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# ACCESS TO HIV PREVENTION SERVICES FOR INJECTING DRUG USERS IN HAI PHONG, VIETNAM: QUALITATIVE RESULTS

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## ABSTRACT

*Background: To attain a deeper understanding of risk behaviour and service engagement among Injecting Drug Users (IDUs) in Hai Phong, Vietnam, we conducted a qualitative follow-up series of in-depth interviews. This paper presents the barriers and facilitative factors relating to prevention services. Methods: Fifteen semi-structured face-to-face interview with IDUs were conducted. Results: The participants are often satisfied with their current access to the HIV prevention services; however, they highlighted the issues for better engagement in the future. The qualitative findings document barriers as well as facilitative factors in accessing the services. Humane approach, pleasant experience, and free treatment facility are commonly cited facilitative factors. The frequently occurring barriers to accessing HIV prevention service include long distances between place of delivery and home, unavailability in local neighbourhoods and mismatched delivery time. Conclusion: Access to HIV prevention services needs to be strengthened according to the need of IDUs to limit the further spread of HIV epidemic.*

**Keywords:** HIV, Services, Barriers, Injecting drug users, Harm reduction, Vietnam, Qualitative.

## Contribution/ Originality

This study is one of very few studies which qualitatively analyzed access to HIV prevention services by injecting drug users in Hai Phong, Vietnam and highlighted interesting findings relating to their service engagement. The discussions provide a crucial insight for improving HIV prevention efforts in Vietnam.

## 1. INTRODUCTION

HIV prevention services for Injecting Drug Users (IDUs) in Vietnam have been challenging since the beginning of the epidemic [1]. The Government of Vietnam adopted a traditional law enforcement approach focusing on compulsory detention and enforced drug treatment to solve the HIV and drug related problems in the country [2]. IDUs were considered as 'social evils'; and as a result, strict sanctions together with stern law enforcement activities were popular to eradicate such evils [3, 4]. These efforts were unsuccessful in controlling the situation and they

failed to achieve their purported benefit; rather, the country saw a rapidly growing HIV epidemic among IDUs within a short time [1]. The first HIV case was identified in 1990 and by 1993 the epidemic was well-established among IDUs [2, 5]. By mid-1995 the epidemic had spread to different parts of the country and other risk groups, particularly Female Sex Workers (FSWs), were affected [2]. The infection spread from the southern part of the country by infecting older IDUs in early 1990s, and later reached the northern part, gradually infecting younger IDUs [6]. Hai Phong, a northern province in Vietnam, became a high HIV prevalent province particularly among younger IDUs [7, 8].

The first HIV infection in Hai Phong was reported in 1994. According to the sentinel surveillance data, the prevalence among IDUs jumped rapidly from 1% in 1997 to 32.8% in 1998 [2]. The level peaked at around 78% and has since HIV prevalence currently levelled-off at around 60% [6]. Consequently Hai Phong still remains one of the provinces with the highest prevalence of HIV in the northern region [6]. According to the latest Integrated Biological and Behavioural Surveillance (IBBS) survey (which generates crucial epidemiological information to monitor the epidemic progression) the HIV prevalence among IDUs in Hai Phong in 2009 was 48% [8]. Over the years other research also documented high levels of HIV prevalence with frequent drug and sex related risk behaviour especially among young injectors [9]. In addition, the unsafe drug and sex related behaviour of HIV infected persons (PLHIV) has become another worrying factor that intensifies the risk of a non-IDU, heterosexual epidemic in the future [10, 11]. The HIV epidemic in Hai Phong gained momentum rapidly as a result of an early diffusion among these two high risk groups (IDUs and FSWs). In response to both the drug and HIV problems, a number of pilot projects have been initiated, similar to other provinces [9]. However, a lack of adequate policy support interrupted such ongoing programs. Gradually, the HIV prevention services expanded and have now reached a mature stage with high coverage and recent improvement in antiretroviral (ARV) treatment and methadone therapy [12].

Over the decade, the country adopted a harm reduction based public health approach [13, 14], however, there was lack of uniformity in service coverage for IDUs throughout the country [15, 16]. Previous research in Hai Phong was primarily quantitative and focused on either younger or HIV infected IDUs in order to document adherence to ARV or methadone treatment [17, 18], thus little evidence exists on service accessibility through qualitative data collection. As a result, there is a lack of qualitative understanding regarding their access to HIV prevention services, which has the potential to generate crucial insights for HIV prevention in IDUs. Qualitative data can focus on the experiences and views of IDUs relating to HIV prevention services and their service engagement, thereby providing insights for a deeper understanding of future public health interventions. This paper presents views and experiences on accessing harm reduction services and proposes suggestions for increasing future service engagement which will reduce the current high level of HIV infection. We then discuss the facilitative factors which need to be encouraged and identify the barriers which need addressing with evidence-based public health strategies to increase service coverage.

## 2. METHODS

We conducted this follow-up qualitative research during September-October, 2012. Fifteen IDUs, including thirteen men and two women, were invited to take part in semi-structured face-to-face interviews. IDUs came from different districts in the Hai Phong province. A topic guide showing necessary probes and points for probing to facilitate the discussion process was used and their answers were fully recorded [19]. A peer educator has played the role of connector between research team and participants which helped to recruit participants from multiple social networks. A set of inclusion criteria such as age, sex, and risk characteristics/profile was applied in order to obtain a range of information. Eligible participants (except for the two female respondents) were selected from those recruited from a larger scale research initiative in Vietnam and during which a field supervisor had asked screening questions and ensured recruitment status. In addition, attention was paid to identify the level and point of information saturation, to indicate the possible end of the interview [20]. The interview lasted for around forty-five minutes and participants were reimbursed VND 100,000 (AUD 5) for their time and any inconvenience that resulted from their participation. A private location was chosen so as not to inconvenience the respondents to any great degree.

Two experienced local interviewers (one male and one female) were hired to conduct the qualitative discussion. The interviews were completed using Vietnamese language in local dialect. Each interview was voice recorded using an mp3 player after attaining the necessary permission. The research was conducted following strict ethical guidelines and clearance was received from the research ethics office of Griffith University, Australia. Authorisation was also obtained from the Vietnam Authority for HIV/AIDS Control (VAAC), Vietnam. Participation was completely voluntary and anonymous. Before each interview, ethical procedures, including informed consent and participants' understanding of their right to withdraw, skip and refuse to answer at any time during the interview, were established. The scripts were transcribed and translated into English and back to Vietnamese (partial) to ensure accuracy of the transcript a process that took some time. Detailed attention was paid during translation to confirm the meaning and context of the original narratives. All the study materials, including audio files, and interview scripts, were assigned unique identification numbers. The transcripts were edited later to delete any personal identifiers mentioned during discussion. The data were categorized and coded according to themes in line with research objectives. Both the topic guide and narratives of the participants were used for framing codes and themes. The thematic analysis technique was used to identify, analyse and report different themes into textual data [21] and a qualitative data analysis thematic framework was adopted [22]. Key themes were compared across transcripts to identify consistencies throughout the exploratory quotes. Major content areas highlighted their risk behaviours and access to HIV prevention services and finally the participants' personal recommendations for improved services. The major questions which were asked to highlight access to HIV prevention services include: *What are the available HIV prevention services that they receive? Where and when do they visit? What has been your experience of t HIV testing? What are the*

*places and treatment for HIV infected persons? What is your overall experience of the services? What has been the experience of your friends?* This paper includes views and experiences describing harm reduction services and their engagement. Participant's recommendations were also highlighted which would increase their future service engagement. Direct quotes from the participants are used to highlight a number of contexts relating to their accessibility to HIV prevention services and engagement with such services [23].

The first author was actively involved in all stages of the research and directly supervised the data collection process. Interview sessions were monitored including discussion with interviewers after each interview, checking completeness and consistencies for ensuring data quality. He performed the data analysis manually and drafted the manuscript.

## 3. RESULTS

### 3.1. Profile of Participants

We conducted the qualitative interviews with a mixed group of participants to obtain deeper insights into service engagement and better accessibility in the future. Table 1 shows the socio-demographic profile of the respondents. We included a mixed group with younger and older males and females along with HIV infected persons. This diverse population enhanced our understanding regarding HIV prevention services and the variety of experiences around their access to these services.

**Table-1.** Socio-demographic Profile of Respondents

| Characteristics | Categories | Number (N=15) |
|---|---|---|
| Gender | Male | 13 |
| | Female | 2 |
| Age | Less than 30 years | 4 |
| (range: 25-49 years) | 30-39 years | 9 |
| | 40 or plus | 2 |
| Ethnicity | Kinh | 15 |
| Place of living | Hai Phong | 14 |
| | Other province | 1 |
| Duration of living | Permanent | 14 |
| in Hai Phong | Temporary | 1 |
| Education | Primary/secondary | 13 |
| | College | 2 |
| Marital status | Currently married | 7 |
| | Unmarried | 8 |
| Living status | Co-habiting | 14 |
| | Alone | 1 |
| Employment status | Casual/non-regular work | 12 |
| | No work | 3 |
| Income level | Less than 5m VND | 8 |
| (range 2m-7m) | 5m VND or more | 4 |
| HIV status | Positive | 6 |
| | Negative | 9 |

### 3.2. Experiences and Views of Services and Their Engagement

Our participants discussed in detail the existing HIV prevention services which they frequently access as part of the provincial program in Vietnam. Principal among the HIV prevention services was their access to free safe practice commodities. A number of sub-themes emerged regarding their experiences and views on existing services and their engagement.

IDUs get free needles/syringes (N/S), condoms and other HIV information materials (leaflet, booklet, and poster) as part of the provincial harm reduction program. Some of them obtain free items frequently, whereas others do not do so on a regular basis ranging from twice in a week to occasionally in a month. As explained by one: "*I received very few times in the rail line areas. I found peer educator distributing near the club area across rail lines (c11)*". Another confirmed the free distribution of these items such as received N/S and some reading (informational) materials frequently. "*I receive condom two to three times in a month not always (c9)*". Some IDUs do not collect free N/S and condoms from the program because of the distance between the work location where a peer educator distributes and their residence or workplace. One of the respondents commented that: "*I know the places where the peer educators distribute free N/S. But I do not go there. It is far away for me (my place of living). I buy when I need from nearby drug store (c2)*". Some of them highlighted different situations like a crisis moment (for example, withdrawal, family problem or supply of heroin); or if drug dealers raise the cost of heroin and IDUs face difficulties in buying drugs. If costs rise, they do not waste their valuable money buying needles/syringes, rather, they invest in drugs. For this reason outreach coverage is essential to minimise the transmission risk among IDUs.

Our discussions reveal another factor, the time of injection, which hinders the service engagement for IDUs. A number of injecting sites or hotspots also operate at night; as many IDUs do not gather in the day time because of other involvement, rather they meet their friends or IDU network members at night. Those who mostly inject at night often face the problem of finding new needles/syringes. One respondent commented: "*We can get the new N/S anytime in the day time. But this is very difficult to get at the night. This is difficult to buy this from drug stores at night also (c6)*". Likewise, another participant emphasized the difficulties that they face at night: "*At the night time this is really very difficult. I do not find a place to get new thing (N/S) and the urge for taking this (heroin) is high so cannot search many drug stores (c7)*". Often the personal condition (withdrawal) of the IDU does not allow additional time to search.

In addition to free distribution of safe practice commodities, IDUs often are interested in specific services, in particular for methadone treatment services. One said: "*I do not ask for condoms. Actually I do not need them so I do not ask them for condoms. But I think I am infected, I shared N/S, and I used others. I am not interested in the services. I am interested in getting methadone treatment. Because I want to quit this (heroin injecting) (c6)*".

The personal views of the participants regarding the service provided by the provincial program are generally satisfactory. They mentioned different types of HIV prevention services which they regularly attend such as receiving free N/S, condoms and different types of

promotional materials (IEC), and attending treatment facilities. One participant said: "*The services like free distribution (needle/syringes) are very good and help the IDUs to avoid sharing behaviours. The problem is we do not find them (needle/syringes) at the time of our need. For this reason, we need to buy most of the time. We cannot take them (needle/syringes) in advance before the time of injection because of the police raid. Many of us get infected because we cannot afford to buy new N/S at the time we buy pack (heroin) and (therefore we) use the used things (N/S) (C3)*". Another commented on the ARV treatment services: "*I like the treatment (ARV) services. These are beneficial. Moreover it is free (c4)*". Yet another added: "*When I visit to the clinics they really take care and behave very well. They treat me as good person. The services are also very good (c9)*". Another participant highlighted the importance of getting treatment services for the PLHIV. He said: "*I think we need to go for services when we feel problem. We need to get treatment immediately. Sometimes we need to buy and pay for injection (medicines), it costs money, time and make us tired. This is important for us to get treatment on time (c10)*".

The participants indicated that their friends or other members of the IDU network already know about the services. Generally the services are good and they utilise the services in different places. They also like the promotional items. One said: "*My friends are happy with these services. Especially my friends who are infected with HIV get free medicines and attend different treatment programs (c14)*". Another respondent described how one of his friends felt, who recently started the methadone treatment services. He said: "*My friend is very happy after starting the treatment (methadone therapy). He is trying to quit injecting (heroin). The services are good and my friend is happy (c7)*".

### *3.3.* Recommendations for Improvements

The participants in the qualitative interviews provided some recommendations for improving their service engagement in order to protect themselves and the community from HIV infection in the future. The most important task is to increase knowledge and awareness about HIV transmission. They commented that there is a lack of understanding of the indirect modes of HIV transmission, associated with group injecting and shared drug use events. IDUs should, they said, obtain the same information on HIV prevention and transmission repeatedly, through different mechanisms. They commented that a group of people needs to be trained and assigned with this task, rather than assigning a single peer educator or health worker. In addition, the number of peer educators should be increased for the free distribution of needles/syringes at different injecting sites. Since the IDUs are mobile and they visit different places, increasing the number of peer educators and volunteers will maximize the time and availability of free distribution in different IDU gathering places. These recommendations were consistently repeated by a number of respondents. One of them pointed out the weakness of the current program and mentioned: "*In my opinion the current awareness building program is not strong. We need more activities to educate us (the IDUs) properly. The rate of spreading the disease (HIV infection) is very high now. There is need to increase the awareness activities (c4)*". Another participant suggested some strategies for raising

awareness, he said: *"I think there is need for more advertisements, banners, leaflets (specific to drug use and sex work behaviours) to educate and (make them) aware (c10)".*

A major area of recommendation focuses on the HIV infected IDUs and the needs of an HIV infected family as a whole rather than only the infected person. One said: *"Those (IDUs) who are already infected with HIV should get necessary support for their family members. This is really important because the whole family suffers. Do not only provide medicine for the infected person (c9)".* Another participant commented on a similar need and added a valuable suggestion: *"Develop a special program with the infected persons only and educate them about the responsibility of the infected persons to protect others. This will be really helpful for others (c11)".* IDUs have misconceptions and often maintain a highly negative perception of their miserable situations and try to depict the drug dealers/sellers as criminals. Many IDUs think that arresting and punishing the drug sellers would help to reduce the supply of drugs and thus reduce the rate of new users.

## 4. DISCUSSIONS

A detailed understanding of the current service engagement among IDUs is essential to modify existing services and develop new public health strategies to reduce HIV infection. Our research findings provide a valid qualitative understanding of the pattern of service engagement and allow us to make valuable suggestions for better service coverage for IDUs in future. Our evidence suggests the need for comprehensive HIV prevention services, based on public health principles, where the whole community will be engaged with a focus to guide a concerted response towards the drug and HIV problem [24]. Our participants, especially the HIV infected IDUs, highlighted positive attitudes of health care service providers which would be the principal facilitative factor in accessing treatment and care services by participants and their friends. They also highlighted the friendly behaviour and humane approach while they visit for ARV or methadone doses, which is undoubtedly a positive contributor to a higher level of treatment adherence [25, 26]. We found that provision for ARV and methadone treatments were the two key services greatly emphasized by our participants, especially by the HIV infected participants. In terms of barriers relating to ARV and Methadone Maintenance Treatment (MMT) [27] despite repeated discussion, no obstacles hindering access to these services were mentioned. They agreed that stigma and discrimination associated with drug user is often a major barrier in treatment seeking behaviour, but did not highlight any major incidents relating to them or their friends in recent times, which had caused their service inaccessibility. Regarding other services, the free distribution of commodities which promote safe practice (drug and sex related) were highlighted and interesting comments made on how beneficial it would be to reduce the current high level of HIV prevalence among IDUs in the long run. The non-HIV infected participants especially highlighted issues around free distribution of N/S and other informational materials which raise awareness and educate them on safe behavioural practices.

A number of barriers often reduce the capacity of IDUs to engage in harm reduction services [28]. Consistent with other research [29-31], our participants emphasized the fear of police

arrests and the problem of carrying extra needles/syringes with them to facilitate safe injection in different public places at the time of need. The police often conduct raids, crackdowns, or extensive searches and if they find IDUs carrying injection paraphernalia this would be sufficient evidence to arrest participants as drug users [2, 6]. Another qualitative evaluation of HIV prevention intervention in northern Vietnam [32] highlighted similar findings regarding the role of police and their negative impact on service engagement. A change in police attitude and their involvement in harm reduction services would be helpful and would, in turn, increase service engagement to such a degree creating a lasting positive impact on safe injection practice. This is particularly a fact for the non-HIV infected participants. Because of the improved knowledge, nowadays, they understand risks associated with N/S sharing and thus intend safe practice. Unfortunately the punitive and non-supportive attitudes of police limit their service engagement. A promising project initiative in Vietnam is already underway [12, 33] to improve this situation, but facing difficulties for an effective collaboration to complement each other in progressing to the common goal of drug and HIV prevention [34].

The majority of the non-HIV infected participants highlighted another important issue which limit IDUs' accessibility to harm reduction services. They mentioned the inadequate field coverage by the peer outreach or health workers. Participants highlighted the fact that many of the injecting sites or hotspots were not covered by the current program for free distribution of needles/syringes. Similarly, fieldwork at night would be beneficial to promote safe injection practice and better service engagement which is not present at this moment. The participants noted the crisis regarding safe practice commodities for the IDUs who gather in the evening and it is clear that strong field coverage will be crucial for HIV prevention services among IDUs [35]. Furthermore, often young IDUs do not visit centre-based facilities because of fear or disclosure of drug use status to others. In this situation many young IDUs remain out of contact with of harm reduction staff and thus fail to obtain risk reduction commodities [36]. Increased numbers of peer educators or outreach health workers will bring benefits to them by reaching a number of unserved pockets or injecting sites and providing them free N/S and other safe practice commodities.

There are limitations related to these qualitative findings that should be taken into account [37]. Although we adopted a thematic framework and checklist to systematically guide the analysis process [23], our qualitative findings relating to service accessibility among IDUs may not be applicable for the entire population in Vietnam, because of a lack of representativeness. The study was primarily with male IDUs (phase 1); as a result female IDUs were categorically excluded from the follow-up interviews. In spite of that, two female participants were included for better understanding of risk behaviour from both perspectives. The inclusion of these two female participants became an additional strength in understanding unresolved aspects of risk behaviours among male IDUs. We did not include any service engagement or personal impact scale [38] to analyse our textual data, which would possibly report different types of findings about services and their engagement and this could be a suggestion for future research in this field. Our

participants were recruited from a broader research project involving male IDUs (phase 1), except for two who were female participants. However, we identified participants from a number of social networks of IDUs in Hai Phong in different districts with a diverse population (Table 1) and provided a valid picture regarding their service engagement. Furthermore, our interviewers were highly experienced in conducting qualitative interviews and facilitated to generate information rich content and narratives that cover important operational and management aspects of existing harm reduction programs after interactive discussion. In addition, the first author had played an active overseeing role (such as supervision, checking) during the data collection process, which enhanced the quality of information and helped contextual analysis of related features.

Despite such limitations, our descriptive evidence as well as the recommendations mentioned by participants show the urgency of strengthening the existing harm reduction services to increase service engagement. They suggested some operational and management issues – the priority is increasing the number of peer field workers and extending field hours through the evening, which will be beneficial to minimize risk engagement and ultimately to reduce HIV risk behaviours.

## 5. CONCLUSION

The qualitative findings present a detailed picture of circumstances surrounding access to HIV prevention services by IDUs in Hai Phong. Overall we documented a satisfactory level of service engagement which could be further encouraged by incorporating the invaluable suggestions raised by participants. At the same time barriers, especially law enforcement and police crackdowns affecting the public injecting environment need to be addressed. A public health partnership between health services and police authorities should be encouraged to support each other towards the common goal of HIV prevention among IDUs.

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