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National AIDS Control Organisation
India's voice against AIDS
Ministry of Health & Family Welfare, Government of India
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Female injecting drug users and female sex partners of men who inject drugs

Assessing care needs and developing responsive services

Project HIFAZAT: Strengthen the capacity, reach and quality of IDU harm reduction services

OPERATIONAL RESEARCH

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Female Injecting Drug Users and Female Sex Partners of Men who Inject Drugs

Assessing Care Needs and Developing Responsive Services

"Currently 'Injecting Drug Users' (IDUs) are referred to as 'People Who Inject Drugs' (PWID). However, the term 'Injecting Drug Users' (IDUs) has been used in this document to maintain consistency with the term used presently in the National AIDS Control Programme".

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Preface

In India, targeted intervention (TI), under the National AIDS Control Programme (NACP) framework, is one of the core strategies for HIV prevention amongst injecting drug users (IDUs). Apart from providing primary health services that include health education, abscess management, treatment referrals, etc., the TIs have also designated centres for providing harm reduction services such as Needle Syringe Exchange Program (NSEP) and Opioid Substitution Therapy (OST). The services under the TIs are executed through a peer based outreach as well as a static premise based approach, i.e., through Drop-In Centres (DIC) which in turn serves as the nodal hub for the above activities to be executed.

To further strengthen these established mechanisms under the NACP and to further expand the reach to vulnerable IDUs, United Nations Office on Drugs and Crime (UNODC) in India provides technical assistance to the National AIDS Control Organisation (NACO) through the Global Fund Round 9 Project (i.e., Project HIFAZAT), amongst others. In doing so, UNODC supports NACO through technical assistance to undertake the following:

1) Conduct Operational Research
2) Develop Quality Assurance SOPs
3) Develop Capacity Building/Training materials
4) Training of Master Trainers

It is in this context, that a study, "Operational Research on Female Injecting Drug Users and Female Sex Partners of Men who Inject Drugs – Assessing Care Needs and Developing Responsive Services" has been conducted. The study aims to document the HIV prevention, treatment and care service needs among the FIDUs and FSPs and review the existing models of related response available.

This report involved reviewing of global, regional and local literature pertaining to drug use among females and analysis of data generated through key informant interviews with FSPs, FIDUs and service providers engaged in interventions among them. Finally, recommendations have also been provided to strengthen the services.

This study therefore, has been conducted with a vision to serve as an invaluable tool to improve the quality of services provided to FIDUs and FSPs. Contributions from the Technical Working Group of Project Hifazat, which included representatives from NACO, Project Management Unit (PMU) of Project Hifazat, SHARAN, Indian Harm Reduction Network and Emmanuel Hospital Association was critical towards articulating and consolidating the study.

Acknowledgement

The UN Office on Drugs and Crime, Regional Office for South Asia (UNODC ROSA), in partnership with national government counterparts from the drugs and HIV sectors and with leading non-governmental organizations in the countries of South Asia, is implementing a project titled "Prevention of transmission of HIV among drug users in SAARC countries" (RAS/H13).

As part of this regional initiative, the UNODC is also engaged in the implementation of the Global Fund Round 9 IDU-HIV Project (i.e., HIFAZAT). Project HIFAZAT aims to strengthen the capacities, reach and quality of harm reduction among IDUs in India. It involves providing support for scaling up of services for IDUs through the National AIDS Control Programme.

We would like to acknowledge the invaluable feedback and support received from various stakeholders, including NACO, Project Management Unit (PMU) of Project HIFAZAT, Emmanuel Hospital Association (the Principal Recipient of the grant "Global Fund to Fight AIDS, Tuberculosis and Malaria- India HIV-IDU Grant No. IDA-910-G21-H"), SHARAN, Indian Harm Reduction Network and individual experts who have contributed significantly in the development of this document.

Special thanks are due to the UNODC Project H13 team for its persistent and meticulous efforts in conceptualizing, editing and consolidating this document.

We would also like to thank co-lead consultants Ms. Tushimenla, Ms. Jibanbala Kshetrimayum and Ms. Kanudeep Kaur and all the NGOs [Nirvana LS, Nirvana UNODC FIDU, SASO Alliance, Shalom EHA/ Avahan, Shalom Alliance, Bethesda UNODC FIDU, Bethesda IDU TI NSACS, Akimbo FSW, Prodigals Home FSW, VHAM UNODC FIDU, Samaritan IDU TI, FSW TI (New Life), FSW TI Volcomh, Agape Home UNODC FIDU, Rapor IDU TI, Ludhiana IDU TI, Navjeevan Panchkula IDU TI, Hopers IDU TI] from where the data was collected.

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
BYWC	Bethesda Youth Welfare Centre
CCC	Community Care Centre
CIHSR	Christian Institute of Health Sciences and Research
CMIS	Computerised Management Information System
DIC	Drop-In Centre
DOTS	Directly Observed Treatment, Short-course
DFID	Department for International Development Finance
FGD	Focus Group Discussions
FSP	Female Sex Partner
FIDU	Female Injecting Drug User
GNM	General Nursing and Midwifery
GHQ	General Health Questionnaire
HIV	Human Immunodeficiency Virus
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
ICMR	Indian Council of Medical Research
IDU	Injecting Drug User
IEC	Information Education and Communication
KI	Key Informant
MIDU	Male Injecting Drug User
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organization
NSEP	Needle Syringe Exchange Program
ORW	Outreach Worker
OST	Opioid Substitution Treatment
PD	Project Director
PE	Peer Educator

PM	Project Manager
PPTCT	Prevention of Parent to Child Transmission
RMC	Routine Medical Check-up
RNTCP	Revised National Tuberculosis Control Programme
RSRA	Rapid Situation and Response Assessment
RTI	Respiratory Tract Infection
SASO	Social Awareness Service Organization
SACS	State AIDS Prevention and Control Societies
STI	Sexually Transmitted Infection
STRC	State Training and Resource Centre
SPYM	Society for Promotion of Youth and Masses
TB	Tuberculosis
TI	Targeted Intervention
UNODC	United Nations Office on Drugs and Crime
UTI	Urinary Tract Infection
VCT	Voluntary Counselling and Testing
VHAM	Voluntary Health Association of Meghalaya

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Executive Summary

Background

Drug use can adversely impact women in two major ways. They may be affected as drug users or as sex partners of men who use drugs. Injecting drug use increases vulnerability to HIV and other infections among women (as in men), both from unsafe injecting and risky sexual practices. This population desperately needs services. In a world full of inequity, stigma and discrimination, poorly developed and networked treatment facilities, creating an enabling environment that reduces these inequities, creating affordable and accessible services that reduce the vulnerability of females who inject drugs and female sex partners poses several challenges. These can be addressed by first recognizing this growing problem, understanding the specific needs of such populations and by evaluating existing mechanisms of service delivery. Such an approach can help in developing responsive and effective services.

This review was undertaken to understand the growing problem of drug use, particularly injecting among females globally and locally as well as to evaluate some of the existing services for them and identify their care needs, particularly with respect to reducing vulnerability to HIV and other blood-borne viruses such as Hepatitis B and C. A similar exercise was undertaken with reference to female sex partners (FSPs) who are in relatively larger numbers in the country. Given the fact that male injecting drug users (MIDUs) form the biggest risk group for HIV, by proxy their female sex partners become an important target group for prevention and intervention.

The service needs for female injecting drug users (FIDUs) must be examined against the recommendations that exist in general for providing a comprehensive package of biomedical and behavioural interventions as the optimal strategy for preventing HIV among injecting drug users (IDUs). The joint technical guide developed by the WHO, UNAIDS and UNODC recommends a package of core public health interventions with nine components namely Needle Syringe Exchange Program (NSEP), Oral Substitution Treatment (OST), Voluntary Counselling & Testing (VCT), Antiretroviral Therapy (ART), Sexually Transmitted Infection (STI) prevention, Condom programming for IDUs and their sex partners, targeted Information, Education, Communication (IEC) materials for IDUs and their sex partners, Hepatitis A, B and C diagnosis and treatment, and tuberculosis (TB) prevention, diagnosis and treatment. These existing recommendations must be re-examined and modified from the gender perspective.

Methodology

The present study was conducted with the twin objectives of:

- Reviewing the existing body of work at the global and national level which documents issues related to FIDUs and FSPs of MIDUs
- Documenting the existing services for this population and their service needs.

To achieve these objectives, a global and local literature review was conducted followed by a secondary data analysis at four UNODC sites providing exclusive services to FIDUs and FSPs. Also, primary data was collected from seven sites providing services exclusively to female IDUs and female sex partners

of male IDUs, seven IDU Targeted Intervention (TI) sites, five TIs providing services to female sex workers (FSWs), and through key informant (KI) interviews with 36 FIDU and 30 FSPs.

Operational Definition

The operational definition of FIDU is consistent with the definition of injecting drug use by NACO. The same is employed in identifying FIDUs and FSPs at the UNODC intervention sites. Thus, FIDU refers to a female who has been injecting drugs any time in the last three months, and FSP refers to a female currently in a sexual relationship with an injecting drug user (IDU).

FINDINGS

Female Injecting Drug Users

Global Literature Review

A global literature review suggests a growing problem of drug use among females worldwide, an increase in injecting drug use and initiation into drug use at an early age. FIDUs are vulnerable not only because of injecting but also because many of them are initiated early into sexual activity. Besides they practice unsafe sex to support their drug habit and have drug injecting partners as well. Injecting drug practices like borrowing and sharing of needle/syringe (N/S), using these after their partner, and often being the last to use these in a group increases the vulnerability of FIDUs to HIV and other STIs. The use of alcohol along with injecting impairs judgement and increases risk taking behaviour. FIDUs are subjected to various kinds of exploitation, including sexual exploitation, particularly in neighbourhood locations where drug use is high. The South Asia region is witnessing an increase in injecting drug use among females.

Reports from India

Reports from India suggest that there has been a gradual increase in the number of FIDUs. Initially the percentage of FIDUs was more in the north-eastern states, but now their numbers are on the rise in other parts of the country as well. Injecting drug use among females appears to mirror patterns among males but with greater adverse consequences. Pharmaceutical injections are preferred because of lower cost and easy accessibility. Social adversity, high levels of exposure to substance, high levels of stigma and poor social support characterize this group. High rates of sharing and reusing, high rates of involvement in sex work, and alcohol intoxication is common. The knowledge of HIV is high, but the uptake of HIV/STI testing is low. Condom usage with regular partners is low; and they have no access to female condoms. Mental distress is very high; a significant number of FIDUs report suicide attempts. Sexual and reproductive health problems, particularly abortions are frequent. Children whose parents are both drug users have higher rates of emotional and behavioural problems. There is a perceived lack of appropriate services for the treatment of drug use and for gainful employment.

Secondary data analysis

A secondary data analysis of 222 FIDUs registered in 2010-11 at four sites implemented by UNODC in the north-east (NE) region showed that FIDUs have a high degree of inter-district mobility (30.6%), commonly engage in selling sex (39.6%), have multiple sexual encounters per day (23% of non-FSW FIDUs report having sex more than three times/day), have high levels of alcohol consumption (nearly all FSW FIDUs and 41% of non-FSW FIDUs reported alcohol consumption), and about 25% are engaged in professional sex work.

Findings from Existing IDU TI Sites

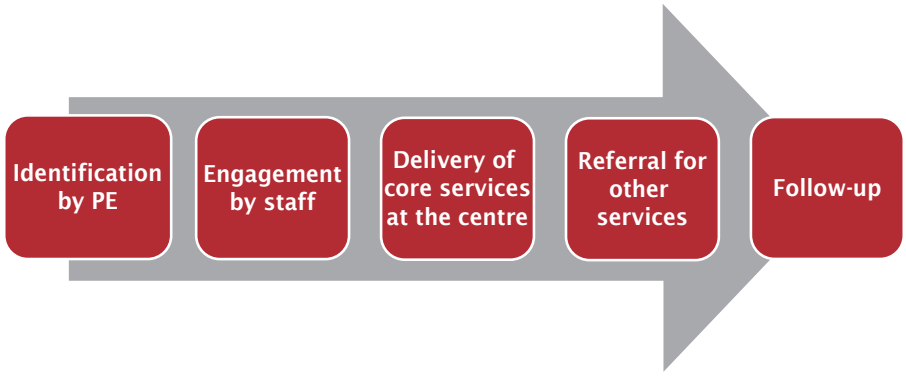
Of the seven IDU TI sites visited, only two offer services to FIDUs. These two sites offer community outreach services, N/S distribution, opioid substitution treatment (OST), condom distribution, counselling and referral for drug treatment to another NGO. One site offers both STI testing facilities and OST. At both sites, there is one female Peer Educator (PE) for reaching out to this group. While one of the TIs has a male Outreach Worker (ORW), the other has a female ORW. However, both the TIs felt that FIDUs are difficult to engage, and the uptake of HIV/STI testing among FIDUs is very low.

Findings from FSW TIs

According to the Project Managers (PMs) working in the FSW TIs, apart from injections, other drug use among FSWs includes alcohol, correction fluid, dendrite inhalation, oral use of Spasmoproxyvon, Alprazolam and chasing of brown sugar. No routine assessments for drug and alcohol use are carried out among FSWs. In Mizoram, quarterly risk assessments suggest that 17.8% of FSWs are injecting. No routine interventions are offered by three of the five sites visited.

Two sites in Mizoram have been offering a range of services to FSW FIDUs for the last one year through the State AIDS Prevention and Control Society (SACS) funding. Here, testing uptake for HIV and STI is relatively higher for FSW FIDUs. Many FSW FIDUs have also accessed condoms. The staff includes a PE (specially identified for FSW FIDUs) at one of the sites and a PE and ORW at the other. The PMs of FSW TIs perceive a need for training on IDU management with respect to outreach, mental health counselling, training of doctors for harm reduction and overdose management. IEC materials are perceived as being insufficient for this group.

The service delivery models followed at both these TIs include:



As per the PMs of these TIs, the needs of the FSW FIDUs and the barriers for receiving services include:

FSW FIDU needs as perceived by PMs

- Separate DIC for FIDUs
- IEC
- Education on safe injecting practices
- Access to OST
- Overdose management
- Drug treatment facilities
- Health education
- Livelihood support

Barriers for providing services to FSW FIDUs

- Stigma and discrimination
- Fear of identification
- Fear of pimps
- Overcrowding in government facilities
- Unable to procure OST
- Low priority given to treatment for other drugs of use

In general, the PMs expressed dissatisfaction about combining FSW and FIDU interventions, as both populations have different needs. They said that the current intervention works for FSWs with respect to reducing high risk sex but not for injecting. A concern was expressed whether injecting behaviour among FIDUs would encourage non-injecting FSWs to take to injecting.

Findings from Female Specific Intervention Sites for FIDUs

These are primarily running as demonstration projects. Seven female specific intervention sites provided information on their service delivery model and the nature of services provided by them. The staffing in all these centres is mostly female. Most centres have a female nurse. Female PEs and ORWs carry out the outreach activities. They provide basic education on HIV/AIDS testing, safe sex, safe injection practices and behaviour counselling. Female counsellors provide psychosocial counselling. All centres have a part-time doctor, mostly female. Only one site has a night shelter. It has a health worker who provides accompanied referral to access services in the government hospital, a caretaker and a cook for the night shelter. All the four sites implemented by the UNODC cater to FSPs of male IDUs, in addition to FIDUs.

All the sites provide a wide range of services. These are summarized below.

Services Offered by Female-Specific Intervention Sites

Direct		Referral
■ Outreach ■ Needle Syringe Program ■ Condom promotion and distribution ■ Education on safer practices, health, hygiene ■ Drop-in Centre ■ Abscess management ■ STI diagnosis and management ■ Regular medical check-up and care	■ Counselling on drug use and HIV ■ Overdose management ■ Crisis management ■ Free meals/Nutrition support ■ Legal help ■ Mental health counselling ■ Distribution of sanitary napkins ■ Advocacy with different stakeholders ■ Care and support	■ ANC (Government based) ■ ART centre (Government based) ■ Community Care Centre (NGO based) ■ DOTS (Government based) ■ Drug treatment (detox and rehab)-NGO ■ ICTC (Government based) ■ OST treatment (NGO based) ■ PPTCT (Government based)

Identification of FIDUs is done through outreach by PEs/peers of FIDUs, FIDUs on OST, obliging pimps and peddlers as well as male IDUs. According to one site in Manipur, their night shelter is an attraction for FIDUs who accompany their friends to the shelter.

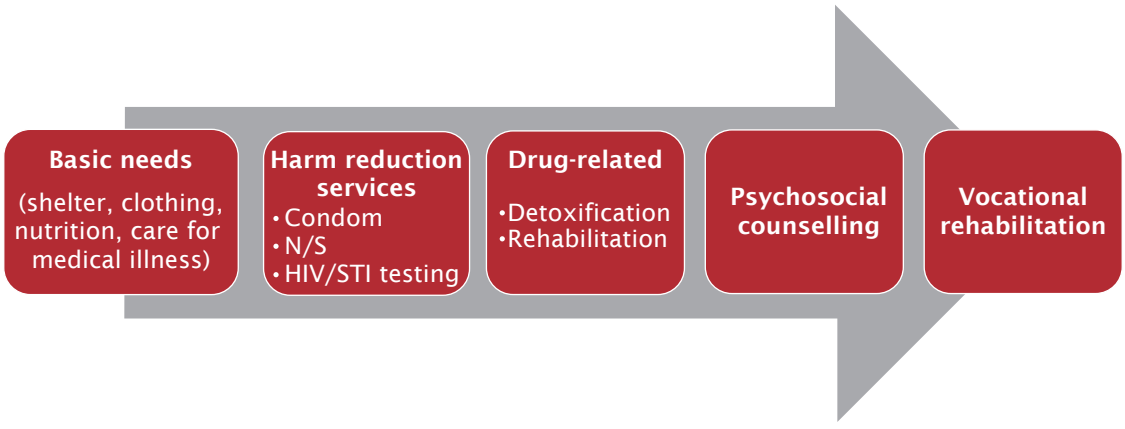
Challenges and Suggestions

Challenges	Suggestions
■ Hidden nature ■ Mobility ■ Stigma and discrimination ■ Denial ■ Poor health seeking ■ Multiple complications	■ Awareness activities and programs ■ Information about services ■ Educate about benefits of the program ■ Motivation and rapport building ■ Networking ■ Advocacy

Compared to other approaches (such as services through existing IDU TIs or FSW TIs), the uptake for HIV and STI testing is more at these sites, which cater exclusively to females. Condom access is also better, and there are high rates of condom distribution at these sites. Also, a substantial proportion of the registered FIDUs access the N/S facility. The PMs perceive significant benefits from distribution of condoms with respect to improved rates of condom use during last sexual encounter. The NSEP has helped to a very large extent in retaining FIDUs in the treatment network. The experience with

OST is, however, very limited. Additionally, there is a lack of IEC materials relevant to FIDUs. None of the sites appeared to be offering any prison based services.

The needs of the FIDUs were rated by the PMs of these TIs in a somewhat 'Maselowian model' of a needs hierarchy:



Key Informant Interviews

Key informant (KI) interviews were carried out with 36 FIDUs.The mean age was 28.6 years (SD: 5.4) and mean education level was 8.7 years (SD: 3.9). Most of the FIDUs (27.75%) were unemployed.

Twenty-seven FIDU KIs (75%) reported injecting heroin and 23 (63.9%) dextropropoxyphene.

- Personal concerns such as medical care were voiced by 26KIs (72.2%) and counselling by seven KIs (19.4%).
- Concerns about partners included worries were expressed by 16 (44.4%).
- Concerns about children pertaining to education were expressed by 13 KIs (36%) and health and nutrition by five KIs (13.9%).
- Concerns about employment were expressed by 28 FIDU KIs, unemployment was a concern for 12 (33.3%) and stigma at work was a concern for three KIs (8.3%).

FIDU KIs perceive a relatively high knowledge regarding HIV in the community, good knowledge regarding how to access condoms, N/S; however, access to OST and female condoms is low. Further, that a substantial number of FIDUs use alcohol, though self-reported of alcohol use among FIDU respondents as part of this study was not very high. Key informants also perceive that FIDUs are able to negotiate condom use fairly well with their partners and use disposable N/S most often. Sources of concern are high perception of alcohol use, borrowing of N/S and the perception that FIDUs have multiple sex partners. With respect to services received, apart from HIV-related services, the perception is that very few females receive vocational training. A majority of the FIDU KIs are satisfied with the services provided in both government and private hospitals.

Female Sex Partners

Global Review

A global review suggests that females are at risk of contracting HIV and other sexually transmitted illnesses from their intimate partners. The MIDU puts his partner at risk both through his unsafe injecting practices and high risk behaviour. The vulnerability of sex partners of MIDUs is particularly

high in developing countries where gender inequity, stigma and discrimination, poor social support, and poor availability and accessibility prevent such females from getting preventive and intervention services.

Review of Studies from India

Studies in India have highlighted concerns regarding FSPs of male drug users. The risk incurred by the FSP stems from two sources – one from the behaviour of the male IDU (sharing of N/S, multiple sex partners, low condom use – particularly in regular relationships, sexual violence, low risk perception, low disclosure of HIV status and drug use, and low uptake for testing) and the other from the FSP's own risk – low decision making powers, low condom negotiation, blame and stigma on account of the partner's drug use, poor sex negotiation capacity, high rates of emotional distress, sexual and reproductive problems that are not addressed, poor economic status and poor social support.

Findings from Existing IDU TI Sites

An analysis of the primary data collected shows that services for the FSPs are provided only in three out of the seven IDU TI sites visited. Even in these three sites, the registration of FSPs is poor. Some degree of behaviour change communication (BCC) does occur in these sites. Though HIV/STI testing is offered to this group at these three centres, there is a very low uptake for HIV and STI. There is no count of FSPs accessing condoms at most sites. A female outreach worker is present in most sites (five out of seven); while a female PE is present at two out of seven sites, and a female nurse is present at only one out of seven sites.

The PMs from the IDU TIs identified the following needs of the FSPs and barriers for seeking services.

Needs of Female Sex Partners

- Health/Medical care
- STI treatment
- Life skills and vocational training
- Forming support groups
- Services for male IDU partner
- Services for children
- Female condoms

Barriers to Seek Services

- Lack of separate facility for women
- Stigma, Discrimination
- Fear of disclosure
- Partner's resistance for help seeking
- Reluctance to come to the centres
- Need for accompanied referral
- Lack of family support

Findings from FSW TIs

Interviews with the staff of the FSW TIs showed that there is no routine assessment to identify FSWs, and most centres do not offer special services to FSWs who are partners.

Findings from Female-Specific Intervention Sites

The sites supported by the UNODC offer services to FSPs. These sites offer services like ante-natal care (ANC), condoms, counselling for HIV/STI, HIV testing, mental health counselling, nutritional support, STI management, recreation, routine medical care, referral, distribution of sanitary napkins and vocational training. The services provided through outreach include awareness, counselling and medicines. They also offer services to the children of FSPs such as crèche, routine medical care

and nutritional support. Referral services for the FSPs include ART, Community Care Centre (CCC), Integrated Counselling and Testing Centre (ICTC), Prevention of Parent to Child Transmission (PPTCT) and treatment of STIs.

An analysis of the data collected shows the following areas of concern – the registration of FSPs into the program is low; the uptake for testing HIV/STI is less; condom access by the FSPs is generally low, and no female condoms are available; and finally, there is no FSP specific IEC material.

As per the PMs who are providing female-specific services, the needs of FSPs include vocational training, livelihood support, self-help groups, mental health promotion and counselling, condom promotion, and information on HIV/AIDS. The level of satisfaction of FSPs with respect to the services that are povided was rated at 40% by the PMs. The PMs felt that providing better services for FSP children, better psychosocial support, and facilities for vocational training would help in increasing the satisfaction levels of the FSPs. They recommend linkages with both government and private agencies, like the Integrated Child Development Services (ICDS), and getting facilities for partners like BPL cards, voter identity cards, etc.

Key Informant Interviews

Key informant interviews were carried out with 30 FSPs who were young (19–39 years). Forty-four per cent of the respondents were unemployed and 20% were housewives.

- Nearly one in four (23%) did not have any knowledge of what substances the partner used
- Personal concerns mainly included concerns about health (46.7%). Personal care needs included medical care (36.7%) and counselling (20.0 %)
- Partner concerns included health problems (56.7%) and unsafe injecting (10.0%)
- Partner care needs included medical care (43.3%)
- Concerns about children pertained to education (30.0%)
- Children's care needs included medical care (13.3%) and support (11%)
- Employment concerns included unemployment (10.0%) and low earning (23.4%)
- Employment needs included vocational training (40%), income-generation (10%) and placement for partner (6.7%)

KI perceptions revealed the following: the knowledge of HIV among the FSPs is high (they are aware of the three modes of HIV transmission and know where to get condoms); awareness about STI/HIV testing is somewhat lower, few persons receive emotional counselling; and very few females have access to vocational programs and female condoms. The figures were generally lower for Punjab as compared to the north-east region.

A significant proportion of those who have accessed services are satisfied with HIV-related services in the government setting (76%), but fewer are satisfied with reproductive health care (67%). A majority have not accessed private sector services. Thus, only a third reported satisfaction with the HIV services and reproductive health care services in the private sector. The FSPs voiced the following challenges to access services: reluctance of male partners to have their female sex partners access services, aversion to receiving NGO staff at home, lack of support from family to receive services, stigma (real and perceived), distance and cost of services.

Sadly, although both service providers and service users indicate medical care as a vital need, the healthcare system has been poorly responsive to the needs of this population. They also have very little inputs from the social, labour, educational and legal sectors. It is now explicit that it is a

combination of medical and psychosocial interventions that is likely to produce change in behaviour and reduce vulnerability.

Recommendations

These recommendations are based on the review of literature, findings from the questionnaire interviews with PMs – of IDU TIs offering services primarily to male IDUs, female sex worker TIs, and specific intervention sites for FIDUs and FSPs of males who inject drugs – and interviews with FIDU and FSP KIs.

On the basis of the review and analysis of the primary data, an interactive, networking model to provide services for females affected by drug use (IDUs, FSPs and females who use drugs) has been provided in the report, along with a flow diagram of the range of activities in the female specific intervention sites and staff composition. Though the range and scope of services would depend on budgetary and other programmatic realities, it is felt that the following issues should be considered while developing female-specific interventions:

- Females who are sex partners of men who inject and females who inject share some similarities but are also very different populations. It is also well known that many FSPs do not like to mix with drug users. However, at the present time, given that there is a relatively larger number of FSPs and a smaller number of FIDUs, it is ***more cost-effective to have combined centre-based services,*** with perhaps different timings for the two groups, and have outreach-based services which cater to the distinct needs of each group. ***These centres should have female staff***, as this increases the acceptability of services among the recipients.
- The female-specific intervention sites should be able to offer a single window of services to both populations as far as possible. If a single window approach is not possible, the activities must be networked with the referral services.

  The services need to be made more attractive to the users, thereby not just attracting them but retaining them in the treatment network. The females in this group are primarily concerned about medical care, care for children and livelihood options rather than HIV prevention and care. Provision of other services would help in gaining their acceptance for HIV prevention services. Options for better engagement with this group include:

  - Networking with drug treatment services, vocational training, night shelters, services to help obtain identification cards like BPL cards, banking and other services
  - Providing services to children, including provision of crèche facilities and nutritional as well as educational support directly or through linkage with existing Government programs such as ICDS, etc.
  - Providing livelihood programs and other income generation activities
  - Providing preventive counselling and other services in the community through home-based care
  - Technologies like mobile telephony should be used to keep females in the service network
  - Service providers also need to maintain some flexibility in their programming to address the time and social constraints that females face
  - Conducting effective awareness and de-stigmatization campaigns
  - Engaging families through awareness, counselling and motivation

- The outreach program must be networked with existing programs and involve the Accredited Social Health Activist (ASHA) and other primary health care personnel. Other sources where the group can be reached out to should also be tapped. For example, FSW TIs are likely to come across FSPs and FIDUs; therefore, their staff needs training to provide comprehensive counselling and appropriate referral. It is important to extend services to all females who use drugs to prevent transition to injecting, as many females who inject drugs begin as non-injecting drug users. Effective counselling and support can help females to discontinue drug use and not transit to injecting. Further, such females continue to be at risk from unsafe sex.
- HIV prevention and intervention programs for FIDUs and FSPs should be part of a comprehensive program that includes counselling, support and education. Counselling should be for drug use cessation, emotional support and vocational counselling, apart from HIV prevention and care.
- Appropriate IEC materials are required which are appropriately tailored to local needs and customs, language and settings of care.
- Service providers need to be trained in identification, assessment, counselling for high risk (injecting and sexual risk), psychosocial counselling to provide support, motivate change and prevent relapse, outreach, follow-up and after care.
- Traditionally, drug use services have not addressed tobacco and alcohol use, which is definitely associated with serious public health implications. Alcohol consumption is an important mediating risk for unsafe sex and lowered immunity. Therefore, treatment services should provide tobacco cessation services as well as treatment of alcoholism as part of their treatment repertoire for females keen on accessing these services and motivate them to access the same.
- In anticipation of the growing problem, all health care personnel need to be sensitized and trained to provide basic services. As low-intensity counselling services can be provided in various healthcare settings, the staff in all healthcare settings needs to be sensitized to the problem of drug use among females, as well as trained on how to assess for injecting and high risk sexual behaviour, and provide appropriate counselling, treatment and referral. The staff to be trained should also include primary health care workers like ASHA workers who can be potentially useful partners to identify and motivate help seeking.
- Inter-sectoral collaboration between different ministries and departments, particularly the Ministry of Health, NACO, Ministry of Social Justice, Women's Welfare Departments, etc. should be enhanced.
- Services must recognize the user's rights to access affordable and easily accessible treatment. The services must be rights-based and user responsive. They must be provided in the least restrictive and most conducive environment.

1 Background and Introduction

It is estimated that between 149 and 272 million people, or 3.3 to 6.1 percent of the world's population between 15-64 years of age used illicit substances at least once in the last year.[1] About half of this number constitutes current users. No global estimates exist for drug use among females. This does not mean that females do not use drugs. It is merely a reflection that comprehensive and gender-disaggregated data is not available from most countries.

Female drug use is more hidden, less studied and less commonly addressed. Recently, however, there has been documentation of visible drug use among females in countries all over the world. Injecting drug use among females is also on the rise. A recent UN Reference Group document on the needs of females who inject drugs, based on more than 600 references, bears testimony to this fact.

1.1 Why Is Drug Use Prevention among Females Not Adequately Addressed?

Drug use is often seen as a problem affecting males, hence most interventions, preventive or therapeutic, are invariably male-centred.

- In many countries, epidemiological surveys for drugs and alcohol usually done only among males
- Lack of gender disaggregated data where data is available
- Drug use among females is triply stigmatized (blame for drug use in partner ***x*** drug use ***x*** gender disadvantage)
- Gender disadvantage in an inequitable society

A social taboo against chronic drug use among females may be a protective factor, which is reflected in lower long-term female use rates,[2] but it should also be seen as a cause for non-reporting/under reporting and thus complicating issues.

1.2 Rising Problem of Drug Use

Country specific information suggests that drug use among females is emerging from all over the world.[3] Moreover, young females, including adolescent girls, are also being affected. Drug use rarely comes alone. It brings with it a variety of individual, family and societal problems. In South Asia, the use of illicit drugs has become overshadowed by the growing misuse of pharmaceutical drugs.[4]

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[1] UNODC, World Drug Report 2011

[2] UNODC, WDR 2011, p.178

[3] UNODC. *The Role of C4D in addressing drug use amongst adolescent girls.* Draft Background Paper for the 12th UNRT on C4D. Nov 2011

[4] Larance B, Ambekar A, Azim A, Murthy P, Panda S, Degenhardt L, Mathers B. 'The availability, diversion and injection of pharmaceutical opioids in South Asia'. *Drug and Alcohol Review* 2011,30:246-254

Reportedly there are two billion alcohol users in the world, and while consumption patterns have stabilized in many regions, there is an increase in AFR and SEAR[5] (WHO 2011); 2.5 million users die each year. Rising consumption is most pronounced in females and young people.[6] Eighty percent of smokers live in low and middle income countries where the burden of tobacco related illness and death is the maximum. Six million die each year from tobacco (WHO Fact Sheet 2011). Invariably, the use of drugs, alcohol and tobacco co-exists among drug users.

1.3 Drug Use among Females in India and Implications

Since 2002, there is a growing body of literature indicating that females are being impacted by drug use both as users themselves as well as by being partners of men who use drugs.[7] FSPs of men who use drugs experience significant personal, emotional and financial problems due to drug use by their partners.

More than two-thirds of the 2.4 million adult females living with HIV in Asia at the end of 2005 were in India.[8] Of the 5.2 million HIV infected people in India in 2005, 38.4% were females[9] (NACO, 2006). In India, the HIV/AIDS epidemic is characterized by its heterogeneity. It seems to be following the Type 4 pattern, where the epidemic shifts from the most vulnerable populations (commercial sex workers, IDUs, MSM) to bridge populations (clients of sex workers, STI patients, partners of drug users) and then to the general population. The shift usually occurs when the prevalence in the first group exceeds 5%, with a two-three year time lag between shifts from one group to another.[10]

HIV infections continue to rise in drug involved females, especially IDUs in Asia and Eastern Europe.[11] The intersection of unsafe injecting drug use and unsafe sexual practices is a significant factor in the increased risk of HIV infection among FIDUs. Female IDUs are not only vulnerable to HIV infection because of unsafe drug injecting practices, they are also often involved in unsafe sexual activities, which further increases their vulnerability to HIV transmission. Female injecting drug users differ from their male counterparts in terms of their background, their reasons for using drugs, and their psychosocial needs. However, most HIV/AIDS prevention and care programs are not reaching this vulnerable group because services are designed for men. Attempts to reach and work with FIDUs are limited. In fact, gender sensitive services addressing the specific needs of FIDUs hardly exist in most of the countries.

Numerous studies have shown that it is very important to reach out to the FSPs of MIDUs as well as to the female IDUs. Successful programs for FSPs as well as FIDUs include provision of female-friendly services with a comprehensive approach under a single roof/setting.[12] Currently, specific services targeted towards these two distinct and vulnerable groups do not exist. As a result, the groups are still hard-to-reach and continue to remain away from the purview of the HIV prevention services. In the context of the planning and execution of the National AIDS Control Programme (NACP), this continues to be a major gap which has been highlighted in the mid-term review of NACP-III.

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[5] WHO.*ATLAS on substance use — Resources for the prevention and treatment of substance use disorders, 2010*

[6] 'Calling time on young people's alcohol consumption'. *Lancet* 2008.Vol. 371:871 (http://www.thelancet.com/journals/lancet/article/PIIS0140673608603864/fulltext?rss=yes, accessed 28 November 2010)

[7] UNDCP. *Women and drug use-the problem in India. Highlights of the report.* 2002

[8] UNAIDS estimate. The National AIDS Control Organisation estimates the number of persons with HIV in India as 2.5 million, according to the NACP-III

[9] National AIDS Control Organisation website: http://www.nacoonline.org

[10] National AIDS Control Organisation (2005) *Monthly updates on AIDS.* July 2005. Available at http://nacoonline.org/facts.htm

[11] Joint UN Program on HIV/AIDS. 2008 *Report on the global AIDS epidemic.* July 2008 http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008

[12] Murthy P, Kumar *S. Assessment of female injecting drug users' intervention sites in the north-east.* 2011

While injecting drug use among females is being increasingly recognized in India, it is clear that services are not gender responsive in terms of meeting the needs of FIDUs. Major concerns are that FIDUs are a hidden population in the community. They do not seek treatment in a male-centred treatment environment and have over-riding concerns regarding their children. Drug use treatment options are also extremely limited for this group. Restrictive treatment polices range from the lack of gender-segregated care, lack of child care facilities, unhelpful attitudes of service provider to several barriers to help-seeking. A major barrier is lack of privacy and confidentiality, leading to fear of being identified and stigmatized.

The situation is no better for FSPs of male IDUs who are often poorly informed about risks, are vulnerable to HIV transmission, are ill-equipped for prevention, and lack the awareness and support to seek treatment. Moreover, few treatment services comprehensively address the needs of this vulnerable group.

1.4 NACP-III

The primary objective of NACP-III is to halt and reverse the spread of HIV epidemic by 2012. It aims to cover 80% of the high risk groups such as IDUs with targeted interventions (TIs). Harm reduction is recommended as the key strategy for intervention among IDUs and their sex partners to reduce the risk of acquiring and transmitting HIV.[13] NSEP and OST are two critical components in the harm reduction strategy. The services provided by the TIs are three-tiered. Tier 1 services are outreach based interventions. NSEP constitutes the backbone of the harm reduction strategy. Tier 2 primarily comprises OST, and Tier 3 provides linkages to other important services that are not directly provided under TIs such as Directly Observed Treatment, Short-course (DOTS), ICTC, ART, reproductive health services and drug use related services.

Outreach-based services: Outreach services form an important part of the services offered by TIs. The ORWs provide the following services for the IDUs: behaviour change communication (BCC), peer-based counselling and support groups for the IDUs. In addition, they also distribute IEC materials and the essential commodities for behaviour change namely, condoms and needles/syringes. Female ORWs have also been recruited to reach out to FSPs of injecting drug users.

1.5 Scope of the Current Review

It is unclear to what extent the current IDU TIs provide services to FIDUs and FSPs of men who inject drugs. Thus, there is a need to:

- Demonstrate to what extent FIDUs/FSPs are provided services within the existing IDU TIs
- Document existing models of interventions for FIDUs/FSPs
- Document outputs on effectiveness of the model followed
- Develop/provide insights into developing a replicable and scalable model for FIDUs/FSPs

[13] DFID TAST. *Harm reduction strategies for injecting drug users and their spouses in India – A situational analysis*. Kumar S, Srikrishan AK, Joseph F, Dhanikachalam D. 2011

2 Methodology

2.1 Objectives

The present study was conducted with the twin objectives of:

- Reviewing the existing body of work at the global and national levels which documents issues related to FIDUs and FSPs of male IDUs
- Documenting the existing services for this population and their service needs

2.2 Methodological Approach

The desk review, development of methodology, data analysis and preparation of the report was carried out by the lead consultant, Pratima Murthy. Individual site visits, personal interviews and organizational data was collected by four co-lead consultants.

I. Desk Review

This included a review of global, regional and local literature pertaining to drug use among females, particularly injecting drug use, their vulnerabilities and needs, and services required for them. Project reports and documents, original papers, reviews, guidelines and manuals developed were included in the review. For clarity, the desk review has been presented separately for FIDUs and FSPs.

II. Secondary Data Analysis

A secondary data analysis of the UNODC sites providing intervention for FIDUs was carried out. These sites are required to maintain information regarding the background characteristics of FIDUs they register. Such information has been analyzed from four sites: SCC Agape Home in Aizawl, Mizoram; Bethesda (BYWC), Aizawl, Mizoram (two sites), VHAM, Shillong, Meghalaya.

III. Questionnaires

Questionnaires were given to five sets of respondents, including service provider representatives and users. Field visits were carried out by the co-consultants at 15 sites in five states (four UNODC sites in Manipur, Nagaland, Mizoram and Meghalaya, one EHA site in Manipur and two in Nagaland, one Alliance site in Manipur, two SACS IDU sites each in Manipur, Nagaland, Mizoram and Punjab).

1. **Seven IDU TIs** were contacted. The Project Managers were asked to fill in a semi-structured questionnaire which focused on the following:

    a. Background of the organization and nature of services provided to FIDUs and FSPs

    b. Range of services provided for FSPs, description of staff, description of centre/clinic-based interventions and community based interventions, linkages, total registrations, uptake for testing, needs of FSPs, needs met by the service, unmet needs, barriers, suggestions to overcome the barriers, and suggested models for intervention

c. Range of services provided for FIDUs, description of staff, description of centre/clinic-based interventions and community based interventions, linkages, total registrations, uptake for testing, needs of FIDUs, needs met by the service, unmet needs, barriers, suggestions to overcome the barriers, and suggested models for intervention

2. **Five adjacent TIs** for female sex workers were contacted. The Project Managers of these TIs were interviewed on a specially constructed semi-structured questionnaire which focused on the following:

   a. Background of the organization, the KIs' perception of the pattern of drug use among FSWs, assessment and existing services for FSWs with drug use, particularly injecting drug use, total registrations, presence and nature of community services, special needs of FSW IDUs, needs addressed by the program, unmet needs, barriers to access services, and suggestions to overcome these barriers

   b. Needs of FSWs who are partners of male injecting IDUs and their specific needs

3. **Seven specific intervention sites for female drug users and female sex partners of male IDUs** were contacted. The Project Managers were interviewed on a specially constructed semi-structured questionnaire which focused on the following:

   a. Background of the organization, details of beneficiaries, staff structure and organogram, range of services offered at the centre/clinic, presence of community-based interventions and types of services

   b. Methods and challenges in the identification of FSPs, range of services, centre-based and community-based services, linkages, registrations, needs of FSPs, needs met by the program, unmet needs, barriers, suggestions to overcome the barriers, existing models and suggestions for change

   c. Methods and challenges in the identification of FIDUs, range of services, centre-based and community-based services, linkages, registrations, needs of FIDUs, needs met by the program, unmet needs, special categories, barriers, suggestions to overcome the barriers, existing models and suggestions for change.

4. **30 Key informant interviews with service users (FSPs):**

   FSP KI interviews were conducted by co-lead consultants and covered 30 KIs across five states. These interviews focused on the common perceived needs of FSPs, where they presently accessed such services, their satisfaction level with these services, perceived barriers to satisfactory care, the services required by FSPs and their desired location.

5. **36 Key informant interviews with service users (FIDUs):**

   FIDU KI interviews were conducted across five states and covered 36 FIDUs. These interviews focused on the common perceived needs of FIDUs, where they presently accessed such services, their satisfaction level with these services, perceived barriers to satisfactory care, the services required by FIDUs and their desired location.

2.3 Operational Definitions

The operational definitions for FIDU and FSP are consistent with the definition of injecting drug user by NACO. The same is used in identifying FIDUs and FSPs at the UNODC intervention sites. Thus, 'female injecting drug user' refers to a woman who has been injecting drug anytime in the last three months; and 'female sex partner' refers to a woman currently in a sexual relationship with an injecting drug user.

2.4 Summary of Sites Contacted for Program Information

Table 1: Sites Contacted

State	IDU TI sites	FSW sites	UNODC sites*	EHA sites	Alliance sites
Nagaland	1 (Bethesda, Dimapur)	2 (managed by EHA in Dimapur)	1 (Bethesda)	–	–
Manipur	1 (Nirvana, Imphal)	–	1 (Nirvana, Imphal)	1 (Churachandpur)	1 (Imphal) 1 (Churachandpur)
Mizoram	1 (Samaritan Society, Aizawl)	2 SACS sites	1 (Agape)	–	–
Chennai	1 (Hopers)	–	–	–	–
Punjab/ Haryana	1 (LS-Don Bosco) + 2 (IDU sites for FSP - Mohali and Ropar)	1 (Ropar/ Mohali)	–	–	–
Meghalaya	–	–	1 (VHAM, Shillong)	–	–

**Information on registered clientele collated from UNODC FIDU sites*

A site visit was also planned to the Samaritans in West Bengal and one FSW site in Manipur. However, these sites could not be visited because of delays in clearances.

3 Findings

For the sake of convenience, the results are organized as follows:

1. **Overview of the sites and introduction to their services for the target groups**
   - A. IDU TI sites
   - B. FSW TI sites
   - C. Female specific intervention sites
2. **Female Injecting Drug Users (FIDUs)**
   - A. Global, regional and local review
   - B. Secondary data analysis of FIDUs from NE sites
   - C. Service providers' responses with regard to FIDU services
     - i. IDU TI sites
     - ii. FSW TI sites
     - iii. Female specific intervention sites
   - D. Service users' responses with regard to FIDU services (FIDU KI responses)
3. **Female Sexual Partners (FSPs): Existing services, needs and directions for improvement**
   - A. Global, regional and local review
   - B. Service providers' responses with regard to FSP services
     - i. IDU TI sites
     - ii. FSW TIsites
     - iii. Female specific intervention sites
   - C. Service users' responses with regard to FSP services (FSP KI responses)

3.1. Overview of Sites and Introduction to Their Services for Target Groups

This section provides a background to the sites visited in order to review the needs and services for FIDUs and FSPs. They include IDU TI sites, FSW TI sites and female specific intervention sites in the country.

3.1.A. IDU TI Sites

Table 2: Background of the Sites

Agency	District and State	Year of Inception of TI	Year of Inception of Services for Females Affected by Drug Use	Services Offered for FIDU/FSPs/ Both/Neither
Ambuja Cement Foundation	Ropar, Punjab	2009	2010	Neither
Don Bosco	Ambala, Haryana	2010	2010	FSPs
Hoper's Foundation	Prabmun, Chennai	2006	-	FSPs (through another source of funds)
D. N. Kotnis Charitable Hospital	Ludhiana, Punjab	2008	2010	FSPs
Nirvana Foundation	Imphal East, Manipur	2003	2003	FSPs
Bethesda	Dimapur, Nagaland	1999	2011	Both
Samaritans	Aizawl, Mizoram	2002	2011	Both

Respondents' Background

Data was collected from seven IDU TI sites. All the respondents were **project managers/coordinators**. At the Samaritans, Mizoram, the respondents included both the project manager and outreach worker. At five of the organizations, the project manager was male while at the Hoper's Foundation and the BYWC, the manager was female. The respondents were in the age group of 30-50 (except the outreach worker who was 22 years old). At all the centres, the project managers were graduates; at the Ambuja Cement Foundation and Don Bosco, the project managers were medical social workers. All the project managers reported experience in similar kind of work ranging from 2 to 13 years.

3.1.B. FSW TI Sites

Table 3: FSW TI Sites

Agency	District and State	Year of Inception of TI	Services Offered for FIDU/FSPs/ Both/Neither
Guru Gobind Singh	Ludhiana, Punjab	2008	Offer services to FSWs using drugs. Not come across FIDUs
New Life	Aizawl, Mizoram	2007	Both
Akimbo	Dimapur, Nagaland	2004	Both
Prodigal's Home	Dimapur, Nagaland	2004	Neither
Volcomh	Aizawl, Mizoram	2002	Both

Respondents' Background

Data was collected from five FSW TI sites. The respondents from all sites were **project managers**. Two of them were females and the rest were males. Their ages ranged from 29-42 years, and they were all graduates. One PM was a medical social worker, one had a PG in rural development, one was in public administration, and another was an economics post-graduate. Years of experience in the current kind of job ranged from 2.5 to 7 years. The New Life site reported working with FIDUs from 2010 with a proper sanctioned budget from the SACS.

3.1.C. Specific Female-centred Intervention Sites

Table 4: Specific Female Centred Intervention Sites

Agency	District and State	Year of site Inception	Project Site of	Services Offered for FIDU/FSPs/ Both/Neither
Agape	Aizawl, Mizoram	October 2010	UNODC	Both
Bethesda	Dimapur, Nagaland	April 2010	UNODC	Both
VHAM	Shillong, Meghalaya	2010	UNODC	Both
Nirvana	Imphal West, Manipur	August 2009	UNODC	Both
Shalom (Alliance)	Churachandpur, Manipur	June 2010	Alliance	FIDU
Shalom (Avahan-EHA)	Churachandpur, Manipur	August 2010	Avahan (EHA)	FIDU
SASO (Alliance)	Imphal West, Manipur	2008	Alliance	FIDU

Respondents' Background

For this, data was collected from seven sites. At the four UNODC sites, the respondents were Project Managers. Project coordinators were the respondents at the Shalom and SASO Alliance sites, and the counsellor was the respondent at the Shalom Avahan site.

At all the sites, the respondents were female in the age range of 27-39 years. Their work experience in the current kind of job ranged from 1 to 7 years. All of them were graduates. Four held post-graduate qualification, and two out of them were medical social workers. Most sites had been initiated in the last couple of years except the Social Awareness Service Organization (SASO) site, which has been functioning since 2008.

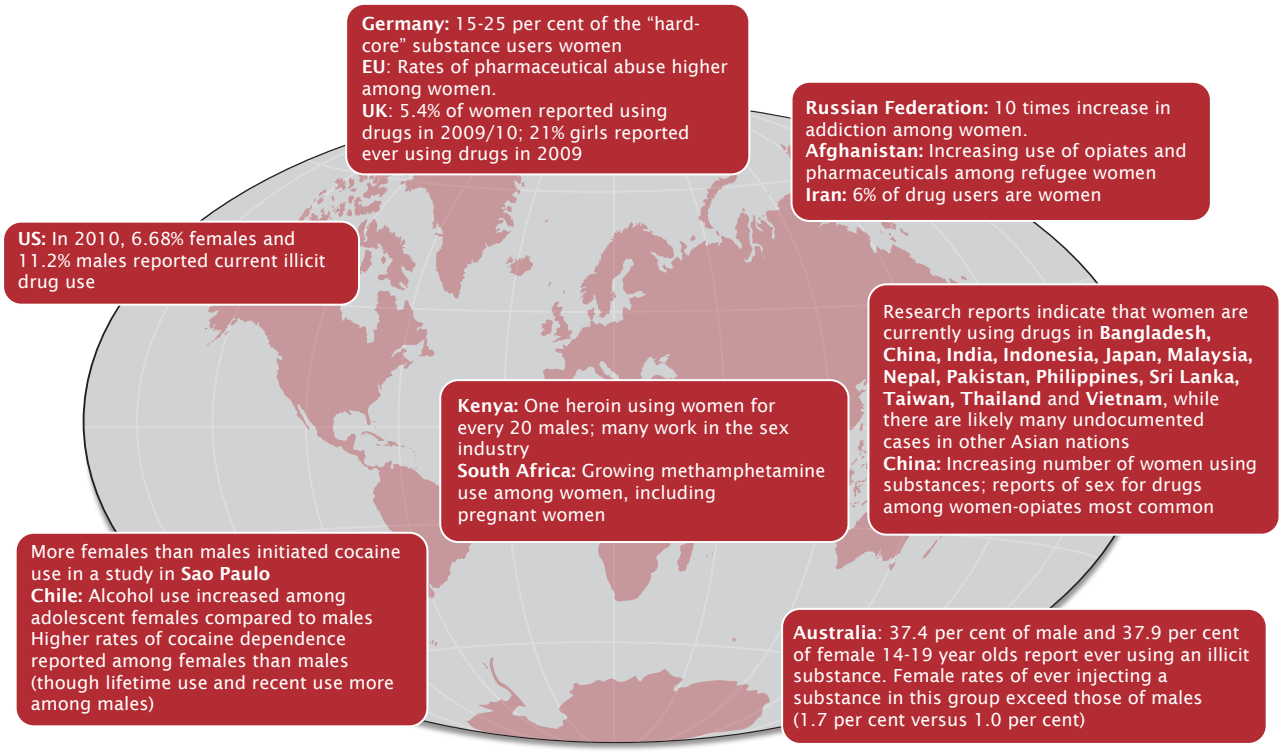
3.2. Female Injecting Drug Users

3.2.A. Global, Regional and Local Review

Global literature indicates a visible increase in drug use all over the world[14] (*See* Figure 1).

[14] Murthy P. *Gender and drug use – challenges for communication.* Paper presented on behalf of the UNODC ROSA at the UN Round Table on C4D, November 2011, New Delhi

Figure 1: Global Trends of Drug Use among Females[15]



Injecting Drug Use

It is estimated that there are 15.9 million (range 11.0 to 21.2 million) people who might inject drugs worldwide and that three million IDUs (range 0.8 to 6.6 million) are HIV positive.[16] Where the largest numbers of injectors were found, i.e., China, USA and Russia, mid-estimates of HIV prevalence among injectors were 12%, 16% and 37% respectively. HIV prevalence among IDUs was 20-40% in five countries and over 40% in nine.[17] Gender segregated estimates for injecting drug use for females are not available globally.

Impact of Injecting Drug use for Females

While drug use and IDU among females is well documented in the developed world, the same is now emerging in the developing world, particularly Asia.[18] Female drug users are particularly vulnerable along the different pathways to drug dependence. With regard to injecting drug use, both males and females who inject drugs experience a significant burden of HIV disease, infection with other blood-borne viruses and also potentially life-threatening conditions such as tuberculosis. However, females who inject drugs face even greater risks. Studies indicate that females who inject drugs are more likely to face violence and greater levels of stigma and are more likely to die earlier.[19]

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[15] Murthy P. *Gender and drug use-challenges for communication.* Paper presented on behalf of the UNODC ROSA at the UN round Table on C4D, Nov 2011, New Delhi

[16] Mathers B, Degenhardt L, Phillips B, Wiessing L, Hickman M, Strathdee S *et al.*, for the UN Reference Group on HIV and injecting drug use. 'Global epidemiology of injecting drug us and HIV among people who inject drugs: a systematic review'. *The Lancet* 2008, Sep 24 online at http://www.who.int/hiv/topics/idu/LancetArticleIDUHIV.pdf

[17] *Ibid.*

[18] Reid G, Costigan G.*Revisiting the "Hidden epidemic"- a situation assessment of drug use in Asia in the context of HIV/AIDS.* Melboure: Centre for Harm Reduction, Burnet Institute, 2002

[19] UNAIDS *2010 Global Report*

The UN Reference Group has recently reviewed the risks, experiences and needs of females who inject drugs.[20] A review of 620 documents from published and grey literature suggests the following risk factors for initiation into injecting among females:

- Engagement in sex work
- Previous history of drug use (non-injecting)
- Lifetime history of sexual abuse
- Exposure to trauma and violence
- Social networks that include injecting drug use
- Family history of drug use
- Social disadvantage
- History of delinquency and incarceration
- Young age of onset of illicit drug use
- Early sexual exposure
- Females of same sex attraction
- Mental illness and suicidal thoughts

India and its neighbourhood have been seeing a significant problem of injecting drug use among males.[21] In India, the first indication of females in drug use came in 1979 when a Government of India report suggested that 25-30% of the registered opium addicts were females. However, epidemiological studies in the 1980s and 1990s indicated that the proportion of females using drugs in locations outside the north-eastern states of India was small.

Preliminary Drug Use Reports Among Females from North-Eastern States of India

Studies carried out in the north-east in the late 1980s and early 1990s revealed that approximately 5% of IDUs recruited from diverse settings in Manipur and Nagaland were females. Females constituted 15% of the samples in Mizoram[22] (Sarkar et al, 1993). In a study of 69 female drug users also involved in sex work, Panda et al[23] (2001) found that 55% of this group was injecting. A majority was having sex with non-regular sex partners and reported sex work in exchange for money and drugs. Female injecting drug users were more likely to be HIV+ (57%) compared to non-injecting drug users (20%).

Gradual Percolation to Other Parts of the Country

A gradual increase of drug use among females has been observed outside the north-eastern states. The Drug Abuse Monitoring System found that 3% of the 16,942 treatment seekers at de-addiction centres were females.[24] Among females seeking treatment at a de-addiction centre in Chandigarh, opioids were reported as the main drugs of abuse.[25]

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[20] Roberts A, Bradley M, Degenhardt L. for the UN Reference Group. *Women who inject drugs: A review of their risks, experiences and needs.* NDARC 2010

[21] UNODC. *Rapid Situation and Response Assessment of drugs and HIV in Bangladesh, Bhutan, India, Nepal and Sri Lanka:A Regional Report.* 2008. Available from:www.unodc.org/india/rsra.html

[22] Sarkar S, Das N *et al.* 'Rapid spread of HIV among injecting drugusers in north-eastern states of India'. *Bulletin on Narcotics* 1993, 45 (1):91-105

[23] Panda S, Bijaya L, Sadhana Devi N et al. 'Interface between drug use and sex work in Manipur'. *The National Medical Journal of India* 2001,14:209-211

[24] United Nations Drug Control Program, Regional Office for South Asia [UNODC ROSA]. (2002c). *Women and Drug Abuse: The Problem in India: Highlights of the report.* United Nations Drug Control Program, Regional Office for South Asia, New Delhi. http://www.unodc.org/pdf/india/publications/drugs Abuse Problem in India Highlights/drugs abuse problem web.pdf

[25] Grover, S, Irpati, AS, Saluja, BS, Mattoo, SK, Basu, D. 'Substance-dependent women attending a de-addiction centre in North India: socio-demographic and clinical profile'. *Indian Journal of Medical Science* 2005, 59:283–291

Reports of Injecting from Community and Clinic Settings

In a study of 75 drug users (across Mumbai, Aizawl and Delhi) in 2001,[26] injecting drug use was reported in 41% of respondents who were injecting mainly heroin and propoxyphene. Pentazocine injecting among females has also been reported.[27]

The Last Decade–Drug Use, Injecting Drug Use and Heightened Vulnerability

In 2002, a Rapid Assessment Study[28] of 4,648 drug users was carried out across 14 urban cities, out of which 8% were females; among them, 40% injected drugs. Typically, female drug users were young, educated, employed and had initiated drugs early. Half of them engaged in sex work to support the habit and more than a third were selling drugs.

In the Rapid Situation and Response Assessment (RSRA) 2008, of the 20% of FSPs who reported using drugs, over half of them reported injecting drugs.

The Women and Drug Use in India study in 2008[29] evaluated 1,865 female drug users from all over the country, out of which 113 (6.2%) were below 20 years of age, nearly a third were illiterate, many had married before the age of 18 years and many of them reported childhoods of poverty. Of the female drug users evaluated, 587 (31.5%) FSUs reported ever injecting. A majority of the heroin and dextropropoxyphene users reported injecting. Injecting drug use has been reported from all over the country, and a third of FIDUs were located outside the north-east. A majority had initiated injecting in their early twenties. Among injectors who initiated with non-injecting, transition to injection was rapid, with common reasons for injecting being peer pressure and economic difficulties. Pharmaceuticals are easier to source than illicit heroin. Only 44% reported consistent use of disposable N/S. There were many instances of reusing disposables. One in two injectors had borrowed or lent syringes. Sexual use, pre-marital sex and sex for money was significantly more commonly reported by female drug users compared to non-drug using FSPs of men who use drugs. Being subjected to violence, reproductive health problems and low risk perception of HIV characterized this group. Mental distress was very high, with nearly 40% having made a suicide attempt in the previous year. Female drug users had high rates of current alcohol (67.5%) and tobacco (79.1%) use. While children in families where the father used drugs reported high rates of emotional and conduct problems, in families where both parents used drugs, the consequences for the children were more severe.

Risk from Injecting and Unsafe Sex

Given the feminization of the HIV epidemic in India, understanding drug use related concerns among females is important for effective HIV prevention. A review by Kumar and Sharma[30] in 2008 identifies four main themes relevant to drug use among females. These include opioid use and injecting drug use among females, alcohol use in sex work settings, sexual transmission of HIV from male IDUs to their regular sex partners, and sexual violence among FSPs of substance-using women.

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[26] Kapoor SL, Pavamani V, Mittal S. *Substance abuse among women in India.* Report submitted to the UNDCP, 2001

[27] Prasad, HR, Khaitan, BK, Ramam, M, Sharma, VK, Pandhi, RK, Agarwal, S *et al.* 'Diagnostic clinical features of pentazocine-induced ulcers'. *International Journal of Dermatology* 2005, 44:110–115

[28] Kumar S. *Rapid Assessment Survey of Drug Abuse in India.* UNDCP 2002

[29] Murthy P. *Women and drug use in India: Substance, women and high-risk assessment study.* UNODC 2008

[30] Kumar MS, Sharma M. 'Women and substance use in India and Bangladesh'. *Substance Use and Misuse* 2008, 43:1062-77

Many females are involved in drug peddling, and often female users are also engaged in drug selling (Ray, Gupta, Dutt, Dhawan, and Sharma, 2001). Thus, vocational rehabilitation is also an important challenge while organizing treatment services for female drug users (Kapoor, Pavamani and Mittal, 2001). Often the partner's influence facilitates drug use, and this has to be considered while providing treatment for females.

In a sample of 35 Indian females in treatment for drug dependence, 60% were dependent upon opioids, almost all using pentazocine and dextropropoxyphene.[31] Most injected the drug, and a significant proportion had originally been prescribed opioids for various kinds of pains.

Drug Use, including Injecting Among Female Sex Workers

Although female sex workers are already considered at high risk of HIV transmission, their injecting of drugs increases this risk further (Moses et al, 2006). The Behavioural Surveillance Study carried out in India indicated that about 6% of female sex workers reported having ever tried any "illicit" drug; 2% reported injecting drugs in the past year. About 2% of clients of female sex workers also reported injecting drugs in the past year. These figures are higher in the north-east. In Manipur, 19% of female sex workers and 11% of the clients self-reported injecting drugs in the past year (NACO, 2001). A study in this state revealed that the HIV prevalence among injecting drug using sex workers was 9.4 times higher than that among non-injecting drug using sex workers (Agarwal et al, 1999). In a study on the interface between drug use and sex work among females in Manipur, 80% of the respondents – many of whom migrated following ethnic clashes in the state – reported having sex with non-regular partners; two thirds reported having had sex in exchange for money or drugs. More than half of the people recruited for the study were injecting drugs, and HIV prevalence was higher in this group than among females using non-injecting drugs (Panda et al, 2001).

Alcohol use is an important determinant of safe sex behaviours in sex work settings. Low condom use is often associated with alcohol use[32,33] Alcohol was often used as a stress coping agent, and many were drinking in order to dealwith distress, alleviate their fears, and drown their depressive feelings.[34]

Size Estimation of FIDU Population

As per the size estimation group for NACP III, the number of FIDUs in the country is estimated to range from 10,005 to 33,392.[35] Due to lack of adequate strategic information, particularly data, it is widely believed that the phenomenon of females injecting drug users is prevalent only in the north-east region of India. There is, however, a need, to begin epidemiological studies on females who use drugs, in order to gauge transition to injecting in different parts of the country. The women and drug use study in 2008[36] suggests that injecting drug users exist in several parts of the country.

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[31] Grover S, Irpati AS, Saluja BS, Mattoo SK, Basu D. 'Substance-dependent women attending a de-addiction centre in North India: socio-demographic and clinical profile'. *Indian Journal of Medical Sciences* 2005, 59 (7):283-291

[32] Madhivanan P, Hernandez A, Gogate A. *et al*. 'Alcohol use by men is a risk factor for acquisition of sexually transmitted infections and human immunodeficiency virus from male sex workers in Mumbai, India'. *Sex Transm Dis* 2005, 32(11):685-90

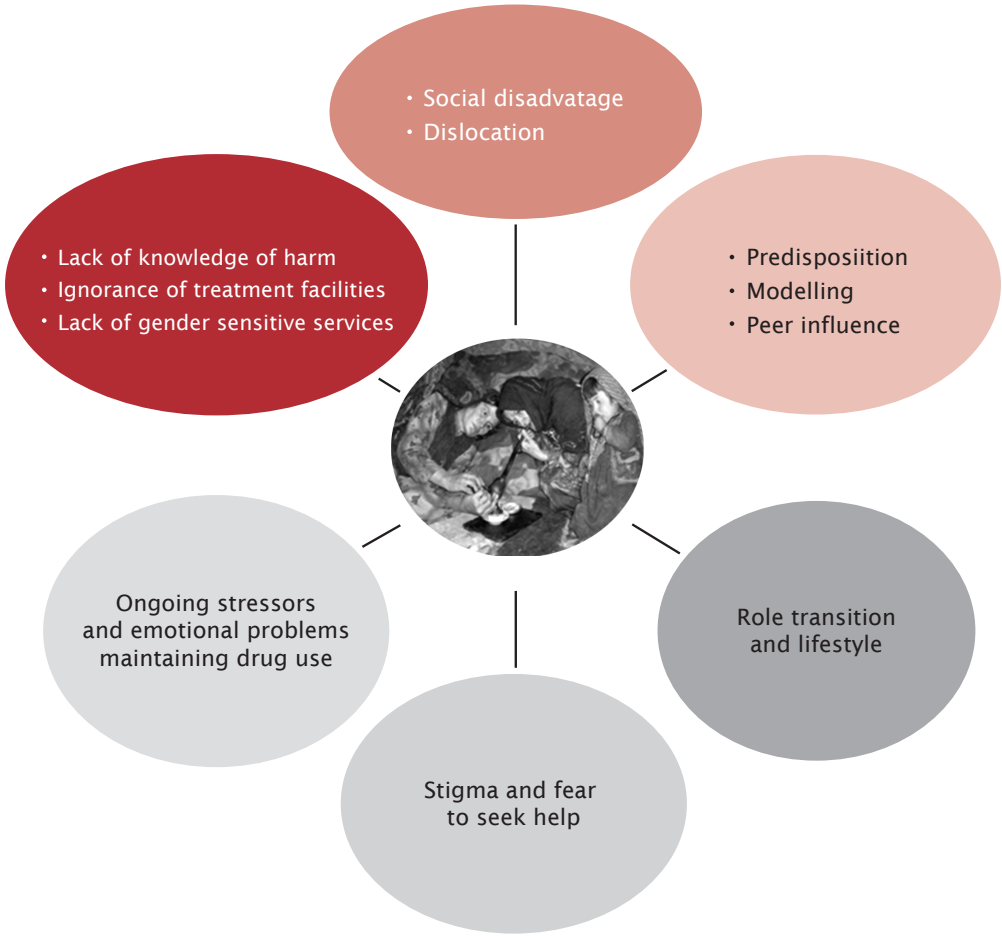
[33] Dandona R, Dandona L, Gutierrez JP *et al*. 'High risk of HIV in non-brothel based female sex workers in India'. BMC Public Health 2005, 5:87

[34] Kumar MS. A *rapid situation assessment of sexual risk behaviour and substance use among sex workers and their clients in Chennai (Madras), South India.* Geneva, World Health Organization, 2003

[35] *India HIV estimates – 2006*. National Institute of Medical Sciences (Indian Council of Medical Research) and National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, 2006.

[36] Murthy P. *2008. op cit*

Figure 2: Interacting Factors for Drug Use among Females



Adapted from Murthy (2011)[37] and Murthy 2002

Pilot Responses

There have been some initiatives to set up services for females affected by drug use in India.[38] The CHARCA initiative in the early 2000s[39] resulted in funding for a treatment and rehabilitation centre and the employment of gender sensitive peer educators. Attempts at initiating income generation activities through self-help groups were initiated. Sharan, an NGO has trained female staff to provide gender sensitive female programs that include detoxification, awareness, counselling, adult education, vocational guidance, skill building, immunization, education and crèche for children, self-help groups, nutritional support and so on. The SASO founded by former drug users extends its services to female drug users.

International Experience of Services for Female Drug Users

One of the earliest practical experiences for setting up a primary health care service for female sex workers, a major proportion of whom used drugs comes from a drop-in centre (DIC) approach in Glasgow in the United Kingdom. It showed that considerable benefits can be achieved if multi-

[37] Murthy P. *2011. op cit*

[38] Murthy P. *2008. op cit*

[39] Singh SK, Lhungdim H, Chattopadhyay A, Roy TK. *Women's vulnerability to STI/HIV in India. Findings of the CHARCA baseline survey*. International Institute of Population Studies, Mumbai, 2004

disciplinary health and social services are provided to treat this population at a time and place convenient to their work.[40] A 10-year follow-up of this program[41] indicated positive outcomes in many areas, although it was not able to make a dent in the use of condoms with regular partners.

A review of female's treatment services for drug use in the United States[42] found six important components of drug use treatment programming that had a positive association with reduced HIV risk, drug use, general and mental health, employment, and birth outcomes.

These included child care, prenatal care, female only programs, female focused topics, mental health programming and comprehensive programming.

Barriers to Effective Care for Females Using Substances

Another international review[43] examining harm reduction for females using drugs suggests that factors that reduce female drug users' access to health care include punitive policies, discrimination by police and health care providers, the intense social stigma associated with drug use among female, a preponderance of programs directed at men, absence of sexual and reproductive services for female, and poor access to effective outpatient drug treatment which often includes substitution treatment.

Services and Barriers for Female Drug Users In General

The study on women and drug use recommended the setting up of a range of services that are easily accessible to the users. It highlighted the need for active collaboration among the health, social welfare, education, legal and labour sectors to provide adequate care for females affected by drug use and interventions addressing vulnerabilities and risk factors to prevent drug use among females.

Another study was conducted by the UNODC as part of the Joint UN program for the north-east. The main objective of the study was identification of barriers to access services in TIs for IDUs.[44] There was a special focus on the female IDUs as well as FSPs of male IDUs. The preliminary findings of the study established the following:

1. A significant number of FIDUs are also engaged in sex work.
2. FIDUs face difficulty in accessing services from two different places since the TI projects are separate for female sex workers and female IDUs.
3. FIDUs find it difficult to access services provided through TIs for IDUs since the drop-in centre or OST centre (within the TI implementing agencies) are primarily occupied by males.

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[40] Carr S, Goldberg DJ, Elliott L, Green S, Mackie C, Gruer L. 'In practice. A primary health care service for Glasgow street sex workers – 6 years experience of the "Drop-in Centre", 1989-94'. *AIDS Care* 1996 Aug; 8 (4): 489-97

[41] Gilchrist G, Taylor A, Goldberg G. *et al.* 'Behavioural and lifestyle study of women using a drop-in centre for female street sex workers in Glasgow, Scotland: A 10-year comparative study'. *Addiction Research and Theory* 2001, 9 (1):43-58

[42] Ashley OS, Marsden ME, Brady TM. 'Effectiveness of Substance Abuse Treatment. Programming for Women: A Review'. *The American Journal Of Drug And Alcohol Abuse* 2003, 29 (1): 19–53

[43] IHRDP. *Women, harm reduction and HIV 2007*

[44] United Nations Office on Drugs and Crime, Regional Office for South Asia, 2010. *Access to comprehensive package of services for Injecting Drug Users and their regular sexual partners in Northeast India: Identification and ranking of barriers – A mixed methods study.*

4. Openly visiting a centre for drug users was a top barrier listed by female IDUs (including those in sex work) for fear of being identified by others as a drug user and fear of possible police/social harassment.

In Manipur, a state in which MIDUs have a 46.8% HIV sero-prevalence, a recent study[45] has specifically explored the links between FIDUs and their sexual vulnerabilities. Using a multiple-methodology study which included mapping, focus group discussion and survey, 200 FIDUs were interviewed from seven districts of Manipur. The salient features of the study are summarized in the box alongside.

Manipur FIDU Study

- High rates of alcohol use (78%)
- Majority initiated with non-injecting drugs (83%)
- Multiple injecting episodes per day (46%)
- High rates of sharing (97%)
- Involvement in sex work common (56%)
- One or more sexual health problems (69%)

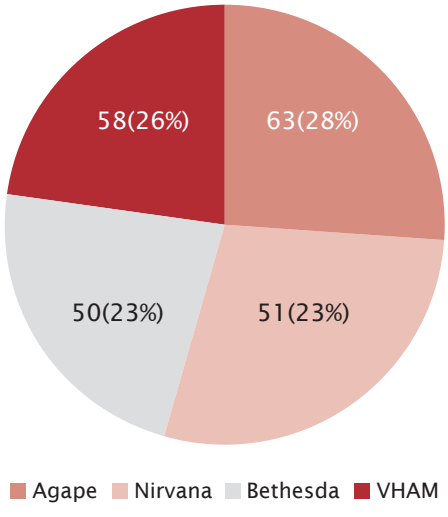
Oinam 2008

In this study, it was found that most FIDUs were seeking help for immediate medical problems (83%). Treatment seeking for reproductive and sexual problems was less common (51%), and for drug use, even lower (38%). Those who had approached the treatment services were satisfied with the care for their drug use problem. Among the respondents who were dissatisfied, reasons included insensitivity of the service provider and lack of confidentiality. Priority felt needs of FIDUs were counselling and support (60%), detoxification (44%), general health services (29%), job and rehabilitation (23%), and vocational training (22%). As recently as 2008, this report recommends more awareness of safe sex and drug use practices among FIDUs in Manipur, IEC materials, a supporting environment, community empowerment, social support, health services and proper counselling.

3.2.B. Secondary Data Analysis of UNODC FIDU Intervention Sites

This data pertaining to FIDUs registered at Agape, Nirvana, VHAM and Bethesda was collected between May 2010 and February 2011. Information is available for 222 FIDUs registered across the four sites.

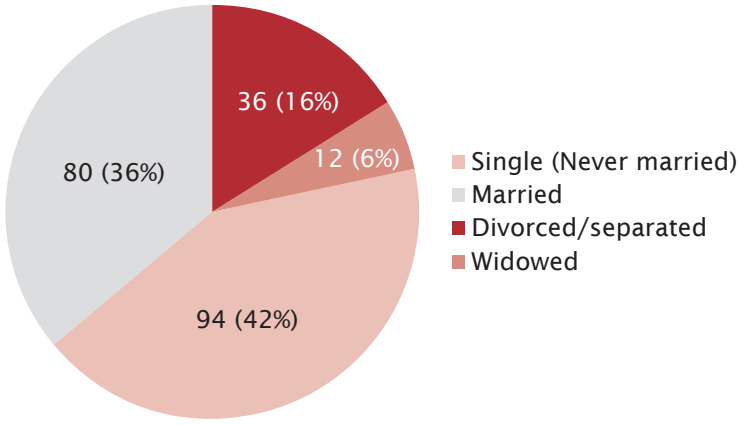
Figure 3: FIDU Registrations at Four Sites in the NE, May 2010–February 2011



[45] Oinam A. 'Exploring the links between drug use and sexual vulnerability among young female injecting drug users in Manipur'. Health and Population Innovation Fellowship Program.Working Paper No. 6. New Delhi: Population Council, 2008

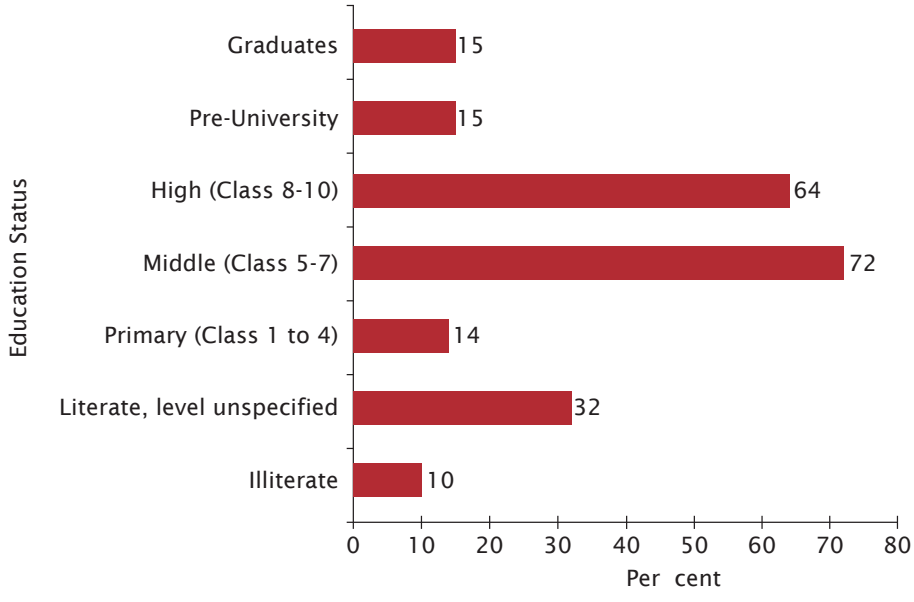
Socio-Demographic Background of the FIDUs

Figure 4: Marital Status



Of the registered FIDUs, 42% were single and 36% were married. While 65 (29.3%) were educated upto high school, 54 (24.3%) were educated up to middle school. Ten FIDUs (4.5%) were illiterate, while fifteen FIDUs (6.8%) were graduates.

Figure 5: Education Status



Mobility

About one-third of FIDUs (30.6%) reported that they were not residing in the same place but would move to other districts in the state. The commonest reason for such movement was because they were permanent residents of a different district.

Table 5: Reasons for Mobility among FIDUs

Reason for Mobility	N	%
Permanent resident of another district	49	22.1
For drugs or sex	7	3.2
For business	4	1.8
For other reasons	8	3.6
Not moving residence frequently	154	69.3

Occupation

Of the registered FIDUs, 56 (25.2%) indicated their occupation as sex work. However, 88 respondents (39.6%) reported being involved in sex work. Of this group, 58 (65.9%) had been involved in sex work for less than 5 years and 30 had been involved for more than 5 years (34.1%).

Frequency of Sexual Encounters

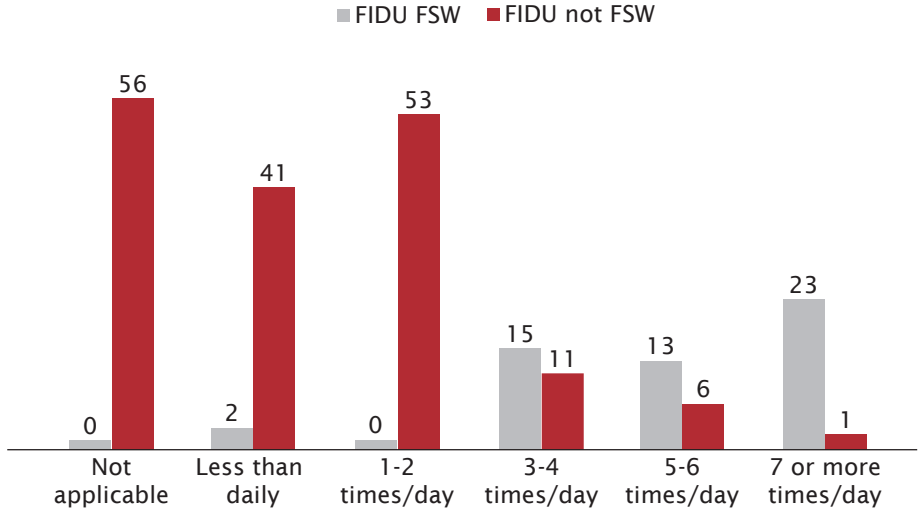
Information was recorded regarding the frequency of sexual encounters in FIDUs.

Table 6: Frequency of Sexual Encounters in FIDUs

	Not applicable/ No response		Less than once a day		1-2 times per day		3-4 times per day		5-6 times per day		7 or more times per day	
	N	%	N	%	N	%	N	%	N	%	N	%
Single (94)	30	31.9	16	17.0	17	18.1	15	16.0	5	5.3	11	11.7
Married (80)	25	31.3	13	16.3	21	26.3	9	11.3	7	8.8	5	6.3
Divorced/Separated (36)	2	5.6	17	47.2	10	27.8	1	2.8	3	8.3	3	8.3
Widowed (12)	2	16.7	2	16.7	1	8.3	1	8.3	1	8.3	5	41.7

More than half of the single FIDUs reported having sex at least once a day or more. A majority of the single females were non-FSWs (63.4%). While FSWs were relatively more likely to report multiple sexual daily encounters, a substantial number of non-FSW FIDUs also reported multiple sexual encounters on a daily basis. Out of non-FSW FIDUs, 23% reported having sex three or more times daily.

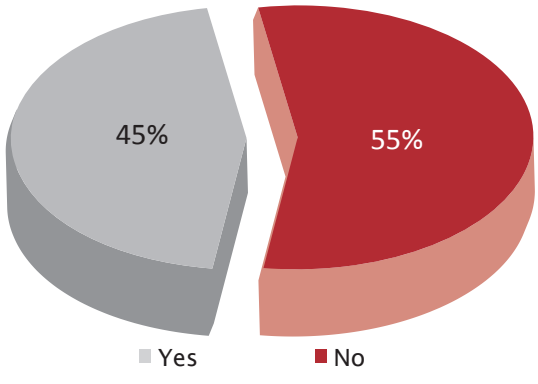
Figure 6: FSW and Non-FSW FIDUs – Frequency of Sexual Encounters



Alcohol Use Among FIDUs

A majority of FIDUs (122, 55%) reported the use of alcohol. Nearly all FSW FIDUs and 41% of non-FSW FIDUs reported alcohol consumption. Tobacco use has not been recorded in this group.

Figure 7: Alcohol Use among FIDUs



Summary of the Secondary Data Analysis of Registered FIDUs

- Among the registered FIDUs, there are both single and married females
- Most of the registered FIDUs have high school levels of education or higher
- Mobility to different districts is reported by nearly one-third
- While one-fourth of FIDUs indicate their occupation as sex work, many more report engaging in commercial sex work
- A significant proportion of FIDUs (51.6%) who are not FSW also report multiple daily sexual encounters and 23% of non-FSW FIDUs have sex three or more times daily
- A majority of FIDUs (55%) report the use of alcohol; its use is reported by nearly all FSW FIDUs and 41% of non-FSW FIDUs

3.2.C. Service Providers' Response with Regard to FIDU Services

i) IDU TI Sites

The following seven IDU TI sites cater primarily to men who inject drugs.

Table 7: FIDUs - Needs and Services

	Ambuja Cement Foundation, Ropar, Punjab	Don Bosco, Ambala, Haryana	Hoper's Foundation, Tamil Nadu	D. N. Kotnis Charitable Hospital, Ludhiana, Punjab	Nirvana Foundation, Imphal East, Manipur	Bethesda Youth Welfare Centre, Dimapur, Nagaland	Samaritans, Aizawl, Mizoram
Number likely to need services	Not come across any so far	Only one identified so far	Not come across any so far; 5 reported in Chennai of whom 2 have died	None reported so far	Nil	50-100	62
Number registered with TI per year	–	–	–	–	–	29	62

Sites in Punjab had no services for FIDUs. The Don Bosco TI reported having identified only one FIDU so far, but she had refused services. The Ambuja Cement Foundation site had not come across any FIDUs. In Tamil Nadu, the Hoper's Foundation reported having come across only five FIDUs so far, two having died and the whereabouts of the others not being known. The site in Ludhiana was not able to provide information regarding FIDUs. In the north-east, two sites were able to provide an estimate of the number of FIDUs likely to be in need of services during a year. The Bethesda TI manager indicated that there may be about 50-100 FIDUs in need of services, while the Samaritans' PM indicated that about 62 FIDUs were in need of services. In terms of actual registrations during the last year, Bethesda had 29 registrations and Samaritans 62 registrations. The Nirvana Foundation did not provide any information regarding FIDU registrations or services at the TI.

Services for FIDUs at NE IDU TI Sites

Both Bethesda and Samaritans reported providing HIV counselling services and condoms. Samaritans reported having facilities for STI identification and referrals for detoxification and rehabilitation. The Bethesda PM said that referrals for OST were made by the TI, as were referrals for short-stay facility

and health services (to Prodigal's Home). Both centres offered linkages for ICTC, DOTS and ART. The Samaritans also indicated linkages with the Prevention of Parent to Child Transmission Centres (PPCTC). Both the TI sites have a community outreach where the same services as available at the TI are provided. The staff providing such services includes one male ORW and one female PE at Bethesda and one female ORW and one female PE at Samaritans.

Testing for HIV and STI

No FIDUs had undergone HIV or STI testing at any centre and none had been put on ART. In the community, at the Samaritans site, 20 FIDUs had undergone testing for HIV and three had undergone testing for STI.

Condoms

At the Bethesda site, 4,000 condoms had been distributed to FIDUs in the previous year.

Needles/Syringes

At the Bethesda centre, 200 needles/syringes had been distributed in the previous year. None had been distributed in the community. At the Samaritans site, 62 FIDUs had accessed needles/syringes.

OST

No FIDUs had been put on OST at the Bethesda site. In the Samaritan's community program, six FIDUs had been put on OST.

Barriers

Only the PM of Bethesda mentioned barriers preventing FIDUs from accessing service which included stigma and the male-dominated nature of the current DIC. Suggestions to overcome these barriers included motivation and constant follow-up, provisions for separate female-friendly set-up in the existing services.The difficulties faced by the NGOs providing FIDU services included the reluctance of FIDUs to reveal their drug use because of the fear of stigma, and unwillingness and/or shyness to come to the DIC (PMs of Bethesda and Samaritans). According to the PM of Samaritans, only hardcore FIDUs will come to the DIC openly.

Suggestions for Improving Services

The only suggestion for improving services for FIDUs came from the PM of Bethesda who suggested either a separate set-up for FIDUs, or issuance of proper guidelines if services are to be provided in the existing set-up or referral to FIDU project under the same NGO.

The PM of Don Bosco emphasized the need for mass sensitization.

> *"Haryana is predominately a male dominated society, and so we need to sensitize the masses in order to pave way for the women to show health seeking behaviour and have the freedom to go out to avail the existing medical facilities whenever the need arises. Women don't wish to come to the male DIC for any kind of help or services."*

ii) FSW TI Sites

These included two TI sites each in Dimapur, Nagaland and Aizawl, Mizoram and one in Ludhiana, Punjab. In Punjab, the site has not come across any injecting drug use among FSWs. However, use of alcohol, pain killers and cigarettes is fairly common. In two FSW TI sites in Mizoram, the projects are funded by Mizoram SACS to provide additional services to the FSWs who inject drugs.

Table 8: Perception of Injecting and Other Drug Use among FSWs

	Guru Gobind Singh, Ludhiana, Punjab	New Life Aizawl, Mizoram	Akimbo, Dimapur, Nagaland	Prodigal's Home, Dimapur, Nagaland	Volcomh, Aizawl, Mizoram
Number of FSWs provided services	100	382	1016	688 (head count)	400
Have you noticed injecting among FSWs?	No	Yes	Yes	Yes, especially in 2004-05	Yes
Drugs injected	NA	Spasmoproxyvon, heroin	SP and heroin	Spasmoproxyvon	Spasmoproxyvon, No 4-heroin
Any changes in pattern of injecting drugs?	NA	Seems to be increasing	Decreasing; IDUs have stopped injecting or shifted to OST	Decreased	Slowly increasing in the last 5 years
Have you noticed use of other drugs among FSWs?	Yes	Yes	Yes	Yes	Yes
Name the other drugs used by FSWs	Alcohol, pain killers, cigarettes	Alcohol, dendrite sniffing, correction fluid, Alprazolam	Alcohol, SP, brown sugar	Alcohol	Alcohol, dendrite
Any changes in pattern of other drug use	Not noticed	Increased	Increased alcohol use	Decreased	Though Mizoram is a dry state, no sexual activity happens without alcohol
Do you routinely assess for IDU among FSWs?	No. Only through quarterly risk assessment	No. Only through quarterly risk assessment	No. Only through quarterly risk assessment	Yes	No Only through quarterly risk assessment
Do you routinely assess for other drug use among FSWs?	Only through quarterly risk assessment	Yes	Only through quarterly risk assessment	Yes	Yes
During the last year, how many FIDUs were identified at your TI?	None	68	None	None	13 in 4 months
During the last year, how many non-injecting drug users were identified at your TI?	10-15	No data	6	None	38

According to the PMs, non-injecting drug use is mainly recreational and associated with sexual activity. In Mizoram, the PMs perceive an increase in injecting among FSWs. The general perception is an increase in alcohol consumption, though the PM from Prodigal's home felt there was a general reduction in drug use.

Registrations

In most FSW TIs, assessments for injecting as well as other drug use are not done routinely but only as part of the quarterly risk assessments. Despite a perception of an increase in the use of alcohol and other drugs, the FSWs are not routinely assessed. Thus, the identification rates of drug and alcohol use are relatively low; and when the use is not identified, it is unlikely that interventions are offered.

Range of Services Offered

Three of the FSW TIs reported that they do not offer routine services to FSW FIDUs (Guru Gobind Singh, Akimbo and Prodigal's Home). However, Akimbo mentioned that it refers clients for OST, ICTC, Revised National Tuberculosis Control Program (RNTCP), general health check and STI services.

New Life and Volcomh in Aizawl report providing comprehensive services for FSWs with injecting drug use as below.

Table 9: Services Offered at Two FSW TI Sites*

New Life, Aizawl, Mizoram	Volcomh, Aizawl, Mizoram
■ ART ■ Condom ■ Counselling ■ De-addiction referral ■ DOTS ■ ICTC ■ Legal Aid ■ Locker facility ■ Needle syringe exchange ■ Rest room ■ STI services	■ Comprehensive Care ■ Abscess prevention and management ■ ART ■ Counselling ■ ICTC ■ Meals ■ Mental health counselling ■ PPTCT ■ Rehab home ■ STI services

* Services include both core and referral services

The PM of Volcomh says that mental health services are a specialized area of the organization. The NGO contributes 50% for the food, and the clients pay the rest. They also get some donations for meals.

Existing Models in FSW-IDU Sites

The PM of New Life outlined their model as shown below:

The PM of Volcomh described their model as follows:

- Personnel: PEs, ORWs, counsellor, doctor, project manager
- One separate ORW (GNM) is in charge of all FIDUs; and two separate PEs especially to reach out to FIDUs
- The staff helps in identification of FIDUs

- Engagement: Provision of services under the TI program to engage FIDUs
- Care: TI provides different types of counselling – psychosocial, risk assessment
- TI provides free meals to FIDUs
- Referral: Tries to link them up with ART, ICTC, DOTS, Rehab centre, Protective home, CCC, etc.
- Follow-up: Done by the PEs and ORW in-charge of outreach activities to analyze the data and find out who is due for what kind of services; the clients are then approached and taken to avail the same
- Aftercare: Tie up with World Vision for after care, routine medical check-up (RMC) and vocational training which can help them get some economical support (they provide free sewing machine, material for setting up a beauty parlour)
- Provide free medicines, for general health care also
- Since FIDUs are all FSW, the NGO tries to inculcate the importance of saving money for their future and helps them to save from whatever they earn.

Table 10: Testing Services, Needle/Syringe and Condom

Last year	New Life, Aizawl, Mizoram	Volcomh, Aizawl, Mizoram
Number of FSWs with IDU tested for HIV	73	75
Number of FSWs with IDU tested for STI	73	71
Number of FSWs with IDU who have been started on ART	24 diagnosed positive on ART	1
Number of FSWs with IDU who accessed male condoms	73	–
Number of male condoms distributed to FSWs with IDU		18,013 (8,321 in centre and 9,692 in outreach)
Number of female condoms distributed to FSWs with IDU	–	Not distributed. But female condoms used for in-house demonstration
Number of FSWs with IDU accessed needles/syringes	73	All of them
Number of needles/syringes distributed to FSWs with IDU	11,477	18,517 (13,632 in centre, 4,885 in outreach)
Number of FSWs with IDU initiated into OST last year	–	0 in centre, 1 in OR

Note: Information is provided only for Volcomh and New Life, which provide services for FSW FIDUs.

The number of FSW FIDUs tested for HIV and the number of registrations of FIDUs does not match, particularly at Volcomh. While a large number of N/S have been distributed at the two centres, OST initiation is very low.

All the organizations report having condom distribution both at the DIC and in community outreach.

Both New Life and Volcomh have an active NSEP; also both have a DIC based as well as an outreach program. In addition, Volcomh has an active condom distribution program.

Staffing

Table 11: Staff Allocation

	Guru Gobind Singh, Ludhiana, Punjab	New Life, Aizawl, Mizoram	Akimbo, Dimapur, Nagaland	Prodigal's Home, Dimapur, Nagaland	Volcomh, Aizawl, Mizoram
Who provides the service (designation and gender)	PEs+ORW+ANM (Females)	PD (Male) PM (Female) Counsellor (Female) ORW-2 (Females - 1 for FIDU) PEs for FIDUs Part-time doctor (Female) Accountant (Male)	No specific services or staff allocated for female drug users-all the existing services provided for FSWs are also extended to those using drugs (at present oral users)	No separate staff	PE and ORW (Female) ORW in charge of FIDU program is also a GNM Doctor (Male) Counsellor and ORW (Female)

Staff Training

The staff of Guru Gobind Singh, Akimbo and Prodigal's Home has not received any specialized training in managing FIDUs.At New Life, all staff has been trained at the State Training and Resource Centre (STRC)/Mizoram SACS, Aizawl. However, the training was in harm reduction in general and not specific to FIDUs. At Volcomh, four staff members (PM, ORW, counsellor, doctor) have undergone an induction and a refresher training conducted by the UNODC on the needs of FIDUs and challenges faced by them in the north-east; and a workshop on harm reduction was attended by ORWs, PM and counsellor.

Areas in Which Staff Needs Training

There are many areas in which a need for training is felt, including outreach planning, harm reduction, mental health counselling, harm reduction basis, documentation, and medical management (including overdose management). Counselling of pregnant FIDUs is another area where the need for training is felt.

IEC Materials for Drug Use Counselling

Three of the PMs said that there is no IEC material for counselling female drug users and that whatever was available had male representations. The PMs from Nagaland said that there was IEC material regarding alcohol use; they use flip charts and pocket calendars for education in the community.

Special Needs of FSW FIDUs

The PM of Volcomh feels that FSW FIDUs need a special care package. The special needs as identified by different PMs are as follows:

- A separate DIC
- Specialized IEC materials
- Safe injecting practices
- Access to OST
- Overdose management
- Drug treatment facilities
- Health education
- Livelihood assistance

Some Opinions Supporting the Perceived Needs of FSW FIDU

FSW FIDUs have very low health seeking behaviour. Most of the times they refuse to access the services.

– PM, Volcomh

Many FIDUs don't know how to inject and they take help of male partners. If they have only one N/S, then the male will inject himself first.

– PM, New Life

FIDUs have male partners waiting for them outside, raising some doubts in the minds of the general community.

– PM, New Life

Barriers in Accessing Services

The barriers identified by the PMs of the FSW TIs include the following:

- Stigma and discrimination – a general barrier to accessing services
- Fear of identification
- Fear of pimps
- Overcrowding at government facilities
- Lack of overdose management services
- Low priority given to address other drug use, as many FSWs are occasional users

Models for Better Service Delivery

Three of the project managers said that they do not have an existing model to provide services for FSW FIDUs. They felt that the model of combining FSW and FIDU interventions at the same place is unsatisfactory for the following reasons:

- Both populations have different needs (PM, Volcomh)
- Current interventions work for FSWs, not for FIDUs (PM, New Life)
- Injecting behaviour of FIDUs attracts FSWs towards injecting (PM, Volcomh)

Specific activities suggested include organizing events, conducting focus group discussions (FGDs), providing education on harm reduction, providing family counselling (PM, Akimbo), providing income generation activities to support families (PM, Prodigal's Home), gender specific IEC material. The PM of Volcomh also felt that separate allocation must be made for psychosocial and emotional support.

In terms of staff, the need to have dedicated staff to carry out interventions was expressed by three PMs. The PM of Volcomh emphasized the need for a separate nurse in the team.

iii) Female Specific IDU Intervention Sites

Staffing

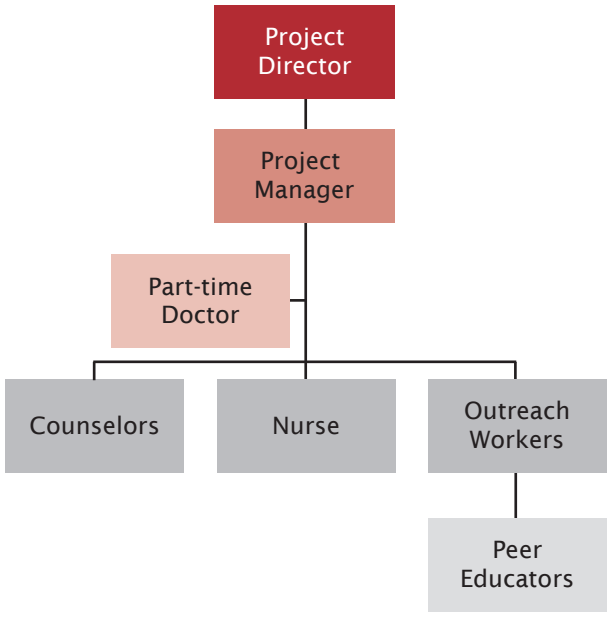
Each of the sites offering FIDU services has a dedicated staff, mostly female.

Table 12: Staff Composition

	Agape	Bethesda	VHAM	Nirvana	Shalom Alliance	Shalom Avahan	SASO Alliance
Structure	PD-1	–	PD-1	PD-1			
	PM-1	PM-1	PM-1	PM-1			
	Coun-1	Coun-1	Coun-1	PC-1	PC-1	PC-1	PC-1
	ORW-3	PEs-7	ORWs	Coun-1	Coun-1	Coun-1	Coun-1
	PE-7	Nurse -1	PEs-5	ORW-3		ORW-2	ORW-1
	Nurse-1	Doc-1	Nurse-1	PEs-7	PE-2		PE-3
	Doc-1	Acct-1	Doc-1	Nurse-1		Nurse-1	
						Doc-1	Doc-1
							HW-1
							Caretaker-1
							Cook-1

Each of the organizations was requested to provide an organogram. The organogram provided by VHAM, Shillong and Bethesda, and the staffing patterns provided by the other organizations have been synthesized into a single organogram (See Figure 8).

Figure 8: Organogram of a Typical FIDU-Specific TI



In most of the centres, the entire staff is female except the part-time doctor in SASO and the accountant in Bethesda. In the case of VHAM, the Project Director is male while all the other functionaries are female.

SASO has some other staff whose functions are described as follows:

- Female health worker (one) – for overdose management/providing STI medicine and follow-up link with ART centre and RNTCP
- ORW (one) – for female outreach activity, referral and linkages, PE management, reporting and documentation
- Female caretaker for night shelter (one) – for overall management of shelter/overdose management/ crisis management and report to staff/time management
- Female cook (one) – to prepare and serve food

Services Provided to FIDUs

Table 13: Direct and Referral Services Provided by Various Sites

Agape	Bethesda	VHAM	Nirvana	Shalom Alliance	Shalom Avahan	SASO Alliance
Abscess management and prevention	Abscess management				Abscess management	
	ANC		ART for those below poverty line		Advocacy BCC Capacity building	Awareness and treatment
• Condoms • Counselling	• Condoms • Counselling	• Condoms • Counselling	• Condoms • Counselling	• Counselling	• Condoms • Counselling • Crisis management	• Condoms • Crisis/ emergency support
		Detox	Detox	Detox		
	Education/ awareness	Education on safer practices, health, hygiene, childcare, nutrition				Education/ awareness on safer injecting and safe sex practices
	FGD	Emotional support				
	IEC materials		• Follow-up Home visits • Information on HIV/ AIDS, safer sexual practices, safer injecting	• Follow-up • Home visits Information on HIV/ AIDS, safer sexual practices, safer injecting etc	• Follow-up • Home visits Information on HIV/ AIDS, safer sexual practices, safer injecting	
		Legal help				
			Medical support			
• NSEP • Nutritional support	• NSEP • Nutritional support	• NSEP • Nutritional support	• NSEP • Nutrition			• NSEP

Contd...

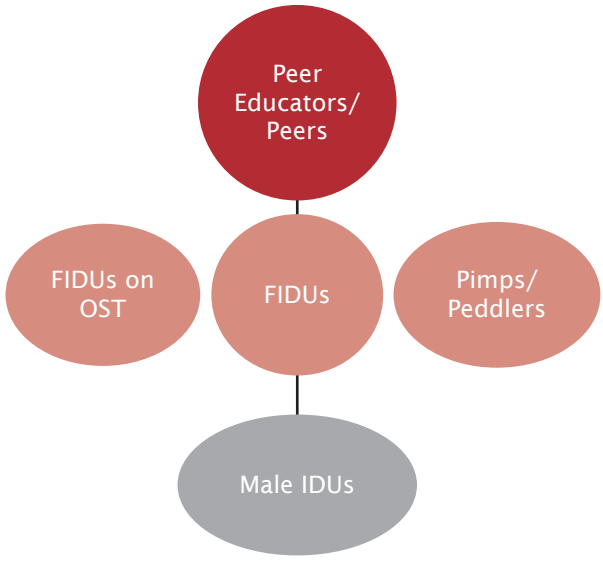
Agape	Bethesda	VHAM	Nirvana	Shalom Alliance	Shalom Avahan	SASO Alliance
			Overdose management Outreach	Outreach		Overdose management
	Recreational facility				Overdose management Outreach	Psychosocial support
				Rehab		Short stay home
			Rehab			
	Sanitary napkins				Rehab	
STI services	STI services		Sanitary napkins STI services			STI services
		Vocational training		Re-integration with family members	STI services Re-integration with family members	
Referral services						
	ART	ANC (govt. based) ART centre (govt. based)	ART	ART		ART
	CCC	Care Centre (NGO based)		CD4 test		CD4 test
					Detox and rehab	• Condom (Family Welfare) • DOTS
	ICTC	DOTS (govt. based) ICTC (govt. based)		ICTC		ICTC
				Income generation	Income generation	
		OST treatment (NGO based)				OST
	PPTCT	PPTCT (govt. based)				
	• STI		• STI • TB	• STI • TB • Vocational training		

Shalom refers clients requiring detoxification and rehabilitation to Mangal, Sneha Bhavan and Priscilla Home. For income generation, clients are referred to SASO.

Identification of FIDUs

In all the organizations, the peer educators identify the FIDUs in the community, particularly in the hot spots, through their peers and partners; in some cases, pimps and peddlers are also sources of referral. According to the PM of SASO, the night shelter is an attraction for FIDUs who accompany their friends there. Shalom Avahan undertakes hotspot-wise mapping and line listing, individual risk assessment and weekly outreach planning, one-on-one or group interaction to identify potential FIDUs in need of services.

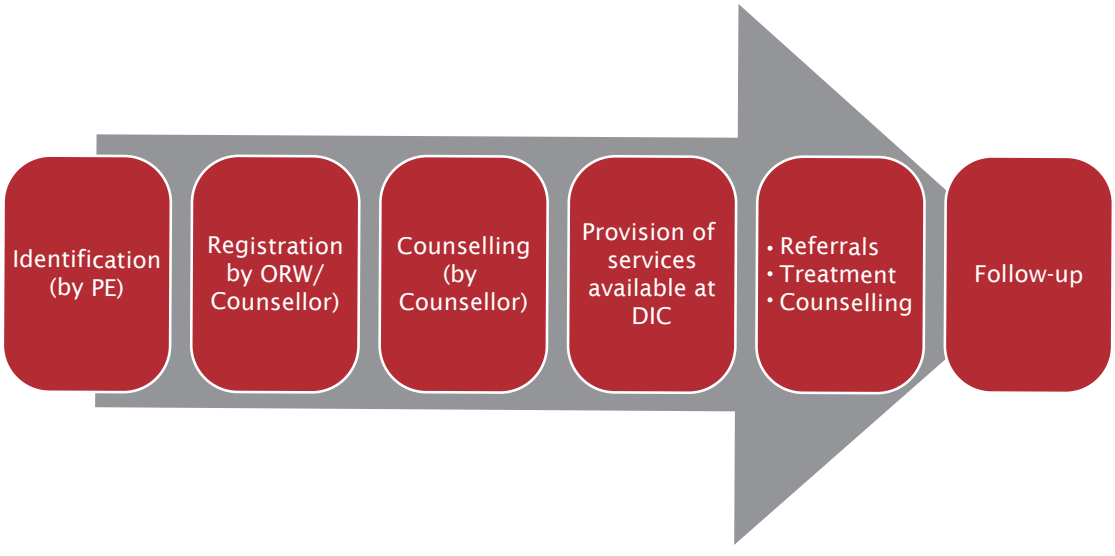
Figure 9: Identification of FIDUs



Flow of Services

At Bethesda and Shalom Alliance, the PEs identify potential clients and refer them to the DIC. The ORWs or counsellors do the preliminary registration. The counsellors carry out the intake and counselling. They carry out the needs assessment, make the clients aware of the various services available, and make referrals as appropriate. The team ensures follow-up care.

Figure 10: Identification and Provision of Services



Challenges in the Identification and Treatment of FIDUs

> *Most (that we cater to) are engaged in sex work and that takes the priority.*
>
> – (PM, VHAM)
>
> *Most of the time, they use poly substances like alcohol with heroin. They are aggressive and not concerned about their health.*
>
> – (PM, VHAM)
>
> *80-85% of the FIDUs have been kicked out of home and have no support at all.*
>
> – (PM, SASO)
>
> *Their menstruation is not regular, so they can't monitor themselves for pregnancy. By the time they come to know, it is too late for an abortion.*
>
> – (PM, SASO)

The following are the common challenges mentioned by the PMs:

- The hidden nature of FIDUs
- Mobility
- Stigma and discrimination
- Denial
- Poor health seeking
- Multiple complications

Suggestions to Overcome the Challenges and Improve Identification and Referral

- Awareness activities and programs
- Proper information about the program
- Educate about the benefits of the program so that it outweighs the stigma (PM, Bethesda)
- Motivate FIDUs to seek services
- Rapport building with FIDUs
- Networking with district NGOs (PM, Shalom)
- Advocacy with church leaders, police personnel/rapport building with pimps and peddlers/families of FIDUs even though they are less involved (PM, Shalom)

FIDU Registrations

Nirvana did not provide any information regarding FIDU registrations.

Table 14: FIDU Registrations at Female Specific FIDU Intervention Sites

Agape	Bethesda	VHAM	Shalom Alliance	Shalom Avahan	SASO Alliance
82	50 (2010-11) 42 (2011–six months data)	51 (2010-11) 29 (2011–six months data)	105 (June 2010 to date)	174 (June 2010 to date)	60 (2009) 55 (2010) 60 (2011)
FIDU registrations in the community over a year					
–	50	–	85	164	20

Except for Agape and Nirvana, all other organizations reported having a community outreach program.

Table 15: Investigations and Treatment Uptake for FIDUs

One year	Agape	Bethesda	VHAM	Nirvana	Shalom Alliance	Shalom Avahan	SASO Alliance
No. of FIDUs who underwent HIV testing	–	36	-	–	2	58	17
No. of FIDUs who underwent STI testing	–	17	38	–	1	124	25
No. of FIDUs on ART	–	–	-	–	–	1	6
No. of FIDUs accessed male condoms	–	47	47	–	–	129	43
No. of condoms distributed	–	3,596	9,090	–	–	57,098	19,040
No. of FIDUs accessed N/S	–	50	51	–	64	159	167
No. of N/S distributed	–	14,522	14,060	–	9,951	24,074	29,204
No. of FIDUs on OST	–	4	5	–	–	9	7

Perception of Benefit of Interventions

With regard to **distribution of condoms**, four of the seven PMs (VHAM, Shalom Alliance, Shalom Avahan and SASO) opined that there was 75% benefit (perception of use of condom during last sexual encounter). The PM from Bethesda rated the benefit between 25-50%.

The benefit from **distribution of needles/syringes** in retaining FIDUs in the treatment network was rated as 75% by Bethesda and between 25-50% by Shalom Alliance, Shalom Avahan. There was a high appreciation that N/S had reduced sharing among FIDUs, with five organizations rating the benefit at more than 75% (Bethesda, Shalom Alliance, Shalom Avahan), one between 50-75% (SASO). VHAM also found it successful.

OST has been accessible to few FIDUs. So far, the use of OST in reducing injecting or use of other drugs appears to show some benefit according to the PM of Bethesda (25-50%) and no benefit according to the PM of SASO.

IEC for FIDUs

All PMs unanimously agreed that there was no FIDU specific IEC material available for their use in the centre or community.

Drug Use Counselling

At Bethesda, VHAM, Shalom Alliance, Shalom Avahan and SASO, drug use counselling is routinely provided both at the centre and in the community.

Needs of FIDUs – Perception of PMs

- Shelter (night shelter, short-stay homes, care homes for FIDUs without homes)
- Work (vocational training, livelihood opportunities, income generation and employment)
- Medical care (testing for HIV, STI, treatment of specific infections, general medical care)
- Nutritional support
- Drug related- N/S, OST, detox, rehab
- Psychosocial support – counselling, motivation, moral support, family counselling
- Pregnant FIDUs, FIDUs living on the street, FIDUs with young children, those without families and those with opportunistic infections in need of more specialised care

Needs Met

The PM of Bethesda felt that about 30% of the needs of FIDUs are being currently met. Unmet needs are mainly drug treatment, rehabilitation and shelter. Suggestions for improved interventions include having more rehabilitation centres, short stay homes and shelters, opportunities for vocational training and livelihood (PM, Bethesda), advocacy (VHAM), mobilizing more donor support (Shalom Alliance), advocacy and sensitization of district hospitals, other departments and agencies (SASO).

Four of the organizations reported satisfaction with the current model, two did not comment and one was dissatisfied.

Figure 11: Strengths and Deficiencies of Female Specific Intervention Sites

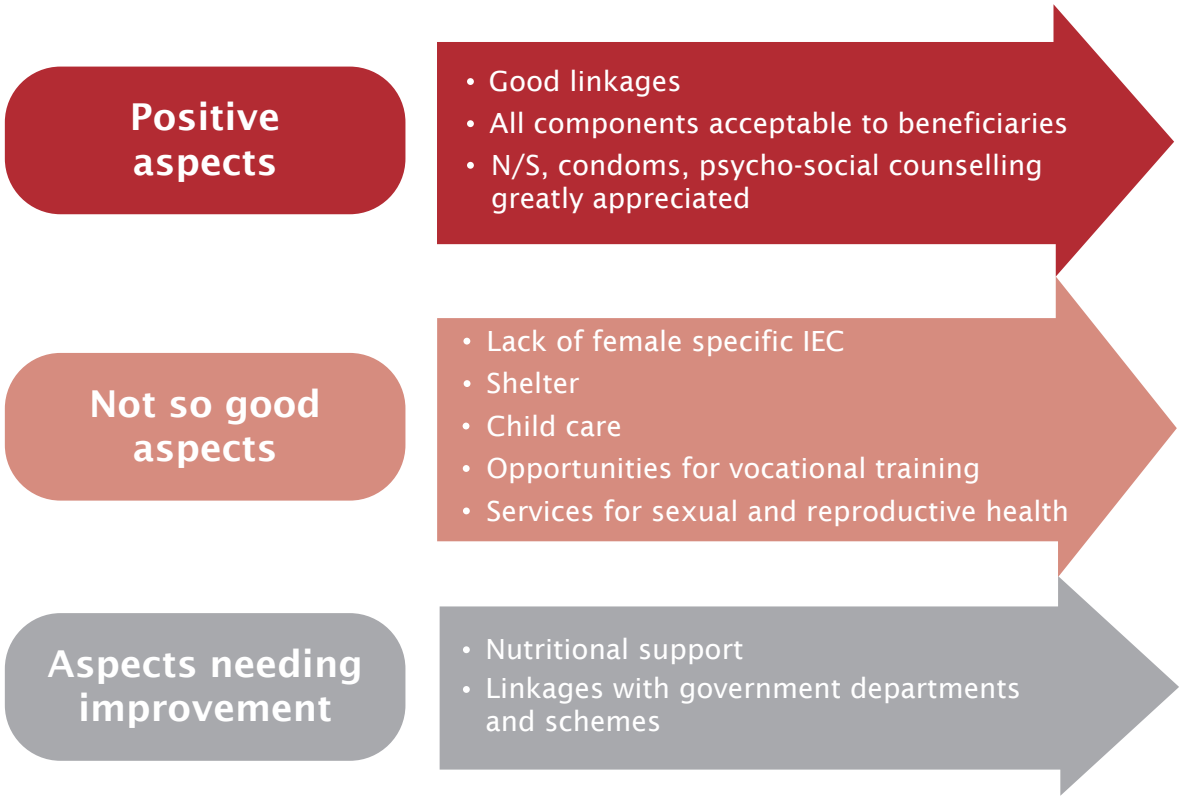


Table 16: Difficulties in Meeting Needs

Barriers/difficulties	Suggestions	Specific additions to the current model
▪ Real stigma ▪ Perceived or self-stigma ▪ Denial ▪ Lack of time ▪ Lack of family support, particularly from partner ▪ Mobility ▪ Harassment from police ▪ Neglect by service providers ▪ No proper place to carry out outreach	▪ Advocacy ▪ Accompanied referral ▪ Community based services, including home based services ▪ Family counselling ▪ Linkages/networking between NGOs, NGO/GO, NGO/other service providers	▪ Hepatitis B and C testing and management (Bethesda) ▪ Linkages with govt., private, church (Bethesda) ▪ Social marketing ▪ Mobile clinics and ICTC ▪ Easier OST distribution ▪ Free detox camps (VHAM) ▪ More ORWs (Shalom Alliance, SASO) ▪ Strengthen IG programs (Shalom Avahan) ▪ Better medical care ▪ Detox referral (SASO)

Barriers and Organizational Difficulties in Addressing Needs

Some of the major difficulties faced were highlighted by the PM of Shalom Alliance:

"All the time they are high and are involved in sex work during day (especially in Churachandpur), so we hardly find time to educate them and inform them of our services.

Family support is very less; especially when they are sick and need to be hospitalized, there is no one to accompany them.

They have no guarantors for taking services like OST and ART."

Suggestions for Local Innovations

"If we can organize a party or an event for FIDUs (they prefer the term party), there will be an occasion for them to get together and we can take the opportunity to give them information on safer injecting and safer sex and can highlight the services available in the nearest centre.

Community mobilization is also important. Also, FIDUs can make a support group or network so that they can give psychosocial support among themselves and will have strength to address their own issues and problems."

– PM of SASO

Budget

The PMs of most of the organizations did not comment on the annual budget. The PM of Bethesda reported an annual budget of INR 11-12 lakh (INR 6 lakh were spent on staff resources and 6 lakh on beneficiaries). The PM of Shalom Avahan felt that limitation of resources (human and money) constrained their work.

Staff-Related Issues

Many members of the staff are trained in harm reduction. According to the PM of Bethesda, their staff has been trained in a variety of areas – community care for HIV, drug use prevention, DOTS tuberculosis program, harm reduction, self-help groups and setting up interventions for FIDUs.

Table 17: Staff Training during 2010-11

Area of training	NGO from where staff was deputed	Area of training	NGO from where staff was deputed
ART adherence	VHAM SASO Alliance	Mental health/illness and reproductive health	Bethesda VHAM
Counselling skills Counsellor training	VHAM Shalom Alliance	Micro-credit	Bethesda
Communication skills	VHAM Shalom Alliance Shalom Avahan	Monitoring and planning	Shalom Alliance
Documentation	SASO Alliance	Motivation skills	VHAM
DOTS provision	Bethesda	Overdose management	VHAM Shalom Avahan
Drug use prevention	Bethesda	Operational guidelines for FIDUs/project management	Bethesda Shalom Avahan
Family counselling	VHAM	Outreach	SASO VHAM Shalom Avahan
Gender sensitive issues	Bethesda	Peer educator training	Shalom Alliance Shalom Avahan
Harm reduction	VHAM SASO Alliance	Proposal writing	Shalom Avahan
HIV/AIDS and STI issues	Bethesda VHAM Shalom Alliance Shalom Avahan SASO Alliance	Project management	Shalom Avahan
Income generation programs	Shalom Alliance Shalom Avahan	Role of NGOs	Bethesda
Strengthening interventions for FIDUs	Bethesda	Self-help groups	Bethesda
Mental health/illness and reproductive health	Bethesda VHAM	–	–

Multiple levels of staff have been recently deputed for training programs conducted by the UNODC, RRTCs, SASO and CIHSR.

A few difficulties mentioned by the PMs with respect to staff are the high staff turnover (Bethesda) and occasional cases of resource misuse by the PEs (Shalom Avahan).

Positive Experience Narrated by Staff at Bethesda

The staff at the DIC related the story of a young FIDU who was initiated into alcohol and drug use at a very early age. Her single mother was an alcohol vendor at one of Dimapur's hot-spots for booze and sex work. Owing to her mother's profession and later on her own drug use habit, their relationship with the extended family with whom they lived was strained for many years. Furthermore, when she tested HIV positive, she was thrown out of their home. When she came to the DIC, she opted for OST treatment. She was initiated on OST by the same organization at another DIC and was provided follow-up support by the project staff. She was later inducted as a Peer Educator and became a considerable asset to the project. She went on to make a complete recovery and was reunited with her family. She was recently invited by her relatives to live with them in Kohima. She has left the project for a new beginning. The team at the DIC is happy for her and is confident that she will do well.

3.2.D. FIDU Key Informants

Thirty-six FIDU KIs were interviewed following identification through nine NGOs. Informed consent was obtained from the respondents. All the FIDU interviews were carried out in the north-eastern states (12 from Mizoram, 13 from Manipur, 6 from Nagaland and 5 from Meghalaya).

Age

The FIDU KIs were all between 16 to 41 years of age. The mean age was 28.6 years (SD: 5.4).

Education Status

The mean education level was 8.7 years (SD: 3.9). seven (20.6%) had received education up to primary level, 20 (54.4%) had received education up to class X, seven (19.4%) had received higher education, and education was not recorded in the case of two respondents (5.6%).

Table 18: Education Status

	N	%
Up to primary level	7	20.6
Up to class 10	20	54.4
Higher education	7	19.4
No response	2	5.6

Occupation

Most of the FIDUs (27, 75%) were unemployed. Two (5.6%) were carrying on a petty business, three (8.4%) were self-employed, one was a peddler and two were working with an NGO as an outreach worker and PE respectively. One was a sex worker.

Table 19: Occupation

	N	%
Unemployed	27	75
Petty Business	2	5.6
Self employed	3	8.4
Peddler	1	2.7
Outreach worker	1	2.7
Peer educator	1	2.7
Sex worker	1	2.7

Types of Drugs Used

Twenty-seven FIDU KIs (75%) reported injecting heroin and 23 (63.9%) Dextropropoxyphene (as Parvon 9, Relipen 8, Spasmoproxyvon 5). Ten (27.8%) reported use of alcohol, six (16.7%) reported use of benzodiazepines or other pills, and 12 (33.3%) use of other opioids (chasing heroin, spasmoproxyvon, codeine syrup). One respondent reported use of cocaine. Three (8.3%) were on OST.

Concerns of FIDUs

A majority of the **personal concerns** of FIDUs were related to health. The 36 respondents mentioned 54 types of personal health problems, some of which included stomach ache, liver problems, fever and bodily pains, menstrual irregularities, white vaginal discharge, and blocked veins. Six reported health problems consequent to being HIV+ and five reported having STIs. Four reported abscesses, four wanted treatment to help them stop injecting and to deal with withdrawal.

The FIDU KIs were asked to express their concerns regarding personal health and multiple responses were recorded. This included the need for **medical care** expressed by 26 KIs (72.2%), **counselling** (7, 19.4%), testing (4, 11.1%), knowledge regarding safe injecting (2, 5.6%), nutritional support (2, 5.6%) and financial help (1, 2.8%).

Sixteen KIs (44.4%) expressed one or more specific concerns regarding their partner, primarily related to worries regarding the partner's health. In terms of help needed, seven (19.4%) KIs expressed the need for **medical care** and four (11.1%) for **counselling.**

Concerns regarding children were expressed in 23 instances (63.8%) and primarily included concerns about their **education** (36%) and **health and nutrition** (5,13.9%). One KI was concerned about having children; another wanted to put her child in an orphanage. The help they expected with regard to their children included **support for education** and other areas (22.2%) and **nutritional support** (16.7%). Two KIs (5.6%) requested medical care and one requested pregnancy counselling.

One or more employment concerns were expressed by 28 FIDU KIs. These included **unemployment** (12, 33.3%), **stigma** at work (3, 8.3%), being in sex work (1, 2.8%) and drug dealing (1, 2.8%). Help required included **capital** for business (8, 22.2%) and **vocational training** (10, 27.8%).

Difficulty in Getting Help

Twenty-two FIDU KIs reported one or more difficulty in getting help. The common difficulties mentioned by FIDU KIs in getting help are mentioned in the Table 20. Other difficulties expressed by one or two KIs include lack of knowledge by the family of her drug use and fear of threat by the underground.

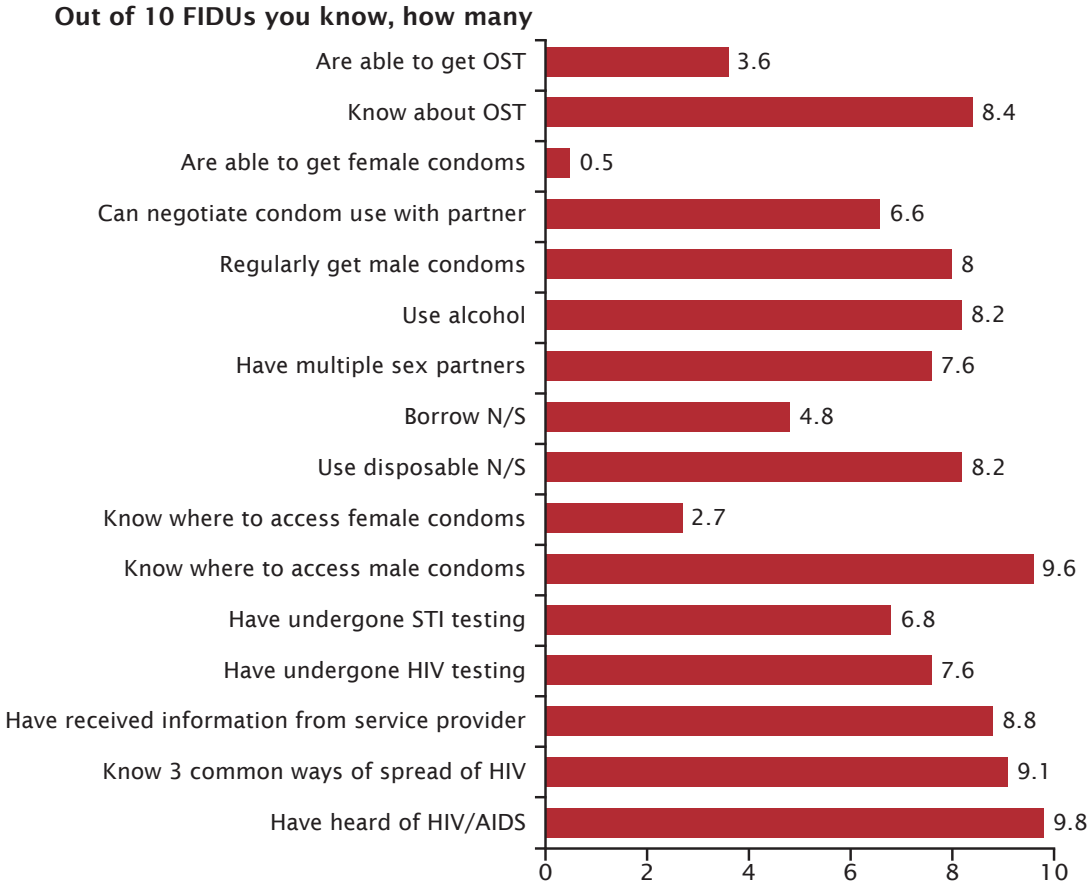
Table 20: Difficulty in Getting Help

Reason	N	%
Stigma, Discrimination	15	41.7
Do not know where to go	5	13.9
Distance	5	13.9
Lack of services	3	8.3
Lack of money	4	11.1
Lack of time	3	8.3
None	11	30.6
Did not want any help	7	19.4

Perception of Knowledge and Service Access by FIDUs

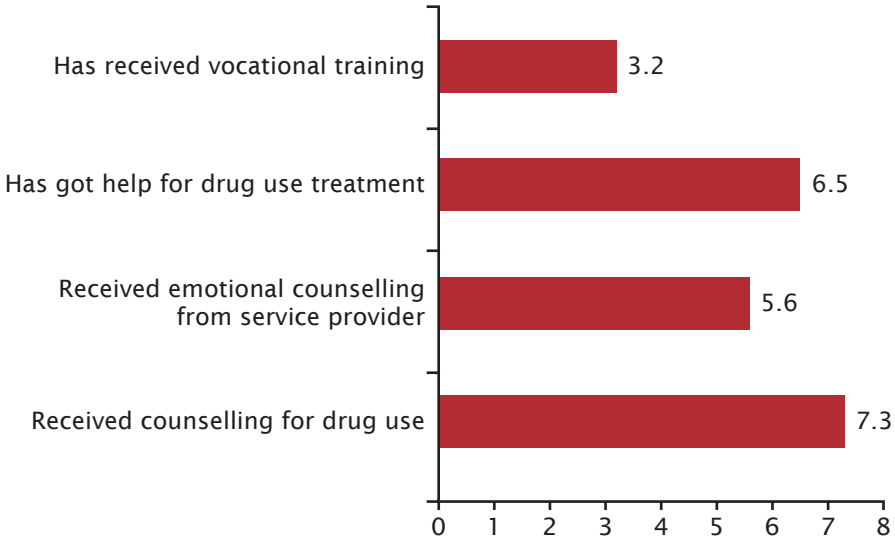
FIDU KIs were asked their opinion regarding the extent of knowledge and access of services by FIDUs they knew in the community. They were asked, 'Out of 10 FIDUs you know in the community, how many do you think know where to get condoms,' etc. The means of the scores are indicated in Figure 12.

Figure 12: Perception of FIDU KIs with respect to knowledge, behaviour, service access among FIDUs



FIDU KIs perceive a relatively high knowledge regarding HIV in the community, good knowledge regarding how to access condoms, needles/syringes. However, their perception is that access to OST and female condoms is low. Their perception is that a substantial number of FIDUs use alcohol, though self-reported use of alcohol among FIDU respondents as part of this study was not very high. They perceive that FIDUs are able to negotiate condom use fairly well with their partners and use disposable N/S most often. Sources of concern are the high perception of alcohol use, borrowing of N/S and perception that FIDUs have multiple sex partners. Although the FIDUs feel that many of their peers have been tested for HIV/STI, the testing uptake is not very high as reflected in the TI statistics.

Figure 13: FIDU KI Perception Regarding Access to Other Services



With respect to services received, apart from HIV related services, the perception is that very few females receive vocational training, and nearly half have not received emotional counselling from a trained service provider. FIDU KIs perceive that a significant number has received counselling for drug use and help for drug treatment.

Choice of Services

FIDU KIs were asked where they would go for a variety of services. Most appear to select facilities they are already familiar with.

Table 21: FIDU Key Informants' Choice of Location for Service

Service	DIC		NGO		De-addiction centre/ Drug rehab		Government Hospital		Clinic		Other (pharmacy etc)		Don't know/no response	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
For care of abscess	23	63.9	9	25			1	2.8	1	2.8	2	5.6		-
N/S	25	69.4	10	27.8							1	2.8		-
OST	17	47.3	16	44.4									3	8.3
Detox	5	13.9	7	19.4	12	33.3	1	2.8			2	5.6	9	25.0
Rehab	2	5.6	10	27.8	19	52.7							5	13.9
Voc. training	3	8.3	8	22.2	4	11.2							21	58.3
Legal problems	9	25	8	22.2									19	52.8

Instances of Help Seeking

FIDU KIs were asked to recall instances when they had required help. Such instances commonly included testing, medical treatment including drug use treatment, financial help, shelter and family violence. Most commonly they had approached an NGO or DIC for help. Help obtained included relief of symptoms, emotional support and help to quit. They also quoted instances of not getting medical help, emergency help, financial help and legal help.

Satisfaction with Services Accessed

A majority of FIDU KIs were satisfied with the services in both the government and private hospitals. However, more than one-third had not accessed facilities in the private sector. Reasons for dissatisfaction with care include stigma, discrimination and waiting time.

Table 22: FIDU KI Satisfaction with Services in Different Settings

	Very satisfied		Satisfied		Dissatisfied		Can't say/ No response	
	N	%	N	%	N	%	N	%
HIV testing in a government hospital	7	19.4	24	66.7	3	8,3	2	5.6
HIV testing in a private hospital	2	5.6	15	41.7	15	41.7	19	52.7
Reproductive health care services in a government hospital	4	11.2	15	41.6	2	5.6	15	41.6
Reproductive health care services in a private hospital	20	55.6		-		-	16	44.4
Treatment of specific illness in a government hospital	3	8.3	12	33.3	10	27.8	11	30.6
Treatment of specific illness in a private hospital	1	2.8	24	66.7		-	11	30.5
Treatment of general illness in a government hospital	3	8.3	17	47.2	1	2.8	15	41.7
Treatment of general illness in a private hospital	15	41.7		-		-	21	58.3

Ideal Location of Services

FIDU KIs would like services to be available nearby and in an NGO or DIC. One respondent wanted services to be offered at the hotspot. Most preferred services to be available nearby in their locality, whereas one respondent desired that services should be far away (addiction treatment). For services that were not available in the NGO sector, a respondent wished that they be made available in both the government and private sector.

3.3 Female Sex Partners of Male Injecting Drug Users

3.3.A. Global, Regional and Local Review

Global

There are an estimated 34 million adults worldwide living with HIV and AIDS, half of whom are females.[46] For females, given their role within society and biological vulnerability, the epidemic has a greater impact. Heterosexual contact is the most common source of acquiring infection for females. Being twice as likely to acquire the infection through biological vulnerability, high sexual coercion and low condom use makes females highly vulnerable.[47]

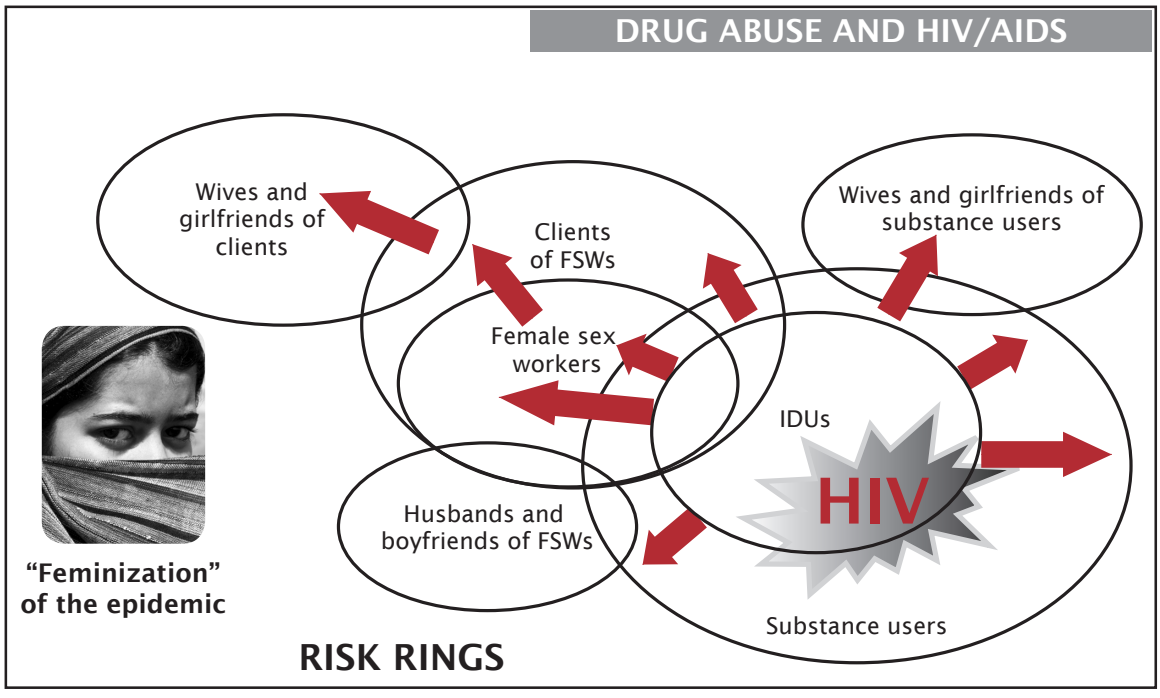
[46] UNAIDS. *World AIDS Report 2011*

[47] UNAIDS. *Women and girls:UNAIDS strategy 2011-15*

Women at Risk of HIV from Their Intimate Partners (UNAIDS, 2009)

Societal Factors	Individual Factors
■ Migration ■ Gender norms ■ Lack of sexual negotiation ■ Lack of economic rights ■ Stigma and discrimination	■ Non-disclosure by partner ■ Intimate partner violence ■ Men's lifestyles ■ Risk factors

Figure 14: Spread of HIV from Drug Users to Female Sex Partners (UNODC)



Regional

Since SAARC countries are home to 22% of the world's population, even low prevalence rates of HIV in the region will impact the course and magnitude of the global AIDS pandemic over the next decade.

In countries such as Indonesia, Vietnam and Pakistan, HIV transmission is largely through injecting drug use. Not only are FIDUs at a high risk of contracting HIV, but an increasing number of females are becoming infected with HIV from male IDU partners.[48]

In Asia, most females are infected by their husbands or partners who engage in paid sex or inject drugs. Patterns vary depending on the country's phase of the HIV epidemic. In countries where the epidemic began in the 1980s, the proportion of infected females has increased remarkably. While 17% of all adult HIV infections comprised females in 1990, this increased to 35% by 2007.[49] This is often attributed to unsafe sexual behaviours of their partners for which injecting drug use is one common reason. There are a reported 4 million injecting drug users in Asia who in turn put their female sexual partners at high risk.[50]

[48] *Ibid.*

[49] UNAIDS. *HIV transmission in intimate partner relationships in Asia. 2009*

[50] *Ibid.*

Some studies in Asia demonstrate considerable cross-over between injecting drug use and transactional sex. Studies from Pakistan indicate that between 41 to 50% of MIDUs are either married or have a regular female sex partner. At least one-fifth of IDUs reported having sex with female sex workers. Well over half did not use condoms.[51,52]

The RSRAs threw light on many aspects of male drug use and FSPs of male users (9,616 current drug users and 4,369 sex partners) through 51 demo sites across five countries in the South Asia region. In a study based on the RSRA,[53] out of 4,612 female regular sex partners across five countries, only 21% reported condom use in the last sexual act.[54]

Table 23: Summary of RSRA Findings Highlighting HIV Vulnerability among IDUs and their FSPs[53]

	Bangla-desh	Bhutan	India	Nepal	Sri Lanka
No. of drug users interviewed	1,090	200	5,800	1,330	417
Injecting users	28%	19%	62%	80%	4%
Married	57%	16%	48%	33%	52%
Sharing N/S	39-43%	–	46-51%	24-38%	–
Median number of sexual partners	2	–	2	2	2
Condom use					
With casual partner	26%	55%	21%	56%	31%
During paid sex	23%	55%	23%	51%	28%
With regular partner	15%	37%	20%	34%	14%
Risky behaviours	Anal sex		MSM		
No. of female sex partners interviewed	136	23	3,328	417	708
Report of condom use by FSP	10%	–	–	37%	12%
Perception of risk	–	33%	25%	23%	17%
Tested for HIV	3%	39%	18%	14%	14%

As is evident, high risk injecting behaviours among the male IDUs, high rates of unprotected sexual activity, risky sexual behaviours, and low perception and testing among FSPs make both groups vulnerable to HIV and other STIs.

India

As per the sentinel surveillance conducted by NACO in 2007, HIV prevalence among IDUs is 7.2%, which is one of the highest rates among the high risk groups (HRGs) in India.[55] The National Behavioural Surveillance Survey (BSS) 2006 shows that a majority of the IDUs were young males in the age group 26-35 years.[56] Further, 32 (68.6%) of the IDUs were ever married and about 10.5% were married but

[51] Sp*ouses of IDUs and sex workers in Pakistan.* Presented at the 17th meeting of the International Society for Sexually Transmitted Diseases Research (ISSTDR), Seattle, Washington, 30 July–1 August 2007

[52] Ahmad S, Mehmood J, Awan AB, Zafar ST, Khoshnood K, Khan AA. 'Female spouses of injecting drug users in Pakistan: a bridge population of the HIV epidemic'. *EMHJ* 2011, 174: *271-276*

[53] UNODC. 2008. *Rapid Situation and Response of drugs and HIV in Bangladesh, Bhutan, India, Nepal and Sri Lanka.A Regional Report.*

[54] Kumar MS, Virk HK, Chaudhuri A, Mittal A, Lewis G. *2008 op cit*

[55] HIV *sentinel surveillance and* HIV *estimation in India 2007 – A technical brief,* National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, October 2008

[56] National Behavioural Surveillance Survey (BSS). *Men who have Sex with Men (MSM) and Injecting Drug Users (IDUs),* National AIDS Control Organisation, Ministry of Health and Family Welfare, Government of India, 2006

living with sex partners other than their spouse. In addition, 3.3–33.3% of the IDUs were not married but were living with sex partners. This shows that a majority of the IDUs are sexually active and have sex partners who are also vulnerable to HIV/AIDS. It is established that females are more vulnerable to contracting HIV, even among those who are not practising high risk behaviour/s. Currently, most HIV infections among females who do not engage in sex work, in rural and urban areas, are attributable to the risk behaviour of their male sex partners. Recent data from NACO (2010) reveals that HIV prevalence is highest among IDUs (9.2%) compared to MSM (7.3%), FSWs (4.9%) and STI clinic attendees (3.6%).

In Manipur,[57] 45% of the wives of HIV positive IDUs were infected within 7 years of their husbands testing positive. By the 1990s, HIV prevalence among men who injected drugs was 80%; and by 1996, 45% of the women attending antenatal clinics in Manipur were reported to be HIV positive.

HIV/AIDS in India disproportionately affects females not because of their own risky behaviour but because of that of their partners. A study in Chennai[58] tried to identify the risks that high risk men pose to their low risk wives/sexual partners. Wives of injecting drug users (who were part of an epidemiological cohort study) were interviewed one-on-one and through focus group discussions. Results suggested that male IDUs generally avoid disclosure. A majority of wives learn about the drug use behaviour only after marriage, making them generally helpless to protect themselves. Fear of poverty and negative influences on children were the major impacts associated with continued drug use.

A 'Guesstimate' of Female Sexual Partners in Need of Services, including HIV Prevention

As per the National Household Survey on Drug Abuse (NHSDA),[59] 59% of the population interviewed was married. RSRA showed that 50% of the respondents were married. Extrapolating the figure of 59% to the 2 million opiate users, we have nearly 1.2 million FSPs of male opiate users who need some form of counselling.

Based on the RSRA figures that 87% of the men interviewed were sexually active, we have 1.74 million FSPs who are in need of special attention. The RSRA finding that 26% had multiple sex partners when generalized suggests that we may have 0.5 million opiate users with multiple sex partners. Given that the median number of partners was two, we have an additional 1 million females in need of counselling for HIV and other STIs.[60]

According to an estimate made during the NACO mapping and size estimation exercise, 200,000 male IDUs existed in the country in 2007.[61]

Female Sex Partners' HIV Prevention Interventions and Beyond

The study, *Women and Substance Use in India (2002),* found a high burden on women caring for drug users in the form of economic burden, stigma, emotional problems, relational problems and neglect of their needs as well as that of their children. Violence was a commonly reported problem. Help seeking for violence was extremely low.

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[57] *HIV/AIDS in Manipur, India: An Annotated Bibliography* December 2005

[58] Solomon SS, Mehta SH, Latimore A, Srikrishna AK, Celentano DD. 'The impact of HIV and high risk behaviours on the wives of married men who have sex with men and injection drug users: Implications for HIV prevention'. *Journal of the International AIDS Society* 2010, 13 (2):57

[59] UNODC. *The extent, patterns and trends of drug abuse in India-National Trends. 2004*

[60] Murthy P. *Desk study for the TAG.* 2009

[61] NACO

The Women, Drug Use and Vulnerability Study, UNODC ROSA

The study[62] highlights some of these findings more vividly. In this study 4,401 FSPs from 109 NGOs throughout the country were interviewed. The salient findings of this study are summarized in the box alongside. Young age, early marriage, unsupportive partners, poor decision making powers and economic dependence characterized many women from this group. These females reported high rates of exposure to domestic violence but low rates of help seeking in such situations. Children in substance using families had significant emotional and behaviour problems. Three out of four partners had high General Health Questionnaire (GHQ) scores, suggesting a diagnosable mental problem, mainly depression; and nearly one-third of them had attempted to end their life during the previous year. The study showed high rates of awareness of HIV/AIDS but poorer knowledge of modes of transmission. FSPs also reported low rates of condom use. Barriers identified for low condom use[63] included lack of power in decision making among married females, lack of condom norms in marital relationships, poor or inadequate condom negotiation skills, and inadequate knowledge about sexual transmission of HIV from male IDU partners to their spouses. The study also revealed low rates of HIV testing among FSPs and poor knowledge of test status of their partners. Twenty to thirty percent of FSPs had symptoms of UTI/reproductive tract infection. One in four to one in five partners/female drug users had induced abortions, making them vulnerable to RTIs.

Women, Drug use and Vulnerability Study 2008 – Highlights

- 4,401 female sex partners of male drugs users
- 75% in their 20s-30s
- 150 FSPs below 20 years of age
- More than half married before 18 years of age
- 93% lived with their drug using male partners
- Nearly one in five illiterate
- 41% perceived partner as hostile or unsupportive
- More than half had no independent income
- One in four was aware of drug using partner having an extramarital affair
- 75% reported having sex when partner was intoxicated. In 2/3 of such cases, no condom was used
- 2/3 had suffered partner violence
- 76% had heard of HIV but less than 20% had been tested
- 3/4 had high GHQ scores, suggesting significant mental health problems
- 50% had experienced thoughts that life was not worth living, and 30% had made a suicide attempt
- Knowledge of services for HIV/AIDS and access to such services was low compared to female drug users
- Only 11-25% had accessed services, suggesting a treatment gap of 75-90%

Low risk perception to HIV infection occurs even among male drug users (RSRA). In the RSRA, only one in five had been tested for HIV, but 42% among those who had not been tested were desirous of getting tested. Only one-third of the respondents in the RSRA had sought treatment for addiction. Even in the women partners' study, nearly one in two respondents (both drug users and non-drug using partners) did not perceive themselves or their partners at risk for HIV.

[62] Murthy *P. Women and substance use in India.Women, substance use and vulnerability.* UNODC 2008
[63] Kumar MS et al. *Int J Drug Policy 2008, op cit*

Vulnerabilities of Spouses and Children – Extending beyond the North-Eastern States of India

A recent report by an NGO, SPYM, identifies and compares vulnerabilities of spouses and children of male injecting drug users in the NE and NW parts of the country.[64] The study was carried out at three sites in the north-west (Chandigarh, Jammu & Kashmir and Patiala) and two sites in the north-east (Imphal and Kohima). Data was collected from 300 couples, 150 at each site. Despite better intervention coverage in the NE, more IDUs here reported sharing N/S as compared to the NW. In the NW, however, high risk sexual behaviour, including lower rates of condom use was evident.

Among wives of IDUs, a higher proportion reported use of condoms in the NE as compared to the NW.

In both areas, there were frequent reports of marital discord, violence, mental health problems, economic hardship, stigma and discrimination. With respect to the children, all areas of child development seemed adversely affected, including behavioural changes in children of IDUs.

The study suggests that injecting drug use should not be considered a problem only of the NE but of the entire country and that services must reach spouses of IDUs. Though the targeted intervention approach in the NACP-III does envisage addressing the regular sex partners of IDUs, no specific interventions/strategies have been developed in that phase. It recommends addressing psychosocial issues as a form of harm reduction and emphasizes the need to go beyond condom provision to address the need of spouses.

Situational Analysis of Harm Reduction Interventions for IDUs and Their Spouses in India

The DFID-TAST[65] undertook a situation analysis of harm reduction interventions for IDUs and their spouses focusing on three key areas of service delivery, namely NSEP, OST and services for spouses. The review included an analysis of peer-reviewed articles, examination of CMIS data for 2007-2010, analysis of 197 in-depth interviews and 15 FGDs with IDUs and their spouses as well as 197 IDU TI forms. With regard to FSPs, what is evident is low condom use, the reasons for which were elaborated earlier. Intimate partner violence can also be associated with low condom use.[66] The DFID review of condom distribution shows an increase in distribution at STI clinics.

Qualitative interviews with IDUs reaffirmed the findings of low condom use, lack of proper counselling, lack of nutritional support, and financial difficulties in obtaining medical services. The interviews with spouses highlighted high burden on account of partner's drug use, low condom use, sex under the influence of alcohol, reluctance to seek help at government settings and poor sexual communication.

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[64] SPYM and Plan International, New Delhi. *HIV vulnerability among injecting drug users, their spouses and children.* Ambekar A, Tripathi BM and Dzuvichu B (eds.), 2009

[65] DFID TAST. *Harm reduction interventions for injecting drug users and their spouses in India: a situational analysis. 2011.* Kumar MS, Srikrishnan AK, Joseph F, Dhanikachalam D

[66] Solomon SS, Srikrishnan AK, Celentano DD, Johnson S, Vasudevan CK, Murugavel KG, Anand S, Kumar MS, Solomon S, Mehta SH. 'The intersection between sex and drugs: a cross-sectional study among the spouses of injection drug users in Chennai, India'. *BMC Public Healt*h 2011, 11:39

3.3.B. Service Providers' response with regard to FSP services

i) IDU TI Sites

Estimation of FSPs of Male IDUs requiring help and FSP annual registrations

Table 24: Annual Registrations and Service Provided at IDU TI Sites

	Ambuja Cement Foundation	Don Bosco	Hoper's Foundation	D. N. Kotnis Charitable Hospital	Nirvana Foundation	Bethesda Youth Welfare Centre	Samaritans
No. of FSPs needing services during a year	162 (married IDUs)	One third of FSPs may need services	• 250 target population • 130 married living with spouses	181 married IDUs living with spouses	173	100-200	500 IDUs Married 201
No. of FSPs registered during a year	–	35 (2010)	Under NIE (ICMR) providing services to 200 female partners of IDUs	50	8	113 (2009) 200 (2010)	201 (2010)
List of services	Only free services like ICTC and counselling provided if required	• STI Counselling • Syphilis		• ART • Condom • Counselling • HIV testing • STI testing	• BCC Condom promotion • Counselling • Health check-up Laboratory tests • Outreach • STI treatment • Referral services	• Awareness • Condoms • Counselling • Referral and linkages to service	• ART Condom • Counselling • ICTC • STI
Have an outreach program	No	No	• ART • Condoms • Counselling • HIV testing • STI treatment		Educational awareness	• Awareness • Counselling • Referral	• ART • Condom • Counselling • ICTC • STI

Although the organizations identified a substantial number of FSPs of male IDUs who are in need of services, except at three sites, the services are being provided to very few FSPs. Four of the organizations reported providing primarily HIV and STI services to FSPs. Two of them provide education and community awareness regarding HIV, while two organizations reported providing a wider range of services. None of the organizations has registered FSPs in the community to whom they provide regular services. At the D.N. Kotnis site, they have registered 50 FSPs but have not been able to provide services to them because they have been unable to obtain the approval of the male partners.

Table 25: Testing Uptake, Condom Distribution at TI Sites

	Ambuja Cement Foundation	Don Bosco	Hoper's Foundation	D. N. Kotnis Charitable Hospital	Nirvana Foundation	Bethesda Youth Welfare Centre	Samaritans
Number who have undergone HIV testing	10 (community)	10 (clinic)	–	50 (community)	24	5	No tracking record
Number who have undergone STI testing	01 (community)	10 (clinic)	–	50 (community)	24	8	0
Number on ART	0	0	–	2 (community)	0	0	0
Number who accessed male condoms	–	No idea	–	50 (community)	173 (clinic)	–	–
Number of condoms distributed	–	–	–	300 (community)	12,040	–	–

At the Don Bosco site, only those FSPs whose partners have STI/HIV have been offered HIV testing. None of the organizations distributed female condoms.

Table 26: Staffing

	Ambuja Cement Foundation	Don Bosco	Hoper's Foundation	D. N. Kotnis Charitable Hospital	Nirvana Foundation	Bethesda Youth Welfare Centre	Samaritans
No. of staff providing services and gender of staff	1 ORW at ICTC 1 counsellor (Female) 1 counsellor (Male)	1 Nurse (Male) 1 Counsellor (Male) 1 Nurse (Male)	1 ORW (Female) 1 counsellor (Male)		PE (Female) ORW (Female) ANM/ Counsellor (Female) & (Male) Doctor (Female)	2 PE (Female); Counsellor/ ORW (Female)	ORW and 2 PE (Female) Doctor (Male) Counsellor (Female)
Community services	1 ORW (Female)	–	–	1 ORW (Female) 1 counsellor (Male)	ORW, PE and ANM/ Counsellor (Female)	1 ORW dedicated for FSPs (Female) and 2 PEs (Female)	

At Bethesda, one additional female ORW and two additional PEs have been provided to reach out to the female sex partners of their core target population of male IDUs. The total strength of their field staff is five ORWs and 22 PEs for a target of 800 IDUs and 200 FSPs for the financial year (2011-12).

Special needs of Female Sex Partners

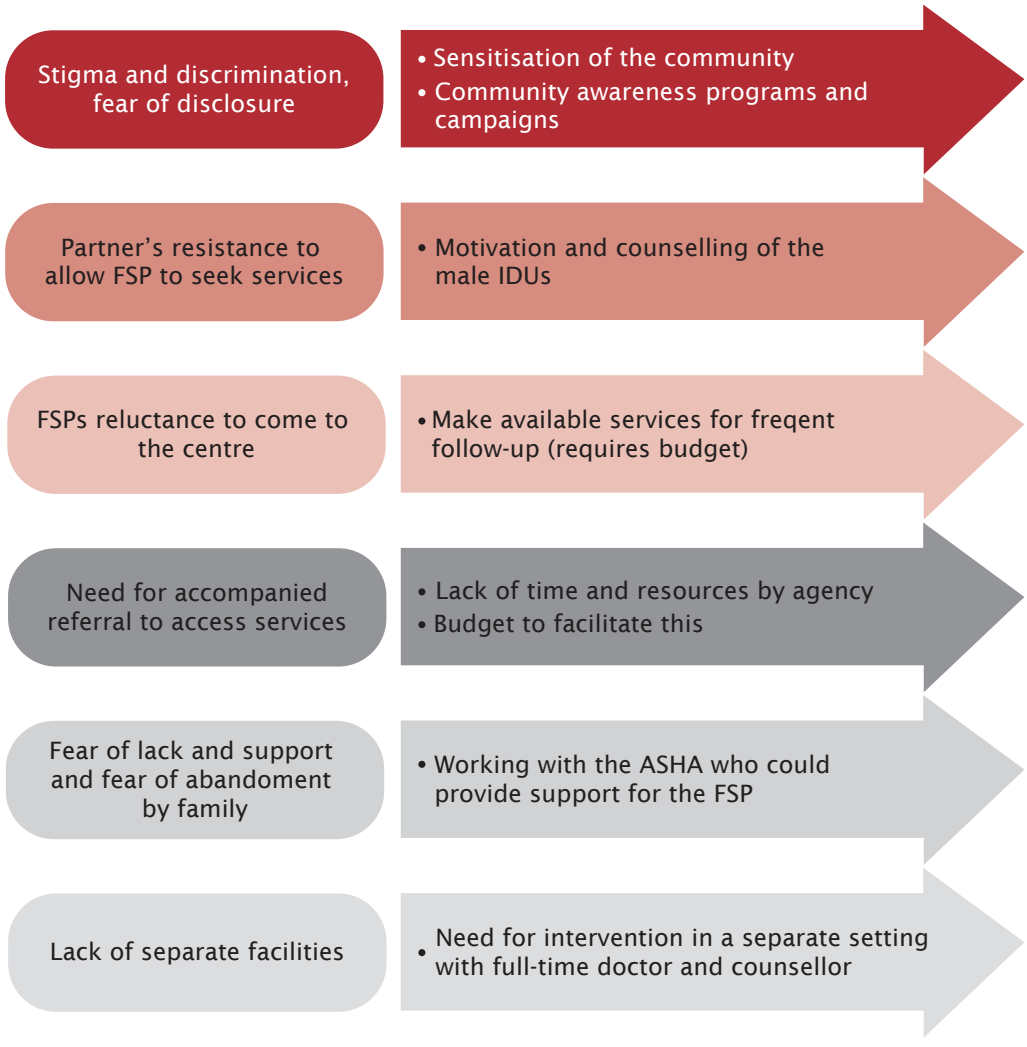
The PMs indicated the special needs of FSPs as follows:

- Health/medical care (one PM specifically mentioned the need for female doctors)
- Facilities for STI treatment
- Rehabilitation/vocational training/methods of dealing with their economic problems
- Like skills training
- Support groups
- Services for their partners (drug treatment) and children
- Availability of female condoms

Suggestions to meet the needs

Three of the PMs felt that vocational training/income generation was an important need that should be addressed. One PM felt that it was important for the agencies to set up SHGs for the purpose of income generation.

Figure 15: Barriers Identified by PMs and Suggestions to Overcome Such Barriers



One of the PMs opined that the reason for male IDUs preventing their partners from seeking services at the DIC was their perception that the FSPs would also be regarded as IDUs. Lack of budget and discrimination by service providers were also listed as barriers.

Working with the community towards a shift in the attitude to, "*I am the wife of a drug user and I am not ashamed; rather I will fight to set him free from this habit*", was also suggested as an approach to overcome barriers.

Not being able to leave their children unattended was another barrier PMs felt prevented FSPs from accessing care. However, they did not provide any suggestions to overcome this. In cases where FSPs lived in a joint family, one PM felt that visits by the ORW would also not be feasible. In such a situation, she suggested that collaboration with the ASHA personnel who regularly visited their homes would help to provide services for the FSPs. Mobility of FSPs was also identified as a barrier for providing services.

Suggestions by Project Managers of IDU TIs for improving services to FSPs

Lack of budget was the most commonly perceived barrier to providing care for FSPs. While one PM opined that female services could be provided in the existing TIs by increasing the budget and recruiting female staff, three others felt that it was important to have a separate facility for women.

Within NACO's existing budget, it is very difficult to think big. The best way to improve the service is to implement a different program for FSPs at a different setting by providing maximum services like health facilities with medicine support, shelter home, psychosocial support, etc.

ii) FSW TI sites

The PMs at three sites (New Life, Akimbo and Volcomh) opined that 15-17% of FSWs had partners who were IDUs. At these organizations, the PMs reported assessing such risk during the quarterly risk assessments and said that vulnerabilities on account of partner's injecting habit was routinely discussed with the FSWs. Such vulnerable FSWs were recognized by the PEs.

Difficulties reported in engaging such FSWs included their reluctance to come to the DIC and the difficulty in persuading regular couples to use condoms. It often requires several visits by the PE to convince vulnerable FSWs to seek help.

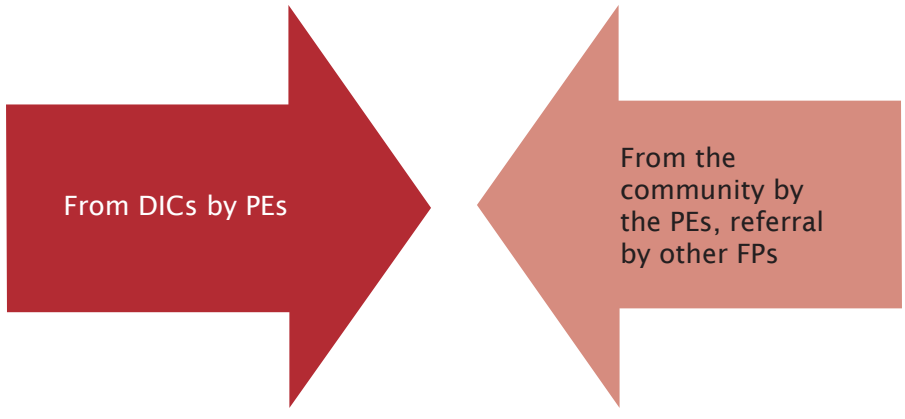
Most of the FSW TIs did not offer any special services for FSWs whose partners injected. Only the PM at Akimbo said that partner treatment was offered and this led to improved family relationships. The response of the PM at the Guru Gobind Singh TI lucidly summarized this aspect.

"No specific intervention exists so far. Never thought on these lines."

iii) Female-specific Intervention Sites

As services for female partners are offered only by the UNODC sites, this section refers to responses from the four sites.

Figure 16: Methods of Identification



According to the PM of Bethesda, PEs who are generally current or recovered users, identify FSPs from the DICs and through networking with the male IDUs. The DIC is also an important access point according to the PM of VHAM where both the ORW and PE are involved in client identification.

From the available information, it appears that drug addiction treatment centres are not active sites of identification of FSPs by these organizations.

Challenges in identifying FSPs

Table 27: Challenges and Suggestions for Identification of FSPs

Challenge	Suggestion by PM to overcome challenge
Reluctance of male IDUs to have FSPs visit NGO and to have NGO visit home Lack of support from partners	Motivation Couple involvement Advocacy and rapport building
Self-stigma and unwillingness to be identified as an FSP	Advocacy and awareness
Distance to be travelled for FSP to avail services	Consider home based services where feasible

Table 28: Services Offered to FSPs

	Agape	Bethesda	VHAM	Nirvana
Direct services to FSPs	• Condoms • Counselling • Nutrition support • STI management • RMC	• Awareness/FGD/ group education • ANC • Condoms • Counselling • HIV testing • Nutrition support • STI management • Recreation facilities • RMC • Referrals • Sanitary napkins • Vocational training	• Awareness • Education • Condoms • Counselling • HIV testing • Nutrition support • Vocational training	• ART • Condoms • Investigations • HIV counselling • Nutrition support • Psychosocial support • RMC
Referral	• ART • CCC • ICTC • PPTCT • STI	• ART centre (govt. based) • ICTC (govt. based) • DOTS (govt. based) • PPTCT (govt. based) • ANC (govt. based) • PPTCT (govt based)	• ART • HIV testing • TB • STI • Other health complications	• ART • CD4 count • ICTC • TB • STI
Services to family members of FSPs	• Male partners • RMC • Children • Nutrition support	• Children • Crèche • Nutrition support • RMC • Recreation • Referral	• Children • Crèche • Nutrition support • RMC	
Community outreach services		• Condom demonstration • Counselling • HIV awareness • IEC materials • Education on hygiene/ sanitation • FGDs	• Condom promotion • Counselling • Motivate for regular check-up • Referral to ICTC	• Condom • Counselling • Medicines • Nutrition • Referral services

Bethesda, VHAM and Nirvana report having community services. The nature of services provided is summarized in Table 29.

Table 29: Community Services Provided

	Agape	Bethesda	VHAM	Nirvana
Number of FSPs registered in clinic/community	190 (Apr 2010–Nov 2011	195 (Apr 2010–Nov 2011)	170 (Apr 2010–Nov 2011)	57 (Oct 2010–Nov 2011)
Number of FSPs undergone HIV testing	–	1	17	38
Number of FSPs who undergone STI testing	–	21	24	7
Number of FSPs on ART	–	0	1	3
Number of FSPs accessed male condoms	–	86	95	28
Number of condoms distributed	–	6,693	19,420	300

With respect to the impact of condom distribution, based on anecdotal information, the PM of Bethesda indicated 25-50% success in getting the partner to use condoms. None of the centres distributed female condoms to FSPs. None of the centres had IEC specific to FSPs.

Nature of counselling

Apart from counselling about HIV and STI, programs at Bethesda, VHAM and Nirvana have mental health counselling both at the centre and in the community.

Special categories of FSPs identified by the PMs

- FSPs who have become widows
- FSPs with mental health problems, particularly suicidal tendencies
- FSPs subjected to domestic violence
- FSPs seeking educational support for their children

Needs of FSPs as Identified by PMs

- Nutritional support
- Vocational training
- Livelihood support
- Self-help groups
- Mental Health Promotion
- Emotional counselling
- Co-dependency counselling
- Short stay home
- Condom promotion
- Information on HIV/STI and services available

Satisfaction with existing services

On a scale of 0-100, the PM of Bethesda reported 40% satisfaction with the services her organization was offering to FSPs. Areas of unmet needs included vocational training, family support, livelihood support and management of Hepatitis B and C. The response from VHAM illustrates what elements the PM was satisfied with and what were perceived as unmet needs (See Table 30).

Table 30: Needs and Unmet Needs – VHAM

Needs	Needs addressed in the program	Unmet needs	Suggestions on how these unmet needs can be met
▪ Nutrition ▪ Child care ▪ Education of children ▪ Emotional counselling ▪ Counselling for co-dependency ▪ Psychosocial support ▪ Condom ▪ Vocational Training ▪ SHG	Not enough Yes Not enough 75-80% met 90% met Yes Male only Not enough Not formal (begin formalizing)	Financial support for children and their education. Not enough nutritional support, especially for those who are HIV positive.	Linking up with govt. and private schemes. Linking up with ICDS (Many don't have BPL and even voter ID cards)

Figure 17: Challenges/Barriers to Providing Care

3.3.C. Female Sex Partners Key Informants

Thirty female partners of male injecting drug users were interviewed during co-lead consultants' visits to understand the felt needs of this group. The distribution of FSPs was as follows: seven from Nagaland, nine from Mizoram, five each from Punjab and Manipur, four from Meghalaya (one of the respondents here was originally from Assam).

Age

The mean age of the FSPs was 28.1 years (SD: 5.2), and the ages ranged from 19 to 39 years.

Education status

The mean education was 7.7 years (SD: 3.7).

Occupation status

A majority of the FSPs were unemployed 13 (43.3%) and 6 (20.1%) were housewives with no remunerative employment.

Table 31: Occupation Status of FSP KIs

	N	%
Unemployed	13	43.3
Housewife with no remunerative employment	6	20.1
Brewing/selling alcohol	2	6.7
Petty business	4	13.3
Domestic	2	6.7
Teacher	1	3.3
Peer educator	1	3.3
Sex worker	1	3.3

Almost all the FSPs who described their occupation as housewives were from Punjab, with the exception of one, who was from Imphal.

Partners' use of injecting drugs

Seven respondents did not know what their partners were using, except that they were injecting some drug. Among the other 23 respondents, their partners most commonly used heroin alone (7, 30.4%), or in combination with dextropropoxyphene (9, 39.1%), or the latter alone (as spasmoproxyvon, relipen, parvon, etc). Three respondents reported no current injecting use among their partners.

Table 32: Health Concerns of FIDUs

Concerns		N	%	Help required	N	%
Personal	Worries about health	14	46.7	Medical care	11	36.7
	Worries regarding HIV/STI	8	26.7	Counselling and support	6	20.0
	Others (mental tension, depression)	4	13.3	Methods to protect health	2	6.7
	None/not specified	4	13.3	Others	1	3.3
				None/not specified	10	33.3
Partner	Health problems	17	56.7	Medical care, including treatment of addiction	13	43.3
	Unsafe injecting	3	10.0	Counselling and motivation	9	30.0
	HIV/Hepatitis	6	20.0	None/not specified	8	26.7
	Other	1	3.3			
	None/not specified	3	10.0			
Children	Education	9	30.0	Medical care	4	13.3
	Health care	6	20.0	Support	7	23.4
	Future	3	10.0	Financial help	1	3.3
	None/not specified	12	33.3	None/not specified	18	60.0

Note: Some responses exceed 100% because multiple responses were provided

Among FSPs, the overwhelming concerns are regarding their health. A major reason for worry appears to be HIV. A large proportion of their concern for their partners also focuses on health problems (commonly skin, liver, sleep, appetite) and unsafe injecting practices. As far as children are concerned, the major concerns are education, health care and paternal neglect.

Overwhelmingly, expectation of help is for medical care for themselves (36.7%), partners (43.3%), and children (13.3%). The second felt need is for counselling for themselves (20.0%), and motivation and counselling for the partners (30.0%). Drug use treatment and information on safe injecting for the partners were the other expressed needs. For the children, an expressed need apart from medical care is for financial help and support.

A 19-year-old recently married FSP from Ludhiana who is married to an injecting drug user was concerned about his deteriorating health.

> *"I'm a little apprehensive in having physical relationship with my husband. It's been just one year of marriage and things have changed drastically."*

Employment concerns

Lack of job, no earning or low earning are the major employment related concerns among FSPs. A few of the respondents who were forced to brew/sell alcohol or sex expressed helplessness. An overwhelming need for vocational training and income generation activities was expressed; and a few respondents said that they needed help to find jobs for their partners.

Table 33: Employment Concerns

Concerns	N	%	Help needed	N	%
No job/no earning	3	10.0	Vocational training	12	40.0
Low earning	7	23.4	Income generation	3	10.0
Forced to brew/ sell alcohol	2	6.7	Job for partner	2	6.7
Partner not working	5	16.6	Alternate livelihood	2	6.7
Others	2	6.7	No help required/ not specified	11	36.6
None/not specified	11	36.6			

A 35-year-old housewife from Morinda, who does not know what her husband is using, said:

> *"It has been 18 years of marriage now. My husband fights a lot with his parents and me. Lots of times there is violence. He does not take any responsibility of the family and not even of the children. My husband is not employed and is not at all supportive towards the family. Instead, one of my children works and supports the family. And my eldest son has started hating his father. He is not earning. My in-laws are taking care of the money. They don't let me work, so I'm worried about the future of the kids and myself."*

Perception of knowledge about HIV related risk, access to other services among FSPs in the community

This was assessed by asking the FSPs how many FSPs out of 10 they thought had knowledge of each of the facts. Among the 27 FSPs, the information was correctly recorded for 22. The responses from FSPs from Nirvana, Manipur have not been considered in this section. State-wise, the FSP respondents in this section include six from Nagaland, five from Punjab, four from Mizoram, four from Manipur and three from Meghalaya. For some of the questions, one or two respondents from Mizoram and Manipur did not provide responses.

Table 34: Perception of FSPs' Knowledge, Access to Services and Care

Out of 10 FSPs that you know how many	All		6 or more		5 or less	
	N*	%	N*	%	N*	%
Have heard of HIV/AIDS	12	**55**	7	**32**	3	**13**
Know 3 common ways of spread of HIV	10	**46**	4	**18**	8	**36**
Have received information from service providers	9	**41**	4	**18**	9	**41**
Have undergone HIV testing	6	**27**	5	**23**	11	**50**
Have undergone STI testing	4	**18**	2	**9**	15	**68**
Have received emotional counselling	4	**18**	1	**5**	16	**73**
Have been involved in vocational programs	3	**13**	0	**0**	18	**82**
Know where to access male condoms	14	**64**	3	**13**	5	**23**
Can get partners to use condoms	4	**18**	6	**26**	11	**50**
Know where to get female condoms	3	**13**	0	**0**	17	**77**
Are actively involved in partner's drug use treatment	7	**32**	9	**39**	5	**23**
Know where to get legal help	4	**18**	1	**5**	17	**77**

*N is the number of FSPs who responded correctly (N=22)

Although the FSP respondents were few and perhaps not representative, their perceptions somewhere do reflect the existing situation to some extent. With regard to **knowledge of HIV/AIDS and mode of spread** among FSPs, a majority of the FSP respondents from Nagaland and Mizoram think that the level of knowledge is good; whereas the FSPs from Manipur and Meghalaya think the level of knowledge is average. All the FSP respondents from Punjab felt that five or less out of 10 respondents know the three main ways in which HIV spreads.

With regard to **receiving information from service providers**, FSPs from Nagaland and Mizoram perceive very good coverage, whereas respondents from Punjab felt that five or less out of 10 respondents receive information from service providers.

With regard to perception of **HIV testing** among FSPs, a majority of respondents from Nagaland felt that most FSPs have not undergone testing. The perception with regard to **STI testing** suggests that such testing is rather infrequent even in Nagaland. All FSP respondents in Punjab felt that STI testing among FSPs is very infrequent.

Only in Mizoram, two of the four FSP respondents felt that all women have **access to emotional counselling**. All the FSP respondents from Nagaland and Punjab and more than half from Manipur and Mizoram felt that less than five out of 10 women have access to emotional counselling.

With regard to **vocational programs**, an overwhelming majority of respondents from all the states felt that very few women have access to vocational programs.

Knowledge about where to **access male condoms** seems to be quite high, according to FSP respondents from Nagaland (all), Mizoram (all) and Meghalaya (all). Such information is available to very few, according to FSP respondents from Punjab.

Most FSP respondents from Nagaland felt that few women are able to **negotiate condom use** with their partners.

However, as expected, only three FSP respondents felt that all FSPs know where to **access female condoms**; while most respondents from across the states felt that this is known by very few, if at all.

Relatively more respondents from Punjab and the NE states felt that a significant number of FSPs are actively **involved in their partner's drug use treatment**.

The general perception is that few women have **access to legal help**, with the exception of the FSP respondents from Mizoram.

Satisfaction with HIV and reproductive health services

The FSP respondents were asked to rate their level of satisfaction with the HIV and reproductive health services offered by both government and private sectors.

Table 35: Satisfaction with Services

Service	Very satisfied		Satisfied		Dissatisfied		Don't know/ Can't say	
	N	%	N	%	N	%	N	%
HIV testing services in government facility	7	23.3	16	53.3	2	6.7	5	16.7
HIV testing services in private facility	3	10.0	9	30.0	1	3.3	17	56.7
Reproductive care services in government facility	5	16.7	15	50.0	6	20.0	4	13.3
Reproductive care services in private facility	5	16.7	9	30.0		–	16	53.3

A majority of the FSP respondents were not aware of the services provided by the private sector, as they had not utilized these services. Of those that had, there was a reasonable amount of satisfaction with the services. Reasons for dissatisfaction included not receiving adequate attention, arrogance and lack of kindness and dirty conditions in some of the government facilities providing reproductive care services.

Services required by FSPs and where they should be provided

The FSP respondents were asked what services they required and where these should be provided.

Figure 18: Services for FSPs – Needs Expressed by KIs

Services Required (in rank order of responses)	Where services should be located (in rank order of responses)
• Medical Care • Nutrition • Vocational training • Income generation/employment • Counselling • Child Care • Partner counselling • Shelter • Protection • Emergency treatment • STI testing • Services for both	• TI/DIC • NGO • Home • Anganwadi • Social Welfare Dept. • Male NGOs should also provide services for partners

Distance, comfort and familiarity seem to guide the responses of FSPs with respect to the location of services. It appears that they would like all the services to be made available in the same vicinity rather than having to access them at multiple sources. Given the FSPs' concerns about stigma, lack of support to access services, and reluctance to seek help, these perceptions are likely to be guided by such concerns.

4 Summary, Discussion and Future Directions

This review was undertaken to understand the growing problem of drug use, particularly injecting drug use, among females both globally and regionally as well as to appreciate the emerging problem of injecting drug use among females in the country; to evaluate some of the existing services for them and identify their care needs, particularly with respect to reducing HIV vulnerability.

A similar exercise was undertaken with reference to FSPs who are in relatively larger numbers in the country. Given the fact that IDUs form the biggest risk group for HIV, by proxy their female sex partners become an important target group for prevention and intervention.

The service needs for FIDUs must be examined against the recommendations that exist in general for providing a comprehensive package of biomedical and behavioural interventions as the optimal HIV prevention strategy for halting HIV among IDUs. The joint technical guide developed by the WHO, UNAIDS and UNODC[67] recommends a package of core public health interventions with nine components namely NSEP; OST; VCT; ART; STI prevention; condom programming for IDUs and their sex partners; targeted IEC for IDUs and their sex partners; Hepatitis A, B and C diagnosis and treatment; and TB prevention, diagnosis and treatment. This existing recommendation must be re-examined and modified from the gender perspective.

FIDUs

For FIDUs, the evaluation comprised a global, regional and local review, secondary data analysis from the four UNODC sites in the north-east, seven learning sites in north-east and north-west India, five FSW sites in the north-east and Punjab, and KI interviews with 36 FIDUs.

The global review suggests a growing problem of drug use among females worldwide, an increase in injecting drug use, and early initiation into drug use. Risk accrues from both unsafe injecting and risky sex practices. Gender inequity, sexual exploitation and economic pressures add to the risks for females. South Asia is witnessing an increase in injecting, and it is expected that a similar scenario will occur in India unless prevented. Many females who inject drugs begin as non-injectors and rapidly transit to injecting.

Reports from India suggest a gradual increase in FIDUs.The patterns of injecting among FIDUs are similar to those of males, and they show a preference for pharmaceutical injecting. High rates of sharing and reusing, high rates of involvement in sex work and intoxication with alcohol is common in this group. The background of social adversity heightens their risks and vulnerability. Knowledge of HIV among them is high, but the uptake of HIV/STI testing is low. Condom usage with regular partners is low, and they have no access to female condoms. Mental distress is very high and a significant number report suicide attempts. Sexual and reproductive health problems are frequent, particularly abortions. Children whose parents are both drug users have higher rates of emotional and behavioural problems. There is a perceived lack of appropriate treatment services for drug use and for gainful employment.

[67] WHO; UNODC; UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.* Geneva, 2009. Available at: http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf

The questionnaire interviews with project managers at TI sites and FSW TIs indicate poor development of services for FIDUs, under-recognition of drug use among females, and staff inadequately trained in addressing gender related issues with respect to drug use and the vulnerability it brings. Barriers to effective care among FIDUs include a tendency to hide the problem because of significant stigma and social disapproval associated with the habit. Lack of services, distance, lack of time, and unhelpful attitudes of service providers are also barriers to effective service utilization.

Characteristics of sites that seem to be more effective in offering services to females include having predominantly female staff, female peer educators and outreach workers, centre and community based outreach activities, counsellors trained in providing psychosocial counselling, particularly mental health counselling and providing general medical care through a female doctor. A few centres that have night shelters and offer support for food and vocational activities appear to attract a greater number of clients. They have an established program of networking with other centres for comprehensive care. Such centres also seem to have a better uptake for testing. The condom distribution and NSEP is perceived to be satisfactory at these centres. However, such findings have not been objectively validated.

Female Sex Partners

With respect to FSPs of males who inject drugs, it is evident that such females, often monogamous, are at risk through unsafe sex with their partners. Poor negotiating capacities, particularly sexual negotiation, stigma, discrimination, blame, poor social support and poorly developed and accessible services are serious barriers to help-seeking by this group. Economic constraints and lack of confidentiality also prevent them from utilizing services. The information gathered from the IDU learning sites and FSW TIs indicates low identification, low uptake for testing in these groups and very limited intervention.

The need for appropriate ***health care*** is a need that reverberates from both service users and service providers. Barriers include stigma and discrimination, partner resistance and lack of support, fear of disclosure and lack of a separate women's facility. There is a felt need for livelihood support, support for drug-using partners and for their children's needs. Sites which offer specific interventions for female partners of male IDUs offer services like ANC, condom distribution, counselling for HIV/STI, mental health counselling, HIV testing, nutritional support, STI management, recreation, routine medical care, referral, sanitary napkins and vocational training. They offer services to children like crèche, routine medical care and nutritional support. Referral services include ART, CCC, ICTC, PPTCT, and STI. Community interventions include awareness, counselling and medicines. Here too, there is a need for improving help-seeking and testing uptake. Lack of female condoms, lack of specific IEC material for females, the need for shelters for females are the perceived lacunae by both service users and service providers. Additional support like accompanied referral, help to source government facilities by getting BPL cards, voter identity cards, etc. is an important need expressed by service providers. Though some networking has been done with government and non-government facilities, it needs to be expanded. While HIV awareness is relatively higher in the north-east, KI interviews reveal that this is lower among FSPs in Punjab. There is thus a need for creating awareness in this area. Service users indicate a real need for emotional counselling and support, and service providers in turn express a need for training of their staff to provide such services. They also underscore the need for specialized services for females.

Many of the findings of this initiative support the findings of the RSRA, Project I-49 and DFID-TAST reviews with regard to high risk behaviours of partners and the gender-related vulnerability of FSPs.

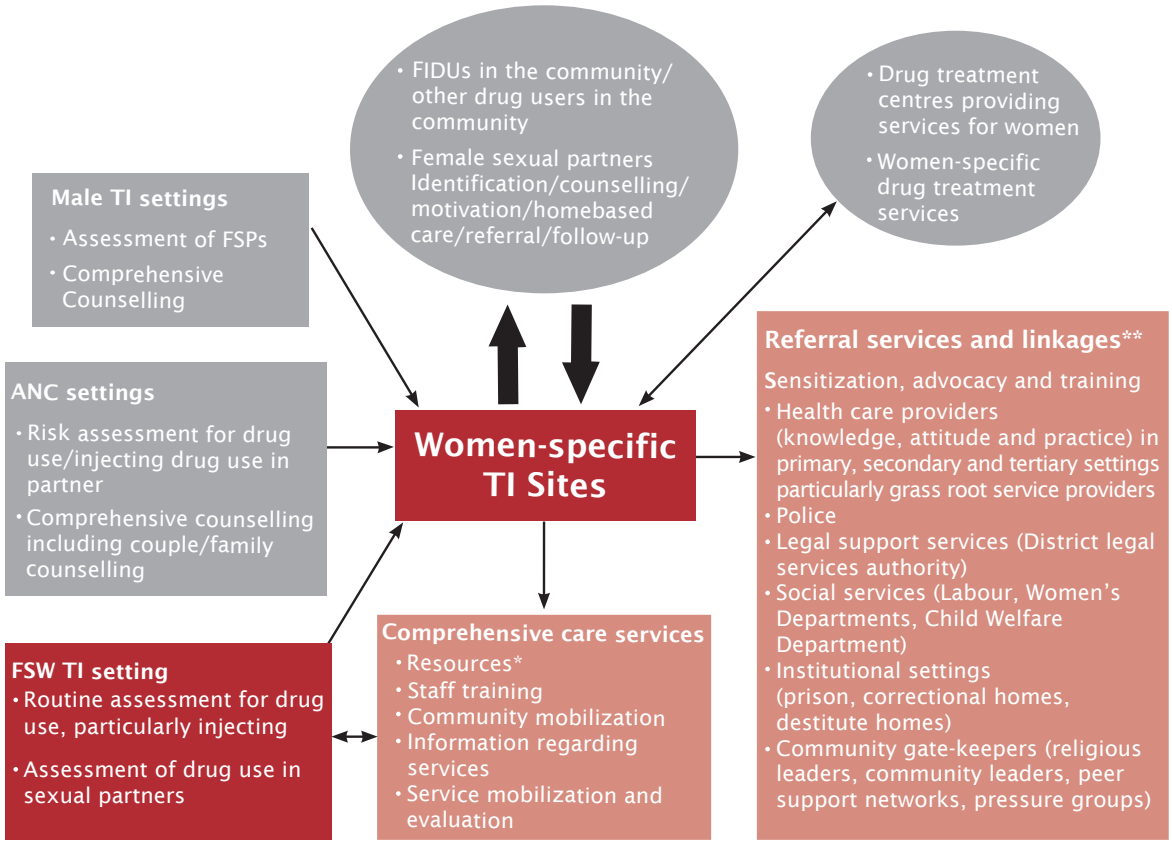
Further, this study shows the additional vulnerabilities faced by FIDUs such as lack of treatment availability, comprehensive services and access to the existing ones. It also highlights the need to strengthen services for FIDUs and FSPs within the existing service provision framework. However, based on the positive experiences of female specific intervention sites and in order to meet service users'expressed needs, it appears that setting up and evaluating such gender-based interventions would be the way forward. However, as the demand is only likely to increase, it would be useful if the existing sites are strengthened to provide a first tier of services to such women. Appropriate linkages need to be developed between these sites and female specific sites as well as drug use treatment facilities. Ways of exploiting government schemes like the ICDS and vocational support schemes need to be devised by training the TI staff in these allied areas as well.

Limitations

There are several limitations to the approach currently taken to understand the needs of FIDUs, FSPs and FSWs who abuse substances. The evaluation was limited to a few TI sites and was not comprehensively carried out throughout the country. The sampling of FIDU and FSP key informants was with a purpose and may not be entirely representative of the needs of this fast growing population. Nevertheless, several important findings with respect to the vulnerabilities and needs of these special groups of females emerge. These provide valuable insights into how services and treatments need to be formulated and rolled out in the country.

Recommendations

Figure 19: An Interactive, Networking Model to Provide Services for Females Affected by Drug Use (FIDUs, FSPs and females who use drugs)



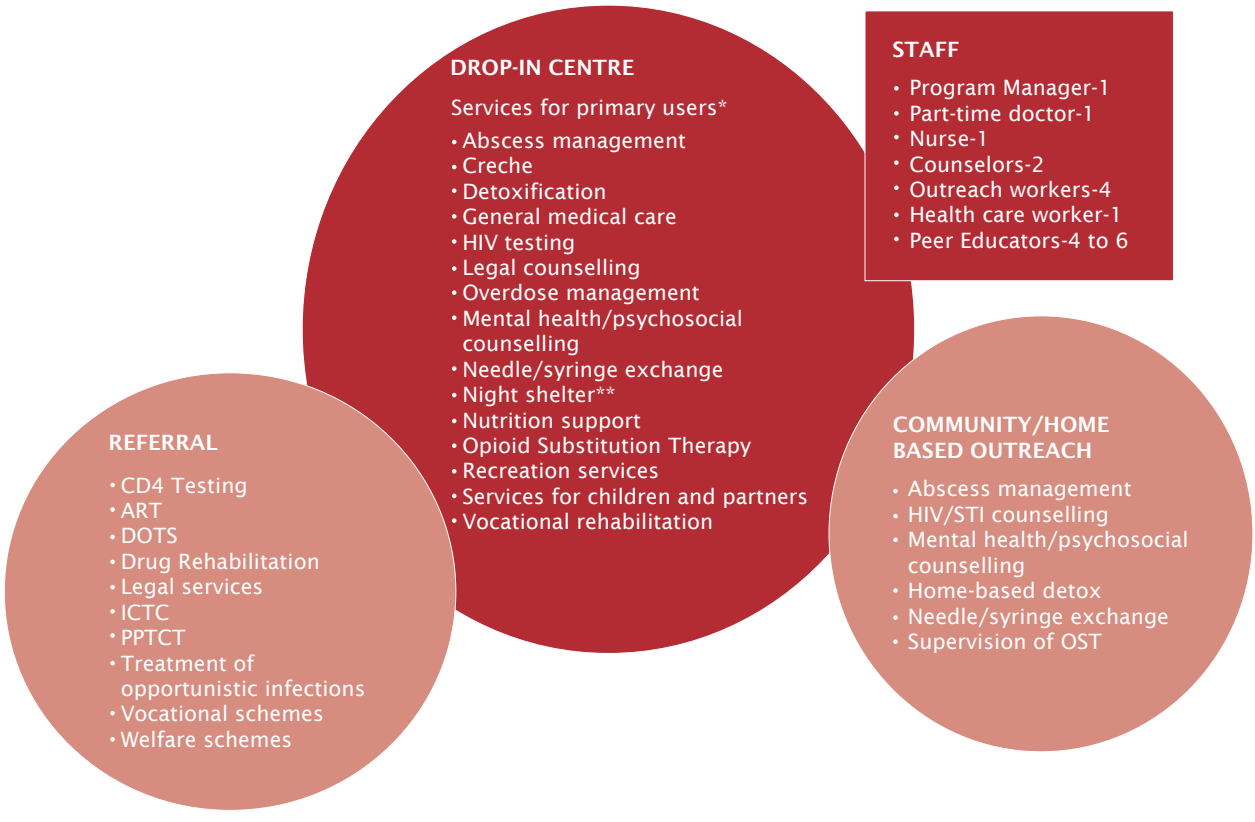
* Include Abscess management, Advocacy with different stakeholders, Care and support, Counselling on drug abuse and HIV, Condom promotion, Capacity building, Crisis management counselling/emergency support, Education on safer practices, health, hygiene, Follow-up, Free meals, Legal counselling, Night shelter, NSE, Nutrition, Overdose management, OST, Outreach, Mental health counselling, Regular medical check-up and care, Distribution of sanitary napkins, STI diagnosis and management, Short stay facility.

** Include ANC, ART, CD 4 monitoring, DOTS, ICTC, PPTCT, drug rehabilitation, vocational training, legal services, services such as ID cards.

Female-Specific TI Sites

The activities recommmended at the drop-in centre and through community and home-based outreach are indicated in Figure 20. It is ideal that as many services as is practically feasible are provided at a single facility, namely the drop-in centre. To make the services more attractive to females, a crèche facility, routine medical care for children and partners may be considered. Although night shelter would require additional staff, it is a very important felt need of the users. Accompanied referral for health care, networking for legal, welfare and vocational programs with addiction treatment facilities also need to be programmed.

Figure 20: Female Specific TI Sites – Range of Activities and Staff Composition



* Primary users include FIDUs, and FSPs ** Night shelter will need some additional staff (A supervisor and arrangements for food/cook)

By way of recommendations, this section addresses 10 important questions with respect to providing services for FIDUs and FSPs.

Frequently raised questions regarding services to reduce vulnerability to HIV/AIDS among females who inject drugs, female sex partners of men who inject drugs and answers based on the current review and findings.

Q1. Are purely HIV prevention and intervention based services adequate to reduce vulnerability and risk?

Ans: No, these are not enough. While service providers perceive better rates of condom use during last sexual encounter, low rates of condom use with regular partners, associated alcohol use, which is likely to impair judgement with respect to safe sex, and unsafe injecting practices all maintain the risk in FIDUs. In FSPs, low negotiation abilities, partner violence, poor family support and stigma prevent access to services. Many FIDUs are also sex partners and have these vulnerabilities in addition to those enumerated earlier. Thus, it is not enough to simply provide the services; it is important to make these services accessible.

A 10-year cohort follow-up study in Vancouver,[68] which introduced a needle exchange program in 1988, offered 2 million needles per year to IDUs identified through street outreach. Independent predictors of HIV positive sero-status were low education, unstable housing, commercial sex, borrowing needles, being an established IDU, injecting others and frequent NSEP attendance. The paper concludes that whereas NSEP is crucial for sterile syringe provision, it should be considered as a component of a comprehensive program including counselling, support and education.

Q2. How can we engage affected females better?

Ans: There is a mismatch between the needs of service providers (to reduce risk by providing condoms, N/S) and the needs of FIDUs and FSPs. Addressing some of the needs of service users in the program can make the services more attractive to them and thereby retain them in the treatment network. Appropriate networking and referral with drug use treatment services, vocational training, night shelter, services to help obtain identification cards like BPL cards, banking and other services can also help in engaging better with them.

Q3. How can the services be improved in our settings to make them more meaningful to FIDUs and FSPs and their families in order to increase uptake?

Ans: Engaging families through awareness, counselling and motivation, providing services to children, vocational training, livelihood programs and income generation activities can improve uptake. Services are not optimally utilized because of stigma, financial difficulties, lack of child support facilities, lack of time and distance. This can be addressed through effective awareness and de-stigmatization, providing support for affected children including food, education and preventive counselling, providing services in the community through home-based care, and innovations like mobile services and telephonic counselling. Accompanied referral can improve access to referral services.

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[68] Strathdee S, Patrick D, Currie SL, Cornelisse PGA, Rekart ML, Montaner JSG, Schechter MT, O'Shaughnessy MV. 'Needle exchange is not enough:lessons from the Vancouver injecting drug use study'. *AIDS 1997*, 11 (8):59-65

Most importantly, there is a lack of drug use treatment services for females. This is another important need. Such treatment services and female-specific intervention sites must 'talk to each other'. This calls for inter-sectoral collaboration between different ministries and departments, particularly the Ministry of Health, NACO, Ministry of Social Justice, Women's Welfare Departments, etc.

Q4. Should the services be provided only for females who inject drugs or for all females who use drugs?

Ans: Many females who inject drugs begin as non-injecting drug users. Therefore, effective counselling and support can help females to discontinue drug use and not transit to injecting. Further, such females continue to be at risk from unsafe sex. Alcohol consumption is an important mediating risk for unsafe sex and lowered immunity, and therefore counselling must include providing treatment services. It is well known that there are common features shared by all addictions and that there is a biological basis underlying its development. Therefore, support for all addictions must be provided.

Q5. Can services for female sex partners and females injecting drugs be combined?

Ans: Many females who inject drugs are also sex partners and hence benefit from both services. However, a majority of females who are sex partners do not themselves use drugs. These females are often in monogamous relationships and face the risk of HIV and other STIs through unprotected sex with their partners, who in turn have risky injecting behaviours and high risk sexual behaviours. However, many FSPs do not like to mix with drug users and their main concerns are psychological and vocational support, care for their partners and children. For such females, there must be both centre-based as well as home-based services. Centre-based facilities may consider offering different timings for partners and drug users.

Q6. Can services for FIDUs be effectively provided for in an FSW intervention?

Ans: The data gathered for this report suggests that there is one section of FIDUs who engage in sex work as their primary profession. However, many of the FIDU service users as well as service providers are not comfortable with accessing services in an FSW setting.

Q7. Who should provide the services?

Ans: As the injecting drug use problem appears to be growing and spreading to all parts of the country, the problem can only be expected to grow. Therefore there needs to be low-intensity counselling services provided in various health care settings. Doctors, nurses, healthcare staff in all healthcare settings need to be sensitized to the problem of drug use among females, assess for injecting and high risk sexual behaviour, and provide appropriate counselling, treatment and referral. Most importantly, service providers need to learn to provide services in an empathetic and non-judgmental manner.

In situations where home-based care is required, health workers like the ASHA personnel are potentially useful partners to identify and motivate help seeking. The UNODC has recently developed a manual for use by TI staff to address the needs of female partners of IDUs.[69] Female staff should provide counselling services.

[69] UNODC. *Reaching out to female partners of injecting drug users. A training module for service providers.* Ambekar A. 2011

Q 8. What areas of training do service providers require?

Ans: Service providers need to be trained in identification, assessment, counselling for high risk behaviour (injecting and sexual), psychosocial counselling to provide support, motivate change and prevent relapse, outreach, follow-up and after care. Technologies like mobile telephony should be used to keep females in the service network. Service providers also need to maintain some flexibility in the programming to address the time and social constraints that females face. IEC materials which are appropriately tailored to local needs and customs, language and settings of care are required.

Q9. Do we know what program components work best for female drug users and female sex partners?

Ans: The service delivery experience so far has been primarily through demonstration projects. It is important to support research initiatives that test models like home-based care in order to develop responsive and effective models. Service delivery models should be established, monitored, evaluated and then scaled up.

Q10. What are the most responsive services?

Ans: These are services that respond to user needs. Recognizing the rights of vulnerable populations including the rights to access services in the least restrictive and most conducive environment is important. Generally when services are planned for females, they need to take into consideration the whole family's needs. In countries where families are the core unit of social structure, garnering the support of families becomes critical to ensure good support. However, it is a grim reality that many FSPs of males who use drugs and females who use drugs are marginalized and discriminated against. Both these counter-forces must be recognized, acknowledged and factored in the planning of services.

Appropriate medical care is the primary need of females affected by drugs but sadly, not the most easily available, accessible and affordable service.

Facilities like crèche support, nutritional support and education for children will make the services more attractive. These could be developed by linking with ICDS schemes, *Anganwadi* programs and other health and welfare programs.

The Way Forward

"What the mind does not know, the eyes do not see."

It is important to recognize that the growing problem of drug use, particularly injecting, among men is undoubtedly going to have repercussions on females who are their sex partners. These problems, in addition to posing risk of HIV and other vulnerabilities, also include the inevitable – drug use, particularly injecting drug use among females. Service development has to be anticipatory, responsive and proactive. Such services need to be comprehensive and encourage women in such circumstances to seek help rather than hide, ventilate rather than suppress, get emotional relief rather than accumulate distress and become suicidal, get timely medical help rather than develop complications. They must seek to empower females with appropriate awareness so that they can protect themselves from diseases like HIV. In the long run, however, there is a need to address the underlying vulnerabilities in society which make people, particularly adolescents, turn to drugs and provide timely intervention and support. Education and empowerment and empathic support are the important components for such prevention.

APPENDIX: QUESTIONNAIRES USED DURING ASSESSMENT

1. Project Managers of IDU TIs

Background

Over the years, services for male injecting drug users have expanded in the country because of the recognition of heightened HIV risk with IDU. However, services for female partners of male IDUs (who are a bridge population at risk for HIV and other vulnerabilities) and female injecting drug users (who have certain common risks with male IDUs and several additional vulnerabilities) are very poorly developed. This exploration attempts to understand existing services available for FSPs and FIDUs, their treatment needs and barriers to care. The information you provide will help agencies like UNODC/NACO in the development/scaling up of services for women affected by drug abuse.

Kindly answer the following questions with regard to the needs of FSPs and FIDUs. This questionnaire will take approximately 60 minutes to complete. Please take the help of other staff members, if required. Any additions to the questions asked and supplementary material from your organization will be greatly appreciated.

Background Information

Name of Centre:

District: State:

Name of respondent/s:

Age: Gender:

Qualification:

Number of years of experience in current type of job responsibility:

Designation:

Contact information:

Year of inception of TI site:

Year of inception of services for females affected by drug use:

Section 1: This section pertains to female partners (FSPs) of male IDUs

1.1. Approximately, what is the number of female partners (FSPs) of male IDUs who may need services during a year at your centre (Please use time-frame April 2010 – March 2011 for one year) _____

1.2. Do you provide any services specifically to FSPs? YES NO

1.3. If your answer is Yes, please list the services that you provide at your centre. If your answer is No, please state the reasons as to why you do not offer these services and move to 1.9.

_____

_____

1.4. Who among the staff provides these services? (please mention gender of staff)

_____

_____

1.5. What are the linkage services you provide for FSPs?

_____

_____

1.6. How many FSPs were registered at your centre each year in the last 3 years?

Year	No. registered

1.7. Do you have a community outreach program? YES NO

1.8. Approximately, what is the number of female partners of male IDUs who may need services during a year in the community that you work in? _____

1.9. Do you provide any services to FSPs in the community? YES NO
(if no, skip to 1.13)

1.10. If your answer is Yes, please list the services that you provide in the community.

_____

_____

1.11. Who among the staff provides these services? (please mention gender of staff)

_____

_____

1.12. How many FSPs were registered in your community service each year in the last 3 years?

Year	No. registered

	Clinic	Community
1.13. How many FSPs underwent HIV testing last year?	_____	_____
1.14. How many FSPs underwent STI testing last year?	_____	_____
1.15. How many FSPs were put on ART last year?	_____	_____
1.16. How many FSPs accessed male condoms last year?	_____	_____
1.17. How many male condoms were distributed to FSPs last year?	_____	_____

1.18. In your opinion, what are the special needs of FSPs who inject drugs? How much of it is met in your intervention? What are the unmet needs? How do you suggest they can be met?

Needs	What are addressed in the program	Unmet needs	Suggest how these can be met

1.19. Are there any specific barriers that FSPs face to access treatment? Please suggest how these barriers can be overcome.

Barriers	Suggestions as to how they can be overcome

1.20. What are the difficulties you face in providing services to FSPs to address the above needs?

_____

_____

1.21. In what way could you set up/improve services for FSPs? (Do you think it should be within the existing set up, or would you suggest a different model for such services?)

_____

_____

Section 2: This section pertains to female drug users, particularly FIDUs

2.1. Approximately, what is the number of FIDUs who may need services during a year at your centre? _____

2.2. Do you provide any services to FIDUs? YES NO

2.3. If your answer is Yes, please list the services that you provide at your centre. If your answer is No, please state the reasons as to why you do not offer these services and move to 2.9.

_____

_____

2.4. Who among the staff provides these services? (please mention gender of staff and whether the same person is providing services for FSPs)

_____

_____

2.5. What are the linkage services you offer for FIDUs?

_____

_____

2.6. How many FIDUs were registered at your centre last year? _____

2.7. Do you have a community outreach program? YES NO
(if no skip to 2.13)

2.8. Approximately, what is the number of FIDUs who may need services during a year in the community that you work in? _____

2.9. Do you provide any services to FIDUs in the community? YES NO

2.10. If your answer is Yes, please list the services that you provide in the community.

_____

_____

2.11. Who among the staff provides these services? (please mention gender of staff)

_____

_____

2.12. How many FIDUs were registered in your community service last year?

	Clinic	Community
2.13. How many FIDUs underwent HIV testing last year?	_____	_____
2.14. How many FIDUs underwent STI testing last year?	_____	_____
2.15. How many FIDUs were put on ART last year?	_____	_____
2.16. How many FIDUs accessed male condoms last year?	_____	_____
2.17. How many condoms were distributed to FIDUs last year?	_____	_____

2.18. How many FIDUs accessed needles/syringes last year? _____ _____

2.19. How many needles/syringes were distributed to FIDUs last year? _____ _____

2.20. How many FIDUs were put on OST last year? _____ _____

2.21. In your opinion, what are the needs of FIDUs with respect to their health and well-being? Please list the needs in order of priority.

_____

_____

2.22. In your opinion, what are the special needs of FSPs who inject use drugs? How much of it is met in your intervention? What are the unmet needs? How do you suggest they can be met?

Needs	What needs are addressed in the program	Unmet needs	Suggest how these can be met

2.23. Are there any specific barriers that FSPs face to access treatment? Can you suggest how these barriers can be overcome?

Barriers	Suggestions as to how they can be overcome

2.24. What are the difficulties you face in providing services to FIDUs to address the above needs?

_____

_____

2.25. In what way could you set up/improve services for FSPs (do you think it should be within the existing set up, or would you suggest a different model for such services?)

_____

_____

Section 3: This last section pertains to both FSPs and FIDUs

3.1. Do you have IEC material on HIV specifically for FSPs? Yes No

3.2. Do you have IEC material specifically for females who abuse drugs? Yes No

3.3. Do you provide mental health counselling for females at the centre? Yes No
in the community? Yes No

3.4. Do you provide alcohol abuse counselling for females at the centre? Yes No
in the community? Yes No

3.5. Do you provide drug abuse counselling for FIDUs at the centre? Yes No
in the community? Yes No

3.6. How many of your staff members have received specialized training to provide services to FSPs/FIDUs? What is the nature of such training? Where was the training provided?

_____

_____

3.7. In what areas does your staff need further training? In what further areas do you need capacity building to deliver better services for FSPs and FIDUs?

_____

_____

3.8. Is there any other information you would like to share with respect to developing services for FSPs/FIDUs?
(*Record any verbatim responses separately – anecdotal, positive experiences of works/what innovations were undertaken, negative experiences and what must not be done*)

_____

_____

Thank you very much for the information. Is there anything else you would like to add? Please provide any information you have in your TI/state regarding services for female partners of male IDUs and for FIDUs that would be a good learning for further programs. Also kindly provide us with any IEC material you may have.

_____

_____

Form completed by: Date:
(Name and signature)

Form checked by: Date:
(Name and signature)

2. Project Managers of Female Sex Worker TIs

Background

Over the years, services for females in sex work have expanded in the country because of the recognition of heightened HIV risk with sex work. Females involved in sex work are also at increased risk on account of their own drug use, or drug use among their sex partners. This exploration attempts to understand to what extent existing services for FSWs with IDU and FSWs who are sex partners (FSPs) of male IDUs address these issues, their treatment needs and barriers to care. The information you provide will help agencies like UNODC/NACO in the development/scaling up of services for FSWs affected by drug use.

Kindly answer the following questions with regard to the needs of FSWs affected by drug use. This questionnaire will take approximately 60 minutes to complete. Please take the help of other staff members, if required. Any additions to the questions asked and supplementary material from your organization will be greatly appreciated.

Background Information

Name of Centre:

District: State:

Name of respondent/s:

Age: Gender:

Qualification:

Number of years of experience in current type of job responsibility:

Designation:

Contact information:

Section 1: This section pertains to injecting and other drug use among FSWs

1.1. Have you noticed injecting among FSWs (name drugs injected)? In the last 5 years, have injecting drug use patterns among FSWs changed (increased/decreased/static)?

_____

_____

1.2. Have you noticed use of other drugs, including alcohol among FSWs (name the drugs, patterns of use)? In the last 5 years, has the use of other drugs among FSWs changed (increased/ decreased/static)?

_____

_____

1.3. During the last year (Please use time-frame April 2010 – March 2011 for one year) how many FSWs were provided services at your centre? _____

1.4. Do you routinely assess for injecting drug use among FSWs? Yes No

1.5. Do you routinely assess for other drug use (including alcohol) among FSWs? Yes No
If No, please state the reasons.

_____

_____

1.6. Kindly describe how you identify injecting and other drug use among FSWs. Is this at the centre/in the community/who identifies/how/ what happens after identification?

_____

_____

1.7. During the last year, how many FIDUs were identified at your centre _____ and in community outreach _____?

1.8. During the last year, how many non-IDU drug users were identified at your centre _____ and in community outreach _____?

1.9. What are the services you offer for FSWs affected by drug use?

Type of service	For FSWs with IDU	For FSWs with other drug use	Centre based service/community based/both	Who provides the service (designation and gender)

	Centre	Community
1.10. How many FSWs with IDU underwent HIV testing last year?	_____	_____
1.11. How many FSWs with IDU underwent STI testing last year?	_____	_____
1.12. How many FSWs with IDU were put on ART last year?	_____	_____
1.13. How many FSWs with IDU accessed male condoms last year?	_____	_____
1.14. How many male condoms were distributed to FSWs with IDU last year?	_____	_____

1.15. Were any female condoms distributed to FSWs with IDU last year? Y/N _____ _____

1.16. How many FSWs with IDU accessed needles/syringes last year? _____ _____

1.17. How many needles/syringes were distributed to FSWs with IDU last year? _____ _____

1.18. How many FSWs with IDU were put on OST last year? _____ _____

1.19. Do you offer follow-up for FSWs with IDU or other drug use? How is this organized? Who is responsible? For how long?

_____

_____

1.20. Do you have any preventive education (IEC/counselling) for FSWs regarding drug use/injecting drug use? How is this carried out? What is available at the centre? What is available in the community? Kindly share with us any such material.

_____

_____

1.21. In your opinion, what are the special needs of FSWs who inject use drugs? How much of it is met in your intervention? What are the unmet needs? How do you suggest they can be met?

Needs	What needs are addressed in the program	Unmet needs	Suggest how these can be met

1.22. Are there any specific barriers that FSWs who inject/use drugs face to access treatment? Please suggest how these barriers can be overcome.

Barriers	Suggestions as to how they can be overcome

Section 2: This section refers to FSWs whose partners are IDUs (FSPs)

2.1. In your opinion, what per cent of FSWs have partners who are IDUs? _____

2.2. Do you routinely discuss with FSWs their vulnerabilities as FSPs of male IDUs? Yes No

2.3. If Yes, please describe how you identify FSPs of male IDUs and also how you engage them.

_____

_____

2.4. What are the difficulties you face in engaging FSPs?

_____

_____

2.5. Are there any special interventions you offer to FSPs? Yes No

If Yes, kindly describe these interventions and indicate if they have resulted in any changes in behaviour.

_____

_____

Section 3: This last section addresses the models of intervention you have for FSWs using drugs/FSWs who are FSPs of male IDUs as well as staff training needs

3.1. Please describe the existing model you have for addressing the needs of FSWs who use drugs or are FSPs of male IDUs (identification, engagement, care, referral, follow-up, aftercare), including specific activity and personnel involved.

_____

_____

3.2. How satisfied are you with this model (Very satisfied/satisfied/can't say/dissatisfied/very dissatisfied). Please give reasons why. What are the positive aspects of the model you have? What are the deficiencies?

_____

_____

3.3. Please suggest a workable model you would like for addressing the care needs of FSWs who inject drugs and are FSPs of male IDUs (identification, engagement, care, referral, follow-up, aftercare), including specific activity and personnel involved. *Also indicate what you think should be the core services provided by the intervention and what can be the linkage services.*

_____

_____

3.4. How many of your staff members have received specialized training to provide services to FSPs/FIDUs? What is the nature of such training? Where was the training provided?

_____

_____

3.5. In what areas does your staff need further training? In what further areas do you need capacity building to deliver better services for FSPs and FIDUs?

_____

_____

3.6. Is there any other information you would like to share with respect to developing services for FSPs/FIDUs?
(*Record any verbatim responses separately – anecdotal, positive experiences of works/what innovations were undertaken, negative experiences and what must not be done*)

_____

_____

Thank you very much for the information. Is there anything else you would like to add? Please provide any information you have in your TI/state regarding services for female partners of male IDUs and for FIDUs that would be a good learning for further programs. Also kindly provide us with any IEC material you may have.

_____

_____

Form completed by: Date:
(Name and signature)

Form checked by: Date:
(Name and signature)

3. Project Managers of Females Specific Based Interventions

Background

Over the years, services for male injecting drug users have expanded in the country because of the recognition of heightened HIV risk with IDU. However, services for female partners of male IDUs (who are a bridge population at risk for HIV and other vulnerabilities) and female injecting drug users (who have certain common risks with male IDUs and several additional vulnerabilities) are very poorly developed. This exploration attempts to understand existing services available for FSPs and FIDUs, their treatment needs and barriers to care. The information you provide will help agencies like UNODC/NACO in the development/scaling up of services for women affected by drug abuse.

Kindly answer the following questions with regard to the needs of FSPs and FIDUs. This questionnaire will take approximately 90 minutes to complete. Please take the help of other staff member, if required. Any additions to the questions asked and supplementary material from your organization will be greatly appreciated.

Background Information

Name of Centre:

District: State:

Name of respondent/s:

Age: Gender:

Qualification:

Number of years of experience in current type of job responsibility:

Designation:

Contact information:

Year of inception of site:

Whether part of project: YES NO

If Yes, name of project:

Project duration: From: To:

Section 1: Section on organizational set up and services

1.1. Organogram with respect to the female intervention program (kindly mention all the positions, their gender, and their responsibilities)

1.2. Who are the beneficiaries of your services? FSPs, FIDUs, FDUs, others – please specify. For example, there may be services you offer to children of the primary beneficiaries. Please mention that too.

_____

_____

1.3. Please describe the interventions you directly offer (services for female partners, services for FIDUs, services for FDUs (non-injecting drug users).

Type of service directly offered	Beneficiaries	Where it is based (DIC/ community, etc.)

1.4. Please describe the services you link your beneficiaries to.

Type of linkage services offered	Beneficiaries	Where such services are located (e.g. Govt. hospital, NGO, private clinic, rehab centre, DIC etc.)

1.5. What percentage of your resources (staff and financial) is spent on different beneficiaries?

FIDUs _____% FSPs _____% Others _____%

Section 2: This section specifically covers services for female sex partners of male IDUs

2.1 How do you identify FSPs?

Methods	Staff responsible (mention gender)

2.2 What are the challenges you face in identifying FSPs and engaging them? How do you overcome these challenges?

Challenges faced in identifying/engaging FSPs	Methods used to overcome such challenges

2.3 How many new FSPs were registered at your centre each year in the last 3 years?

Year	Number registered

2.4 Do you have a community outreach program? YES NO

2.5 Approximately, what is the number of FSPs who may need services during a year in the community that you work in? _____

2.6 Do you provide any services to FSPs in the community? YES NO
(if No, skip to 2.9)

2.7 If your answer is Yes, please list the services that you provide in the community.

_____

_____

2.8 How many new FSPs were registered in your community service each year in the last 3 years?

Year	No registered

(For the questions below, last year refers to April 2010-March 2011)

	Clinic	Community
2.9 How many FSPs underwent HIV testing last year?	_____	_____
2.10 How many FSPs underwent STI testing last year?	_____	_____
2.11 How many FSPs were put on ART last year?	_____	_____
2.12 How many FSPs accessed male condoms last year?	_____	_____
2.13 How many male condoms were distributed to FSPs last year?	_____	_____

2.14 What have been the benefits of condom use? Rate each benefit as
(No success/less than 25% success/25-50% success/50-75% success/>75% success)

	Benefit rating
Able to get partner to use condom in last sexual encounter	_____

2.15 Were any female condoms distributed to FSPs last year? If Yes, to how many FSPs? _____

2.16 Do you have IEC material on HIVs specifically for FSPs? Yes No

2.17 Do you provide mental health counselling for females at the centre? Yes No
in the community? Yes No

2.18 Are there special categories of FSPs in need of specialized services? (Please specify)

_____

_____

2.19 In your opinion, what are the special needs of FSPs? How much of it is met in your intervention? What are the unmet needs? How do you suggest they can be met?

Needs	What needs are addressed in the program	Unmet needs	Suggest how these can be met

2.20 Are there any specific barriers that FSPs face to access treatment? Please suggest how these barriers can be overcome.

Barriers	Suggestions as to how they can be overcome

2.21 What are the difficulties you face in providing services to FSPs to address the above needs?

_____

_____

2.22 Please provide a diagrammatic model of your existing services for FSPs.

2.23 How satisfied are you with the above model (Very satisfied/satisfied/can't say/dissatisfied/very dissatisfied). Please give reasons why. What are the positive aspects of the model you have? What are the deficiencies? What components are acceptable to beneficiaries? Not acceptable to beneficiaries?

_____

_____

2.24. Could you please suggest a model for addressing the care needs of FSPs (identification, engagement, care, referral, follow-up, aftercare) including specific activity and personnel involved).

_____

_____

Section 3: This section addresses services for FIDUs

3.1. How do you identify FIDUs?

Methods	Staff responsible

3.2. What are the challenges you face in identifying FIDUs and engaging them? How do you overcome these challenges?

Challenges faced in identifying/engaging FIDUs	Methods used to overcome such challenges

3.3. How many new FIDUs were registered at your Centre each year in the last 3 years?

Year	Number registered

3.4. Do you have a community outreach program? YES NO
(if No skip to 3.9.)

3.5. Approximately, what is the number of FIDUs who may need services during a year in the community that you work in?

3.6. Do you provide any services to FIDUs in the community? YES NO

3.7. How many FIDUs were registered in your community service in the last year?

	Clinic	Community
3.8. How many FIDUs have undergone HIV testing last year?	_____	_____
3.9. How many FIDUs have undergone STI testing last year?	_____	_____
3.10. How many FIDUs have been put on ART last year?	_____	_____
3.11. How many FIDUs have accessed male condoms last year?	_____	_____
3.12. How many condoms were distributed to FIDUs last year?	_____	_____

3.13. What have been the benefits of condom use? Rate each benefit as
(No success/less than 25% success/25-50% success/50-75% success/>75% success)

Benefit rating

Able to get partner to use condom in last sexual encounter _____

3.14. Were any female condoms distributed to FIDUs last year? If Yes, to how many FIDUs _____

3.15. How many FIDUs accessed needles/syringes last year? _____

3.16. How many needles/syringes were distributed to FIDUs last year? _____

3.17. What have been the benefits of NSEPs? Rate each benefit as
(No success/less than 25% success/25-50% success/50-75% success/>75% success)

Benefit rating

Retaining FIDUs in the treatment network _____

Reported no sharing/reusing in last injecting episode _____

3.18. How many FIDUs were put on OST last year? _____

3.19. What have been the benefits of OST? Rate each benefit as
(No success/less than 25% success/25-50% success/50-75% success/>75% success)

Benefit rating

Retaining FIDUs in the treatment network _____

Reduced injecting _____

Reduced use of other drugs including alcohol _____

Better engagement in vocational training _____

Others (kindly specify) _____

3.20. Do you have IEC material specifically for females who abuse drugs? Yes No

3.21. Do you provide drug abuse counselling for FIDUs in the centre? Yes No
in the community? Yes No

3.22. Do you provide alcohol abuse counselling for FIDUs at the centre? Yes No
in the community? Yes No

3.23. Are there any special categories of FIDUs who need special care? (Please specify)

_____

_____

3.24. In your opinion, what are the special needs of FIDUs? How much of it is met in your intervention? What are the unmet needs? How do you suggest they can be met?

Needs	What needs are addressed in the program	Unmet needs	Suggest how these can be met

3.25. Are there any specific barriers that FIDUs face to access treatment? Please suggest how these barriers can be overcome.

Barriers	Suggestions as to how they can be overcome

3.26. What are the difficulties you face in providing services to FIDUs to address the above needs?

_____

_____

3.27. Please provide a diagrammatic model of your existing services for FIDUs.

3.28. Would you be able to say what is the annual budget for the women's program and the breakup for staff/management/beneficiaries?

_____

_____

3.29. How satisfied are you with the above model? (Very satisfied/satisfied/can't say/dissatisfied/very dissatisfied) Please give reasons why. What are the positive aspects of the model you have? What are the deficiencies? What components are acceptable to beneficiaries? Not acceptable to beneficiaries?

_____

_____

3.30. Please suggest a model for addressing the care needs of FIDUs (identification, engagement, care, referral, follow-up, aftercare) including specific activity and personnel involved. *Also indicate in this what you think should be the core services provided by the intervention and what can be the linkage services.*

_____

_____

3.31. Do you think FSP services and services for FDUs can be combined? What are the advantages of such an approach? What are the disadvantages?

_____

_____

Section 4: This section refers to the staff needs

4.1. How many of your staff members have received specialized training to provide services to FSPs/FIDUs? What is the nature of such training? Where was the training provided?

_____

_____

4.2. Do you face any particular problems with staff members who provide services for FSPs/FIDUs? What measures have you taken to address such problems and with what result?

Nature of problem	Measures taken to address	Result of action taken

4.3. In what areas does your staff need further training? In what further areas do you need capacity building to deliver better services for FSPs and FIDUs?

_____

_____

4.4. Is there any other information you would like to share with respect to developing services for FSPs/FIDUs?
(*Record any verbatim responses separately – anecdotal, positive experiences of works/what innovations were undertaken, negative experiences and what must not be done*)

_____

_____

Thank you very much for the information. Is there anything else you would like to add/share? Please provide any information you have in your TI/state regarding services for FSPs of male IDUs and for FIDUs that would be a good learning for further programs. Also kindly provide us with any IEC material you may have.

_____

_____

Form completed by: Date:
(Name and signature)

Form checked by: Date:
(Name and signature)

4A. KII Questionnaire Service User–Female Sex Partner

Background

The purpose of this questionnaire is to ask you to provide us information regarding the needs of females who are partners of men who inject drugs (FSPs) so that the information you provide can help policy makers to develop an appropriate program for these groups. The questions relate to the specific care needs of FSPs, the way they access services currently, difficulties in obtaining services and how services could be made more readily available to them. The questionnaire would take about 20 to 30 minutes.

There are no right or wrong answers. Kindly answer the questions to the best of your ability. Your individual responses will be kept confidential.

Age:

Education:

Employment status:

Place: Village/city/district/state

1. In your opinion, what are the concerns of female sex partners of men who inject drugs and what help do they need in the following areas:

	Concerns	Help needed
Personal health		
Partner's health		
Child care		
Employment		
Other areas		

2. What in your opinion are the difficulties FSPs face to get help for their health and other care needs?

_____

_____

3. Once they know where to go, are there still any difficulties they face to continue to get support from these facilities? (If Yes, provide details)

_____

_____

The next few questions deal with the level of awareness among FSPs regarding the following:

4. Out of 10 FSPs of male injecting drug users how many:

   a. Have heard of HIV/AIDS _____
   b. Know the three most common ways that HIV/AIDS spreads _____
   c. Have received information regarding HIV/AIDS from service providers _____
   d. Have undergone HIV testing _____
   e. Have undergone STI testing _____
   f. Receive emotional counselling from a trained counsellor _____
   g. Are involved in vocational programs _____
   h. Know where to get male condoms _____
   i. Are able to ensure that their partner uses condoms _____
   j. Know where to get female condoms _____
   k. Are actively involved with their partner's drug abuse treatment _____
   l. Know where to get legal help _____

5. Have you known any instances where an FSP wanted to get some help and was able to? (Please mention the kind of help she needed, where she got it and what was the benefit)

   _____

   _____

6. Have you known any instances where an FSP wanted to get some help but was unable to? (Please mention the kind of help she needed, where she tried, and what prevented her from getting the services)

   _____

   _____

7. Of 10 females whom you know have used the following service, what do you think was their level of satisfaction with the service: (VS – very satisfied; S – satisfied; CS – Can't say; D – dissatisfied; VD – very dissatisfied

   _____

   _____

	Level of satisfaction	Reasons for not being satisfied
HIV testing/related services in a government setting		
HIV testing/related services in a private setting		

Care for reproductive health issues (childbirth, family planning, abortion etc) in a government setting		
Care for reproductive health issues (childbirth, family planning, abortion etc) in a private setting		

8. According to you, what kind of services should be provided to address the needs of FSPs of men who inject drugs and where should such services be located? What needs of FSPs are not met by the current services?

_____

_____

Thank you very much for your co-operation. Is there anything else you would like to share?
(*Record any verbatim responses separately – anecdotal, positive experiences of using services and their benefit, negative experiences and how that could have been changed*)

_____

_____

Form filled by:

Date:

4B. KII Questionnaire for Service User – Female Drug Users, including Injecting Drug Users

Background

The purpose of this questionnaire is to ask you to provide us information regarding the needs of females who use drugs including injecting so that the information you provide can help policy makers to develop an appropriate program for these groups. The questions relate to the specific vulnerabilities that such females face, their needs, the way they access services currently and how services could be made more readily available to them. The questionnaire would take about 30 minutes.

There are no right or wrong answers. Kindly answer the questions to the best of your ability. Your individual responses will be kept confidential.

Age:

Education:

Employment status:

Place: Village/city/district/state

1. In your opinion, what are the concerns of females who use drugs, including injecting and what help do they need in the following areas:

	Concerns	Help needed
Personal health		
Partner's health		
Child care		
Employment		
Other areas		

2. What in your opinion are the difficulties female drug users, including injecting users, face to get help for their health and other care needs?

_____

_____

3. Once they know where to go, are there still any difficulties they face to continue to get support from these facilities? (If Yes, provide details)

_____

_____

The next few questions deal with the level of awareness among female drug users, including injecting users regarding the following:

4. Out of 10 female drug users how many:

   a. Have heard of HIV/AIDS _____
   b. Know the three most common ways that HIV/AIDS spreads _____
   c. Have received information regarding HIV/AIDS from service providers _____
   d. Have undergone HIV testing _____
   e. Have undergone STI testing _____
   f. Know where to get male condoms _____
   g. Know where to get female condoms _____
   h. Receive emotional counselling from a trained counsellor _____
   i. Use alcohol _____
   j. Have been able to get help for drug abuse treatment _____
   k. Are involved in vocational programs _____

5. Of 10 females injecting drugs in your area:

   a. How many use disposable needles and syringes all of the time _____
   b. Borrow/lend needles and syringes _____
   c. Have multiple sex partners _____
   d. Use alcohol _____
   e. Regularly get male condoms _____
   f. Are able to ensure that their partners use condoms _____
   g. Have been able to get female condoms _____
   h. Know about opioid substitution treatment (OST) _____
   i. Have been able to get OST _____
   j. Have stopped injecting on OST _____
   k. Have received counselling for drug abuse _____

6. Where would a female injecting drug user go:

   a. For care for an injection abscess _____
   b. For disposable needles/syringes _____
   c. For OST _____
   d. For drug detoxification _____
   e. For rehabilitation _____
   f. For vocational training _____
   g. For legal problems _____

7. Have you known any instances where an injecting drug user wanted to get some help and was able to? (Please mention the kind of help she needed, where she got it and what was the benefit)

   _____

   _____

8. Have you known any instances where an injecting drug user wanted to get some help but was unable to? (Please mention the kind of help she needed, where she tried, and what prevented her from getting the services)

_____

_____

9. Of 10 female drug users whom you know have used the following service, what do you think was their level of satisfaction with the service: (VS – very satisfied; S – satisfied; CS – Can't say; D – dissatisfied; VD – very dissatisfied

	Level of satisfaction	Reasons for not being satisfied
HIV testing/related services in a government setting		
HIV testing/related services in a private setting		
Care for reproductive health issues (childbirth, family planning, abortion etc.) in a government setting		
Care for reproductive health issues (childbirth, family planning, abortion etc.) in a private setting		
Care for general health issues (tiredness, weakness, common ailments) in a government setting		
Care for general health issues (tiredness, weakness, common ailments) in a private setting		
Care for specific illnesses (like TB) in a government setting		
Care for specific illness (like TB) in a private setting		

10. According to you, what kind of services should be provided to address the needs of females who use drugs, particularly those who inject, and where should such services be located? What needs of FSPs are not met by the current services?

_____

_____

Thank you very much for your co-operation. Is there anything else you would like to share?
Record any verbatim responses separately – anecdotal, positive experiences of using services and their benefit, negative experiences and how that could have been changed)

_____

_____

Form filled by:

Date:

Consent Form

We are currently carrying out a study to understand the needs of females who inject drugs and of females who are partners of men who inject drugs. This includes questions regarding the drugs females or their partners may be using, the personal needs of such females, and what they feel their partners and children, if any, need. The questions will include your opinions on health care, working needs and social supports of this group, what facilities are present in the community, how easily females in such circumstances can use these services, and how satisfied they are with such services. The information provided can help policy makers to develop an appropriate program for these groups. The questionnaire would take about 30 minutes. There are no right or wrong answers.

You are invited to kindly answer this questionnaire. Your personal identity will remain confidential. Although there may be no direct benefits for you by participating in this study, it will help us to plan better services for females in such circumstances. If you need some specific information or help, I would direct you to the appropriate source to obtain the necessary help. Your participation in this is voluntary.

I have understood the purpose of this interview and volunteer to participate.

Signature

Date

Signature of interviewer and date