Sexual and Reproductive Health Services for People who Use Drugs

A Qualitative Study in Georgia, Indonesia, Kenya, Kyrgyzstan, Nepal, Pakistan, Tajikistan and Ukraine

Tatiana Mouhebati

Thesis Master Health Sciences
Specialization International Public Health
Vrije Universiteit (VU) Amsterdam

tmouhebati@gmail.com

Placement Organizations: AIDS Foundation East-West (AFEW) & Mainline

VU Supervisor
Dr. Lia ven der Ham

De Boelelaan 1105
1181 HV Amsterdam

a.j.vander.ham@vu.nl

Onsite Supervisor AFEW
Dr. Anke van Dam

Herengracht 208
1016 BS Amsterdam

anke_van_dam@afew.nl

Onsite Supervisor Mainline
Machteld Busz

Frederik Hendrikstraat 111-115
1052 HN Amsterdam

m.busz@mainline.nl

Abstract

Background: According to the Universal Declaration of Human Rights (article 25), all human beings should have access to appropriate health services, including Sexual and Reproductive Health (SRH) services. However, People who Use Drugs (PUD), are among populations whose rights are violated. PUD need general, as well as specific SRH services. So far, limited number of studies have been conducted on the specific SRH needs of PUD and the status of their access to related services. This study aims to recognize the specific SRH requirements of PUD and the current status of service delivery to this population, in terms of availability, accessibility, acceptability and quality, in eight countries: Georgia, Indonesia, Kenya, Kyrgyzstan, Nepal, Pakistan, Tajikistan and Ukraine.

Methods: A qualitative study was performed. In total one focus group discussion was conducted with participation of eight people and 18 respondents were interviewed. The participants were experts who work at the local organizations of the eight countries, as well as regional and International organizations active in the field of PUD. A thematic analysis was conducted.

Results: The respondents confirmed that PUD have specific SRH needs, including need to information and services, such as maternal health, HIV and STIs prevention, family planning and intervention related to sexual violence. They mostly utilize general available SRH services. There are different barriers in their access to these services, including financial issues, geographical inequalities, discrimination and legal barriers. The services are mostly not acceptable for this population due to stigma and their lack of trust to confidentiality of services. Moreover, the quality of services is not appropriate for this group, as a result of lack of knowledge of service providers and lack of guidelines on the specific issues of this population.

Recommendations: In order to improve the current situation of services, different activities at the policy-making and implementing levels are recommended, such as advocacy, mapping stakeholders, different strategies to reach PUD and gender-sensitive services.

Discussion: This study gave a comprehensive picture of SRH needs of PUD and status of available services. The results of this study can be used by harm reduction organizations, in bridging the gaps of SRH service delivery to this population, by designing accessible, acceptable and quality services.

Key words: Sexual and Reproductive Health, Sexual and Reproductive Health Services, People who Use Drugs.

Introduction

Sexual and Reproductive Health

Reproductive Health is defined as "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, its functions and processes" (1). Accordingly, Sexual Health is defined as physical, emotional, mental, and social wellbeing in relation to sexuality (2, 3). Sexual and Reproductive Health (SRH) involves all sexual and reproductive processes and functions of an individual, in all stages of life and therefore consists of diverse components, including Puberty, maternal care and delivery, family planning, sexually transmitted diseases, HIV/AIDS, (safe) abortion, infertility, cancers of reproductive system and menopause (1, 4). Other issues such as sexual and gender-based violence are also considered as components of SRH, due to their impact on SRH of victims (5, 6).

The right to health, which has been endorsed in the article 25 of universal declaration of human rights (7) and several international and regional treaties (8-11) is universal right of all human beings . According to the plan of action of the UN committee on Economic, Social and Cultural Rights, one of the factors which ensure the right to health, is health care (12). According to this plan, the health care services should be available, accessible and acceptable and have sufficient quality (12). Since SRH is a component of overall health for all human beings (13), SRH care should also be available for all people and should meet the mentioned criteria (4, 14). Despite this right, there are sub-populations who do not have equal access to these services and whose rights are violated (15). One of the sub-populations are People who Use Drugs (16).

People who Use Drugs and SRH

The phrase "People who Use Drugs (PUD)" refers to people who use different substances recurrently; whether illicit drugs or prescribed and over the counter drugs (17). Male and female PUD have SRH needs, such as all other individuals in the society. Moreover, they have greater vulnerability to SRH ill-health and specific SRH needs. These specific needs can be the result of their involvement in risky behaviors, such as sharing needles in Injecting Drug Users or high risk sexual behaviors, which can happen due to impairment of judgment of PUD (18). In addition, some PUD sell sex in order to procure drugs (18) which can have other consequences including higher risk of being victim of sexual violence (19).

Another reason for specific SRH needs of PUD is the effect of drugs in their bodies. Female PUD show higher risk of reproductive complications comparing to other women, including infertility, repeated

miscarriages, premature deliveries and higher risk on reproductive tract infections (20, 21). For instance the results of a hospital-based retrospective cohort study in USA, suggested that women who use cocaine have 38% higher risk on miscarriages (22). Another example is the possible interaction of drugs with contraceptives in body (23). Furthermore, the SRH complications can be caused by other hazardous habits which are accompanied with drug use, such as smoking. For instance women, who smoke in preconception period have 1.2 to 3.6 relative risk for infertility and the ones who smoke during pregnancy have 20% to 80% higher risk of miscarriage comparing to non-smokers (24, 25).

Despite the specific SRH issues of PUD, conducted studies suggest different barriers in their access to SRH services. One of the barriers is facing discrimination or exclusion while seeking services. A pregnant woman who uses drugs might face stigma being blamed as immoral. High level of stigma can affect this population's utilization of available services. (23). Another barrier in access to services is financial. For instance in Kyrgyzstan, pregnant women who want abortion cannot access free of charge services and therefore should wait for a long time, until it is too late for safe abortion (26). Furthermore, PUD may reject using available general services, due to the fear that their drug use being identified by service providers, and consequently facing threats by police or other legal references, such as child protection services (23, 27).

One of the international projects, which aim to ensure health and rights for key populations, including PUD, is "Bridging the Gaps" (28). It is a joint project of a network of Dutch NGOs, global key population's networks and grassroots NGOs. Under this project, the specific programs for PUD are being implemented in eight countries, including: Georgia, Indonesia, Kenya, Kyrgyzstan, Nepal, Pakistan, Tajikistan and Ukraine. The Dutch NGOs which are responsible for this component, AIDS Foundation East-West (AFEW) and Mainline Foundation, have planned to include SRH in their future projects.

So far, limited number of studies has been conducted on SRH needs of PUD in these eight countries. Although many studies have been performed on STIs and HIV/AIDS in this population, other aspects of SRH have received little attention. In addition, the status of available services for this group in these countries -if any- is not known. The aim of this study is gaining insight into the key informants' opinion on the SRH needs of PUD and current status of SRH service delivery to them in the eight countries: Georgia, Indonesia, Kenya, Kyrgyzstan, Nepal, Pakistan, Tajikistan and Ukraine. The results of the study will contribute to preparation of an intervention plan to promote SRH services in the mentioned countries.

Methods

In this study, a qualitative approach was used for conduction of Key-informants needs assessment. The key-informants technique, which was originally used in ethnographic studies, is now being used in other fields as well (29) and is one of the traditional needs assessment approaches, applicable in the health sector. In this approach, the data is acquired from key informants who are professionally or organizationally in a position that have knowledge about needs and characteristics of the studied population (30, 31).

Theoretical framework

The approach used in this study was right-based approach, which emphasized that every human being should have the right to enjoy the highest attainable level of health. To operationalize this approach, the model of "the right to health", adopted by the UN committee on Economic, Social and Cultural Rights was used (12). According to this model, which is presented in figure 1, one of the fundamental components that ensures the right to health, is health care. The health care services should meet certain criteria. Firstly they should be available, which means that the services, facilities and needed equipment should be adequate in number and health programs should be in place. The second criterion is accessibility of services. The services should be accessible for all individuals, in terms of physical distance, price (affordability) and willingness to provide services to everyone without discrimination. The third characteristic of health care services is acceptability. The facilities and programs should respect the medical ethics and cultural values of the clients. They should also consider the demands of both men and women in all stages of life. The last essential criterion is sufficient quality of facilities and services. The application of this model for development of research questions and sub-questions of this study has been illustrated in annex 1.

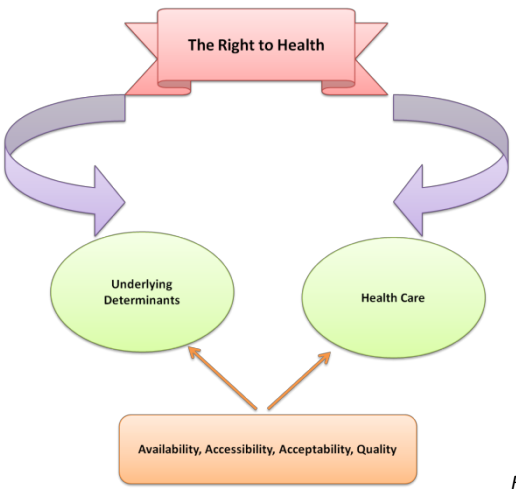

Figure 1: Model for the Right to Health

Study population and sampling

The method for selection of the first participants of this study was purposive sampling. Based on this method, which is mostly applicable in key-informants studies, the researcher determined what is needed to be known and afterwards selected people who had the needed information and were willing to cooperate with the study (32, 33). The first participants were recognized and recruited with assistance of AFEW and Mainline offices. Another method of sampling was snowball method. In this sampling method, additional informants were identified during the process of research, or were introduced by former respondents (34). In total, eight interviewees were recognized based on this method.

The participants were selected among the experts of the eight countries, who worked at the local or national harm reduction NGOs. Besides, two experts from regional and international harm reduction organizations were recruited. They had overarching view on the studied issues and had experiences in a number of the studies countries. All of the respondents had direct contact with PUD and therefore, were aware of their specific SRH requirements. Furthermore, due to their professional positions, they had extensive information regarding the status of the available SRH services. A number of these experts were ex- or current drug user. This assisted in obtaining the information from an insider perspective.

In total 26 people participated in this study. All of the respondents were invited by email. The form of informed consent was sent to all of them before the interview or FGD. They were asked to read the content of the form. But the consent was obtained orally, during the FGD and interviews.

Data collection

The data collection took place in April and May 2014. The qualitative techniques used in this study, were semi-structured interviews and a FGD. During the interviews and FGD, an interview guide was used. This promoted the consistency during the interviews and increased the reliability of the findings (35). The interview guide was developed, based on the theoretical background of the study and research question (Annex 1).

In total 18[1] people were interviewed (table 1). Sixteen of the interviews were conducted by the researcher through Skype. These interviews were mostly in English; three of them were carried out with assistance of a translator. The people who acted as translator were experts, who already

[1] In one of the interviews 2 people were interviewed at the same time, due to poor internet connection.

participated in the study, were familiar with the process of the interview and were fluent in English and the second language. The two other interviews were held by the employees of the regional AFEW offices and were translated into English. All of the Skype interviews were recorded, using a voice recorder and was later transcribed verbatim. The duration of the interviews was from 41 to 67 minutes.

Table 1: number and gender of participants per country

Countries	No. FGD Participants	No. of interviewees	Female	Male
Georgia	1	2	1	2
Indonesia	1	2	2	1
Kenya	1	2	1	2
Kyrgyzstan	1	2	3	0
Nepal	1	3	2	2
Pakistan	1	2	0	3
Tajikistan	1	2	1	2
Ukraine	1	1	2	0
Regional organizations	-	1	1	0
International Organizations	-	1	1	0
Total	8	18	14	12

Another qualitative technique in this study was a FGD, with participation of eight experts from the countries (table 1), who were present in Amsterdam, to participate in the partner meeting of the bridging the gaps project. During the FGD, the researcher acted as moderator and one of the interns assisted as note-taker. The FGD session took 75 minutes; was recorded and later transcribed verbatim.

During the FGD, the participants discussed the answers to the questions and the information collected during the discussion, was used for answering research questions (36). The value that FGD added to this research was the interaction between the participants and dynamic of the group. This gave the researcher a better overview of the participants' opinions on the topic (37, 38) and resulted in gaining a better understanding of the similarities and differences between the eight countries, in terms of SRH requirements of PUD and barriers in SRH service delivery to them.

In the FGD, two main topics were discussed. The first one was required SRH services for PUD. The participants were asked to prioritize three SRH services which are mostly needed by PUD in their

countries. They were also asked to determine which services are less needed. The controversial answers were discussed with the participants. The second subject was barriers in the access of PUD to the available services. They were asked to imagine that the services are fully available in their countries and think of potential barriers that hinder access of PUD. The similarities and differences between countries were discussed.

Analysis

The data was analyzed, using software MAXQDA® 11 (VERBI GmBH). The method used for analysis of data was thematic analysis. This method, which has a descriptive and explanatory orientation, was used for identifying, analyzing and reporting patterns of meaning and themes (39, 40). The analysis was guided by the theoretical framework and core concepts of the study (annex 1).

The process of data analysis was performed in six stages. At the first stage, the data was read repeatedly. The close and repeated reading led to familiarizing with it (39). Afterwards, the initial codes were produced from data. This was an iterative process and after recognition of a new code, the whole dataset was reviewed.

In the next step, the themes were recognized. A theme is a pattern of meaning, which captures an important issue in relation to the research question (39). To identify themes, the similar codes were grouped together and were clustered into sub-themes and core themes. At the fourth stage, the themes were reviewed and the ones which did not have enough supporting data were merged in other themes. It was taken into account that the data under each theme to be homogenous and cohere together meaningfully (39). When a satisfactory thematic map of data was produced, the themes were named, defined and the analysis of each theme was written. At the last stage, the results of the study were written, considering the relation of themes together and to the research questions (39).

Results

After analysis of dataset, six main themes were recognized. The themes consisted of: specific SRH needs of PUD, availability, accessibility, acceptability and quality of services and recommendations. Below, the description and explanation of each theme is presented.

Specific SRH needs of PUD

The respondents believed that PUD need *"as many services as possible"*-R3. However in prioritizing the services, the most important ones were: need for information, STI/HIV prevention and condom promotion, maternal health, family planning, sexual violence and SRH services for adolescents.

Need for information

More than half of the interviewees believed that lack of information of PUD on their specific SRH issues is one of the most important problems and therefore providing information to this group was one of their priorities. Many of PUD do not have any information regarding the effects of different drugs on their reproductive system. For instance, they are not aware of the effects of drugs on the fetus in a pregnant woman or are not aware that they can give birth to healthy babies, despite using drugs or living with HIV/AIDS. According to the respondent from the international organization International Network of Women who Use Drugs (INWUD)[2]:

"in these countries, most women who use drugs do not know about heroine effecting menstrual cycle and you can still get pregnant, even if your period stops."-R10

"So they aren't aware of the support they can get around prevention of the mother to child transmission; they might not be aware if there is potential to get a hold of post-exposure prophylaxis."-R10

In addition to the lack of information on SRH, health is not one of the priorities of PUD, as they have many other concerns, such as earning money and obtaining drugs. They need to have awareness on the importance of health. One of respondents confirmed:

[2] INWUD: International Network of Women who Use Drugs

"It is very hard to work with women IDUs[3] because health for them is like the last priority. […] she has a lot of symptoms of STIs but she doesn't see it… that she has to go somewhere…, to a doctor and take a pill; because she only thinks about drugs."-R1

STI/HIV prevention and condom promotion

In prioritizing the services, the most recurring issue was prevention of HIV/AIDS, STIs and condom distribution/promotion. Although condom distribution is one of the basic activities, which is being implemented in the harm reduction programs, there is still need for more similar activities. Many of PUD do not practice safe sex and do not use condoms. This leads to huge risk of transmission of HIV and STIs. According to one of the respondent from Pakistan:

"[…] but the main problem that we usually encounter when we are dealing with them (male IDUs) is that they do not use condoms. Such a large number of people who inject drugs, they do not use condom and most of them reported that in their last sexual activity they did not use condoms. So this is I think, the main reason of…, once again in, propagation of HIV virus and STIs as well." –R5

In condom promotion programs, special attention should be paid to female condoms. Respondents believed that many female PUD are in a weak position that makes them unable to negotiate safe sex. Therefore promotion and distribution of female condoms might be a solution for this group.

The other required service, recognized by participants, is prevention of mother to child transmission of HIV/AIDS. This is a specialized service, which is specifically needed by female PUD who live with HIV/AIDS. This service cannot be directly provided by SRH service providers. In order to make it available, the harm reduction centers should have collaborations with national HIV/AIDS programs. According to the respondent from INWUD:

"They (harm reduction centers) must have link to, if not provide onsite…, have link to prevention of mother to child programs."-R10

Maternal health

One of SRH services specifically important for female PUD is maternal health. Respondents confirmed that different drugs have some effects on the women's physiological cycle. For instance, heroin can interrupt the menstruation cycle. Despite this interruption, the woman can become pregnant. This will lead to late diagnosis of unwanted pregnancies. Moreover, different drugs have some effects on

[3] IDU: Injecting Drug User

the fetus. A pregnant woman who uses opiates should start substitution therapy as soon as possible, in order to prevent effects on fetus. If the mother continues using drugs during pregnancy, abstinence syndrome will occur to neonate. This infant needs immediate medical interventions to stay alive. Therefore maternal health services, including prenatal care, safe delivery and post-natal care are one of the important services for female PUD.

Family Planning

Need for family planning services, was among other requirements, which was raised during the interviews and FGD. The specific complication related to family planning is the possible interaction between contraceptives and the drugs that women use. For example, one respondent mentioned:

"Women who use drugs often take different drugs…, sometimes they are on this… opioid substitution treatment; and when doctor decides which contraceptive she needs to prescribe to the patient, doctor should keep in mind the possible interactions and this is specific."-R13

Sexual violence

One third of interviewees believed that sexual violence against female PUD, is one of the problems, which deserves special attention. They mentioned that female PUD may be sexually harassed by drug dealers, police and hospital staff. They had contrary ideas regarding the stimulating factors of violence. Some of them believed that sexual violence mostly happens to sex workers who use drugs and some others said this issue is more associated with single female users. The rest of them mentioned it can happen by intimate partners. They believed that women need to know how to prevent sexual violence. Besides, the harm reduction programs should have a link with specific programs on violence and emergency housing centers.

SRH for adolescents

A number of respondents mentioned that there is a need to provide SRH services to adolescence. This is specifically needed, in countries where the age of first drug use is in the adolescence and there is no systematic sexual education at schools. Respondents said that adolescents suffer from lack of information on condom use, contraceptives and other SRH issues. They are not allowed to utilize general SRH services without consent of their parents. In these countries there is an accurate need to provide SRH information and services to this group.

Sexual dysfunctions

A limited number of participants talked about sexual dysfunctions in male PUD. They believed that different drugs have different effects. Besides, each person might react differently to the same drug.

"Some people on amphetamines might have multiple sex partners in a party night and other people won't. Some people on heroine find that their libido is affected in a positive way; some people find it is negative."- R10

However they suggested psychological support for overcoming this problem in PUD.

Availability of SRH services

The first component of ensuring the right to health is availability of health care services, which means that the services, facilities and needed equipment should be adequate in number and health programs should be in place. In almost all of the studied countries, some SRH services are being delivered within the harm reduction projects. The scope of these services is very small and in addition to HIV prevention and condom distribution, includes sporadic distribution of pregnancy tests and limited number of medicines for treatment of STIs such as metronidazole. Only one of the respondents from Georgia confirmed that there are some harm reduction NGOs in this country, which provide gynecological services to female PUD, some hours per week.

In all of the countries, the PUD generally go to general health centers for receiving SRH services. These centers differ per country and include general hospital, community clinics, narcotic centers, poly-clinics, gynecologist offices, HIV/AIDS centers or maternity clinics. These centers may belong to government, private sector or NGOs. The general health facilities are available in all of the studied countries. However, in some of the countries, such as Indonesia and Kenya, the number of centers and health care professionals or the range of services might be limited. This is illustrated in the following quote from one of the Kenyan respondents:

"Commodities are there but are limited. Because what you find in SRH…, I mean there are only male and female condoms. But we don't have contraceptives and other family planning services."-R18

Accessibility of SRH services

Different barriers can hinder access of PUD to available services. The most important barriers, which were raised in discussions, were financial inaccessibility, geographical inequality, discrimination and legal barriers. Although in this study, PUD were considered as one group, some specific barriers were

raised in the dataset, which were specifically related to some sub-populations within this group, such as women and adolescents. Therefore, two sub-themes of 'access of women' and 'access of adolescents' were recognized under this theme. The specific barriers, which hamper access of these two sub-populations, have been presented under these sub-themes.

Financial inaccessibility

One of the dimensions of accessibility is financial accessibility or affordability of services. In some of the studied countries, the primary SRH services are free of charge or available with minimum costs, which is affordable for this population. The range of these services differ per country and can encompass condom distribution and HIV/AIDS counseling and testing to very limited STI tests and treatment and regular prenatal care visits. Also the organizations which provide these services differ. In some of the countries, the government provides free of charge or affordable services while in other countries, NGOs take this responsibility, with support of different international organizations such as Global Fund. However, as already mentioned, these free of charge services are not available in all countries.

There are also some problems associated with utilizing free of charge services, which are made available by International organizations such as Global Fund. These services are delivered only for key populations such as PUD, MSM and sex workers. In order to utilize these services, the clients should open up their status and declare that to which group they belong. According to respondents, one of the barriers in utilizing these services is hesitation of PUD to declare that they belong to this population. Specifically in smaller cities, where people mostly have stronger societal ties, PUD are afraid of being recognized, by utilizing these services.

The other option is utilizing SRH services, delivered by private sector. In all of the countries, these services are financially not affordable for PUD. For instance in Georgia:

"The general population can use the wide variety of different services with different prices starting from quite middle prices to very high but frankly drug users do not afford those services."-R3

The other dimension of financial affordability is inequality in prices. Although the majority of PUD are less privileged, in some countries they are forced to pay even for the free of charge services. This issue was raised in one of the interviews and was referred to as *"bribing"*.

Geographical inequality

Geographical inequality is one of the other barriers in access to services. The respondents from all of the eight countries believed that there is huge inequality between rural and urban areas and between bigger and smaller cities, in terms of access to health care services. Although the geographical inequality affects the whole population, it has more effects on PUD, as PUD are less privileged to travel to bigger cities to access services.

"If (in big cities) they refuse to give them (PUD) services in one medical facility, they can try to go to another. And in smaller towns they have, like…, one regional medical establishment and they have to go there; to pay some money for transportation…, for bus and to go there and unfortunately they don't have many choices to decide where to receive services."-R2

Discrimination

Another dimension of accessibility is refusal of health care professionals to provide services, due to discrimination. At least half of the respondents believed that the health care providers in their countries may refuse proving SRH services to PUD, because of having stigma towards this group. According to one of the experts from Eurasian Harm Reduction Network (EHRN), in most of the studied Central Asian and East European countries: *"women who use drugs cannot get into the maternity clinics, because of the basis of drug use. If they are using drugs, maternity clinics do not take them…, on that basis. In case maternity clinics take these women, they do not provide them with necessary drug dependence treatment."*-R13

Legal barriers

Another barrier in access to SRH services is the issue of ID card and other needed legal documents. In many countries, people have to show their ID cards or patient cards to be able to use different services. Many PUD are not in possession of ID cards or are not willing to show them, because of fear of further legal consequences. This happens especially in countries where drug use is illegal. According to one of respondents:

"[..] because drug use is illegal and of course this is why people don't want to show their ID cards. I show my ID card and I am saying I use drugs, I can easily putting to jail for 3 years."-R3

Barriers in access of women

Specific barriers in access of women to services include dependency to male partner, children and their limited mobility.

Dependency to male partner

In the studied countries, many female PUD have partners who use drugs as well. In this situation, it is the responsibility of the male partner to obtain drugs. Also the male partner mostly goes to harm reduction center to receive needle, syringe and condom for both of them. Therefore female PUD do not see the necessity to go to harm reduction center. In some cases, even if the female PUD wants to go to the center, she will not be allowed by the male partner or her family.

Children

The other barrier in access of female PUD is their responsibility for taking care of children and doing the household. They cannot leave the children at home to go to the center, because there is no one to take care of them. Also they cannot take children to the center, since the centers do not provide child care services.

Mobility

The next barrier is lack of mobility of women in some countries. According to respondents of Pakistan and Nepal, women cannot move in the society unaccompanied. This is because of specific cultural issues and social norms. Therefore they do not have the opportunity to go to the harm reduction centers. According to these respondents:

"Most of the (female) clients…, they hide in the houses only"-R9 (Nepal)

"The mobility is a challenge for women. They live in different areas, is very cultural society. […] it is difficult for women to move from their places."-R14 (Pakistan)

Access of adolescents

Some of the respondents mentioned that the age of first drug use is very low in their countries. For instance according to the respondents of one of the countries, drug use starts mostly between 13 to 15 years of age. In these countries, adolescents face some specific issues which hamper their access to services, including legal barriers and their lack of intention to utilize services.

Legal barriers

In some of the studied countries, there are some legal barriers in providing services to adolescents. When this group of PUD goes to the harm reduction center, they need to have the consent of their parents or guardians. This will limit their access to the services.

Lack of intention

The other problem in some countries is that this sub-population do not consider themselves as PUD. In order to utilize the harm reduction services, first they have to admit they are drug user and need these services. But adolescents do not admit this fact and prefer to avoid the centers, which are intended for adult PUD and IDUs.

Acceptability of services

Acceptability of services was one of the other recurring themes in the dataset. According to the respondents, issues that make services unacceptable for PUD include stigma and lack of trust of PUD to confidentiality of services. The presence of the above-mentioned issues will lead to lack of intention of PUD to utilize services. In addition, there are some issues which make the services specifically unacceptable for women. Therefore, under this theme, the sub-theme 'acceptability of services for women' was recognized. The issues which make services specifically unacceptable for women have been presented under this sub-theme.

Stigma

According to all respondents, using drugs is associated with stigma in the studied countries. Being stigmatized can occur by service providers and/or other clients of the services. Regarding Stigma in service providers, respondents had contrary ideas. Some of the respondents of Indonesia, Nepal and Pakistan believed that health service providers do not stigmatize PUD, as they had never received any complaints in this regard. For instance one respondent from Pakistan mentioned:

"Considering that we are working in more than 35 districts in Pakistan, until now, we haven't received any single complaint from the common hospitals."-R5

However, all other respondents (including other respondents of these three countries) believed that health care providers stigmatize PUD. Some respondents mentioned, although stigma exists everywhere, there is more stigma in health care providers of rural areas and smaller towns comparing to big cities.

Being stigmatized by health care providers may have different consequences. The most important result of stigma is that PUD do not intend to utilize services. As one of respondents said:

"The other issue is that, because of that high stigma and discrimination, women who use drugs do not want to contact those doctors and they prefer to… just not go and visit them and that is also not very good."-R13

The other outcome of stigma is that PUD will try to hide their drug use status from service providers and therefore, they may not receive appropriate interventions. This issue is well illustrated in the following quote:

"Or at least they would not say they are drug users, which might affect the tailored services they might be getting from this particular service provider, if they hide that they are drug users."-R3

Being stigmatized may also happen by other clients of the services. According to respondents, this issue happens at the general settings, where the other clients are from general population. This will make the services unacceptable for PUD and will lead to their lack of intention to utilize services.

Lack of trust

The last barrier which makes the services unacceptable for PUD is lack of their trust to the confidentiality of the services. This issue was raised only in one of the interviews. Due to the lack of trust, the PUD would rather hide their identity or hide their status of using drugs and in case they have to reveal that, they will prefer to avoid using the services. This respondent said:

"The other barrier is that they don't trust the health service providers, to keep their data, or their identity in secret. They lack trust to service providers. They are afraid to make open their identity."-R6

Acceptability of services for women

The issues which make the services specifically unacceptable for women include: gender related issues, self stigma and forced interventions.

Gender related issues

The first issue related to gender, which is associated with unacceptability of services, is gender stigma. Although the whole PUD face stigma from heath service providers, women may face more stigma. Almost all of the participants from East Europe, Central Asia and Kenya believed that there is more stigma associated with female drug use than men who use drugs. However the participants

from Indonesia, Nepal and Pakistan believed that although the general population may stigmatize female PUD more than male PUD, health care professionals do not stigmatize this group comparing to male PUD. According to one of Pakistani respondents:

"As far as the government hospitals are concerned, they are not doing that (gender stigma), because we have not received a single case (complaint)."-R5

The same respondent mentioned:

"Yes, stigma can happen outside the hospitals (towards female PUD)…, because that is the general population." –R5

The female PUD may also be stigmatized by the other clients of the harm reduction services, namely by male PUD. This will encourage women to hide their drug using status and not o utilize harm reduction services. This issue is illustrated in the following quote:

"Because it is even discrimination from men who use drugs side in those countries; not only from general population… but also men who use drugs have a negative attitude towards women who use drugs in those countries."-R13

Another gender-related issue associated with acceptability of services is respecting the specific needs of different gender groups. According to the respondents, a large proportion of female PUD do not use any service, including the harm reduction services, because the available services do not respect their specific needs. The services are the same for male and female and are not tailored for them.

Self stigma

According to respondents, self blaming, hesitation, being shy and embarrassed, feeling guilty, or in other words self stigma, is one of the most important barriers which is mostly associated with female PUD. Since in many societies, it is more acceptable for men to use drugs, women who use drugs feel guilty and blame themselves. As a result of this feeling, they expect themselves to be stigmatized and this makes the services unacceptable for them. According to one of respondents:

"[…] they would expect themselves to get that kind of attitude (being stigmatized). That is very important…, self stigma and self blaming…. SO if they disclose their status of being drug user, they would expect different attitude and from very beginning they would behave like: I am so sorry."-R3

Forced interventions

The last barrier in acceptability of services is forced interventions for women and lack of respect to their reproductive rights. This issue happens especially when female PUD become pregnant. Most of health care providers believe that female PUD are not entitled to have children. Therefore, mostly advise them to do an abortion and even in some cases force them to it. As a result, many female PUD prefer to ignore using the services. According to one of respondents:

"Very often gynecologists, when they see that the woman who uses drugs is pregnant they refer them for abortion and do not leave any other alternatives."-R10

Quality of SRH services

In assessment of the quality of services, four important factors were raised. These factors were lack of knowledge of service providers, lack of guidelines, effect of geographical location of the facility on the quality and effect of the organization which provides service on the quality.

Lack of knowledge of service providers

The first factor in the quality of services was knowledge of health care professional on specific SRH needs of PUD. Most of the respondents believed that in their countries, the majority of health care providers do not have enough knowledge to manage specific SRH issues that PUD may face. The following quotes confirm this:

"*I have never met a doctor in Tajikistan that has specific knowledge on… for example on how to work with pregnant women who are using drugs."*-FGD respondent 6

"And one of the other issues is a big and huge problem… that's gynecologists' lack of knowledge about those specific issues. For example what kind of contraception they need to provide to women who use drugs."-R13

In some countries, such as some regions of Indonesia and Kyrgyzstan, limited number of providers has been trained on the SRH issues of PUD, but still these trainings are limited to some specific regions in each country and are not implemented at the national level. For instance in Indonesia:

"*they started with few local community clinics like…, for example in "Samarinda", there are only less than 10 community clinics that the services providers are given the knowledge about specific needs of people using drugs".*-R4

Lack of Guidelines

The other important factor in the assessment of the quality of services is implementation of guidelines in all medical practices. According to respondents, the specific guidelines on the management of the SRH complications of PUD have not been developed yet. Only one of the respondents from Kyrgyzstan believed that guidelines have been developed in this country, but are not implemented yet. She said:

"*Three years ago they prepared guidelines to work with sexual and reproductive health. Until now these modules are not working there."*-R1

Geographical location

Some interviewees believed that the health care professionals of the facilities located in the big cities, might have more knowledge on the management of SRH issues of PUD. But in small cities and rural areas, the professionals do not have sufficient knowledge. Thus the quality of SRH services in bigger cities is higher, comparing to smaller cities and rural places. One of respondent mentioned:

"Then, in small towns… the personnel of small medical facilities do not know about addiction, do not know how to provide support for pregnant drug users."-R2

Service provider organization

The association between the quality of health care and the organization which provides service was raised in one of the interviews. The interviewed expert believed that the quality of services at the private and non-governmental centers is higher than governmental facilities. He mentioned:

"it depends on what service we are talking about, if we are talking about private service providers, those which are expensive, yes; most of them are trained and manage (SRH complaints of PUD) very well. On the other hand if we go to the government service, you will see people who are formally trained, but are not interested in working; because they work for the government. On the third side you see NGO clinics, like Family Planning Association of Pakistan for example. And they would be very well trained."-R14

Recommendations

The recommendations that have been provided in this section are divided into policy-making and implementing levels. They are based on the discussions with the respondents of the study and are categorized, prioritized and interpreted by the researcher. When the recommendations are consistent with available literature, the references are reported and the ones that are merely based on the literature are made clear.

Policy-making level

At the policy-making level, the organizations are recommended to plan some activities to change policies and prepare a suitable ground for provision of SRH services for PUD. The recommended activities at this level include mapping stakeholders and advocacy. These activities aim to facilitate development of SRH services for PUD at the national level.

Mapping stakeholders

The partner organizations are recommended to map stakeholders, including governmental, nongovernmental and private SRH providers, organizations active in the field of PUD, organizations involved in the area of legislations on drugs and international organizations work on SRH or PUD. In the process of mapping, the activities of each organization should be specified and the gaps should be recognized. This will assist in recognition of potential allies.

Advocacy

One of the most important activities, that should constantly be implemented, is advocacy. Partner organizations should advocate for the rights of PUD. Since these organizations work at different levels (local, regional, national), the scope of their advocacy activities might differ. However the main goal of advocacy is the same: recognition of PUD as members of society, who have similar human rights, including the right to health and changing the legal barriers in their access to health services, such as compulsory submission of ID cards. In addition, advocacy campaigns should be implemented for raising awareness of general population on rights of PUD. According to experiences of some of the respondents and based on literature, one of the advocacy strategies can be documenting the stories of PUD and difficulties which have happened to them as a result of violation of their right to access SRH services (41). For this purpose, media can be used, including internet and social networks, radio and television and newspapers.

It is also recommended to advocate for training of health care providers on specific SRH of PUD. The trainings can be included in the curriculum of the medical universities and refreshing training. Development and implementation of the guidelines on SRH of PUD should also be advocated.

Implementing level

At the implementing level, the organizations should plan and implement activities to ensure appropriate access of PUD to SRH services. In this section, recommendations have been presented on training of partner NGOs, provision of basic SRH services, provision of advanced SRH services, separation or integration of services, training of health care providers, strategies to reach PUD, empowerment of PUD and supportive activities. In addition, specific recommendations have been provided for provision of SRH services to sub-populations within PUD, including women and adolescents.

Training of the partner NGOs

One of the most important priorities is training of staff of the partner NGOs on specific SRH issues of PUD. Literature has also recommended this issue (41). The partner organizations are mainly active in the field of harm reduction. Although the staff has extensive awareness on harm reduction activities, including prevention of HIV and condom use, they might not have information about specific SRH issues of PUD. Lack of information of the staff was also recognized during this study. Some respondents of this study didn't have information on abstinence syndrome or were not aware of the fact that women who use heroin can become pregnant despite interruption in their menstruation and they interpreted this disorder as infertility.

When an organization plans to include SRH in its services, all of its employees should be trained. Managers and program staff should be trained to understand the importance of SRH in general, understand the specific SRH issues of PUD, change their attitude in planning future programs, advocate for SRH of PUD and understand importance of training of all staff members on SRH of PUD. The harm reduction staff, social workers and peer educators should also be trained to understand effects of drugs on SRH of PUD, complications which may happen during pregnancy and delivery and specific care needed in this period. Besides, they should receive extensive training on HIV and STI prevention and condom promotion.

Provision of basic SRH services in harm reduction centers

It is advised to provide basic SRH services in harm reduction centers. These services should include information on SRH issues, distribution of male and female condoms, instructions on condom use

and pregnancy tests. Pregnancy tests are specifically needed to diagnose pregnancy in women whose menstruation period is interrupted due to use of drugs. These services are the most essentials ones and are minimum SRH requirements that can be provided by social workers or harm reduction workers (41). Quick STI tests are among other services that can be provided. However, in the literature it has been recommended to provide syndromic treatment of STIs in harm reduction settings, without time consuming laboratory confirmations (41).

Provision of advanced SRH services

Respondents of this study had quite various ideas about the priority SRH services, in addition to minimum basic requirements which were mentioned before. Per country, the discussed priorities differed. Moreover, sometimes the respondents from the same country had different priorities. Therefore, it is recommended that, when the financial and human resources are adequate, the SRH services which were discussed in the results section[4] to be provided. These services include information on SRH, STI/HIV prevention, condom promotion, maternal health, family planning, sexual violence and SRH services for adolescents. If due to the financial restrictions, limited services can be delivered, it is advised to conduct a needs assessment with participation of PUD to determine which services are mostly needed. Besides, the desired criteria for services should be discussed with this population. Focus Group Discussion is one of the advised techniques to discuss these issues with PUD. In conducting any needs assessment, specific attention should be paid to the sub-populations within PUD, such as IDUs, women, sex workers and adolescents and representatives of all sub-groups should participate in the assessment.

In provision of advanced SRH services, it is advised to deliver them at harm-reduction centers. One of the possibilities is recruiting health care professionals (based on the country can be midwives, gynecologists, urologists, reproductologists, dermato-venerologist…) to be present at the harm reduction center for some hours per week and to offer their services in that location. The costs of these services should be paid by the harm reduction center.

When provision of onsite SRH services is not possible, harm reduction centers can build a collaborative relationship with general SRH facilitates. It can be in the form of a contract or memorandum of understanding between the harm reduction center and the general SRH center/specialists. However, even if the SRH services are provided onsite, the referral system should be built for people who need further specialized services. In all of the above-mentioned cases, the services should be delivered to PUD free of charge or with minimum affordable costs. In addition,

[4] Under heading: Specific SRH needs of PUD

collaboration should be built with shelters for victims of sexual and domestic violence; because some of these centers do not admit female PUD.

Integration or separation of services

The respondents of this study provided us with contrary recommendations on provision of advanced SRH services in a separated center for PUD or integration of advanced SRH services for PUD into the general facilities. They named different advantages and disadvantages for both strategies. The respondents who recommended integration of services believed that the advantages of this strategy are reducing stigma and discrimination, including self-stigma, giving PUD equal rights and opportunities as other people and reducing barriers and limitations of their access to all services. This group believed that provision of services in separate centers has some disadvantages. One of the most important disadvantages is increasing stigma and discrimination. PUD will be labeled as they walk through the door and this will create a basis for stigma. The other disadvantage is that separation of services will limit access of PUD to the general services and will create more obstacles for them.

In contrast to this group, other respondents recommended provision of services in separate centers for PUD. They believed that the most important advantage of separation is provision of services in a safe place, without stigma and discrimination, while integration of services has some disadvantages such as high workload and waiting time at the general centers. They believed that the general health care facilities are mostly crowded and clients should wait for a long time. It is not tolerable for PUD to wait for a long time and this may discourage them to utilize services.

Training of health care providers

The harm reduction organization may decide to provide onsite SRH services and refer PUD for specialized services or may collaborate with SRH centers. In all of these situations, health care providers who are responsible for delivering services to PUD should be trained on the specific SRH issues of this population. Special attention should be paid to training of health professionals on maternal care, opioid substitution therapy during pregnancy and management of abstinence syndrome in newborns. Furthermore, they should be trained on the rights of PUD and to avoid stigmatizing or discriminating them. However, it should be taken into account that these trainings are small-scaled and are not sustainable. The ideal situation is inclusion of the specific SRH issues of PUD in the curriculum of the medical universities and in refresher trainings.

Strategies to reach PUD: peer-outreach workers

One of the advised strategies to reach PUD is outreach activities. The outreach services can include provision of basic SRH services, raising awareness of PUD and short consultation on their SRH issues. The most important component of outreach activities is inviting PUD to harm reduction services, giving them extensive information on the available services, their prices and the criteria of the services (for instance that they do not need to submit their ID cards or reveal their identity). The outreach workers should go to the using sites of the PUD, to the places where they gather or in case the cultural and social issues allow, can go to their houses. It is highly advised that the outreach workers be selected from current or ex-PUD. PUD will trust their peers better and will share their problems with them. Also, it is worth emphasizing that outreach workers should be from same sex.

Some countries have already recruited outreach and peer-workers for their activities. One of the associated problems is lack of awareness of peer workers or their incorrect information. Therefore the literature has recommended at least monthly educational sessions for peer workers, in addition to the educational courses at the beginning of their recruitment. This will educational sessions will empower and educate them and will give them the opportunity to share their experiences with the group (42).

Empowerment of PUD

Another important activity is raising awareness of PUD and empowering them. They should become aware about their rights and the right to health. They should be encouraged to seek health services with confidence and without self-stigma. Furthermore, they should be trained on their reproductive system, sexuality and sexual risk behaviors[5].

Supporting activities

Some harm reduction centers provide supportive services to PUD; for instance by accompanying them to the health center. The person who accompanies PUD will make sure that the service provider does not stigmatize them and will assist in the communication between PUD and health care provider. Moreover he/she can assure that PUD will benefit from health services with minimum costs. This strategy is advised at the first stages, when the links between harm reduction and SRH centers are not built yet and also for harm reduction centers which have limited number of clients. However, it should be taken into account that this strategy is not sustainable.

[5] This is already explained in the essential needed services

Another supportive activity is providing transportation for PUD. This is especially effective in countries where geographical inequality is a barrier in the access of PUD to SRH services. In this situation, harm reduction center can provide transportation means for groups of PUD, who want to go to the center.

Specific recommendation for sub-populations

As already mentioned in the results section, in this study, PUD were considered as one population. However there are some specific barriers that make the services specifically inaccessible and unacceptable for some sub-populations, such as women and adolescents. In this section the recommendations are presented on how to overcome these barriers. The recommendations for women include strategies to reach women, gender sensitive services and incentives to attract women. Furthermore, specific recommendations have been provided on how to deliver services to adolescents and youth.

Strategies to reach women

As mentioned in the general recommendations, one of the strategies to reach PUD, including female PUD, is outreach activities. The outreach workers can go to the places where women gather, such as using-sites, beauty salons, a friend's house where they gather …. However it is quite challenging to reach out women who mostly stay at home. In some cultures, it is not acceptable to go to women's houses to deliver services, especially when they live with their families. In this situation, the suitable reaching strategies should be asked from the women themselves. It can be done officially by conducting FGDs, with participation of female PUD who already came to the center, or indirectly, by unofficial discussions with them.

The outreach activities can also be implemented for female PUD who work as sex-worker. To reach these women, outreach workers should go to the working places of these women during the night to identify them. However, as these women mostly work during night, outreach services should be delivered during day.

Another strategy to reach women is the snowball strategy. In this strategy, female PUD, who utilize the harm reduction services, should be asked to invite their friends to the center. It is worth mentioning that the first step to implement this strategy is to build a friendly relationship with female clients and provide them a safe and inviting environment, to encourage them to invite their peers.

Another recommended strategy is to reach female PUD through their male partners. This strategy has also been advised in the literature (42). During the service delivery to men, they should be asked about their female partners who use drugs and should be encouraged to bring them to the center. One of the useful techniques is couple-counseling. In order to make it possible, it is very important to create a safe and friendly environment for male clients and to ensure them about confidentiality of the services.

In reaching women through their partners, it is very important to encourage female partners to come to the center themselves. In some countries, where access to female PUD is difficult, the harm reduction projects try to deliver services indirectly, by sending women condoms, syringes and educational materials through men. This will make women more dependent on men and will disable them to benefit the specific SRH services.

Gender sensitive services

One of the most recommended strategies, which make the services acceptable for women, is provision of gender-sensitive services. For this purpose, there are a number of interventions that should be implemented. First of all, based on the literature, the organizations and NGOs which are involved in the process of programming and service delivery should receive in-depth training on the gender issues. This will assure the sustainability of this approach.

One of the interventions is performing some adjustments in the center. Where possible, the services should be provided in separate centers for men and women or in different hours (41,42). In case it is not possible, the center should have different entrances and different waiting rooms for men and women. Furthermore, the service providers should be from the same sex.

One of the other important barriers in access of women is their children. It is very important that the center provides child care services for mothers who are visiting the center (41). This will minimize the barriers of access of female PUD who have children.

The other recommended approach is recruiting female PUD or ex-PUD to attend in the center some hours per week. They can be trained and assigned for different responsibilities. This will provide female clients a more comfortable sphere.

Incentives to attract women

To attract women to the center, some activities can be implemented. One of the recommended activities is distribution of incentive kits, such as hygienic kits, for themselves and for the family.

These kits should only be distributed among women, to encourage male PUD to bring their partners. Also provision of other services, which can attract women is advised; for instance setting up a beauty salon in the center to offer free of charge or affordable services to women some hours per week, recruiting dentists to provide affordable dental services, forming women peer groups to enable them sharing their experiences and problems and income-generating workshops and projects.

Service delivery to adolescents

It is recommended to pay specific attention to adolescents who use drugs. The programs for this sub-population should include SRH information dissemination, behavior change communication and provision of SRH services, including condom distribution, STI and HIV prevention and family planning. Furthermore, it is important to provide prenatal care to pregnant adolescents and if they tend to terminate pregnancy, provide them safe abortion services, in countries where abortion is legal. In countries where there is lack of systematic sexuality education, specific attention should be paid to educating this group.

In order to reach adolescents, peer-outreach activities should be implemented. The outreach workers should go to the places where adolescents and youth gather. These places can differ based on the country and region and can include schools, universities, dormitories, computer-game nets, clubs…. The outreach workers should give them information about SRH and about the services that are available at the center and should invite them to the center. Another recommended strategy to invite adolescents is snowball strategy. The young clients should be encouraged to bring their peers to the center.

The SRH services for youth PUD should be provided in youth-friendly centers, where the environment is friendly, without stigma and discrimination. These centers should overcome the national legal barriers, such as necessity of consent of parents or guardians for provision of SRH services to adolescents.

Discussion

This study aimed to gain insight into the gaps in the SRH service delivery to PUD, by exploring the specific SRH requirements of this population and the current status of SRH service delivery to them, in eight countries: Georgia, Indonesia, Kenya, Kyrgyzstan, Nepal, Pakistan, Tajikistan and Ukraine. To our knowledge, this is the first study of its own in the studied countries. So far, many researches have been conducted on the status of harm reduction services. Also among SRH issues, the issue of HIV/AIDS and STIs has received great attention. But similar studies, that include all components of SRH, have not been conducted yet.

This study suggests that the available SRH services for PUD in these countries are general SRH services, utilized by general population. However, PUD face different barriers in accessing them. One of the most important barriers is high level of stigma and discrimination, which makes the services inaccessible and unacceptable for PUD. Literature confirms that stigma is a major barrier to health care (43). There is a misperception among general population that PUD use drugs voluntarily and they continue using it despite its negative consequences, due to their weak will (44). High level of stigma is associated with use of drugs, in general population. SRH care providers are not exempt from this general perception and the stigma associated with it. According to results of this study and available literature, as a result of this stigma, many care providers discriminate this population by refusing to provide services to them or PUD lose their intension to utilize services (45).

According to this study, another important barrier in access of PUD to services is affordability of them. The available services are not necessarily expensive; however, they are not affordable for this population. This is in compliance with previous studies. For instance, a study in Kyrgyzstan has shown that 82% of PUD who had not attended a medical facility in the previous year to the study, named financial issues as their reason (41).

Although in this study, PUD were considered as one population, the results suggest that sub-population of ‘women who use drugs’ has more SRH-related requirements. Due to their social status and high levels of poverty, dependence and abuse, they mostly lose their ability to negotiate safer sex (42, 46, 47). Therefore, they are prone to unwanted pregnancies, unsafe abortions, STIs and HIV/AIDS (46). Although women have greater needs, they face more barriers in access to services. This study suggests that higher level of stigma is associated with a woman who uses drugs, comparing to a male drug user. If the female drug user becomes pregnant, she will face more stigma (48). In addition, women face some specific barriers that men don’t. They are less likely to seek

services, due to housework, child care responsibilities, gender norms, disagreement of male partners and fear of losing custody of their children (41, 46, 47). They are mostly overlooked in harm reduction settings (46, 49). One of the reasons for being ignored is that, due to the inaccurate estimation of number of female PUD in developing countries (48), the experts of these countries believe that the proportion of female PUD is insignificant. Therefore, in providing services, they mostly focus on men. For instance in Pakistan, the majority of harm reduction services are specifically designed for street-based male IDUs and their spouses. However based on a study, which was conducted by United Nations Office on Drugs and Crime (UNODC), 4,632 female PUD were mapped over 13 cities of Pakistan. This can indicate the large number of these women, who are ignored and their needs are not met (48).

This study could not determine whether it is expedient to provide SRH services to PUD in separated centers or to integrate their services into the general SRH facilities. The relevant literature on separation or integration of services for PUD is not available, which implies lack of research on this subject. The conducted studies on the same subject for people who live with HIV/AIDS (PLHIV) have controversial results. Some studies suggested that provision of services in separated specialized centers will lead to higher stigma (50), while integration of services will reduce it (51-55). Some other studies have shown that PLHIV prefer to receive services at separated specialized centers (56, 57). They referred to these centers as the only safe place, where they can open up their status (58). The controversial opinions of the respondents of the study and the discussed advantages and disadvantages, led us to conclusion that in separation or integration of services in each country, the cultural and social issues in terms of public opinion on drug use and status of PUD in that society, should be taken into account. In some countries, the public might be ready to accept PUD among them. In these countries, integration of services can lead to a decrease in the level of stigma. In other countries, the public might not be ready yet and integration may lead to a higher level of stigma, which may reduce the intention of PUD to utilize services.

In this study, despite the great differences in the geographical location of the studied countries and their cultural background, various similarities were seen in the issues related to sexuality and SRH. Lack of systematic sexuality education for adolescents, obstacles in providing information and services to young adults (59-61), hesitation to discuss sexual issues and considering sexual problems as a private matter (62-65) are among issues that can be seen in most of the studied countries. Also in the context of this study, there are significant similarities in the availability and status of SRH services for PUD. This might imply the possibility of generalizing the results of this study to a wider range of countries, in terms of SRH needs of PUD and applying the recommendations provided by the

participants, in designing interventions in those countries. However in generalizing the results, one should take the specifications of each country in terms of health system, economic issues, drug-related legislations and social status of PUD into account.

The variation of the respondents of this study is one of the issues worth notifying. They were from different organizations, from local NGOs active in one or more cities, NGOs which were nationally active, regional organizations which have projects in the whole Eurasian region and International organizations, active in different countries across the globe. Moreover, the respondents had different positions within their organizations; from program managers and coordinators to outreach and social workers. This gave us the opportunity to discuss the issue from different points of view. In addition, a number of respondents were ex- or current PUD. Therefore, we received the opinions of the 'insider' population as well and they gave us a more detailed picture of their barriers in accessing services. Participation of PUD in this study enabled us to examine whether their opinion is consistent to experts' opinions.

This study had some limitations. One of the important limitations of the study was the communication barrier due to language differences. In some of the studied countries, most of the experienced experts are not able to communicate in English. This issue limited our choices. To overcome this problem, a number of former participants were recruited as translators. However, as these people were not professional interpreters, this might have affected the quality of translations.

The other limitation of this study was time limitation. The whole process of design, data collection, analysis and reporting of this study was done in five months. Due to the time limitation, it was not possible to recruit more respondents for this study. However, with this number of participants, we reached the point of saturation and no new themes or sub-themes were emerged in the last four interviews.

This study can contribute to literature, by providing a comprehensive picture of SRH needs of PUD and status of available services. We recommend more studies to be performed, on SRH requirements of PUD, specifically on the areas that less literature is available, including maternal health, sexual violence and family planning. Moreover, we recommend more studies on barriers of utilization of available SRH services and desired characteristics of services. These studies should be conducted with participation of different sub-populations within PUD, including male and female PUD, adolescents and youth.

Implications

The results of this study can be used by harm reduction and health organizations, in designing SRH services for male and female PUD, in the eight countries. However, we recommend that in designing any projects, the national legislations on drug use to be taken into account. Furthermore, in designing large-scaled service-delivery projects, we recommend examining the results of this study, by conducting needs assessments, with participation of PUD.

Acknowledgement:

I would like to thank AIDS Foundation East-West Netherlands and Mainline Foundation to give me the opportunity to conduct this study for my master thesis. I would like to extend my appreciation to Dr. Anke van dam, Executive Director of AIDS Foundation East-West, and Ms. Machteld Busz, Program Manager of International Department of Mainline for their support and technical input to this project. I would like to offer my sincerest gratitude to Dr. Lia van der Ham, my supervisor at the Vrije Universiteit (VU) of Amsterdam, for her scientific supervision during conduction of this study. My special thanks to Ms. Corie Leifer, Project and Office Manager of AIDS Foundation East-West Netherlands, for her assistance in administrative issues and in recruitment of respondents.

Furthermore, I would like to express my deepest appreciation to all respondents of this study, who kindly shared their experiences and knowledge with me. The respondents were from the following organizations:

- AIDS Foundation East-West office in Kyrgyzstan
- AIDS Foundation East-West office in Tajikistan
- AIDS Foundation East-West office in Ukraine
- Asteria Public Foundation in Kyrgyzstan
- Bemoni Public Union in Georgia
- Eurasian Harm Reduction Network (EHRN) office in Lithuania
- International Network of Women who Use Drugs (INWUD) in Australia
- Kenyan Network of People who Use Drugs (KENPUD) in Kenya
- Laras (NGO) in Indonesia
- Muslim Educational Welfare Association in Kenya
- Nai Zindagi Charity in Pakistan
- Podruga Public Foundation in Kyrgyzystan
- Rutgers WPF in Pakistan
- SPIN Plus (NGO) in Tajikistan
- Tanadgoma Center for Information and Counseling on Reproductive Health in Georgia
- Youth Vision (NGO) in Nepal

References:

1. (POPIN). Report of the International Conference on Population and Development. 18-11-1994. Report No.: A/CONF.171/13.
2. Glasier A, Gülmezoglu AM, Schmid GP, Moreno CG, Van Look PF. Sexual and reproductive health: a matter of life and death. The Lancet. 2006;368(9547):1595-607.
3. WHO. Gender and human rights- Sexual Health. WHO; 2014 [cited 16-06-2014]; Available from: http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/.
4. Becker S. Couples and reproductive health: a review of couple studies. Studies in family planning. 1996:291-306.
5. Cardia N. World report on violence and health. Bulletin of the World Health Organization. 2002;80(11):915-.
6. IGWG. Gender-Based Violence: Impediment to Reproductive Health. In: Bureau PR, editor.: Population Reference Bureau; 2010.
7. Universal Declaration of Human Righs, (1948).
8. American Declaration of the Rights and Duties of Man, (1948).
9. The European Social Charter, STE No. 163 (1996).
10. International Covenant on Economic, Social and Cultural Rights, (1966).
11. The African (BANJUL) Charter on Human and Peoples' Rights (1981).
12. WHO. The Right to Health. WHO; 2013 [cited 16-06-2014]; Available from: http://www.who.int/mediacentre/factsheets/fs323/en/.
13. UNFPA. Protecting Reproductive Rights. N.D. [cited 09-02-2014]; Available from: http://www.unfpa.org/rh/rights.htm.
14. United Nations. Report of the Fourth World conference on women. New York: 1996 Contract No. A/CONF.177/20/Rev.1.
15. European Convention on Human RIghts, (2010).
16. AIDS Fonds. People who Use Drugs. Netherlands n.d [cited 04-07-2014]; Available from: http://www.hivgaps.org/key-populations/people-who-use-drugs/.
17. Encyclopedia ADAMM. Substance abuse; Illicit drug abuse; Narcotic abuse; Hallucinogen abuse. PubMed Health; 2014 [updated 08-02-2013; cited 10-03-2014]; David B. Merrill, MD:[Available from: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002670/.
18. National Institue on Drug Abuse. Rates of HIV infection are converging in drug abusers who inject drugs and those who do not inject. Addiction Science: From Molecules to Managed Care [Internet]. 2008 [cited 17-02-2014].
19. Surratt HL, Inciardi JA, Kurtz SP, Kiley MC. Sex work and drug use in a subculture of violence. Crime & Delinquency. 2004;50(1):43-59.
20. Blume SB. Chemical dependency in women: Important issues. The American journal of drug and alcohol abuse. 1990;16(3-4):297-307.
21. Marsh KL, Simpson DD. Sex differences in opioid addiction careers. The American journal of drug and alcohol abuse. 1986;12(4):309-29.
22. Schempf AH, Strobino DM. Illicit drug use and adverse birth outcomes: is it drugs or context? Journal of Urban Health. 2008;85(6):858-73.
23. Indian HIV/AIDS Alliance. HIV/SRHR integration for People who Use Drugs. In: India, editor: India HIV/AIDS Alliance; 2012.
24. Keegan J, Parva M, Finnegan M, Gerson A, Belden M. Addiction in pregnancy. Journal of Addictive Diseases. 2010;29(2):175-91.
25. Einarson A, Riordan S. Smoking in pregnancy and lactation: a review of risks and cessation strategies. European journal of clinical pharmacology. 2009;65(4):325-30.
26. Pinkham ASS. Technical report: Women and Harm reduction in Central Asia. USAID, 2011.
27. Poland ML, Dombrowski MP, Ager JW, Sokol RJ. Punishing pregnant drug users: enhancing the flight from care. Drug and alcohol dependence. 1993;31(3):199-203. 29

28. AIDS Fonds. About us. Netherlands n.d [04-07-2014]; Available from: http://www.hivgaps.org/about/our-partners/.
29. Marshall MN. The key informant technique. Family practice. 1996;13(1):92-7.
30. Warheit GJ, Buhl JM, Bell RA. A critique of social indicators analysis and key informants surveys as needs assessment methods. Evaluation and program planning. 1978;1(3):239-47.
31. Perkins J, Sanson-Fisher R, Girgis A, Blunden S, Lunnay D. The development of a new methodology to assess perceived needs among indigenous Australians. Social Science & Medicine. 1995;41(2):267-75.
32. Patton MQ. Qualitative evaluation and research methods: SAGE Publications, inc; 1990.
33. Tongco MDC. Purposive sampling as a tool for informant selection. 2007.
34. Sofaer S. Qualitative methods: what are they and why use them? Health services research. 1999;34(5 Pt 2):1101.
35. Boyce C, Neale P. Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input: Pathfinder International Watertown, MA; 2006.
36. Rabiee F. Focus-group interview and data analysis. Proceedings of the nutrition society. 2004;63(04):655-60.
37. Wong LP. Focus group discussion: a tool for health and medical research. Singapore Med J. 2008;49(3):256-60.
38. Power R. The application of qualitative research methods to the study of sexually transmitted infections. Sexually transmitted infections. 2002;78(2):87-9.
39. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative research in psychology. 2006;3(2):77-101.
40. Guest G, MacQueen K, Namey E. Introduction to Applied Thematic Analysis. Applied Thematic Analysis. 2012:3-18.
41. Deacon H. Towards a sustainable theory of health-related stigma: lessons from the HIV/AIDS literature. Journal of community & applied social psychology. 2006;16(6):418-25.
42. Volkow ND, Li T-K. Drug addiction: the neurobiology of behaviour gone away. Nature Reviews Neuroscience. 2004;5(12):963-70.
43. UNODC. Providing services to pregnant drug users in low-resource settings. Pakistan country office: UNODC; n.d
44. Burns K. Women, Harm Reduction, and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine: Open Society Institute; 2010.
45. Pinkham S, Shapoval A. Making Harm Reduction Work for Women: The Ukrainian Experience: Open Society Institute, Public Health Program; 2010.
46. Dvinskykh LSATASN. Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users. Ukraine: International HIV/AIDS Alliance in Ukraine, 2011.
47. Gaventa M. Keeping women who use drugs healthy- Case study. Ukraine: International HIV/AIDS Alliance, 2013.
48. Pinkham S, Malinowska-Sempruch K. Women, harm reduction and HIV. Reproductive health matters. 2008;16(31):168-81.
49. UNODC Pakistan. Female Drug Use in Pakistan, Mapping Estimates, Ethnographic Results & Behaviourial Assessment. Pakistan: , 2010.
50. Mill JE, Edwards N, Jackson RC, MacLean L, Chaw-Kant J. Stigmatization as a social control mechanism for persons living with HIV and AIDS. Qualitative Health Research. 2010;20(11):1469-83.
51. Osborne C, Van Praag E, Jackson H. Models of care for patients with HIV/AIDS. AIDS (London, England). 1996;11:S135-41.
52. Criel B, De Brouwere V, Dugas S. Integration of vertical programmes in multi-function health services: ITG Press Amberes; 1997. 30

53. Matovu JK, Makumbi FE. Expanding access to voluntary HIV counselling and testing in sub-Saharan Africa: alternative approaches for improving uptake, 2001–2007. Tropical Medicine & International Health. 2007;12(11):1315-22.
54. Bradley H, Bedada A, Tsui A, Brahmbhatt H, Gillespie D, Kidanu A. HIV and family planning service integration and voluntary HIV counselling and testing client composition in Ethiopia. AIDS care. 2008;20(1):61-71.
55. Tollman SM, Kahn K, Sartorius B, Collinson MA, Clark SJ, Garenne ML. Implications of mortality transition for primary health care in rural South Africa: a population-based surveillance study. The Lancet. 2008;372(9642):893-901.
56. EngenderHealth U. Sexual and reproductive health needs of women and adolescent girls living with HIV: research report on qualitative findings from Brazil, Ethiopia and the Ukraine, July 2006. New York: EngenderHealth. UNFPA; 2006.
57. Saha A, Sellers T, Panda M, Bidla R, Khan I. Options and challenges for converging HIV and sexual and reproductive health services in India. Findings from an assessment in Andhra Pradesh Bihar Maharashtra and Uttar Pradesh.
58. Sayles JN, Ryan GW, Silver JS, Sarkisian CA, Cunningham WE. Experiences of social stigma and implications for healthcare among a diverse population of HIV positive adults. Journal of Urban Health. 2007;84(6):814-28.
59. Talpur AA, Khowaja AR. Awareness and attitude towards sex health education and sexual health services among youngsters in rural and urban settings of Sindh, Pakistan. Education. 2012;62(708).
60. Handrio. Sex Education in Indonesia: Understanding the Problems. Worldpress; 2011 [06-07-2014]; Available from: http://handrionurhan.wordpress.com/2011/05/31/sex-education-in-indonesia-understanding-the-problems/.
61. UNFPA. Adolescent pregnancy in Eastern Europe and Central Asia. Istanbul, Turkey: 2013.
62. Colombini M, Mayhew SH, Rechel B. Sexual and reproductive health needs and access to services for vulnerable groups in Eastern Europe and Central Asia. 2011.
63. Ranjha SM, Hussain A. Sexual health services for adolescents at sex clinics in Rawalpindi Pakistan. 2003.
64. Adhikari R, Tamang J. Premarital sexual behavior among male college students of Kathmandu, Nepal. BMC Public Health. 2009;9(1):241.
65. Ancker S, Rechel B, McKee M, Spicer N. Kyrgyzstan: still a regional 'pioneer'in HIV/AIDS or living on its reputation? Central Asian Survey. 2013;32(1):66-84.

Annex 1: theoretical background of the study