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India's voice against AIDS
Department of AIDS Control
Ministry of Health & Family Welfare, Government of India
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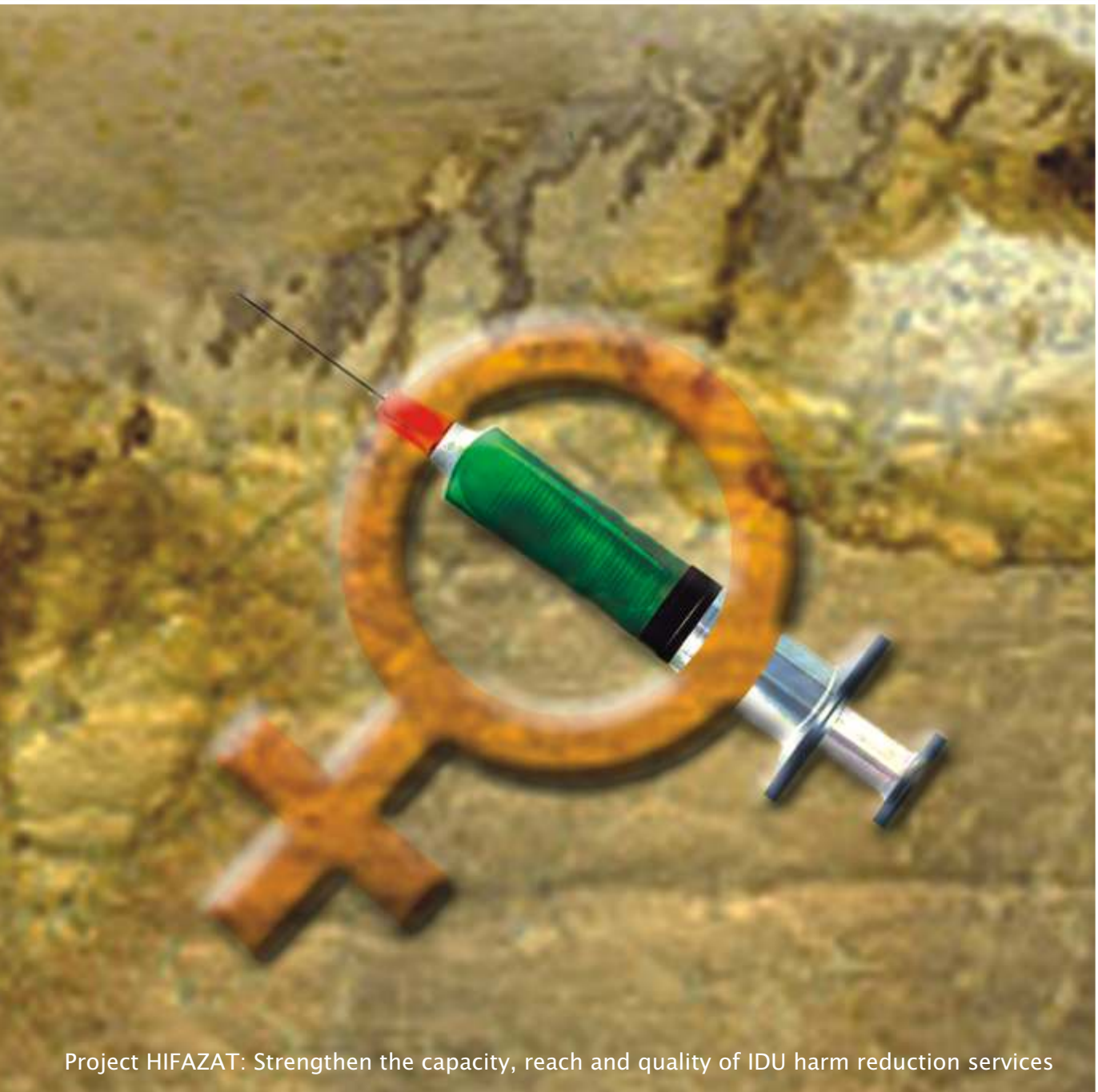
Intervention Among Female Injecting Drug Users



STANDARD OPERATING PROCEDURE

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

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Standard Operating Procedure for Intervention Among Female Injecting Drug Users

"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 National AIDS Control Program".

Supported by The Global Fund to Fight AIDS, Tuberculosis and Malaria- Round-9 India HIV-IDU Grant No. IDA-910-G21-H with Emmanuel Hospital Association as Principal Recipient.

Preface

In India, Targeted Intervention (TI), under the National AIDS Control Program (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 are 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 all 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 for undertaking 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 series of seven Standard Operating Procedures (SOPs) including the present one on “SOP for intervention among female injecting drug users” has been developed. This SOP also feeds into the broader NACP goals and helps strengthen and consolidate the gains of the TIs towards scaling up of critical services.

This SOP is seventh (last) in a series of seven SOPs developed. The main purpose of this SOP is to help address the operational challenges of program implementation with specific reference to DIC, NSEP and outreach. It hopes to guide and address day-to-day implementation challenges and also serve as a ready reference on issues related to female injecting drug users.

Furthur, this SOP has been developed with a vision to serve as an invaluable tool for the service providers engaged in IDU TIs in India and to enable them to deliver quality services. Contributions from the Technical Working Group of Project (TWG) 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 inputs that went into finalising this SOP.

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 (NGOs) in the countries of the 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, 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 Program.

We would like to acknowledge the invaluable feedback and support received from various stakeholders who include 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 to the development of this document.

Special thanks are due to the UNODC Project H13 team for their persistent and meticulous efforts in conceptualising and consolidating this document.

Abbreviations

AIDS	–	Acquired Immuno Deficiency Syndrome
ANC	–	Antenatal Care
ART	–	Anti Retroviral Treatment
BBV	–	Blood Borne Virus
BCC	–	Behavioral Change Communications
CNA	–	Community Need Assessment
CBO	–	Community Based Organization
CCC	–	Community Care centre
DIC	–	Drop-In Centre
DOTS	–	Direct Observation Treatment, short-course
FIDU	–	Female Injecting Drug User
HCV	–	Hepatitis C Virus
HIV	–	Human Immuno Deficiency Virus
ICTC	–	Integrated Counselling and Testing Centre
ICDS	–	Integrated Child Development Services
IDUs	–	Injecting Drug Users
IRB	–	Indian Reserved Battalion
N/S	–	Needles & Syringes
NACO	–	National AIDS Control Organization
NDPS act	–	Narcotic Drugs and Psychotropic Substances Act
NE region	–	North East region of India
NGO	–	Non Governmental Organization
NRHM	–	National Rural Health Mission
NSEP	–	Needle Syringe Exchange Programme
ORWs	–	Outreach Workers
OST	–	Oral Substitution Thearpy

PEs	–	Peer Educators
PM	–	Project Managers
PPTCT	–	Prevention of Parents to Child Transmission
RMC	–	Regular Medical Checkup
SACS	–	State AIDS Control Society
SHG	–	Self Help Group
SOP	–	Standard Operating Procedure
SRH	–	Sexual & Reproductive Health
SSA	–	Sarva Shiksha Abhiyan
STI	–	Sexually Transmitted Infection
TB	–	Tuberculosis

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1. Female Injecting Drug Users (FIDUs) and their vulnerabilities

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's drug use is more hidden, less studied, 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[1] on the needs of women who inject drugs, based on more than 600 references, bears testimony to this fact.

The South Asia region is also witnessing an increase in injecting drug use among females. Reports from India suggest a gradual increase in FIDUs, initially in the North East region, now evident from other parts of the country as well. Injecting drug use among female appear to mirror patterns among males, but with greater adverse consequences. Pharmaceutical injections are preferred because of lower cost and accessibility. Social adversity, high levels of exposure to substance using families, high levels of stigma and poor social support characterize this group. High rates of sharing and reusing, high rates of involvement in sex work, intoxication with alcohol is common. Knowledge of HIV is high, but 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 suicidal attempts. Sexual and reproductive health problems are frequent, particularly abortions. Children whose parents are both drug users have higher rates of conduct, emotional and behavioral problems. There is a perceived lack of appropriate treatment services for substance use and for gainful employment.

Even though evidences suggest an increase in the number of Female Injecting Drug Users (FIDUs), FIDUs are still a group of population that lacks visibility. Drug use related stigma, both actual and perceived is a huge barrier. In case of females the barrier increases multifold. This makes them harder to reach and more neglected than their male counterparts.

[1] 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.

Females and their vulnerability to HIV:

It has been shown that though a far higher number of men are infected with HIV, but females are more vulnerable to HIV as compared to men, due to various **biological, socio-cultural and economic factors.**

Biological factors

- The shape of female sexual organs – like a receptacle offering larger area of contact-thus the semen remains there for a long time and have a greater opportunity to infect.
- Higher concentration of HIV in semen than vaginal fluids.
- Less physical power than males, hence vulnerability to forced sex.

Socio-cultural factors

- Position of females in society.
  - Less bargaining power
  - Lower levels of education and literacy
  - Less decision making power
- The age difference between couples and trend of early marriages.
- Social values regarding sexual behaviour between men and females.

Economic factors

- Females have less of a say in economic matters and reduced resources to generate economic power.
- If involved in sex work females are treated as commodities and men as buyers.

There is a great disadvantage with regard to treatment, care and support for the FIDUs. Treatment facilities are scarce, often inaccessible and service providers are not oriented to the needs of the FIDUs. Moreover, most FIDUs are not comfortable in accessing services from centres dominated by male drug users. In many cases, their male partners, especially if they are drug users, do not like them to visit such centres and interact with other male IDUs. The FIDUs often bear the additional burden of caring for their children. In many cases they also have to take up the responsibility of earning and running the family in the absence of the male partner or male partner being preoccupied with drug use. Apart from the usual risks and vulnerabilities of Injecting Drug Users, the FIDUs are burdened with additional ones: they may need to exchange sex for money or drugs to support their own drug use and sometimes of their male partners too. Injecting drug practices like sharing, using after their partner and often being the last to use in a group add to their vulnerability. Many of them

do not know how to and where to procure drugs from and how to inject and are mostly dependent on the partner or peers or others.

Thus, they are at dual risk of acquiring Blood Borne Viruses (BBVs) and STIs through unsafe drug use and risky sexual practices.[2]

About the Standard Operating Procedure

This SOP is designed to support organizations providing services to FIDUs under the harm reduction programmme by building the capacities of the TI staff. The SOP provides guidance for improving outreach activities, NSEP, setting up and running DIC for FIDUs and counselling services for them.

The SOP is intended for use by all the staff working in the IDU TI. However, specifically project managers and counsellors will benefit most out of it.

Figure 1: Factors affecting drug use among females

Adapted from Murthy (2011)[3] and Murthy 2002

[2] Female who inject drugs and females sexual partners of men who inject drugs- Assessing care needs and developing responsive services UNODC-2012

[3]Murthy P.2011, op cit.

2. Community needs assessment

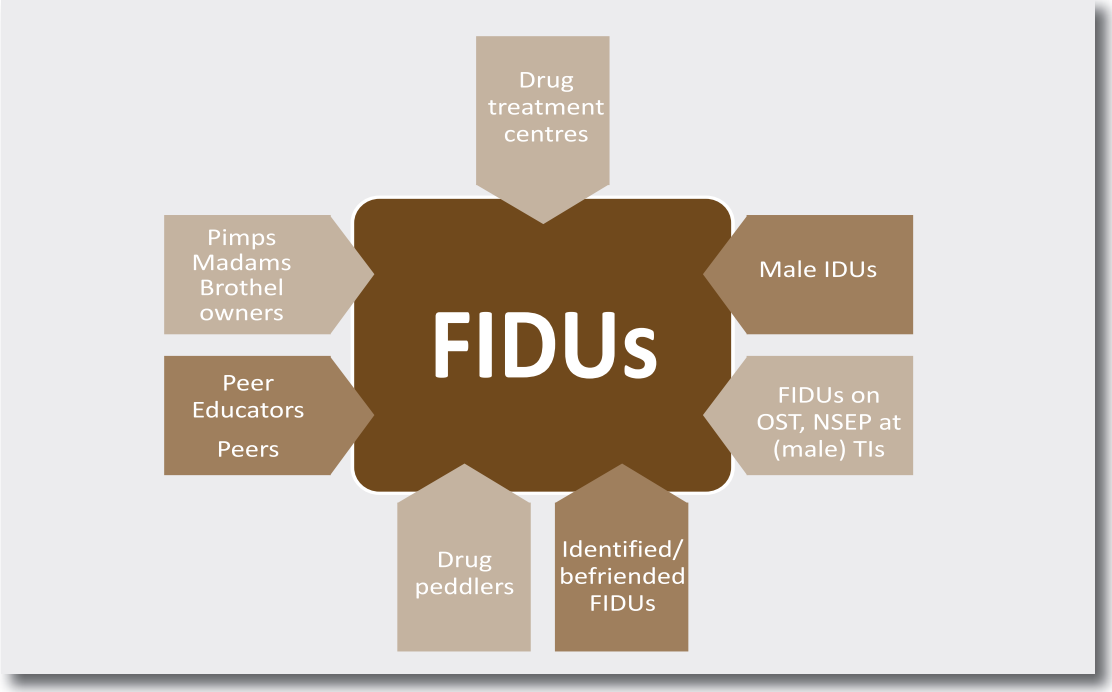
Community Needs Assessment (CNA), conducted before the commencement of the targeted intervention explores the needs, gaps in present services and challenges faced by the target community in accessing them. Since needs and the challenges faced by the FIDU are different from those of the male IDUs, a specialized approach needs to be adopted.

Before conducting the CNA, it will be necessary to recruit some 'peers' who can contact the FIDUs and interview them to do the needs assessment. These peers can be presently injecting (preferably) or those who have injected in the past. The nearby IDU intervention is a good first contact point for recruitment of such 'peers'. Other drug treatment (e.g. detoxification) centres may also provide some contacts. In order to reach out to FIDUs also involved into sex work, it will be necessary to contact the pimps, madams, brothel runners etc. It is important to recruit present FIDUs through these contacts, to reach out to the current ones, as they are aware of the sites where they may be reached.

The recruited 'peers' will need to be oriented on their role in the CNA and the tools to be used. A simple questionnaire based interview tool for the community members is provided **(Annexure1)**.

The above mentioned sources are often also good sources for recruitment of the FIDUs for intervention.

Figure 2: Potential sources of FIDU contacts and recruitments



3. Human resource for FIDU interventions

In order to effectively intervene it is very important to recruit the correct staff, sensitize and build their capacities appropriately. FIDUs being clearly a disempowered and a highly vulnerable group, they are socially isolated, face stigma both perceived and actual and many of them have experienced physical and sexual violence. Most of them have low self-esteem. In this context, it is necessary to create a supportive environment that enables FIDUs to discuss and address their needs more openly and comfortably without any fear and hesitation. FIDUs attending harm reduction services may feel most comfortable with female staff. It should be ensured that at least the staffs that are to be interacting closely with the female drug users, namely - the Peer Educators, the Outreach Workers, the counsellors, the nurse and the doctor are all females. This will help the females to open up and share their problems/issues more freely. It is essential to ensure that the PEs are females and also from the community i.e. female drug users- current or recovering, to reach out to the FIDUs to contact and open channels of communication easily with easier acceptance from the community.

All staff, whether female or male, should receive proper training in harm reduction, be sensitised on the specific needs of FIDUs and maintenance of confidentiality.

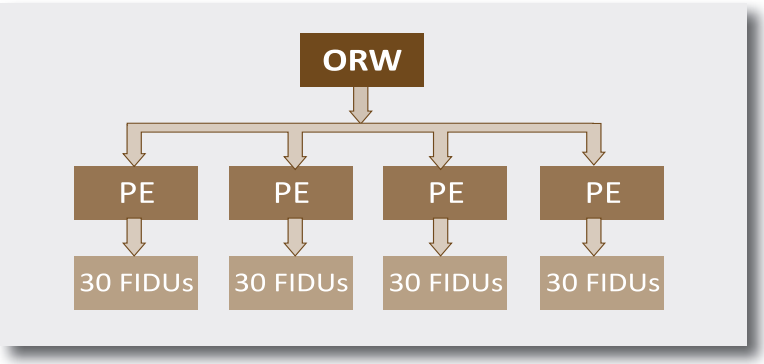
3.1 Suggested team for the FIDUs program:

Project Coordinator	Female	One
Counselor	Female	One
Nurse	Female	Two
Doctor	Female	One
Outreach Worker	Female	Depending on the no. of FIDUs
Peer Educator	Female	Depending on the no. of FIDUs
Accountant	Either	One/part time

3.2 Ratio of ORWs & PEs

FIDUs are difficult to reach out in hotspots drug using/procuring as many are home based, thus requiring more time to be visited regularly. It is recommended that there should be one PE for every 30 FIDUs to be covered and one ORW for every four PEs.

Figure 3: Ratio of ORWs, PEs and FIDUs



4. Setting up a DIC

Definition: The DIC is a community-based facility for drug users including injecting drug users who are at high risk of HIV infection. The drop-in centre caters to individuals at highest risk of HIV and those who have the least access to resources. The harm reduction DIC is client centre - focused with the goal to reduce the spread of HIV and other blood borne infections. A DIC is a doorway for IDUs and their sex partners to a welcoming and caring environment. It is a hub for all services, which an IDU can access as per his or her need and convenience timing[4].

Location of DIC: The major population of FIDUs are mostly mobile and usually do not have a permanent residence; many of them stay together with friends in rented accommodation or in a hotel in the town. The accommodations they are staying are temporary and they often return to their areas of origin from time to time. DIC will be most suitable in the area where there is a major population of FIDUs residing or near a hotspot where the FIDUs either come to procure or use drugs or hang out after use or cruise for sex clients.

Other than in the hotspot area, DIC can also be located in a convenient area, preferably not in a residential area but which has a better connectivity with public transport.

Discretion is key to attracting FIDUs, thus DICs should be discretely located, preferably with entry or exit points away from the direct public view (should have provision for back door/side door entry not opening directly on the main road) allowing females to arrive and depart with minimal observation from others. This can also be achieved by co-locating a DIC with other health facilities, such as a female health clinic or hospital, so that when females arrive, it is not immediately obvious that they are only seeking drug use or HIV related services. It may also be useful for signboards to be discrete, such as "Special Health Services for Female."

Space: The DIC should be spacious and should be more than a place for getting health related services. FIDUs are mostly mobile and many of them are engaged in sex work to support their drug use. They have very little time to take care of themselves. DIC should be a place where they can come and relax. A place where they can take a proper bath, clean themselves up and have a cup of tea or a bite. It will be always good if the project would have the provision to provide facilities for making tea and

[4] Standard Operating Procedure-Drop-in Centre For Injecting Drug Users, UNODC.

snack whenever they come to the DIC and they prepare it themselves. It should be closely monitored or supported by the ORW or PEs, as it will also increase service accessibility among them.

There should be separate space for children. FIDUs with children often find it hard to access services, as many of the services available do not look into this need. The space for the children can be provided with the availability of minimum things like cradle, formula milk for infants, eatable items for small children and soft toys. It is good to have children recreation facilities at the DIC so that FIDUs may feel comfortable and can always come with their children. In many cases those FIDUs who have children are unable to come to the DIC as there are no designated places for their children.

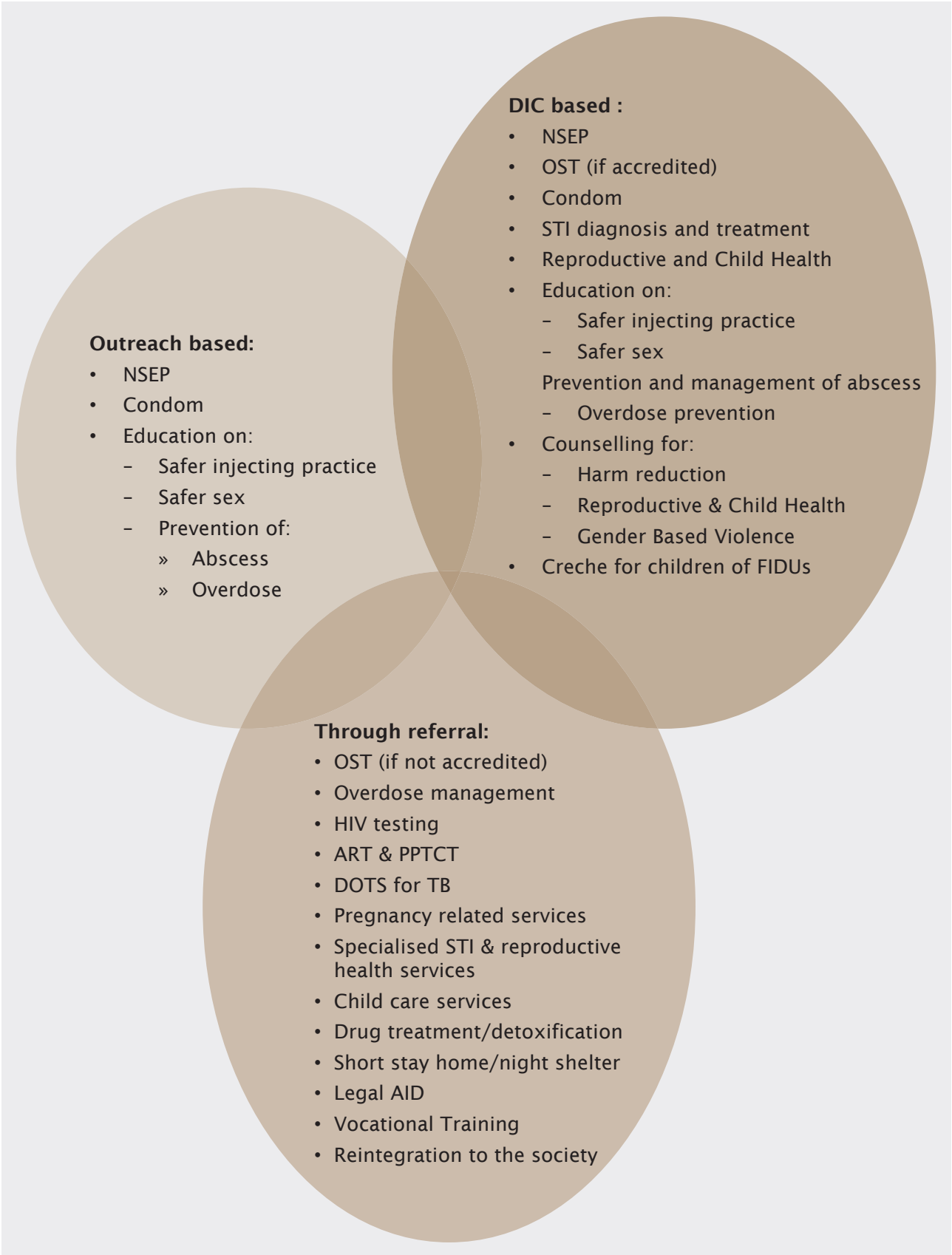
Creating a female friendly space is essential for attracting and retaining FIDUs. When creating space in a female DIC, it is helpful to have:

- A space for the FIDUs to relax and watch TV or videos, or play some indoor games as suitable
- A toilet with showers/bathing facilities
- A crèche or childcare room
- A small kitchen where the female can make a cup of tea or boil a bowl of noodles

DIC working hours

Flexible hours are important in making a female friendly DIC. A FIDU DIC should remain open seven days a week, if possible, depending on local restrictions and should operate at least seven hours a day. Shorter hours may be appropriate on weekends and holidays. The timings and the days should be finalised in discussion with the FIDUs and should be flexible to change with changing times and requirements of the community.

Figure 4: Services required by FIDUs and mode of delivery



5. Implementation/operationalising basic services

5.1 Outreach

Outreach needs for FIDUs will be slightly different. While the males can be easily reached in their places of drug procurement/use or hangout, it may be difficult to find the FIDUs in these areas, as many of them may not be procuring drugs themselves directly, or may be mostly using in homes- their own or that of their partners/peers or in their places of sex work (in case the FIDUs are into sex work). In all these places, there is a higher chance of needing to go through some 'gate keepers' e.g. the partners or family members of FIDUs or the brothel owners, madams, pimps (in case of FIDUs engaged in sex work).

Thus, it will be important to follow the usual procedure of outreach planning as given in the flowchart below:

The same outreach planning tools are used in case of the male IDUs such as:

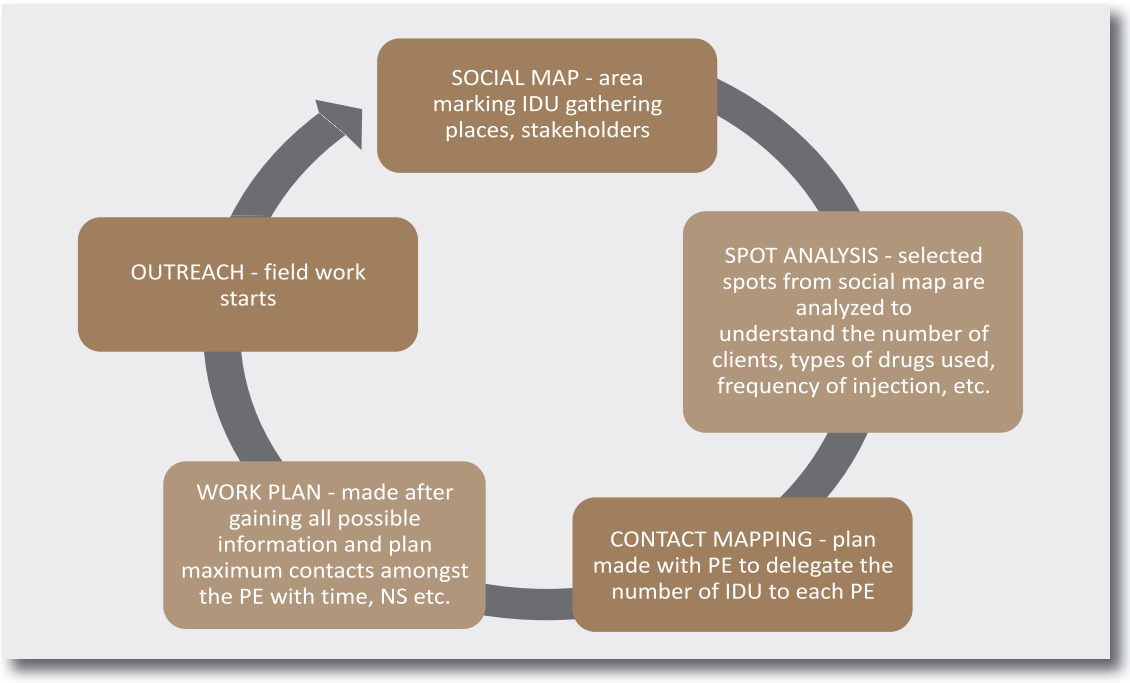
- Social mapping
- Spot analysis
- Contact mapping
- Work plans
- Outreach activities

(For details please refer to the SOP on outreach developed by UNODC for NACO).

In case of FIDUs, it is important during the planning process to allot appropriate time for the PEs and ORWs to reach out to the FIDUs usually not found in groups, e.g. those set at home or places of sex work etc.

Moreover it is also important to take into account that some additional time and effort will also be required to deal with or overcome the 'gate

Figure 5: Procedure of Outreach Planning

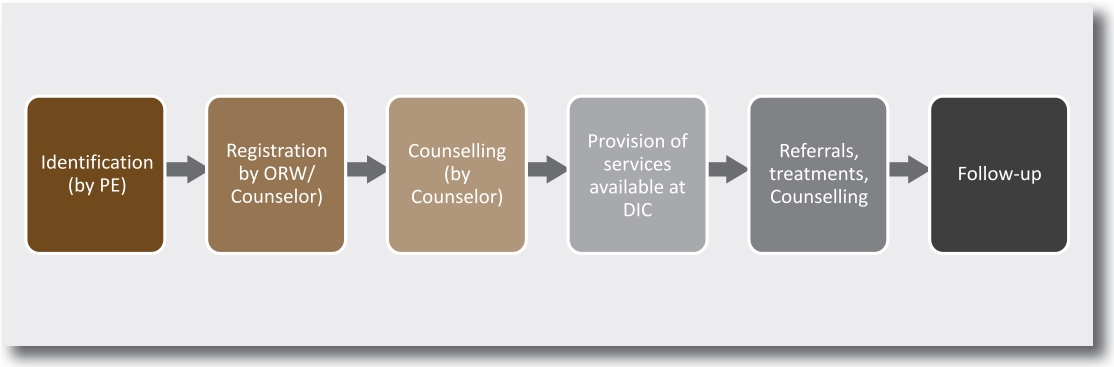


keepers'. It will be important to sensitise these 'gate keepers' and take them into confidence before initiating the outreach services. Before initiating the process of sensitization, it is absolutely necessary to receive consent and approval from the FIDUs to inform/ discuss their drug use and related issues with these 'gate keepers'. If necessary, spend enough time with them to help them understand its importance. Working without taking these 'gatekeepers' into confidence or attempts at sensitizing them without the consent of the FIDUs may jeopardize the intervention.

Timings of outreach should suit the FIDUs. Plans may need to be made to reach the FIDUs beyond the regular hours i.e., early in the morning or late in the evening. Thus, it will be necessary to minutely record the availability timings during the spot analysis.

The details of operationalizing Outreach is provided in the Standard Operating Procedure Needle Syringe Exchange Program for Injecting Drug Users developed by UNODC for NACO.

Figure 6: Flow chart service provisions



5.2 Needle Syringe Exchange Programme

Before operationalising NSEP among FIDUs, it is important to assess the local context/situation as in some settings, due to the fear of stigma associated with drug use FIDUs may not be able to come forward to access clean needle/syringe through outreach or from the DIC. As mentioned earlier, it will be important to deal with the partners, family members, brothel owners/madam/ pimps or other 'gate keepers'. It will be important to take them into confidence with informed consent of the FIDUs. But needle/syringe (and alcohol swab, cooker, distilled water etc., as applicable) should always be handed over directly to the FIDUs at least in the initial stages so that it may be ensured that the needle/syringe reaches the FIDUs. At later stages

when relationships are strengthened and trust is built, needle/syringe meant for the FIDUs may be left with these 'gate keepers'.

It is necessary to assess injecting practice of the FIDUs in the area before initiating NSEP. It is important to understand the injecting practices to be able to overcome the barriers and challenges that may be posed during intervention. It is important to also understand the role that their partners and family members play in their injecting. Opposition from a regular partner and related gender-based violence can be an obstacle to FIDUs accessing Needles & Syringes.

Some questions that need to be asked before the initiation of NSEP are:

1. Do you inject alone?
2. If, not, who do you inject with?
3. Do you know how to inject on your own?
4. If not, who injects for you?
5. Can you please provide details of the process that is followed when you are injecting?

In case, the FIDU is injected by partner/others, then it is important to educate the FIDU on 'how to inject safely'. This can be done by PEs or ORWs during their regular contacts.

NSEP should be provided through outreach, from DIC and also through satellite/secondary distribution points or channels. The 'gatekeepers' like the brothel owners and family members may also act as secondary distribution channels.

The first priority is to cover the daily injectors as in case of the male IDUs, but in case of the FIDUs it is also necessary to reach out to the non-daily IDUs regularly and fulfill their needle/syringe demand. The FIDUs will find it very difficult to procure sterile needle/syringe when injecting.

While providing free N/S among FIDUs, we need to consider their injecting frequency and type of drug they inject. Experience from the NE region shows that the injecting frequency is very high while injecting non-injectable drugs like Spasmo Proxyvon (Dextropropoxyphene) or other pharmaceutical drugs as compared with Heroin. Injecting Spasmo Proxyvon or other pharmaceutical requires 2ml syringes whereas, heroin injectors prefer 1 ml ones. Studies have also shown that sharing of injecting paraphernalia increased HCV infection among the IDUs. Hence it is also important to provide other injecting paraphernalia like cooker, cotton and distilled water as well as information and education among them.

The details of NSEP planning, implementation and monitoring is provided in the Standard Operating Procedure Needle Syringe Exchange Program for Injecting Drug Users developed by UNODC for NACO.

5.3 Drop -In Centre

The DIC is a very important centre for the FIDUs, apart from the Harm reduction services; it also provides them with a safe secure, space

where they can come, share their issues without stigma or fear of confidentiality being breached. It is also a space where they can rest, access entertainment and also leave the children to be cared for, while they can receive treatment, counselling or get some urgent work done. For the homeless, it is also a place to wash up or cook a simple meal or have their food.

The services to be provided at the DIC:

- NSEP
- OST (if accredited)
- Condom
- STI diagnosis and treatment
- Reproductive and Child Health
- Education on:
  - Safer injecting practice
  - Safer sex
- Prevention and management of abscess
- Overdose prevention
- Counselling for
  - Harm reduction
  - Reproductive & Child Health
  - Gender Based Violence
  - Reintegration to the society
- Creche for children of FIDUs

Detailed information on setting up, running and monitoring of DICs is provided in the Standard Operating Procedure for Drop-in Centre For Injecting Drug Users developed by UNODC for NACO.

5.4 Sexually Transmitted Infection/Reproductive and Child Health:

It has been evidenced that many FIDUs in order to support their drug use and/or maintain their family may resort to sex work. Thus making them vulnerable to multi-partner, unprotected sex and increases their risks of STI and HIV. They also have very poor health seeking behavior, as many of them do not have time to go to the health care setting. Moreover, they have limited information/ knowledge on these issues. Hence, FIDUs may not always report or complain of the signs and symptoms. Some of the issues are:-

1. The drugs injected by the FIDUs often have analgesic properties and as a result, IDUs may not feel the pain associated with some of the STIs.
2. FIDUs often need antibiotics for their abscesses; these antibiotics may reduce the visible signs of ulceration in the genital area or partially treat the infection.
3. Due to the injecting practices of FIDUs in groin area, genital ulcers may sometimes be misinterpreted for ulcers caused due to the injections.
4. Being a FIDU, all signs/ symptoms may be attributed to injections and the drugs that she is taking, thereby missing out the STI related symptoms.
5. Among FIDUs living under unhygienic conditions, the

femoral lymphadenopathy (swelling of the lymph nodes groins etc.) may be due to infections from blisters/ abscesses in the foot, rather than STI.

6. Some FIDUs may not want to report signs and symptoms due to stigma attached to STIs in general.

Hence, it is important to especially enquire about the signs/symptoms of STIs when a FIDU visits the DIC. Thorough medical check up including internal examinations by the doctor need to be conducted during Regular Medical Checkup (RMC) to ensure that existing signs and symptoms are identified and treated as required.

Note from the field:

"I didn't even know that I was pregnant, as I wasn't getting my period for the past 7/8 months. When I came to know about it, it was too late for me to abort. Still I am involved in sex work. Yesterday I got 8 clients."

– 17 year old FIDU originally from Assam – IDI at North AOC in Imphal (A. Oinam 2008).

Care for pregnant females who inject drugs

Drug use can lead to irregular menstrual cycles and females may not realize that they are pregnant. They may discover pregnancy too late to go for abortion even if they want to. However, with proper care, it is possible for females who inject drugs to have safe pregnancies and healthy children.

A gender sensitive FIDU program should consider the following:

- Encourage screening for pregnancy and provide interventions at the early stage of pregnancy.
- Stigma at the health care settings is prevalent and health care providers can have discriminating attitude towards pregnant females who use drugs.
- Collaborative network between FIDU interventions, pregnancy services and child care services.
- Female drug users are less likely to receive support during their pregnancies, from their regular partners and family members.
- During counselling, address the guilt and shame associated with injecting drug use among pregnant females who inject drugs.
- Advise about the adverse consequences related to abrupt withdrawal from drugs.
- Counsel about the problems associated with continued use of illicit drugs, alcohol and injecting drug use.
- OST is highly recommended for opioid dependent pregnant females.
- Methadone is the standard drug recommended for OST during pregnancy.
- Recent evidence points out that OST with Buprenorphine is also a safe option during pregnancy.

- Buprenorphine has less potential to cause severe neonatal abstinence syndrome.
- In case a FIDU is HIV positive, she should also be registered with the nearest PPTCT centre.

5.5 Condom promotion

Condom should be provided through both outreach and from the DIC. In case of condoms, some of the good learning from the NE region is to sensitize the pimps and keep condom at the hotel where FIDUs engage in sex work. While initiating condom promotion it is also important to have proper assessment whether free condoms (like Govt. supplies) are really used by them or not. It is also recommend to have some provision for social marketing of condoms for FIDUs and their clients.

There is a significant demand for female condoms among the FIDUs as they often lack negotiation skills to make their male sex partners use condoms. Sometimes the FIDUs who engage in sex work are forced to have unprotected sex by their commercial partners. Thus it would be useful to make female condoms available wherever possible.

Note from the field:

"If I can get free female condom then I can put the condom easily inside me and wait for my customer"

– 28 years FIDUs from North AOC at Imphal in a FGD.

Moreover, it will be necessary to conduct sessions on condom use and negotiation skills for the FIDUs in the field and at the DICs.

5.6 Counselling of FIDUs

Counselling is a very important component of services to the FIDUs. Apart from the standard harm reduction related counselling the FIDUs may need psychological support for emotional problems caused by their drug use, issues with the partner, other family members and the children. FIDUs also engaged into sex work may require additional support in relation to issues of commercial partners, pimps, madams or brothel owners or their 'business' related issues. FIDUs, whether in sex work or not, may also be faced with violence or abuse by their partners-regular as well as irregular, police, local goons, pimps or others. They may also need psychosocial support in relation to their children.

It is important to spend considerable time in building the rapport with the client before trying to assess the drug and sex related issues. It will also be very important to share with the client the need for this sensitive information. They will need greater reassurance that confidentiality will be ensured and may take a few sessions before they finally open up and share the 'true' information. However, it is very important to assure the clients all through, (even if they are changing their versions) that they are being believed and trusted.

The FIDUs will especially need counselling for the following:

- Harm reduction
  - Safer injecting
  - Safer sex
  - Motivation for diagnosis and treatment of HIV & STIs
- Reproductive & Child Health
- PPTCT
- Comorbidities- physical and mental
- Gender Based Violence
- Reintegration into the society

For details please refer to Counselling in Targeted intervention for Injecting drug users– a counsellor's handbook developed by UNODC for NACO

In addition, the counsellors should also ensure that regular educative sessions are held on the following topics at the field level by the ORWs and the counsellors at the DIC:

- Safer injecting practice
- Safer sex
- OST
- Prevention and management of abscess
- Overdose prevention
- Comorbidities- physical and mental
- Reintegration to the society
- PPTCT
- Gender Based Violence

The counsellors at the TI should also provide the primary support required for issues related to:

- Reproductive & Child Health
- Gender Based Violence
- Legal issues

During counseling for crisis faced by the client the, following steps may be followed:

- Make the client comfortable
- Assure her that support is available
- Express genuine concern for her condition
- Let the client talk and ventilate out all her negative emotions
- Validate her experiences and needs
- Assess what is it that she immediately requires
- Make a referral to a medical facility or police station if need be (for example, in case of gender based violence. In such cases, somebody - either a PE or ORW must accompany the client).
- Gather as many resources as possible for the client.

Once the client has calmed down to some extent, use problem-solving strategy to help her get a perspective about the problem and probable solution. Assure her that the problem can be resolved if handled calmly. In case further support is required the client should be referred to specialized counsellors/experts in the relative field.

6. Providing add on services for FIDUs & their children

Child care: FIDUs often also have the responsibility of looking after their children. Childcare facilities at the DIC is a necessity, and should be made available, to help the FIDUs come to the centre without having to worry about their children being left unattended. Lack of childcare facilities can be the greatest obstacle to females accessing treatment.

A creche or a space for the children to be cared for, looked after and engaged will be very beneficial to the FIDUs and help them access the services regularly. In the initial stages, PEs and ORWs may take turns to attend to the children but later volunteers from among the FIDUs may be entrusted with this responsibility.

Note from the field:

'When I fell sick a year ago I approached X (a particular drug treatment centre) for treatment. They refused to admit me with my daughter. As I don't know who my daughter's father is… there was no one to look after her. She is no more now… I will never go for treatment. I am not interested.

- (26 years female injecting drug user' Imphal, West district (A. Oinam 2008)

Facilities for toys will be helpful in making the space child friendly. Small nutrition programme can also help. In case of substantial number of children, linking up with ICDS or other available nutrition programme shall prove beneficial.

Linkages also need to be established with Adoption centre run by Govt./ NGOs for FIDUs who want to give up their children for adoption.

The doctor and nurse should provide regular health check ups, diagnosis and treatment of the regular ailments, advice for immunization from the DIC.

Service Providers have to encourage the regular use of pregnancy test kit. Education and counseling on proper nutrition, provision of iron and calcium tablet from Govt, health centre, when to stop sex work during pregnancy, pregnancy care, enrolling for ANC care at Govt. centre, breast feeding information need to be provided on a regular basis. For pregnant FIDUs who are HIV positive, information on PPTCT and linking up with NGO doing PPTCT has to be facilitated.

Unwanted pregnancy is a frequent occurrence among the FIDUs. Other than the ignorance of pregnancy among opiod users, FIDUs also face another problem in undergoing abortion. Consent of the father is required for abortion which is often impossible to obtain. This requirement cannot be compromised,

in the Government hospital. In private hospital, where this can be compromised, the process is expensive. FIDUs often land up doing in cheap places where the facilities are not hygienic and abortion is done by unskilled personnel which may lead to life threatening problems.

FIDUs in their drug use period have often tried giving up drug but the percentage of relapsing to drug use is very high. There has to be a continuum of care and support that should be facilitated. For example, Narcotic Anonymous (NA) Fellowship/ Support group is a popular program in sustaining recovery among drug users. NA meetings for male IDUs are widely available. Similar set up need to be established for the FIDUs. There has to be a peer led continuous support. Efforts to bring together and empower the community are essential. This can be achieved by establishing peer-led interventions, which would be acceptable to FIDUs, and would provide both social support and health services in a trusting environment.

Considering the high relapse rate and the lack of support from the family/ society, the FIDUs are engaged in high risk activities. Effort should be made to reintegrate the FIDUs to society and family. Treatment alone is not sufficient as long as their capacity is not built or there is provision of economic rehabilitation.

Children for FIDUs are another population which needs serious attention. FIDUs left with no choice for livelihood often hand over their children to the extended family members – grandparents, uncles, aunts etc. These children are neglected and do not enjoy the basic rights. The needs of these children can be addressed by linking up with organization working on children or linking with Government schemes like SSA for education and mid day meal.

FIDUs often face physical, mental, sexual harassment. In order to cope up with such situation, crisis response team can be set up within the FIDUs community. These team will consist of members possibly PE who are active. Their capacity can be built on rights issue and knowledge on NDPS Act. This will help them in dealing with the harassment they often face from different sections of the wider community.

Vocational training and micro finance: The survival needs of female injecting drug users must be addressed by way of efforts to build livelihood or vocational skills, offer work opportunities and raise awareness about their rights and available options. Support Group/ Self Help Groups can be formed for micro finance and skills trainings like tailoring and flower making, food processing, small-scale printing and other crafts, can be provided to females who are interested. This will also give an opportunity to empower them financially and to build up their capacity and provide them with a means to sustain them.

7. Networking for referral

Networking is an integral part of the program as a single program cannot cater to all the needs of an individual client. No programs have unlimited resources that it can meet all the required needs under one roof. Referral and Network has to be in place so that an individual client can access the additional services easily.

FIDUs are disempowered and highly vulnerable group. They are socially isolated, face stigma and have few realistic options. In this context, it is necessary to create and strengthen the networking with different NGOs/ CBOs/GOs. The networking has to go beyond the drug treatment and the medical health care set up. Females using drugs have gender specific injection related vulnerabilities and gender specific barriers to accessing services. Drug treatment facilities generally had poor or non-existent linkages with sexual and reproductive health services.

Before beginning the referral, networking meetings should be held with the management of the referral centres. They should be sensitized to the challenges and needs of the FIDUs. Referral for FIDUs in the initial stages to any new centre should be accompanied. Regular meetings should be held with the counterparts of the referral centres to share updates, take stock of effective referral, barriers /challenges and their solutions.

The following services are recommended to be provided through referral are:-

1. ICTC
2. ART
3. PPTCT
4. CCC
5. Government hospital
6. Mental health institutes
7. TB DOTS Centre
8. STI Clinics
9. ANC
10. RCH
11. Other drug treatment services (detoxification)
12. Short stay home or night shelter (having the provision of child care facilities)
13. NGOs providing Care and Support (nutrition and shelter for the FIDUs)
14. ICDS for nutrition and health care of the children
15. Vocational training
16. Micro finance
17. Legal AID

A continuum of care needs to be established for FIDUs with HIV/AIDS comprising of a number of services, which will be made available through referral processes. Linking up should continue with coordinating the services in order to ensure that proper treatment and care is not denied to FIDUs who are HIV positive. Peers should be trained for availing the ICTC, Pre ART care, ART provision, CCC, STIs treatment etc.

It will be very important to conduct referral analysis regularly as the stigma attached to drug use and sex among females is very high in the society, the FIDUs are more likely to be discriminated against. In case stigmatization and related attitude affects the referral and accessing of services by the FIDUs, prompt action in terms of solving it and or reporting it to proper authorities is very much necessary.

Details of the processes involved in referral networking are available in the Standard Operating Procedure, for Care and Support for Co-morbid Conditions Among Injecting Drug Users developed by UNODC for NACO.

8. Advocacy for service accessibility and uptake

Studies have shown across the world that FIDUs are socially disadvantaged, have less opportunity or access to education, health care, and adequate income. They remain a hidden population hard to reach, under - represented at drug treatment services because of high stigma & discrimination.

The societal disapproval and the stigma attached to drug use often make females believe that they deserve physical, violence or sexual abuse from the general community at large. The social and cultural set up increases the female's risk to engage in risky sexual as well as injecting practices. Biologically as well females are at greater risk. Females are more vulnerable to HIV infection as sperm contains high concentration of HIV than vaginal secretions & it stays inside females for a longer span. Area of absorption is greater in vagina than penis and often STIs remain asymptomatic in females. The incidence of gynecological disorders is high among FIDUs.

The fear of police action in the community leads FIDUs to engage in risky behaviours despite having the knowledge of protection. For example, in studies it has been reported that FIDUs seek isolated spaces, such as the banks of the river, funeral places/ cremation grounds and public toilets for drug use, and disregard issues of safety and hygiene. FIDUs therefore engage in high levels of risky drug use and unsafe sexual behaviours.

FIDUs with HIV/AIDS are often unwilling to access HIV/AIDS treatments or general medical care from a public health care set up or private institution.

Note from the field:

"I can somehow hide the stuff (heroin) but not the needle and syringe. When the police are in our place (where she lives in Imphal West), I can't inject so I go to the riverbank. I always find a syringe there because people use them and throw them near the riverbank. I have to take my daily dose. I have shared (syringes) many times in the past".

- 30 years, FIDU, Imphal West district, Manipur.

Advocacy with Government health care system, media, law enforcers, pressure group, students body or any other bodies strong or having influence in the particular society is required. The media plays a big role in sensitizing the issue of FIDUs among the general public. More research/ studies are require to advocate for policy/program change.

The Health Department and the State Social Welfare Departments need to acknowledge the problems and needs of FIDUs. Generation of more evidences will shed light on the magnitude of FIDUs, their risk taking patterns, obstacles they face in adopting safe behaviours or acquiring appropriate services and the experiences of successful interventions for this group is needed.

In the context of conflict zone in North East India, there is the high presence of Law Enforcement agencies like army, police, and commandos etc. There are evidences of drug users being harassed and ill treated by these forces. Frisking and money extortion is very common. All these have ripple impact on increasing risk-associated behavior. For example IDUs are not able to carry clean injecting equipment's and for the fear of disclosure they remain hidden and underground.

One time advocacy with higher official is not enough. This has to be a continuous and consistent with respective security departments (police, Commandos etc). Educating and giving awareness about the rights of IDUs is necessary.

The harm reduction activities are often hindered due to bandh/curfew/ strike/blockade. Local specific strategy needs to be adopted to address such problem like provision of health card for the client, take away doses for the OST client. The concerned State Health Department should be advocated for making provision of providing health card, which will enable the clients to get access to program on days of bandh/ curfew etc.

9. Monitoring and Evaluation

The Project Manager is responsible for monitoring the progress of activities, collection of reports, and analysing the same. Based on the analysis, suggestions and improvements will be incorporated.

PEs and the ORWs will maintain daily diaries and will report to the center on various aspects of project activities such as BCC contacts, condom distribution, NSEP, STI/ICTC/ ART referrals, advocacy meetings and treatment completion. The ORW will also conduct regular field visits to provide onsite support to the PEs by giving constructive feedback to them to improve their performance and overcome difficult situations. The DIC in charge will collect and verify the reports of ORWs and PEs.

The Project Manager will facilitate these monthly meetings. The monthly reports sent from the DIC will be pooled into a consolidated monthly project report. For further improvement the PM will document the qualitative and quantitative achievements, failures and reasons for the same. A participatory mid-term review will be conducted with external partner on the first three months of the project to take mid-course correction. At the end, an end line review along with an external consultant to assess the program will be conducted.

Monitoring calendar - Source of data: Monthly/quarterly reports, stocks register, visiting register, client log book, books of accounts, evaluation formats etc.

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11. Annexure

Annexure1

Community Needs Assessment among Female Injecting Drug Users

A. Demographic profile

Age (in completed yrs)	
Marital status	1. Married
	2. Never married
	3. Staying together without getting married
	4.Divorced
	5. Separated
	9. Not Known
Education	1. Illiterate
	2. Literate (read and write)
	3. Primary education (5 yrs of schooling)
	4. Middle (8 yrs of schooling)
	5. Matriculation / Higher Secondary (10 yrs of schooling)
	6. Graduate
	7. Post graduate/Technical/Professional education
	8. Any other (specify)
	9. Not known
Profession / Occupation	1. Professional
	2. Administrator / Clerical work
	3. Business/self-employed
	4. Transport worker
	5. Skilled worker
	6. Unskilled worker / laborer
	7. Farmer
	8. Student
	9. Sex worker
	10. Homemaker / housewife
	11. Unclassifiable (beggar, thief, etc.)
	12. Any other (specify)
	13. Not Known

Employment status	1. Never employed
	2. Currently unemployed
	3. Full time employed
	4. Part time employed
	5. Self-employed
	6. Student
	7. Housewife
	8. Any other (pensioner, retired etc.)
	9. Not known
Monthly income	1. < Rs. 1500 pm
	2. Rs. 1500 – 3000 pm
	3. Rs. 3000 – 4500 pm
	4. Rs. 4500 – 6000 pm
	5. Rs. 6000 - 10000pm
	6. > Rs. 10000 pm
Migration status	1. Whether from the same place or from outside
	2. From the same district
	3. Moved in from another district but the same state
	4. Moved in from another
	5. Moved in from another state
Please specify reason for migration (if applicable)	
Residential status	1. Living in own house
	2. Living in rented house
	3. Living with partner in his house (owned or rented)
	4. Homeless
	5. Others
Current living arrangement	1. In a joint family
	2. In a nuclear family - husband and kids
	3. Alone – at home
	4. With friends / co-workers at their home
	5. Cohabitating with a partner
	6. With co-workers at workplace
	7.Any other (please specify)

B. Drug use status

Drugs injected in the last three months	
Heroin/Brown Sugar	1 Yes
	2 No
Dextropropoxyphene (SP, parvon spas, proxyvon, Relipen, etc.)	1 Yes
	2 No
Buprenorphine (norphine, tidigesic, bupigesic, etc.)	1 Yes
	2 No
Other opioids (fortwin, etc.)	1 Yes
	2 No
Benzodiazepines (e.g. diazepam, lorazepam, etc.)	1 Yes
	2 No
Others sedatives (avil, phenargan, etc.)	1 Yes
	2 No
Any other drugs injected (If yes, give details)	1 Yes
	2 No
Other drugs used (last three month)	
Alcohol	1 Yes
	2 No
Cannabis	1 Yes
	2 No
Chased/ smoked heroin/brown sugar	1 Yes
	2 No
Oral use of spasmoproxyvon/proxyvon/parvon spas/relipen	1 Yes
	2 No
Sedatives (Diazepam/alprazolam/nitrazepam) orally	1 Yes
	2 No
Inhalants	1 Yes
	2 No
Any other drug use	1 Yes
	2 No
If yes, give details	

C. Injecting related practices

Have you injected at least once in the last 3 months?	1 Yes
	2 No
Do you inject daily?	1 Yes
	2 No
If daily, how many times a day?	
If non daily, specify whether	1. About 3-4 days per week
	2. About 1-2 days per week
	3. About 2-4 days per month
	4. Rarely, about once a month or so
	5. Less than once a month
Frequency of injecting on the day you inject	1. 4 or more times a day
	2. 2-3 times a day
	3. Once a day
Where do you inject? (More than one answer possible)	1. Home
	2.friends home
	3. partner's home
	4. drug peddling/drug shooting spots
	5.Public toilets
	6. abandoned houses
	7.Others (please specify)
Who do you inject with? (More than one answer possible)	1.Alone
	2.Drug using peers - male
	3. Drug using peers - female
	4. Drug using regular partner
	5. Drug using casual / non-regular partner
	6. Drug dealer
	7. Others (please specify)
If not injecting alone. Do you know how to inject on your own?	1 Yes
	2 No
If not, who injects for you?	1 Drug using peers - male
	2 Drug using peers - female
	3. Drug using regular partner
	4. Drug using casual / non-regular partner
	5. Drug dealer
	6. Others (please specify)
Have you ever shared Needle syringe, drug, cooker with anyone else?	1 Yes
	2 No
Have you shared during the last injecting episode	1 Yes
	2 No

If yes, reasons for sharing	1. Usual practice
	2. Needle syringe not available
	3. Peer pressure
	4. Pressure from regular sex partner
	5. Pressure from irregular sex partner
	6. Others (please specify)

D. Sex related practices

Have you ever had sexual intercourse	1. Yes
	2. No
	3. No response
Age at first sexual intercourse	1. <15 years
	2. 15 to 18 years
	3. >18 years
Nature of first sexual intercourse	1. with boyfriend
	2. with husband
	3. with casual sex partner
	4. with a paying partner (sex work)
	5. Any other (please specify)
Do you have any regular sex partner	1. Yes
	2. No
	3. No response
How often did you have sex with regular sex partner during last one month?	1. < 5 times
	2. 5-10 times
	3. > 10 times
Did you use condoms with your regular partner in the last sex act?	1. Yes
	2. No
	3. No response
Did you have sex with any non regular sex partner in last one month?	1. Yes
	2. No
	3. No response
If yes, how many non-regular partners did you have in the last one month?	

Did you use condoms with your non-regular partner in the last sex act?	1. Yes
	2. No
	3. No response
Do you usually use drugs/alcohol before sex with your regular partner?	1. Yes
	2. No
	3. No response
Do you usually use drugs/alcohol before sex with your non- regular partner?	1. Yes
	2. No
	3. No response
Did you ever have sex for money/drugs	1. Yes
	2. No
	3. No response
Did you have sex for money/drugs in the last one year?	1. Yes
	2. No
	3. No response
Do you identify yourself as a sex worker?	1. Yes
	2. No
	3. No response
Did you engage in sex for money before starting heroin smoking/SP orally/ injecting drug use	1. Yes
	2. No
	3. No response

E. Knowledge regarding STI/HIV

Have you heard about STI?	1. Yes
	2. No
	3. Not Sure
Have you ever heard about HIV/AIDS	1. Yes
	2. No
	3. Not Sure
If yes, what is the source of this information	1. Friends/ Peers
	2. TV/ Media
	3. NGOs/CBOs
	4. Others (specify)
How is HIV transmitted?	1. Unsafe sexual contacts
	2. Sharing contaminated needle /syringes
	3. Infected mother to child
	4. Through infected blood & blood products
	5. All of the above
	6. Any other (Please specify)

F. HIV status

Have you ever underwent HIV testing	1. Yes
	2. No
	3. Not sure
If yes, do you know your HIV status?	1. Yes
	2. No
	3. Not sure

G. Marital / reproductive History

Status of Male partner	1. Non-drug user (doesn't use any substance except tobacco)
	2. Alcohol user (consumes alcohol but no illicit drug use)
	3. Drug User (consumes illicit drugs but by non-injecting route only)
	4. IDU (uses drugs through the injecting route - at least one injecting act in last 3 months)
Occupation of the male partner	1. Professional
	2. Administrator / Clerical work
	3. Business/self-employed
	4. Transport worker
	5. Skilled worker
	6. Unskilled worker / laborer
	7. Farmer
	8. Student
	9. Sex worker
	10. Unclassifiable (beggar, thief, etc.)
	11. Any other (specify)
	12. Not Known
Employment status of the male partner	1. Never employed
	2. Currently unemployed
	3. Full time employed
	4. Part time employed
	5. Self-employed
	6. Student
	7. Housewife
	8. Any other (pensioner, retired etc.)
	9. Not known

Monthly income of the male partner	1. < Rs. 1500 pm
	2. Rs. 1500 – 3000 pm
	3. Rs. 3000 – 4500 pm
	4. Rs. 4500 – 6000 pm
	5. Rs. 6000 - 10000pm
	6. > Rs. 10000 pm
No. of children born (Male)	
No. of children born (Female)	
Nos. of children living (male)	
Nos. of children living (female)	
Are you currently pregnant?	1. Yes
	2. No
	3. Not sure