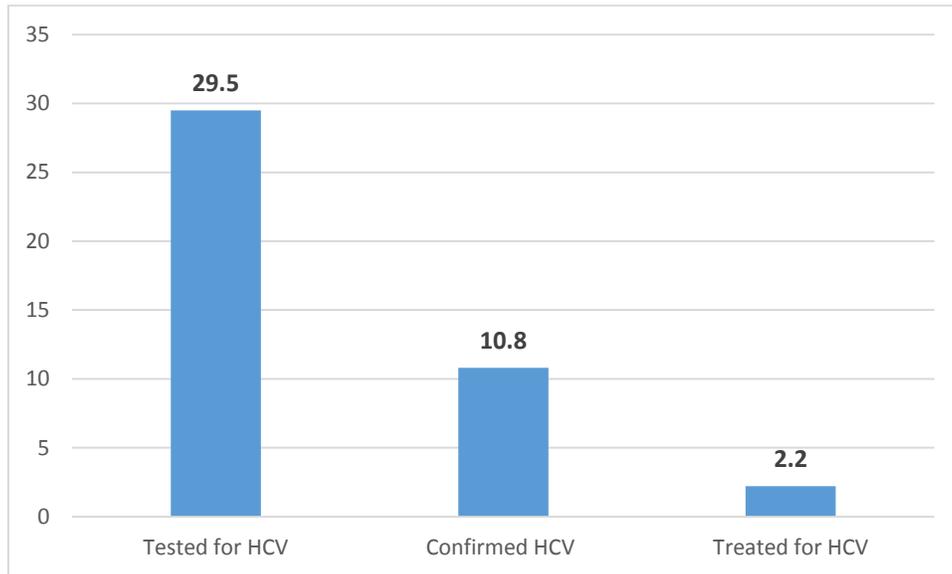
**7. Access To HCV-Related Services.**

Slightly more than half of the study participants (50.1 percent; N=273) were found aware about the Hepatitis C Viral infection, slightly less than were about HIV/HCV Co-infection (45.3 percent; N=247).



**Figure 26. Proportion of Study Respondents knowledgeable about HCV & HIV/HCV Co-infection (N=545).**

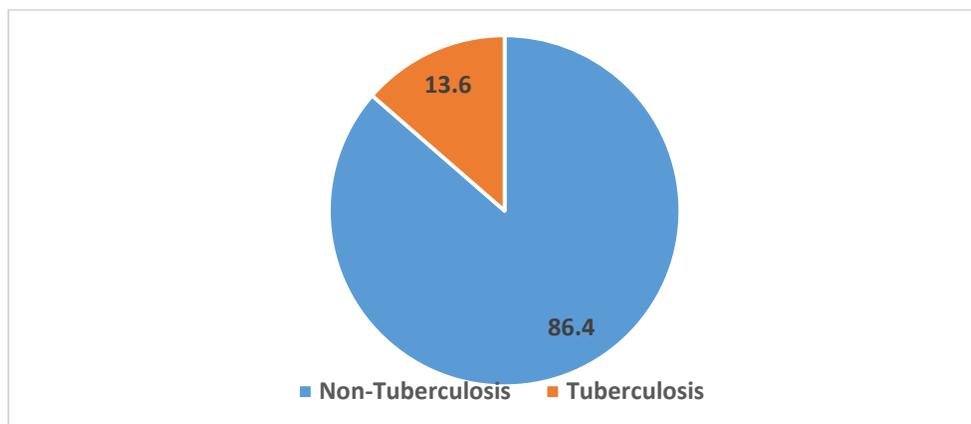
29.5 percent (N=161) of study respondents were tested for HCV, with 10.8 percent (N=59) reported positive for HCV infection, while 2.2 percent (N=12) were on treatment for HCV. Out of those on treatment 1.1 percent (N=6) completed HCV treatment.



**Figure 27. Proportion of Study Respondents, Tested, Confirmed & Treated for HCV Infection (N=545).**

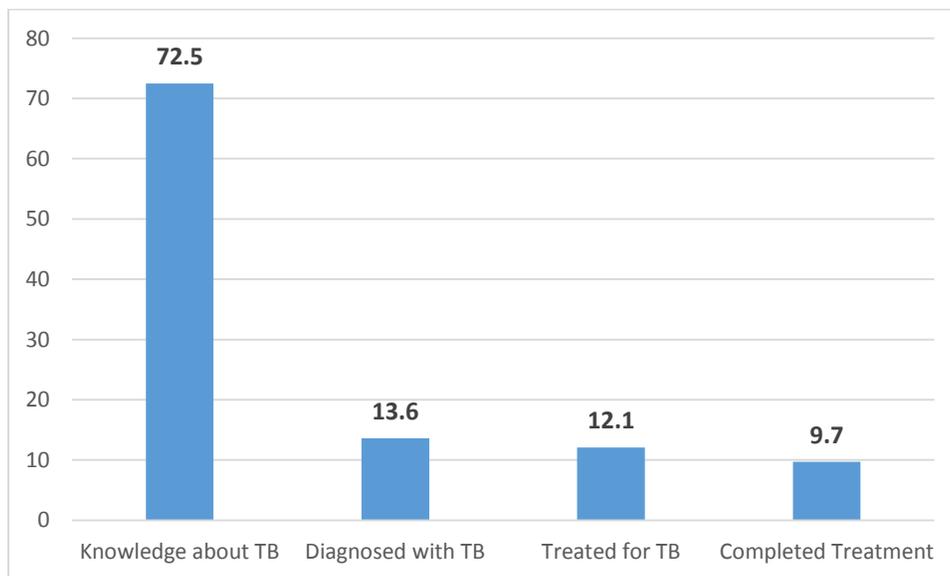
**8. Access to TB Services.**

A vast majority of the study respondents (72.5 percent; N=395) were found aware of about vulnerability of people who use drugs, to Tuberculosis Infection; prevalence of TB infection was recorded in 13.6 percent (N=74) of the study respondents.



**Figure 28. Prevalence of TB among Study Respondents (N=545).**

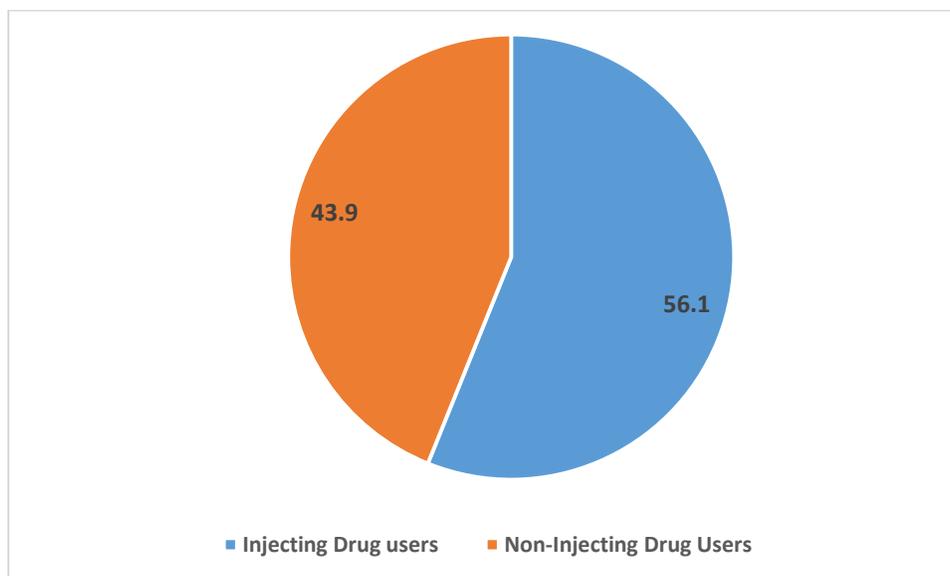
Those diagnosed with TB infection; 12.1 percent (N=66) got themselves treated, yet 9.7 percent completed the treatment. Majority received treatment from Government facilities. The data reported for issues/problems with the treatment remained insignificant.



**Figure 29. Proportion of Study Respondents (N=545) knowledgeable / Diagnosed / Treated / Completed Treatment for Tuberculosis (N=545).**

### **9. Access to Needle Syringe Programs.**

Out of the study respondents 56.1 percent (N=306) reported injecting drugs, with 45.7 percent (N=249) describing access to syringes as “easy”.



**Figure 30. Proportion of Injection Drug Use among the Study Respondents (N=545).**

Frequency of injection use among the study respondents was recorded twice (20.7 percent; N=113) to thrice (21.8 percent; N=119), lesser (6.1 percent; N=33) were injecting drugs once a day. Majority of the study respondents (13 percent; N=71) injected at the streets, followed by their residence (11 percent; N=60), abandoned building (4.4 percent; N=24), spots (3 percent; N= and graveyards (2 percent; N=11). Source of syringes was reported as Outreach Workers in 24.4 percent (N=133) and pharmacy 17.2 (N=94) of the study respondents. Some 35.6 percent (N=194) were recorded knowledgeable about the place, from where they can get free of cost the syringes.

Do you inject with used syringes?				
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	239	43.9	43.9	43.9
No	99	18.2	18.2	62.0
Yes	207	38.0	38.0	100.0
Total	545	100.0	100.0	

**Table 15. Reuse of Syringes.**

18.2 percent (N=99) disclosed non-use of syringes. Frequency of reuse of syringes was recoded among 82.6 percent (N=450) of the study respondents, while 69.7 percent (N=380) shared syringes while injecting drugs. Mode of disposal of used syringes was recoded as 'taken by NGOs' 24.2 percent (N=132) and 'thrown away' in 17.1 percent (N=93) of the study respondents. Three major Issues / problems related to getting access to syringes were recorded as police harassment (15.8 percent; N=86), limited locations for getting syringes (11.9 percent; N=65) and limited supplies (9.5 percent; N=52).

### **10. Access To Drug-Dependence Treatment (Detoxification Services).**

39.1 percent (N=231) of the study respondents recoded knowledgeable about the Detoxification Services, for the drug users. Majority 22.0 percent (N=120) heard about the detoxification services from some NGO, followed by friends/peers/family (8.3 percent; N=45).

Are you aware of detoxification services for drug users?				
	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	332	60.9	60.9	60.9
No	213	39.1	39.1	100.0
Yes	545	100.0	100.0	
Total				

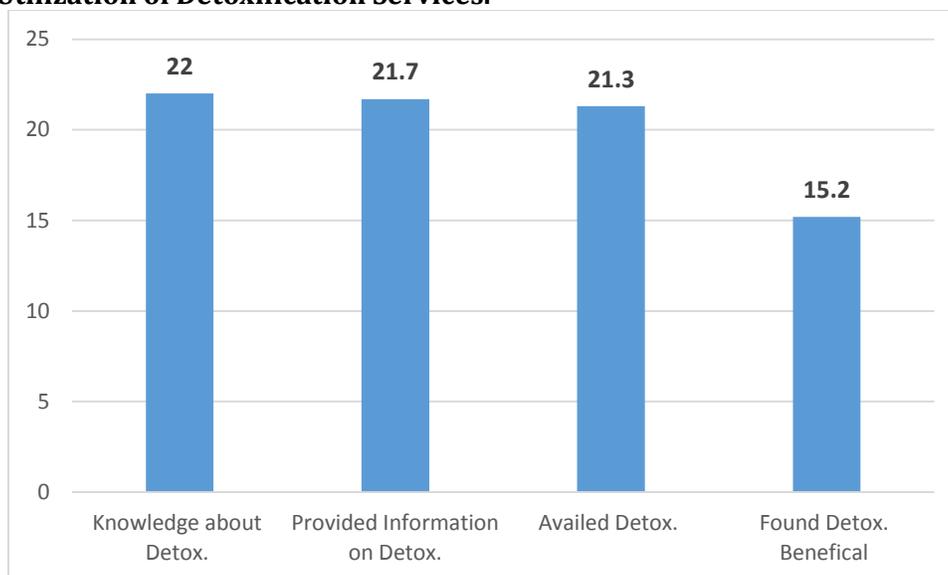
**Table 16. Awareness about Detoxification Services.**

21.3 percent (N=116) availed from the Detoxification Services; yet fewer (10.3 percent; N=56) had issues with the available services. High cost (4.8 percent; N=26) and attitude of health care providers (1.7 percent; N=9) were described as issues with low uptake of detoxification services.

**Did you ever availed these services?**

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	332	60.9	60.9	60.9
No	97	17.8	17.8	78.7
Yes	116	21.3	21.3	100.0
Total	545	100.0	100.0	

**Table 17. Utilization of Detoxification Services.**



**Figure 31. Proportion of Study Respondents, with Knowledge about Detox. Services / provided information / Availed Services and described them Beneficial (N=545).**

### III. ACCESS TO RIGHTS

#### 1. Knowledge About Rights.

Over fifty percent of the study respondents (55.6 percent; N= 303) found aware of their rights as human beings and described them as dignity, right to treatment, independence, sovereignty, religious freedom, etc.

**Are you aware of your human rights as human being?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	242	44.4	44.4	44.4
	Yes	303	55.6	55.6	100.0
Total		545	100.0	100.0	

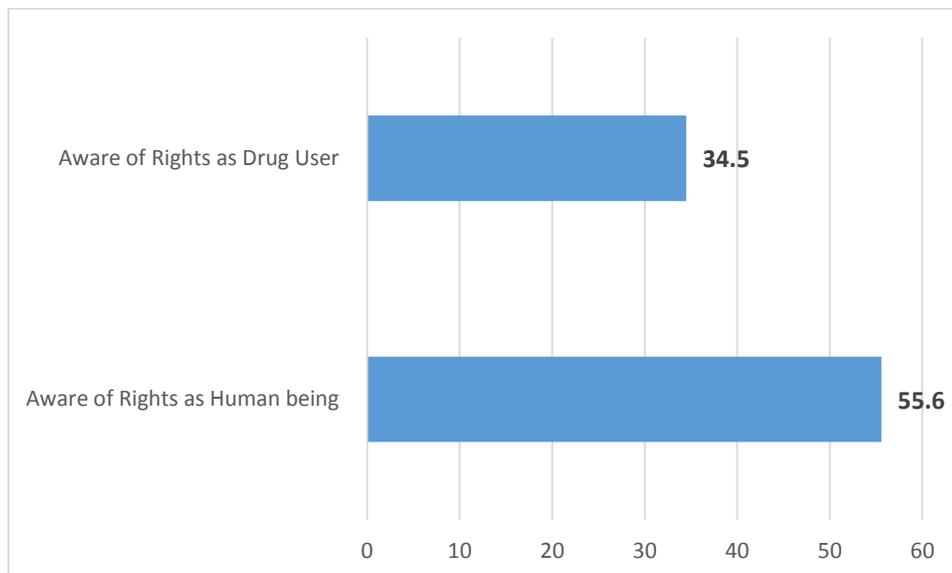
**Table 18. Awareness about Human Rights.**

More than a quarter (34.5 percent; N=188) were aware of their right as drug user; independence, right to treatment, equality, dignity, sovereignty etc. were expressed as their rights as drug users.

**Are you aware of your rights as drug user?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	357	65.5	65.5	65.5
	Yes	188	34.5	34.5	100.0
Total		545	100.0	100.0	

**Table 19. Awareness of Rights as Drug User.**



**Figure 32. Proportion of Study Respondents, found Aware about their rights (N=545).**

Few of the Study respondents; 5.0 percent (N=27) confirmed about some sort of campaigns to sensitize drug users community about their rights, by local NGOs. Fewer NGOs have undertaken advocacy campaigns in this area.

## 2. Discrimination In Health Care Setting.

Over twenty five percent (25.3 percent; N=138) were denied access to medical care in the recent past, and some 28.1 percent (N=153) denied for admission in the hospital.

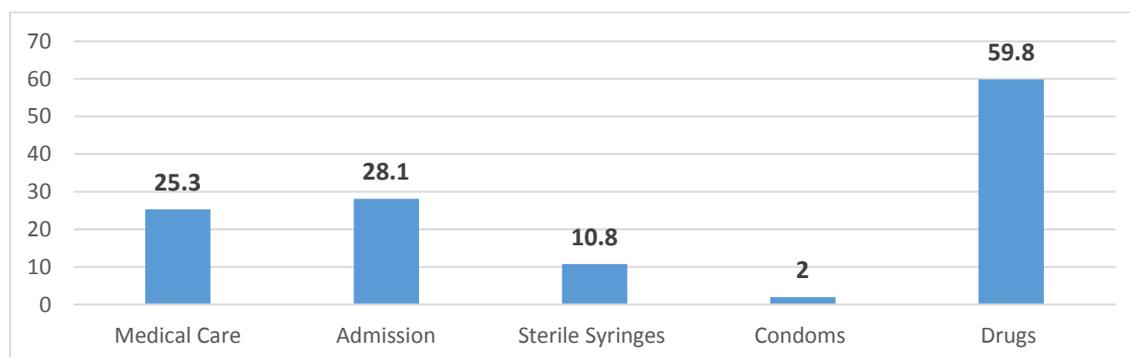
		Have you ever been refused medical care?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	407	74.7	74.7	74.7
	Yes	138	25.3	25.3	100.0
	Total	545	100.0	100.0	

**Table 20. Refusal for Medical Care.**

Study respondents have denied access to sterile syringes (10.8 percent; N=59); condoms (2 percent; N=11), and drugs (59.8 percent; N=326). Majority get access to drugs which they use through supplier (50.5 percent; N=275) / pharmacy / shop (14.7 percent; N=80) or friends/peers (8.8 percent; N=48).

		Have you ever been denied access to drugs?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	219	40.2	40.2	40.2
	Yes	326	59.8	59.8	100.0
	Total	545	100.0	100.0	

**Table 21. Denied Access to Drugs.**



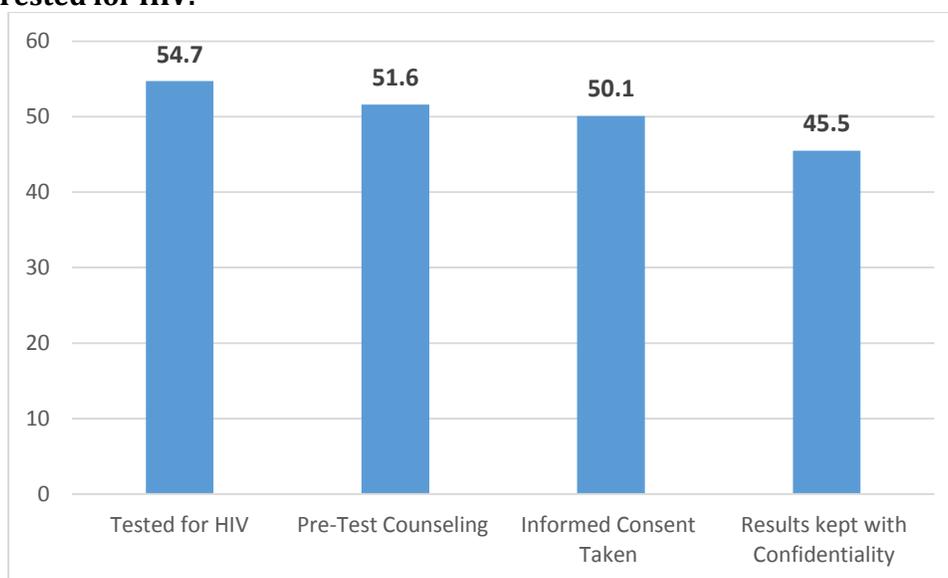
**Figure 33. Proportion of Study Respondents Access to Medical Care, Admission in hospital, Sterile Syringes, Condoms and Drugs (N=545).**

### 3. HIV/AIDS Counseling, Testing And Treatment Coverage And Experience.

Over fifty percent (54.7 percent; N=298) got their HIV status tested; with majority tested twice (23.3 percent N=127), followed by those tested just once (22.9 percent; N=125); 51.6 percent (N=281) were provided with counseling services; informed consent was taken in 50.1 percent (N=273), while 45.5 percent (N=248) were confident about their result to be kept with confidentiality.

		Have you been tested for HIV?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	247	45.3	45.3	45.3
	Yes	298	54.7	54.7	100.0
Total		545	100.0	100.0	

**Table 22. Tested for HIV.**



**Figure 34. Proportion of Study Respondents with Tested for HIV, subjected to Pre-test Counseling, Informed Consent Taken and their Results kept with Confidentiality (N=545)**

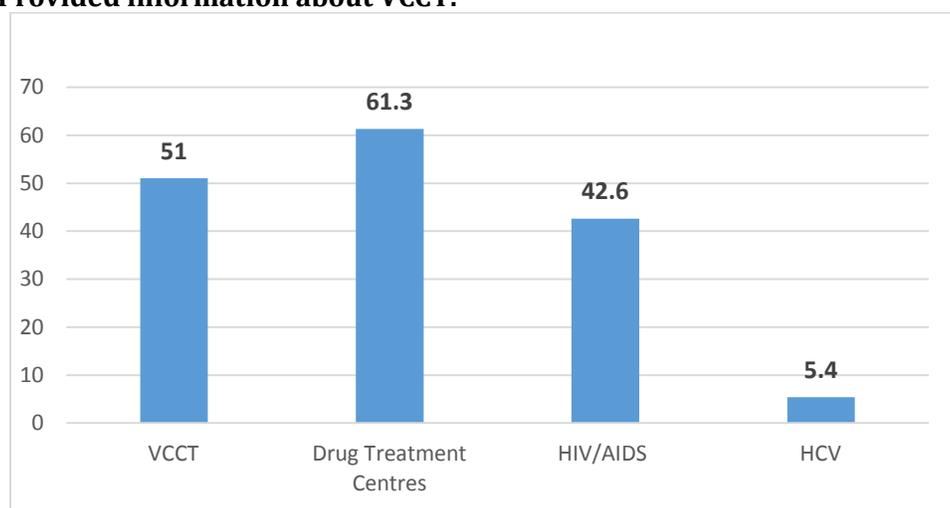
Some 7.5 percent (N=41) perceived themselves to be eligible for ART; however 4.8 percent (N=26) were actually recorded currently on ART.

#### 4. Lack Of Health Information.

Slightly over fifty percent (51.0 percent; N=278) denied being provided with information about VCCT; 61.3 percent (N=334); 42.6 percent; N=232) about HIV/AIDS and 53.4 percent (N=291) about HCV, of the study respondents.

		Have you been provided information about VCCT?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	278	51.0	51.0	51.0
	Yes	267	49.0	49.0	100.0
Total		545	100.0	100.0	

**Table 23. Provided information about VCCT.**



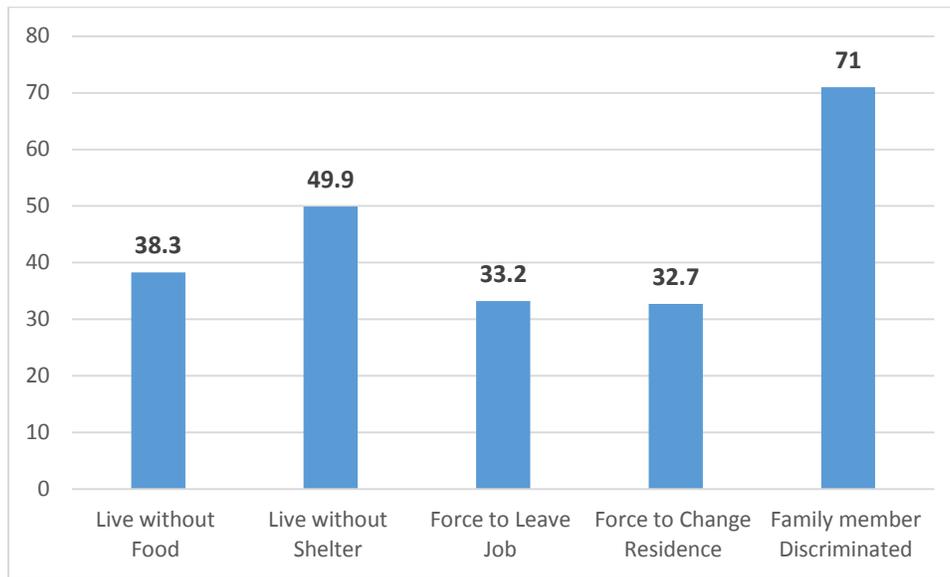
**Figure 35. Proportion of Study Respondents who were not provided information on VCCT, Drug Treatment Centres, HIV/AIDS and HCV Infection (N=545).**

#### 5. Inadequate Living Conditions.

38.3 percent (N=209) of the study respondents were reported forced to live without food due to their drug use, similarly 49.9 percent (N=272) lived without shelter (Out of their home). Another 33.2 percent (N=181) were forced to leave their job; 32.7 percent (N=178) forced to change their place of living and 71 percent (N=387) family members stigmatized due to their drug use.

		Have you ever been forced to live without food due to drug use?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	336	61.7	61.7	61.7
	Yes	209	38.3	38.3	100.0
Total		545	100.0	100.0	

**Table 24. Forced to live without Food due to Drug Use.**



**Figure 36. Proportion of Study Respondents Forced to live without Food, Shelter, leave job, change residence & Family member discriminated due to their Drug use (N=545).**

## 6. Arbitrary Arrests.

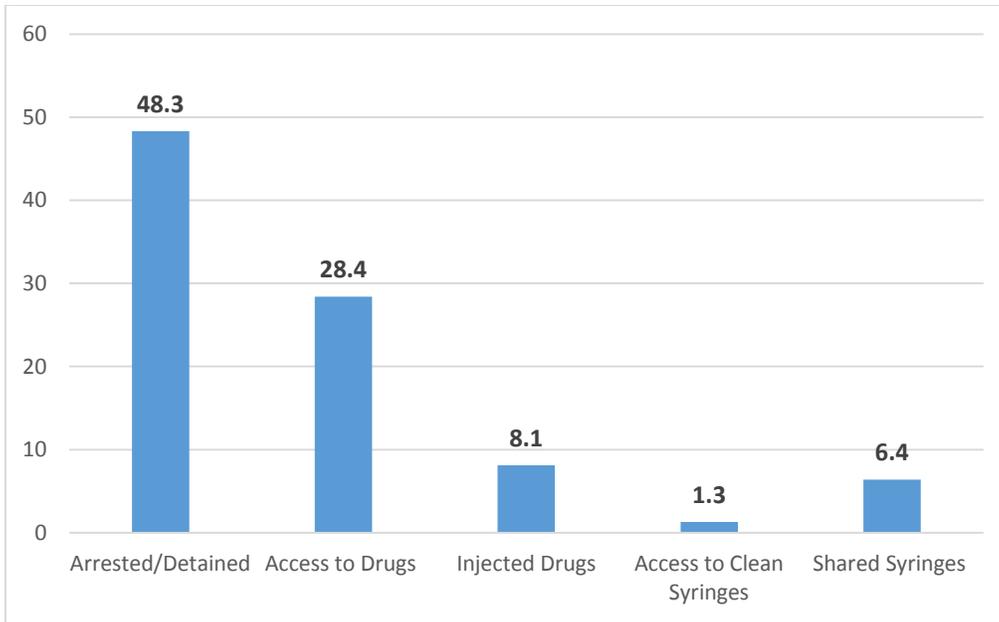
Just under fifty percent (48.3 percent; N=263) got arrested / detained due to drug use and major reasons for this was recorded as drug use (26.4 percent; N=144), followed with possession of drugs (2.2 percent; N=10), carrying needles (1.3 percent; N=7), personal reasons (1.2 percent; N=6), burglary ( 1.1 percent; N=5) etc. 15.6percent; N=85) got themselves arrested more than three times. On average, among those arrested, stayed in jail for 3 - 6 months among 11.74 (N=64) percent of the study respondents.

**Have you been arrested or detained?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	282	51.7	51.7	51.7
	Yes	263	48.3	48.3	100.0
Total		545	100.0	100.0	

**Table 25. Arrested / Detained.**

During the stay at jail 28.4 percent (N=155) had access to drugs, yet 8.1 percent (N=44) had also injected drugs; 1.3 percent (N=7) reported access to new/clean syringes, and 6.4 percent (N=35) also shared syringes) during the stay in jail.



**Figure 37. Proportion of Study Respondent who were arrested/detained in jail; had access to drugs, injected drugs, had access to clean syringes and injected while in jail (N=545).**

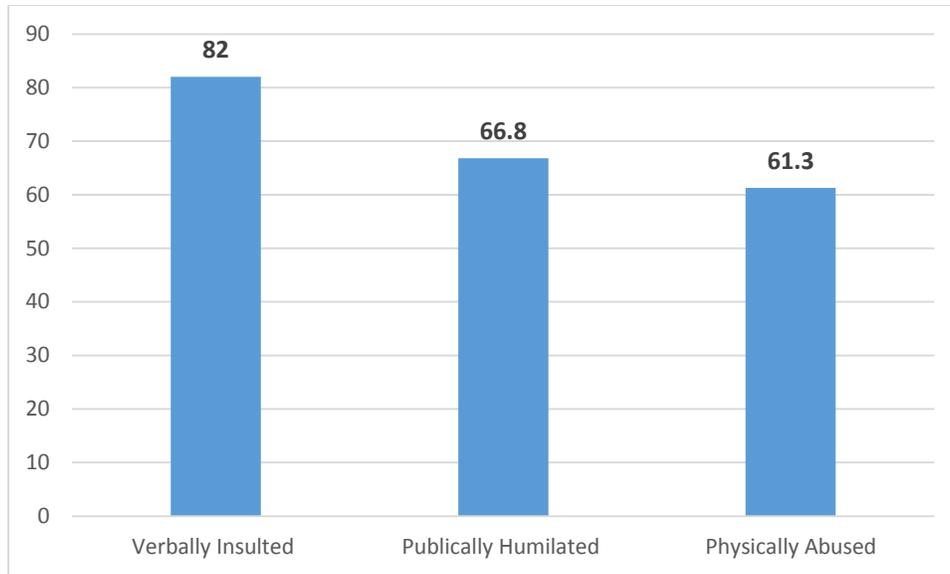
### **7. Torture And Other Degrading Treatment.**

Over eighty percent (82 percent; N=447) were reported insulted with derogatory words; 66.8 percent (N=364) publically humiliated; 61.3 percent (N=334) physically abused, twice (17.1 percent; N=93), once (12.3 percent; N=67) and thrice (11.4 percent; N=62). In majority of the reported cases, the family members (20.6 percent; N=112) were reported for mishandling, followed by police (15.8 percent; N=86). The nature of physical abuse included; beaten by stick (17.6 percent; N=96), punched (11 percent; N=60), kicked (10.8 percent; N=59) etc.

**Are you publically humiliated?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	181	33.2	33.2	33.2
	Yes	364	66.8	66.8	100.0
Total		545	100.0	100.0	

**Table 26. Publically Humiliated.**



**Figure 38. Proportion of Study Respondents who Verbally, Publically & Physically Abused (N=545).**

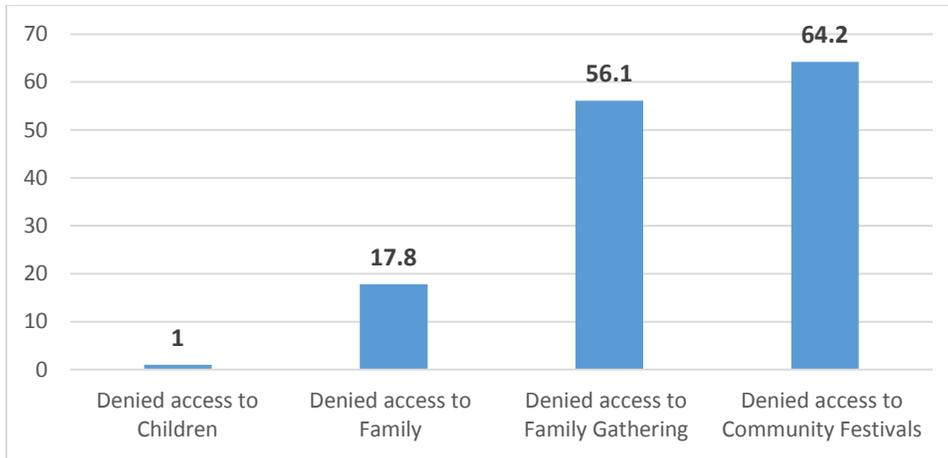
**8. Social Exclusion.**

Among those married, 45.7 percent (N=249) denied any difficulty in meeting their children, just 1 percent (N=5) were not allowed to meet their children. Fewer 17.8 percent (N=97) were NOT allowed to meet their families; while 56.1 percent (N=306) were deprived from participating in family gathering, another 64.2 percent (N=350) were stopped to participate in the community festivals.

**Are you allowed to meet your family?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	97	17.8	17.8	17.8
	Yes	448	82.2	82.2	100.0
Total		545	100.0	100.0	

**Table 27. Allowed to Meet Family.**



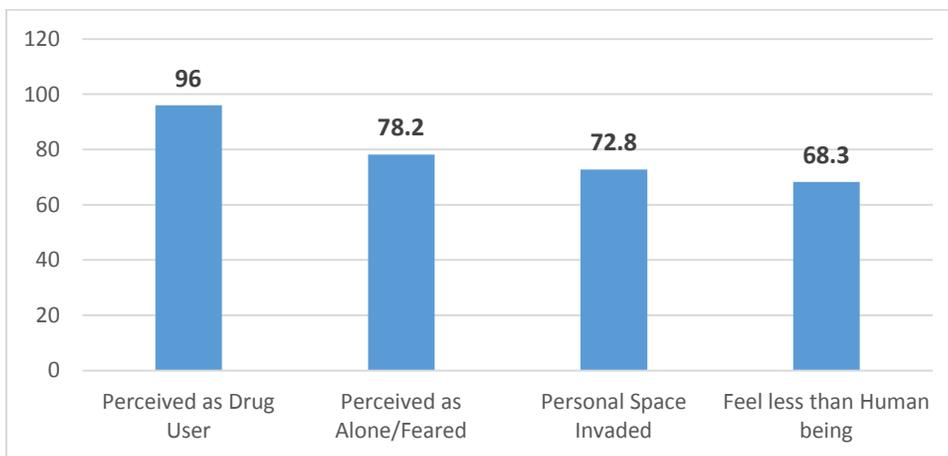
**Figure 39. Proportion of Study Respondents denied access to Children, Family, Gatherings & Community Festivals (N=545).**

**9. Dignity Violation.**

96 percent (N=523) of the study respondents felt of being perceived as a drug user only; majority 78.2 percent (N=426) reported perceived of being alone or feared; 72.8 percent (N=397) reported their personal space being invaded and 68.3 percent (N=372) felt being seen less than a human being.

Do you only feel perceived as a drug user?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	22	4.0	4.0	4.0
	Yes	523	96.0	96.0	100.0
	Total	545	100.0	100.0	

**Table 28. Perceived as a Drug User.**



**Figure 40. Proportion of study Respondents perceiving themselves as Drug user, being Alone/Feared, Personal Space Invaded and Felt less a Human being (N=545).**

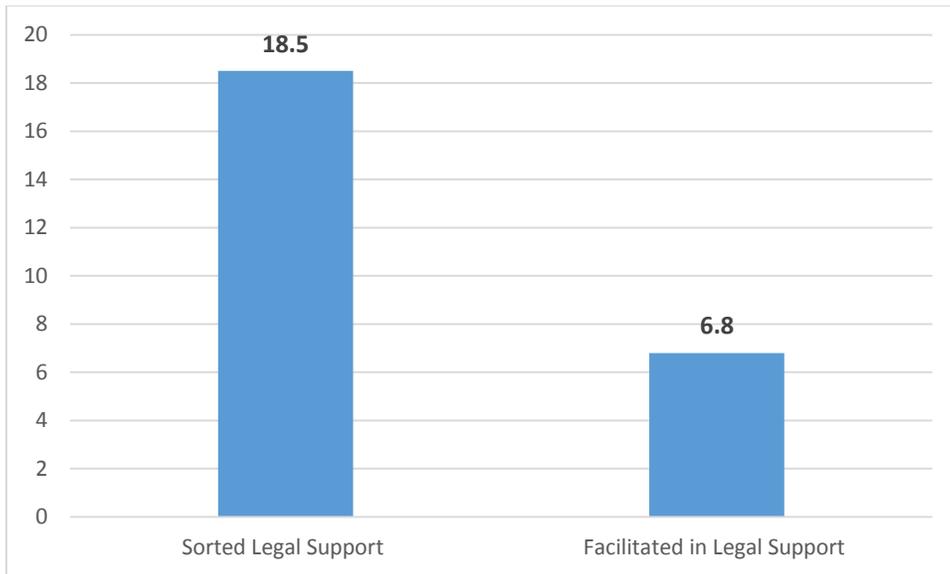
**10. Application Of Legal Rights.**

18.5 percent (N=101) reported ever sorting legal support and just 6.8 percent (N=37) confirmed being facilitated in sorting legal support. Less than a quarter (23.7 percent; N=129) reported detained without putting under any trial, and 10.1 percent (N=55) were provided access to legal support in such cases. Knowledge about any organization providing legal support to the drug user was not significant (Reported data was too low for any sort of analysis).

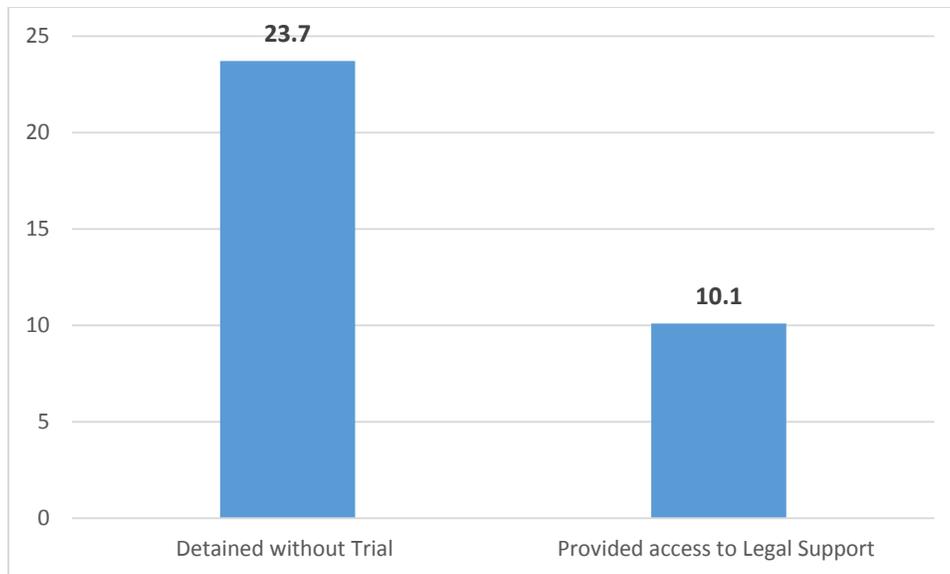
**Were you facilitated in sorting legal support?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	508	93.2	93.2	93.2
	Yes	37	6.8	6.8	100.0
Total		545	100.0	100.0	

**Table 29. Facilitation in Sorting Legal Support.**



**Figure 41. Proportion of Study Respondents Sorting Legal Support & Facilitated in getting Legal Support (N=545).**



**Figure 42. Proportion of Study Respondents Detained without Trial and provided Legal Support (N=545).**

## D. DISCUSSIONS.

Pakistan sits on one of the world’s busiest drug trafficking corridors, largely due to the cultivation of opium poppy and cannabis in neighboring Afghanistan. According to UNODC estimates 40 per cent of the drugs (heroin & charas) produced in Afghanistan are routed through Pakistan. This generates a considerable opiate supply for export but also for domestic use. The border area between Afghanistan and Pakistan is porous, inhospitable, and unstable in many areas. Few official border crossing points exist, resulting in a challenging task for law enforcement authorities from both countries when attempting to address drug trafficking.<sup>xxviii</sup> Global trafficking routes and seizure data in Pakistan indicate that the most, well-travelled trafficking routes within Pakistan run from Afghanistan through the western provinces of Khyber Pakhtunkhwa and Balochistan to Iran in the west and Pakistan’s coastline in the south, including its seaports of Karachi and Port Qasim.

In addition, to the historical and geographical context, socio-demographic, psychological, economic factors also play a role in determining drug use, in Pakistan. Research conducted in Pakistan show that features of life such as unemployment<sup>xxix</sup> and post-traumatic stress disorders<sup>xxx</sup> are highly associated with substance use. In addition, cultural and environmental factors including the availability of both licit and illicit substances are likely to render many segments of the Pakistani population - from both urban and rural areas - increasingly vulnerable to drug use.<sup>xxxi</sup>

A wealth of research and literature exists indicating that people who inject drugs (PWIDs) are at increased risk of drug-related harm, including the acquisition of blood-borne viruses such as HIV, hepatitis B, and hepatitis C. Pakistan is currently in the midst of a concentrated HIV epidemic, notably among PWIDs. According to the 2011 report of HIV Second Generation Surveillance, carried out by the National AIDS Control Program, the overall prevalence of HIV among PWIDs is 37.8%. The prevalence of HIV varies between different cities: Faisalabad has a prevalence of 52.5 per cent, Karachi has 42.2 per cent, and Sargodha has 40.6 per cent. The National Program also reported that among those who have received an HIV test in the past 12 months only 9.1 per cent know their results<sup>xxxii</sup> – indicating that a very high proportion of people who inject drugs are unaware of their HIV status, leading to a degree of complacency to change behaviors and therefore posing high risk of HIV transmission to other injectors and partners.

Self-reported HIV prevalence among PWIDs in this study revealed a major discrepancy between the estimated prevalence of HIV from sero-prevalence studies and the prevalence of who actually know they are infected. This gap in self-reported HIV status and HIV prevalence estimates could be due to the high levels of stigma associated with HIV-positive status, leading respondents to hide their status from the data collectors. It is however, more likely due to the use of unlinked anonymous testing in sero-prevalence studies or low testing levels for HIV among PWIDs in Pakistan. Unlinked anonymous testing is a practice used to estimate population prevalence of HIV without informing the participant of their status. Instead, the participant is referred to other testing services.<sup>xxxiii</sup>

Using known risk factors for HIV transmission and other socio-demographic variables, the key factors<sup>xxxiv</sup> most strongly associated with HIV infection among drug users were explored. In a model predicting HIV infection (self-reported), sharing syringes due to peer influences was associated with an increased risk of HIV, after adjustment for marital status, age, severity of dependence, and trading sex for drugs or money, which was also a significant predictor of HIV infection, conferring an increased risk. In other words, sharing syringes because another drug user and trading sex for money or drugs were the two strongest predictors of HIV infection among drug users. These factors should be considered in the broader context of the implementation of outreach programs and interventions.

The research findings demonstrate an urgent need to increase community treatment services, to address the issue of persistence of stigma and discrimination toward Drug User'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, DUs support groups and DUs networks. DUs 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 not available in Pakistan, access to treatment sites is limited due to smaller number and their located in the capital/major cities.

The impact of drug use on community life can be profound and often leads to a host of socio-economic problems with respect to family, society, employment, criminality, and direct and indirect costs arising thereof. Drug use is seen as both a “problem of the family” and a “problem for the family”.<sup>xxxv</sup>. The social problems, relating to drug use, are most prevalent in their communities. The social problems reported were: family and marital disputes, high rates of unemployment, high risks of transmitting HIV and other communicable diseases, as well as crime and police corruption, that is when police ask for bribes from drug users so the user can avoid arrest or be released from police custody without charge.

In addition to drug use, there are the warning signs for a rapid expansion of the HIV epidemic. The survey results detected a very high prevalence of HIV risk behaviors among people who inject drugs. Because the majority of HIV positive people who inject drugs are not aware of their status, they are also not taking precautions to prevent further transmission. Further, because knowledge of how HIV is transmitted is extremely low in the general population, opportunities to prevent infection are being missed.

Despite extensive efforts, prevalence estimates reported here are likely to underestimate drug use among women. Further, taking into consideration the very high levels of dependency among those who were detected, the recreational or casual drug use is more common than presented here, but was not detected due to underreporting in the general population.

The study aimed to provide the basis for design and implementation of effective prevention, treatment and care services that are evidence-based, targeted, responsive, and needs-led to counter the extent of a diverse nature of drug use in Pakistan. The education and health sectors, especially at provincial and district levels, along with civil society organizations and other service providers, need increased support to design and implement prevention and treatment programs that are evidence based and consistent with international best practice.

## **E. LIMITATIONS OF THE STUDY.**

Highly stigmatized and illegal behaviors, such as drug use, can be extremely challenging to survey. While, low capacity of the data collectors, might have affected quality of responses from the participants. In addition as both the data collectors and respondents, were from the same community and in some cases, from the same groups i.e. DUs getting the data from their fellows, there could be an element of bias. Both were vigorously addressed, through training of data collectors, field monitoring, prompt feedback and cross checking of filled questionnaires, before entry into the PHP MySQL.

In addition, approximately 40 percent of the respondents were members of some NGO/CBO/network, there already have access to service delivery; the data recorded in some of the variable indicated a skewed picture. In order to minimize this, a comparison of data collected through this survey was made with the available national data, wherever possible.

The study elicited responses from only 82 women making up only 15 per cent of the sample of regular drug user users. This resulted in a lack of generalizable data on problem drug-using women regarding the severity of use, levels of dependency, and other drug-related behaviours. Drug-using women are often considered a hidden and hard-to-reach population, especially in more conservative Islamic countries and rural areas. In such locations female drug users also face greater stigma than drug using men.

Non-probability sampling techniques (snow-ball) used to recruit study participants which may increase the possibility that those who participated in study differ systematically compared to those who were never peer recruited, i.e. there is a risk that the study participants may not be representative of all study population in Pakistan. Efforts were made to minimize participation bias by recruiting a broader range of seeds and participation from drug users, across the country, including far flung areas e.g. Turbat.

Most of the variables in the questionnaire are designed to assess the participants past exposure or experiences which may increase the risk of recall bias. All of the study participants were drug users which may result in non-differential recall of an exposure status or experiences.

The study primarily reflects response of Drug Users community; yet the service providers i.e. civil society, health care providers and program managers was not planned in the overall methodology.

## **F. CONCLUSIONS.**

The participants of this research included Drug Users (DUs) who were more likely to be informed and linked to available services. Despite this, they continue to confront significant barriers to accessing essential treatment, access to fundamentals human rights. The results provided clear evidence of the enormous gaps which persist and the plight of those without any linkages to a DUs support system.

Often structural and systemic barriers such as the stigma of being identified by others as a drug user or fear of police harassment prevent people from initial access or continued use of services. The findings suggest that taking steps for overcoming barriers, including establishing systems for their identification and handling by the service providers may assist in improved outcomes in relation to HIV prevention and treatment of IDUs and their partners.

The following recommendations have been developed to provide strategic directions for both policy and program development and aimed to achieve collective vision of national commitment to Universal to prevention and treatment for drug users; for the early identification, treatment, education, after-care, rehabilitation, and social reintegration of the persons involved.

## **G. RECOMMENDATIONS.**

1. Developing and implementing a national policy and action plan to ensure equity in ART access for DUs living with HIV, through effective advocacy with the parliamentarian, by APLHIV;
2. Initiating & rapidly scale-up OST program to ensure adequate coverage of all IDUs and integrating active drug users living with HIV to OST programs in order to assist them in initiating and adhering to ART, by advocating structural reforms in existing treatment protocols;
3. Sensitizing police (at all levels) and anti-drug agencies on drug dependency and need for NSP and OST – awareness campaigns with ANF and police authorities;
4. Developing fool-proof mechanisms to ensure that adequate number of needles/syringes are available for IDUs because the current ceiling (about four needles/syringes per day) is not sufficient for high frequency users, resulting in needle-sharing;
5. Developing close collaboration / coordination, between the Detoxification Centre and the Treatment Centre (ART Centre), ensuring early initiation of ART (as soon as the DU, becomes eligible for the ART);
6. Developing 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, at the public health care facilities – APLHIV provincial support mechanism should ensure the same

- through working closely with the drug users community;
7. Mass awareness campaign on HCV/TB Co-infection, among drug users, ensuring integrated diagnostics & treatment facilities availability at ART centers;
  8. Prevention of the negative social consequences of drug use, critical for both drug users and society at large, through advocacy, at various levels, by APLHIV;
  9. Sensitization and training health-care professionals on an on-going basis on how to prevent, recognize and manage the non-medical use of prescription drugs and related consequences;
  10. Implementing stigma reduction measures in the health care settings and sensitize health care providers on the health and human rights issues of IDUs and people living with HIV, through APLHIV existing set-up;
  11. Combining legal and harm reduction measures for Drug Users, giving providers the space needed to treat drug users with respect and ensure access to health services;
  12. Addressing stigma and discrimination, faced by Drug Users by implementing anti-discriminatory policies in healthcare settings and workplace, and sensitizing/training health care providers;
  13. Raising awareness among policymakers and clinicians, parents, young people, and teachers on basic fundamentals rights of drugs users;
  14. Community based campaigns, with Drug Users, creating awareness and knowledge about their fundamental and legal rights, with active involvement of APLHIV;
  15. Strengthening APLHIV, through ensuring representation of all key at risk population (KAPs), among their board;
  16. Developing and implementing comprehensive stigma reduction plan to increase support from family and society through education (mass media) and counseling.
  17. Supporting Drug Users support groups and community support mechanism, working with marginalized groups to initiate and sustain income generation programs. APLHIV may ensure such mechanisms in place, through awareness campaigns, advocacy at all levels and donor support for micro-financing;
  18. Ensuring 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 preventive programs and other treatment services, through existing APLHIV forum;
  19. Developing mechanism to ensure legal aid at the pretrial stage may help to persuade a judge not to detain a criminal defendant, thus averting the harmful effects of incarceration;
  20. Reforming laws that authorize police surveillance and pretrial detention of drug users.

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