



**MULTICENTRE OPERATIONAL
RESEARCH ON DRUG USE
& HARM REDUCTION AMONG
PEOPLE LIVING WITH HIV/AIDS
IN THE MIDDLE EAST & NORTH
AFRICA REGION**



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LIST OF ACRONYMS

ART	Antiretroviral Therapy
CSO	Civil Society Organization
CD4	Cluster of Differentiation 4
FGD	Focus Group Discussion
HBV	Hepatitis B virus
HCP	Healthcare Providers
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
HTC	HIV Testing and Counselling
IEC	Information, Education and Communication
KIs	Key Informants
MENA	Middle East and North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MMT	Methadone Maintenance Treatment
MSM	Men Who Have Sex with Men
NSP	Needle and Syringe Programmes
OR	Operational Research
OST	Opioid Substitution Therapy
PLHIV	People Living with HIV/AIDS
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SME	Small and Medium Enterprise
STI	Sexually Transmitted Infection
TB	Tuberculosis

TABLE LEGEND

MOR	Morocco
TUN	Tunisia
LEB	Lebanon
EGY	Egypt
PAK	Pakistan
AFG	Afghanistan
W	Weeks
M	Months
Y	Years
YO	Years Old

FOREWORD

The Middle East and North Africa Harm Reduction Association (MENAHRRA) has been working towards supporting evidence based harm reduction programs within the Middle East and North Africa (MENA) region for the past decade. As a leading organization and network on harm reduction in the MENA, MENAHRRA has conducted a number of researches in collaboration with diverse experts and research teams, in order to contribute to the availability of region-specific literature and evidence.

Following a number of Operational Researches conducted with different focuses within the harm reduction and drug use fields, this Operational Research explores and assesses the situations and risks faced by People Living with HIV (PLHIV) who use drugs. There is no denying that PLHIV and People Who Use Drugs (PWUD) alike are stigmatized and highly discriminated against in our region, and PLHIV who use drugs are exposed to double stigma, often preventing proper access to essential life-saving services.

This report investigates and details the health-related harms, stigma and discrimination, service access and adherence barriers, as well as the impact of current (if existing) harm reduction strategies among PLHIV who use drugs. The results of this report should guide decision-makers and civil society organizations towards the provision of more comprehensive and accessible harm reduction and HIV services.

MENAHRRA would like to thank Ms. Oumnia Abaza for producing this report under an exceedingly tight schedule and many constraining obstacles. We would also like to extend a warm thank you to our strategic partners, UNAIDS and WHO, for their continuous collaboration and support. And last but not least, thanks to all those who contributed to the compilation of this report, the MENAHRRA team, and the Global Fund for making the production of this report possible.

Sincerely,

Mr. Elie Aaraj
Executive Director
MENAHRRA

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Oumnia Abaza
Consultant

EXECUTIVE SUMMARY

In the Middle East and North Africa (MENA) region, the access to Harm Reduction (HR), Human Immunodeficiency Virus (HIV) treatment, care and support services remains limited among People Living with HIV/AIDS-(PLHIV)-People Who Use Drugs (PWUDs)/People Who Inject Drugs (PWIDs). To acquire a comprehensive understanding of the drug use and HR situation among PLHIV-WUDs/WIDs, a Multicentre Operational Research (OR) was conducted by the Middle East and North Africa Harm Reduction Association (MENAHR) with support from the Global Fund.

A. Research Objectives:

i) To explore the drug use context among PLHIV-WUDs/WIDs; ii) To measure the levels of knowledge about HIV/AIDS, harms of drug use, and HR and healthcare services; iii) To identify HR and healthcare services and service provision; iv) To define the reasons leading to stigma and discrimination; v) To identify barriers and facilitators hindering/facilitating access to HR, HIV treatment, care and support services; and vi) To provide recommendations for improved HR and healthcare services for PLHIV-WUDs/WIDs in the region

OR subjects included 230 participants: 149 PLHIV-PWUDs/PWIDs and 81 key informants (KIs) from Morocco, Tunisia, Lebanon, Egypt, Pakistan and Afghanistan. Data were collected by trained fieldwork teams through focus group discussions (FGDs), case studies and semi-structured interviews and analysed using a socio-ecological framework

B. Summary of Findings:

Background characteristics of participants

Participants were relatively young with an overall mean age of 31.8 years and an average of 4.1 years of living with HIV. Around half of them (49%) reported being single and a quarter were married (26.2%). Fifty-five participants had 128 children among which only 32% were tested for HIV and 10% were detected HIV positive. Educational attainments were very low with 17.4% never having been into school, 32% having completed primary school, and only 12.1% having completed high school or university. More than half of participants were unemployed (60.4%) and about one third (30.8%) were involved in full time or part time unskilled work. Participants main sources of income were family, partner and friends supports (62.8%).

Almost all participants reported unstable housing situation (77.8%), with the vast majority living in a rented house or sharing a family, partner or friend houses and 11.4% being homeless. About one third of participants tested for HIV because of their own or their partner's bad physical condition. Out of all participants, 26 (17.4%), including all male participants in Lebanon and two in Morocco were Men Who Have Sex with Men (MSM) living with HIV and using drugs and eight females, half of which were from Morocco (4), 2 from Egypt and 1 from each of Tunisia and Pakistan were engaging in sex work.

Substance abuse and drug patterns

The use of drugs was very high with 77.8% of participants currently using drugs, and more than half (55%) were injecting drugs at time of data collection. A high number of their partners were also using drugs (45.6%), out of which 39.6% were injecting drugs, mostly women's partners (72.3% vs 24.5% of men's partners). The mean age of drug initiation was 22.6 years and the average years of using drugs among all participants was 9.1 years. Heroin (63.9%), cannabis (46.2%) and cocaine (32.8%) were the drugs mostly used among all participants, also identified as polydrug users. Other drugs used were country specific such as Avil in Pakistan, Subutex in Tunisia, Opium in Afghanistan and Tramadol/Tamol in Egypt.

About third the participants (29.5%), 25 in Morocco and 19 in Afghanistan were on Methadone Maintenance Treatment (MMT). High risky injecting patterns were identified, with more than half (56.1%) reporting "always" sharing needles/syringes. Unavailability of syringes at time of drug injection (51.5%) and financial constraints (42.6%) were the main causes for sharing needles/syringes. Third the participants cited peer pressure or partner/family influence as the main factor for drug use. The main drug use related challenges were incarceration, financial constraints and unemployment.

Sexual behaviours

When engaging in sexual relations, 37.5% never used condoms. Multiple factors play a role in non-condom use, the most relevant among which were fear that their sexual partner suspect their HIV status; and reduced sexual sensation/pleasure when using condoms.

HIV/AIDS related knowledge

More than third (37.5%) had poor knowledge of HIV and AIDS, with 32.1% not knowing the difference between HIV and AIDS. Although the overall knowledge about HIV/AIDS modes of transmission and prevention methods was relatively fair, the knowledge of sharing injection equipment as a mode of HIV transmission was only reported by 6% of participants, mainly from Morocco.

Knowledge of drug-and drug use-related harms

Most drug use-related physical and mental harms were actual harms. Due to drug abuse and non-compliance to treatment, almost all participants were in poor physical and mental health condition. Multiple diseases/co-infections (mainly HCV/TB) and symptoms, both mild and severe were reported. Short- and long-term effects related to HIV treatment were also found to be common.

Knowledge of HR and healthcare services, and service utilization

Knowledge gaps regarding services, and service utilization and availability were detected. The services mostly utilized were needle and syringe programmes (NSP) (64.3%), antiretroviral therapy (ART) (53.2%), condoms (30.1%) and Methadone (23.8%). Almost half the participants (42%) reported only knowing one organization providing services when 20.6% reported knowing one CSO and one hospital. About one third of participants (32.9%) reported not knowing any services other than HR and healthcare services.

HIV Treatment-related beliefs and level of adherence

Participants who believed that HIV treatment: decreased the effect of drugs or OST, should not be taken with other drugs, or is ineffective and probably fatal, had low levels of ART adherence. On the contrary, those with positive beliefs had high levels of adherence.

Impact of medical condition on service uptake

There was a correlation between medical condition and service uptake and the number who reported otherwise was rather low. Important factors hampering service access were fatigue/weakness (41.4%), nausea/vomiting (33.6%), and depression (31.9%).

Quality of HR and healthcare services

HR services were more satisfactory than healthcare services, with which all countries (except Lebanon) expressed high levels of dissatisfaction (66.9%). Denial of medical/social services due to HIV status (46.7%); and that services in public hospitals were not stigma free were also claimed by 74.2%. A dysfunctional relationship - ranging from normal to very bad - with healthcare providers (HCP) was found among half the participants (53%).

Underlying causes of stigma and discrimination

The most significant causes of stigma were lack of human rights knowledge among about three quarter of participants (70.9%); non-involvement in activities to improve one's situation (86.9%); low levels of HIV disclosure with full support received (44.1%); and PLHIV-WUDs/WIDs internalized¹, anticipated², intersected and experienced stigmas. Primary perpetrators were family members (32.6%), HCP in public hospitals (31.8%), friends/neighbours and other community members (27.9%). The low level of no HIV status-related stigma reported (16.3%), was largely due to keeping it secret.

PLHIV-WUDs/WIDs' reported barriers, facilitators, needs and suggestions

Three main barriers to accessing services were acknowledged: the bad quality of service delivery and provision (38.6%); stigma and fear of stigma (37.9%); and service accessibility (30.7%). Conversely, the most common facilitators were access to high quality services (notably in healthcare facilities) (35.2%); and increase in service coverage (30.4%). A cluster of needs was expressed including but not limited to, drug addiction treatment (27.2%), psychological support (24.8%), access to improved services (24%), the need for an improved socioeconomic status through employment (20%), financial support (15.2%) and stable housing situation (14.2%). Room for improvement was correlated to defined barriers, such as a wider geographical service coverage, better quality of service provision and reduced stigma in public hospitals through awareness raising and HCP' training.

Conclusion

Contextual limiting factors: lack of safe and enabling environment, sociocultural constraints, legal restrictions, limited geographical service coverage, and low quality of service provision and delivery.

Individual limiting factors: low socioeconomic status, knowledge and information gaps about important issues, poor physical and mental health conditions, risky behaviours, demographic determinants, lack of involvement in advocacy efforts, dysfunctional interpersonal relationships, and internalized, anticipated, intersected and enacted stigma.

Medical and informational facilitating factors: appropriate diagnosis of diseases, including substance abuse; provision of correct information and referrals; initiating drug dependence treatment with treatment of other diseases; and developing a follow-up system.

Social and psychological facilitating factors: improved communications with HCP; encourage attendance of psychological support/ support group sessions, and communities to receive counselling; assist service seeking in public hospitals (social workers); provide free transportation; and provision of social and psychological support upon disclosure.

¹ The negative beliefs and feelings held about the self

² Expectation of discrimination due to HIV status

PROBLEM IDENTIFICATION

Since 2011, the efforts of MENA countries to implement effective national HIV prevention programmes that would slow down the HIV spread in the region faced many challenges. Ongoing civil wars in Iraq, Libya, Syria and Yemen have contributed, among others, to the political, social and financial instability of the region (World Bank, 2016). The resultant unprecedented massive movements throughout the region and beyond have put most migrants in vulnerable and poor living conditions. The past few years have also witnessed an increased drug consumption and drug trafficking; the Middle East accounts for 64 per cent of the world amphetamine seizures, and North Africa for the greatest number of cannabis resin and cocaine seizures in the world (INCB 2013, Africa). This was further aggravated by possessing one of the fastest growing young population and the highest unemployment rate among youth at the global level. Importantly, the youth represents almost half the newly detected HIV cases in the region.

Legal, religious and sociocultural restrictions against extramarital sex, sex work, same-sex relations, drug use and possession are threatening the low HIV prevalence, estimated at less than 0.1% in most of the MENA countries. HIV is a taboo, discussed with reluctance and is often associated with illicit behaviour. Furthermore, women exhibit poor health seeking behaviours in MENA highly conservative societies. Gender inequality exposes them to a higher risk of HIV infection than men.

The global decline in HIV and HR funding, and the reliance of most MENA countries on single donors, coupled with poor quality of service delivery/provision, absence of effective surveillance systems, inadequate monitoring and evaluation systems, lack of human resources, HIV/AIDS information and knowledge gaps, and limited geographical coverage of healthcare and HR services have had a double effect: reinforcing the high levels of stigma and discrimination towards HIV/AIDS and key populations, and preventing people from HIV testing. In the region, over the past decade, the number of those tested for HIV increased considerably among the general population - rather than key population. This created a discrepancy between the registered, estimated and actual PLHIV numbers. Yet, 37% of the population does not know their HIV status, largely due to low levels of HIV testing.

The MENA region has one of the highest growing HIV epidemics in the world, with 35% annual increase in newly detected HIV infections since 2001 (HIV and AIDS in the Middle East & North Africa (MENA), 2015b). In 2013, two country estimates (32%, Iran and 21%, Sudan) represented more than half the newly detected HIV infections (Gap Report 2014). The estimated PLHIV number is 240,000, among which 88 per cent are concentrated in five countries: Algeria, Iran, Morocco, Somalia and Sudan (UNAIDS 2014). A growing HIV epidemic is concentrated in Libya, Egypt and Afghanistan, while South Sudan, Djibouti, and Somalia have generalized epidemics. Recent data show that the HIV/AIDS situation in many countries is still unknown, (HIV/AIDS Alliance, 2016).

HIV/AIDS transmission modes vary from one country to another and within the same country. The two primary causes of HIV spread are unsafe sexual and injecting practices. Surveillance surveys conducted in some MENA countries over the past years revealed growing HIV epidemics among key populations, mainly PWIDs. According to UNAIDS 2016 estimates, 626,000 (299,000-1,280,000) people are injecting drugs in MENA. Among them, more than half are concentrated in Iran, Pakistan and Egypt (Mumtaz, 2014). PWIDs are among the populations most at risk of acquiring HIV/AIDS, with a prevalence 28 times higher than the general population, and an estimated number of 1 out of 7 PWID living with HIV/AIDS (Harm Reduction International, 2016).

PLHIV drug abuse resulted in a delayed HIV diagnosis, low level of HIV treatment retention, poor use of HR and healthcare services, and an increased risk of both an onward transmission of HIV, and AIDS-related deaths. While the rate of AIDS-related deaths declined by 45% at the global level since 2005, such deaths reach 66% in the region, largely in Iran, followed by Sudan, Somalia, and Morocco. ART coverage in the MENA is one of the lowest. Only 17% of PLHIV have access to HIV treatment (UNAIDS, 2016).

HIV/AIDS AND DRUG SITUATIONS IN THE 6 SELECTED COUNTRIES

Morocco

With an estimated PLHIV number of 30,000 [22,000-40,000], Morocco accounts for 13 per cent of all HIV- infected cases in the region, 51 per cent of which occurred between 2010 and 2014. Sexual transmission is the most common (85.1 per cent), and HIV epidemic is mainly concentrated in three regions, that comprise 56 per cent of all infected cases: Sous-Massa-Draa, Marrakesh-Tensift-El Haouz and Casablanca. The estimated PWID number is 18,500 with an HIV prevalence of 10.7 per cent and about 1,200 AIDS-related deaths. Morocco is the first country in the region to implement HR interventions and include Methadone in the standard package of services provided to PWIDs (Morocco Country Progress Reports 2015).

Tunisia

The estimated PLHIV number in Tunisia is 2,600 [1,700-3,800], with sexual transmission accounting for 63 per cent of all detected HIV positive cases, concentrated largely in Tunis and the coast. There are about 9,000 PWIDs with an HIV prevalence of 3.1 per cent and less than 100 AIDS-related deaths. The standard comprehensive care package of HR interventions and services for PWIDs does not include Opioid Substitution Therapy (OST), as it is yet to be implemented (Tunisia Country Progress Reports 2014).

Lebanon

The estimated PLHIV number is 2,400 [2,100-2,700]. HIV transmission mode is sexual for 90 per cent of all detected cases. According to the Ministry of Health, PWIDs number in Lebanon is between 2,000 and 3,000 with an HIV prevalence of about 1 per cent, and AIDS-related deaths accounting for less than 100. Lebanon introduced Buprenorphine as a drug replacement treatment in 2012. To date, about 1,000 PWIDs are on OST (Lebanon Country Progress Reports 2014).

Egypt

The estimated PLHIV number is 11,000 [7,200-19,000]. PWIDs number is about 30,000 with an HIV prevalence of 6.8 per cent (and less than 500 AIDS-related deaths) concentrated largely in Greater Cairo and Alexandria. In 2013, Egypt established the Network of Associations for Harm Reduction (NAHR) - a local network of all local HR associations/projects in the country. OST is not included in Egypt's standard package of services (Egypt Country Progress Reports 2015).

Pakistan

The estimated PLHIV number is 100,000 [77,000-160,000]. According to the 2012 UNODC drug survey, there are about 430,000 PWUDs, and 78 per cent amongst them inject drugs. Markedly, the PWID number had doubled from 2000 to 2012. HIV prevalence among PWIDs in Pakistan is one of the highest in the region (27.2 per cent), mostly concentrated in the main cities of Punjab and Sindh. AIDS-related deaths are estimated at 3,600. Pakistan standard package of HR services does not include OST (Pakistan Country Progress Reports 2015).

Afghanistan

The estimated PLHIV number in Afghanistan is 6,900 [3,800-16,000]. HIV prevalence is 4.4 per cent among PWIDs; the rate varies from one city to another with a prevalence of 0.3 per cent in Mazar and 13.3 per cent in Herat. AIDS-related deaths are less than 500. The estimated PWUDs number of 940,000, among which 23,000 are injecting drugs, is mostly concentrated in Kabul, Mazar-i-Sharif and Jalalabad cities. Afghanistan has introduced OST (Methadone) in its standard package of HR services (Afghanistan Country Progress Reports 2014).



RESEARCH METHODS

1.1. PURPOSE OF THE RESEARCH

The OR is to generate data on drug use and identify factors hindering PLHIV-WUDs/WIDs access to HR and HIV diagnosis, treatment, care and support services in the region. The results will serve as an evidence-based tool to identify barriers to the full utilization of said services as well as causes/consequences of the high levels of stigma and discrimination. Further, the results will be used as an advocacy tool to scale up existing services and assist countries in developing and implementing programmes and strategies specifically tailored to PLHIV-PWUDs/PWIDs.

1.2. RESEARCH OBJECTIVES

- To explore the drug use context among PLHIV-WUDs/WIDs
- To measure the levels of knowledge about HIV/AIDS, the harms of drug use, and HR and healthcare services
- To identify HR and healthcare services and service provision
- To define the reasons leading to stigma and discrimination
- To identify facilitators and barriers to PLHIV-WUDs/WIDs access to HR and HIV treatment, care and support services
- To provide recommendations for improved HR and healthcare services for PLHIV-WUDs/WIDs in the region

1.3. SELECTED COUNTRIES AND CSOS

Six countries (Morocco Tunisia, Lebanon, Egypt, Pakistan and Afghanistan) were chosen based on their representativeness of the main MENA sub-regions, data availability in terms of the existing problem and available PLHIV-WUDs/WIDs programmes/services, as well as willingness to participate. Nine CSOs were selected to participate in the research as shown in the following table:

TABLE 1

LIST OF CSOS IN PARTICIPATING COUNTRIES

COUNTRY	CSOS/HR PROJECT
MOROCCO	ASSOCIATION HASNOUNA DE SOUTIEN AUX USAGERS DE DROGUES (AHSUD), TANGER RÉSEAU DES ASSOCIATIONS DE RÉDUCTION DES RISQUES (RDR), SECTION DE NADOR
TUNISIA	ASSOCIATION TUNISIENNE DE LUTTE CONTRE LES MST ET LE SIDA (ATLS) CENTRE D'ACCUEIL POUR LA PRÉVENTION DE MELLASSINE, CENTRE D'ACCUEIL POUR LA PRÉVENTION DE GAFSA CENTRE D'ACCUEIL POUR LA PRÉVENTION DE KASSERINE ESPACE COMMUNAUTAIRES DE SOUSSE ESPACE LES JASMIN
LEBANON	SOINS INFIRMIERS ET DÉVELOPPEMENT COMMUNAUTAIRE (SIDC)
EGYPT	ASSOCIATION OF EVOLUTIONARY PSYCHIATRY IN CAIRO (HAYAT) YOUTH ASSOCIATION FOR POPULATION AND DEVELOPMENT IN ALEXANDRIA (YAPD) FRIENDS IN MINYA
PAKISTAN	AMITIEL WELFARE SOCIETY
AFGHANISTAN	ORGANIZATION OF HARM REDUCTION IN AFGHANISTAN (OHRA)

1.4. RESEARCH DESIGN

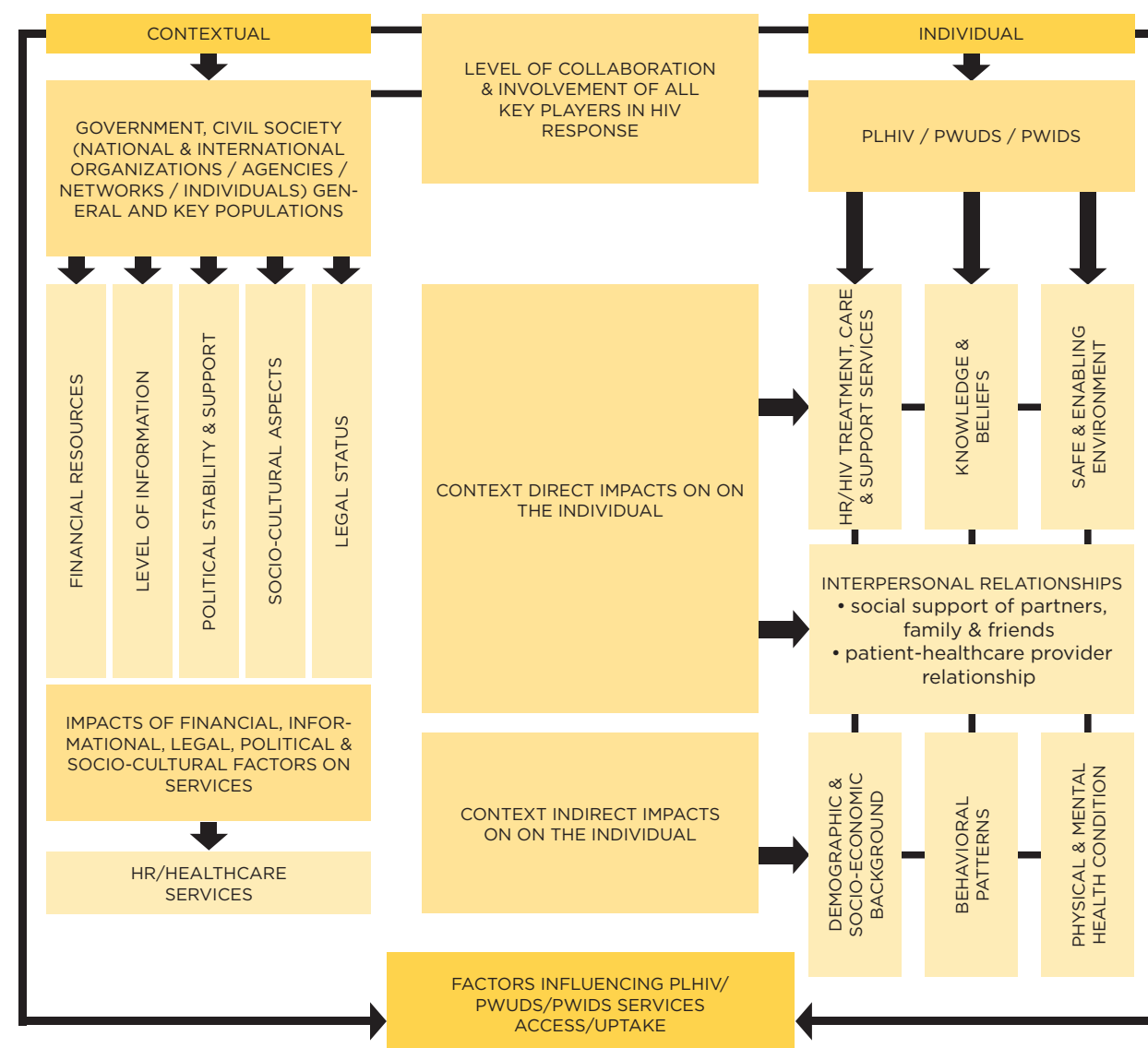
A qualitative approach was deemed appropriate to analyse and interpret data collected in the countries. Qualitative methods help understand a research problem from the local perspective and allow for detailed and in-depth comprehension of the study subjects' attitudes, opinions, beliefs, behaviours, and feelings about certain issues.

THE OR CONCEPTUAL FRAMEWORK

A main objective of the research was to explore the different personal and environmental factors that motivate PLHIV-WUDs/WIDs behaviours. Following the review of several models related to service uptake, the socio-ecological framework for determinants of uptake and retention in preventing mother to child transmission was found to be most compatible with the literature review findings. This is because individual, interpersonal, institutional and structural levels were identified as factors influencing service access/uptake (Busza et al, 2012).

FIGURE 1

OR CONCEPTUAL FRAMEWORK



FINANCIAL RESOURCES

- Level of HIV national & international funding
- Allocation of funding

LEVEL OF INFORMATION

- National HIV data/statistics
- Availability of research studies
- HIV related knowledge among GP

POLITICAL STABILITY & SUPPORT

- Assistance in the implementation of effective HR programs & stigma discrimination reduction strategies

LEGAL STATUS

- Human rights & HIV/AIDS
- Anti-discrimination laws
- Drug policy reforms

HR/HIV TREATMENT, CARE & SUPPORT SERVICES

- Availability
- Accessibility
- Quality

KNOWLEDGE & BELIEFS

- HIV/AIDS
- Harms of drug use
- HR/HIV related services
- HIV treatment

SAFE & ENABLING ENVIRONMENT

- Treatment with respect & dignity regardless of HIV status
- Societal acceptance & legal protection upon disclosure

SOCIO- CULTURAL ASPECTS

- Values
- Traditions
- Religious beliefs
- Level of HIV related stigma
- Gender norms & relations

HR/HEALTHCARE SERVICES

- Geographic coverage
- Adequate comprehensive care package of HR healthcare services
- Integration of HR in healthcare services
- Provcy & confidentiality of service
- Provision/delivery
- Gender specific services
- Revised clinical guidelines

DEMOGRAPHIC & SOCIO-ECONOMIC BACKGROUND

- Sex
- Age
- Education
- Income
- Occupation
- Marital status

BEHAVIORAL PATTERNS

- Drug history
- Substance use/abuse status
- Injecting & sexual trends

PHYSICAL & MENTAL HEALTH CONDITION

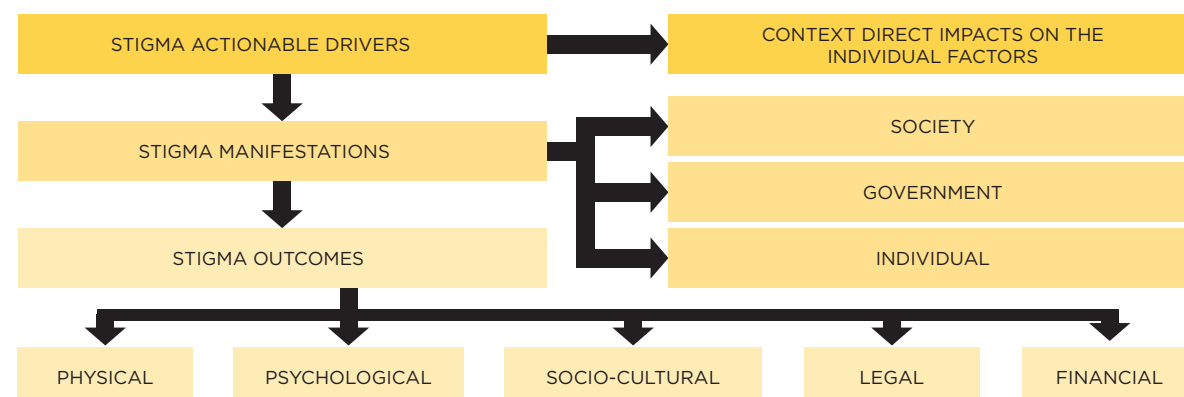
- Level of drug use related harms & HIV treatment impact on health

Stigma Conceptual Framework

The conceptual framework selected to identify the underlying causes and effects of HIV related stigma and discrimination was adapted from Stangl framework to reduce HIV-related Stigma and discrimination developed in 2010.

FIGURE 2

STIGMA ACTIONABLE DRIVERS, MANIFESTATIONS & OUTCOMES



1.5. RESEARCH SUBJECT INCLUSION/EXCLUSION CRITERIA

Eligibility criteria included: Men and women above 18 years, living with HIV/AIDS, using or injecting drugs at the time of data collection, and having had access to HR and HIV prevention, treatment and care services; PLHIV using or injecting drugs from different key population groups (MSM or sex workers); and PLHIV who used or injected drugs over the past year were also eligible to participate in the research. PLHIV under 18 years old or in prison settings were excluded.

KIs inclusion criteria were representatives of National AIDS Program (NAP)/government and international organizations/agencies, service providers in HR projects, and HCP in public and private healthcare settings working in the fields of HIV/AIDS and HR. KIs not working in the fields of HIV/AIDS and HR were excluded.

1.6. SAMPLING PROCEDURES

Both purposive and snowball sampling techniques were used to select participants through CSOs/HR projects. The sample size consisted of 230 participants, 149 of which were PLHIV-WUDs/WIDs (102 men and 47 women) and 81 KIs: 18 NAP/government representatives, 15 international organizations/agencies representatives, 24 service providers in HR projects and 24 HCP.

TABLE 2

SAMPLE SIZE OF PLHIV-WUDS/WIDS

PLHIV, PWUD/PWID N=149			
COUNTRY	MALES	FEMALES	TOTAL
MOROCCO	13	13	26
TUNISIA	13	13	26
LEBANON	16	3	19
EGYPT	14	12	26
PAKISTAN	13	13	26
AFGHANISTAN	26	0	26
TOTAL	102	47	149

TABLE 3

SAMPLE SIZE OF KEY INFORMANTS

KEY INFORMANTS N=78							
COUNTRY	MOR	TUN	LEB	EGY	PAK	AFG	TOTAL
NAP/GOVERNMENT REPRESENTATIVES	2	2	4	2	4	4	18
INTERNATIONAL ORGANIZATIONS AGENCIES REPRESENTATIVES	2	2	2	2	3	4	15
SERVICE PROVIDERS IN HR PROJECTS	4	4	4	4	4	4	24
HCP IN PUBLIC AND PRIVATE HOSPITALS	4	4	4	4	4	4	24
TOTAL OF KIS PER COUNTRY	12	12	14	12	15	16	81

1.7. DATA COLLECTION TOOLS

Data were collected by means of focus group discussions (FGDs), case studies and semi-structured interviews. Using a combination of both individual and group interviews allowed for a triangulation of research methods and sources, thus increasing the reliability and consistency of the findings. For the purpose of this research, six separate question guides, each including verbal consent forms and sociodemographic background questionnaires were developed.

TABLE 4

RESEARCH TOOLS

RESERACH TOOLS	NUM
FGDS WITH PLHIV-WUDS/WIDS	9
CASE STUDY WITH PLHIV-WUDS/WIDS	69
SEMI-STRUCTURED INTERVIEWS WITH NAP/GOVERNMENT REPRESENTATIVES	16
SEMI-STRUCTURED INTERVIEWS WITH INTERNATIONAL ORGANIZATIONS/AGENCIES	14
SEMI-STRUCTURED INTERVIEWS WITH SERVICE PROVIDERS IN HR PROJECTS	24
SEMI-STRUCTURED INTERVIEWS WITH HEALTHCARE PROVIDERS	24
TOTAL OF FGDS, CASE STUDIES AND SEMI STRUCTURED INTERVIEWS	9 FGDS 69 CASE STUDIES 81 SEMI STRUCTURED INTERVIEWS

1.8. DATA COLLECTION PROCESS

Focal points and team leaders in each country were selected to recruit research participants and assist in conducting FGDs, case studies and semi-structured interviews. The terms of references of the research team were developed and 11 focal points were trained by the Principal Investigator (PI) in Egypt, Lebanon, Morocco and Tunisia.

1.9. RECRUITMENT OF RESEARCH SUBJECTS

Both purposive and snowball techniques were used to select participants. Focal points ensured that selected participants met the OR inclusion criteria and understood its goal and objectives.

1.10. DATA QUALITY CHECK

Data were collected daily, followed by debriefing sessions by the PI and the Focal points, record of which were kept by the team leaders. The notes taken during FGDs, case studies, and semi-structured interviews were translated from Urdu, Persian, Arabic and French to English.

1.11. DATA ANALYSIS

Both constant comparison and classical content analysis methods were employed to analyse the data collected. Data were grouped per theme and assigned codes, and the frequency of theme emergence assessed. A matrix to assess consensus in the focus groups (with FGD questions and participant number) was used to calculate the number of FGD participants under each category.

1.12. ETHICAL CONSIDERATIONS

Ethical approvals were sought from the Institutional Review Boards of Sagesse University in Beirut and the Ministry of Public Health in Afghanistan. Ethical guidelines were followed throughout the OR's preparation and implementation stages, including by trained focal points. The OR subjects' consent and anonymity were secured.

1.13. RESEARCH CHALLENGES

Gender balance was sought when selecting participants, but was rather challenging. Women under-representation was prevalent in Afghanistan (0), Lebanon (3) and Morocco (6 women only). Another important research limitation is the representativeness of the sample size, which might not reflect the situation on the ground and which varies considerably among countries.

The lack of information about PLHIV in general, and PLHIV-WUDs/WIDs in particular was a challenge. Most of the service-access related indicators identified in the literature review were reflected in the research to define correlations, gaps and discrepancies among different factors. This led to developing lengthy questionnaires including up to 60 open-ended questions, the administration and interpretation of these proved to be time consuming.

It was rather hard to find and recruit PLHIV-WUDs/WIDs, because of the high levels of conservatism, the hidden nature of the targeted community, and fear of exposing of their HIV positive status. In fact, the reluctance of some to take part in FGDs prompted a radical change in the research methodology. Data had to be collected through individual case studies (69 instead of the 36 initially planned).

The translation of the data collected in local languages to English, along with the exclusion of ineligible interviews and recollection of others to ensure data reliability, greatly impacted timelessness of deliverables. This, coupled with the need to address the HIV epidemic in the region by generating relevant and previously unavailable data, steered the research exclusively towards PLHIV-WUDs/WIDs.

FINDINGS

2.1. SOCIODEMOGRAPHIC BACKGROUND

2.1.1. Number of Participants, Mean Age and Years of Living with HIV

The mean age of the 149 PLHIV-WUDs/WIDs - 102 males and 47 females- was 31.8 years (range: 28.7-35.2). Men were slightly older than women [32.7 for men vs 31 for women]. The youngest was 21 in Pakistan and the eldest was 61 in Afghanistan. The average mean years of living with HIV was 4.1 years [4.4 for men vs 3.9 for women]. The average mean years of living with HIV were much higher in Afghanistan, Tunisia, and Lebanon than Egypt, Pakistan and Morocco. The shortest duration of living with HIV was one week (Morocco) and the longest 19 years (Tunisia).

TABLE 5

NUMBER OF PARTICIPANTS, MEAN AGE AND YEARS OF LIVING WITH HIV/AIDS

NUMBER OF PARTICIPANTS, MEAN AGE AND YEARS OF LIVING WITH HIV/AIDS														
GENDER	MOR		TUN		LEB		EGY		PAK		AFG	TOTAL		ALL TOTAL
	M	W	M	W	M	W	M	W	M	W	M	M	W	
NUMBER OF PARTICIPANTS PER COUNTRY	20	6	13	13	16	3	14	12	13	13	26	102 [13-26] 68.5%	47 [3-13] 31.5%	149 [9-26]
MEAN AGE	31 [24-37]	30 [28-30]	33.1 [22-42]	33.6 [26-40]	33.6 [27-46]	32.3 [30-35]	33.2 [25-44]	31.4 [26-49]	30 [21-41]	27.5 [23-35]	35.2 [22-61]	32.7 [21-61]	31 [23-49]	31.8 YO [28.7 - 35.2]
MEAN AGE OF MEN & WOMAN	30.5		33.3		32.9		32.3		28.7		35.2	31.8		31.8
YEARS OF LIVING WITH HIV/AIDS	1.2 [1W - 2Y]	1.3 [3M - 2Y]	7.7 [2Y - 19Y]	6.3 [3M - 14Y]	6.1 [3Y - 11Y]	5.3 [4Y - 7Y]	1.8 [3M - 4Y]	4.7 [2Y - 12Y]	2.1 [3M - 4Y]	2.1 [6M - 4Y]	7.7 [2 - 15Y]	4.4 [1W - 19Y]	3.9 [3M - 14Y]	4.1Y [1.2 - 7.7 Y]
YEARS OF LIVING WITH HIV/AIDS BOTH GENDERS	1.2		7.0		5.7		3.2		2.1		7.7	4.2		4.1

2.1.2. Reasons for HIV Testing

Almost all Pakistanis tested for HIV when approached by HR projects, two Egyptians tested after engaging in risky sexual and/or injecting behaviours. Only 21, mostly men in Morocco and Lebanon tested during routine check-up. Others tested on account of poor health or during hospitalization. Testing following a partner's infection or death was reported by 12 (including 9 women from Tunisia, Lebanon and Egypt), during blood donation (1 each from Tunisia, Egypt and Pakistan) and through child HIV positive diagnosis (1Tunisian female).

TABLE 6

REASONS FOR HIV TESTING

REASONS FOR HIV TESTING N=114																
COUNTRY	MOR N=21		TUN N=26		LEB N=17		EGY N=18		PAK N=26		AFG N=26		TOTAL N=114		ALL TOT N=114	%
	M N=15	W N=6	M N=13	W N=13	M N=15	W N=2	M N=14	W N=4	M N=13	W N=13	M N=6	M N=76	W N=38			
APPROACHED BY HR PROJECT	1	0	0	0	0	0	2	0	13	11	0	16	11	27	23.7	
REGULAR CHECK UP	7	1	3	0	7	0	1	0	0	0	2	20	1	21	18.4	
FEELING SICK	4	1	7	2	1	1	5	0	0	0	0	17	4	21	18.4	
PRIOR TO METHADONE	2	3	0	0	0	0	0	0	0	0	3	5	3	8	7.0	
PARTNER INFECTED	0	0	0	0	3	1	0	3	0	0	0	3	4	7	6.1	
DURING HOSPITALIZATION	0	0	1	2	0	0	2	0	0	0	0	3	2	5	4.4	
PARTNER'S DEATH	0	0	0	5	0	0	0	0	0	0	0	0	5	5	4.4	
PARTNER FEELING SICK	0	0	0	3	0	0	0	0	0	0	0	0	3	3	2.6	
BLOOD DONATION	0	0	1	0	0	0	1	0	0	1	0	2	1	3	2.6	
EMPLOYER REQUEST	0	0	0	0	2	0	1	0	0	0	0	3	0	3	2.6	
PARTNER REQUEST	0	0	0	0	2	0	0	0	0	0	0	2	0	2	1.8	
RISKY BEHAVIOR	0	0	0	0	0	0	1	1	0	0	0	1	1	2	1.8	
CHILD TESTED +	0	0	0	1	0	0	1	0	0	0	0	1	1	2	1.8	
FRIENDS' ADVICE	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0.9	

REASONS FOR HIV TESTING N=114 (CONT'D)

PARTNER INJECTING DRUGS	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.9	
DRUG PARTNER INFECTED	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0.9	
FOLLOWING TB DIAGNOSIS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0.9	
PRIOR TO DETOXIFICATION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0.9

2.1.3. Marital Status

Reportedly, 49 per cent were single (the highest number in Lebanon and Morocco). Only 26.2 per cent were married (highest in Pakistan and Afghanistan). A high number of divorced (in Morocco and Egypt, then Tunisia). Half the women were either divorced or widowed. All seven widows were from Tunisia and Egypt. Two Egyptian women, and two Lebanese men were in relationships, and one Afghani man was engaged at the time of data collection.

TABLE 7

MARITAL STATUS

MARITAL STATUS N=149																
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26		TOTAL		ALL TOT N=149	%
	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47			
MARRIED	4	0	2	3	0	0	3	0	4	10	13	26 [0-13]	13 [0-10]	39 [0-14]	26.2	
ENGAGED	0	0	0	0	0	0	0	0	0	0	1	1 [0-1]	0 [0-1]	1 [0-1]	0.7	
IN A RELATIONSHIP	0	0	0	0	2	0	0	2	0	0	0	2 [0-2]	2 [0-2]	4 [0-2]	2.7	
SINGLE	13	0	8	3	14	2	8	2	8	3	12	63 [0-14]	10 [0-3]	73 [0-16]	49	
DIVORCED	3	6	3	3	0	1	3	5	1	0	0	10 [0-3]	15 [0-6]	25 [0-9]	16.8	
WIDOWED	0	0	0	4	0	0	0	3	0	0	0	0 [0]	7 [0-4]	7 [0-4]	4.7	

2.1.4. Number of Children, Mean Age and HIV Status

Thirty-seven per cent of participants had 128 children with a mean age of 8.2 years (range: 2 months-21 years). The highest number of children was in Afghanistan and Pakistan, then Egypt, Tunisia and Morocco. Only 41 of them were tested for HIV, including all children in Tunisia and Morocco. Four were found HIV positive (in Egypt, Tunis, and Morocco). One Moroccan participant who kept his HIV status to himself reported the pregnancy of his wife.

TABLE 8

NUMBER OF CHILDREN, MEAN AGE AND HIV STATUS

NUMBER OF CHILDREN, MEAN AGE AND HIV STATUS N=149						
COUNTRY	N	N OF PARTICIPANTS HAVING CHILDREN	N OF CHILDREN	MEAN AGE OF CHILDREN	N OF CHILDREN TESTED FOR HIV	HIV STATUS OF CHILDREN WHO TESTED FOR HIV
MOROCCO	26	8 (30.8%)	13	8 YO [2 - 16]	13/13	ONE CHILD WAS DETECTED HIV + (10 M)
TUNISIA	26	10 (38.5%)	17	11 YO [4 - 21]	17/17	ONE CHILD WAS DETECTED HIV + (14 YO)
EGYPT	26	10 (38.5%)	29	7.7 YO [2M - 21YO]	5/29	TWO CHILDREN WERE DETECTED HIV + (SIBLINGS 2 & 9 YO)
LEBANON	19	0 (0%)	0	NA	NA	NA
PAKISTAN	26	14 (53.8%)	33	7.8 YO [8M - 15YO]	6/33	ALL NEGATIVE
AFGHANISTAN	26	13 (50%)	36	6.4 YO [3 - 13]	UNKNOWN	UNKNOWN
TOTAL	149	55	128	8.2 YO [2M - 21YO]	41/128	4/41 WERE DETECTED HIV +
%		37	NA	NA	32	9.8

2.1.5. Educational Level

Educational attainment differed among participants. Illiteracy was observed only among 26 participants (in Pakistan, Afghanistan, Egypt and Morocco). A minimum of primary school education was found (in Lebanon and Tunisia), whereas Afghanistan had the lowest general level of education.

Most common was completion of primary education (28 per cent). At least one from each country completed high school except for Pakistan where the highest educational attainment was preparatory school. Completion of university was more prevalent among participants from Egypt and Lebanon.

Gender differences in educational attainment exist, with females scoring higher across all educational levels. Less women received no schooling (7 women vs 19 men), and more finished university than men (except for Lebanon).

TABLE 9

EDUCATIONAL LEVEL

EDUCATIONAL LEVEL N=149															
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26	TOTAL (IN %)		ALL TOT N=149	%
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47		
NO SCHOOLING COMPLETED	1	1	0	0	0	0	5	2	5	4	8	19 (18.6)	7 (14.9)	26	17.4
SOME PRIMARY SCHOOL COMPLETED	0	0	0	0	0	0	0	0	0	0	7	7 (6.9)	0 (0)	7	4.7
PRIMARY SCHOOL COMPLETED	5	4	4	5	3	2	1	1	4	4	9	26 (25.5)	16 (34)	42	28.2
PREPARATORY SCHOOL COMPLETED	13	1	0	1	3	0	1	1	4	5	0	21 (20.6)	8 (17)	29	19.5
SECONDARY SCHOOL COMPLETED	0	0	8	7	4	1	4	3	0	0	0	16 (15.7)	11 (23.4)	27	18.1
HIGH SCHOOL COMPLETED	1	0	1	0	1	0	2	0	0	0	1	6 (5.9)	0 (0)	6	4.0
UNIVERSITY COMPLETED	0	0	0	0	5	0	1	5	0	0	1	7 (6.9)	5 (10.6)	12	8.1

2.1.6. Employment Status

The rate of unemployment (60.4 per cent), inactivity and termination due to bad physical condition was relatively high (the highest in Egypt, Morocco, Tunisia, Pakistan and Lebanon respectively). About third did unskilled work, such as sex workers; merchandise porter at the borders (notably in Morocco); construction workers (in Tunisia); garbage scavengers, car and house cleaners (mostly in Pakistan); and street vendors and garbage collectors (in Afghanistan). Apart from one Tunisian female working (hairdresser), all others involved in semi-skilled and skilled work were from Lebanon (mostly freelancers and full-time employees in different organizations). With regard to part-time semi-skilled/skilled work, three worked in different HR projects (in Afghanistan). Two part-time unskilled participants from Lebanon and Pakistan worked as cleaners. Despite higher educational levels, unemployment rate was greater among females.

TABLE 10

EMPLOYMENT STATUS

EMPLOYMENT STATUS OF ALL PARTICIPANTS N=149																
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26	TOTAL (IN %)		ALL TOT N=149	%	
	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47			
FULL TIME SKILLED/ SEMI SKILLED WORK	0	0	0	1	9	0	0	0	0	0	0	9 (8.8)	1 (2.1)	10	6.7	
PART TIME SKILLED/ SEMI SKILLED WORK	0	0	0	0	0	0	0	0	0	0	3	3 (2.9)	0 (0)	3	2.0	
FULL TIME UNSKILLED WORK	5	4	8	0	2	0	2	0	7	7	9	33 (32.4)	11 (23.4)	44	29.5	
PART TIME UNSKILLED WORK	0	0	0	0	1	0	0	0	1	0	0	2 (2.0)	0 (0)	2	1.3	
UNEMPLOYED	15	2	5	12	4	3	12	12	5	6	14	55 (53.9)	35 (74.5)	90	60.4	

2.1.7. Income Sources

47.4 per cent (from Egypt, Morocco, Tunisia and Lebanon respectively) received family support. Partner support was reported (in Tunisia, Lebanon, and to a lesser extent Morocco and Egypt). Support from friends was only reported by 4 females (Tunisia and Lebanon); and theft (Tunisia and Pakistan). Other sources were country specific, including driving (Afghanistan), begging (Pakistan) and smuggling and drug dealing (Morocco).

TABLE 11

INCOME SOURCES

SOURCES OF INCOME N=78																
COUNTRY	MOR N=16		TUN N=15		LEB N=7		EGY N=15		PAK N=18		AFG N=7	TOTAL (IN %)		ALL TOT N=78	%	
	M N=13	W N=3	M N=3	W N=12	M N=4	W N=3	M N=7	W N=8	M N=13	W N=5	M N=7	M N=47	W N=31			
FAMILY SUPPORT	7	2	2	5	2	2	6	5	5	1	0	22 (46.8)	15 (48.4)	37	47.4	
PARTNER SUPPORT	1	0	0	3	2	0	0	1	0	0	0	3 (6.4)	4 (12.9)	7	9.0	
BEGGING	0	0	0	0	0	0	0	0	4	3	0	4 (8.5)	3 (9.7)	7	9.0	
ANY DAILY WORK	0	0	0	0	0	0	0	0	0	0	7	0 (0)	7 (22.6)	7	9.0	
STEALING	0	0	0	1	0	0	0	0	4	1	0	4 (8.5)	2 (6.5)	6	7.7	
FRIENDS SUPPORT	0	0	1	3	0	1	0	0	0	0	0	1 (2.1)	4 (12.9)	5	6.4	
SMUGGLING	4	1	0	0	0	0	0	0	0	0	0	4 (8.5)	1 (3.2)	5	6.4	
PENSIONS	0	0	0	0	0	0	1	2	0	0	0	1 (2.1)	2 (6.5)	3	3.8	
DRUG DEALING	1	0	0	0	0	0	0	0	0	0	0	1 (2.1)	0 (0)	1	1.3	

2.1.8. Housing Situation

At the time of data collection, 53 per cent resided in the family house, half of them from Egypt and Tunisia. Renting a house was the highest in Pakistan, and none in Egypt. Only two from Lebanon and one from Egypt lived at a partner's house, whereas two from Egypt and one from Tunisia lived at a friend's house. Homelessness (11.4 per cent) was mainly in Afghanistan followed by Morocco.

TABLE 12

HOUSING SITUATION

HOUSING SITUATION N=149															
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26	TOTAL (IN %)		ALL TOT N=149	%
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47		
STABLE HOUSE	2	2	2	0	2	0	1	0	3	0	4	14 (13.7)	2 (4.3)	16	10.7
RENTED HOUSE	3	0	1	3	6	0	0	0	3	6	9	22 (21.6)	9 (19.1)	31	20.8
FAMILY HOUSE	12	3	9	9	6	2	12	10	6	7	2	48 (47.1)	31 (66.0)	79	53
PARTNER'S HOUSE	0	0	0	0	2	0	0	1	0	0	0	2 (2.0)	1 (2.1)	3	2.0
FRIENDS HOUSE	0	0	1	0	0	0	1	1	0	0	0	2 (2.0)	1 (2.1)	3	2.0
HOMELESS	3	1	0	1	0	1	0	0	1	0	11	14 (13.7)	3 (6.4)	17	11.4

2.2. DRUG PATTERNS

2.2.1. Mean Age of Drug Use Initiation and Average Years of Drug Use

The mean age of drug use initiation was age 22.6 years: 22.2 for men and 23 for women (range: 19.5-25.4); with the lowest in Afghanistan (10 years) and the highest in Lebanon and Egypt respectively (41 years). Average years of drug use was 9.1 years and was higher among men (10.2 years) than women (8 years) (range: 7.3-13.5). The shortest (10 months) and longest (32 years) periods of drug use initiation was in Afghanistan.

TABLE 13

MEAN AGE OF DRUG USE INITIATION, AVERAGE AGE OF DRUG USE

MEAN AGE OF DRUG USE INITIATION, AVERAGE AGE OF DRUG USE N=149															
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26	TOTAL		ALL TOT N=149	
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47		
MEAN AGE OF DRUG USE INITIATION	21.6 [16-28]	20 [16-24]	21.3 [17-26]	25 [16-31]	25.6 [19-41]	25.3 [22-28]	25 [16-41]	21.7 [13-34]	20 [14-35]	22.8 [17-31]	19.5 [10-36]	22.2 YO [10-41]	23 YO [13-34]	22.6Y [20.8-25.4]	
MEN & WOMEN	20.8 [16-28]		23.1 [16-31]		25.4 [19-41]		23.3 [13-41]		21.4 [14-35]		19.5 [10-36]				
AVERAGE YEARS OF DRUG USE	10 [3-20]	10 [5-15]	11.8 [5-24]	8.5 [5-18]	7.6 [1-20]	7 [4-10]	8.4 [3-15]	9.7 [5-15]	10 [3-25]	4.7 [2-7]	13.5 [10M-32Y]	10.2 [10M-32Y]	8 [2-18Y]	9.1Y [7.3-13.5]	
MEN & WOMEN	10 [3-20]		10.1 [5-24]		7.3 [1-20]		9 [3-15]		7.3 [2-25]		13.5 [10M-32Y]				

2.2.2. Current Drug Use Situation

At the time of data collection, 29.5 per cent were on MMT (in Morocco and Afghanistan). About three quarter (77.8 per cent) - almost all females and about three quarter males- were using drugs regularly (notably in Tunisia, Egypt and Pakistan). The lowest number of drug users was in Afghanistan, while only 6 were using drugs occasionally. More than half (55 per cent) were injecting drugs (mostly women). Drug injection was the highest in Tunisia and Pakistan, followed by Egypt, and lowest in Morocco. Only five in Afghanistan were injecting drugs occasionally.

TABLE 14

CURRENT DRUG USE SITUATION

MEAN AGE OF DRUG USE INITIATION, AVERAGE AGE OF DRUG USE N=149															ALL TOT N=149	%
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26		TOTAL (IN %)			
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47			
CURRENT REGULAR DRUG USERS	12	3	13	13	13	3	14	12	13	13	7	72 [7-14] (70.6)	44 [3-13] (93.6)	116 [3-26]	77.8	
MEN & WOMEN	15 (57.7%)		26 (100%)		16 (84.2%)		26 (100%)		26 (100%)		7 (26.9%)					
CURRENT OCCASIONAL DRUG USERS	0	1	0	0	3	0	0	0	0	0	2	5 [0-3] (4.9)	1 [0-1] (2.1)	6 [0-3]	4.0	
MEN & WOMEN	1		0		3		0		0		2					
CURRENT INJECTING DRUG USERS	4	0	13	13	2	0	10	12	13	13	2	44 [2-13] (43.1)	38 [0-13] (80.8)	82 [0-26]	55	
MEN & WOMEN	4 (15.4%)		26 (100%)		2 (10.5%)		22 (84.6%)		26 (100%)		2 (7.7%)					
CURRENT OCCASIONAL INJECTING DRUG USERS	0	0	0	0	0	0	0	0	0	0	5	5 [0-5] (4.9)	0	5 [0-5]	3.4	
MEN & WOMEN	0		0		0		0		0		5					

2.2.3. Partner Drug Use Situation

Almost half the partners - mostly women's partners - were currently using drugs (mostly in Tunisia and Pakistan). Partners of the majority of Tunisian, more than half the Pakistani and almost half the Egyptian and Moroccan participants were currently injecting drug users. None of the partners of Afghani participants used or injected drugs at the time of data collection.

TABLE 15

PARTNER CURRENT DRUG USE SITUATION

PARTICIPANTS' PARTNERS CURRENT DRUG USE SITUATION N=149															ALL TOT N=149	%
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=26		TOTAL (IN %)			
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=26	M N=102	W N=47			
PARTNERS' CURRENTLY USING DRUGS	7	3	8	11	8	2	3	8	5	13	0	31 [0-8] (30.4)	37 [2-13] (78.7)	68 [0-19]	45.6	
MEN & WOMEN	10 (38.5%)		19 (73.1%)		10 (52.6%)		11 (42.3%)		18 (69.2%)		0 (0%)					
PARTNERS' CURRENTLY INJECTING DRUGS	7	3	8	11	3	0	3	8	4	12	0 (0%)	25 [0-8] (24.5)	34 [0-12] (72.3)	59 [0-19]	39.6	
MEN & WOMEN	10 (38.5%)		19 (73.1%)		3 (15.8%)		11 (42.3%)		16 (61.5%)		0 (0%)					

2.2.4. Types of Drugs Used

Polydrug abuse, or the mixture of different drugs, was prevalent among those currently using drugs. The drugs most commonly used were Heroin, (63.9%) (notably in Pakistan, Egypt and Morocco), cannabis (46.2%) (mostly in Lebanon, followed by Tunisia, Morocco and Afghanistan) and cocaine (32.8%) (high in Morocco and Lebanon). MDMA (ecstasy) was mostly consumed in Lebanon; Methamphetamine (Crystal Meth) by 5 (in Afghanistan and Lebanon); and Benzodiazepines (Diazepam and Temesta) was used by 3 (in Tunisia and Afghanistan). Other drugs were country specific: Buprenorphine (Subutex) was used in Tunisia, Pheniramine (Avil) in Pakistan; Tramadol and Tamol in Egypt; and opium in Afghanistan. Other prescription drugs, referred to simply as "pills" were used by 22.7 per cent, and Alcohol was consumed by 10.1 per cent (Morocco, Lebanon and Afghanistan).

TABLE 16

TYPES OF DRUGS CURRENTLY USED

TYPES OF DRUGS CURRENTLY USED N=119															
COUNTRY	MOR N=16		TUN N=26		LEB N=16		EGY N=26		PAK N=26		AFG N=9	TOTAL (IN %)		ALL TOT N=119	%
	M N=12	W N=4	M N=13	W N=13	M N=13	W N=3	M N=14	W N=12	M N=13	W N=13	M N=9	M N=74	W N=45		
HEROIN	12	4	5	1	0	0	8	11	13	13	9	47 (63.5)	29 (64.4)	76 [0-26]	63.9
CANNABIS	8	3	11	8	13	1	0	2	0	0	9	41 (55.4)	14 (31.1)	55 [0-19]	46.2
COCAINE	12	4	7	1	8	3	0	2	0	0	2	29 (39.2)	10 (22.2)	39 [0-16]	32.8
PHENIRAMINE (AVIL)	0	0	0	0	0	0	0	0	13	13	0	13 (17.6)	13 (28.9)	26 [0-26]	21.8
BUPRENORPHINE (SUBTEXT)	0	0	13	13	0	0	0	0	0	0	0	13 (17.6)	13 (28.9)	26 [0-26]	21.8
MDMA (ECSTASY)	0	0	4	1	9	0	0	0	0	0	1	14 (18.9)	1 (2.2)	15 [0-9]	12.6
TRAMADOL/TAMOL	0	0	0	0	0	0	9	4	0	0	0	9 (12.2)	4 (8.9)	13 [0-9]	10.9
OPIUM	0	0	0	0	0	0	0	0	0	0	6	6 (13.3)	0 (0)	6 [0-6]	5
METHAMPHETAMINE (CRYSTAL METH)	0	0	0	0	1	0	0	0	0	0	4	5 (6.7)	0 (0)	5 [0-4]	4.2
BENZODIAZEPINES (DIAPAZAM/TEMESTA)	0	0	1	2	0	0	0	0	0	0	2	2 (2.7)	2 (4.4)	4 [0-3]	3.4
OTHER PRESCRIPTION DRUGS	12	2	2	5	0	0	0	6	0	0	0	14 (18.9)	13 (28.9)	27 [0-14]	22.7
ALCOHOL	4	1	0	0	1	2	0	1	0	0	3	8 (10.8)	4 (8.9)	12 [0-5]	10.1

2.2.5. Needle and Syringe Sharing Practices

Around 56.1 per cent of those who used drugs at the time of data collection reported “always”, vs only 7.3 per cent reporting “sometimes”, sharing needles. Most of those who “always” shared needles were from Pakistan and Egypt, and of those “sometimes” sharing from Pakistan, Egypt and Morocco. Worthy to note that none in Afghanistan reported sharing needles in the first place.

TABLE 17

NEEDLES/SYRINGES SHARING PRACTICES AMONG CURRENT INJECTING DRUG USERS

NEEDLE/SYRINGE SHARING PRACTICES AMONG CURRENT INJECTING DRUG USERS N=82															
COUNTRY	MOR		TUN		LEB		EGY		PAK		AFG	TOTAL (IN %)		ALL TOT N=82	%
	M N=4	W N=0	M N=13	W N=13	M N=2	W N=0	M N=10	W N=12	M N=13	W N=13	M N=2	M N=44	W N=38		
ALWAYS SHARING NEEDLES	3	0	2	1	2	0	8	9	8	13	0	23 (52.3)	23 (60.5)	46	56.1
MEN & WOMEN	3		3		2		17		21		0				
SHARING NEEDLES SOMETIMES	1	0	0	0	0	0	2	0	3	0	0	6 (13.6)	0 (0)	6	7.3
MEN & WOMEN	1		0		0		2		3		0				

2.2.6. Factors Associated with Sharing Needles/Syringes

This research identified 15 reasons for sharing needles/syringes, the two common to half the participants were unavailability of syringes (51.5 per cent) and financial constraints (42.6 per cent). Syringe unavailability, as a primary cause for sharing needles, was most prevalent in Pakistan, followed by Egypt and Morocco.

TABLE 18

FACTORS ASSOCIATED WITH SHARING NEEDLES/SYRINGES

FACTORS ASSOCIATED WITH SHARING NEEDLES/SYRINGES N=101															
COUNTRY	MOR N=23		TUN N=15		LEB N=2		EGY N=19		PAK N=26		AFG N=16	TOTAL		ALL TOT N=101	%
	M N=20	W N=3	M N=4	W N=11	M N=2	W NA	M N=10	W N=9	M N=13	W N=13	M N=16	M N=65	W N=36		
UNAVAILABILITY OF SYRINGES	9	1	2	1	0	0	10	3	11	12	2	35	17	52	51.5
FINANCIAL CONSTRAINTS	2	2	0	5	0	0	1	1	8	13	11	22	21	43	42.6
WITHDRAWAL SYMPTOMS	7	2	1	0	0	0	0	2	0	0	0	8	4	12	11.9
FEAR FROM THE POLICE	2	0	0	0	0	0	4	2	0	0	0	6	2	8	7.9
LACK OF AWARENESS ABOUT DRUG INJECTION RISKS	2	0	1	1	0	0	0	0	0	0	3	6	1	7	6.9
PHARMACIST REFUSAL TO SELL SYRINGES	3	1	1	2	0	0	0	0	0	0	0	4	3	7	6.9
DISTANCE TO PHARMACY	2	1	1	1	0	0	0	0	0	0	0	3	2	5	4.9
DISTANCE TO HR PROJECT	2	1	0	0	0	0	0	0	0	0	0	2	1	3	3

FACTORS ASSOCIATED WITH SHARING NEEDLES/SYRINGES N=101 (CONT'D)

COUNTRY	MOR N=23		TUN N=15		LEB N=2		EGY N=19		PAK N=26		AFG N=16	TOTAL		ALL TOT N=101	%
	M N=20	W N=3	M N=4	W N=11	M N=2	W NA	M N=10	W N=9	M N=13	W N=13	M N=16	M N=65	W N=36		
SHARING IS PLEASURABLE	0	0	0	0	0	0	1	2	0	0	0	1	2	3	3
SHARING OUT OF LOVE	1	0	0	0	2	0	0	0	0	0	0	3	0	3	3
FEAR FROM SOCIAL WORKER	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1
SYRINGE SHUTTING DOWN	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1
NEEDS HELP IN INJECTION	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1
PHARMACY BEING ALWAYS CLOSED	0	0	0	1	0	0	0	0	0	0	0	0	1	1	1
LACK OF KNOWLEDGE ABOUT WHERE TO FIND SYRINGES	0	0	0	1	0	0	0	0	0	0	0	0	1	1	1

2.2.7. Reasons for Using Drugs

Eighteen reasons identified by 50 currently using drugs, the most significant were peer pressure, and partner, and family influence (one third), and experimenting and increasing energy level (another third). Other reasons included relieving stress and relax (notably in Lebanon); unemployment (mainly in Pakistan and Afghanistan); Poverty (Afghanistan and Tunisia); family stress (Tunisia, Egypt and Pakistan); and lack of awareness about the harms of drugs (in Pakistan), and about drug dealing (in Morocco), and hopelessness (Afghanistan and Pakistan). These and others are displayed in Table 19.

TABLE 19

REASONS FOR USING DRUGS

REASONS FOR USING DRUGS N=50															
COUNTRY	MOR N=16		TUN N=6		LEB N=10		EGY N=6		PAK N=6		AFG N=6	TOTAL		ALL TOT N=50	%
GENDER	M N=10	W N=6	M N=3	W N=3	M N=7	W N=3	M N=3	W N=3	M N=3	W N=3	M N=6	M N=32	W N=18		
PEER PRESSURE	4	1	1	1	1	0	1	0	0	0	0	7	2	9	18
TO INCREASE ENERGY / PHYSICAL ACTIVITY	0	3	0	1	0	2	1	0	0	1	1	2	7	9	18
EXPERIMENTING	2	1	0	1	0	0	0	0	2	1	0	4	3	7	14
TO RELIEVE STRESS/RELAX	2	0	0	0	4	1	0	0	0	0	0	6	1	7	14
UNEMPLOYMENT	0	0	0	0	0	0	0	0	0	3	3	3	3	6	12
PARTNER INFLUENCE	0	1	0	1	1	1	0	1	0	0	0	1	4	5	10
POVERTY	0	0	0	2	0	0	0	0	0	0	3	3	2	5	10
FAMILY STRESS	0	0	1	1	0	0	0	1	0	1	0	1	3	4	8
DRUG DEALING	1	2	0	0	0	0	0	0	0	0	0	1	2	3	6
LACK OF AWARENESS ABOUT THE HARMS OF DRUG USE	0	0	0	0	0	0	0	0	0	3	3	3	0	3	6
FAMILY INFLUENCE	0	0	0	0	0	0	0	0	1	1	0	1	1	2	4

REASONS FOR USING DRUGS N=50 (CONT'D)															
COUNTRY	MOR N=16		TUN N=6		LEB N=10		EGY N=6		PAK N=6		AFG N=6	TOTAL		ALL TOT N=50	%
GENDER	M N=10	W N=6	M N=3	W N=3	M N=7	W N=3	M N=3	W N=3	M N=3	W N=3	M N=6	M N=32	W N=18		
HOPELESSNESS	0	0	0	0	0	0	0	0	0	1	1	1	1	2	4
MOBILITY	1	0	0	0	0	0	0	0	0	0	0	1	0	1	2
LOW SELF ESTEEM	0	0	0	0	0	0	1	0	0	0	0	1	0	1	2
TO RELIEVE BOREDOM	0	0	0	0	0	0	1	0	0	0	0	1	0	1	2
FEELING LONELY	0	0	0	0	0	0	0	1	0	0	0	0	1	1	2
BEING MISTREATED	0	0	0	0	0	0	0	1	0	0	0	0	1	1	2
NOT CARING AFTER INFECTION	0	0	0	0	1	0	0	0	0	0	0	1	0	1	2

2.2.8. Drug Use Related Challenges

Fear of imprisonment and police harassment/physical abuse feature prominently as main challenges. About half the participants were imprisoned, some twice or thrice, for drug-related offenses, i.e., drug use, possession or dealing. The total number of incarcerations, excluding recidivism, was 108. Almost half the incarcerated and recidivists were from Morocco, where drug use related incarcerations were most prevalent. Such incarcerations also prevailed in Tunisia, Afghanistan, Egypt and Pakistan and dwindled to one in Lebanon. Egypt and Pakistan had the highest number incarcerations for drug possession.

On the other hand, drug dealing was common among participants from Morocco and Egypt, with small numbers in Afghanistan, Pakistan, and Tunisia, and none in Lebanon. One third of the participants cited imprisonment for theft, prostitution and fights. Other causes included extramarital sex, same sex relations, kidnapping, debts, illegal migration and document falsification.

TABLE 20

REASONS FOR INCARCERATION

REASONS FOR INCARCERATION N=71															
COUNTRY	MOR N=24		TUN N=10		LEB N=5		EGY N=11		PAK N=11		AFG N=10	TOTAL		ALL TOT N=71	%
	M N=19	W N=5	M N=7	W N=3	M N=4	W N=1	M N=7	W N=4	M N=7	W N=4	M N=10	M N=54	W N=17		
DRUG USE	13	2	5	2	1	0	3	2	4	1	5	31	7	38	53.5
DRUG DEALING	10	1	0	1	0	0	3	1	2	0	2	17	3	20	28.2
THEFT	5	0	1	1	0	0	0	0	1	2	4	11	3	14	19.7
DRUG POSSESSION	0	1	0	0	1	0	4	1	4	0	0	9	2	11	15.5
PROSTITUTION	0	4	0	1	0	0	0	2	0	1	0	0	8	8	11.3
FIGHTS	3	0	0	1	0	1	0	0	0	0	2	5	2	7	9.8
SEX OUTSIDE MARRIAGE	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1.4
SAME SEX RELATIONS	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1.4
FALSIFICATION OF DOCUMENTS	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1.4
KIDNAPPING	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1.4
ILLEGAL IMMIGRATION	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1.4
DEBTS	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1.4
NUMBER OF INCARCERATIONS	45		12		7 (*)		16		15		13	108			

(*) Three quarters of Lebanese men didn't disclose the motive for incarceration

Financial constraints are another major challenge affecting the lives of participants on many levels. Actually, most expressed the inability to abstain from drugs and unaffordability of proper treatment in rehabilitation centres, and to a lesser degree of transportation to HR and health services. Such constraints were further exacerbated by the prevalence of an unstable housing situation and unemployment among most participants, largely due to a history of incarceration and poor health.

Most women reported physical abuse and being forced in illicit activities such as exchanging sex for drugs and/or stealing. Some were forced to engage in unskilled activities such as garbage scavenging, begging, house cleaning to afford drugs (notably in Pakistan). Also, dysfunctional relations with family and community members, characterized by rejection, separation, divorce and loss of children custody. Other major challenges included discrimination, general public negative perception, lack of respect and trust due to low social status and bad reputation, as well as belonging to a highly stigmatized key population group, mainly injecting drug use, sex workers and MSM.

2.3. SEXUAL BEHAVIOUR

2.3.1. Condom Use

Around 44.8 per cent of the participants never used condoms when engaged in sexual relations (mostly in Egypt, Pakistan, followed by Morocco). Condoms were used consistently/regularly by almost all participants in Afghanistan and Tunisia, almost half those in Lebanon and Morocco, and more than a quarter in Pakistan. None used condoms regularly in Egypt. In fact, irregular condom use prevailed among participants in Egypt and Lebanon.

TABLE 21

LEVEL OF CONDOM USE

CONDOM USE N=136															
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=26		PAK N=26		AFG N=13	TOTAL (IN %)		ALL TOT N=136	%
	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=12	M N=13	W N=13	M N=13	M N=89	W N=47		
ALWAYS	12	0	13	8	9	2	0 (*)	0	6	0	11	51 (57.3)	10 (21.3)	61	44.8
MEN & WOMEN	12 (46.1)		21 (80.1)		11 (57.9)		0 (0)		6 (23.1)		11 (84.6)				
SOMETIMES	0	4	0	1	5	0	6	2	1	3	2	14 (15.7)	10 (21.3)	24	17.6
MEN & WOMEN	4 (15.4)		1 (3.8)		5 (26.3)		8 (30.8)		4 (15.4)		2 (15.4)				
NEVER	8	2	0	4	2	1	8	10	6	10	0	24 (27)	27 (57.4)	51	37.5
MEN & WOMEN	10 (38.5)		4 (15.4)		3 (11.5)		18 (69.2)		16 (61.5)		0 (0)				

(*) One male from Egypt reported regular condom use with his wife, but none with sex workers

2.3.2. Reasons for Non-condom Use

Twenty-one reasons were reported by 45 participants, among whom 5 reported having no sexual partner at the time of data collection. In Morocco where the level of HIV status non-disclosure was the highest, the main reason was fear of status discovery by the sexual partner. Reduced sexual sensation/pleasure was reported (in Lebanon, Egypt and Pakistan) as well as condom unavailability at the time of sexual relation (in Tunisia, Lebanon, Egypt and Pakistan).

The misconception that there is no need to use a condom with an infected partner was reported by three from Tunisia, and one each from Morocco and Lebanon. Never actually using condoms with infected sexual partners was also the case of one each from Egypt and Lebanon. Three females from Egypt and one from Morocco reported partner refusal to use condoms during sexual relations.

Lack of awareness about the risks of non-condom use was expressed by three (from Egypt and Tunisia). Two from Morocco cited trust in their partners; two from Pakistan disliked the condom smell; while two others lacked the financial resources to buy condoms. For not using condoms, females in Morocco gave the following justifications: commercial sex clients pay more for unprotected sex, sexual over activity, fear of partner's violence, not caring for condom use, and aversion to condoms. One participant from Pakistan reported dislike for the semen discharge in the condom. One participant from each of Lebanon and Pakistan argued that women cannot use condoms and that the decision not to use condoms was upon the partner's request.

TABLE 22

REASONS FOR NON-CONDOM USE

COMMON REASONS FOR NON-CONDOM USE N=45															
COUNTRY	MOR N=14		TUN N=5		LEB N=8		EGY N=10		PAK N=8		AFG N=0	TOTAL		ALL TOT N=101	%
	M N=8	W N=6	M N=0*	W N=5	M N=7	W N=1	M N=6	W N=4	M N=5	W N=3	M N=0*	M N=26	W N=19		
FEAR FROM PARTNER SUSPICION	4	1	0	0	0	0	1	0	0	0	0	5	1	6	13.3
REDUCED SEXUAL SENSATION/PLEASURE	0	0	0	0	3	0	2	0	1	0	0	5	1	6	13.3
PARTNER INFECTED	1	0	0	3	1	0	0	0	0	0	0	2	3	5	11.1
NOT HAVING A SEXUAL PARTNER	4	0	0	0	0	1	0	0	0	0	0	4	1	5	11.1
PARTNER REFUSAL TO USE CONDOMS	0	1	0	0	0	0	0	3	0	0	0	0	4	4	8.9
UNAVAILABILITY OF CONDOMS	0	0	0	1	1	0	1	0	1	0	0	3	1	4	8.9
LACK OF AWARENESS ABOUT THE RISKS	0	0	0	1	0	0	1	1	0	0	0	1	2	3	6.7
TRUST IN PARTNER	2	0	0	0	0	0	0	0	0	0	0	2	0	2	4.4

(*) All male participants from Tunisia reported regular condom use with all partners

(*) The two from Afghanistan who reported not using condoms consistently, didn't reply to this question

COMMON REASONS FOR NON-CONDOM USE N=45 (CONT'D)																
COUNTRY	MOR N=14		TUN N=5		LEB N=8		EGY N=10		PAK N=8		AFG N=0	TOTAL		ALL TOT N=101	%	
	M N=8	W N=6	M N=0*	W N=5	M N=7	W N=1	M N=6	W N=4	M N=5	W N=3	M N=0*	M N=26	W N=19			
DISLIKING CONDOMS SMELL	0	0	0	0	0	0	0	0	0	1	1	0	1	1	2	4.4
NEVER USING CONDOMS WITH INFECTED PERSONS	0	0	0	0	1	0	1	0	0	0	0	2	0	2	4.4	
LACK OF FINANCIAL RESOURCES	0	0	0	0	0	0	0	0	1	1	0	1	1	2	4.4	
CLIENTS' PAYING MORE WITHOUT A CONDOM	0	1	0	0	0	0	0	0	0	0	0	0	1	1	2.2	
FEAR FROM PARTNER VIOLENCE	0	1	0	0	0	0	0	0	0	0	0	0	1	1	2.2	
NOT CARING ABOUT CONDOM USE	0	1	0	0	0	0	0	0	0	0	0	0	1	1	2.2	
BEING SEXUALLY TOO ACTIVE	0	1	0	0	0	0	0	0	0	0	0	0	1	1	2.2	
DOESN'T LIKE CONDOMS	1	0	0	0	0	0	0	0	0	0	0	1	0	1	2.2	
NOT CARING ABOUT CONDOM USE	0	1	0	0	0	0	0	0	0	0	0	0	1	1	2.2	
DOESN'T LIKE THE SEMEN DISCHARGE IN THE CONDOM	0	0	0	0	0	0	0	0	1	0	0	1	0	1	2.2	
WOMEN CAN'T USE CONDOMS	0	0	0	0	0	0	0	0	0	1	0	0	1	1	2.2	
PARTNER REQUEST	0	0	0	0	1	0	0	0	0	0	0	1	0	1	2.2	

(*) One Egyptian male reported regular condom use with his wife, but none with sex workers

(*) All males from Tunisia reported regular condom use with all partners

2.4. LEVEL OF KNOWLEDGE ABOUT HIV AND AIDS, HIV/AIDS TRANSMISSION MODES AND PREVENTION METHODS

2.4.1. Knowledge about HIV and AIDS

More than half the participants who replied to this question did not provide a definition of AIDS in their answers. About third (30.9 per cent) of the participants stated not knowing the difference between HIV and AIDS (majority in Egypt and Morocco), and that there is no difference between HIV and AIDS. Half the participants who reported that HIV is a virus leading to death were from Egypt, whereas five (in Lebanon, Morocco and Tunisia) related HIV to death.

TABLE 23

LEVEL OF KNOWLEDGE ABOUT HIV AND AIDS

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS N=123														
COUNTRY	MOR N=25		TUN N=22		LEB N=17		EGY N=22		PAK N=26		AFG N=11	TOTAL PER GENDER N=123		ALL TOTAL (IN %)
GENDER	M N=19	W N=6	M N=9	W N=13	M N=14	W N=3	M N=14	W N=8	M N=13	W N=13	M N=11	M N=80	W N=43	
DON'T KNOW THE DIFFERENCE BETWEEN HIV AND AIDS	8	3	0	6	1	0	6	4	0	1	0	15	14	29 (23.8)
HIV IS A VIRUS THAT WEAKENS THE IMMUNE SYSTEM, ITS LAST PHASE IS AIDS	0	1	4	3	2	0	0	0	0	0	9	4	15	19 (15.4)
HIV IS A VIRUS THAT HAS TREATMENT AIDS DOESN'T HAVE A TREATMENT	0	0	0	0	0	0	0	0	8	6	0	8	6	14 (11.4)
HIV IS A VIRUS THAT WEAKENS THE IMMUNE SYSTEM	3	1	1	0	1	1	3	3	0	0	0	8	5	13 (10.6)
HIV IS A VIRUS; AIDS IS A COMBINATION OF MANY DISEASES	0	0	0	0	0	0	0	0	5	6	0	5	6	11 (8.9)
THERE IS NO DIFFERENCE BETWEEN HIV AND AIDS	3	0	2	1	0	1	1	1	0	0	0	6	3	9 (7.3)

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS N=123 (CONT'D)														
COUNTRY	MOR N=25		TUN N=22		LEB N=17		EGY N=22		PAK N=26		AFG N=11	TOTAL PER GENDER N=123		ALL TOTAL (IN %)
GENDER	M N=19	W N=6	M N=9	W N=13	M N=14	W N=3	M N=14	W N=8	M N=13	W N=13	M N=11	M N=80	W N=43	
HIV IS A VIRUS THAT LEADS TO DEATH	2	0	1	0	1	1	4	0	0	0	0	8	1	9 (7.3)
HIV IS A VIRUS THAT WEAKENS THE IMMUNE SYSTEM & TURNS INTO AIDS IF NOT TREATED	1	1	0	0	6	0	0	0	0	0	0	7	1	8 (6.5)
HIV IS AN STI	0	0	0	3	0	0	0	0	0	0	0	0	3	3 (2.4)
THE VIRUS EVOLVES AND BECOMES AIDS	2	0	0	0	0	0	0	0	0	0	0	2	0	2 (1.6)
HIV IS A MICROBE THAT WEAKENS THE IMMUNE SYSTEM AND CAUSES MANY DISEASES	0	0	0	0	0	0	0	0	0	0	2	2	0	2 (1.6)
HIV IS A VIRUS THAT DOESN'T HAVE A TREATMENT	0	0	0	0	0	0	0	0	8	6	0	8	6	14 (11.4)
HIV IS A NON-TREATABLE DISEASE	0	0	0	0	2	0	0	0	0	0	0	2	0	2 (1.6)
HIV IS A SMALL VIRUS AND AIDS IS A BIG VIRUS	0	0	0	0	0	0	0	0	0	2	0	0	2	2 (1.6)
AIDS IS WHEN THE PERSON STARTS TAKING MEDICATION	0	0	1	0	0	0	0	0	0	0	0	1	0	1 (0.81)
HIV IS A VIRUS AND AIDS AN ILLNESS THAT HAS SYMPTOMS	0	0	0	0	1	0	0	0	0	0	0	1	0	1 (0.81)

2.4.2. Knowledge about HIV/AIDS Transmission Modes

The four major modes of HIV transmission are blood, semen, vaginal fluid and breast milk. Yet, 19 different modes were mentioned by the 132 participants; 1 to 4 modes per participant. More than half (55.3%) reported needle/syringe sharing, followed by blood (52.3%), unprotected sex (36.4%) and mother to child/breast milk (34.1%). Only 6.8 per cent (8 from Morocco and 1 from Afghanistan) cited sharing injection equipment. Pakistani participants were the most knowledgeable, reporting needles/syringes sharing and unprotected sex as major HIV transmission modes. Almost all Afghani and two third Tunisian participants had correct knowledge about blood as a mode of transmission, followed by Morocco, Egypt, Lebanon and only 2 from Pakistan. Seven from Pakistan and four from Egypt, mainly women, viewed blood transfusion as a mode of HIV transmission.

Inaccurate knowledge about HIV transmission through sex was prevalent. More than one third reported sex and sexual relations (notably in Egypt). Others included: anal sex (5 in Afghanistan, Egypt and Morocco); engaging in illicit or extramarital sex, and having many sexual partners (2 from Afghanistan and Lebanon); sharp tools such as razor blades, nail clippers and surgical instruments (mostly in Morocco and Pakistan); toothbrushes (6 from Morocco, Lebanon and Afghanistan); personal utensils and infected wounds (Pakistan); and shaking hands and kissing someone (Morocco).

TABLE 24

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS TRANSMISSION MODES

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS TRANSMISSION MODES N=132															ALL TOT	%
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=22		PAK N=26		AFG N=13	TOTAL PER GENDER N=132				
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=8	M N=13	W N=13	M N=13	M N=89	W N=43			
NEEDLES/ SYRINGES SHARING	8	0	7	8	2	1	11	3	13	12	8	49	24	73	55.3	
BLOOD	11	5	11	8	9	0	9	3	1	1	11	52	17	69	52.3	
UNPROTECTED SEX	1	0	3	2	13	2	0	0	13	13	1	31	17	48	36.4	
SEX/ SEXUAL RELATIONS	7	3	2	6	1	2	13	5	0	0	6	29	16	45	34.1	
MOTHER TO CHILD/ BREAST MILK	1	1	2	4	0	0	3	1	0	0	6	12	6	18	13.6	
RAZOR BLADE	5	0	0	0	0	0	0	0	6	1	1	12	1	13	9.8	
BLOOD TRANSFUSION	0	0	0	0	0	0	1	3	1	6	0	2	9	11	8.3	

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS TRANSMISSION MODES N=132 (CONT'D)															ALL TOT	%
COUNTRY	MOR N=26		TUN N=26		LEB N=19		EGY N=22		PAK N=26		AFG N=13	TOTAL PER GENDER N=132				
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=14	W N=8	M N=13	W N=13	M N=13	M N=89	W N=43			
INJECTION EQUIPMENT SHARING	6	2	0	0	0	0	0	0	0	0	1	7	2	9	6.8	
SURGICAL INSTRUMENT	0	0	0	0	0	0	0	0	2	3	3	5	3	8	6	
NAIL CLIPPER	1	1	0	0	0	0	0	0	2	1	1	4	2	6	4.5	
TOOTH BRUSH	4	0	0	0	1	0	0	0	0	0	1	6	0	6	4.5	
ANAL SEX	1	0	0	0	0	0	0	2	0	0	2	3	2	5	3.8	
SHARP INSTRUMENTS	4	2	0	0	0	0	0	0	0	0	0	4	0	4	3	
SEMEN	3	0	0	0	0	0	0	0	0	0	1	4	0	4	3	
PERSONAL UTENSILS	0	0	0	0	0	0	0	0	2	0	0	2	0	2	1.5	
ILLICIT SEX	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0.7	
MULTIPLE SEXUAL PARTNERS	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0.7	
INFECTED WOUNDS	0	0	0	0	0	0	0	0	1	0	0	1	0	1	0.7	
SHAKING HANDS/ KISSING	1	0	0	0	0	0	0	0	0	0	0	1	0	1	0.7	

2.4.3. Knowledge about HIV/AIDS Prevention Methods

More than half reported that condom use and injecting drugs with new/clean syringes were the two main HIV/AIDS prevention methods. Just like with transmission modes, Pakistan had the greatest number of participants who viewed condom use and new/clean syringes as prevention methods. Only Moroccans mentioned the use of new/clean injection equipment and one Lebanese mentioned pre-exposure prophylaxis. Other methods included quitting drug use and not engaging in illicit sex by Egyptians. Misconceptions prevailed though and included razor blades, nail clippers and surgical instruments (mostly in Morocco, Pakistan and Afghanistan); toothbrush (in Morocco, Lebanon and Afghanistan); personal utensils and infected wounds (Pakistan); and finally shaking hands and kissing someone (Morocco).

TABLE 25

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS PREVENTION METHODS

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS PREVENTION METHODS N=130															
COUNTRY	MOR N=26		TUN N=26		LEB N=18		EGY N=21		PAK N=26		AFG N=13	TOTAL PER GENDER N=132		ALL TOT N=130	%
	M N=20	W N=6	M N=13	W N=13	M N=15	W N=3	M N=14	W N=7	M N=13	W N=13	M N=13	M N=88	W N=42		
CONDOM USE	14	5	12	8	13	3	6	2	12	11	9	66	29	95	73
NEW/CLEAN SYRINGES	10	4	11	9	3	0	6	6	13	11	7	50	30	80	61.5
SCREENING ALL BLOOD PRODUCTS	0	0	0	0	1	0	2	2	1	8	1	5	10	15	11.5
NEW/OWN RAZOR BLADE	4	0	0	0	0	0	0	0	5	0	2	11	0	11	8.5
NEW/CLEAN INJECTION EQUIPMENT	10	0	0	0	0	0	0	0	0	0	0	10	0	10	7.7
TO QUIT USING DRUGS	0	0	0	0	0	0	7	1	0	0	1	8	1	9	6.9
TO NOT ENGAGE IN ILLICIT SEX	2	0	0	1	0	0	3	2	0	0	0	5	2	7	5.4
TO STERILIZE ALL EQUIPMENT	0	0	0	0	1	0	0	0	2	2	2	5	2	7	5.4
UP OF PREGNANT WOMEN	0	0	3	0	0	1	0	0	0	0	0	3	1	4	3

LEVEL OF KNOWLEDGE ABOUT HIV/AIDS PREVENTION METHODS N=130 (CONT'D)															
COUNTRY	MOR N=26		TUN N=26		LEB N=18		EGY N=21		PAK N=26		AFG N=13	TOTAL PER GENDER N=132		ALL TOT N=130	%
	M N=20	W N=6	M N=13	W N=13	M N=15	W N=3	M N=14	W N=7	M N=13	W N=13	M N=13	M N=88	W N=42		
TO USE NEW/OWN NAIL CLIPPER	0	0	0	0	0	0	0	0	0	2	1	1	2	3	2.3
TO NOT SHARE SHARP EQUIPMENT	3	0	0	0	0	0	0	0	0	0	0	3	0	3	2.3
HIV TEST BEFORE MARRIAGE	0	0	0	3	0	0	0	0	0	0	0	0	3	3	2.3
TO AVOID PROBLEMS	0	0	1	2	0	0	0	0	0	0	0	1	2	3	2.3
TO ABSTAIN FROM DONATING BLOOD	0	0	0	0	0	0	1	0	0	1	0	1	1	2	1.5
TO NOT SHARE UTENSILS/ TOOLS	0	0	0	0	0	1	0	1	0	0	0	0	2	2	1.5
TO AVOID HAVING MULTIPLE SEXUAL PARTNERS	1	0	0	0	0	0	0	0	0	0	1	2	0	2	1.5

2.4.4. Sources of HIV/AIDS Information/Knowledge

About 80 per cent of participants (all from Morocco and Pakistan, then Tunisia and Afghanistan) reported CSO/HR projects as the main source of HIV/AIDS knowledge. Those who acquired such knowledge from hospitals were mainly in Tunisia, followed by Lebanon and Egypt. Only three Moroccans and two Pakistanis acquired knowledge from HCP/Hospital. Interestingly, none from Afghanistan acquired knowledge through healthcare facilities. On the other hand, NAP was the source for one third of Egyptian participants, while knowledge from the internet mostly prevailed in Tunisia and Lebanon. Other sources included television (Morocco, Egypt, Afghanistan and Lebanon); radio (Afghanistan); awareness campaigns (Morocco and Tunisia); friends and other PLHIV/drug addicts (third Egyptian participants); prison (Morocco); and publications (one Lebanese).

TABLE 26

SOURCES OF INFORMATION/KNOWLEDGE ABOUT HIV/AIDS

SOURCES OF INFORMATION/KNOWLEDGE ABOUT HIV/AIDS N=133											
COUNTRY	N	CSO/HR PROJECT	HCP/HOSPITAL	NAP	INTER-NET	TV	RADIO	AWARE-NESS CAMPAIGN	FRIENDS/ OTHER PLHIV/ DRUG ADDICTS	PRISON	NUMBER OF SOURCES
MOROCCO	26	26	3	0	3	5	0	2	4	2	45
TUNISIA	26	25	15	0	5	0	0	1	1	0	47
LEBANON	19	6	8	0	5	1	0	0	0	0	20
EGYPT	23	10	7	8	1	4	0	0	8	0	38
PAKISTAN	26	26	2	0	0	0	0	0	2	0	30
AFGHANISTAN	13	12	0	0	0	3	3	0	0	0	18
TOTAL	133	105	35	8	14	13	3	3	15	2	198
%	89.2 OF ALL PARTICIPANTS	78.9	26.3	6	10.5	9.8	2.2	2.2	11.3	1.5	NA

(*) One participant from Morocco mentioned media and a participant from Lebanon mentioned publications

2.5. LEVEL OF KNOWLEDGE ABOUT DRUG USE RELATED HARMS

PLHIV drug use/abuse damages the immune system, increases HIV progression in the body and the risk of HIV transmission, and affects PLHIV compliance to ART and access to healthcare and HR services. Knowledge of drug use harms was largely based on the personal experiences and health conditions of participants or other infected PLHIV-WUDs/WIDs. This research classified drug use related harms into three distinct categories: Physical harms, Mental harms, and Other/Social Harms, such as incarceration, job loss, family and marital problems.

2.5.1. Knowledge about Drug Use Physical Harms

About one quarter (24.2 per cent) of participants, mainly Moroccans, Tunisians and Egyptians, reported Hepatitis C virus (HCV) as the major drug use related harm. Moreover, overdose was reported by 22.1% of participants, HIV/AIDS by 17.4% and Tuberculosis (TB) by 11.4%.

TABLE 27

LEVEL OF KNOWLEDGE ABOUT THE PHYSICAL HARMS OF DRUG USE

LEVEL OF KNOWLEDGE ABOUT PHYSICAL HARMS N=149								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=149	%
HCV	19	10	1	2	0	4	36	24.2
OVER-DOSE	17	0	3	9	4	0	33	22.1
HIV/AIDS	1	17	2	0	5	1	26	17.4
TB	11	0	0	0	6	0	17	11.4
FEVER	0	7	0	0	7	0	14	9.4
STIS	0	0	6	6	0	1	13	8.4
FATIGUE	1	0	0	0	4	5	10	6.7
BREATHING PROBLEMS	1	0	0	0	4	3	8	5.4
VOMITING/ NAUSEA	0	4	0	0	4	0	8	5.4
CANCER	4	0	0	1	2	0	7	4.7
LIVER PROBLEMS	3	0	0	0	4	0	7	4.7
WEIGHT LOSS/ LOSS OF APETITE	0	5	0	1	1	0	7	4.7
NECK PAIN	0	0	0	7	0	0	7	4.7
HBV	1	0	0	1	0	3	5	3.3
HEART DISEASE/ PROBLEMS	1	0	1	1	1	1	5	3.3

LEVEL OF KNOWLEDGE ABOUT PHYSICAL HARMS N=149 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=149	%
ULCERS	4	0	0	0	0	0	4	2.7
DIARRHEA	0	1	0	1	1	1	4	2.7
INFECTIOUS DISEASES	0	0	3	0	0	1	4	2.7
ABSCESSSES	0	0	0	0	2	2	4	2.7
AMPUT- ATION	0	0	0	1	2	1	4	2.7
VEIN COLLAPSES	3	0	0	0	0	0	3	2
DEATH	3	0	0	0	0	0	3	2
COLD	0	2	0	0	0	1	3	2
DETERIO- RATION OF HEALTH STATUS	0	0	0	2	0	1	3	2
ASTHMA	0	0	0	3	0	0	3	2
ABSCESSSES	2	0	0	0	0	0	2	1.3
JAUNDICE	0	0	0	0	2	0	2	1.3
TB	0	1	1	0	0	0	2	1.3
SHIV- ERING	0	0	0	0	2	0	2	1.3

LEVEL OF KNOWLEDGE ABOUT PHYSICAL HARMS N=149 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=149	%
CHEST PAIN	0	0	0	2	0	0	2	1.3
HEADACHE	0	1	0	0	0	0	1	0.7
ALLERGIES	0	1	0	0	0	0	1	0.7
TEETH FALLING	0	1	0	0	0	0	1	0.7
HAIR LOSS	0	1	0	0	0	0	1	0.7
DRY LIPS	0	1	0	0	0	0	1	0.7
DARK CIRCLES	0	1	0	0	0	0	1	0.7
CANCER	0	0	1	0	0	0	1	0.7
HYPER TENSION	0	0	1	0	0	0	1	0.7
GANGRENE	0	0	0	1	0	0	1	0.7
WOUNDS	0	0	0	1	0	0	1	0.7
STOMACH PAIN	0	0	0	1	0	0	1	0.7
GONORRHEA	0	0	0	0	1	0	1	0.7

LEVEL OF KNOWLEDGE ABOUT PHYSICAL HARMS N=149 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=149	%
SEXUAL DYSFUNCTION	0	0	0	0	1	0	1	0.7
WITHDRAWAL SYMPTOMS	0	0	0	0	1	0	1	0.7
PARALYSIS	0	0	0	0	1	0	1	0.7
INFECTED WOUNDS	0	0	0	0	1	0	1	0.7
ANAL BLEEDING	0	0	0	0	1	0	1	0.7
SKIN RASH	0	0	0	0	1	0	1	0.7
VEIN COLLAPSES	0	0	0	0	1	0	1	0.7
DIZZINESS	0	0	0	0	0	1	1	0.7
DROWSINESS	0	0	0	0	0	1	1	0.7
NAUSEA	1	0	0	0	0	0	1	0.7
DIZZINESS	1	0	0	0	0	0	1	0.7

2.5.2. Knowledge about Drug Use Mental Harms

Almost half the participants (48.1%) viewed depression as the major harm related to drug use, followed by isolation/loneliness (21.8%), aggression (18%) and suicidal thoughts (11.3%).

TABLE 28

LEVEL OF KNOWLEDGE ABOUT DRUG USE MENTAL HARMS

LEVEL OF KNOWLEDGE ABOUT MENTAL HARMS N=133								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=133	%
DEPRESSION	17	17	13	11	5	1	64	48.1
ISOLATION/ LONELINESS	5	17	3	3	1	0	29	21.8
AGGRESSION	14	1	1	1	5	2	24	18
SUICIDAL THOUGHTS	5	1	1	5	3	0	15	11.3
RESTLESSNESS	0	0	0	0	10	0	10	7.5
MEMORY LOSS	0	1	0	0	0	6	7	5.2
MOOD SWINGS	0	1	3	2	0	0	6	4.5
FEARFULNESS/ FEAR FROM OTHERS	2	0	0	0	4	0	6	4.5
ANXIETY	0	3	1	0	0	1	5	3.7
MEMORY LOSS	0	0	0	2	3	0	5	3.7

LEVEL OF KNOWLEDGE ABOUT MENTAL HARMS N=133 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=133	%
HATRED	0	0	1	3	0	0	4	3
SOCIAL PHOBIA	0	4	0	0	0	0	4	3
SUSPICION	2	0	0	2	0	0	4	3
OBSESSION ABOUT DRUGS	3	0	0	0	0	0	3	2.2
INCAPACITY TO THINK	0	0	0	0	3	0	3	2.2
PESSIMISM	0	1	0	0	2	0	3	2.2
REVENGEFUL THOUGHTS/ ATTITUDE	3	0	0	0	0	0	3	2.2
LOW SELF-ESTEEM/LACK OF SELF-CONFIDENCE	0	3	0	0	0	0	3	2.2
WORTHLESSNESS	1	0	0	1	0	0	2	1.5
SUICIDAL ATTEMPT	1	0	0	1	0	0	2	1.5
PARANOIA	0	0	2	0	0	0	2	1.5
HOPELESSNESS	0	0	0	2	0	0	2	1.5

LEVEL OF KNOWLEDGE ABOUT MENTAL HARMS N=133 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=133	%
OBSESSION WITH DRUGS	0	0	0	0	2	0	2	1.5
MADNESS	0	0	0	0	2	0	2	1.5
BIPOLAR DISORDER	0	0	1	0	0	0	1	0.7
SCHIZOPHRENIA	0	0	1	0	0	0	1	0.7
SELF HATRED	0	0	1	0	0	0	1	0.7
MENTALLY DESTROYED	0	0	0	1	0	0	1	0.7
GUILTY	0	0	0	1	0	0	1	0.7
LOSS OF IDENTITY	0	0	0	1	0	0	1	0.7
ANGRINESS	0	0	0	1	0	0	1	0.7
EGO-CENTRIC	0	0	0	1	0	0	1	0.7
CARELESS	0	0	0	1	0	0	1	0.7
ANTI-SOCIAL	0	0	0	1	0	0	1	0.7
CONFUSION	0	0	0	0	1	0	1	0.7

LEVEL OF KNOWLEDGE ABOUT MENTAL HARMS N=133 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=133	%
EMOTIONAL STRESS	0	0	0	0	1	0	1	0.7
LACK OF INTEREST IN ANYTHING	0	0	0	0	1	0	1	0.7
SHAMEFULNESS	0	0	0	0	1	0	1	0.7
ANTI-SOCIALITY	1	0	0	0	0	0	1	0.7
SENSE OF GUILT	1	0	0	0	0	0	1	0.7
SOCIAL EXCLUSION	1	0	0	0	0	0	1	0.7

2.5.3. Knowledge about the Social Harms of Drug Use

As mentioned earlier under the section on Drug Use Related Challenges, about half the participants were imprisoned. Hence, imprisonment is reportedly the principal harm related to drug use (26.9%). Others included job loss/unemployment (17.2%); community rejection (13.4%) and theft (10.4%). For women, it was physical abuse and having to exchange sex for drugs.

TABLE 29

LEVEL OF KNOWLEDGE ABOUT OTHER/SOCIAL HARMS

LEVEL OF KNOWLEDGE ABOUT SOCIAL HARMS N=134								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=20	PAK N=17	AFG N=26	TOT N=134	%
IMPRISONMENT	9	10	10	5	1	1	36	26.9
JOB LOSS/ UNEMPLOYMENT	3	8	5	3	4	0	23	17.2
COMMUNITY REJECTION	0	12	2	0	0	4	18	13.4
THEFT	7	1	1	0	4	1	14	10.4
PHYSICAL ABUSE	2	1	0	1	1	5	10	7.5
FAMILY REJECTION	0	1	1	2	1	2	7	5.2
POVERTY	0	6	0	0	0	0	6	4.5
POVERTY	0	0	0	0	0	6	6	4.5
LOSING CHILD CUSTODY	0	0	0	1	1	2	4	3
CAR ACCIDENTS	0	0	0	3	0	1	4	3
PUBLIC NUISANCE	1	0	0	0	0	2	3	2.2

LEVEL OF KNOWLEDGE ABOUT SOCIAL HARMS N=134 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=20	PAK N=17	AFG N=26	TOT N=134	%
HOMELESSNESS	0	0	0	0	0	3	3	2.2
DRUG DEALING	1	0	0	1	0	0	2	1.5
ENGAGING IN ILLICIT BEHAVIOR	1	1	0	0	0	0	2	1.5
COMMITTING CRIMES	0	2	0	0	0	0	2	1.5
POVERTY	0	2	0	0	0	0	2	1.5
MARGINALIZATION	0	0	0	0	0	2	2	1.5
AGGRESSION	0	0	0	2	0	0	2	1.5
DOMESTIC VIOLENCE	0	0	0	0	2	0	2	1.5
COMMITTING CRIMES	0	0	2	0	0	0	2	1.5
SEPARATION /DIVORCE	0	0	1	1	0	0	2	1.5
SELLING VALUABLE ITEMS	1	0	0	0	0	0	1	0.7
SCAVENGING THROUGH GARBAGE	1	0	0	0	0	0	1	0.7

LEVEL OF KNOWLEDGE ABOUT SOCIAL HARMS N=134 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=20	PAK N=17	AFG N=26	TOT N=134	%
BAD REPUTATION	1	0	0	0	0	0	1	0.7
POICE HARASSMENT	1	0	0	0	0	0	1	0.7
SEX WORK	0	1	0	0	0	0	1	0.7
DISCRIMINATION	0	0	1	0	0	0	1	0.7
DEATH THREATS	0	0	0	1	0	0	1	0.7
LYING	0	0	0	0	1	0	1	0.7
LACK OF RESPECT	0	0	0	0	1	0	1	0.7
ANGER	0	0	0	0	1	0	1	0.7
PROPERTY LOSS	0	0	0	0	0	1	1	0.7
JOB LOSS	0	0	0	0	0	1	1	0.7
POOR HYGIENE	0	0	0	0	0	1	1	0.7

2.5.4. Actual Drug Use Related Harms

These related mainly to drug interactions, types of drug(s) used, drug mixtures, and the way drugs were administered. The OR documented 55 physical and mental diseases/symptoms ranging from mild to severe.

2.5.5. Actual Physical Harms

HCV co-infection (25.5%) and TB co-infection (16%) were identified in 57 participants; almost half of them were from Morocco and Egypt.

TABLE 30

ACTUAL PHYSICAL HARMS

ACTUAL PHYSICAL HARMS N=137								
INDICATOR	MOR N=26	TUN N=26	LEB N=7	EGY N=26	PAK N=26	AFG N=26	TOT N=137	%
HCV	21	5	0	7	2	0	35	25.5
TB	15	2	0	1	4	0	22	16
OVER DOSE	9	0	0	4	2	1	16	11.7
FEVER	0	0	0	1	8	0	9	6.6
BREATHING PROBLEMS	1	0	1	2	3	1	8	5.8
FATIGUE/WEAKNESS	4	0	0	1	2	1	8	5.8
DIARRHEA	0	0	0	4	1	2	7	5.1
LIVER PAIN	0	0	0	1	5	0	6	4.4
WOUNDS/INJURIES	0	0	0	0	4	2	6	4.4
CANCER	3	1	1	0	0	0	5	3.6
WEIGHT LOSS/LOSS OF APPETITE	0	0	0	1	0	4	5	3.6
ASTHMA	0	0	0	0	5	0	5	3.6
STIS	1	1	1	1	0	0	4	2.9
KIDNEY PROBLEMS	0	0	0	0	4	0	4	2.9

ACTUAL PHYSICAL HARMS N=137 (CONT'D)

INDICATOR	MOR N=26	TUN N=26	LEB N=7	EGY N=26	PAK N=26	AFG N=26	TOT N=137	%
VEIN COLLAPSES	2	0	0	0	1	0	3	2.2
VERTIGO	0	3	0	0	0	0	3	2.2
DETERIORATION OF HEALTH STATUS	0	0	0	2	0	1	3	2.2
VOMITING	0	0	0	0	3	0	3	2.2
HBV	0	0	0	2	0	0	2	1.4
ABSCESSES	0	0	0	1	1	0	2	1.4
COLD	0	0	0	1	0	1	2	1.4
BACK PAIN	0	0	0	1	1	0	2	1.4
SLEEPING DISORDERS	0	0	0	0	2	0	2	1.4
SKIN INFECTIONS	1	0	0	0	0	1	2	1.4
HEART DISEASES/PROBLEMS	0	1	0	0	0	1	2	1.4
DIZZINESS	0	0	2	0	0	0	2	1.4
PULMONARY INFECTIONS	0	0	2	0	0	0	2	1.4
CHEST PAIN	0	0	0	2	0	0	2	1.4
SKIN RASH	0	0	0	0	2	0	2	1.4

ACTUAL PHYSICAL HARMS N=137 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=7	EGY N=26	PAK N=26	AFG N=26	TOT N=137	%
LIVER PROBLEMS	1	0	0	0	0	0	1	0.7
ULCERS	1	0	0	0	0	0	1	0.7
HEAD-ACHES	1	0	0	0	0	0	1	0.7
NOSE BLEEDING	0	1	0	0	0	0	1	0.7
DROWSINESS	0	1	0	0	0	0	1	0.7
MOOD SWINGS	0	0	1	0	0	0	1	0.7
ALLERGIES	0	0	1	0	0	0	1	0.7
TB	0	0	1	0	0	0	1	0.7
AMPUTATION	0	0	0	1	0	0	1	0.7
STOMACH PAIN	0	0	0	1	0	0	1	0.7
ITCHING	0	0	0	1	0	0	1	0.7
NECK PAIN	0	0	0	0	1	0	1	0.7
INCREASE IN BODY TEMPERATURE	0	0	0	0	1	0	1	0.7
ANAL BLEEDING	0	0	0	0	1	0	1	0.7
GONORRHEA	0	0	0	0	1	0	1	0.7
COUGH	0	0	0	0	0	1	1	0.7

2.5.6. Actual Mental Harms

The most prevalent mental harm reported was depression (27.9%), followed by restlessness (23.2%); loneliness/isolation (13.9%) and stress (11.6%).

TABLE 31

ACTUAL MENTAL HARMS

ACTUAL MENTAL HARMS N=43								
INDICATOR	MOR N=2	TUN N=12	LEB N=2	EGY N=5	PAK N=16	AFG N=6	TOT N=43	%
DEPRESSION	0	2	1	5	0	4	12	27.9
RESTLESS BRAIN	0	0	0	0	10	0	10	23.2
LONELINESS / ISOLATION	1	4	0	0	1	0	6	13.9
STRESS	0	4	0	0	1	0	5	11.6
OBSESSION WITH DRUGS	1	0	0	0	2	0	3	7
BAD MOOD	0	2	0	0	0	0	2	4.6
CONFUSION	0	0	0	0	2	0	2	4.6
FEAR FROM DEATH	0	0	1	0	0	0	1	2.3
SUICIDAL THOUGHTS	0	0	0	0	1	0	1	2.3
VIOLENCE	0	0	0	0	1	0	1	2.3

2.5.7. Actual Social Harms

More than third (35.7%) reported community rejection as the main social harm, in addition to a deficient socioeconomic status such as unemployment (28.6%), financial constraints (14.3%) and homelessness (14.3%).

TABLE 32

ACTUAL SOCIAL HARMS

ACTUAL OTHER/SOCIAL HARMS N=14								
INDICATOR	MOR N=0	TUN N=7	LEB N=0	EGY N=0	PAK N=2	AFG N=5	TOT N=14	%
COMMUNITY REJECTION	0	5	0	0	0	0	5	35.7
UNEMPLOYMENT	0	1	0	0	1	2	4	28.6
FINANCIAL PROBLEMS	0	2	0	0	0	0	2	14.3
HOMELESSNESS	0	0	0	0	0	2	2	14.3
FIGHTING	0	0	0	0	1	0	1	7.1
POOR HYGIENE	0	0	0	0	0	1	1	7.1

Morocco

Moroccan participants had the highest levels of HCV and TB co-infection. A third reported overdose, and three had cancer, while two felt dizziness. Only two women suffered actual mental harms (loneliness and obsession about drugs), but not men. Three had friends who died of overdose, and another three from HCV. One was receiving treatment for HCV, but not TB.

Tunisia

Participants reported (5) HCV and (2) TB co-infections. Other physical harms were fatigue for men and vertigo for women, followed by cancer, sexually transmitted infection (STI), heart diseases, multiple diseases, nosebleed and drowsiness (1case each). Mental harms comprised isolation (3/26), depression (2/26) bad mood (2/26) and a case each of stress, aggression and feeling of loneliness. Only one reported no drug related harms.

Lebanon

Lebanese participants suffered the least physical and mental drug related harms, with only 2 reporting dizziness, and 2 other pulmonary infections. Mood swings, allergies, breathing problems, cancer, TB, and STI were mentioned by one participant each. Drug use related mental harms included depression (1) and fear of death (1). More than half the participants (12 in total) suffered no harms at all.

Egypt

Hepatitis B Virus (HBV), HCV, and TB co-infections were experienced by almost half the participants. Drug overdose (4/26) and depression (5/26) were common among both men and women.

Pakistan

Asthma (4) and kidney related complications (3) were the biggest physical harms experienced by Pakistani men. Fever (6) and Liver problems (4) mainly affected women. TB was recorded in both genders (2 each) while HCV found in two men. On the mental harms associated with drug use, restless brain was prevalent across the board, and reported by 10 participants (5 males and 5 females).

Afghanistan

Loss of appetite and depression were suffered by four participants respectively. Homelessness (3) and unemployment (2) seemed to be relatively common.

2.6. LEVEL OF KNOWLEDGE ABOUT HR AND HEALTHCARE SERVICES

The overall knowledge of services available was rather low among participants. Three (from Egypt and Pakistan) claimed no knowledge. Others (56.4%) had knowledge of NSP (42.9%); HIV treatment (30.2%); condom distribution (20.1%); OST (18.1%); HTC (18.1); and HIV and addiction counselling (12.7%). Knowledge about other HR services was rather deficient: Only 6% of PLHIV-WUDs/WIDs knew of TB treatment and 4.7% of HBV and HCV treatments. Knowledge about STI treatment was severely limited to two.

TABLE 33

LEVEL OF KNOWLEDGE ABOUT HR AND HEALTHCARE SERVICES

LEVEL OF KNOWLEDGE ABOUT HR AND HEALTHCARE SERVICES N=149								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=24	PAK N=25	AFG N=26	TOT N=149	%
NSP	22	24	1	5	23	9	84	56.4
ART	10	12	17	11	6	8	64	42.9
CONDOM DISTRIBUTION	9	21	5	5	2	3	45	30.2
OST	20	0	3	0	0	7	30	20.1
HTC	0	0	15	3	4	5	27	18.1
HIV/ADDICTION COUNSELLING	15	0	4	0	0	0	19	12.7
TB TREATMENT	6	0	1	0	0	2	9	6
HBV/HCV TREATMENTS	0	0	5	0	0	2	7	4.7
FREE MEDICAL CARE	0	6	0	0	0	0	6	4

LEVEL OF KNOWLEDGE ABOUT HR AND HEALTHCARE SERVICES N=149 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=24	PAK N=25	AFG N=26	TOT N=149	%
HIV/AIDS BLOOD RELATED TESTS	0	0	2	2	0	1	5	3.3
FIRST AID	0	0	0	0	5	0	5	3.3
IEC MATERIAL	1	0	0	1	0	2	4	2.7
AWARENESS SESSIONS	2	0	0	0	0	1	3	2
DON'T KNOW OF ANY SERVICES	0	0	0	2	1	0	3	2
STIS TREATMENT	0	0	1	0	0	1	2	1.3
HIV DIAGNOSIS	0	0	1	0	0	0	1	0.7

2.6.1. Level of Knowledge about Other Support Services

Other than HR and healthcare, 32.9 per cent of the participants (notably in Pakistan, Morocco and Egypt) knew no other services. Legal services, however, were known to (22.1 per cent), or 33 participants from four countries (except Pakistan and Afghanistan). Further, 16.8 per cent of participants knew about social support services/ social workers' assistance. Finally, almost all participants in Tunisia were aware of psychological support services.

TABLE 34

LEVEL OF KNOWLEDGE ABOUT OTHER/SUPPORT SERVICES

LEVEL OF KNOWLEDGE ABOUT OTHER/SUPPORT SERVICES N=149								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=26	PAK N=26	AFG N=26	TOT N=149	%
DON'T KNOW OF ANY OTHER SERVICES	12	1	0	9	26	1	49	32.9
LEGAL SUPPORT	12	11	4	6	0	0	33	22.1
SOCIAL WORKERS ASSISTANCE/SOCIAL SUPPORT	9	6	8	1	0	1	25	16.8
PSYCHOLOGICAL SUPPORT	0	21	0	0	0	0	21	14.1
FINANCIAL SUPPORT	6	14	0	0	0	0	20	13.4
SUPPORT GROUPS	0	0	2	9	0	0	11	7.4
PSYCHO-SOCIAL SUPPORT	0	0	8	0	0	0	8	5.4
FOOD SUPPLY	0	0	0	0	0	7	7	4.7
HYGIENE	4	1	0	0	0	0	5	3.3
FREE TRANSPORTATION	0	4	0	0	0	0	4	2.7
PROVISION OF CLOTHES	0	0	0	0	0	2	2	1.3
REFERRAL	0	0	1	0	0	1	2	1.3
FAMILY SUPPORT	0	0	1	0	0	0	1	0.7
REHABILITATION	0	0	1	0	0	0	1	0.7

2.6.2. Knowledge about Healthcare Service Provision

Around half the participants only knew one organization providing services to PLHIV-WUDs/WIDs while 20.6 per cent reported knowing one CSO and one hospital. Three from Egypt and Pakistan did not know any such services.

TABLE 35

LEVEL OF KNOWLEDGE ABOUT ORGANIZATIONS/HEALTHCARE FACILITIES PROVIDING SERVICES

LEVEL OF KNOWLEDGE ABOUT ORGANIZATIONS/HEALTHCARE SETTINGS PROVIDING SERVICES N=131								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=23	PAK N=26	AFG N=11	TOT N=131	%
1 CSO ONLY	7	19	1	3	22	3	55	42
1 CSO AND 1 HOSPITAL	15	0	0	12	0	0	27	20.6
MORE THAN 2 CSOS/ HOSPITAL	3	6	4	0	0	6	19	14.5
NAP/ MOH ONLY	0	0	5	3	0	0	8	6.1
1 HOSPITAL ONLY	0	0	2	3	2	0	7	5.3
1 CSO AND NAP/ MOH	0	0	7	0	0	0	7	5.3
2 CSOS/ HOSPITAL	1	1	0	0	2	2	6	4.6
DON'T KNOW OF ANY SERVICE	0	0	0	2	1	0	3	2.3

2.6.3. Availability of HR and Healthcare Services

Both PLHIV-WUDs/WIDs and KIs reported 32 services. Table 36 illustrates the combination of the standard package of HR and healthcare services in the countries, and the services available in the participating local CSOs/HR projects. Evidently, Tunisia had the highest number (22), followed by Afghanistan (21) Morocco (19), Egypt (18), Lebanon (15) and Pakistan (14).

TABLE 36

PACKAGE OF AVAILABLE HR AND HEALTHCARE SERVICES

PACKAGE OF AVAILABLE HR AND HEALTHCARE SERVICES N=126						
SERVICE	MOR N=26	TUN N=26	LEB N=19	EGY N=20	PAK N=25	AFG N=10
NEEDLE AND SYRINGE PROGRAMS (NSPS)	*	*	*	*	*	*
OPIOID SUBSTITUTION THERAPY (OST) AND OTHER DRUG DEPENDENCE TREATMENT	*		*			*
HIV COUNSELING AND TESTING (HCT)	*	*	*	*	*	*
ANTIRETROVIRAL THERAPY (ART)	*	*	*	*	*	*
PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS (STIS)	*	*	*	*	*	*
CONDOM DISTRIBUTION	*	*	*	*	*	*
TARGETED INFORMATION, EDUCATION, AND COMMUNICATION FOR PWIDS AND THEIR SEXUAL PARTNERS (IEC MATERIAL)	*	*	*	*	*	*
PREVENTION, VACCINATION, DIAGNOSIS, AND TREATMENT OF VIRAL HEPATITIS (INCLUDING HAV, HBV, HCV)	*	*	*	*	*	*
PREVENTION, DIAGNOSIS, AND TREATMENT OF TUBERCULOSIS	*	*	*	*	*	*
HIV RELATED BLOOD TESTS (CD4, VIRAL LOAD, ETC.)	*	*	*	*	*	*
PREVENTING MOTHER TO CHILD TRANSMISSION (PMTCT)	*	*	*	*	*	*
PEER EDUCATION	*	*	*	*	*	*
PSYCHOLOGICAL SUPPORT	*	*	*	*		
ADDICTION COUNSELING	*	*		*	*	
HIV COUNSELING	*	*		*		
INDIVIDUAL AND GROUP COUNSELING						*
AWARENESS SESSIONS ABOUT HIV, HCV, HBV, TB	*					*
AWARENESS SESSIONS ABOUT HUMAN RIGHTS		*				*
AWARENESS SESSIONS ABOUT STIS		*				*
SOCIAL SUPPORT/ASSISTANCE TO SEEK SERVICES	*		*			*
RECREATIONAL AND SPORTS ACTIVITIES	*	*				*
REFERRAL TO MEDICAL AND NON-MEDICAL SERVICES	*	*	*	*		*
PSYCHOSOCIAL SUPPORT		*				
LEGAL SUPPORT		*		*		
MONTHLY ALLOWANCE		*				
INCOME GENERATING ACTIVITIES		*		*		
SUPPORT GROUPS				*		
FIRST AID					*	
REFERRAL TO DETOXIFICATION AND REHABILITATION					*	*
HYGIENE SERVICES						*
TOTAL OF SERVICES AVAILABLE =32	19	22	15	18	14	21

2.6.4. Most Utilized HR, Healthcare and Support Services

Only Morocco, Lebanon and Afghanistan included OST in their packages of services. The services most commonly mentioned were: NSP (64.3%), ART (55.5%), condoms (31%), OST (23.8%) and TB treatment (9.5%). Twenty-four participants reported HIV and addiction counselling, and psychological and social supports. While testing and support groups were mostly utilized by twelve persons. Least of all was STI treatment, used by two. Although a high level of HCV co-infections was identified, none reported taking the treatment. Table 37 illustrates the mostly utilised services as reported by PLHIV-WUDs/WIDs.

TABLE 37

MOST UTILIZED HR, HEALTHCARE AND SUPPORT SERVICES

MOSTLY UTILIZED HR AND HEALTHCARE SERVICES N=126								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=20	PAK N=25	AFG N=10	TOTAL	%
NSP	19	23	0	9	25	5	81	64.3
ART	13	21	19	10	0	7	70	55.5
CONDOMS	8	17	13	1	0	0	39	31
OST	26	0	0	0	0	4	30	23.8
TB TREATMENT	11	0	0	1	0	0	12	9.5
PSYCHOLOGICAL SUPPORT	0	4	1	4	0	0	9	7.1
ADDICTION/HIV COUNSELLING	6	0	0	0	0	2	8	6.4
ALCOHOL PADS	0	0	0	0	7	0	7	5.5
HIV/AIDS RELATED BLOOD TESTS	1	3	0	2	0	0	6	4.8
SUPPORT GROUPS	0	0	0	6	0	0	6	4.8
MONTHLY ALLOWANCE	0	5	0	0	0	0	5	4

MOSTLY UTILIZED HR AND HEALTHCARE SERVICES N=126 (CONT'D)								
INDICATOR	MOR N=26	TUN N=26	LEB N=19	EGY N=20	PAK N=25	AFG N=10	TOTAL	%
HTC	0	0	5	0	0	0	5	4
SOCIAL SUPPORT	4	0	0	0	0	0	4	3.2
PLASTER	0	0	0	0	3	0	3	2.4
HYGIENE SERVICES	0	0	0	0	0	3	3	2.4
SOCIAL SUPPORT	1	0	2	0	0	0	3	2.4
HIV COUNSELLING	1	0	0	0	0	1	2	1.6
PSYCHO-SOCIAL SUPPORT	0	0	2	0	0	0	2	1.6
CLINICAL/MEDICAL CARE	0	0	1	1	0	0	2	1.6
FOOD SUPPLY	0	0	0	0	0	2	2	1.6
STIS TREATMENT	0	0	1	0	0	1	2	1.6
LEISURE ACTIVITIES	0	1	0	0	0	0	1	0.8
LUBRICANT	0	0	1	0	0	0	1	0.8
AWARENESS SESSIONS	1	0	0	0	0	0	1	0.8
LEGAL SUPPORT	0	0	0	1	0	0	1	0.8
TOTAL OF SERVICES UTILIZED =25	11	7	9	9	3	8	NA	NA

2.6.5. Summary of Available, Known and Utilized Services

The analysis of the actual number of available, known and utilized services showed a gap between the existing services and service utilization. In Lebanon, the services known have exceeded those available, cause services are sought from different organizations, as previously shown.

TABLE 38

SUMMARY OF THE NUMBER OF AVAILABLE, KNOWN AND UTILIZED SERVICES

SUMMARY OF AVAILABLE, KNOWN AND UTILIZED SERVICES			
COUNTRY	NUMBER OF SERVICES AVAILABLE	NUMBER OF SERVICES KNOWN	NUMBER OF SERVICES UTILIZED
MOR	19	14	11
TUN	22	11	7
LEB	15	18	9
EGY	18	8	9
PAK (*)	14	5	3*
AFG	21	12	8

(*) In Pakistan the 3 services utilized include bandage and alcohol pad

2.7. HIV TREATMENT RELATED BELIEFS AND LEVEL OF ADHERENCE

2.7.1. HIV Treatment Related Beliefs

Some of the beliefs associated with HIV treatment were based on negative real life experiences; others were acquired through the experience and reaction of other PLHIV using or injecting drugs. Moroccan, Egyptian and Pakistani participants had the highest levels of negative experiences in terms of HIV treatment and incorrect beliefs. For example, HIV treatment decreases the effect of methadone and drugs; taking HIV treatment for a long time leads to death; ART should not be taken with other drugs or treatment of other diseases; Mixing HIV treatment with other drugs leads to very bad side effects. On the contrary, Tunisian, Lebanese and Afghan participants harboured positive and accurate beliefs, such as HIV treatment prevents HIV spread in the infected body; and that HIV treatment is compatible with the treatments of other diseases.

TABLE 39

HIV TREATMENT RELATED BELIEFS

COUNTRY	N	HIV TREATMENT RELATED BELIEFS N= 122
MOR N=24	17/24	HIV TREATMENT DECREASES THE EFFECT OF METHADONE
	4/24	HIV TREATMENT CAUSES WITHDRAWAL SYMPTOMS
	2/24	THE DOSE OF METHADONE HAS TO BE INCREASED WITH TREATMENT
	1/24	HIV TREATMENT HAS BAD SIDE EFFECTS SUCH AS NAUSEA AND FATIGUE
	1/24	TAKING TREATMENT FOR A LONG TIME LEADS TO DEATH
TUN N=26	ALL PARTICIPANTS FROM TUNISIA BELIEVED THAT ART IS ONE OR TWO OF THE FOLLOWING: LIFE-SAVING TREATMENT A PART OF THEIR EVERYDAY LIFE/ROUTINE ESSENTIAL TO LEAD A NORMAL LIFE SHOULD BE TAKEN ON TIME SOURCE OF HOPE TO LIVE LONGER FOR THEIR CHILDREN DECREASES THE SPREAD OF HIV AND IMPROVES THEIR HEALTH STATUS REINFORCES IMMUNITY AND EXTENDS LIFE SPAN	
LEB N=15	7/19	BOTH, DRUG ADDICTION AND HIV HAVE A TREATMENT
	4/19	HIV TREATMENT STRENGTHENS THE IMMUNITY SYSTEM
	1/19	HIV TREATMENT CAN BE TAKEN WITH DRUG TREATMENT
	1/19	HIV TREATMENT SHOULD NEVER BE STOPPED EVEN WHEN USING DRUGS
	1/19	HIV TREATMENT DECREASES THE EFFECT OF DRUGS
	1/19	DOESN'T HAVE ANY BELIEF RELATED TO HIV TREATMENT
EGY N=20	6/20	TAKING TREATMENT FOR A LONG TIME LEADS TO DEATH
	5/20	ART PREVENTS THE SPREAD OF HIV IN THE BODY
	3/20	ART SHOULDN'T BE TAKEN WITH THE TREATMENT OF OTHER DISEASES (HCV AND TB)
	2/20	2/20 HIV TREATMENT HAS BAD EFFECTS SUCH AS DIZZINESS AND PAIN
	2/20	2/20 HIV TREATMENT SHOULDN'T BE TAKEN WHEN ONE IS IN A GOOD SHAPE
	2/20	2 /20 ART DECREASES THE EFFECT OF DRUGS
	1/20	1 /20 TREATMENT DETERIORATES PLHIV HEALTH
	1/20	1/20 TREATMENT IS BEING EXPERIENCED ON THEM
PAK N=22	20/22	HIV TREATMENT SHOULDN'T BE MIXED WITH DRUGS
	2/20	2/20 REPORTED THE FOLLOWING REASONS: MIXING ART WITH TREATMENT LEADS TO SIDE EFFECTS SUCH AS SKIN RASH THE TREATMENT HAS NO BENEFITS AND DOESN'T IMPROVE HEALTH THERE IS NO TREATMENT FOR HIV THE TREATMENT IS BEING EXPERIENCED ON THEM
AFG N=15	9/15	HIV TREATMENT PREVENTS THE SPREAD OF HIV
	6/15	ART CAN BE TAKEN WITH THE TREATMENT OF OTHER DISEASES

(*) Four participants from Lebanon reported having no answer to this question.

2.7.2. HIV Treatment Accessibility and Level of Adherence

Although ART is free in the MENA countries, due to financial constraints, it is only provided in limited places. Often, in public hospitals, which offer little choice in treatment and lack other essential services, such as counselling or condom and syringe distribution. Strict adherence to HIV treatment is essential to reach optimal outcomes. Although all participants had access to HIV treatment, only (55.7%) took it. The level of HIV treatment uptake varied considerably among participating countries, with the highest in Tunisia (88.5%), Lebanon (78.9%), Afghanistan (73%) and Morocco (61.5%). All these countries - save for Tunisia - included OST in their package of services. Egypt and Pakistan had the lowest ART adherence, with only 19.2% of reported regular treatment intake. Overall, ART adherence was higher among males than females (except Tunisia).

TABLE 40

LEVEL OF ART ADHERENCE

LEVEL OF ART ADHERENCE N=149									
COUNTRY	N	REGULAR	N	IRREGULAR	N	DIDN'T START TREATMENT	N	DON'T TAKE TREATMENT	N
MOR	26	61.5% M=70% W=33%	16	19.2 %	5	7.7%	2	11.5%	3
TUN	26	88.5% M=92% W=85%	23	4%	1	4%	1	4%	1
LEB	19	78.9% M=78.9% W=100%	15	22.2%	4	NA	NA	NA	NA
EGY	26	19.2% M=14% W=8%	5	23%	6	4%	1	54%	14
PAK	26	19.2% M=23% W=15.4%	5	69.2%	18	7.7%	2	4%	1
AFG	26	73%	19	27%	7	NA	NA	NA	NA
TOTAL	149	55.7%	83	27.5%	41	6.4%	6	12.7%	19

2.7.3. Reasons for Non-adherence to HIV Treatment

All the reasons for non-adherence to the treatment are illustrated in Table 41.

TABLE 41

REASONS FOR NON-ADHERENCE

REASONS FOR NON-ADHERENCE TO ART N=66						
REASONS FOR NON-ADHERENCE	MOR N=10	TUN N=3	LEB N=4	EGY N=21	PAK N=21	AFG N=7
POOR PHYSICAL AND MENTAL HEALTH CONDITION	*			*	*	*
HIV-RELATED STIGMA	*	*		*		*
DRUG ADDICTION	*			*	*	*
FEAR FROM FAMILY MEMBERS	*					*
HIV TREATMENT SIDE EFFECTS	*	*			*	
FEAR FROM SIDE EFFECTS	*					
LACK OF KNOWLEDGE/AWARENESS	*			*		*
MISINFORMATION				*		
HIV TREATMENT RELATED BELIEFS				*		*
UNSTABLE HOUSING SITUATION	*					*
FINANCIAL CONSTRAINT				*	*	*
DEFICIENT HEALTHCARE SYSTEM				*	*	
LOW COVERAGE OF SERVICES						*
FORGETTING TO TAKE HIV TREATMENT	*	*	*	*		
LOOSING HIV TREATMENT	*					
BEING TOO LAZY TO GET HIV TREATMENT	*			*		
INCONVENIENT SIZE OF HIV TREATMENT PILL					*	
INCARCERATION/IMPRISONMENT			*			
TOTAL OF NUMBER OF REASONS FOR NON-ADHERENCE	11	3	2	10	6	9

Morocco: ART adherence was much higher among males (70%) than females (33%). Eight participants (4 males and 4 females) cited 11 reasons for non-adherence: Poor physical and mental health conditions; HIV-related stigma; drug addiction; fear of family members; HIV treatment side effects; fear of side effects; lack of knowledge/awareness; unstable housing situation; forgetting to take HIV treatment; losing HIV treatment and being too lazy to get HIV treatment.

Tunisia: ART adherence was a bit higher among males (92%) than females (85%). Ten females on treatment stated that regular intake of medication was a source of hope, while one cited the desire to live longer. Two females found HIV-related stigma, HIV treatment side effects and forgetting to take HIV treatment as the reasons for irregular or non-adherence to HIV treatment.

Lebanon: Almost all participants (78.9 per cent) reported regular HIV treatment intake, compared to 22.2 per cent irregular. Two found no barriers nor reasons to taking the treatment, and none knew the factors hindering access to HIV treatment. A third of the 19 participants did not reply to this question. Six others (including five men) mentioned forgetting to take the treatment. One woman reported imprisonment.

Egypt: ART adherence was generally low, but much higher among males (14 per cent) than females (8 per cent). The 14 participants (9 females and 5 males) gave ten reasons for non-adherence to ART: poor physical and mental health conditions, HIV-related stigma, drug addiction, lack of knowledge/awareness, misinformation, HIV treatment related beliefs, financial constraint, deficient healthcare system, forgetting to take HIV treatment, and too lazy to get HIV treatment.

Pakistan: The only country whose nearly all participants (21) replied to the question related to non-adherence to treatment. ART adherence was higher among males (23%) than females (15.4%). Six reasons were given: Poor physical and mental health conditions, drug addiction, HIV treatment side effects, financial constraint, deficient healthcare system and inconvenient size of HIV treatment pill.

Afghanistan: About three quarter (73 per cent) of participants had been adhering to treatment. Seven participants gave the following nine reasons: Poor physical and mental health conditions, HIV-related stigma, drug addiction, fear of family members, lack of knowledge/awareness, HIV treatment related beliefs, unstable housing situation, financial constraint and low coverage of services.

2.7.4. Complications Related to HIV Treatment

Side effects of HIV Treatment were main factors for non-adherence, and were therefore examined. A total of 36 different side effects, largely mild were cited by 96 participants, with the majority being fatigue/weakness and nausea/vomiting as well as dizziness. Some were country specific, such as the increased body temperature and dry mouth/dry spit/white tongue (Pakistan).

TABLE 42

HIV TREATMENT SIDE EFFECTS

HIV TREATMENT SIDE EFFECTS N=96								
INDICATOR	MOR N=18	TUN N=20	LEB N=19	EGY N=24	PAK N=24	AFG N=4	TOTAL N=96	%
INCREASE IN BODY TEMPERATURE	0	0	0	0	16	0	16	16.7
DRY MOUTH/DRY SPIT /WHITE TONGUE	0	0	0	0	14	0	14	14.6
FATIGUE/WEAKNESS	4	5	0	2	0	1	12	12.5
NO SIDE EFFECTS	0	0	11	0	0	0	11	11.4
NAUSEA /VOMITING	4	1	2	0	2	1	10	10.4
DIZZINESS	3	0	1	5	1	0	10	10.4
SKIN RASH	0	0	0	0	6	0	6	6.2
WEIGHT GAIN/ INCREASED APPETITE	1	5	0	0	0	0	6	6.2
VERTIGO / FEELING UNBALANCED	0	5	0	1	0	0	6	6.2
WITHDRAWAL SYMPTOMS	5	0	0	0	0	0	5	5.2
TOOTH PROBLEMS	0	5	0	0	0	0	5	5.2
DIARRHEA	0	0	3	0	1	1	5	5.2
FEVER	0	0	0	0	5	0	5	5.2
INFLAMMATION OF THE WOUNDS	0	0	0	0	4	0	4	4.2
ITCHING	0	3	0	0	0	0	3	3.1
WEIGHT LOSS / LOSS OF APPETITE	1	2	0	0	0	0	3	3.1
AGGRESSIVE BEHAVIOUR	0	0	0	0	3	0	3	3.1
KIDNEY PAIN	0	0	0	0	2	0	2	2.1
DROWSINESS	1	1	0	0	0	0	2	2.1
LACK OF CONCENTRATION	0	0	2	0	0	0	2	2.1
HEADACHE	0	0	0	2	0	0	2	2.1
GASTRICPROBLEMS	0	1	0	0	0	0	1	1
HAIRLOSS	0	1	0	0	0	0	1	1
CHESTPAIN	0	0	0	1	0	0	1	1
BREATHING PROBLEMS	0	0	0	1	0	0	1	1
INCAPACITY TO MOVE	0	0	0	1	0	0	1	1
LIVER PAIN	0	0	0	0	1	0	1	1
ITCHING	0	0	0	0	1	0	1	1
CONSTIPATION	0	0	0	0	1	0	1	1
ANAL BLEEDING	0	0	0	0	1	0	1	1
DEHYDRATION	0	0	0	0	1	0	1	1
SHIVERING	1	0	0	0	0	0	1	1

Morocco: Morocco: Nausea and dizziness were more common among women than among men. Withdrawal symptoms experienced at night and fatigue by both genders. One mentioned splitting the pill in two to avoid withdrawal symptoms.

Tunisia: Female reported less side effects than males. Tooth problems (21%), hair loss and feeling unbalanced were only reported by women; itching and fatigue by men. Four participants (15.3%), three males and one female, did not experience any side effects.

Lebanon: Lebanon had the highest number of participants (11/19) with no HIV treatment side effects. Only 3 reported occasional diarrhoea; vomiting and lack of concentration (2 each); and drowsiness, dizziness and overeating (1 each).

Egypt: In general, adverse side effects were felt by more men than women, except for dizziness, experienced equally by both gender. Two women believed that treatment leads to death. Three reported no side effects or complications. Distance to public hospital and financial constraints were a challenge for one participant.

Pakistan: No differences recorded between men and women regarding side effects. Pakistan participants were the only ones reporting an increase in body temperature and symptoms such as white tongue.

Afghanistan: Most participants reported no side effects related to HIV treatment. The number of replies to this question was too small to generate any comprehensive insights; but one participant each reported the following side effects: weakness, vomiting, diarrhoea and heavy treatment.

2.7.5. Impact of Medical Condition on Service uptake

Only 38% of participants reported that medical condition had no impact on service uptake. The highest numbers were from Tunisia, Lebanon and, to a lesser extent, Afghanistan. The most recorded medical conditions were fatigue/weakness (41.4%); nausea/vomiting (33.6%); and depression (31.4%).

TABLE 43

IMPACT OF MEDICAL CONDITION ON SERVICE UPTAKE

IMPACT OF MEDICAL CONDITION ON SERVICES UPTAKE N=113								
INDICATOR	MOR N=19	TUN N=26	LEB N=19	EGY N=14	PAK N=23	AFG N=12	TOTAL N=113	%
NO IMPACT	0	20	16	2	0	5	43	38
FATIGUE/WEAKNESS	11	5	0	5	9	4	34	30
DEPRESSION	11	1	3	5	8	0	27	23.9
NAUSEA/VOMITING	6	0	0	0	16	1	23	20.3
SKIN RASH	0	0	0	0	10	0	10	8.8
HEADACHE	2	0	0	0	6	0	8	7.1
INCREASE IN BODY TEMPERATURE	0	0	0	0	4	0	4	3.5
WITHDRAWAL SYMPTOMS	3	0	0	0	0	0	3	2.6
DIZZINESS	0	0	0	1	2	0	3	2.6
RESTLESS BRAIN	0	0	0	0	2	0	2	1.8
STOMACH PAIN	1	0	0	0	0	0	1	0.9
CHEST PAIN	1	0	0	0	0	0	1	0.9
BREATHING PROBLEMS	1	0	0	0	0	0	1	0.9
LIVER PROBLEMS	0	0	0	1	0	0	1	0.9
DIARRHEA	0	0	0	0	0	1	1	0.9
WEIGHT LOSS	0	0	0	0	0	1	1	0.9

Morocco: Almost all participants (18/19) reported depression and fatigue; two lamented the long waiting period at hospitals; and two complained about the mistreatment by HCP. One was critical about the complexity of procedures; denial of services, and receiving different treatment at the hospital when unaccompanied by the social worker.

Tunisia: Most participants (20/26) reported no medical impact; however, fatigue and weakness were felt simultaneously by five (3 women and 2 men); and depression by one only. A participant did complain about the long wait to receive services at the hospital.

Lebanon: Almost all the 19 participants reported no impact of medical condition on service uptake. Depression was only experienced by three of them.

Egypt: Depression, fatigue and weakness were prevalent among more than half of the participants. Two males reported no impact, and two hopelessness, and obsession with drugs. One complained about the inability to get HIV treatment when hospitalized and one about the delay in receiving CD4 test results. One was denied services.

Pakistan: Vomiting equally affected men and women and was reported by 16 of the 23 participants. Fatigue and weakness were cited 9, and depression 8 times. One female heard that vomiting and headache were the consequences of not taking HIV treatment.

Afghanistan: Five out of 12 participants reported no impact; 3 experienced weakness and 1 each diarrhoea, fatigue, vomiting and weight loss respectively.

2.8. QUALITY OF HR AND HEALTHCARE SERVICES

2.8.1. Levels of Satisfaction with HR and Healthcare Services

Only around 29.1 per cent of participants expressed satisfaction with HR and healthcare services. In Lebanon, such satisfaction was unanimous. Two thirds felt dissatisfaction, with highest level in Pakistan (88.5%), Tunisia (84.6%) and Afghanistan (83.3%). Dissatisfaction, which was much higher among males than females, related mainly to services received in public hospitals.

TABLE 44

LEVEL OF SATISFACTION WITH SERVICES

PLHIV-WUDS/WIDS LEVEL OF SATISFACTION WITH SERVICES N=134								
COUNTRY	MOR N=24	TUN N=26	LEB N=19	EGY N=21	PAK N=26	AFG N=18	TOTAL	%
SATISFIED	9 (37.5%)	2 (7.7%)	19 (100%)	3 (14.3%)	3 (11.5%)	3 (16.7%)	39	29.1
VERY SATISFIED	0	1	0	0	0	0	1	0.7
NEUTRAL	0	1	0	2	0	0	3	2.2
DISSATISFIED	15 (62.5%)	22 (84.6%)	0 (0%)	16 (76.2%)	23 (88.5%)	15 (83.3%)	91 (66.9%)	66.9

Morocco: About half the participants complained about the distance to the hospitals. Reasons for dissatisfaction with healthcare services in public hospitals included: physician appointments at hospitals set too far; long wait and delays in receiving services; HCP mistreatment, lack of care and attention; being gossiped about by other drug users and HCP when seeking services; complexity of procedures to access services; long distance to the hospital and unaffordable transportation; and lack of respect for privacy and breach of confidentiality when receiving test results.

Tunisia: Almost all (84.6 per cent) participants were dissatisfied. Both HCP work load and the discriminatory attitudes were the reason. It is worthy to note that the only one very satisfied with the services was from Tunisia.

Lebanon: All participants expressed satisfaction with services in both HR projects and the CSO/HR projects. One attributed his high level of satisfaction to access to HIV treatment through CSO and not public healthcare settings.

Egypt: Seventy-six per cent of participants were not satisfied with services in fever hospitals. This is because of the high levels of stigma, discrimination and mistreatment from HCP; lack of services HIV infected children; lack of respect for privacy and anonymity, breach of confidentiality; gossiped about; lack of information about HIV treatment and services; having to meet the NAP manager to access services; lack of political and financial support from the government to HR projects; and lack of collaboration and communication among service providers, especially with regard to PLHIV co-infected with HCV or other diseases.

Pakistan: Has the highest percentage of those dissatisfied with services (88.5 per cent). The reasons were delay in receiving services, some of the medicines not provided for free, and mistreatment by HCP. Participants in Pakistan were the only ones who complained about HR services. Deficient working hours, not enough syringes distributed by service providers in HR projects, as well as delay in receiving services.

Afghanistan: Only three participants reported satisfaction, but also reported irregular provision of food supplies. Almost all participants (15/18) believed that number of service providers were insufficient vis a vis number of patients.

2.8.2. Denial of Medical/Social Services Because of HIV status

About half the participants in the research (46.7 per cent) reported being denied services because of their HIV positive status. This was mostly the case in public healthcare facilities, except for Tunisia and Afghanistan, where denial was also undertaken by private physicians. Denial of social services included not being allowed into shops by shopkeepers in Pakistan. In Afghanistan, some participants have even lost their jobs. In Lebanon, family and friends were reported to refuse providing services too.

TABLE 45

DENIAL OF (MEDICAL/ SOCIAL) SERVICES BECAUSE OF HIV STATUS

DENIAL OF SERVICES (MEDICAL OR SOCIAL) BECAUSE OF HIV STATUS N=137		
COUNTRY	YES WAS DENIED SERVICES	%
MOROCCO N=22	8	36.4
TUNISIA N=26	9	34.6
LEBANON N=19	2	10.5
EGYPT N=22	11	50
PAKISTAN N=26	23	88.5
AFGHANISTAN N=22	11	50
TOTAL	64	46.7%

2.8.3. Level of HIV Stigma Related to Service Uptake

Three quarter of the participants believe that services in public healthcare settings were not stigma free; and that they were subjected to discrimination, with the majority from Pakistan (88.5%), followed by Afghanistan (85%), Morocco (84.6%), Tunisia (83.3%) and Egypt (73.7%). More than half the Lebanese participants stated that this depended on the service provider, and that it is difficult to say as they had not tried all available services.

TABLE 46

LEVEL OF HIV STIGMA RELATED TO SERVICE UPTAKE

SERVICE UPTAKE RELATED STIGMA N=132				
COUNTRY	YES SERVICES ARE STIGMA FREE	NO SERVICES ARE NOT STIGMA FREE	IT DEPENDS	I CAN'T KNOW
MOROCCO N=26	4	22 (84.6%)	0	0
TUNISIA N=24	4	20 (83.3)	0	0
LEBANON N=17	4	2 (11.8%)	3	8
EGYPT N=19	0	14 (73.7%)	1	4
PAKISTAN N=26	2	23 (88.5%)	1	0
AFGHANISTAN N=20	3	17 (85%)	0	0
TOTAL	17	98	5	12
%	12.9	74.2	6.8	9

2.8.4. PLHIV-PWUDs/PWIDs Relationship with HCP

The provider-patient relationship in health care contributes to increased adherence to prescribed treatment and to high levels of satisfaction with services provided. Around 46.8% participants (notably in Tunisia and Lebanon) had very good or good relationships with HCP; and (28.1%) (mainly in Morocco and Tunisia) had normal and average ones. More than half (in Egypt and Pakistan) had unstable, bad and very bad relationships with their caregivers in public healthcare settings.

TABLE 47

PLHIV-WUDS/WIDS RELATIONSHIP WITH HCP

RELATIONSHIP STATUS WITH HCP N=128							
COUNTRY	VERY GOOD	GOOD	NORMAL	AVERAGE	VARIABLE/ UNSTABLE	BAD	VERY BAD
MOROCCO N=26	0	9	11	2	1	3	1
TUNISIA N=26	6	11	3	5	0	1	0
LEBANON N=19	4	9	2	4	0	0	0
EGYPT N=20	0	5	3	0	3	7	2
PAKISTAN N=26	0	8	4	0	4	10	0
AFGHANISTAN N=11	0	8	3	0	0	0	0
TOTAL	10	50	26	10	8	21	3
%	7.8	39	20.3	7.8	6.2	16.4	2.3

2.9. UNDERLYING CAUSES OF STIGMA AND DISCRIMINATION

2.9.1. Level of Knowledge of Human Rights

The main goal of human rights is to reduce HIV/AIDS associated stigma and discrimination. Basic knowledge about human rights was relatively low among participants (29 per cent) except for Tunisia. The rights to treatment, marriage, work and good health, were cited. Some believed that human rights are the same for all, infected or not. Others received awareness sessions on "How to protect yourself and protect others". In Lebanon, no trainings were received and knowledge was obtained through personal readings. The four who had no knowledge of human rights, stated that PLHIV rights are the same as that of any other. In Egypt, most knowledge was acquired from other PLHIV, and only three attended a formal human rights awareness session.

TABLE 48

PLHIV-WUDS/WIDS KNOWLEDGE OF HUMAN RIGHTS

PLHIV-WUDS/WIDS' KNOWLEDGE OF HUMAN RIGHTS N= 141			
COUNTRY	KNOWLEDGE ABOUT HUMAN RIGHTS	DON'T KNOW ANYTHING ABOUT HUMAN RIGHTS	TYPES/SOURCES OF KNOWLEDGE
MOROCCO N=26	1	25	1/1 AWARENESS SESSION ABOUT STIGMA AND DISCRIMINATION
TUNISIA N=25	24	1	24/24 BASIC HUMAN RIGHTS AWARENESS SESSIONS
LEBANON N=19	4	15	4/4 PERSONAL KNOWLEDGE ACQUIRED THROUGH READINGS
EGYPT N=26	6	20	3/6 AWARENESS SESSIONS ABOUT HUMAN RIGHTS OF PLHIV, HIV/AIDS PREVENTION AND MODES OF TRANSMISSION, HEALTHY DIET 3/6 KNOWLEDGE OF HUMAN RIGHTS ACQUIRED FROM OTHER PLHIV THROUGH SUPPORT GROUPS
PAKISTAN N=26	3	23	3/3 KNOWLEDGE THAT THEY HAVE TO DISCLOSE THEIR HIV STATUS UPON INCARCERATION
AFGHANISTAN N=19	3	16	3/3 PERSONAL KNOWLEDGE ACQUIRED THROUGH READINGS
TOTAL	41	100	24/141 BASIC HUMAN RIGHTS SESSIONS
%	29	70.9	7/141 PERSONAL KNOWLEDGE ACQUIRED THROUGH READINGS 4/141 AWARENESS SESSIONS 3/141 KNOWLEDGE OF HUMAN RIGHTS THROUGH OTHER PLHIV 3/3 KNOWLEDGE THAT THEY HAVE TO DISCLOSE THEIR HIV STATUS UPON INCARCERATION

2.9.2. Level of PLHIV-WUDs/WIDs Collaboration/Involvement in HIV Response

Both PLHIV-WUDs/WIDs level of involvement in activities aiming at improving their situation, and level of collaboration with NAP or other policy makers in HIV response were limited. Afghanistan ranked the highest as participants had a representative in the Ministry of Health. About half the Tunisian and third the Lebanese participants were involved in such activities. Third the Egyptian and almost all Pakistani participants never heard of NAP. Moroccans were neither involved in activities nor collaborated with NAP.

TABLE 49

PLHIV-WUDS/WIDS COLLABORATION AND INVOLVEMENT IN HIV RESPONSE

PLHIV-WUDS/WIDS INVOLVEMENT AND COLLABORATION IN HIV RESPONSE N=149		
COUNTRY	INVOLVEMENT IN ACTIVITIES AIMING AT IMPROVING THEIR SITUATION	COLLABORATION WITH NAP IN HIV RESPONSE
MOROCCO N=26	ALL PARTICIPANTS REPORTED NOT BEING INVOLVED IN ANY ACTIVITY EXCEPT ATTENDING THE AWARENESS SESSIONS HELD AT THE HR PROJECT	ALL PARTICIPANTS REPORTED NO COLLABORATION WITH THE NAP
TUNISIA N=26	14/26 (8 MALES AND 6 FEMALES) REPORTED BEING INVOLVED THROUGH ACTIVITIES AND WORK IN HR PROJECTS	ALL PARTICIPANTS REPORTED NO COLLABORATION WITH THE NAP
LEBANON N=19	4/19 MALE PARTICIPANTS REPORTED INVOLVEMENT THROUGH ACTIVITIES AND WORK IN HR PROJECTS 1/19 REPORTED BEING A MEMBER OF THE NETWORK FOR PLHIV 4/19 REPORTED NOT HAVING TIME FOR ACTIVITIES	4/19 PARTICIPANTS REPORTED COLLABORATION FOR TREATMENT PURPOSES ONLY
EGYPT N=26	ONLY 1 PARTICIPANT REPORTED BEING THE FOUNDING MEMBER OF AN HR PROJECT AND ANOTHER ONE REPORTED HAVING ATTENDED SEVERAL CONFERENCES ON HIV/AIDS BUT NOT BEING DIRECTLY INVOLVED IN ACTIVITIES	7/26 PARTICIPANTS REPORTED NEVER HAVING HEARD OF THE NAP
PAKISTAN N=26	ALL PARTICIPANTS REPORTED NOT BEING INVOLVED IN ANY ACTIVITY	24/26 PARTICIPANTS REPORTED NEVER HAVING HEARD OF THE NAP ONLY 2/26 PARTICIPANTS REPORTED EVER HAVING HEARD OF THE NAP
AFGHANISTAN N=26	ALL PARTICIPANTS REPORTED HAVING A REPRESENTATIVE WHO IS INVOLVED IN IMPROVING THEIR SITUATION	ALL PARTICIPANTS REPORTED GOOD COLLABORATION WITH THE NAP THROUGH THEIR REPRESENTATIVE AND THEIR ANNUAL MEETING ON THE WORLD'S AIDS DAY
TOTAL	20/149 (OF DIRECT INVOLVEMENT) ONLY 13.4% OF ALL PARTICIPANTS	NO DIRECT COLLABORATION WITH THE NAP WAS REPORTED

2.9.3. HIV Disclosure Status

Only 44.1% of participants reported full or partial support from their families and friends after disclosure of HIV Status. About one quarter (26.8%) did not receive any support, and only 7.9% received partial support. About 21.2% did not share their status and preferred to keep it secret. Disclosure was found to be more prevalent among immediate family members (parents and siblings), specially mothers; and to have several advantages (emotional and social support) as well as disadvantages (social exclusion and family rejection).

TABLE 50

PLHIV-WUDS/WIDS DISCLOSURE STATUS

PLHIV-WUDS/WIDS DISCLOSURE STATUS N=127								
DISCLOSURE STATUS	MOR N=26	TUN N=26	LEB N=19	EGY N=21	PAK N=26	AFG N=9	TOTAL N=127	%
DISCLOSURE OF HIV STATUS TO MOTHER / PARTNER / SIBLINGS / FRIENDS AND RECEIVED FULL SUPPORT	6 (23%)	18 (69%)	8 (42.1%)	7 (33%)	13 (50%)	4 (44%)	56	44.1
DISCLOSURE OF HIV STATUS AND RECEIVED PARTIAL SUPPORT	4 (15%)	1 (4%)	3 (15.7%)	1 (5%)	1 (4%)	0 (0%)	10	7.9
DISCLOSURE OF HIV STATUS AND DIDN'T RECEIVE ANY SUPPORT	2 (8%)	5 (19%)	4 (21%)	11 (52%)	10 (38.5%)	2 (22%)	34	26.8
DIDN'T DISCLOSE THEIR HIV STATUS	14 (54%)	2 (8%)	4 (21%)	2 (9.5%)	2 (8%)	3 (33%)	27	21.2

Morocco: More than half the participants (3/6 women and 11/20 men) did not disclose their HIV status except to social workers and HCP. Of the six who disclosed it and received support, a man and a woman said they had HCV and not HIV. Those who disclosed their status did so only to one to two family members or partners, with mothers found to be the most supportive. Two wanted to disclose their status, but did not know how. One reported that he would never disclose his status.

Tunisia: The highest level of participants who received full support after disclosure was found in Tunisia. Almost all (92 per cent) participants disclosed their status mainly to their families (20/24), friends (4/20) and, in some cases, to both. Only two preferred not to inform anyone to maintain a normal life. Men who disclosed their status and did not receive support were 5/26. One female who received support regretted disclosure to her sisters and mother.

Lebanon: Twenty-one per cent of the participants did not disclose their HIV status, mainly because all male participants were MSM who kept their sexual orientation to themselves (intersected stigmas).

Egypt: More than half (52 per cent) of the participants disclosed their HIV status and received no support; but men received more support than women did. Two men received support only after a service provider passed the right information about HIV/AIDS to their families. No one disclosed their HIV status to friends. In addition, 2/21 did not tell anyone while 8/21 shared their status with their families, mostly supportive mothers and partners.

Pakistan: After HIV status disclosure, women received more support than men, and half the participants received full support. A high number (10/26) received no support. HIV positive status was mainly shared with family and partners.

Afghanistan: Very few participants replied to this question. However, among the nine who shared their HIV status disclosure experience, about half received full support upon disclosure, mainly from families and partners.

2.9.4. Reasons for Non-disclosure of HIV Status

The reasons for non-disclosure were classified into categories mainly attributable to anticipated, enacted and intersected stigmas as follows: Fear of being negatively perceived; fear of family reaction; fear of social isolation; fear of community rejection; negative experience upon disclosure; intersected stigma and other reasons such as fear of losing child custody, fear of divorce, fear of losing employment, fear of incarceration and fear of ruining children reputation.

TABLE 51

CLASSIFICATIONS OF REASONS FOR NON-DISCLOSURE OF HIV STATUS

CLASSIFICATIONS OF REASONS FOR NON-DISCLOSURE N=98	
FEAR FROM BEING NEGATIVELY PERCEIVED	FEAR OF BEING HATED; OF SHAME; OF DISGRACE; OF BEING SEEN AS A CRIMINAL; OF LOOING RESPECT
FEAR OF FAMILY REACTION	FEAR OF LOSING FAMILY TRUST; OF FAMILY DISAPPOINTMENT; OF LOSING FAMILY; OF LOSING FRIENDS; OF CAUSING PAIN TO FAMILY; OF GETTING KICKED OUT FROM FAMILY HOUSE
FEAR FROM SOCIAL ISOLATION	FEARS OF REJECTIONS; SOCIAL EXCLUSION, LONELINESS OR AVOIDANCE
FEAR OF COMMUNITY REJECTION	FEAR OF LOSING EVERYONE OR BEING GOSSIPED ABOUT BY NEIGHBORS
NEGATIVE EXPERIENCE UPON DISCLOSURE	VERBAL AND PHYSICAL ABUSE UPON DISCLOSURE, DUE TO PREVIOUS MISTREATMENT BECAUSE FOR DRUG ADDICTION
INTERSECTED STIGMA	ALREADY ABUSED BECAUSE OF DRUG ADDICTION; ENGAGING IN SAME SEX RELATIONS OR SEX WORK
OTHER	FEAR OF LOSING CHILD CUSTODY; OF DIVORCE; OF LOSING EMPLOYMENT; OF INCARCERATION RUINING CHILDREN REPUTATION

The main factors were fears of community rejection (37.7%), of stigma and discrimination (26.5%), of being negatively perceived (21.4%), of family reaction (24.5%), and of physical and mental abuse (13.3%), in addition to the negative experience that PLHIV-WUDs/WIDs had upon disclosure. Other factors included expectation of negative attitude (anticipated stigma); belonging to different highly stigmatized key population groups (intersected stigma) - namely MSM, sex workers and drug addicts. Reasons for nondisclosure varied across participating countries and were regrouped as follows:

TABLE 52

REASONS FOR NON-DISCLOSURE BY COUNTRY

REASONS FOR NON-DISCLOSURE OF HIV STATUS N=98															ALL TOT	%
COUNTRY	MOR N=24		TUN N=15		LEB N=4		EGY N=17		PAK N=26		AFG N=12		TOTAL ALL GENDER N=98			
GENDER	M N=18	W N=6	M N=3	W N=12	M N=3	W N=1	M N=9	W N=8	M N=13	W N=13	M N=12	M N=58	W N=40			
FEAR FROM COMMUNITY REJECTION	5	3	1	13	1	0	3	2	8	1	0	18	19	37	37.7	
FEAR FROM STIGMA AND DISCRIMINATION	4	0	1	10	1	0	3	2	0	0	5	14	12	26	26.5	
FEAR FROM BEING NEGATIVELY PERCEIVED	3	0	0	3	0	0	2	2	4	6	1	10	11	21	21.4	
FEAR FROM FAMILY REACTION	6	2	0	1	2	0	3	0	0	4	2	13	7	20	20.4	

REASONS FOR NON-DISCLOSURE OF HIV STATUS N=98 (CONT'D)															ALL TOT	%
COUNTRY	MOR N=24		TUN N=15		LEB N=4		EGY N=17		PAK N=26		AFG N=12		TOTAL ALL GENDER N=98			
GENDER	M N=18	W N=6	M N=3	W N=12	M N=3	W N=1	M N=9	W N=8	M N=13	W N=13	M N=12	M N=58	W N=40			
FEAR FROM PHYSICAL AND MENTAL ABUSE	0	2	0	0	0	0	2	5	3	0	1	6	7	13	13.3	
NEGATIVE EXPERIENCE UPON DISCLOSURE	2	2	0	0	0	0	0	1	1	0	0	3	3	6	6.1	
BETTER NOT TO DISCLOSE HIV STATUS	3	1	0	0	0	0	0	0	0	0	0	3	1	4	4.1	
FEAR FROM LOSING SOCIAL STATUS	0	0	0	0	0	0	0	0	0	0	2	2	0	2	2	
FEAR FROM LOSING CHILD CUSTODY	1	1	0	0	0	0	0	0	0	0	0	1	1	2	2	
FEAR FROM DIVORCE	1	0	0	0	0	0	0	0	0	0	0	1	0	1	1	
FEAR FROM INTERSECTED STIGMA	0	0	0	0	1	0	0	0	0	0	0	1	0	1	1	
FEAR FROM LOSING EMPLOYMENT	0	0	0	0	0	0	0	0	0	0	1	1	0	1	1	
FEAR FROM INCARCERATION	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1	
FEAR FROM RUINING CHILDREN'S REPUTATION	0	0	0	0	0	0	0	1	0	0	0	0	1	1	1	
BEING TOO SCARED TO DISCLOSE HIV STATUS	0	1	0	0	0	0	0	0	0	0	0	0	1	1	1	

2.9.5. Perceptions of Self, of other PLHIV-WUDs/WIDs, and by Others

Three indicators used to measure the levels of internalized stigma and anticipated stigma were: (i) Self-perception, (ii) perception of other PLHIV-WUDs/WIDs and (iii) Perception of PLHIV-WUDs/WIDs by the general population. High levels of negative perceptions and labelling were reported, in terms of self-perception and perceptions by others. Perceptions were then classified into positive and negative ones as follows:

TABLE 53

CLASSIFICATION OF NEGATIVE PERCEPTIONS

CLASSIFICATION OF NEGATIVE PERCEPTIONS OF SELF AND OTHERS, AND BY OTHERS	
SHOULD BE PUNISHED	SHOULD BE IMPRISONED; SHOULD BE BLAMED; SHOULD BE ABUSED; SHOULD BE MISTREATED; SHOULD BE REJECTED; SHOULD BE AVOIDED; SHOULD BE BURNT ALIVE; SHOULD BE IMPRISONED; INFECTED THEMSELVES; PAYING FOR MISBEHAVIOR AND GOD PUNISHMENT; DESERVE TO HAVE HIV; DESERVE TO DIE
DISRESPECTED AND DISRESPECTFUL	WORTHLESS; LOSERS; JUNKIES; PROSTITUTES; DRUG ADDICTS; DOGS; DIRTY; CHEAP; PARASITE; INFERIOR; HAVING MULTIPLE DISEASES; SEXUALLY VERY ACTIVE/PROMISCUOUS, LOST THEIR HONOR BECAUSE OF THEIR HIV STATUS
ENGAGING IN ILLICIT BEHAVIORS	CRIMINALS; IMMORAL; SINNERS; NON-RELIGIOUS; THIEVES; UNETHICAL; DECADENT
EVIL/MEAN	RESENTFUL; REVENGEFUL; CARELESS; GOSSIPERS; HATEFUL; DANGEROUS; VIOLENT; UNTRUSTWORTHY; SCARY; DISGUSTING; UNHUMAN
GUILTY	REGRETFUL; BLAMING THEMSELVES; SHAMEFUL; ASHAMED
DEPRESSED	MENTALLY DESTROYED; DEVASTATED; SAD; HAVING SUICIDAL THOUGHTS; HOPELESS

TABLE 54

CLASSIFICATION OF POSITIVE/COMPASSIONATE PERCEPTIONS

CLASSIFICATION OF POSITIVE/COMPASSIONATE PERCEPTIONS OF SELF AND OTHERS, AND BY OTHERS	
VICTIMS	STIGMATIZED AND DISCRIMINATED AGAINST; REJECTED; EXCLUDED; SOCIALLY ISOLATED; MARGINALIZED; HELPLESS; SICK; HAVE LOW SELF-ESTEEM AND SELF-CONFIDENCE; NEED HELP; SHOULD BE SUPPORTED; SHOULD BE PROVIDED WITH CARE; SHOULD BE PITIED; PEOPLE WHO ARE SUFFERING; SICK PERSONS; FEELING SAD FOR THEM; FEELING BAD FOR THEM AND BEING PERCEIVED AT BY THE GENERAL POPULATION IN A JUDGMENTAL AND DISCRIMINATORY WAY
PERSONS IN THE SAME SITUATION	CLOSER TO THEMSELVES THAN OTHER PEOPLE; ACCEPTING THEMSELVES
GOOD PERSONS	TRUSTFUL, RESPECTFUL; NOT BAD PEOPLE; LOVING THEM; HAVING SYMPATHY FOR THEM, SHOULD BE PROUD
NORMAL PEOPLE	LIKE ANY OTHER HUMAN BEING
DEPENDS ON THE PERSON	CONFUSED; HAVING MIXED FEELINGS; DEPENDS ON THEIR BEHAVIOR
OTHERS	FEELING DIFFERENT; ABNORMAL; FRUSTRATED; IGNORANT AND BEING IN DENIAL

2.9.6. PLHIV-WUDs/WIDs Self-Perception (Internalized Stigma)

Only about one quarter (24.5%) of participants perceived themselves as good (14.1%) or normal (10.2%) (notably from Tunisia, followed by Lebanon and Afghanistan). Being confused about one's self was only recorded in Pakistan. Negative self-perceptions included guilty (33.8%), victims (32.3%), depressed (22.8%), disrespected/disrespectful (22.8%) and evil/mean person (10.2%).

TABLE 55

SELF-PERCEPTIONS

COUNTRY	REASONS FOR NON-DISCLOSURE OF HIV STATUS N=127														ALL TOT N=127	%
	MOR N=26		TUN N=26		LEB N=19		EGY N=20		PAK N=26		AFG N=10		TOTAL ALL GENDER			
GENDER	M N=20	W N=6	M N=13	W N=13	M N=16	W N=3	M N=12	W N=8	M N=13	W N=13	M N=10	M N=84	W N=43			
GUILTY	5	0	0	0	6	1	7	4	13	5	2	33	10	43	33.8	
VICTIM	6	2	4	4	0	2	7	4	4	4	4	25	16	41	32.3	
DEPRESSED	8	3	4	0	0	2	3	3	1	4	1	17	12	29	22.8	
DISRESPECTED/DISRESPECTFUL	12	8	0	1	0	2	0	1	1	2	1	14	14	28	22	
GOOD PERSON	0	0	0	11	7	0	0	0	0	0	0	7	11	18	14.1	
EVIL/MEAN PERSON	2	3	1	0	2	0	0	4	1	0	1	6	7	13	10.2	
NORMAL PERSON	0	0	5	1	1	1	1	0	0	0	4	11	2	13	10.2	
CONFUSED	0	0	0	0	0	0	0	0	0	4	0	0	4	4	3.1	
SHOULD BE PUNISHED	1	0	1	0	0	0	0	0	0	0	1	3	0	3	2.4	
ABNORMAL	0	1	0	0	0	0	0	0	0	1	0	0	2	2	1.6	
DIFFERENT	0	0	2	0	0	0	0	0	0	0	0	2	0	2	1.6	
FRUSTRATED	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0.8	
IN DENIAL	0	0	0	0	0	1	0	0	0	0	0	0	1	1	0.8	
PROUD	0	0	1	0	0	0	0	0	0	0	0	1	0	1	0.8	

2.9.7. Perception of Other PLHIV-WUDs/WIDs

Only 26.7% of participants perceived other PLHIV-WUDs/WIDs as good persons (mostly from Pakistan and Afghanistan). Perceiving others as normal was also high (in Tunisia and Afghanistan); and perceiving others as in the same situation was reported (in Egypt, Lebanon and Tunisia). Only three in Tunisia and one in Pakistan stated that it depended on the person, and only one in Afghanistan had mixed feelings about the perception of others.

Negative perceptions of other PLHIV was the highest (in Morocco and Egypt). In Morocco, 16 perceived others as engaging in illicit behaviours vs only 5 in Afghanistan, 3 in Egypt and 1 in each of Pakistan and Lebanon. None of the participants in Tunisia and Pakistan perceived others as engaging in illicit behaviours (except for one in Pakistan) or as people who should be punished, guilty or disrespected/disrespectful.

TABLE 56

PERCEPTION OF OTHER PLHIV-WUDS/WIDS

PERCEPTION OF OTHER PLHIV-WUDS/WIDS N=135															
COUNTRY	MOR N=26		TUN N=26		LEB N=16		EGY N=18		PAK N=26		AFG N=25	TOTAL ALL GENDER		ALL TOT N=135	%
GENDER	M N=20	W N=6	M N=13	W N=13	M N=11	W N=3	M N=12	W N=6	M N=13	W N=13	M N=25	M N=94	W N=41		
GOOD PERSONS	0	0	2	0	0	0	0	0	12	9	13	27	9	36	26.7
ENGAGING IN ILLICIT BEHAVIORS	15	1	0	0	1	1	0	3	1	0	5	22	5	27	20
NORMAL PERSONS	0	0	6	8	0	0	0	0	0	0	11	17	8	25	18.5
VICTIMS	0	0	1	0	4	1	5	0	1	0	11	22	1	23	17
DEPRESSED	3	0	4	3	1	0	0	0	0	4	8	16	7	23	17
SHOULD BE PUNISHED	3	3	0	0	2	0	4	0	0	0	0	9	3	12	8.9
EVIL/MEAN PERSONS	4	0	0	1	3	0	0	1	1	0	0	8	2	10	7.4
PERSONS IN THE SAME SITUATION	0	0	1	0	1	0	4	1	0	0	0	6	1	8	5.9
GUILITY	4	0	0	0	0	0	0	4	0	0	0	4	4	8	5.9
DISRESPECTED/DISRESPECTFUL	2	2	0	0	0	1	0	2	0	0	0	2	5	7	5.2
DEPENDS ON THEIR BEHAVIORS	0	0	2	1	0	0	0	0	0	1	0	2	2	4	3
HAVING MIXED FEELINGS	0	0	0	0	0	0	0	0	0	1	0	0	1	1	0.7

2.9.8. PLHIV-WUDs/WIDs Perception by Others (Anticipated Stigma)

About half (43 per cent) the participants think that the general population perceives them as individuals who should be punished for misbehaviour – mainly in Pakistan, Lebanon (because they engage in same sex relations), Egypt, and Morocco. Around 34.7% think that they are perceived as evil/mean, and 30.6% as engaging in illicit behaviours. Perceived as disrespected or disrespectful was felt by 19.8% of participants, while half the Tunisians were perceived in a judgmental and discriminatory way.

TABLE 57

PLHIV-WUDs/WIDs PERCEPTIONS BY OTHERS

PLHIV-WUDs/WIDs PERCEPTIONS BY OTHERS N=121															
COUNTRY	MOR N=26		TUN N=26		LEB N=14		EGY N=18		PAK N=26		AFG N=11	TOTAL ALL GENDER		ALL TOT N=135	%
GENDER	M N=20	W N=6	M N=13	W N=13	M N=11	W N=3	M N=12	W N=6	M N=13	W N=13	M N=11	M N=94	W N=41		
SHOULD BE PUNISHED	5	3	1	0	11	1	6	3	9	9	4	36	16	52	43
EVIL/MEAN PERSONS	6	4	2	2	1	0	6	2	6	9	4	25	17	42	34.7
ENGAGING IN ILLICIT BEHAVIORS	16	1	0	0	4	1	5	3	0	0	7	32	5	37	30.6
DISRESPECTED/DISRESPECTFUL	6	5	0	1	4	0	3	2	2	1	0	15	9	24	19.8
IN A JUDGMENTAL/DISCRIMINATORY WAY	0	0	8	6	0	0	0	0	0	0	0	8	6	14	11.6
DEPENDS ON PEOPLE	0	0	4	2	0	0	0	1	0	0	0	4	3	7	5.8
SCARED OF THEM	0	0	0	2	0	1	1	0	0	0	0	1	3	4	3.3
VICTIMS	0	0	1	0	1	0	0	1	0	0	0	2	1	3	2.5
GUILTY	0	0	0	0	1	0	0	1	0	0	0	1	1	2	1.6
IGNORANT	0	0	0	0	1	0	0	0	0	0	0	1	0	1	0.8

2.9.9. Sources and Forms/Types of Stigma/Discrimination (Enacted Stigma)

• Sources of stigma/discrimination experienced

Disclosure of HIV status is often followed by stigma and discrimination. Only 16.3% of participants (mainly in Lebanon and Tunisia) were not discriminated against vs 32.6% - mainly by family members (mainly in Pakistan, followed by Egypt and Morocco). Very few cited family as the main source of stigma (in Lebanon and Tunisia). HCP discrimination was cited by the majority of participants (in Morocco, Afghanistan, Egypt and Tunisia, followed by Pakistan and Lebanon). More than one quarter cited friends, neighbours and other community members as the main source of discrimination (mainly in Pakistan). Other forms of discrimination were police and security (in Morocco and Afghanistan); other drug addicts or PLHIV (in Morocco); other prisoners (in Tunisia); by private physicians (in Tunisia and Afghanistan); and by an outreach worker (Afghanistan).

TABLE 58

SOURCES OF STIGMA/DISCRIMINATION

SOURCES OF STIGMA/DISCRIMINATION N=129								
DRIVER	MOR N=19	TUN N=26	LEB N=19	EGY N=19	PAK N=26	AFG N=20	TOTAL	%
FAMILY MEMBERS	7	2	3	10	20	0	42	32.6
HCPs IN PUBLIC HOSPITALS	10	11	1	8	2	9	41	31.8
FRIENDS/NEIGHBORS AND OTHER COMMUNITY MEMBERS	3	1	2	5	25	0	36	27.9
HAVEN'T EXPERIENCED DISCRIMINATION	0	8	12	0	1	0	21	16.3
POLICE/SECURITY	7	0	0	0	0	3	10	7.7
OTHER DRUG ADDICTS / OTHER PLHIV	5	0	0	0	0	0	5	3.9
PRISONERS	0	2	0	0	0	0	2	1.5
PRIVATE PHYSICIAN	0	1	0	0	0	1	2	1.5
OUTREACH WORKER	0	0	0	0	0	1	1	0.8

(*) Family members include parents, siblings, children, relatives and partners

• Forms/types of Stigma and Discrimination

Most of the stigma and discrimination was experienced following disclosure to HCP in private and public hospitals, family members, friends, partners, or other community members, including neighbours, employers and legal authorities. Table 59 illustrates the forms/types of the discrimination experienced.

TABLE 59

TYPES/FORMS OF DISCRIMINATION EXPERIENCED

TYPES/ FORMS OF DISCRIMINATION EXPERIENCED (ALL COUNTRIES TOGETHER)	
SOCIAL ABUSE	LOSING FAMILY MEMBERS; PARTNERS (SEPARATION/DIVORCE); CHILDREN (CHILD CUSTODY); FRIENDS; COLLEAGUES; EMPLOYMENT
PHYSICAL ABUSE	BEATEN UP; FORCED INTO SEX; INVOLVED IN FIGHTS (AGGRESSION); PHYSICALLY EVICTED FROM FAMILY HOUSE; PHYSICALLY EVICTED FROM HOSPITALS; POINTED AT; LOOKED DOWN UPON; TALKED TO FROM A DISTANCE
VERBAL ABUSE	INSULTED; NOT TALKED TO; NOT GREETED; GOSSIPED ABOUT
EMOTIONAL ABUSE	PARTNER BLAME FOR HAVING HIV; THREATENED WITH EXPOSURE OF HIV STATUS; HELD RESPONSIBLE FOR FAMILY MISFORTUNE; BLAMED OF RUINING FAMILY REPUTATION; A SOURCE OF FEAR FOR COMMUNITY MEMBERS; TREATED DIFFERENTLY THAN OTHER FAMILY MEMBERS; BLAMED FOR THEIR LACK OF HYGIENE
NEGLECT	DENIED MEDICAL CARE (DENIAL OF DELIVERY, SURGERY, ABORTION ETC.); DELAY IN RECEIVING SERVICES; REFUSED ACCESS TO EMPLOYMENT; REFUSED ACCESS TO FAMILY HOUSE; REFUSED THE PURCHASE OF MEDICINE IN PHARMACIES

TYPES/ FORMS OF DISCRIMINATION EXPERIENCED (ALL COUNTRIES TOGETHER) (CONT'D)

LIMITATION OF PHYSICAL SPACE	NOT ALLOWED IN PUBLIC PLACES SUCH AS BATHS AND GROCERY AND COFFEE SHOPS; FORCED TO SLEEP OUTSIDE THE HOUSE (IN THE ROOF FOR INSTANCE); PHYSICALLY ISOLATED AT HOME; NOT ALLOWED TO SHARE THE SAME BATH-ROOM WITH FAMILY; HOSPITALIZED BY FORCE; FORCED OUT OF FAMILY HOUSE; NOT ALLOWED TO GET INTO THE HOSPITAL; NOT ALLOWED TO SHARE THE SAME OFFICE; NOT ALLOWED TO SHARE THE SAME TRANSPORTATION WITH OTHER COLLEAGUES; FORCED TO LEAVE TO OTHER CITIES; EXCLUDED FROM FAMILY ACTIVITIES/GATHERINGS; IMPRISONMENT/INCARCERATION/POLICE HARASSMENT
LIMITATION OF PERSONAL BEHAVIOUR	NOT ALLOWED TO SHARE PERSONAL UTENSILS; NOT ALLOWED TO SHARE MEALS; NOT ALLOWED TO TOUCH ANYTHING AT HOME; NOT ALLOWED TO ATTEND FAMILY OFFICIAL EVENTS/GATHERINGS; FORCED TO HIDE HIV TREATMENT
SELF- DISCRIMINATION	LIVING IN SOCIAL ISOLATION/EXCLUSION

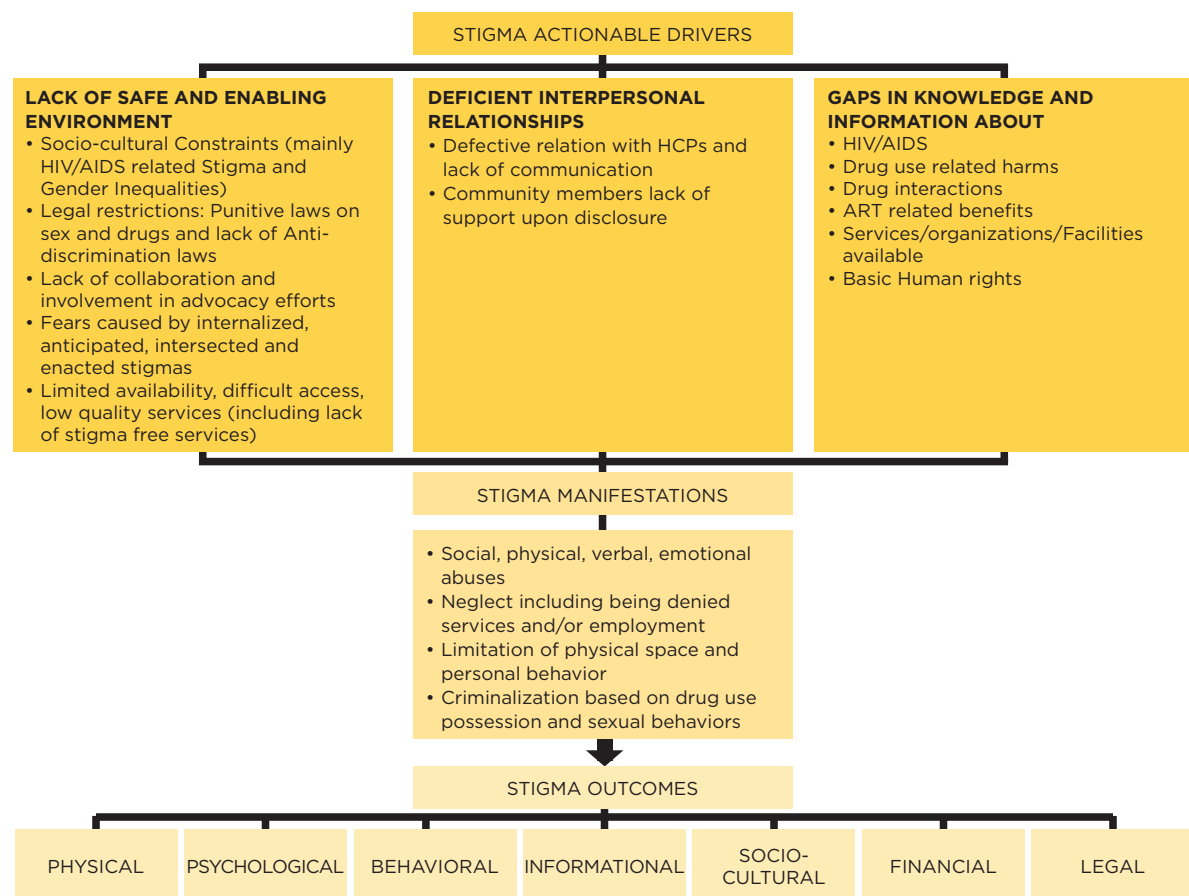
In Morocco, half the sample did not disclose their HIV status; hence, stigma was mostly related to drug addiction rather than HIV status. Morocco had the highest level of PLHIV-WUDs/WIDs experiencing discrimination from the community, especially family members. Hospital security related problems, and insults by other drug addicts/PLHIV were specific to Morocco and seemed to lead to serious problems such as physical fights. Participants from Morocco also reported self-discrimination. In Tunisia, most of the stigma and discrimination related to the HIV status were practiced by HCP in healthcare settings. Very few from Lebanon reported discrimination, which mainly related to friends avoiding and refusing to deal with them. All males from Lebanon were MSM living with HIV and using drugs. Most of them reported feeling afraid that family members know about their sexual preference because of the stigma attached. Like Moroccans, Lebanese participants reported social isolation and exclusion. Half the participants reported service denial in healthcare settings. The delay in receiving CD4 test results was very prevalent among participants in Egypt. In Pakistan, almost all reported service denial by HCP in public hospitals. Some also stated that HCP constantly complain about their lack of hygiene, refusing to touch them during medical check-up. In Afghanistan, problems related to discrimination were mainly experienced from private physicians.

2.9.10. Stigma Outcomes

Stigma outcomes were on multiple levels: physical, psychological, behavioural, informational, sociocultural, legal and financial as shown in the following figure:

FIGURE 3

CAUSES AND EFFECTS OF STIGMA AND DISCRIMINATION



- PHYSICAL**
 - Limited access to HR and Healthcare services
 - Limited access to knowledge/information
 - Poor physical condition
 - Drug interactions side effects
 - Reluctance to take ART and other treatments
- PSYCHOLOGICAL**
 - Multiple Mental Health Diseases
 - Depression and depressive symptoms
 - Self-discrimination/Social Isolation
 - Fear from negative consequences upon disclosure/family and other community members' attitudes/perception/reaction/rejection
- BEHAVIORAL**
 - Drug abuse and poly-drug use
 - Risky sexual and injecting behaviors
 - Low/inconsistent condom use
 - Exchange of Sex for Drugs
 - Overlap of risky behaviors
 - Risk of HIV transmission
 - Risk of detecting other Infections/ diseases

- INFORMATIONAL**
 - Limited access to knowledge about basic human rights, available services drug use related harms and drugs interactions effects
- SOCIO-CULTURAL**
 - Social Repression
 - Community rejection,
 - Exclusion
 - Avoidance
 - Lack of support
 - Bad reputation
 - Low social status
- FINANCIAL**
 - Unemployment
 - Work cessation
 - Early retirement
 - Inactivity
 - Loss of income/steady revenue
 - Dependence on family support
 - Poverty
- LEGAL**
 - Engaging in in illicit/illegal behaviors to generate income
 - Fear from police arrest/harassment
 - Imprisonment
 - Recidivism

PLHIV-WUDS/WIDS REPORTED BARRIERS AND FACILITATORS

3.1. PLHIV-WUDS/WIDS REPORTED BARRIERS

Almost all (85.7%) participants experienced barriers to accessing services. The bad quality of service delivery (38.6%), high level, and fear of, stigma (37.9%), limited geographic accessibility of services (30.7%), and financial constraints (10.7%) feature predominantly among them. Stigma and fear of stigma largely related to mistreatment by HCP in public hospitals in Egypt, Morocco and Tunisia. Most Moroccans and Egyptians regarded distance to healthcare facilities and HR projects as the main barrier to services.

TABLE 60

PLHIV-WUDS/WIDS REPORTED ACCESS BARRIERS TO HR AND HEALTHCARE SERVICES

PLHIV-WUDS/WIDS REPORTED ACCESS BARRIERS TO HR AND HEALTHCARE SERVICES N=140								
BARRIER	MOR N=26	TUN N=20	LEB N=16	EGY N=26	PAK N=26	AFG N=26	TOTAL	%
QUALITY OF SERVICES	17	1	1	14	18	3	54	38.6
STIGMA AND FEAR FROM STIGMA	14	10	5	16	6	2	53	37.9
ACCESSIBILITY OF SERVICES (LOW COVERAGE/DISTANCE)	22	6	1	11	2	1	43	30.7
FINANCIAL CONSTRAINTS	5	3	3	2	0	2	15	10.7
DEPRESSION/MENTAL CONDITION	0	0	0	5	0	0	5	3.6
DRUG ADDICTION	0	0	0	5	0	0	5	3.6
LACK OF KNOWLEDGE ABOUT THE IMPORTANCE OF SERVICES	0	0	2	0	0	2	4	2.8
FEAR FROM MISTREATMENT	0	0	0	4	0	0	4	2.8
LACK OF KNOWLEDGE ABOUT SERVICES AVAILABLE	0	0	1	1	0	0	2	1.4
MEDICAL CONDITION	2	0	0	0	0	0	2	1.4
LACK OF HUMAN RESOURCES	2	0	0	0	0	0	2	1.4
LAZINESS	0	0	0	2	0	0	2	1.4
FEAR FROM THE POLICE	0	0	0	1	0	0	1	0.7
LACK OF GENDER SPECIFIC SERVICES	0	0	0	0	0	1	1	0.7
NO BARRIERS	0	2	4	0	2	12	20	14.3

3.2. PLHIV-WUDS/WIDS REPORTED FACILITATORS

According to PLHIV-WUDS/WIDS the three major facilitators to improved access to services were: high quality of service delivery/provision (35.2%), wider geographical coverage (30.4%) - due to unaffordable transport cost, and awareness raising about HIV/AIDS among HCP and the general public (16.8%). Other reported facilitators were good health condition, compliance to HIV treatment, employment, access to free transportation to services, access to shelter, access to available services, enforce punitive laws against HCP, access to social, financial and psychological support, and increased support to the HR projects implemented.

TABLE 61

PLHIV-WUDS/WIDS REPORTED ACCESS FACILITATORS TO HR AND HEALTHCARE SERVICES

PLHIV-WUDS/WIDS REPORTED ACCESS FACILITATORS N=125								
FACILITATORS	MOR N=26	TUN N=20	LEB N=16	EGY N=26	PAK N=26	AFG N=11	TOTAL	%
HIGH QUALITY SERVICES	18	4	6	11	0	5	44	35.2
WIDER GEOGRAPHICAL COVERAGE	20	4	0	10	0	4	38	30.4
AWARENESS RAISING	0	0	9	9	0	3	21	16.8
GOOD HEALTH CONDITION	2	4	0	0	0	0	6	4.8
HIV TREATMENT COMPLIANCE	1	0	0	4	0	0	5	4
EMPLOYMENT	1	0	0	0	0	0	5	4
FREE TRANSPORTATION	0	4	0	0	0	0	4	3.2
HAVE ACCESS TO SHELTER	0	0	0	0	0	4	4	3.2
ACCESS TO INFORMATION ABOUT SERVICES AVAILABLE	0	0	3	0	0	0	3	2.4
PUNITIVE LAWS AGAINST HCPS	0	0	0	3	0	0	3	2.4
SOCIAL SUPPORT	2	0	0	0	0	0	2	1.6
FINANCIAL SUPPORT	1	0	0	0	0	0	1	0.8
PSYCHOLOGICAL SUPPORT	1	0	0	0	0	0	1	0.8
SUPPORT CURRENTLY IMPLEMENTED HR PROJECTS	0	0	1	0	0	0	1	0.8

3.3. PLHIV-WUDS/WIDS REPORTED NEEDS

As most participants were using drugs at the time of data collection, access to drug urgent need acknowledged by (27.2%) of them; mainly by current injecting drug users in countries where OST was not available: Pakistan, Egypt and Tunisia. The need for psychological support was voiced by 24.8%, mainly by Moroccans. Other commonly mentioned needs included access to better services (24%), employment (20%), financial support (15.2%), and improved housing situation (14.4%).

TABLE 62

PLHIV-WUDS/WIDS REPORTED NEEDS

PLHIV-WUDS/WIDS REPORTED NEEDS N=125								
NEED	MOR N=26	TUN N=20	LEB N=12	EGY N=24	PAK N=26	AFG N=11	TOTAL	%
DRUG ADDICTION TREATMENT	0	9	0	10	17	0	34	27.2
PSYCHOLOGICAL SUPPORT	17	7	4	3	0	0	31	24.8
ACCESS TO BETTER SERVICES	7	0	0	12	10	1	30	24
EMPLOYMENT	5	4	0	5	2	9	25	20
FINANCIAL SUPPORT	4	9	1	0	5	0	19	15.2
IMPROVED HOUSING SITUATION	0	0	0	0	0	18	18	14.4
AWARENESS RAISING	0	1	0	4	0	4	9	7.2
STIGMA FREE SOCIETY/ SERVICES	0	0	7	0	0	0	7	5.6
ANTI-DISCRIMINATION LAWS	0	0	0	5	0	1	6	4.8
NO NEEDS	0	2	3	0	0	0	5	4
CAPACITY BUILDING TRAINING	0	1	0	0	4	0	5	4
LEGAL SUPPORT	0	3	0	0	0	0	3	2.4
SOCIAL SUPPORT	0	2	1	0	0	0	3	2.4
INCOME GENERATING ACTIVITIES /SME	0	0	0	2	0	0	2	1.6
GOOD HEALTH CONDITION	1	0	0	0	0	0	1	0.8
FAMILY SUPPORT	1	0	0	0	0	0	1	0.8
GENDER SPECIFIC SERVICES	0	0	0	0	0	1	1	0.8

3.4. PLHIV-WUDS/WIDS SUGGESTIONS FOR IMPROVED SERVICES AND REDUCED HIV RELATED STIGMA TO SERVICE UPTAKE

The barriers and facilitators reported by PLHIV-WUDs/WIDs were found to be correlated to their suggestions for improved services. On top of these suggestions were a wider geographical coverage of HR and healthcare services; a better quality of service provision, and HCP capacity building on how to deal with PLHIV in general, and PLHIV- WUDs/WIDs in particular. Suggestions to reduce stigma related to service uptake included launching HIV/AIDS awareness campaigns in schools and universities; organizing media campaigns; developing a special TV programme; training HCP on the negative impact of stigma and discrimination; and participating in developing and help in enforcing anti-discriminatory laws.

TABLE 63

PLHIV-WUDS/WIDS SUGGESTIONS FOR IMPROVED SERVICES AND REDUCED HIV RELATED STIGMA

PLHIV-WUDS/WIDS SUGGESTIONS FOR IMPROVED SERVICES AND REDUCED HIV RELATED STIGMA		
COUNTRY	SUGGESTIONS FOR SERVICE IMPROVEMENT	SUGGESTIONS TO REDUCE HIV RELATED STIGMA TO SERVICES UPTAKE
MOROCCO	<ul style="list-style-type: none"> • Increase HR and healthcare services Coverage • Increase HCPs number in healthcare settings • Include HCPs from both genders (men specially) • Improve the working hours of healthcare facilities • Decrease the time between appointments in hospitals • Establish special hospitals for PWUDs/ PWIDs • Increase legal support services in HR projects 	<ul style="list-style-type: none"> • Launch awareness campaigns in schools and Universities • Have special TV programs for HIV and AIDS • Increase PLHIV participation in programing and decision making • Enforce anti-discrimination laws
TUNISIA	<ul style="list-style-type: none"> • Further build HCP capacity to provide stigma free services • Increase the number of social/recreational activities for PLHIV 	<ul style="list-style-type: none"> • Implement an effective PLHIV strategy • Launch awareness campaigns in TV, media and public spaces
LEBANON	<ul style="list-style-type: none"> • Have access to more information on available services • Improve HIV prevention services (make them more attractive) • Provide job opportunities through HR project • Increase the number of services • Train HCPs on how to deal with PLHIV 	<ul style="list-style-type: none"> • Enforce anti-discrimination laws • Increase awareness HIV/AIDS Awareness
EGYPT	<ul style="list-style-type: none"> • Provide services in other places than public Hospitals • Train HCPs on HIV and AIDS and increase their salaries to provide better services • Provide access to detoxification/ rehabilitation centers through HR projects • Increase the number of HR projects in all governorates 	<ul style="list-style-type: none"> • Participate in developing laws that would protect PLHIV • Organize awareness and media campaigns that would involve key players such as religious leaders
PAKISTAN	<ul style="list-style-type: none"> • Provide access to more syringes • Provide access to drug treatment • Provide support to quit drugs 	<ul style="list-style-type: none"> • Launch awareness campaigns • Have special TV programs on HIV and AIDS • Train HCPs on how to deal with PLHIV • Implement anti-discrimination laws
AFGHANISTAN	<ul style="list-style-type: none"> • Build HCPs through trainings and workshops • Widen the geographical coverage of HR projects • Implement gender specific services 	<ul style="list-style-type: none"> • Train HCPs on stigma and discrimination • Launch awareness campaigns in public places including mosques • Have TV and radio programs

SUMMARY OF KEY FINDINGS AND OPERATIONAL RECOMMENDATIONS

DEMOGRAPHIC AND SOCIOECONOMIC BACKGROUND	
CORRELATION BETWEEN MEAN AGE OF PARTICIPANTS AND ART ADHERENCE	THE MEAN AGE OF PARTICIPANTS FROM TUNISIA (33.3 YEARS), LEBANON (32.9 YEARS) AND AFGHANISTAN (35.2 YEARS) WHO HAD HIGH LEVELS OF ART ADHERENCE WAS HIGHER THAN THOSE FROM MOROCCO (30.5 YEARS), EGYPT (32.3 YEARS) AND PAKISTAN (28.7 PER CENT)
CORRELATION BETWEEN MEAN YEARS OF LIVING WITH HIV/AIDS AND ART ADHERENCE	THE MEAN YEARS OF LIVING WITH HIV/AIDS WAS MUCH HIGHER AMONG PARTICIPANTS IN AFGHANISTAN (7.7 YEARS), TUNISIA (7 YEARS), AND LEBANON (5.7 YEARS) THAN THOSE IN EGYPT (3.2 YEARS), PAKISTAN (2.1 YEARS) AND MOROCCO (1.2 YEARS)
HIGH LEVEL OF PARTICIPANTS GETTING TESTED BECAUSE OF POOR MEDICAL CONDITION	GETTING TESTED FOR HIV DID NOT STEM FROM A PERSONAL INITIATIVE/CHOICE FOR MOST OF THE PARTICIPANTS; RATHER IT WAS CORRELATED WITH POOR MEDICAL CONDITION OR FOLLOWING A PARTNER'S/FAMILY MEMBERS' INFECTION
HIGH LEVEL OF PARTICIPANTS HAVING YOUNG CHILDREN	MORE THAN ONE THIRD (37 PER CENT) REPORTED HAVING CHILDREN WITH A RATHER YOUNG MEAN AGE OF 8.2 YEARS
LOW LEVELS OF CHILDREN WHO TESTED FOR HIV	ONLY ABOUT ONE THIRD (32 PER CENT) OF CHILDREN HAVE TESTED FOR HIV, ABOUT 10 PER CENT OF THEM WERE FOUND HIV POSITIVE
POOR EDUCATIONAL ATTAINMENTS	32 PER CENT COMPLETED PRIMARY SCHOOL AND 17.4 PER CENT HAVE NEVER HAVING BEEN TO SCHOOL (ILLITERATE)
HIGH LEVELS OF UNEMPLOYMENT AND INVOLVEMENT IN UNSKILLED WORK	60.4 PER CENT WERE UNEMPLOYED AND 30.8 PER CENT WERE INVOLVED IN FULL TIME OR PART TIME UNSKILLED WORK THAT REQUIRE GOOD PHYSICAL HEALTH (LABOURERS, CLEANERS, SEX WORK)
UNSTEADY REVENUE	FINANCIAL DEPENDENCE ON FAMILY/PARTNERS/FRIENDS AS MAIN SOURCES OF INCOME (62.8 PER CENT)
HIGH LEVELS OF INVOLVEMENT IN ILLICIT/ILLEGAL BEHAVIOURS/ ACTIVITIES AS SOURCES OF INCOME	MAINLY STEALING, SMUGGLING AND DRUG DEALING (15.4 PER CENT)
UNSTABLE HOUSING SITUATION	ALMOST ALL PARTICIPANTS (89.3 PER CENT) WERE LIVING AT A FAMILY/PARTNER OR A FRIENDS' HOUSE AND HIGH LEVELS OF HOMELESSNESS (11.4 PER CENT)
GENDER DIFFERENTIAL IN EMPLOYMENT STATUS AND EDUCATIONAL LEVEL	HIGHER LEVEL OF UNEMPLOYMENT AMONG WOMEN (74.5 PER CENT) THAN MEN (53.9 PER CENT) DESPITE WOMEN HAVING HIGHER LEVELS OF EDUCATIONAL ATTAINMENT THAN MEN
OPERATIONAL RECOMMENDATIONS	
<ul style="list-style-type: none"> • Increase awareness and promote the positive health impacts of early detection and routine screening among family members (mainly partners and children) of PLHIV-WUDs/WIDs • Integrate HIV testing of all partners and children of newly diagnosed people in the package of HR and healthcare services for early initiation of ART • Develop and implement special programmes for children LHIV and women PLHIV-WUDs/WIDs • Initiate income generating activities for PLHIV-WUDs/WIDs • Provide PLHIV-WUDs/WIDs with loans to start SME projects • Establish monthly allowances and pensions • Increase the number of PLHIV-WUDs/WIDs working in HR projects • Link PLHIV-WUDs/WIDs with organizations offering employment opportunities 	

DRUG PATTERNS	
HIGH LEVEL OF PLHIV-WUDS/WIDS CURRENTLY USING/INJECTING DRUGS	77.8% WERE CURRENT DRUG USERS AND 4% OCCASIONAL, AMONG WHICH 55% WERE CURRENTLY INJECTING DRUG USERS AND 3.4% OCCASIONAL.
HIGH NUMBER OF PARTICIPANTS' PARTNERS USING/INJECTING DRUGS	ALMOST HALF THE PARTICIPANTS' PARTNERS (45.6%) WERE CURRENTLY USING DRUGS, OUT OF THEM 39.6% WERE CURRENT INJECTING DRUG USERS
PREVALENCE OF POLYDRUG USE/ABUSE PATTERNS	MIXING DIFFERENT DRUGS TOGETHER AND USING OTHER DRUGS WITH OST (METHADONE); HEROIN CONSUMED BY 63.9%, CANNABIS BY 46.25 AND COCAINE BY 21.8%. OTHER PRESCRIPTION DRUGS ACCOUNTED FOR 22.7% OF ALL DRUGS CONSUMED. ALCOHOL CONSUMED BY 10% OF PARTICIPANTS
HALF OF THE DRUGS USED WERE FOUND TO BE COUNTRY SPECIFIC	SUBUTEX IN TUNISIA, AVIL IN PAKISTAN, TRAMADOL AND TAMOL IN EGYPT AND OPIUM IN AFGHANISTAN
HIGH RISK INJECTION BEHAVIOURS/PRACTICES	HIGH LEVELS OF NEEDLE/SYRINGE SHARING PRACTICES: 56.1% ALWAYS AND 7.3% SOMETIMES SHARED NEEDLES/SYRINGES
UNAVAILABILITY OF SYRINGES AS THE MAIN REASON FOR SHARING NEEDLES/SYRINGES	SYRINGE UNAVAILABILITY AS A REASON FOR SHARING SYRINGES/NEEDLES WAS REPORTED BY HALF (51.5%) THE PARTICIPANTS
IMPACT OF FINANCIAL CONSTRAINTS ON UNSAFE INJECTING BEHAVIOURS	LACKING FINANCIAL MEANS REPORTED BY ALMOST HALF (42.6%) THE PARTICIPANTS TO PAY FOR TRANSPORT, BUY NEW SYRINGE AND OWN DRUG DOSE
REASONS FOR USING DRUGS ASSOCIATED TO EXTERNAL INFLUENCES	ABOUT ONE THIRD (32%) OF PARTICIPANTS' DRUG ABUSE WAS INFLUENCED BY PEERS, PARTNERS AND FAMILY
HIGH LEVELS OF INCARCERATION AND RECIDIVISM RELATED TO DRUG OFFENCES	DRUG USE ACCOUNTED FOR 53.5% OF ALL INCARCERATIONS AND DRUG POSSESSION FOR 15.5%
GENDER DIFFERENTIAL IN DRUG PATTERNS	NUMBER OF WOMEN'S PARTNERS USING DRUGS (78.7%) HIGHER THAN MEN'S (30.4%) AND NUMBERS OF WOMEN'S PARTNERS INJECTING DRUGS (72.5%) HIGHER THAN MEN'S (24.5%); HIGHER LEVELS OF USING AND INJECTING DRUGS AMONG WOMEN (93.6%) THAN MEN (70.6%); AND HIGHER LEVELS OF WOMEN INJECTING DRUGS (80.8%) THAN MEN (43.1%)

OPERATIONAL RECOMMENDATIONS

- Link people using or injecting drugs and newly diagnosed with HIV to substance abuse treatment centres/programmes for detoxification and rehabilitation
- Integrate services for PLHIV-WUDs/WIDs partners and related communities in the package of services
- Give PLHIV-WUDs/WIDs access to information about side effects of drug interactions
- Create records of past and current drug taking history
- Ensure that PLHIV-WUDs/WIDs fulfil the inclusion criteria before initiating OST
- Monitor the dosage of methadone or other drug dependence treatment to increase efficiency of treatment
- Promote techniques of drug administration other than injection to decrease HIV transmission risks
- Promote behaviour change through the provision of accurate information about injecting safely
- Clean injecting equipment and dispose of used syringes or other injecting equipment
- Increase the availability of sterile syringes in HR projects
- Adapt the distribution of syringes to PLHIV-WUDs/WIDs availability
- Facilitate access to services through providing free transportation or allocate a budget to pay fees for PLHIV-WUDs/WIDs transportation
- Refer PLHIV-WUDs/WIDs to social reintegration/reinsertion programmes following imprisonment
- Create programmes to reinforce family and friends support
- Increase the message that drug addiction is a healthcare condition rather than a crime punishable by law
- Reform laws related to drug use, extramarital sex and same sex relations, and enforce anti-discrimination laws

SEXUAL BEHAVIOUR	
INCONSISTENT/LOW CONDOM USE	OF ALL PARTICIPANTS, 37.5% NEVER USED CONDOMS AND 17.6% SOMETIMES USED IT FOR FEAR OF PARTNER'S SUSPICION (13%), REDUCED SEXUAL PLEASURE (13.3%) PARTNER ALREADY INFECTED (11.1%), PARTNERS' REFUSAL TO USE A CONDOM (8.9%) AND UNAVAILABILITY OF CONDOMS AT TIME OF SEXUAL INTERCOURSE (8.9%)
OVERLAP OF RISKY BEHAVIOURS TRIGGERED BY ANTICIPATED STIGMA	HIGH LEVELS OF PLHIV-WUDS/WIDS ENGAGING IN SEX WORK AND SAME SEX RELATIONS WITHOUT USING A CONDOM OUT OF FEAR OF LOSS OF THEIR CLIENTS WHO PREFER UNPROTECTED SEX
GENDER DIFFERENTIAL IN SEXUAL BEHAVIOURS	CONSISTENT CONDOM USE AMONG WOMEN WAS 21.3% COMPARED TO 57.3% OF MEN. NEVER USING CONDOMS WAS REPORTED BY 27% OF WOMEN AND 57.4% OF MEN. HIGH LEVELS OF WOMEN EXCHANGING SEX FOR DRUGS; HIGH LEVELS OF PHYSICAL ABUSE AND SEXUAL VIOLENCE AGAINST WOMEN

OPERATIONAL RECOMMENDATIONS

- Improve the quality and increase the number of condoms distributed to PLHIV-WUDs/WIDs
- Distribute lubricants along with condoms to increase their consistent use
- Promote consistent condom use among infected partners
- Encourage newly diagnosed people to disclose their HIV status to their partners
- Link PLHIV-WUDs/WIDs engaging in same sex relations and sex work to CSOs providing specific services tailored to their needs
- Develop and implement a combination of interventions to promote safe sexual practices among women
- Refer women living with HIV, using/injecting drugs, to associations dealing with violence against women

KNOWLEDGE ABOUT HIV AND AIDS, HIV/AIDS TRANSMISSION MODES AND PREVENTION METHODS

LACK OF KNOWLEDGE AND HIGH LEVELS OF MISCONCEPTIONS ABOUT HIV AND AIDS	ABOUT ONE THIRD (31.1%) OF PARTICIPANTS DID NOT KNOW THE DIFFERENCE BETWEEN HIV AND AIDS. OTHER MISCONCEPTIONS IDENTIFIED INCLUDED: HIV LEADS TO DEATH (7.3%), HIV IS AN STI OR A MICROBE AND THAT AIDS IS WHEN THE PERSON START TAKING HIV TREATMENT (6%)
LOW LEVEL OF KNOWLEDGE ABOUT CERTAIN TRANSMISSION MODES	ONLY 6.8% (8 PARTICIPANTS FROM MOROCCO AND 1 FROM AFGHANISTAN) REPORTED INJECTION EQUIPMENT AS A MODE OF HIV TRANSMISSION, AND 39.4% BELIEVED THAT SEXUAL RELATIONS, ANAL SEX, ILLICIT SEX AND HAVING MULTIPLE SEXUAL PARTNERS TRANSMITTED HIV/AIDS
LOW LEVEL OF KNOWLEDGE ABOUT CLEAN INJECTION EQUIPMENT AS A PREVENTION METHOD	ONLY 7.7% (ALL FROM MOROCCO) REPORTED USING NEW/CLEAN INJECTION EQUIPMENT AS A PREVENTION METHOD
PREVALENCE OF A SINGLE SOURCE OF HIV/AIDS INFORMATION	78.9% OF PARTICIPANTS, MAINLY FROM EGYPT (34.8%), HAVE THEIR INFORMATION ABOUT HIV/AIDS FROM A SINGLE CSO/HR PROJECT, AND 26.3% FROM HCP, WHILE 11.3% FROM FRIENDS/OTHER PLHIV/DRUG ADDICTS
CORRELATION BETWEEN SOURCES OF HIV/AIDS INFORMATION AND KNOWLEDGE ABOUT HIV AND AIDS	THE MAIN SOURCE OF INFORMATION OF 11.3% OF THE PARTICIPANTS ENGAGING IN HIGH RISK BEHAVIOURS, MAINLY IN EGYPT (34.8%) WAS FROM FRIENDS AND OTHER PLHIV/PWUD OR/AND PWIDS; INSTEAD OF PROFESSIONALS IN HEALTHCARE SETTINGS AND HR PROJECTS
GAP BETWEEN KNOWLEDGE ABOUT HIV/AIDS AND INJECTING/SEXUAL BEHAVIOURS:	PARTICIPANTS WHO REPORTED GOOD KNOWLEDGE ABOUT HIV AND AIDS, HIV/AIDS MODES OF TRANSMISSION AND PREVENTION METHODS WERE STILL ENGAGING IN RISKY BEHAVIOURS

OPERATIONAL RECOMMENDATIONS

- Ensure that both HIV and AIDS are well explained to PLHIV through peer education and/or counselling
- Include injection equipment as a main route of HIV transmission in the prevention messages
- Inform PLHIV-WUDs/WIDs that protected sex and sexual abstinence prevent HIV transmission
- Insist on relying on a trustworthy source of information about HIV/AIDS
- Conduct an in-depth assessment to identify factors leading to risky behaviours among PLHIV-WUDs/WIDs other than unavailability of syringes and condoms identified in the research

KNOWLEDGE ABOUT DRUG USE RELATED HARMS AND ACTUAL HARMS	
CORRELATION BETWEEN KNOWLEDGE OF DRUG USE RELATED HARMS AND ACTUAL DRUG USE RELATED HARMS	HCV, TB, OVERDOSE AND DEPRESSION WERE REPORTED AS BOTH, PLHIV-WUDS/WIDS KNOWLEDGE OF DRUG USE RELATED PHYSICAL AND MENTAL HARMS AS WELL AS THEIR ACTUAL HARMS. LOW SOCIOECONOMIC STATUS AND IMPRISONMENT WERE ALSO REPORTED AS THE MAIN KNOWLEDGE OF SOCIAL HARMS AND AS THEIR ACTUAL EXPERIENCE OF INCARCERATION AND RECIDIVISM
HIGH LEVELS OF CO-INFECTIONS AND DRUG OVERDOSE	HCV (25.5%), TB (16.8%), AND HBV (1.4%) MAINLY IN MOROCCO AND EGYPT. DRUG OVERDOSE WAS EXPERIENCED BY 11.7% OF PARTICIPANTS
DEPRESSION AS THE MAIN MENTAL HARM RELATED TO DRUG USE	16.8% HAD DEPRESSION AND DEPRESSIVE SYMPTOMS SUCH AS LONELINESS, ISOLATION, SUICIDAL THOUGHTS AND FEAR OF DEATH
DISCRIMINATION AND LOW SOCIOECONOMIC STATUS AS MAIN DRUG USE SOCIAL RELATED HARMS	COMMUNITY REJECTION, UNEMPLOYMENT, HOMELESSNESS AND FINANCIAL CONSTRAINTS AS THE MAIN SOCIAL HARM RELATED TO DRUG USE
OPERATIONAL RECOMMENDATIONS	
<ul style="list-style-type: none"> • Include awareness sessions about harms related to drug use in the package of HR services • Provide PLHIV with accurate information about all drug use related harms including the non-medical ones • Identify all health problems before initiating HIV treatment and OST • Include overdose management strategies in the package of intervention services • Include psychological support and support groups for PLHIV in the package of HR services • Raise awareness among community members about the importance of supporting PLHIV • Conduct an assessment of the main areas in the socioeconomic status that need adjustment (employment, housing, income) 	

KNOWLEDGE ABOUT HR/HEALTHCARE/OTHER SERVICES AND ORGANIZATIONS/HEALTHCARE FACILITIES PROVIDING SERVICES	
LIMITED KNOWLEDGE ABOUT HR AND HEALTHCARE SERVICES	THE MOST KNOWN SERVICES WERE NSP (56.4%); ART (42.9%); CONDOM DISTRIBUTION (24.8%); OST (20.1%); HTC (15.4%) AND HIV/ADDICTION COUNSELLING (12.7%)
LACK OF KNOWLEDGE ABOUT SUPPORT SERVICES OTHER THAN HR AND HEALTHCARE SERVICES	32.9% DID NOT KNOW ABOUT OTHER SERVICES, ONLY 22.1% KNEW ABOUT LEGAL SUPPORT SERVICES; 14.1% ABOUT PSYCHOLOGICAL SUPPORT; 10.1% ABOUT SOCIAL SUPPORT; 7.4% ABOUT SUPPORT GROUPS AND 6% ABOUT THE AVAILABILITY OF SOCIAL WORKERS' ASSISTANCE IN SEEKING SERVICES
LACK OF KNOWLEDGE ABOUT ORGANIZATIONS/HEALTHCARE FACILITIES PROVIDING SERVICES	ABOUT HALF OF THE PARTICIPANTS (42%) REPORTED ONLY KNOWING ONE ORGANIZATION PROVIDING SERVICES. ONLY 20.6% HAD KNOWLEDGE OF ONE CSO AND ONE HOSPITAL AND 4.6% KNEW ABOUT MORE THAN 2 CSOS AND HOSPITALS PROVIDING SERVICES TO PLHIV
OPERATIONAL RECOMMENDATIONS	
<ul style="list-style-type: none"> • List all services (medical and non-medical) available for all key populations • Increase HCP and service providers' knowledge about all available services • Inform PLHIV-WUDs/WIDs about all of the services available including referrals • Promote the availability of services other than NSP; ART and condom distribution • Promote the availability of other organizations/healthcare facilities providing services 	

AVAILABILITY AND UTILIZATION OF HR AND HEALTHCARE SERVICES	
DISCREPANCY BETWEEN SERVICES AVAILABLE AND UTILIZATION OF SERVICES	ALMOST HALF THE SERVICES AVAILABLE IN CSOS AND IN STANDARD PACKAGES OF SERVICES WERE NOT UTILIZED BY PLHIV, PWIDS/PWUDS
CORRELATION BETWEEN THE LEVEL OF KNOWLEDGE ABOUT HR AND HEALTHCARE SERVICES AND UTILIZATION OF SERVICES	THE FOUR MOST KNOWN SERVICES REPORTED BY PARTICIPANTS WERE THE ONES UTILIZED: NSP (64.3%); ART (53.2%); CONDOM DISTRIBUTION (30.1%); AND OST (23.8%)
UNDERUTILIZATION OF CO-INFECTION TREATMENTS	ALTHOUGH ALMOST HALF THE PARTICIPANTS WERE CO-INFECTED WITH HCV/HBV AND TB, ONLY 12 PARTICIPANTS (9.5%) REPORTED UTILIZING TB TREATMENT. NONE OF THE PARTICIPANTS REPORTED TAKING HCV OR HBV TREATMENT
INCOMPLETE PACKAGE OF SERVICES	THREE COUNTRIES DON'T HAVE OST INCLUDED IN THEIR PACKAGE OF HR SERVICES: EGYPT, TUNISIA AND PAKISTAN
OPERATIONAL RECOMMENDATIONS	
<ul style="list-style-type: none"> • Increase HCP and service providers' knowledge about all available services • Integrate HR services into the healthcare package of services • Promote all services available in different CSO/HR projects and healthcare facilities through the establishment of a strong referral mechanism • Educate HCP about the necessity to inform PLHIV-WUDs/WIDs about the availability of co-infection treatments • Ensure that PLHIV-WUDs/WIDs report their co-infections or other diseases to HCP • Include OST in the package of HR services in Egypt, Pakistan and Tunisia • Increase OST coverage in Morocco, Lebanon and Afghanistan 	

ART RELATED BELIEFS, LEVEL OF ADHERENCE AND REASONS FOR NON-ADHERENCE	
HIGH LEVELS OF PESSIMISTIC/FALSE BELIEFS ABOUT HIV TREATMENT	BELIEFS AMONG PARTICIPANTS THAT TAKING HIV TREATMENT LEADS TO DEATH; HIV TREATMENT DETERIORATES HEALTH; AND HIV TREATMENT IS BEING EXPERIMENTED ON THEM
HIGH LEVELS OF NEGATIVE SIDE EFFECTS/EXPERIENCE RELATED TO HIV TREATMENT:	ART WAS REPORTED AS DECREASING THE EFFECT OF METHADONE AND DRUGS, AND TO BE RESPONSIBLE FOR WITHDRAWAL SYMPTOMS AS WELL AS SIDE EFFECTS SUCH AS NAUSEA, FATIGUE, DIZZINESS AND PAIN
LOW LEVEL OF ART ADHERENCE	ONLY ABOUT HALF OF THE PARTICIPANTS (55.7%) REPORTED TAKING ART ON A REGULAR BASIS, 27.5 ON AN IRREGULAR BASIS AND 12.7% REPORTED NOT TAKING ART. PAKISTAN AND EGYPT HAD THE LOWEST ART ADHERENCE, 19.5 RESPECTIVELY
CORRELATION BETWEEN HIV TREATMENT RELATED BELIEFS AND THE LEVEL OF ADHERENCE	HIGHEST LEVEL OF ADHERENCE WAS MORE PREVALENT AMONG PARTICIPANTS WHO HAD OPTIMISTIC AND RIGHT KNOWLEDGE ABOUT THE ART BENEFITS: TUNISIA (88.5%); LEBANON (78.9%) AND AFGHANISTAN (73%)
CORRELATION BETWEEN ART ADHERENCE AND LESS RISKY BEHAVIOURS	COUNTRIES WITH THE HIGHEST LEVELS OF ART ADHERENCE (TUNISIA, LEBANON AND AFGHANISTAN) WERE ENGAGING IN LESS RISK BEHAVIOURS
CORRELATION BETWEEN HIGH LEVELS OF ART ADHERENCE AND INITIATION OF OST	TWO (EGYPT AND PAKISTAN) OUT OF THE THREE COUNTRIES THAT DID NOT INCLUDE OST IN THEIR PACKAGE OF SERVICES HAD THE LOWEST ART ADHERENCE (19.5%) RESPECTIVELY
REASONS FOR NON-ADHERENCE TO HIV TREATMENT	POOR PHYSICAL AND MENTAL HEALTH CONDITIONS INCLUDING DRUG ADDICTION; LACK OF INFORMATION/AWARENESS/BELIEFS OR MISINFORMATION; LOW SOCIO-ECONOMIC STATUS; HIV TREATMENT SIDE EFFECTS AND FEAR OF SIDE EFFECTS; DEFICIENT HEALTHCARE SYSTEMS; LOW COVERAGE OF SERVICES; FORGETTING OR LOSING HIV TREATMENT; BEING TOO LAZY TO GET HIV TREATMENT, AND INCARCERATION/IMPRISONMENT
GENDER DIFFERENTIAL IN ART ADHERENCE	ART ADHERENCE WAS 48.3% AMONG WOMEN COMPARED TO 58.5% AMONG MEN

OPERATIONAL RECOMMENDATIONS FOR ART RELATED BELIEFS, LEVEL OF ADHERENCE AND REASONS FOR NON-ADHERENCE

- Address PLHIV-WUDs/WIDs false beliefs through workshops or working groups aiming at promoting optimistic beliefs about HIV treatment
- Create a system of regular follow-up on PLHIV to check their physical and mental health
- Ensure that the dosage of OST is appropriate
- Reinforce the message about the relationship between HIV treatment intake and positive outcomes
- Educate HCP on ART adherence strategies
- Evaluate PLHIV commitment to treatment in each of the selected countries to identify factors leading to poor adherence

SIDE EFFECTS OF HIV TREATMENT AND IMPACT OF MEDICAL CONDITION ON SERVICES UPTAKE

MULTIPLE SIDE EFFECTS RELATED TO HIV TREATMENT	36 DIFFERENT SIDE EFFECTS REPORTED BY PARTICIPANTS, AMONG WHICH FATIGUE, WEAKNESS, VOMITING, NAUSEA AND DIZZINESS
IMPACT OF PHYSICAL AND MENTAL HEALTH CONDITION ON SERVICE UPTAKE	ONLY ABOUT ONE THIRD (37%) OF PARTICIPANTS REPORTED NO IMPACT OF MEDICAL CONDITIONS ON SERVICE UPTAKE; WHILE 63% REPORTED THE IMPACT OF PHYSICAL AND MENTAL HEALTH CONDITIONS ON SERVICE UPTAKE: FATIGUE/WEAKNESS (41.4%); NAUSEA AND VOMITING (33.6%); AND DEPRESSION (31.9%)

OPERATIONAL RECOMMENDATIONS

- Identify all health problems (full medical history and check-up) before initiating treatment
- Ensure that newly diagnosed people had full blood tests
- Assess the interactions between illicit drugs and HIV treatment or the treatment of other diseases
- Enhance HCP knowledge and skills related to drug interactions
- Consider administrating simple regimen (simple dosing)
- Encourage PLHIV-WUDs/WIDs to take treatment at the same time exactly
- Encourage PLHIV to inform HCP if the side effects don't go away
- Encourage PLHIV to report (short term and long term) side effects to HCP
- Promote other infectious disease testing already included in the package of HR and healthcare services

QUALITY OF HR AND HEALTHCARE SERVICES

HIGH LEVELS OF DISSATISFACTION WITH HEALTHCARE SERVICES	70.9% OF PARTICIPANTS WERE DISSATISFIED FROM THE SERVICES RECEIVED IN HEALTHCARE FACILITIES
DENIAL OF (MEDICAL/SOCIAL) SERVICES BECAUSE OF HIV STATUS	46.7% WERE DENIED SERVICES BECAUSE OF THEIR HIV STATUS
HIV STIGMA RELATED TO SERVICE UPTAKE	74.2% OF PARTICIPANTS REPORTED STIGMA RELATED TO SERVICES
DEFICIENT RELATIONSHIP WITH HCP	ONLY 46.8% OF PARTICIPANTS REPORTED A GOOD RELATIONSHIP WITH HCP

OPERATIONAL RECOMMENDATIONS

- Conduct assessments on the quality of the services provided to PLHIV-WUDs/WIDs
- Encourage beneficiaries to fill in the client feedback form
- Develop culturally sensitive strategies on how to reduce HIV related stigma in public hospitals
- Develop a code of ethics and implement it in all facilities providing services
- Establish a complaint mechanism to protect beneficiaries from mental harms
- Ensure equal access to healthcare and social service through monitoring and law enforcement.
- Train HCP on the necessity of treating patients with respect, dignity and fairness to promote non-judgmental attitude
- Educate HCP on the importance of communicating with the patient and building a relationship of trust for better treatment outcomes
- Increase collaboration with patients through their involvement in the treatment process

UNDERLYING CAUSES OF STIGMA AND DISCRIMINATION

LACK OF KNOWLEDGE ABOUT BASIC HUMAN RIGHTS	70.9% OF PARTICIPANTS DID NOT KNOW ANYTHING ABOUT HUMAN RIGHTS
LOW LEVELS OF INVOLVEMENT IN ACTIVITIES AIMING AT IMPROVING THEIR SITUATION	OVERALL, ONLY 13.4% OF PARTICIPANTS REPORTED INVOLVEMENT IN ACTIVITIES
LOW LEVELS OF COLLABORATION IN HIV RESPONSE	SOME PARTICIPANTS REPORTED NEVER HEARING OF NAP; OTHERS REPORTED NO COLLABORATION WHATSOEVER WITH NAP EXCEPT FOR TREATMENT PURPOSES
HIGH LEVELS OF NON-DISCLOSURE OF HIV STATUS	21.2% OF PARTICIPANTS DID NOT DISCLOSE THEIR HIV STATUS
HIGH LEVELS OF DISCLOSURE AND NOT RECEIVING ANY SUPPORT	ONLY 44.1% OF PARTICIPANTS RECEIVED FULL FAMILY AND FRIENDS SUPPORT UPON DISCLOSURE OF THEIR HIV STATUS
CORRELATION BETWEEN POSITIVE SEROPOSITIVE DISCLOSURE AND ACCESS TO SERVICES	COUNTRIES IN WHICH PARTICIPANTS RECEIVED THE HIGHEST LEVELS OF SUPPORT BY FAMILY AND FRIENDS WERE ACCESSING MORE SERVICES
THE MAIN REASONS FOR NON-DISCLOSURE ARE LINKED TO THE FEAR OF FAMILY AND COMMUNITY REJECTION AND NEGATIVE PERCEPTIONS	FEAR OF COMMUNITY REJECTION (37.7%); FEAR OF STIGMA AND DISCRIMINATION (26.5%); FEAR FROM BEING NEGATIVELY PERCEIVED (21.4%); AND FEAR OF FAMILY REACTION (20.4%)
HIGH LEVELS OF NEGATIVE FEELINGS ASSOCIATED WITH THE SELF	FEEL GUILTY (33.8%); PERCEIVE THEMSELVES AS VICTIMS (32.3%), AS DEPRESSED (22.8%), AS DISRESPECTED AND DISRESPECTFUL (22%); AND AS EVIL/MEAN PERSONS (10.2%)
HIGH LEVELS OF NEGATIVE FEELINGS ASSOCIATED WITH OTHER PLHIV- WUDS/WIDS	ONLY 51.1% PERCEIVED OTHERS AS GOOD OR NORMAL OR PERSONS IN THE SAME SITUATION
HIGH LEVELS OF NEGATIVE FEELINGS ASSOCIATED WITH THE WAY PLHIV WUDS/WIDS THINK THE GENERAL POPULATION PERCEIVE THEM	43% BELIEVE THAT THE GENERAL POPULATION THINK THAT THEY SHOULD BE PUNISHED, 34.7% THAT THEY ARE EVIL/MEAN, 30.6% THAT THEY ARE EVIL AND 19.8% IN A DISRESPECTFUL WAY
CORRELATION BETWEEN INTERNALIZED STIGMA AND ANTICIPATED STIGMA	THE WAY THEY PERCEIVED THEMSELVES WAS COMPATIBLE TO THE WAY THEY THINK THE GENERAL POPULATION PERCEIVED THEM.
CORRELATION BETWEEN POSITIVE PERCEPTIONS AND ADHERENCE TO HIV TREATMENT	PARTICIPANTS HOLDING POSITIVE PERCEPTIONS (TUNISIA AND LEBANON) HAD A GOOD ADHERENCE TO TREATMENT
HIGH LEVELS OF PLHIV WHO EXPERIENCED STIGMA AND DISCRIMINATION	83.7% EXPERIENCED STIGMA AND DISCRIMINATION
STIGMA AND DISCRIMINATION ARE PERPETRATED BY THREE MAIN SOURCES:	FAMILY MEMBERS (32.6%); HCP IN PUBLIC HOSPITALS (31.8%); AND FRIENDS, NEIGHBOURS AND OTHER COMMUNITY MEMBERS (27.9%)
DIFFERENT FORMS/TYPES OF STIGMA/DISCRIMINATION:	SOCIAL ABUSE, PHYSICAL ABUSE, VERBAL ABUSE, EMOTIONAL ABUSE, NEGLECT, LIMITATION OF PHYSICAL SPACE, LIMITATION OF PERSONAL BEHAVIOUR AND SELF-DISCRIMINATION
IDENTIFICATION OF SEVEN STIGMA OUTCOMES	SEVEN FACTORS WERE IDENTIFIED AS HAVING AN IMPACT ON PLHIV-WUDS/WIDS PHYSICAL, PSYCHOLOGICAL, BEHAVIOURAL, INFORMATIONAL, SOCIOCULTURAL, LEGAL AND FINANCIAL ASPECTS

OPERATIONAL RECOMMENDATIONS FOR UNDERLYING CAUSES OF STIGMA AND DISCRIMINATION

ON THE LACK OF KNOWLEDGE ABOUT HUMAN RIGHTS:

- Integrate human rights in the package of HR services
- Inform PLHIV-WUDs/WIDs that discrimination is a violation of basic human rights and that they might resort to the law to protect themselves

OPERATIONAL RECOMMENDATIONS FOR UNDERLYING CAUSES OF STIGMA AND DISCRIMINATION (CONT'D)

ON THE LOW LEVELS OF INVOLVEMENT IN ACTIVITIES AIMING AT IMPROVING THEIR SITUATION, AND THE LOW LEVELS OF COLLABORATION IN HIV RESPONSE:

- Increase the number of PLHIV-WUD/WIDs working as service providers in HR projects and/or in healthcare facilities
- Promote existing ongoing activities implemented for PLHIV
- Inform PLHIV-WUDs/WIDs about PLHIV networks available in their countries and in the region
- Involve PLHIV in programme design and implementation

ON HIV DISCLOSURE STATUS AND REASONS FOR NON-DISCLOSURE:

- Develop culturally adapted disclosure intervention strategies
- Encourage PLHIV to inform their sexual partners about their HIV status upon diagnosis
- Assist PLHIV-WUDs/WIDs in the HIV disclosure process, depending on their willingness to share it
- Promote family counselling
- Follow up on the social support received by PLHIV following HIV disclosure
- Educate community, family and HCP on the relationship between PLHIV-WUDs/WIDs self-disclosure and the necessity of
- Providing them with consistent support
- Inform PLHIV-WUDs/WIDs about the challenges and benefits of disclosure

ON SELF-PERCEPTIONS, PERCEPTIONS OF OTHERS AND OTHERS PERCEPTIONS:

- Develop strategies to improve self-perception through sharing successful PLHIV stories
- Integrate support groups and psychological support in the package of HR services

ON SOURCES AND TYPES OF DISCRIMINATION:

- Encourage law reform and the use of anti-discrimination laws to protect their rights
- To develop specific programmes to raise awareness about the respect of human rights among family members of PLHIV- WUDs/WIDs

ON STIGMA OUTCOMES:

- Conduct individual assessments of which aspects of the seven factors identified affect PLHIV-WUDs/WIDs the most and develop strategies accordingly

PLHIV-WUDS/WIDS REPORTED BARRIERS AND FACILITATORS

HR AND HEALTHCARE SERVICES RELATED BARRIERS	QUALITY OF SERVICES INCLUDING STIGMA AND FEAR OF STIGMA RELATED TO SEEKING SERVICES (76.4 %) AND ACCESSIBILITY OF SERVICES, (30.7%)
HR AND HEALTHCARE SERVICES RELATED FACILITATORS	HIGH QUALITY SERVICES (35.2%); WIDER GEOGRAPHICAL COVERAGE (30.4%) AND AWARENESS RAISING (16.8%) TO REDUCE THE HIGH LEVELS OF STIGMA AND DISCRIMINATION

OPERATIONAL RECOMMENDATIONS

- Evaluate service provision in healthcare settings
- Conduct PLHIV-WUDs/WIDs population size estimates to prioritize the areas that need coverage

PLHIV-WUDS/WIDS REPORTED NEEDS

- Improved mental and physical health conditions: drug treatment (27.2%) and psychological support (24.8%),
- Having access to better services: high quality services (24%)
- Improved socioeconomic status: employment (20%); financial support (15.2%); stable housing (15.2%)

PLHIV-WUDS/WIDS REPORTED SUGGESTIONS FOR SERVICES IMPROVEMENT

- Increase and improve accessibility, availability and quality of services provided

PLHIV-WUDS/WIDS REPORTED SUGGESTIONS TO REDUCE HIV RELATED STIGMA

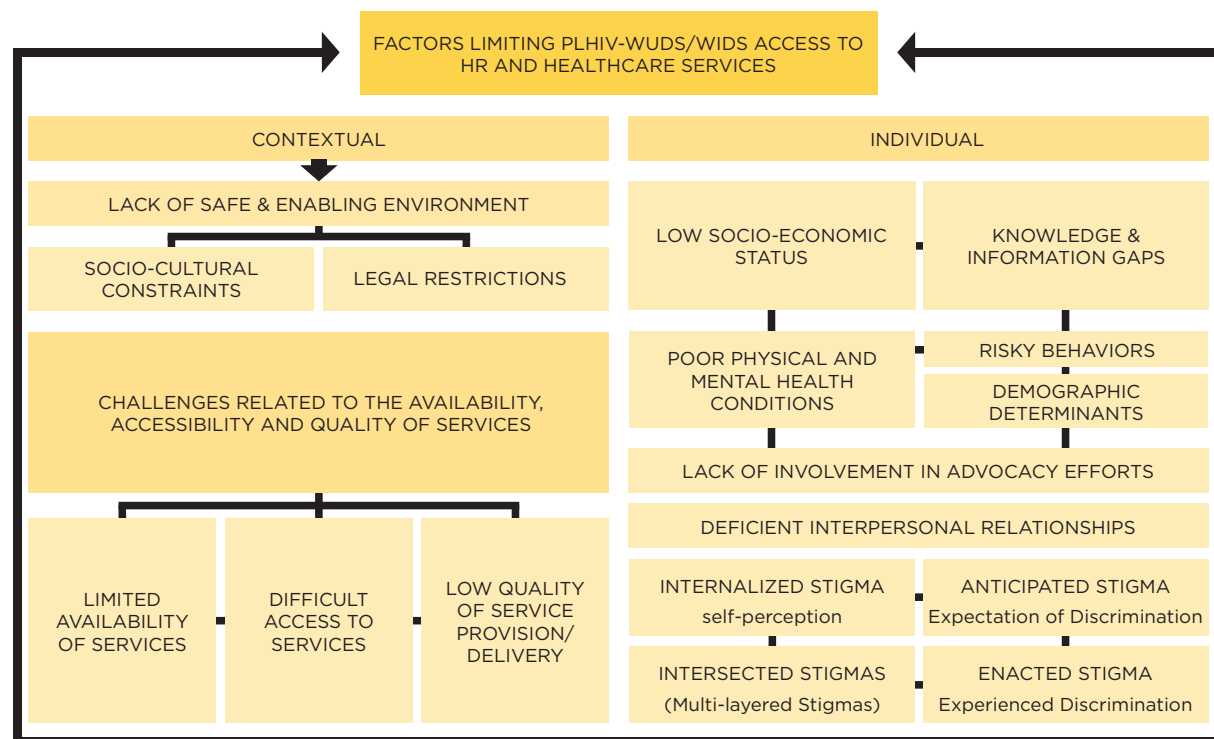
- Launch awareness raising campaigns in public places, TV, media and radio
- Promote anti-discrimination strategies/laws
- Further train HCP on stigma and discrimination
- Increase PLHIV-WUDS/WIDS involvement in programing and decision making

CONCLUSION

There is a correlation between good physical and mental health conditions and access to services. Correct knowledge and beliefs, community support upon disclosure, positive self-perception and self-acceptance were all associated with an increased adherence to HIV treatment. Regular HIV treatment intake was also linked to improved injection practices and sexual behaviours that decrease the probability of co-infection with other diseases. Contextual and individual factors limiting service utilization include the lack of safe and enabling environment, influence by sociocultural constraints and legal restrictions, as well as the limited availability of services, difficult access to services and low quality of service provision and delivery. Individual factors were related to PLHV, WID/WUD's low socioeconomic status, knowledge and information gaps, poor physical and mental health conditions, risky behaviours, demographic determinants, lack of involvement in advocacy efforts, dysfunctional interpersonal relationships, and the impact of internalized, anticipated, intersected and enacted stigma.

FIGURE 4

FACTORS LIMITING PLHIV-WUDS/WIDS ACCESS TO HR AND HEALTHCARE SERVICES



SOCIO-CULTURAL CONSTRAINTS

- HIV-related Stigma
- Gender Gap/Inequalities
- Social Norms and Traditions
- Conservative Values
- Religious Beliefs

LEGAL RESTRICTIONS

- Punitive Laws on Sex and Drugs
- Deficient Anti-stigma & Discrimination strategies/ Laws that would protect PLHIV-WUDs/WIDs Rights
- Police Harassments/Arrests
- Incarceration/Recidivism

LIMITED AVAILABILITY OF SERVICES

- Low coverage of Services
- Unavailability of services in small cities/towns
- Gap between services needed and services available
- Gap between services available and services utilized
- Disrupted supply of services (ART, syringes, condoms)
- Incomplete/inadequate package of services (OST still not available in some of the countries)
- Closing out of some of HR projects because of lack of funding
- Understaffed hospitals and HR projects
- Lack of gender and children LHIV specific services
- Underutilization/unavailability of national list of all services available

LOW SOCIO-ECONOMIC STATUS

- Poor Educational Attainments
- Unemployment
- Inactivity/work cessation
- Involvement in Unskilled Work
- Involvement in illicit/illegal behaviors as sources of income
- Unsteady revenue
- Financial dependence on Family/Friends for living
- Unstable Housing Situation
- Low Social Status

KNOWLEDGE & INFORMATION GAPS

- Lack of knowledge about:
- HIV/AIDS Transmission modes and Prevention Methods
 - Drug use related physical and mental harms
 - Drug interactions risks and side effects
 - Benefits of art adherence/compliance
 - Services available (medical and non-medical)
 - Organizations/Hospitals providing services
 - Basic human rights (mainly Patient's Rights)
 - HIV Treatment related pessimistic/wrong beliefs

INTERNALIZED STIGMA

- Self-perception as: Guilty/Victim/Depressed/ Evil/ Mean/Disrespected/Disrespectful/Abnormal

DIFFICULT ACCESS TO SERVICES

- Long Distance to HR project/ healthcare facility
- Disintegration of HR and healthcare services
- Inconvenient working hours
- Complexity of procedures to seek services
- Low levels of admission in private hospitals
- Evictions from Public Hospitals
- Medical appointments set too far apart
- Long waiting period between initial diagnosis and receiving treatment
- Delay in receiving services
- Lacking the financial means to pay for transportation fees to seek HR and Healthcare services

LOW QUALITY OF SERVICE PROVISION/DELIVERY

- High levels of dissatisfaction with service provision
- Low levels of stigma free services
- Unskilled/unqualified medical personnel
- Denial of medical care based on HIV status
- Negative attitudes towards PLHIV
- Lack of communication with patients
- Insufficient information about medical history of patients
- Low levels of full checkups
- Burn out and workload among HCPs
- Lack of knowledge about services available
- Lack of coordination among HR and healthcare services
- Lack of collaboration with other organizations/ hospitals providing services
- Weak referral mechanisms to other available medical and non-medical services
- Lack of referral to detoxification and rehabilitation centers

ANTICIPATED STIGMA

- Holding the belief that others think PLHIV should be punished and that they are perceived as people engaging in illicit behaviors
- Fears from negative consequences/family and other community members' perception/reaction/rejection

ENACTED STIGMA

- Social/Physical/Verbal/Emotional Abuses/Neglect including denial of services/Limitation of Physical Space/Limitation of Personal Behavior/Self-discrimination

POOR PHYSICAL AND MENTAL HEALTH CONDITIONS

- Multi-drugs interactions impact
- Inadequate/Insufficient methadone dosages
- Risk of overdose/Withdrawal Symptoms
- Irregular/Non-adherence to ART
- ART related Complications
- Mild and severe side effects
- Co-infections (HCV-HBV-TB)
- Chronic diseases
- Depression and Depressive symptoms

RISKY BEHAVIORS

- Increased risks of getting infected by other diseases (Health deterioration) and infecting others due to:
- Drug abuse and poly-drug use
- Sharing needles/syringes practices
- Inconsistent/low condom use
- Exchange of Sex for Drugs
- Overlap of risky behaviors
- Low levels of ART and other co-infections and diseases treatment intake

DEMOGRAPHIC DETERMINANTS

- Older age and higher years of living with HIV/AIDS correlated with increased adherence to HIV Treatment
- Gender differential in services access/uptake, drug and sexual patterns

LACK OF INVOLVEMENT IN ADVOCACY EFFORTS

- Low level of participation in activities aiming at improving their situation
- Underrepresentation at both, civil society (CSOs) and governmental levels
- Lack of collaboration with key players and policy makers in program design and implementation

DEFICIENT INTERPERSONAL RELATIONSHIPS

- Lack of Community Members Support upon disclosure
- Defective Relation with family, partners, friends and HCPs

INTERSECTED STIGMAS

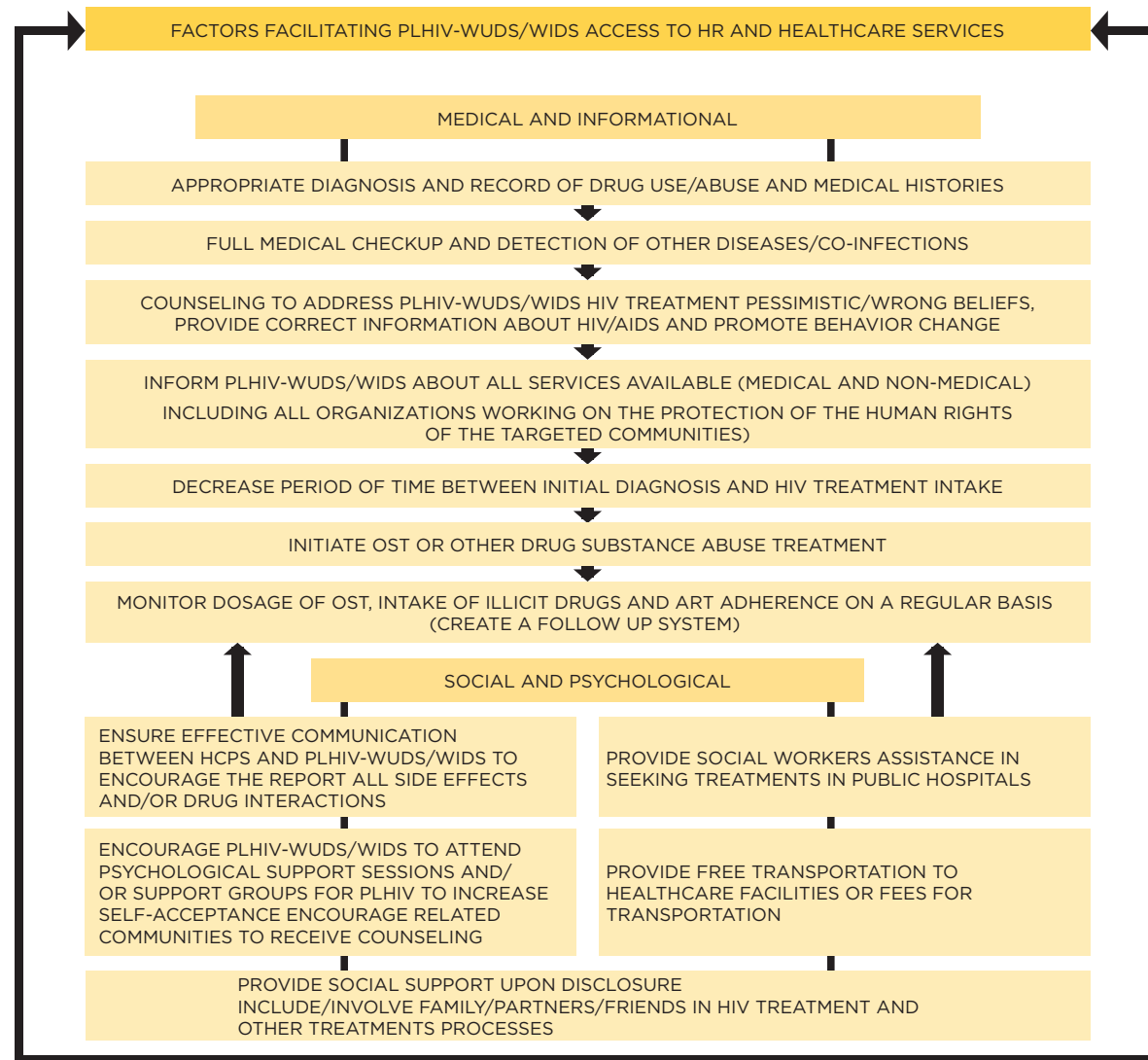
- HIV and Drug abuse
- HIV, Drug abuse and sex work
- HIV, Drug abuse and same sex relations
- HIV, Drug abuse, sex work and same sex relations

Two sets of factors influence HIV treatment intake: i) medical and informational; and ii) social and psychological. On the medical and informational levels, the proper diagnoses of medical conditions other than HIV such as substance abuse, co-infections and other diseases are essential to positive HIV treatment related outcomes. Appropriate medical check-up should be followed by prevention counselling for behavioural change purposes, and inform newly diagnosed persons of all medical and non-medical services available as well as referral to drug detoxification/ rehabilitation centres, or to facilities offering OST in countries, where available. Following HIV- related blood test results and the selection of appropriate regimen, the period between diagnosis and treatment intake should not be long. A follow-up system should be established to monitor the OST dosage, ART adherence and the drugs used with the treatment of other diseases.

Social and psychological support is directly linked to ART adherence, which can only be achieved by establishing a relationship of trust with HCP to encourage reporting side effects and drug interactions. Furthermore, encourage PLHIV-WUDs/WIDs to attend psychological support sessions and/or support groups to increase self-acceptance, and their related communities to receive counselling. Assist service seeking in public hospitals (social workers). Provide transportation to healthcare facilities or transportation fees. Finally ensure that PLHIV-WUDs/WIDs are provided with social and psychological support upon disclosure, and that their families are involved in the treatment of HIV and other diseases.

FIGURE 5

FACTORS FACILITATING PLHIV-WUDS/WIDS ACCESS TO HR AND HEALTHCARE SERVICES



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