What do HIV-positive drug users' experience tell us about their antiretroviral medications taking? An international integrated literature review

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Title: What do HIV-positive drug users’ experience tell us about their antiretroviral medications taking? An international integrated literature review

Running head: Adherence to antiretroviral medications

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Abstract

**Background and aims:** HIV-positive drug users’ poor adherence to antiretroviral regimens can pose a significant and negative impact on individual and global health. This review aims to identify knowledge gaps and inconsistencies within the current evidence base and to measure HIV-positive drug users’ adherence rates and the factors that influence their adherence.

**Methods:** A search of quantitative and qualitative studies in relation to HIV-positive drug users’ adherence to antiretroviral treatment was performed using five databases: Applied Social Sciences Index and Abstract (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Embase and PsycINFO (Ovid interface). Relevant studies were retrieved based on the inclusion and exclusion criteria stated in the review. Findings were compared, contrasted, and synthesised to provide a coherent account of HIV-positive drug users’ adherence rates and the factors that influence their adherence.

**Results:** The proportion of HIV-positive drug users who achieved $\geq 95\%$ adherence across the studies varied widely, from 19.3%-83.9%. Adherence rates changed over the course of HIV treatment. The factors that influenced adherence were reported as follows: stigmatisation, motivation, active drug use, accessibility and conditionality of HIV and addiction care, side effects and complexity of treatment regimens, forgetfulness and non-incorporation of dosing times into daily schedules.

**Conclusions:** HIV-positive drug users’ medication-taking is a dynamic social process that requires health professionals to assess adherence to HIV treatment on a regular basis.

**Keywords:** Adherence, HIV-positive drug users, antiretroviral treatment, international literature review
Introduction

The literature on Human Immunodeficiency Virus (HIV)-positive individuals’ adherence to Highly Active Antiretroviral Therapy (HAART) reveals the importance of strict adherence for maximum therapeutic impact. A cut-off of 95% or better adherence has been studied as the appropriate threshold for clinical efficacy, and this finding is consistent throughout empirical research and government publications [1-5]. Individuals with poor adherence to long-term HAART compromise the effectiveness of the treatment and pose a threat to the public, including incomplete viral suppression, increased HIV transmission, development of drug resistance, and limitation of treatment options [2, 6-7].

Despite the importance of adherence to HAART, there is a growing body of literature that recognises that among the general HIV population, HIV-positive drug users have lower adherence rates compared to other HIV groups [3, 8-15]. In light of this evidence in the existing literature, it is becoming extremely difficult to ignore the existence of the importance of understanding HIV-positive drug users’ adherence behaviour.

Adherence refers to “the extent to which patients’ behaviours matches agreed recommendations from the prescriber [2: p.12]” This term is adopted more by many as an alternative to compliance, because adherence involves ‘patient’s agreement’ to doctor’s recommendations [2]. To date, a systematic understanding of HIV-positive drug users’ adherence to HAART is still lacking. Only two systematic reviews have been done to investigate the rates of adherence to HAART among HIV-positive drug users and its influencing factors [10,16].
Feelemyer et al. [16] conducted a systematic review of 15 empirical studies aiming to examine the levels of adherence to HAART among people with active injection drug use or with a history of injection drug use in transitional/low/middle income countries. The results of this review showed that the adherence levels ranged from 33%-97%, and the overall mean weighted adherence among all studies was 71.9%. However, several issues were identified in this review article. Firstly, most of the included studies did not focus on HIV-positive drug users but the general HIV population. Secondly, twelve out of fifteen studies did not aim to measure adherence rates, and some of those did not have such data. Of the 15 studies, it was found that only one study appeared to be related to HIV-positive drug users’ adherence to HAART. Therefore, the level of adherence to HAART among drug users remains unclear in the current evidence base.

Malta and her associates’ systematic review of 41 quantitative studies aimed to assess the adherence to HAART among HIV-positive drug users and its facilitators and barriers [10]. The results showed that active substance use, depression and low social support were associated with poor adherence. On the other hand, receiving care in structured settings (e.g. directly observed treatment) and drug addiction treatment were associated with higher adherence. The results of this review provide insight into the influencing factors of HIV-positive drug users’ adherence to HAART. There is one major limitation in this review [10], which is the exclusion of relevant qualitative studies. The inclusion of relevant qualitative studies can help to gain a deeper understanding of underlying issues in relation to HIV-positive drug users’ adherence to HAART.

Taken together, while some research has identified drug users as a less adherent group, uncertainty remains as to why this HIV subgroup is less adherent compared
to other HIV populations. Therefore, this review aims to critically review international quantitative and qualitative literature relating to HIV-positive drug users’ adherence to HAART. Through a review of the relevant literature, it can provide a comprehensive understanding of HIV-positive drug users’ adherence to HAART and its underlying issues, and identify any knowledge gaps and inconsistencies within the current evidence base.

**Methods**

Through the process of a literature search, it was revealed that all included quantitative studies used a non-experimental design with various adherence assessment approaches and standards to investigate drug users’ adherence levels. As a result, pooling a meta-analysis or meta-regression of separate studies to estimate the overall adherence rate and identify its significant influencing factors across studies becomes less meaningful. In an attempt to synthesise the quantitative and qualitative studies, an integrated literature review was, therefore, carried out to systematically categorise and thematically analyse the selected studies based on their characteristics and findings [17]. Meta-ethnography was used to compare conceptual data from the included qualitative studies to identify and develop overarching themes [18].

**Search strategy**

A search was performed using the databases of the Applied Social Sciences Index and Abstract (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, Embase and PsycINFO (Ovid interface). The keywords used in the search were ‘antiretroviral’ OR ‘HAART’ AND ‘adherence’ OR ‘adher*’ OR

Inclusion and exclusion criteria

Inclusion criteria:
1. Studies that involved HIV-positive drug users
2. Study sample is at the age of 18 or older
3. Published in English or Traditional Chinese
4. Empirical studies that focus on adherence to HAART
5. Qualitative, quantitative, and mixed-methods studies, and dissertations (grey literature)
6. With full text
7. Studies from 2000 to July 2018

Exclusion Criteria:
1. Studies that did not involve HIV-positive drug users
2. Study sample is less than 18 years old
3. Simplified Chinese
4. Unclear study methodology
5. Studies that did not focus on adherence to HAART

Articles published in traditional Chinese and dissertations set in the inclusion criteria are to maximise the chance of finding empirical studies and to reduce publication bias. In terms of the language selection, literature written in English and the first author’s original language, traditional Chinese, was included in the search.

Reporting study selection

Figure 1 shows the PRISMA diagram for the search that led to the final included studies in this review. This literature search included studies from 2000 to July, 2018. The literature searched was restricted to dates from 2000 onwards due to combined HAART regimens accelerated during the early 2000s, called HAART era, and the
overwhelming amount of quantitative literature relating to adherence to HAART. Through the search strategy, 3968 articles were generated from the databases. Based on the inclusion and exclusion criteria, 3848 articles were excluded during the title screening stage, leaving 120 studies. After removal of the articles that did not meet the criteria, abstract and full-text screening eliminated further 74 articles. Five articles were hand-searched and included, leaving 51 articles for inclusion in this review. At abstract and full-text screening stage, numerous quantitative studies in relation to HIV-positive drug users’ adherence to HAART were identified as opposed to qualitative studies. The study selection process and the rationale for exclusion are shown in Figure 1. Summary of selected studies is presented in Table 1 and 2.

Results

Characteristics of the included studies

Of the retrieved quantitative studies (n=40), 13 were from Canada, 20 from the United States of America (USA), 4 from France, 1 from the Netherlands, 1 from India and 1 from Vietnam (Table 1). Of the 13 articles from Canada, 11 were from the same prospective and ongoing research project in Vancouver. The 4 articles from France were also derived from the same prospective research project. In total, 26 articles were prospective studies (the follow-up period, ranging from 1 month to 91 months), 12 cross-sectional, and 1 secondary data analysis. There were 27 studies involving HIV-positive drug users (either illicit drug users or injecting drug users); 1 involving methadone maintained patients; 7 studies involving HIV-positive substance users with a clear sample description of what constitutes substance users; 5 studies involving HIV-positive individuals divided into subgroups (active drug users, past
drug users, and non-drug users). All of the included quantitative studies recruited sample through convenient and/or snowball sampling.

The retrieved quantitative studies predominantly focused on levels of adherence, and its influencing factors, however, these studies defined adherence in a variety of ways and used different measurement tools. Most studies measured participants’ levels of adherence to HAART through self-report (continuous variable: doses taken/total prescribed doses during certain period of time, or ordinal variable: self-rating adherence level), pharmacy dispensation record (the number of days patients received HAART refills/the total number of days of medical follow-up), or electronic monitoring system (Medication Events Monitoring System caps, MEMS caps). Three studies focused on drug users’ discontinuation of HAART. Four measured the mean adherence rate across study participants. Of the studies measuring drug users’ adherence with a continuous scale, 19 studies defined adherence as taking ≥95% prescribed doses, 2 defined adherence as taking ≥90% prescribed doses, 4 defined adherence as taking 100% prescribed doses, and 2 defined it as taking ≥ 80% prescribed doses.

In terms of qualitative studies, 11 were retrieved for this review (Table 2). There was a paucity of qualitative research focusing on HIV-positive drug users’ experiences of adherence to HAART at the literature screening stage. All the qualitative studies that involved HIV-positive drug users’ experiences of taking HAART were included in this review. Although some included studies had not gone much further than describing and summarising what participants said, participants’ statements presented in the studies still allow readers to see the voice of HIV-positive drug users regarding their HAART taking. In other words, the quality of these qualitative studies was assessed according to the degree to which authors
represented the views of their participants [19]. Of the 11 qualitative studies, 2 were from Canada, 3 from the USA, 1 from Spain, 2 from Russia, 1 from Ukraine, 1 from India, and 1 from the Netherlands. Of the included studies, 4 studies used thematic analysis, 2 used framework analysis, 1 used content analysis, 1 conducted ethnographic interviews, 2 followed Strauss and Corbin’s codification process [20], and 1 followed Glaser and Strauss’s analytic approach [21].

In the following sections, the quantitative findings related to adherence rates is firstly introduced, followed by the synthesis of quantitative and qualitative findings pertaining to the factors that influence adherence.

**An estimate of adherence levels among HIV-positive drug users**

Ten studies involving only drug users and defining adherence as taking ≥95% prescribed doses revealed that drug users who had ≥95% adherence ranged from 19.3% to 85.9% [22-31]. However, this result largely represented the USA and Canada, because 7 out of the 10 studies were from Canada [23-29], and 3 were from the USA [22, 30, 31]. Two studies from France, involving IDUs and using 80% as the cut-off point for adherence, showed that 65.2% of 164 IDUs in Moatti’s study [32] and 70% of 210 IDUs in Bouhnik’s study [33] had ≥ 80% adherence. One cross-sectional study by Arnsten et al. [34] measured 636 HIV-positive drug users’ adherence rate with use of 90% as the cut-off point for good adherence, showing that 75% of them had ≥ 90% adherence. Two studies from the USA, involving HIV-positive substance abusers (illicit drugs and alcohol abusers) and using 100% as the cut-off point, showed that 46% of 1889 substance abusers in Tucker's cross-sectional study [35] and 55% of 1138 substance abusers in Mellins’s cohort study [36] had 100% adherence. Two prospective studies by Kalichman et al. [37] and Ti et al. [38] measured the average adherence rate among 85 and 587 HIV-positive illicit
drug users in the USA and Canada respectively, which were reported to be approximately 50%. Compared to former drug users and non-drug users, active drug users were reported to be significantly associated with poorer adherence to HAART [22, 34, 39-46].

Drawing on the results, there was an indication that HIV-positive drug users had lower adherence rates. Nonetheless, a few included studies showed that HIV-positive drug users had high adherence rates. For example, one prospective study from Vietnam showed that 83% out of 100 HIV-positive drug users had perfect or very good adherence at some point (self-reported categorical scale) [43]. Another study from the USA reported that the mean adherence rates among low-income HIV-positive substance abusers ranged from 94.46%-97.97% [47]. The results are not consistent across the studies, and the aforementioned studies only measured HIV-positive drug users/substance abusers’ adherence at some points. Thus, it cannot represent participants’ overall adherence levels.

There are four included studies, Mann et al. from Canada [26], Waldrop-Valverde et al. [48], Hinkin et al. [42] from the USA and Lambers et al. [49] from the Netherlands, investigating the change in adherence levels.

The study from the Netherlands showed that 25% of 102 drug users became less adherent (was defined by the authors as < 95% adherence) at some points during the study period [49]. This indicates that adherence to HAART does not always stay at the same level. Congruently, three quantitative studies from Canada and India investigated HIV-positive IDUs’ discontinuation of HAART [50-52]. These studies showed that 33.8% of 545 IDUs in Hadland’s study [50] in Canada, 44% of 160 IDUs
in Kerr’s study [51] in Canada, and 32.7% of 226 IDUs in Sharma’s study [52] in India discontinued HAART during the follow-up period.

In terms of the trend of HIV-positive drug users’ adherence levels over time, the prospective study from Mann et al. [26] looked into pharmacy dispensation records, and the results showed that the proportion of achieving ≥ 95% adherence among HIV-positive drug users increased over time, from 19.3% in 1996 to 65.9% in 2009. By contrast, a prospective study from Waldrop-Valverde et al. [48] investigated cocaine users’ adherence levels using an electronic monitoring device, and the results showed that there was a significant drop in adherence from Month 1 to Month 6. The reduction in percentage dose adherence was from 76.7% at Month 1 to 66.5% at Month 6. The difference in the adherence rates over time was found to be due to personal factor in Waldrop-Valverde’s study [48] and the advance of HAART in Mann’s study [26]. Mann’s study [26] investigated drug users’ adherence levels over a longer period of time, from the early era of HAART to more recent era of HAART. The advance in HAART has changed the form of HAART regimens, contributing to increased adherence rates over that period of time [26]. As opposed to Mann’s study [26], the follow-up period was shorter in Waldrop-Valverde’s study [48], and the decrease in adherence rates among drug users was reported to be more associated with self-efficacy of taking HAART. In a longitudinal study by Hinkin et al. [42], it was revealed that both drug positive and drug negative groups had a decrease in adherence rates over time. The mean adherence rate had dropped from 77.4% to 68.4% in the drug negative group, whereas there was a significant decrease in the adherence rate among the drug positive group, from 70.1% to 51.3%. The trend of the adherence rate in the entire sample was from 74.4% for the first 2 months, to 68.5% for month 3, and down to 62.6% for month 5 and 6.
By and large, the results of the included quantitative studies demonstrated the adherence rates among HIV-positive drug users, and its dynamic process. However, it is not without limitations. Firstly, as most of the included studies used convenient sampling methods to recruit participants, the adherence rates cannot be representative of HIV-positive drug users [53]. Secondly, most of the included studies used self-report or pharmacy dispensation records to assess adherence rates. Self-report measure may bring social desirability bias or recall bias in research [54]. Nevertheless, it has been reported that drug users’ self-report was correlated with patients’ clinical outcomes, criminal records, and interviews, and it has been tested as a reliable method [55]. In terms of measuring adherence by using pharmacy dispensation records, issues arise as to whether patients who refill medications actually take them. This pharmacy record method has been reported by Palepu et al. [56] as unreliable because of the insignificant association between HIV-positive drug users’ adherence level and HIV-1 RNA suppression. Taking this into account, measuring adherence levels with more than one method may enhance the accuracy of adherence assessment.

**Factors influencing adherence to HAART**

Having gained insight into HIV-positive drug users’ adherence rates in the current evidence base, this section focuses on its influencing factors. A multitude of influencing factors have been identified and explored in the included qualitative studies (n=11). Of the 11 qualitative studies, 8 involved HIV-positive individuals who had a history of injecting drugs [57-63]. One involved HIV-positive active drug users (smoked/ injecting drug use) [64]. One involved IDUs who use methadone maintenance [65]. One involved HIV-positive individuals who had a history of using drugs and treatment interruption for 30 days [66]. The conceptual data from the
included qualitative studies were compared and contrasted, and were subsequently
collated into themes, and then the themes was triangulated with relevant quantitative
evidence in an attempt to gain a comprehensive account of HIV-positive drug users’
experiences of taking HAART.

Throughout the process of comparing findings across the included studies, six
themes were identified—

1) Stigmatisation in relation to HIV and illicit drug use

2) The motivation for taking HAART

3) Active drug use and HAART adherence

4) Accessibility and conditionality of HIV and addiction treatment

5) Side effects and complexity of HAART regimens

6) Forgetting and not fitting HAART regimen into schedule.

The six themes are discussed in the following sections.

**Stigmatisation in relation to HIV and illicit drug use**

Stigma was identified as one of the predominant themes. Seven studies reported
that HIV-positive drug users/inmates had experienced stigmatisation and
discrimination associated with HIV and illicit drug use [57,59,61-62,64-66]. Some
experienced violence in the prison settings [62] and others were shunned and
discriminated by family [57,64-66], police officers [59] and health professionals
[61,65,67] due to their HIV status. In addition to HIV status, participants’ engagement
in the everyday violence associated with their drug dependence appeared to
exacerbate their negative image portrayed by society [66].
Two major factors that led to families’ and public stigmatisation and discrimination towards HIV-positive drug users emerged from participants’ statements across the included qualitative studies — lack of knowledge relating to HIV, and images of ‘HIV and illicit drug use’ discredited by society. As with lack of knowledge, misconceptions about the transmission routes of HIV were revealed to bring public fear and lead to estrangement. For example, HIV-positive drug-using participants in Mimiaga’s study [59] reported that police officers in Ukraine were afraid of them, and avoided physical contact from them or even things they had touched. As a result, their experiences of stigmatisation had influenced their willingness to access care.

Three qualitative studies from Ukraine (n=16), India (n=19), and Russia (n=42) revealed that health professionals held assumptions in relation to HIV-positive drug users’ poor adherence and refused to treat them [57,59,61,67]. Aside from health professionals’ negative assumptions of drug users, Pach et al.’s [60] (n=34) and Kiriazova et al.’s [67] qualitative studies (n=25) indicated that some drug users did not trust health professionals, either. This created the barrier to accessing HIV care. With a lack of engagement and trust in the health system, some drug users did not have adequate knowledge about HIV and HAART [57,60,64]. As a result, they were more likely to gain knowledge of HAART based on information circulating through social networks, and held negative assumptions and misinterpretation of HAART [57,60,64]. Congruently, Kelly’s study [68] with the use of secondary data analysis (n=76) pointed out that having HIV-positive drug users in friend circles was associated with less adherence to HAART.

Experiences of stigmatisation from families has also been reported in Chakrapani’s qualitative study [57] in India, where being HIV positive and using illicit drugs were perceived by IDUs’ families to bring shame to the whole family. By holding negative
perceptions of HIV and illicit drugs, some were forced by their families to move out of their house, leading to homelessness [57]. As a consequence, financial instabilities (e.g. lack of money, food and housing), social stigmatisation, and disruptions in drug users’ daily lives had affected their ability to follow treatment regimens [60,63,64,66]. Several quantitative studies also showed the significant association between homelessness and nonadherence [23,29,33,39,49].

The impact of stigmas related to HIV and illicit drug use not only impeded HIV-positive drug users’ acquisition of support, but worsened their psychological distress, self-stigmatisation, and willingness to seek support [59,63,65,66]. With the feelings of denial, shame, and fear of stigmatisation, some tended to not disclose their HIV status, and were more likely to hide or not bring HAART medications with them [59,64,65]. In some cases, HIV-positive drug users articulated their low levels of motivation to live and take HAART [59,63,66].

In line with the findings derived from the qualitative studies, the included quantitative studies indicated that HIV-positive drug users’ poor adherence to HAART was significantly associated with their psychological distress or depression [34,36,39,45,69]. In addition, two studies from the USA by Magidson et al. [47] and France by Moatti et al. [32] indicated that environmental punishment (perception of being exposed to punishing experience) and frequency of negative life events were related to poor adherence to HAART. Of particular concern, environmental punishment was the mediator between depression and poor adherence [47]. The results illustrated the influence of social environment on individuals’ psychological well-being and subsequent HAART-taking behaviour.
In brief, it seemed that stigma related to HIV and illicit drug use could pose an impact on HIV-positive drug users’ acquisition of support. Without the support available for them, it can further increase drug users’ levels of perceived stigma and psychological distress. Social and self-stigmatisation was revealed to be linked to the lack of knowledge pertaining to HIV and illicit drug users, and the influence of social values.

Motivation for taking HAART

Despite the impact of stigma on HIV-positive drug users' HAART-taking behaviour, some HIV-positive drug users appeared to be motivated to take HAART. Two factors were identified to enhance HIV-positive drug users’ motivation of taking HAART—acceptance of HIV status and acquisition of support from health professionals, family or friends [58-60,63-65]. With the acquisition of support, it facilitated affected individuals’ life stability and adherence to HAART by providing tangible support [59,60,64]. In addition, drug users having a stable job has been identified as a factor enhancing their sense of responsibility and level of motivation to adhere to HAART [64,70].

One qualitative study (n=23) by de la Hera et al. [58] pointed out that maintaining a good relationship between health professional and HIV-positive drug users enhanced drug users’ knowledge related to HAART management. In turn, drug users with adequate knowledge were found to be more likely to be aware of their HAART-taking acts and managed HAART more consciously. Aside from external support, internally, drug users’ self-acceptance and wanting to live longer were revealed to strengthen their will to adhere to HAART [59,64,65].
Drawing on the qualitative findings from the included studies, HIV-positive drug users’ motivation to take HAART seemed to be influenced by the degree of support they got and their self-acceptance. As such, it had helped drug users grow belief and confidence in their capacity for taking HAART [58,65].

**Active drug use and HAART adherence**

The majority of the included quantitative studies indicated that illicit drug use significantly and negatively affected HIV-positive drug users' adherence to HAART [9,22-24, 33,36,39,41-43,45,47,52,69,71-73]. A longitudinal study conducted in New York by French et al. [22] investigated the impact of the change in substance abuse on participants’ adherence to HAART. The result showed that participants who changed from no substance use at one interview to substance use at the follow-up interview were more likely to transition from adherence to non-adherence. However, this paper does not specify the patterns of drug use among the participants. It would enhance understanding if this study had included more details about the dynamics of drug use as to whether participants experienced relapse or just started using illicit drugs. The tendency to use drugs to cope with stress was reported in Arnsten’s prospective study [39] to be significantly associated with non-adherence to HAART. This indicates that drugs could be used as a coping strategy by users to deal with stress, resulting in poor adherence.

Concerned about the impact of drug use on adherence, getting a fix was the heroin users’ main focus [57-60,63,64]. The large amount of time active drug users spent on pursuing their next fix had affected their ability to access health care [59,60]. In addition, the large sum of money spent on heroin placed HIV-positive drug users in poor financial circumstances [63,64]. Drawing on the findings, both stigma and illicit drug use were revealed to collectively increase HIV-positive drug users’ vulnerability
related to incarceration, employment, family relationships, mental health, and access to care, contributing to breakdowns in the continuity of HIV care [24,49,51,64,66].

Congruent with the qualitative research findings, Mellins et al. [36] and Tucker et al. [35] in their cross-sectional studies reported that HIV-positive drug users’ non-adherence to HAART was associated with low attendance rates at a medical appointment and poor integration of the medication regimens into their lifestyle. Wittveen and Ameijden [63] in their ethnographic interviews noticed that the drug use patterns among drug-taking adherers ranged from using drugs once a day to using drugs once a month. Although Wittveen and Ameijden [63] did not further explain what enabled them to regularly use illicit drugs and take HAART medications, they pointed out that methadone had alleviated participants’ withdrawal symptoms and stabilised their emotions, further enhancing their adherence to HAART. In line with this, numerous included quantitative studies also reported methadone maintenance treatment was significantly related to adherence to HAART among HIV-positive drug users [24,25,27,29,31,41,49,71,72,74]. These findings are incongruent with the results of a cross-sectional study with 133 methadone users by Shrestha and Copenhaver [75] which indicated that methadone users who continue using drugs were more likely to have suboptimal adherence and incomplete viral suppression.

In summary, it seemed that the addictive effects of illicit drugs could disrupt HIV-positive drug users’ lifestyle and their ability to access HIV care, whereas methadone appeared to have the protective effect of alleviating their withdrawal symptoms and enhancing adherence. However, due to the prevalence of methadone users who continue injecting drugs [75], the impact of methadone use on affected individuals’ drug-taking and adherence behaviour remains complex, which requires future research on their complex interplay.
Accessibility and conditionality of HIV and addiction treatment

Though HAART and addiction treatments play an important role in facilitating HIV-positive individuals’ adherence to HAART, some drug users articulated the difficulty in accessing HIV and addiction care [52,57,60-62,66,67]. The accessibility of HIV and addiction care varied from country to country. Sharma’s cross-sectional study [52] from India illustrated that the financial cost of HIV diagnostic testing, treatment of opportunistic infections, and transport significantly increased HIV-positive drug users’ financial burden and impeded their access to HAART. In correctional systems, issues in relation to difficulty accessing HIV medications were reported in two qualitative studies by McNeil et al. [66] and Small et al. [62] in Canada. In the two studies, some participants complained about the unavailability of HIV medication between the times of arrest, trial, and arrival at the institution where they served their sentence, and upon release from custody [62,66]. As such, these structural factors increased the challenge of drug users’ access to HIV care.

In addition to these structural factors, two qualitative studies from Russian and India revealed that HIV treatment conditionality was a great hindrance of access to HIV care among HIV-positive drug users [57,61]. In Chakrapani’s [57] and Rhodes and Sarang’s [61] studies, physicians’ provision of HAART to HIV-positive drug users appeared to be contingent. Physicians provided HAART to affected individuals, only when affected individuals could show evidence that they were reliable, deserved taking HAART, and were able to be in control of their drug use. Such value judgement was upheld by physicians’ concerns in an attempt to decrease drug resistance, maximise treatment outcomes, and adapt to economic constraints within healthcare [57,61]. As a result, it had led to delayed access to care, treatment
interruption, or disengagement from health care among HIV-positive drug users [57,61].

Such ways of treating HIV-positive drug users situated HAART as a relative priority in the hierarchy of immediate need where managing the ‘problems’ of illicit drug use came first. Moreover, this policy was revealed to be put in place due to physicians’ doubts of drug users’ capacity to adhere to HAART in the face of ongoing and untreated drug use [57,61]. In addition to the conditionality of access to HIV care, HIV-positive drug users’ accounts, in the qualitative studies by Pach et al. [60] from the US (n=34 HIV+ IDUs), Chakrapani et al. [57] from India (n=19 HIV+ IDUs), and Rhodes and Sarang [61] from Russia (n=42 HIV+ IDUs), showed the inadequacy and ineffectiveness of addiction treatment, and a lack of effective linkage between HIV care and drug dependence treatment/needle syringe programme. In contrast to the findings from these studies, easy access to HAART was reported by HIV-positive drug users who had a good relationship with health professionals in a qualitative study by de la Hera et al. [58] from Spain (n=23 HIV+ IDUs). Drawing on the findings from the aforementioned studies, it seemed that the accessibility of HIV care can also be linked to the establishment of the trusting relationship between health professionals and HIV-positive drug users.

Although infrastructure within healthcare varies from country to country, the findings from the included studies pointed out that it still created a barrier to individuals’ willingness to access care, especially for those who were in a financially disadvantaged situation. In addition, the distrusting relationship between healthcare providers and HIV-positive drug users could also widen the accessibility gap.
Side effects and complexity of HAART regimens

Side effects have been reported by several qualitative studies and one cross-sectional study as a barrier to adherence to HAART among HIV-positive drug users [52,59,60,63,67]. The commonly reported side effects were diarrhoea, fatigue, nausea, vomiting, and stomach-aches [52,59,60,63,67]. Some had treatment interruption due to the experience of side effects [52,59,60,63,67], and others did not receive HAART because of their misconception and concerns over the toxicity and danger of taking the treatment [60,66].

For HIV-positive drug users who started HAART in the early to mid-1990s or lived in a country where HAART options were limited (such as Ukraine), complexity of the treatment regimen was reported to influence their adherence to HAART [58-59,63,66]. A qualitative study by Mimiaga et al. [59] from Ukraine pointed out that several participants found it challenging to adhere to HAART due to high pill counts, the necessity of taking medications at specific times, and with food restrictions. Nonetheless, McNeil’s study [66] from Canada indicated that the use of modern HAART has transformed the treatment regimens into a more simplified form, which had enhanced participants’ adherence.

To sum up, the advance in HAART regimen globally has simplified the way that individuals take HAART regimens, and has decreased individuals’ burden of taking HAART. Nonetheless, ‘side effects’ of HAART remained one of the major barriers to adherence to HAART in the included studies. Misconception and experience of side effects of HAART were found to exert an impact on receiving and/or continuing HAART among participants in the included studies.
Forgetting and not fitting HAART regimen into schedule

Fitting HAART regimen into daily schedules has been reported to bring challenges to adherence to HAART among drug users [59,63,76]. Though this theme emerged in the included qualitative studies, there was a lack of explanation and exploration in the studies as to in what situations or how HIV-positive drug users were more likely to forget doses and not incorporate HAART into life.

To avoid forgetfulness, some HIV-positive drug users, from Wittveen and Ameijden’s [63], Mimiaga’s [59], Ware’s [64] qualitative studies, developed strategies to promoting adherence to treatment. The strategies included incorporating medication regimens into drug use routines, use of medication containers, phone alarms/alarm clocks, or stickers to remind their dosing schedules. Some took HIV medications with them all the time [59,63].

Discussion

Drawing on the quantitative results from the included studies, the proportion of HIV-positive drug users who achieved ≥ 95% adherence across the studies varies widely across and within countries, from 19.3%-83.9% [22-31]. This indicates that adherence rates tended to be inconsistent amongst the included studies. Drug users’ adherence levels could drop and change over time [42,48,50-52]. Over the course of receiving HAART, many drug users had a history of discontinuing HAART at some points [50-52]. The average adherence rate was approximately 50% [37-38].

However, the advance in HAART, from complex regimens to simplified regimens, have enhanced the level of adherence among HIV-positive drug users [26]. This indicates that HIV-positive drug users’ HAART-taking behaviour is an ongoing and dynamic social process where the patterns of their HAART-taking behaviour did not
remain the same but fluctuated over time. Although several attempts have been made to assess HIV-positive individuals’ adherence levels by using self-reported questionnaires, pharmacy dispensing records or electronic monitoring devices, current assessment tools cannot capture the dynamic process of drug users’ HAART-taking behaviour. In that sense, the question with regards whether HIV-positive drug users adhere to HAART cannot be simply answered as one or the other. Therefore, the review of qualitative studies played an important role in this paper to deeply understand and explore drug users’ experiences of taking HAART.

Among HIV-positive drug users, active drug use was reported to be significantly associated with poor adherence to HAART [22,34,39-46]. In particular, the impact of drug use on drug users’ lifestyle and financial instability was found to be linked to their poor adherence to HAART [57-60,63,64]. Furthering the results from quantitative studies, the included qualitative studies showed that active drug use, specifically heroin, was found to affect participants’ decision of prioritising needs. They tended to prioritise the need of getting fixed over enhancing health condition, resulting in decreasing their motivation of taking HAART. In response to stress, drug use was reported in Arnsten et al. [39] prospective study as a coping strategy among HIV-positive drug users. These findings imply the complex relationships between individuals’ emotion, coping, and HAART-taking behaviour. As a result, active drug use had increased the challenge of initiating and sustaining HAART use among HIV-positive drug users. On the other hand, methadone treatment was reported to have a protective effect on enhancing adherence [24,25,27,29,31,41,63,71,72,74].

In addition to drug use, stigma related to HIV and illicit drug use was revealed in the included studies to greatly impede drug users’ access to care and adherence to HAART [57,59,61,62,64,65]. In particular, the included qualitative studies from the
middle/low-income countries tended to report the negative impact of social stigma on HIV-positive drug users’ adherence to HAART compared to those from high income countries. Public lack of knowledge and social values attached to HIV and drug use were found to shape one’s assumptions and stigmatisation towards HIV-positive drug users. Drug users’ experiences of stigmatisation from family, health professionals, and friends could undermine their psychological wellbeing and delay their access to HIV treatment. Participants’ experiences of stigmatisation was shown to affect their psychological well-being, self-stigmatisation, and willingness to seek support and regularly receive HAART. By contrast, self-acceptance and acquisition of support were identified to enhance HIV-positive drug users’ motivation of taking HAART.

Infrastructures within healthcare were another factor revealed in the included studies to impede participants’ access to HIV and addiction treatment. Accessibility of care was particularly found, in the qualitative studies from Russia and India, to be linked to the economic constraints and value judgement towards drug users within the society [57,61]. As for HAART regimens, concerns over side effects were revealed to shape participants’ preconception of HAART and decrease their willingness to take HAART. Not fitting HAART regimen into everyday life was reported to increase the chance of missing doses.

Together, based on the results from the included studies, there are several implications for practice, policy and future research. In practice, firstly, it is recommended that health professionals should assess HIV-positive drug users’ adherence to HAART on a regular basis, given the dynamic and fluid process of drug users’ adherence to HAART. Secondly, this paper recommends health professionals to provide care to HIV-positive drug users with respect, dignity, and non-judgemental
attitudes. Thirdly, it is suggested that HIV-positive drug users’ psychological well-being, support system, and experience of HAART taking should be incorporated and emphasised in the care plan. The provision of coping strategies by health professionals and peer support groups, with regards the common issues experienced by drug users, can enable them to manage HAART taking more effectively. Fourthly, this review stresses the importance of linking HIV care with addiction care and prison settings. In doing so, it can help to retain HIV-positive drug users’ access to HIV care and optimise their health outcomes.

For policy uptake, this review offers suggestive evidence for policy makers to create a supporting and inclusive environment for HIV-positive drug users to minimise social stigmatisation. Policy makers can take the initiative to increase the accessibility of HIV care in communities and prison settings, and bridge the gaps between HIV and addiction services. In addition, this paper suggests that national governments should ensure the rights of HIV-positive drug users are protected, thereby they can access health and social services without fear of discrimination or stigmatisation.

In terms of implications for future research, although quantitative research on HIV-positive drug users’ adherence rates has been conducted extensively, there is a paucity of qualitative research focusing on HIV-positive drug users’ experiences of HAART taking. This review suggests the need to gain insight into their experiences of taking HAART and further develop a model or framework that can enhance understanding their adherence behaviour. This can provide a guideline for policy makers and health professionals to assess HIV-positive drug users’ adherence to HIV care, and further develop associated interventions.
While this review provides a comprehensive understanding of HIV-positive drug users’ adherence rates across the studies and the influencing factors, there are limitations. Firstly, this review article did not conduct statistical tests. Due to different standards of optimal adherence rates and adherence assessment tools used by the included studies, this increased the difficulties of estimating HIV-positive drug users’ adherence levels. Secondly, during the process of this systematic literature review, expert discussion panels were not involved in the reviewing process. Consequently, this may bring authors’ biases into the analysis. Last but not least, all of the included studies assess HIV-positive drug users’ adherence levels and experience of HAART taking through self-report. This might lead to overestimation of their adherence levels and introduction of socially-desirable answers when synthesising the evidence.

**Conclusion**

This is the first review article that includes both qualitative and quantitative research, and provides a more comprehensive and in-depth understanding of HIV-positive drug users’ experience of HAART-taking. The results from this review can provide insight into the underlying issues that could potentially influence HIV-positive drug users’ adherence to HAART. However, the mechanism of HAART-taking behaviour in HIV-positive drug users remains to be elucidated. This would be fruitful area for further work to ensure appropriate system, services, and support for this group of the HIV population.
References


8. Ingersoll K. The impact of psychiatric symptoms, drug use, and medication regimen on non-adherence to HIV treatment. AIDS Care 2004;16:199-211.


75. Shrestha R., Copenhagen M. M. Viral suppression among HIV-infected methadone-maintained patients: The role of ongoing injection drug use and adherence to antiretroviral therapy (ART). *Addict Behav* 2018;85:88-93.

Figure 1: Flowchart of the study selection process

Published articles:
CINAHL (N=1074)
ASSIA (N=756)
Ovid database (Medline, Embase, and PsycINFO) (N=2137)
Thesis:
CINAHL (N=0)
ASSIA (N=0)
Ovid (N=1)

Articles found (N=3968)

Reasons for excluding the articles during the title screening stage (N=3848):
1. Intervention research
2. Children.
3. Sample is not HIV-positive drug users
4. Not related to antiretroviral adherence or non-adherence
5. Duplicates

Remaining articles for the abstract and full text screening N=120

Reasons for excluding the articles (N=74):
1. Small sample size of drug users group
2. Full text is not accessible
3. Examining the effectiveness of interventions
4. Aims were to test adherence measurement
5. Review literature
6. Did not define adherence or explain how 95% adherence was measured
7. Unclear definition of substance abusers
8. Not focusing on drug users, and simply reporting the association between adherence and drug use among general HIV population
9. Results drawing from an intervention evaluation research, simply reporting the association between appearance concerns and non-adherence
10. Focusing on viral suppression or CD4 count not adherence
11. Dependent variable is acceptance of HAART or health seeking behaviour
12. Not drug users but persons with incarceration or sexual abuse
13. Simply reporting the association between adherence and influencing factors without explicit explanation

Articles were assessed for eligibility (N=46)

11 qualitative studies, 40 quantitative studies were included in this review

Hand searched 3 articles from the reference lists of systematic review articles
Two recently-published articles were included in this review

Identified

Screening

Eligibility

Included
<table>
<thead>
<tr>
<th>Method</th>
<th>Authors /Project period</th>
<th>Sample size</th>
<th>Sample</th>
<th>Sampling</th>
<th>Measure of adherence</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ongoing prospective observational cohort study conducted in Vancouver since 1996</td>
<td>Azar et al. (2015)/(1996-2013) Title: Drug use patterns associated with risk of non-adherence to antiretroviral therapy among HIV-positive illicit drug users in a Canadian setting: A longitudinal analysis</td>
<td>N=692</td>
<td>HIV-positive illicit drug users</td>
<td>Convenient sampling Snowball sampling</td>
<td>Pharmacy dispensation record The ratio of number of days the patients received HAART refills/Total number of days of medical follow-up</td>
<td>Heroin and cocaine use was associated with lower likelihoods of optimal adherence (≥95% adherence rate); MMT was associated with greater likelihood of adherence. 51% of the participants were categorised by ≥95% adherence.</td>
</tr>
<tr>
<td>Canada Hadland et al. (2012) / (1996-2008) Title: Young Age Predicts Poor Antiretroviral Adherence and Viral Load Suppression Among Injection Drug Users</td>
<td>N=545 HIV-positive IDUs Convenient sampling Pharmacy dispensation record</td>
<td>Follow-up period: 8.5months to 91.6 months. Adherence rate was significantly lower among young IDUs. Adherence is a mediator of the relationship between age and viral load suppression 66 (33.8%) discontinued ART during follow-up period.</td>
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</table>
Hayashi et al. (2016) / (2005-2013)
Title: Factors associated with optimal pharmacy refill adherence for antiretroviral medications and plasma HIV RNA nondetectability among HIV-positive crack cocaine users: a prospective cohort study
N=438
HIV-positive crack cocaine users
Convenient sampling
Pharmacy dispensation record
There were 26.6% periods in which individuals were more than 95% adherent in 4460 observations

Title: Dose-response relationship between methadone dose and adherence to antiretroviral
N=297
HIV-positive individuals who use opioid
Convenient sampling
Pharmacy dispensation record
Median follow-up period: 42.1 months
MMT dose > 100mg per day was associated with optimal adherence (≥95% adherence rate)

Convenient sampling
Snowball sampling
Pharmacy dispensation record
<table>
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<tr>
<th>Joseph et al. (2015)/(1996-2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title:</strong> Factors linked to transitions in adherence to antiretroviral therapy among HIV-infected illicit drug users in a Canadian setting</td>
</tr>
<tr>
<td>N=703</td>
</tr>
<tr>
<td>HIV-positive illicit drug users</td>
</tr>
<tr>
<td>Convenient sampling</td>
</tr>
<tr>
<td>Pharmacy dispensation record</td>
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</tbody>
</table>

27% of the participants (n=190) had optimal adherence. Transition out of optimal adherence (≥ 95%) was associated with younger age, periods of homelessness, active injecting drug use, and incarceration. Individuals who transitioned into optimal adherent were older. Periods of sex work and injecting drug use were barriers to becoming optimally adherent. MMT was associated with optimal adherence and had a protective effect against being non-adherent.
<table>
<thead>
<tr>
<th>Study Authors (Publication Year) / (First and Last Treatment Years)</th>
<th>Title</th>
<th>Sample Size</th>
<th>Participant Characteristics</th>
<th>Data Collection Method</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann et al. (2012) / (1996-2009)</td>
<td>Improved adherence to modern antiretroviral therapy among HIV-infected injecting drug users</td>
<td>N=682</td>
<td>HIV-positive IDUs</td>
<td>Convenient sampling</td>
<td>The proportion of achieving at least 95% adherence increased over time from 19.3% in 1996 to 65.9% in 2009. Initiation year was associated with ≥ 95% adherence.</td>
</tr>
<tr>
<td>Nolan et al. (2011) / (1996-2008)</td>
<td>Adherence and plasma HIV RNA response to antiretroviral therapy among HIV-seropositive injection drug users in a Canadian setting</td>
<td>N=267</td>
<td>HIV-positive IDUs</td>
<td>Convenient sampling</td>
<td>17-95 months of follow-up. 30% of the 267 participants had ≥ 95% of adherence during the first year of ART. ≥95% adherence, participation in MMT, and older age, year of ART initiation was positively associated with viral suppression.</td>
</tr>
</tbody>
</table>
| Palepu et al. (2011) / (1996-2008) | N=545 | HIV-positive IDUs | Convenient sampling | Pharmacy dispensation record | 26.6% had ≥ 95% adherence
Follow-up duration: 23.8 months (8-91 months)
Homelessness and frequent heroin use were negatively associated with optimal adherence (≥ 95%), whereas MMT was positively associated. |
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<tr>
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<tbody>
<tr>
<td>Title: Homelessness and Adherence to Antiretroviral Therapy among a Cohort of HIV-Infected Injection Drug Users</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lee et al. (2016) / (2005-2013)</th>
<th>N=667</th>
<th>HIV-positive IDUs</th>
<th>Convenient sampling</th>
<th>Pharmacy dispensation record</th>
<th>85.9% of 650 participants achieved 95% or greater ART adherence at some point during the study period. In multivariable analyses, factors positively associated with 95% or greater ART adherence included adherence self-efficacy, age, current enrollment in MMT, and CD4 cell count, while drug use patterns and negative outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: Psychosocial Factors in Adherence to Antiretroviral Therapy Among HIV-Positive People Who Use Drugs</td>
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<tr>
<td>Study</td>
<td>Sample Size</td>
<td>Study Design</td>
<td>Data Collection</td>
<td>Follow-up</td>
<td>Findings</td>
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<tr>
<td>Ti et al. (2014) (1996-2012) Suboptimal plasma HIV-1 RNA suppression and adherence among sex workers who use illicit drugs in a Canadian setting: an observational cohort study</td>
<td>N=587</td>
<td>Prospective cohort study in Vancouver</td>
<td>Convenience sampling</td>
<td>18-60 months follow-up</td>
<td>Average adherence rate was 50% Adherence mediated the relationship between sex work and suppression of viral load</td>
</tr>
<tr>
<td>Wood et al. (2004) Elevated rates of antiretroviral treatment discontinuation among HIV-infected injection drug users: implications for drug policy and public health</td>
<td>N=1422</td>
<td>Prospective cohort study in Vancouver</td>
<td>Convenience sampling</td>
<td>Discontinuation was defined as the first day of a ≥3-month period without receiving any antiretrovirals</td>
<td>History of injection drug use was associated with more rapid discontinuation of therapy At 12 months of after ART initiation, 30.3% of non-IDU versus 42.5% of IDU had discontinued HAART (P &lt; 0.001).</td>
</tr>
<tr>
<td>Kerr (2003) Psychosocial determinants of maintenance of, and adherence to, antiretroviral</td>
<td>N=160</td>
<td>Dissertation</td>
<td>Convenience sampling</td>
<td>In total, 71 (44%) participants discontinued HAART, and 89 (56%) remained on HAART.</td>
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</tr>
<tr>
<td>Country</td>
<td>Study Type</td>
<td>Authors</td>
<td>Study Title</td>
<td>Sample Size</td>
<td>Measures</td>
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<tr>
<td>USA</td>
<td>Longitudinal study</td>
<td>Kerr et al. (2005)</td>
<td>Determinants of HAART discontinuation among injection drug users</td>
<td>4340</td>
<td>Discontinuation, which refers to the cessation of ART. Discontinuation: They had not picked up any components of their HAART regimen for one month.</td>
</tr>
<tr>
<td>USA</td>
<td>Longitudinal study in New York</td>
<td>French et al. (2011)</td>
<td>Changes in Stress, Substance Use and Medication Beliefs are Associated with Changes in Adherence to HIV Antiretroviral Therapy</td>
<td>2089/4340 (48.1%)</td>
<td>HIV-positive substance users (use of cocaine, crack, heroin in the past 3 days)</td>
</tr>
<tr>
<td>Study Description</td>
<td>Reference</td>
<td>Sample Size</td>
<td>Data Collection</td>
<td>Data Analysis</td>
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<tr>
<td>Cross-sectional study in 9 states of the USA</td>
<td>Chitsaz et al. (2013)</td>
<td>N=1270</td>
<td>Convenient sampling</td>
<td>Self-report: The number of pills prescribed per day and the number of doses they missed in the 7 days</td>
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<tr>
<td>Title: Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail</td>
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Clients who transitioned from being not sure to very sure about the effectiveness of ART were significantly more likely to transition from non-adherent to adherent. Clients who changed from low stress to high stress were three times more likely to change from adherent to non-adherent.

Among all subjects, 72% had used drugs in the 30 days. Drug use severity was negatively correlated with 1) having an HIV care provider, 2) being prescribed ART, 3) high levels of adherence (>95%). Being employed and paid for work was associated with a two-fold
<table>
<thead>
<tr>
<th>Study Type</th>
<th>Authors (Year)</th>
<th>N</th>
<th>Population Description</th>
<th>Sampling Method</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sectional study in multiple sites of USA</td>
<td>Sharpe et al. (2004)</td>
<td>785</td>
<td>HIV-positive black women</td>
<td>Convenient sampling</td>
<td>The outcome variable, ART adherence, was measured with a single question, “How often are you able to take the HIV/AIDS drugs exactly the way your doctor told you to take them?” The four-category Likert scale (always, usually, sometimes, rarely) was dichotomized into always and not always.</td>
</tr>
<tr>
<td>Cross-sectional study in South Florida</td>
<td>Surratt et al. (2015)</td>
<td>503</td>
<td>HIV-positive substance abusers (Heroin and Cocaine users)</td>
<td>Convenient sampling</td>
<td>Total ARV doses prescribed and total doses missed in the past 7 days</td>
</tr>
</tbody>
</table>

Increased likelihood of optimal adherence. The commonly used drugs were marijuana, cocaine, and heroin.
<table>
<thead>
<tr>
<th>Study Type</th>
<th>Authors</th>
<th>Sample Size</th>
<th>Participants</th>
<th>Sampling Method</th>
<th>Self-report Measure</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sectional study in USA</td>
<td>Shrestha and Copenhaver (2018)</td>
<td>N=133</td>
<td>HIV-infected methadone-maintained patients</td>
<td>Convenient sampling</td>
<td>Self-report measure: percent of doses taken during the previous 30 days</td>
<td>Optimal adherence means 95% adherence. One in five was not able to achieve viral suppression. Opioid-dependent individuals who are stabilised on methadone remain at high risk for poor virologic suppression and increased HIV transmission.</td>
</tr>
<tr>
<td>Prospective observational study in Florida</td>
<td>Waldrop-Valverde et al. (2013)</td>
<td>N=99</td>
<td>HIV-infected Cocaine users</td>
<td>Convenient sampling</td>
<td>Using an electronic monitoring device (MEMs) and self-report Adherence</td>
<td>Compared to the first month, there was a significant drop in adherence at Months 2, 3, 4, and 6 for percentage dose adherent. There was a reduction from 76.7 at Month 1 to 66.5 at Month 6 for percentage dose adherent (MEMs). From 66.4 at M1 to 57.3 at M6 for percentage days.</td>
</tr>
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</table>


<table>
<thead>
<tr>
<th>Study Type</th>
<th>Authors</th>
<th>Sample Size</th>
<th>Participant Characteristics</th>
<th>Data Collection Method</th>
<th>Adherence Definition</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sectional</td>
<td>Harzke et al. (2004)</td>
<td>N=137</td>
<td>HIV-positive African American drug users</td>
<td>Self-reporting</td>
<td>Self-rating their level of adherence (ranging from always missing doses to never missing doses)</td>
<td>Perceived efficacy of ART, and perceived barriers, simply forgetting to take medications were independently associated with adherence.</td>
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<tr>
<td>Cross-sectional</td>
<td>Hicks et al. (2007)</td>
<td>N=659</td>
<td>HIV-positive former, current, and never substance abusers</td>
<td>Self-reporting</td>
<td>The doses missed in the past 2 weeks. Adherence was defined as taking greater than or equal to 95% of prescribed doses of all antiretroviral drugs in the HAART regimen</td>
<td>67% had ≥ 95% adherence rate. Current users (60%) were significantly less likely to be adherent than former (68%) or never users (77%). Former users in substance abuse treatment were as adherent to HAART as never users. Former users who had not received recent substance abuse treatment were significantly less adherent than never users. Current substance users were significantly less adherent than...</td>
</tr>
<tr>
<td>Study Type</td>
<td>Study Title</td>
<td>Sample Size</td>
<td>Methods</td>
<td>Findings</td>
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<tr>
<td>Cross-sectional study</td>
<td>Title: Affective Correlates of Stimulant Use and Adherence to Anti-retroviral Therapy Among HIV-positive Methamphetamine Users</td>
<td>N=122</td>
<td>Convenient sampling</td>
<td>The majority of participants were MSM (94%). Among the MSM, 84% identified as predominantly or exclusively gay. Positive affect was independently associated with a decreased likelihood of reporting any injection drug use and an increased likelihood of reporting perfect ART adherence. Increase in affect regulation decreased the likelihood of regular stimulant use and non-adherence to ART.</td>
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<tr>
<td></td>
<td>Title: Affect Regulation, Stimulant Use, and Viral Load Among HIV-Positive Persons on Antiretroviral Therapy</td>
<td>N=858</td>
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</tr>
<tr>
<td>A multisite cohort study</td>
<td>Title: Adherence to antiretroviral medications and medical care in HIV-infected adults diagnosed with mental and substance abuse disorders</td>
<td>N=1138</td>
<td>Self-report: The number of missed doses in the past three days</td>
<td>Complete adherence in the past 3 days: 55% of the participants 45% of those on ARVs reported skipping medications in the past three days</td>
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</table>
The factors associated with non-adherence were current drug and alcohol abuse, increased psychological distress, less attendance at medical appointments, non-adherence to psychiatric medications and lower self-reported spirituality. Increased psychological distress was significantly associated with non-adherence, independent of substance abuse.

<table>
<thead>
<tr>
<th>Cross-sectional study</th>
<th>Magidson et al. (2015)</th>
<th>N=83</th>
<th>Low-income HIV-positive substance abusers</th>
<th>Convenient sampling</th>
<th>Self-report: The number of doses missed versus doses prescribed over the past 4 days for all daily medications</th>
<th>Mean adherence rates ranged from 94.46 to 97.72 % in the past 4 days Crack use is significantly associated with missing doses There was only an indirect effect of environmental punishment; depressive symptoms were associated with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-sectional study</td>
<td>Moore et al. (2012)</td>
<td>N=125</td>
<td>67 HIV-positive lifetime meth users</td>
<td>Convenient sampling</td>
<td>Self-report: Taken doses/prescribed doses in the past 4 days</td>
<td>Major depressive disorder uniquely predicted ART non-adherence after controlling for the other variables. Ancillary analyses indicated that current METH users (use within 30 days) were significantly less adherent than lifetime METH users and non-Meth users. Of those, neurocognitive impairment was associated with non-adherence.</td>
</tr>
</tbody>
</table>
Cross-sectional study

Title: Psychosocial Mediators of Antiretroviral Nonadherence in HIV-Positive Adults With Substance Use and Mental Health Problems

N=1889

HIV-positive individuals (23% of those were IDUs)

Convenient sampling

Self-report Adherence: Not missing any doses

46% of the participants were adherent. Those in the drug use only group were not significantly more likely to be nonadherent than those with no mental health or substance use problems. Substance use group was more likely than those with no problems to have poor access. Drug use group was more likely to report poorer fit of the medication regimen with their lifestyle.

Secondary data analysis from another study

Title: Social Networks of Substance Users With HIV Infection: Application of the Norbeck Social Support Scale

N=76

HIV-positive individuals who use methadone

Self-report measure

The presence of network drug users and HIV-infected network members was associated with less antiretroviral medication adherence. Note: The dependent variable, antiretroviral adherence, was
| Study Type                  | Title                                                                 | N   | Population | Methodology | Outcome                                                                 |
|----------------------------|-----------------------------------------------------------------------|-----|------------|-------------|=========================================================================|
| Prospective cohort study   | Lucas et al. (2001) Detrimental effects of continued illicit drug use on the treatment of HIV-1 infection | 764 | HIV-positive individuals | Conventional sampling | Self-report: Non-adherence means participants report of more than two missed doses over the 2 weeks. Active drug users were more likely to be non-adherent. Forty-four percent of active drug users failed to utilise HAART compared with 22% of former drug users and 18% of non-drug users. |
| Longitudinal study         | Hinkin et al. (2007) Drug use and medication adherence among HIV-1 infected individuals | 105 | Stimulant users Non-stimulant users | Conventional sampling | MEMS caps: Dividing actual dose events by prescribed doses during 1 month period. Adherence: taking ≥ 90% doses. The drug-negative group's adherence rate was 79% as compared to 63% for the drug-positive group. Over time, adherence rates for the entire sample dropped from 74.4% for the first 2 months, to 68.5% for months |
Stimulant positive group’s adherence rate was significantly lower than both the other-drug positive group ($P = .001$) as well as the non-drug group.

Between group comparisons revealed a trend toward the cocaine + methamphetamine group evidencing poorer adherence than did the cocaine only group. The mean adherence rate for the cocaine only group was 68.1% vs. 54.5% for the cocaine + methamphetamine group. Although the non-abuse group’s mean adherence rate was significantly lower than both the other-drug positive group ($P < .001$) as well as the non-drug group, comparisons revealed a trend toward the cocaine + methamphetamine group evidencing poorer adherence than did the cocaine only group.
Cross-sectional study  | Arnsten et al. (2007)  
Title: Factors Associated With Antiretroviral Therapy Adherence and Medication Errors Among HIV-Infected Injection Drug Users  
N=636  | HIV-infected drug users  | Convenient sampling  | Self-report Good adherence: taking ≥ 90% doses  | 75% (n=477) self-reported good adherence. Depressive symptom and self-efficacy were associated with poor adherence.  

Prospective study  | Arnsten et al. (2002)  
Title: Impact of active drug use on antiretroviral therapy adherence and viral suppression in HIV infected drug users  
N=85  | HIV-positive current and former drug users  | Convenient sampling  | MEMS caps (electronic pill caps) –Dividing the number of cap opening by the number of doses prescribed  | Mean overall adherence was 53%. Active cocaine use, female, not receiving social security benefits, not being married, positive for depression, the tendency to use alcohol or drugs to cope with stress were all associated with poor adherence. The strong
A predictor of poor adherence was active drug use. Adherence among active cocaine users was 20%, compared to 66% in subjects who did not use cocaine.

<table>
<thead>
<tr>
<th>Study Type</th>
<th>Study Details</th>
<th>Sample Size</th>
<th>Methodology</th>
<th>Measures</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Prospective study</td>
<td>Kalichman et al. (2015) Title: Intentional Medication Nonadherence Because of Interactive Toxicity Beliefs Among HIV-Positive Active Drug Users</td>
<td>N=530</td>
<td>HIV-positive drug users</td>
<td>Convenient sampling Telephone-based unannounced pill counts over a 6-week period</td>
<td>189 (35%) participants indicated that they intentionally miss their ART when they are using drugs. These participants perceived hazards of mixing HIV medications with alcohol and other drugs. Participants who reported intentional nonadherence at the initial assessment were significantly more likely to have poorer adherence over the subsequent 6 weeks</td>
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<tr>
<td>Retrospective cohort study</td>
<td>Turner et al. (2003) N=1827 (female) N= 3246 (male) HIV-positive IDUs</td>
<td>Convenient sampling Pharmacy-based measurement of adherence</td>
<td>The mean adherence was 83.2%</td>
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<tr>
<td>Title: Relationship of gender, depression, and health care delivery with antiretroviral adherence in HIV-infected drug users</td>
<td></td>
<td></td>
<td>adherence (filled prescription) Adherence means &gt;95%</td>
<td>22% of the study population were adherent at a 95% level. Adherence was higher among those who received regular drug treatment and psychiatric care. Women were less adherent than men. In women, adherence was significantly poor for those with cocaine or heroin use.</td>
<td>51</td>
</tr>
<tr>
<td>Study</td>
<td>Authors</td>
<td>Title</td>
<td>Sample Size</td>
<td>Population</td>
<td>Sampling Method</td>
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<tr>
<td>France</td>
<td>Carrieri et al. (2003)</td>
<td>Failure to Maintain Adherence to HAART in a Cohort of French HIV-Positive Injecting Drug Users</td>
<td>N=96</td>
<td>HIV-positive IDUs</td>
<td>Convenient sampling</td>
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<tr>
<td>France</td>
<td>Moatti et al. (2000)</td>
<td>Adherence to HAART in French HIV-infected injecting drug users: the contribution of buprenorphine drug maintenance treatment</td>
<td>N=164</td>
<td>HIV-positive IDUs</td>
<td>Convenient sampling</td>
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<tr>
<td>Bouhnik et al. (2002)</td>
<td>210</td>
<td>HIV-positive former or current IDUs</td>
<td>Convenient</td>
<td>Self-report Non-adherence means taking less than &lt;80% of prescribed doses</td>
<td>Among ex-IDUs, the only factor associated with nonadherence was social instability. Among opioid-dependent patients, injection behaviour was the only determinant of nonadherence behaviour.</td>
</tr>
<tr>
<td>Roux et al. (2008)</td>
<td>276</td>
<td>HIV-positive IDUs</td>
<td>Convenient</td>
<td>The visual analogue scale was used to reclassify as non-adherent those whose score was &lt;100%. Patient’s adherence to HAART in the 4 days and in the 4 weeks prior to the interview.</td>
<td>Patients ceasing injection during OST and abstinent patients exhibited comparable adherence. Patients reporting injection, on OST or not, had a twofold and threefold risk, respectively, of non-adherence compared with abstinent patients.</td>
</tr>
</tbody>
</table>
The Netherlands

Lambers et al. (2011)

Title: Harm reduction intensity—Its role in HAART adherence amongst drug users in Amsterdam

N=102

HIV-positive drug users

Convenient sampling

Self-report measure: the number of days that medication was not taken in the last 6 months.

The rate of non-adherence (95%) ranged from a minimum rate of 6.2% (in 2002) to a maximum rate of 18.9% (in 2005) of the visits per year. Of the 76 participants who were adherent on their first included visit and who had a follow-up visit, 26 became non-adherent at least once in the study period. Non-injecting DUs with low dependence on harm reduction were less adherent than DU with complete harm reduction. Unsupervised housing (no access to structural support at home) and having a steady partner were significantly associated with respectively more and less non-adherence.
<table>
<thead>
<tr>
<th>Vietnam</th>
<th>Prospective study</th>
<th>Jordan et al. (2014)</th>
<th>N=100</th>
<th>HIV-positive individuals with a history of drug use</th>
<th>Convenient sampling</th>
<th>Subjective rating (perfect, very good, good, fair, or poor adherence)</th>
<th>48% of participants reported drug use within the previous 6 months, with 22% reporting current drug use. Overall levels of self-reported ART adherence in this cohort were high (83% reporting perfect/very good adherence at the time of study enrollment) Active drug use and duration of ART increase the odds of suboptimal ART adherence</th>
</tr>
</thead>
</table>
India Cross-sectional study Sharma et al. (2007) Title: Access, adherence, quality and impact of ARV provision to current and ex-injecting drug users in Manipur (India): An initial assessment N=226 Current and ex-injecting drug users Purposive sampling and convenient sampling Treatment discontinuation One-third of the sample reports ever having discontinued ART (74/226).
Experience of side effects, whether ART is provided free, whether patients received counselling, and alcohol use was associated with ART discontinuation.

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<tr>
<th>Country</th>
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<th>Data analysis method</th>
<th>Major themes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Pach et al. (2003)</td>
<td>A qualitative investigation of antiretroviral therapy</td>
<td>34 HIV-positive IDUs</td>
<td>Convenient sampling Snowball sampling</td>
<td>Ethnographic interviews</td>
<td>-</td>
<td>Group 1 (N=8): Never on ART 1. Involving in active drug use</td>
</tr>
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<tr>
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<td>among injection drug users</td>
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</table>

2. Lacking information from health professionals about HAART
3. Having ambivalent or negative attitudes about the safety of the medication and the intentions of health care providers

**Group 2 (N=7): Stopped AZT and never sought other treatment.**
1. Active drug use
2. Lack of contact with HIV services
3. Negative experience with side effects from AZT
4. Exposure to negative attitudes about AZT deterred members of this group from continuing their use of ART or later considering the use of ART

**Group 3 (N=9): Stopped undergoing HAART**
1. Perceptions of HAART that altered in significance as their circumstances and experiences with the medication changed (e.g. level of drug use, lack of available drug treatment, severity of side effects, prior experience with clinicians)

**Group 4 (N=10): Undergoing HAART**
Working, living with relatives, receiving disability payments,
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
|         | Ware et al. (2005) | Adherence, stereotyping and unequal HIV treatment for active users of illegal drugs    | 52 HIV-positive active drug users | Convenient sampling | Qualitative interviews | Analytic approach – Glaser and Strauss, Strauss and Corbin | 1. Daily lives of participants  
2. How drug use impedes adherence  
*Acquiring drugs  
*Consuming drugs  
*Recovering from drug use  
3. Not carrying medication  
4. Competing priorities  
5. Redefining regimens  
6. Efforts to adhere to HAART  
*Taking medications while using  
*Prioritising adherence  
*Sticking with a set of rules: the significance of routines for adherence |
| Canada  | Small et al. (2009) | The impact of incarceration upon adherence to HIV treatment among HIV positive injection drug users: A qualitative study | 12 HIV-positive IDUs | Sampling at correctional settings | In-depth individual interviews | Thematic analysis | 1. Entry into the correctional system and interruption of treatment  
2. Difficulties accessing HIV medications within the correctional system  
3. Challenges related to institutional health care services and HIV care  
4. The importance of advocacy and communication  
5. HIV discrimination amongst prisoners  
6. Problems upon release to the community |
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<tr>
<td></td>
<td>Russian</td>
<td>Drug treatment and the conditionality of HIV treatment access: a qualitative study in a Russian city</td>
<td>42 HIV-positive IDUs 11 health practitioners</td>
<td>Chain referral sampling</td>
<td>In-depth qualitative interviews</td>
<td>Thematic analysis</td>
<td>1. HIV treatment conditionality and delay 2. The problem of drugs in HIV treatment access 3. The problem of inadequate drug treatment</td>
</tr>
<tr>
<td></td>
<td>Kiriazova et al. (2016)</td>
<td>“It is easier for me to shoot up”: stigma, abandonment, and why HIV-positive drug users in Russia fail to link to HIV care</td>
<td>HIV-positive drug users</td>
<td>Convenient sampling</td>
<td>Individual interviews</td>
<td>Thematic analysis</td>
<td>1. Stigma and poor patient-provider relationships 2. Fragmentation of health care</td>
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</table>
| India   | Chakrapani et al. (2014) | Barriers to antiretroviral treatment access for injecting drug users living with HIV in Chennai, South India | 19 HIV-positive IDUs 4 key informants | Recruited by peer outreach workers | Semi-structured interviews | Framework analysis | Family and social barriers  
1. Lack family support and fear of societal discrimination  
2. Unmet basic needs - food and shelter  
Health care system barriers  
1. Actual or perceived unfriendly hospital environment and procedures  
2. Provider-perceived nonadherence  
3. Actual or perceived inadequate counselling services and lack of confidentiality  
4. Lack of effective linkages between ART centres, needle/syringe programs, and drug dependence treatment centres  
Individual-level barriers  
1. Active drug use  
2. Lack of self-efficacy and low motivation  
Inadequate knowledge about ART |
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</tr>
</thead>
</table>
| Spain   | De la Hera et al. (2011) | The opinions of injecting drug user HIV patients and health professionals on access to antiretroviral treatment and health services in Valencia, Spain | 23 HIV-positive IDUs, 9 health professionals | Convenient sampling | Semi-structured interviews | The codification process followed Strauss and Corbin’s (1990) analytic procedure | Health professionals
1. Lack of coordination among hospital services
2. Difficulties in accessing non-specialised services
3. Their perceptions of a patient’s likelihood of treatment adherence

IDUs
1. A good doctor-patient relationship
2. Family responsibility (Female participants)
3. Complexity and side effects of the treatment
4. lack of social support
5. active use of recreational drugs
6. Accessibility of services
7. Beliefs about HAART |