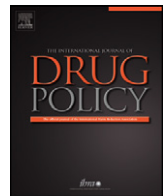




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Short report

Expanding the reach of harm reduction in Thailand: Experiences with a drug user-run drop-in centre

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ABSTRACT

Background: Despite an ongoing epidemic of HIV among Thai people who inject drugs (IDU), Thailand has failed to implement essential harm reduction programmes. In response, a drug user-led harm reduction centre opened in 2004 in an effort to expand reduction programming in Thailand.

Methods: We examined experiences with the Mitsampan Harm Reduction Centre (MSHRC) among IDU participating in the Mitsampan Community Research Project (Bangkok). Multivariate logistic regression was used to identify factors associated with MSHRC use. We also examined services used at and barriers to the MSHRC.

Results: 252 IDU participated in this study, including 66 (26.2%) females. In total, 74 (29.3%) participants had accessed the MSHRC. In multivariate analyses, MSHRC use was positively associated with difficulty accessing syringes (Adjusted Odds Ratio [AOR] = 4.05; 95% Confidence Interval [CI]: 1.67–9.80), midazolam injection (AOR = 3.25; 95%CI: 1.58–6.71), having greater than primary school education (AOR = 1.88; 95%CI: 1.01–3.52), and was negatively associated with female gender (AOR = 0.20; 95%CI: 0.08–0.50). Forms of support most commonly accessed included: syringe distribution (100%), food and a place to rest (83.8%), HIV education (75.7%), and safer injecting education (66.2%). The primary reason given for not having accessed the MSHRC was “didn't know it existed.”

Conclusion: The MSHRC is expanding the scope of harm reduction in Thailand by reaching IDU, including those who report difficulty accessing sterile syringes, and by providing various forms of support. In order to maximise its benefits, efforts should be made to increase awareness of the MSHRC, in particular among women.

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Introduction

Injection drug use continues to be a driving factor in the global HIV/AIDS pandemic. Although a large body of research supports the application of harm reduction programmes such as needle exchanges and methadone maintenance (World Health Organization, 2006), these programmes remain controversial, and coverage of such programmes remains low. For instance, a report by the Global HIV Prevention Working Group estimates that only 8% of injection drug users (IDU) globally have access to proven HIV prevention services – the lowest rate for any group highly vulnerable to HIV/AIDS (Global HIV Prevention Working Group, 2007).

Although Thailand has experienced a longstanding epidemic of HIV among IDU, policy makers have been slow to imple-

ment evidence-based harm reduction programmes (Human Rights Watch, 2007). In response, a group of drug users opened a drug user-run drop-in centre in Bangkok, with the goal of providing harm reduction programmes to local IDU. Previous studies from diverse settings have documented the evolution of drug user organisations (Anker, 2007; Crofts & Herkt, 1993; Friedman et al., 1987; Kerr, Small, Peeace, Pierre, & Wood, 2006) and indicated that drug user-led initiatives are effective in addressing gaps in services (Broadhead et al., 1998) and in extending the reach of harm reduction programmes (Grund et al., 1992). However, little is known about drug user-led initiatives outside of North America, Europe, and Australia. Therefore, we sought to describe the experiences of Thai IDU with a drug user-led harm reduction centre in Bangkok.

The Mitsampan Harm Reduction Centre (MSHRC)

The Mitsampan Harm Reduction Centre (MSHRC) opened in 2004 with funding from the Global Fund to Fight HIV/AIDS, Malaria

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and Tuberculosis (Kerr, Kaplan, Suwannawong, Jurgens, & Wood, 2004). The MSHRC was opened by the Thai Drug Users Network in collaboration with the Thai AIDS Treatment Action Group (TTAG). When the grant from the Global Fund expired in 2008, TTAG assumed oversight of the MSHRC, which continued to be operated by local drug users. The MSHRC is open 6 days a week from 10 am to 7 pm, and provides various forms of support, including sterile syringe distribution, food and peer support, information (e.g., where to access health services) and education (e.g., safer injecting, overdose prevention). There are approximately 25–30 visits per day (or 500–600 visits per month) to the MSHRC. There is one full-time employee who oversees the MSHRC, and on any given day approximately two volunteers are working at MSHRC in various capacities (e.g., cooking, providing syringe exchange or peer support programming).

Methods

The Mitsampan Community Research Project (MSCRP) is a collaborative research project involving the British Columbia Centre for Excellence in HIV/AIDS (Vancouver, Canada), the Mitsampan Harm Reduction Centre (Bangkok, Thailand), the Thai AIDS Treatment Action Group (Bangkok, Thailand), and Chulalongkorn University (Bangkok, Thailand). During July–August 2008, the partners undertook a cross-sectional study involving 252 community-recruited IDU. Potential participants were recruited through peer-based outreach efforts and word of mouth. Study participants were invited to attend the Mitsampan Harm Reduction Centre to participate in the study. All participants provided informed consent and completed an interviewer-administered questionnaire eliciting information about demographic charac-

teristics, drug use, HIV risk behaviour, criminal justice system exposure, and experiences with health care. The questionnaire was administered by a team of peer-researchers (i.e., current and former IDU) who underwent extensive training. The peer research team was selected to match the demographic characteristics of the IDU who visit the MSHRC (e.g., the team included men, women, and one transgendered individual). All participants were given 250 Baht (approximately \$7 USD) upon completion of the questionnaire. The study has been approved by the Research Ethics Boards of the University of British Columbia and Chulalongkorn University.

Using univariate statistics and multivariate logistic regression, we compared IDU who had and who had not accessed the MSHRC previously. Variables considered included: median age, gender, education level (<secondary school vs. ≥secondary school), heroin injection in the last 6 months (yes vs. no), methamphetamine injection in the last 6 months (yes vs. no), midazolam injection in the last 6 months (yes vs. no), history of non-fatal overdose (yes vs. no), history of difficulty accessing syringes (yes vs. no), history of sex trade involvement (yes vs. no), and history of incarceration (yes vs. no). To examine the bivariate associations, we used the Pearson χ^2 -test. Fisher's exact test was used when one or more cells contained values less than or equal to five. We then examined factors independently associated with a history of MSHRC use by fitting a multivariate logistic regression model that included all variables that were associated with MSHRC use at the $p \leq 0.05$ level in univariate analyses. All p -values were two-sided. We also asked participants who had been to the MSHRC previously to indicate what types of support they had received at the MSHRC. Further, we asked participants who had not been to the MSHRC to indicate why they had never been there.

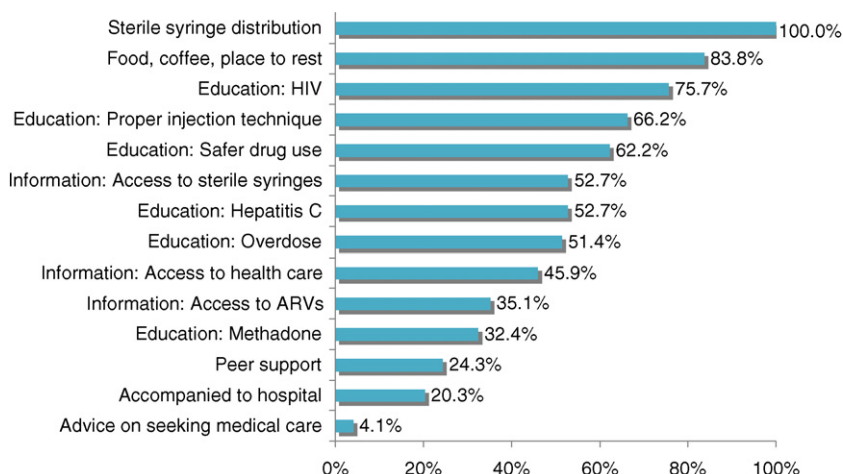
Table 1
Factors associated with access to Mitsampan Harm Reduction Centre among IDU ($n = 252$).

Characteristic	Yes 29.3 (%) $n = 74$	No 70.7 (%) $n = 178$	Odds Ratio (95%CI)	p -Value
Median age				
<36.5 years	35 (47)	91 (51)	0.86 (0.50–1.48)	0.580
≥36.5 years	39 (53)	87 (49)		
Gender				
Female	6 (8)	60 (34)	0.17 (0.07–0.42)	<0.001
Male	68 (92)	118 (66)		
Education				
≥Secondary	57 (77)	102 (57)	2.50 (1.35–4.63)	0.003
<Secondary	17 (23)	76 (43)		
Heroin injection				
Yes	70 (95)	160 (90)	1.97 (0.64–6.03)	0.327
No	4 (5)	18 (10)		
Yaba (methamphetamine) injection				
Yes	47 (64)	98 (55)	1.26 (0.81–2.42)	0.263
No	27 (36)	80 (45)		
Midazolam injection				
Yes	62 (84)	104 (58)	4.67 (1.85–7.30)	<0.001
No	12 (16)	74 (42)		
Experienced difficulty accessing sterile syringes				
Yes	17 (23)	13 (7)	3.79 (1.73–8.28)	<0.001
No	57 (77)	165 (93)		
Ever overdosed				
Yes	26 (35)	49 (28)	1.43 (0.80–2.55)	0.229
No	48 (65)	129 (72)		
Ever in prison				
Yes	57 (77)	140 (79)	0.91 (0.48–1.74)	0.776
No	17 (23)	38 (21)		
Ever involved in sex trade				
Yes	6 (8)	25 (14)	0.54 (0.21–1.38)	0.191
No	68 (92)	153 (86)		

Drug use behaviours refer to the last 6 months.

Table 2Multivariate logistic regression analysis of factors associated with access to the MSHRC among IDU ($n = 252$).

Characteristic	Adjusted Odds Ratio (AOR)	95% Confidence Interval (CI)	p-Value
Gender (female vs. male)	0.20	0.08–0.50	<0.001
Education (\geq secondary vs. <secondary)	1.88	1.01–3.52	0.050
Ever injected midazolam (yes vs. no)	3.25	1.58–6.71	<0.001
Experienced difficulty accessing sterile syringes (yes vs. no)	4.05	1.67–9.80	0.002

**Fig. 1.** Services and support accessed by IDU at the Mitsampan Harm Reduction Centre, Bangkok ($n = 74$).

Results

In total, 252 IDU participated in this study, including 66 (26.2%) females. The median age of participants was 36.5 years (range = 19–70 years). In total, 74 (29.3%) participants reported that they had accessed the MSHRC previously. As indicated in Table 1, in univariate analyses, factors positively associated with MSHRC use included having greater than primary school education (Odds Ratio [OR] = 2.50, 95% Confidence Interval [CI]: 1.35–4.63), midazolam injection (OR = 4.67, 95%CI: 1.85–7.30), and reporting difficulty accessing syringes (OR = 3.79, 95%CI: 1.73–8.28). Female gender (OR = 0.17, 95%CI: 0.07–0.42) was negatively associated with MSHRC use. As indicated in Table 2, in multivariate analyses, MSHRC use was positively associated with difficulty accessing syringes (Adjusted Odds Ratio [AOR] = 4.05; 95%CI: 1.67–9.80), midazolam injection (AOR = 3.25; 95%CI: 1.58–6.71), having greater than primary school education (AOR = 1.88; 95%CI: 1.01–3.52), and was negatively associated with female gender (AOR = 0.20; 95%CI: 0.08–0.50). As shown in Fig. 1, among the 74 participants who had attended the MSHRC, the forms of support most commonly accessed included: syringe distribution (100%), food and a place to rest (83.8%), HIV education (75.7%), safer injecting education (66.2%), information about safer drug use (62.2%), and information about where to access sterile syringes (52.7%). Among the 178 participants who had not been to the MSHRC previously, the primary reason given for not accessing the MSHRC previously was “didn’t know it existed” (82.6%). Other reasons given included: “didn’t know where to go” (15.7%); “too far from where I live” (15.2%); and “fear that information concerning drug use could be shared with police” (3.9%) (values add up to >100% as participants could provide more than one reason).

Discussion

In the present analysis, we found that approximately 30% of a community-recruited sample of IDU in Bangkok had accessed the drug-user run Mitsampan Harm Reduction Centre (MSHRC). Participants who had accessed the MSHRC were more likely to report

having greater than a primary school education, midazolam injection, and difficulty accessing sterile syringes. Female gender was negatively associated with MSHRC access. Forms of support most commonly received included syringe distribution, food and a place to rest, HIV education, safer injecting education, information about safer drug use and places to access sterile syringes. The primary reason given for not previously accessing the MSHRC was “didn’t know it existed.”

Consistent with previous studies focused on drug user-led programs (Broadhead, Heckathorn, Grund, Stern, & Anthony, 1995; Broadhead et al., 1998; Friedman et al., 2004; Grund et al., 1992; Kerr et al., 2006), our findings suggest that the MSHRC has succeeded in extending the reach and scope of harm reduction programming in Bangkok. The forms of support offered at the MSHRC are not widely available in Thailand and have not been supported by the Thai government (Human Rights Watch, 2007). Given the high rates of syringe sharing observed previously among Thai IDU (Perngmark, Vanichseni, & Celentano, 2008), it is significant the MSHRC is attracting individuals who experience difficulty accessing sterile syringes, and is providing them sterile syringes as well as information about where to access sterile syringes. Previous studies (Wood et al., 2002), including studies recently undertaken in Thailand (Perngmark, Celentano, & Kawichai, 2003), have found that difficulty in accessing syringes is strongly associated with syringe sharing. At present, the MSHRC appears to be having less success in reaching women and individuals with lower levels of education, which is of particular concern given the elevated rates of HIV risk behaviour and infection observed among female IDU in various settings (Breen, Roxburgh, & Degenhardt, 2005; Maher et al., 2001; Spittal et al., 2002). Future efforts should focus on promoting access to the MSHRC among women and individuals with lower levels of education, through various methods, including peer outreach. The primary reason for not attending the MSHRC was “didn’t know it existed.” This dynamic may be reflective of the broader policy environment, which favours aggressive law enforcement and coercion over harm reduction. Within this environment, advertising the MSHRC may prove to be difficult, and it may be that few health care professionals are referring IDU to this programme. Future outreach

efforts should be made to increase awareness of the MSHRC and the forms of support offered there among the IDU community in Bangkok.

This study has limitations. Specifically, because the study was undertaken at the MSHRC, we may have overestimated the true proportion of the local IDU community that had accessed the centre. However, great efforts were made to recruit local IDU into our study through outreach and word of mouth, including those IDU who had not previously attended the MSHRC. Further, the study sample was not randomly selected and therefore may not be representative of local IDU or IDU populations in other settings.

In summary, we found that the drug user-led Mitsampan Harm Reduction Centre in Bangkok has succeeded in reaching local IDU and in expanding the scope of harm reduction programming in Bangkok. Given the persistent lack of support for harm reduction in Thailand, and the extreme stigma and discrimination experienced by drug users in this setting (Amnesty International, 2003), efforts should be made to ensure continued support for this programme and others like it.

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