HIV/SRHR Integration for People Who Use Drugs

How integration responds to the SRHR needs of people who use drugs

People who use drugs have the same sexual and reproductive rights as anyone else – such as to choose who to have sex with and to have sexual relations free from violence. They also share many of the same needs for SRHR information, support, commodities and services – such as advice about family planning.

However, due to many factors, people who use drugs often experience greater vulnerability to SRH ill health than other community members. They may experience one or all of: specific or more complex SRHR needs; additional or stronger barriers to accessing SRHR services; and weaker capacity or opportunities to demand SRHR services [see Box 2]. These factors are further affected – sometimes complicated – by the differences between individual people who use drugs, such as in terms of their gender, age, legal status, relationship status, HIV status and whether they are involved in sex work.

As a result, people who use drugs often have significant unmet needs for SRHR [see Box 1]. These can “fall through the net” of both: HIV services (often designed to address specific risk behaviors rather than the ‘whole person’); and SRHR services (often designed for the general public and focused on mainstream services, such as family planning).

Terminology: HIV/SRHR integration

HIV/SRHR integration refers to one or more components of HIV programming being integrated into (or joined with) one or more components of SRHR programming; or vice versa. This includes referrals from one service to another. The overall aim is to provide more comprehensive support.

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Addressing the HIV/SRHR needs of people who use drugs matters in all contexts. However, the approach, scale and pace of integration depend on a range of factors, including the local HIV epidemic. Depending on whether a country has a concentrated or generalised epidemic, a ‘package’ of HIV/SRHR support for people who use drugs might include services for all or just some of:

- **Full range of options to prevent HIV, STIs and unwanted pregnancy, including (but going beyond) condoms.**
- **Interactions between different types of drugs (such as methadone, ART and contraceptives).**
- **Safer sex practices while under the influence of different types of drugs (such as risk reduction and skills to improve condom efficacy).**
- **Specific SRHR issues for people who use drugs, such as sexual dysfunction for men and impact on menstruation and fertility for women.**
- **Support to female drug users who are pregnant (such as information on methadone use and dosage), with access to full range of services for PMTCT, ANC, post-natal care (PNC) and maternal, newborn and child health (MNCH).**
- **Empowerment on sexual and health rights.**
- **SRHR needs of female partners of men who use drugs (such as family planning options).**
- ‘Drug user-friendly’ SRHR options, including a full range of appropriate contraception (such as long-lasting contraceptives) and male and female condoms.
- **Sexual violence, including post-exposure prophylaxis in relation to rape or sexual assault.**
- **Sexual counselling, for example on the relationship between sexual drive, performance and drug use.**
- **Family welfare services - to support people who use drugs to maintain custody of their children.**
- **Hepatitis B/C information, diagnosis and treatment.**
- (Where legal) access to safe and confidential abortion and (in all contexts) post-abortion care, including in cases of unsafe or illegal abortion.
- **Diagnosis and treatment for TB.**

### Box 1: Unmet SRHR needs of women who use drugs

A study by India HIV/AIDS Alliance and SASO of women who use drugs in Manipur, India, found that:

- 56% of those that were married had an unmet need for contraception.
- In the last three months:
  - 52% had experienced an STI-related symptom.
  - 15% had experienced forced sex.
  - 17% had experienced physical violence.
- Many concealed their drug use from health providers.

### Box 2: Factors that affect people who use drugs in the context of SRHR

| Factors | For example, compared to other community members ...
|---------|--------------------------------------------------|
| **Specific or more complex SRHR needs** | • A man might need behavior change support to ensure safer sex while under the influence of drugs.  
• A woman whose male partner uses drugs might need strong negotiation skills to use condoms and protect herself from HIV infection and unwanted pregnancy.  
• A couple who use drugs and are living with HIV might require specialist information about the interactions between methadone, contraceptives and Antiretroviral therapy (ART).  
• A woman who uses drugs who is living with HIV and pregnant might need counseling on drug use while pregnant and prevention of mother-to-child transmission.  
• A sex worker who uses drugs might experience higher levels of coerced and violent sex – increasing her need for emergency contraception and post-exposure prophylaxis. |
| **Additional or stronger barriers to accessing SRHR services** | • A woman who takes drugs might face discrimination by staff at mainstream antenatal (ANC) services.  
• A woman who takes drugs might not feel comfortable discussing her SRHR needs in a harm reduction project run by men.  
• A man who uses drugs might not access a public SRHR service if they face threats by the police.  
• A person who uses drugs might not be allowed to register at a government STI center if they are criminalized. |
| **Weaker capacity or opportunities to demand SRHR services** | • A woman who uses drugs might be excluded from a district consultation on women’s SRHR needs.  
• A person who uses drugs and is living with HIV might lack the self-esteem to request attention to their SRHR needs in health services.  
• A man who uses drugs and is criminalized might lack a safe space to advocate for his SRHR needs to decision-makers.  
• A person who uses drugs might lack the skills to define their SRHR needs because they are left out of community capacity building projects. |
Lessons learned about HIV/SRHR integration for people who use drugs

There are many general lessons about the challenges of implementing HIV/SRHR integration for key populations [see Box 3]. There are also insights into success factors. Examples include that it helps to: start by building on what’s there, gathering evidence and identifying entry points; ensure a strong chain of services (including high quality referrals); and address the political, legal and funding context of HIV/SRHR. In addition, experiences around the world suggest specific lessons about integration for people who use drugs. These include that it is vital to:

• **Assess, recognise and address the complex interactions between drug use/harm reduction, HIV and SRHR.** This includes how drug use can affect people’s choices and decisions in relation to sexual pleasure and risk taking and how different drugs and medicines (such as methadone, hormonal contraceptives and ART) interact with each other.

• **Not make presumptions about the HIV/SRHR behaviours or needs of people who use drugs.** For example, an India HIV/AIDS Alliance study found that male drug users may have sexual relations with women, men and hijras – all associated with different SRHR issues and needs for support and services.

• **Provide a comprehensive package of HIV/SRHR support for people who use drugs.** For example, the National AIDS Control Organisation, India, recommends Drop-In Centres to provide: condoms and STI diagnosis/treatment as a core package; SRHR support for women who use drugs and the female partners of men who use drugs; behaviour change communication among sexual partners; and accompanied referrals to other SRHR services. The package of SASO (an NGO in India) combines services for harm reduction, HIV and SRHR.

• **Address the cross-cutting issue of gender dynamics.** This includes acknowledging that women can be affected by drug use, HIV and SRHR in different ways to men and that projects for people who use drugs are often both male-orientated and focused on drug use and HIV. For example: programmes supported by the Open Society Institute in Ukraine found that opiate substitution therapy (OST) programmes did little outreach to pregnant women who use drugs; and the Global Network of People Living with HIV emphasises the needs of women who use drugs who are living with HIV [see Box 4]. The International HIV/AIDS Alliance recommends that specific attention is paid to:
  - Women who use drugs
  - Women who are partners of drug users, including wives and widows
  - Women who use drugs and sell sex
  - Women living with HIV who are using drugs
  - Pregnant women who are using drugs and mothers who are using drugs
  - Young women and girls who are using drugs.

**Box 3: Top 10 challenges to HIV/SRHR integration for key populations**

1. Stigma and discrimination about HIV and key populations.
2. Low demand for HIV/SRHR integrated services.
3. Lack of rights-based approaches to HIV/SRHR.
4. Low attention to gender inequality in HIV/SRHR integration.
5. Missed obvious opportunities for HIV/SRHR integration.
6. Low understanding of key populations’ specific HIV/SRH needs.
7. Presumptions or lack of expertise among service providers.
8. Lack of a strong referrals systems for HIV/SRHR.
9. Inappropriate design of HIV/SRHR integration.
10. Lack of technical and financial support to over-stretched groups.

**Box 4: Supporting the SRHR needs of women who use drugs and are living with HIV**

“Contraception is a very important issue for IDU women living with HIV; menstruation often ceases with regular use of opiates, which can make it difficult to detect pregnancy. It is vital that the full range of contraceptive options be made available, and that women are not forced to use a particular method in order to comply with ART contraception stipulated by service-providers. Family planning and abortion choices should be made with the same range of choices available to women who are not HIV-positive; pressured or forced sterilization is diametrically opposed to the human rights of IDU women living with HIV and should be specifically outlawed.”

‘Snapshots’ of HIV/SRHR integration for people who use drugs

**INDONESIA: Perkumpulan Keluarga Berencana (PKBI)** runs SRHR clinics and community service delivery points in Pisangan. These integrate: SRHR (including family planning, ANC, PNC, management of post-abortion care and cervical cancer screening); HIV (including HIV counselling and testing and STI/HIV prevention); and harm reduction (including needle and syringe exchange, information and support groups). Clients are referred to hospitals for other services, including PMTCT. Non-judgmental attitudes have proved critical, for example to support women who use drugs who are HIV positive and pregnant.

**CAMBODIA: Korsang** works in Phnom Penh providing a harm reduction and HIV programme (with services including needle and syringe exchange and information about HIV and safe injection) that integrates SRHR (including condoms and information on women’s health). It emphasises human rights, safe spaces and support for livelihoods. The programme is delivered through outreach by multi-disciplinary teams (including a specialist in women’s health) and complemented by advocacy with local authorities to reduce discrimination. Its lessons include that outreach is critical in a context where many people who use drugs are unaware of the SRHR services available or are unwilling to go to a Drop-In Centre for fear of police prosecution.

**INDONESIA: Pusat Kesehatan Masyarakat (Puskesmas)** Gambi is a government centre, with 25 polyclinics on the same site. It joins services for SRHR (such as family planning, STI prevention, ANC and MNCH), HIV (such as HCT, ART and TB screening) and harm reduction (such as needle and syringe exchange, OST and Hepatitis screening). Services are delivered through in and out patients, health posts and mobile units. Men who use drugs are given STI treatment at the methadone polyclinic, while women are referred to the MNCH polyclinic. Integration involved staff training (including in non-discrimination) and meetings with people who use drugs. The challenges have included increased staff workload. The lessons include that a centre’s leaders must be committed to integration and, where possible, core SRHR services for women who use drugs (such as screening for cervical cancer) should be free.

**INDIA: Social Awareness Service Organisation (SASO)** runs a Drop-In Centre in Manipur providing a package of harm reduction, HIV and SRHR services [see Figure 5]. It also serves as an entry point for referrals to services such as ART, PMTCT, MNCH and OST. A female doctor provides free basic health care for women who use drugs (many of whom are also involved in sex work). SASO also advocates to the government and health care providers on the needs of people who use drugs and raises awareness among the public on the impact of stigma. The lessons include that medical staff need hands-on training on the complexities of the SRHR needs of women who use drugs or are the partners of men who use drugs.
For people who use drugs, integration requires a three-way approach – combining support and services for harm reduction as well as HIV and SRHR. For example, in practice, this might involve providing information and counselling on the interactions between methadone, ART and contraceptives.

Integration is a vital strategy to respond to the unmet – and sometimes very specific and complex – HIV and SRHR needs of people who use drugs. In particular, it can decrease stigma and discrimination (related to both HIV and drug use) and increase access to comprehensive support. This moves beyond focusing on people who use drugs as ‘transmitters of infection’ to promoting their rights (including to sexuality) and taking a ‘whole person’ approach.

Groups by and for people who use drugs are vital to HIV/SRHR integration. However, the strategy can bring additional work and pressure to already over-stretched groups: start small. Comprehensive integration may be a good long-term goal for some, but, in the short-term, full integration is not required. Efforts should start with joining selected HIV and SRHR services that are priorities for people who use drugs and have an obvious overlap, such as effective condom use to protect from HIV and unwanted pregnancy while using drugs.

HIV/SRHR integration must recognise and respond to the significant diversity among people who use drugs and in their HIV/SRHR needs. Integration requires new thinking and a tailor-made approach. For example, groups with experience of working with communities on harm reduction should not presume that they know their SRHR needs.

Integrated programmes must specifically address the HIV/SRHR needs of women who use drugs or who are the partners of men who use drugs. Such women may have specific and complex needs, while being hidden within society and marginalised from mainstream services.
About this brief

This issue brief is part of a series of materials resulting from a review of good practice in the integration of HIV and sexual and reproductive health and rights (SRHR) for key populations. The review was commissioned by the India HIV/AIDS Alliance and explored experiences and lessons from Asia and the Pacific and globally.

Background information – such as what HIV/SRHR integration is, what particular benefits it brings to key populations and what lessons have been learned among such communities – are summarized in Policy Brief: Key Linkages and Key Populations: Is HIV/SRHR Integration Serving the Needs of Vulnerable Communities? Further detail, including the references for the information in this document, can be found in the full report of the review¹.

This brief specifically focuses on the importance, but also challenges, of HIV/SRHR integration for people who use drugs. It is based on the experiences of a growing number of groups working with such communities to put integration into practice in a range of setting. These have given important insights into ‘what works’. But they also highlight that everyone is still learning and questions remain about what constitutes good practice.

This issue brief promotes integration as a desirable goal in the long-term. However, it also emphasizes that organizations must work in a way and at pace that is appropriate and feasible for them – to ensure that the joining of HIV and SRHR services and systems enhances, rather than compromises, support for people who use drugs.