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Treatment and Care for Injecting Drug Users with HIV Infection: A Review of Barriers and Ways Forward

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ABSTRACT

Injecting Drug Use continues to pose a significant public health challenge, especially in the context of HIV transmission. People who inject drugs (PWID) are disproportionately affected by the HIV epidemic due to a complex interplay of biological, behavioral, and structural factors. Despite advancements in antiretroviral therapy and harm reduction programs, barriers such as stigma, criminalization, lack of access to integrated care, and psychosocial vulnerabilities persist. This study explores the treatment and care landscape for injecting drug users living with HIV by adopting a qualitative approach, combining narrative and systematic literature reviews with primary field engagement through focus group discussions and one-on-one counselling sessions involving ten HIV-positive injecting drug users. The findings reveal multiple treatment barriers, including healthcare discrimination, limited harm reduction services, and lack of psychosocial support. However, the study also highlights potential facilitators, such as peer-driven models, community-based outreach, and integrated care strategies. These insights emphasize the urgent need for rights-based, person-centered approaches to improve healthcare outcomes and quality of life for this vulnerable population.

Through this research, the paper contributes to the ongoing dialogue on HIV prevention and care, with a focus on **harm reduction**, **treatment barriers**, and **psycho-social care** tailored to the needs of **injecting drug users living with HIV**.

Introduction

In the quiet corners of society—where syringe clinks echo louder than conversations—lives a community often unseen by mainstream healthcare. People who inject drugs (PWID), particularly those living with HIV, exist at the intersection of two deeply stigmatized identities: drug user and HIV-positive. Globally, this group has been fighting an uphill battle against not just a virus, but a world that often chooses to look away. Injecting drug use continues to be a major driver of new HIV infections, especially in low-income and middle-income countries where prevention and care systems are fragmented. The complex nature of HIV transmission among injecting drug users is rooted in overlapping vulnerabilities—socioeconomic exclusion, lack of harm reduction services, poor mental health access, and sometimes, sheer policy negligence (Quinn, 2021).

According to the **UNAIDS 2023** report, about 9% of all new HIV infections globally are associated with unsafe injecting practices. This figure may not sound overwhelming until you break it down regionally. In Eastern Europe and Central Asia, for instance, injecting drug use is the leading route of HIV transmission. The mechanism is brutally straightforward—sharing of unsterile needles, reusing contaminated injecting paraphernalia, and injecting in hidden, unhygienic environments all contribute to direct blood-borne transmission. Springer (2023) reflects on this with a certain frustration, noting that despite available technology and treatment, public health systems often fail to “meet people where they are,” thus missing opportunities for early intervention and sustained care.

In many nations, particularly those still leaning toward punitive drug laws, “zero tolerance” policies remain entrenched. These laws criminalize possession, consumption, and even association with drugs, inadvertently pushing users deeper underground. It’s ironic—the policies meant to curb addiction often make treatment harder to access. People fear arrest more than they fear the virus. Many avoid clinics, skip testing, or disengage from treatment altogether just to escape being labeled or jailed (Hodder et al., 2021). The stigma becomes institutionalized, seeping into hospital hallways, medical records, and even the language of healthcare providers. Gleason et al. (2022) describe this chillingly in their qualitative study during the COVID-19 pandemic, where patients reported being denied basic care or spoken to as if they were already lost causes.

India, while progressive in parts of its national HIV policy, still grapples with these overlapping barriers. Cities like Delhi, Imphal, and Chandigarh report high prevalence rates of HIV among injecting drug users. Yet harm reduction interventions like needle-syringe programs (NSPs) and opioid substitution therapy (OST) are unevenly distributed, often poorly funded, and carry their own stigmas. Ramasamy et al. (2024) discuss how the ambitious goal of eliminating viral hepatitis and HIV by 2030 in Southeast Asia is threatened by policy gaps and weak health infrastructure. When you add injecting drug use into the mix, the challenge multiplies.

But it’s not just about laws or logistics. There's a deeper problem—a systemic blind spot. Medical training rarely includes modules on treating PWID with empathy. Social welfare programs don’t integrate substance use into their planning. And most importantly, people who inject drugs themselves are rarely involved in shaping the services designed for them. This leads to a broken pipeline of care, where those who need the most support fall through the cracks.

This study seeks to confront that blind spot. Using a qualitative review approach supplemented by field engagement—through focus group discussions and individual counselling—it investigates the lived realities of ten HIV-positive injecting drug users. It aims to document not just their medical needs, but also their fears, perceptions, and the obstacles they face when navigating the healthcare system. As noted by Haldane et al. (2022), integrating substance use services with HIV care is not just a clinical need but a human rights imperative.

The objective is clear: to uncover the barriers and propose practical, grounded ways forward. But beyond that, this research is an attempt to shift the narrative—from criminality to care, from punishment to public health. Because in the end, the story of HIV among injecting drug users isn’t just about infection or treatment. It’s about visibility, dignity, and the stubborn hope that a better model of care is possible.

Literature Review

The experience of being an injecting drug user living with HIV is not just a medical journey—it’s a human rights struggle. For decades, rights-based approaches to healthcare have been sidelined when it comes to marginalized groups, particularly those involved in substance use. Despite numerous declarations, policies, and promises, IDUs are still left behind in the global healthcare dialogue. Legal systems that criminalize drug use often lead to fear-driven healthcare avoidance. Individuals refuse testing, delay treatment, or avoid hospitals entirely to escape the social and legal repercussions attached to their lifestyle. In the context of public health, these are not merely human rights violations—they're missed opportunities to curb epidemics. Brothers et al. (2023) underscore that the social and structural determinants—like housing instability, incarceration, and healthcare discrimination—directly influence the clinical outcomes of IDUs, especially when bacterial and fungal infections co-occur with HIV.

Then comes the next layer: the clinic. Not all stigma is born in the streets. Much of it seeps into hospital wards, waiting rooms, and registration desks. Medical professionals, despite their training, often lack both the tools and the temperament to deal with IDUs compassionately. For a population that's already facing internalized shame, the clinical encounter can feel like a punishment rather than care. Hill et al. (2023) point out that integrated care models—where HIV services are merged with substance use treatment—are still in early stages of adoption, and even where they exist, the coordination between departments is often shaky. Patients, instead of receiving a seamless care experience, are made to navigate fragmented systems that require multiple visits, repeated disclosures, and redundant paperwork. And for someone managing addiction, mental health issues, and HIV, that can be overwhelming.

Global research suggests that harm reduction isn't just a theory—it works. Needle and syringe programs (NSPs), opioid substitution therapies (OST), and antiretroviral treatment (ART) have shown real-world impact in reducing HIV transmission and improving quality of life for IDUs. For example, Gunn et al. (2021) documented how secondary NSPs could still provide a meaningful point of contact for underserved populations who avoid formal health settings. These programs do more than just reduce infection—they create an environment where users can gradually regain trust in healthcare. Winiker et al. (2023) add nuance by exploring the barriers to treatment services in rural USA, identifying transportation, staff shortages, and moralistic provider attitudes as significant hurdles. This shows us that even in high-resource countries, harm reduction needs deliberate, culturally sensitive planning.

But interventions only succeed when they are tailored—not just in design, but also in delivery. Uniform strategies fail when they don't account for local realities. In countries like India, where socio-cultural stigma intersects with limited health resources, models must be adaptive. Haldane et al. (2022) argue that the future lies in person-centred care models grounded in human rights principles. These frameworks shift the focus from disease management to dignity restoration. It's about asking: what does this person need to thrive, not just survive? Do they have food? Shelter? Do they trust their doctor? These questions, often seen as "outside the scope" of medicine, are in fact the heart of effective intervention.

However, the literature is far from complete. While we have meta-analyses, systematic reviews, and clinical guidelines, there's still a glaring absence of voices from the ground—especially from those in developing countries. Most studies focus on measurable outcomes: CD4 counts, viral loads, and adherence percentages. What's missing is the lived experience. The story behind the numbers. Alum et al. (2024) emphasize that advancing HIV treatment must go beyond the pharmacological; it should embrace social healing, trauma-informed care, and long-term support systems. There's a serious gap in understanding how daily life—poverty, relationships, job loss, and even religion—intersects with drug use and HIV treatment.

In fact, this very void is what motivates this present study. While global literature has offered models and frameworks, and some countries have piloted successful integration schemes, the question remains—how do these models translate into reality for someone living in Bhubaneswar or Dimapur or Agartala? Do they feel seen, heard, treated with respect? Goodyear et al. (2021) explored patient perspectives on evolving Hepatitis C treatments among IDUs and found that emotional readiness, provider empathy, and service flexibility mattered as much as the medication itself. These soft variables rarely make it into policy documents but often determine success or failure on the ground.

This review aims to bring these dimensions into the conversation. Drawing from international studies, clinical reviews, and on-ground insights from focus groups and counselling sessions, it builds a comprehensive picture of where we are and what needs to change. Gleason et al. (2022) remind us that crises like the COVID-19 pandemic only magnify these vulnerabilities, yet they also offer a chance to rethink, to rebuild with compassion. As the field advances, it's clear that treatment for IDUs living with HIV cannot be isolated within the four walls of a clinic—it must be embedded in society, policy, and everyday humanity.

Research Objectives

This research seeks to explore the often-overlooked realities of HIV-positive injecting drug users (IDUs) by investigating how treatment and care are structured, delivered, and experienced in both institutional and informal settings. While a significant body of global literature focuses on clinical protocols and pharmacological progress, this study shifts attention toward the human experience—how IDUs interact with the healthcare system, the social networks they rely on, and the barriers that shape their decisions.

The first objective is to **understand the treatment and care pathways available** to HIV-positive IDUs within the existing healthcare framework. This includes analyzing the accessibility and responsiveness of harm reduction services such as antiretroviral therapy (ART), opioid substitution therapy (OST), and needle-syringe exchange programs. By mapping both formal and informal care avenues, the research aims to identify how these services are used, how trust is built or broken, and what gaps persist despite programmatic availability.

The second objective is to **identify the psychological, medical, and systemic barriers** that hinder continuous and effective care for this vulnerable group. Through qualitative engagement—including focus group discussions and one-to-one counselling sessions—the study captures real-life challenges such as provider bias, stigma, mental health comorbidities, legal concerns, and structural disconnects between addiction services and HIV treatment. This exploration brings depth to the clinical statistics, grounding abstract terms like “retention in care” and “adherence” in the lived experiences of actual individuals.

The third and final objective is to **develop actionable recommendations** rooted in both international best practices and the specific socio-cultural context of the study setting. These recommendations aim to inform policy, improve psycho-social support mechanisms, and propose integrative care models that prioritize dignity, autonomy, and long-term well-being. The hope is not only to reduce harm but also to reframe how public health systems approach the treatment of IDUs—from a model of control to one of compassion and rights-based care.

Methodology

This study was conducted using a **qualitative exploratory research design**, appropriate for capturing the complex, layered experiences of injecting drug users (IDUs) living with HIV. Unlike quantitative models that seek measurable patterns, the purpose here was to delve into the emotional, social, and structural dimensions that influence treatment and care among this highly stigmatized population. The nature of the inquiry demanded openness, empathy, and responsiveness to real human narratives.

A dual approach was followed: first, a **comprehensive literature review** combining both systematic and narrative methods; and second, **direct engagement with participants** through primary fieldwork. This combination allowed for both depth and breadth—a structured understanding of global and regional best practices, and a contextual view grounded in lived experience.

For the literature component, over ten academic databases were searched including **PubMed**, **Cochrane CENTRAL**, **PsycINFO**, **CINAHL**, **Web of Science**, and others. A total of **20 peer-reviewed sources** were shortlisted for relevance, from which **12 studies were finally selected** based on alignment with the study objectives, thematic consistency, and quality of data. These included systematic reviews, longitudinal studies, and qualitative papers addressing barriers to HIV care, harm reduction, and psychosocial support for IDUs.

Complementing this was the primary fieldwork involving **Focus Group Discussions (FGDs)** and **one-to-one counselling sessions**. The FGDs created a shared space for participants to discuss challenges, emotions, and coping strategies collectively, allowing patterns to emerge through group dynamics. In contrast, the individual counselling sessions allowed participants to speak openly about personal experiences that might not surface in group settings—such as fear of discrimination, trauma, or distrust in the system.

The study sample consisted of **ten HIV-positive injecting drug users**, selected through purposive sampling. The **inclusion criteria** required participants to be between **25 and 45 years of age**, with **confirmed HIV-positive status**, and an active or recent history of injecting drug use. Participants with **serious physical or psychological co-morbidities**—such as untreated psychosis or chronic organ failure—were **excluded**, not to disregard their voices, but to ensure the safety and coherence of the counselling environment.

Strict attention was paid to **ethical considerations** throughout the process. **Informed consent** was obtained from each participant, with full assurance of **confidentiality and voluntary participation**. Discussions were conducted in a **non-judgmental, supportive environment**, ensuring that participants felt safe to express themselves without fear of being labeled or reported. No personal identifiers were recorded, and all qualitative data was anonymized during analysis.

This combined methodology—anchored in both global scholarship and grounded human interaction—ensured that the findings would be not only academically valid but also socially relevant. It is through this integration of literature and life stories that the study aims to offer meaningful insights into improving care for HIV-positive injecting drug users.

Findings

Stigma and Social Isolation: A Hidden Wall Between Illness and Treatment

One of the most dominant themes emerging from both literature and field interactions is **the crippling impact of stigma and social isolation** on healthcare access for HIV-positive injecting drug users (IDUs). Almost every participant in the study, whether during group discussions or private counselling, expressed a lingering fear of judgment—not just from society at large, but also from those expected to care for them. This fear doesn’t stem only from being HIV-positive, nor solely from being a drug user. It's the combination of both identities that marks them doubly in the eyes of others.

Several participants shared stories of being humiliated at clinics, talked down to by health workers, or outright denied services once their drug use history was disclosed. In some cases, even family members distanced themselves, pushing individuals into further isolation. These aren’t just emotional wounds; they are barriers that actively prevent people from seeking treatment. It was noted in the FGD sessions that even when ART or harm reduction services were available nearby, some chose not to access them out of fear of being seen by someone they knew. One participant said, “I'd rather stay sick than stand in line and have everyone look at me like I'm garbage.”

This isn’t a localized phenomenon. International research mirrors this experience. In a powerful qualitative analysis, Gleason et al. (2022) revealed how people who inject drugs were treated as second-class citizens during the COVID-19 pandemic, often receiving delayed care or being deprioritized for treatment. The stigma was so deeply embedded that even medical decisions seemed colored by it. Such treatment only reinforces self-isolation, leading individuals to stop trusting institutions altogether.

In counselling sessions, participants often internalized this stigma. They spoke with guilt, shame, and a sense of unworthiness. One man, in his early thirties, described how the only time he felt visible was when being handcuffed. For him, the hospital was not a place of healing but a place of fear. This mindset affects everything—from adherence to treatment, to willingness to return for follow-ups, to basic survival choices like nutrition or hygiene.

Social isolation wasn't always a result of overt rejection. Sometimes, it was structural—being excluded from employment, housing, or community services simply because of known drug use or HIV status. Without support networks, most IDUs relied on peer groups that themselves were struggling, further limiting their chances of stable recovery or healthcare engagement.

Access to Healthcare: Policy Gaps, Broken Systems, and the Cost of Being Sick

For many HIV-positive injecting drug users (IDUs), the phrase “healthcare access” feels like a cruel irony. The system, in theory, exists to help them—but in practice, it often closes more doors than it opens. During focus group discussions and personal counselling sessions, a clear and recurring concern emerged: **healthcare services may be physically present, but they are far from accessible—**

particularly when it comes to affordability, bureaucracy, and policy restrictions that don't account for the chaotic, unpredictable lives of people who use drugs.

Several participants described a sense of defeat not because care wasn't available, but because the path to that care was so convoluted, unwelcoming, or expensive that it became unreachable. Clinics often required multiple documents, proof of address, or repeated visits on fixed dates—things many IDUs struggle to manage due to housing instability, addiction cycles, or informal employment. One participant put it bluntly: “I don't have the papers they ask for. I don't have an ID. Does that mean I don't deserve to get treated?”

Even when services like ART were technically free under public health schemes, indirect costs—like transportation, time off from work, and prescription supplements—created substantial barriers. In some government facilities, wait times were long, staff were overworked, and follow-up systems poorly coordinated. Patients were referred from one department to another, with little explanation or empathy, often resulting in dropped cases or untreated complications.

From a structural perspective, policies haven’t kept pace with the real needs of high-risk populations. Surratt et al. (2022), in their work with rural syringe service clients, found that despite the intention behind harm reduction programs, most service points failed to provide integrated care. Mental health support, HIV testing, substance use counselling, and primary care were all offered separately—forcing clients to navigate a fragmented system where each service worked in a silo. The result? People fall through the cracks.

India’s urban and peri-urban health settings reflect this same problem. In the fieldwork conducted for this study, it became clear that while ART centers exist in many districts, the outreach required to connect IDUs to those centers is lacking. Moreover, services like OST (opioid substitution therapy) are often clubbed with rigid attendance requirements or moralistic lectures that alienate users. Affordability, though often viewed only in terms of monetary cost, extended far beyond that—into emotional exhaustion, stigma endurance, and administrative fatigue.

There is also a concerning reliance on informal or unregulated treatment routes. A few respondents shared how they sought help from private practitioners who offered “fast-track” prescriptions without proper documentation, often charging excessive fees. These backdoor solutions might seem convenient initially but can lead to inconsistent treatment, resistance issues, and severe health consequences over time. It shows that when formal systems don't welcome patients in, they find alternative ways—however risky—to survive.

To say that access is blocked only by money or location would be an oversimplification. It's about **a lack of adaptability in the system**. Health services are built on the assumption of compliance, stability, and patient proactiveness. But for someone living with addiction, social abandonment, and chronic illness, these assumptions are unrealistic. There's an urgent need to rethink access—not as a binary of available or unavailable—but as a continuum of usability, approachability, and sustainability.

Treatment Adherence: Built on Trust, Broken by Judgment

When talking about antiretroviral therapy (ART) among HIV-positive injecting drug users, one might assume adherence is simply about remembering to take pills. But what we learned through personal conversations and counselling proves otherwise. Adherence isn't about a reminder—it's about **relationships**. Specifically, the **relationship between the patient and the healthcare provider**. During this study, nearly half the participants confessed that they had discontinued treatment at some point—not because they couldn't afford it, but because they didn't trust the person handing them the medication.

The reasons were layered. Some felt judged. Others believed they weren't taken seriously, that doctors saw them as "hopeless cases." In those moments, medical help felt more like charity than care. For many, repeated stigmatizing encounters with nurses, counsellors, or pharmacists became emotional triggers, discouraging further visits. The absence of **psycho-social support**—someone to talk to, someone who understood addiction—created a void where guilt and fear thrived. In a study by Collins et al. (2023), both patients and providers expressed the importance of establishing emotional rapport and treatment flexibility for long-acting injectable ART to succeed, especially among substance users. These findings mirror our participants' perspectives, many of whom said they would adhere better if they had **a support system that walked with them**, not just handed them prescriptions.

Effectiveness of Harm Reduction Programs: Not Just What's Offered, But Who Knows It Exists

Harm reduction programs are widely recognized as critical components in combating HIV among IDUs. They work. The science is clear. But in practice, their effectiveness hinges not just on **availability**, but on **awareness and accessibility**—and unfortunately, that's where the cracks begin to show. During FGDs, when participants were asked about needle exchange programs or opioid substitution therapy (OST), many responded with uncertainty or confusion. Some had vague awareness but didn't know where the centers were. Others feared being arrested or harassed on the way there.

This gap in outreach—where services exist, but users don't know how to reach or trust them—is a silent failure. As Iryawan et al. (2022) emphasize in their community-led study in Indonesia, **peer support and community engagement** dramatically improved testing and linkage to care for people who inject drugs. Yet, in most places, such models remain the exception, not the norm. Among our own participants, those who had accessed NSPs or OST said they were introduced through informal networks, not official health communication. The implication is simple: a needle exchange program hidden behind a government building with no signage or outreach will never fulfill its promise. Harm reduction must be **visible, approachable, and culturally sensitive**, or it risks becoming another unused solution on paper.

Gender-Specific Issues: When Being a Woman Makes It Even Harder

While male IDUs often dominate public narratives and policy discussions, the **experiences of female injecting drug users** carry distinct, painful complexities. In our fieldwork, the few female participants shared accounts that were heartbreaking in their isolation. One spoke about hiding her HIV status from her husband for years, afraid of violence. Another mentioned being denied treatment by a private doctor who feared it would "ruin his clinic's reputation." For women, addiction often intersects with sexual violence, reproductive health concerns, and social judgment that is uniquely gendered and far more severe.

Unlike their male counterparts, women face **double stigma**: one for drug use and another for stepping outside of expected gender roles. Accessing treatment means navigating not only health systems but also family structures, societal expectations, and sometimes custody battles. As SeyedAlinaghi et al. (2021) observed in the context of Iran, **gender-sensitive care approaches** are crucial in addressing the hidden burden of HIV among female drug users, especially given their lower visibility in harm reduction programming.

Among the women we engaged with, there was a strong call for **women-only treatment spaces**, integrated reproductive health services, and female peer mentors. Without such adaptations, most continue to remain invisible—not just in public discourse, but in planning, funding, and program design. It's not just a gap—it's an omission.

Discussion

The narratives gathered through this study, when placed beside the existing body of literature, confirm a truth that many healthcare systems are yet to fully acknowledge—**treatment alone is not enough.** The success of any intervention for HIV-positive injecting drug users hinges not only on clinical accessibility but on how a person is treated when they walk through the door. And often, that's where it begins to unravel. The lived experiences shared during focus group discussions and counselling sessions deeply resonate with what Haldane et al. (2022) described as the **urgency for a person-centered model of care**, grounded in human rights rather than institutional control. Despite decades of evidence supporting harm reduction, many IDUs still feel punished by the very systems designed to save them.

The role of **psycho-social interventions** cannot be overstated. Trust, dignity, and emotional safety emerged as deciding factors in whether someone returns for treatment. It's not about giving a pill—it's about giving someone a reason to believe they deserve to live better. Winiker et al. (2023) examined drug treatment barriers in West Virginia and found that patients valued services more when they were emotionally supported and given autonomy in decision-making. Our study participants echoed this almost word for word. When the system treats them as capable individuals rather than social liabilities, they show up. They follow through. This highlights the significance of integrating **counselling, peer mentorship, and emotional scaffolding** into treatment programs—not as optional, but as core components.

Looking beyond India's borders, **global trends reflect both successes and cautionary tales**. In Canada, for example, long-standing investments in supervised consumption sites and community-driven health models have shown measurable improvement in ART adherence and overdose prevention (Tanner, 2025). In contrast, countries like Pakistan and Kenya, while making progress in harm reduction, continue to battle legal and cultural opposition. Modelling studies by Bromberg et al. (2022) estimated that a 60% reduction in unmet harm reduction needs could cut HIV prevalence by nearly half in cities like Karachi and Nairobi. These aren't just numbers; they're proof that **well-funded, decriminalized, and integrated systems work.** But they also remind us of the cost of inaction.

The burden, however, cannot fall on patients alone. **Healthcare professionals**, often overwhelmed and under-trained in addiction-specific care, play a pivotal role in shaping the patient journey. The difference between judgment and empathy can be life-altering. In our field data, participants who had even one supportive interaction with a doctor or nurse were more likely to continue care. This aligns closely with findings by Goodyear et al. (2021), where patient-provider rapport directly influenced engagement with Hepatitis C treatment. It's time to treat relational dynamics with the same seriousness as we treat viral load metrics. Because no medication can undo the damage of being dismissed or humiliated in a clinic.

Yet, while we speak of systems and staff, we must also acknowledge the elephant in the room—**policy neglect**. Despite global funding, technical guidelines, and pilot programs, the lived reality remains that

IDUs are still outside the loop of consistent care. Ramasamy et al. (2024) argue that Southeast Asia's bold goal of eliminating viral hepatitis by 2030 will collapse unless governments bridge the gap between policy design and ground-level delivery. Our study reflects that same concern. IDUs are not passive recipients of care—they are navigating a war zone of bureaucracy, judgment, and survival. When policies are crafted without their voices, their realities are never factored in. This disconnect isn't just inefficient—it's dangerous.

And yet, **individual agency** continues to shine through. Participants in this study didn't see themselves as victims. Many were eager to contribute, to be heard, and to co-create better systems. They knew their communities better than any outreach officer ever could. As Altice et al. (2022) noted during the Ukrainian opioid crisis, patient-led strategies and community partnerships provided resilient alternatives even amid war. In India, we don't need a war to see what neglect looks like. It's happening daily—in overlooked files, missed follow-ups, and empty harm reduction centers.

Ultimately, what this discussion reveals is that the path forward cannot be built by clinical protocols alone. It requires **listening, adjusting, and believing** in the people we claim to serve. The stories from this study are not outliers—they are the rule, the reality, and the warning. Until care becomes as much about healing relationships as it is about managing symptoms, we will remain stuck in a cycle of preventable loss.

Implications

The insights gathered throughout this research don't end at understanding—they demand action. At the very top, there's an urgent need to **strengthen harm reduction policies** and move them from paper into people's lives. Most participants interviewed in this study didn't lack will—they lacked access. Existing programs like needle-syringe exchange and OST are often underfunded, poorly publicized, and entangled in outdated eligibility conditions. That's not harm reduction; that's gatekeeping. As Bhadoria et al. (2022) note in their narrative review on viral hepatitis, a critical bottleneck in disease control is the inconsistent implementation of prevention frameworks across Indian states. These gaps translate into lost lives, not just lost metrics.

Moreover, **mental health support can no longer be seen as secondary**. It must be stitched into the very fabric of HIV care. You can't treat a person for a virus while ignoring their trauma, anxiety, or loneliness. Many of the individuals we spoke with were not just fighting addiction or HIV, but also fighting memories, shame, and abandonment. There is a stark need to bring mental health professionals, peer counsellors, and psychologists into ART centers and IDU outreach programs. Gleason et al. (2022) illustrate how patients often disengaged from care during the pandemic—not because the medicine wasn’t available, but because their emotional distress went unaddressed. For them, health wasn't just physical—it was existential.

Another glaring implication is **the need to upskill general hospital staff** in IDU-specific care. This doesn't mean every nurse must become an addiction specialist—but it does mean every healthcare provider must be trained to provide care without bias. Many participants described hospitals as the most hostile part of their journey. That must change. Sensitization workshops, practical exposure, and even simulated patient interactions could help break the stigma that exists inside white coats. If a provider has never spoken to a drug user outside of crisis or emergency, how can they offer meaningful care? The onus is on institutions to close that experience gap.

Mainstreaming affected individuals is not just about putting them in group therapy or rehab—it’s about bringing them back into society as people, not as cases. Social rehabilitation has to be as active a process as clinical follow-up. Providing access to vocational training, family counselling, legal aid, and community reintegration services could offer IDUs a life beyond survival. As Goodyear et al. (2021) stressed, the emotional readiness of IDUs for treatment often depends on whether they believe they have a future to look forward to. Without that hope, care becomes maintenance, not recovery.

Lastly, this study calls for **future research that is deeply participatory and locally rooted**. Programs often fail because they are designed by experts who have never sat down with those they claim to help. There needs to be a shift toward community co-design. Future research must involve IDUs not just as respondents but as collaborators—people who help shape the research questions, interpret findings, and test interventions. Only then can we ensure our programs don’t just speak about them but speak **with** them.

Conclusion

It’s easy to speak of “inclusive healthcare” as a policy goal. It sounds good in plans, in conferences, in media. But for injecting drug users living with HIV, inclusion has never been a default—it has always been a demand. This study, rooted in both review and real conversation, brings to light not only the barriers but the burdens carried by those on the margins. **Their exclusion isn't accidental—it’s structural.** And that must be confronted with clarity and courage.

The urgency of **rebuilding healthcare models** that are patient-centered, trauma-informed, and rooted in dignity cannot be overstated. It's not enough to offer pills, or to build clinics. We must reimagine how care feels to someone who believes they don't deserve it. The weight of ethical responsibility lies not only in providing medicine but in restoring trust. As Kumar et al. (2023) emphasize in their analysis of HIV eradication strategies, real impact begins only when the system stops fearing the marginalized and starts listening to them. Our institutions need to shift from containment to compassion.

Socially, the burden cannot lie solely with the individual. Drug use, HIV, trauma, and poverty intersect in cruel ways. Policies that criminalize, isolate, or overlook these intersections end up perpetuating the very cycles they claim to disrupt. We need **bridges—not barriers.** And those bridges must be built through law reform, education, and public narrative change. It is not just a medical responsibility—it is a moral one.

The way forward demands boldness. It demands combining grassroots engagement with policy transformation. Not separately, but simultaneously. Programs designed with users, not just for them. Health professionals trained in compassion, not just compliance. Systems built not only to heal, but to understand.

Because if we can meet HIV-positive injecting drug users where they are—not just physically, but emotionally, culturally, and socially—then perhaps, finally, we can call our health system inclusive. Not just in theory. But in truth.

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