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RESEARCH ARTICLE

MANIFESTATIONS OF GENDER INEQUALITY AND ITS INFLUENCE ON HEALTH SERVICE USE AMONG FEMALE INJECTING DRUG USERS- A STUDY IN CHAMPAI, MIZORAM

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Abstract

Context: Gender inequalities affect women's access to and use of health services. The current study focused on Female Injecting Drug Users with human immunodeficiency virus positive status, residing in Champa district of Mizoram. Drug use and drug peddling beset the district and injecting drug use and sharing of injecting equipment caused the rising HIV infection among users. In Mizoram, the human immunodeficiency virus infection recording 2.04% prevalence rate has topped the list of States.

Aims: The study was conducted with the aim of understanding how FIDUs experience gender inequality and discrimination and the impacts the same have on their abilities to access health services.

Methods and Materials: The qualitative study was conducted among Female HIV positive intravenous drug users. The data were collected through individual interviews with Key Informants involved in health service delivery; and focus groups with HIV positive FIDUs. Given the hidden nature of FIDUs, snowball sampling was attempted to recruit participants. Qualitative data analysis was conducted using the framework approach and informed by theories of risk environments.

Statistical Analysis used: A summary of socio-demographic with drug use and HIV positive status of participants was generated using Microsoft Excel systems. Transcripts were analyzed through QAD MINAR software and codes were generated

Results: This study identified important structural and contextual factors that affect the uptake of the preventive health services by FIDUs of Champa and other vulnerable districts of Mizoram state. **Conclusion:** The findings suggest systemic interventions that reduce community deprivation and social disorder likely to yield important benefits.

Key words- Female Injecting Drug Users, People Living with HIV,

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Introduction:-

The Human Immunodeficiency Virus infection is on the rise among women in some states of India, probably due to complex social and cultural issues affecting women ⁽¹⁾. HIV-positive women in India continue to face inequalities with health, social and economic ramifications ⁽²⁾. In the North-Eastern states, Mizoram tops with the virus "strike

rate” and HIV prevalence rate of 2.04% (3). Data compiled by the Mizoram State AIDS Control Society show that 67.21% of the positive cases from 2006 to March 2019 have been transmitted sexually, with infected needles shared by intravenous drug users accounting for 28.12% (4). This Christian-majority State bordering Bangladesh and Myanmar has battled drug trafficking and abuse for a long time. According to the 2019 study, Mizoram is estimated to have more than 28 thousand people injecting drugs for non-medical purposes (5). The HIV prevalence of 19.8 % was considered stable to rising epidemic as per HSS 2017 (6). Notably, female morbidity is higher in Mizoram than male morbidity levels. Contrary to morbidity levels, the rate of hospitalization among sick is higher for males as compared to females and the average out-of-pocket expenses is also substantially higher for males. (7) This is perhaps an indicator of inherent bias in the society’s perception of women’s health wherein sickness among males is given more importance and substantially more money is spent on the treatment of men compared to that of women

The current study attempts to focus Female Injecting Drug Users of Champai district. As per the study in 2017, heroin addiction among young people of Champai stood at 81.7% and injecting drug use affected 96.2% young males and females with 61.2% sharing of injecting paraphernalia reported for the district (4). Notably, a comprehensive package of harm reduction interventions is being implemented by National AIDS Control Organization through the State AIDS Control Societies in India. But the major service components of harm reduction program remain inaccessible to FIDUs of Champai, as observed.

We conducted the qualitative study and used content analysis with the broad aim of understanding the ways in which FIDUs experience inequality and discrimination and the impacts the same have on their abilities to access health services.

Methods:-

Study design:

This study, performed in August 2019, was conducted among Female HIV positive intravenous drug users registered in the Champai ART centre for more than two years. The data were collected through focus groups with PLHIV FIDUs and individual interviews with Key Informants involved in providing services to this population. Two focus groups were conducted with experienced local moderator and note takers conversing in Mizo tawng language with participants. The interviews were semi-structured consisting of a series of broad open-ended questions. Four individual interviews with Key Informants were undertaken with the objectives to obtain their ‘views on FIDUs’ experiences and perspectives. The study had the approval of Mizoram State AIDS Ccontrol Society authority vide No.11019/1/11/CMO(CPI)/DAPCU 2562 Dated 23.09.2019.

Settings:

The focus groups were conducted at participants’ convenient location near to New Hope Society in Champai; among 14 FIDUs who were HIV positive.

Participant selection and recruitment:

In the current study a person who has injected at least once in the last three months is categorized as an IDU in keeping with the definition followed in the National AIDS Control Programme. She should be above 18 years of age and give consent to participate.

Sampling:

Given the hidden nature of FIDUs, we attempted snowball sampling to recruit participants for the study. Altogether 18 FIDUs were approached, of whom 2 females declined to participate stating time constraints. Only 14 females consented to participate in the focus groups organized. 4 Key Informants including ARTC Doctor, Nurse, Community Care Coordinator and CSC NGO functionary participated in the Individual interviews.

Data Collection & Analysis:

Qualitative data analysis was conducted using the framework approach (8,9). Taking cue from Rhodes’ conceptualization of ‘risk environment framework’, we conceived that the interactions between the various types of environment and level of environmental influence the harm reduction praxis. (10) Data analysis was guided by the ‘risk environment’ framework’ accordingly.

All focus groups lasted between 60-75 minutes. A summary of socio-demographic with drug use and HIV positive status of participants was generated using Microsoft Excel systems. Transcripts were analyzed through QAD MINAR software and codes were generated.

Results:-

The socio-demographic profile of participants (n= 14) and years of IV drug use, PLHIV status and ART regimen are summarized in Table-1.

Table-1
SOCIODEMOGRAPHIC PROFILE WITH SUBSTANCE USE HISTORY & ART STATUS OF PARTICIPANTS

Age	
20-35 years	78.6
Above 35 years	21.4
Education	
College level-	28.6
High School level-	50.0
Primary-	21.4
Illiterate	0.0
Employment status-	
Service-	14.3
Business-	35.7
Housewife-	0.0
Without formal job-	7.1
Unemployed-	42.9
Income-	
No income-	42.9
Below 5000-	7.1
5000-10000-	42.9
Above 10000	7.1
Mean Income	5250.0
Marital status-	
Single-	28.6
Married-	21.4
Widow-	7.1
Seperated-	35.7
Single-	7.1
Substance use status	
Oral & Chasing –	0.0
Heroin & Ors –	100.0
Frequency	Daily (100.0)
Injecting drug use-	Heroin (100.0)
Frequency	
Weekly-	50.0
Monthly-	50.0
HIV treatment status	
Registered with ARTC-	
2-5 years	71.4
Above 5 years	28.6
Adherence in the last 12 months-	
Above 95% -	0.0
90 – 95%-	50.0
80% and below-	50.0

Desk review of literates and documents enabled to group the manifestations of gender inequality in Mizo society into four conditional groups- modern, transitional, conservative and traditional ⁽¹⁰⁾ One vital side of the stated types is that woman's sex restriction is innate across the conditional groups as she is perceived within the roles of

mother solely. This suggests that woman's sexuality is valued within the context of reproduction, instead of her individual happiness.

Four major themes emerged through the analysis that are in keeping with the risk environment approach. These themes are enumerated as follows.

Female Injecting Drug Users are missing on the policy agenda-

The findings reflected very little acknowledgement of the importance of providing harm reduction services for FIDUs. The non-availability of needle-syringe exchange programme with safer injecting practices knowledge and dearth of their accessing the male-dominated opioid substitution therapy by FIDUs is their major handicap in averting HIV infection.

'Female outreach worker meets us to inform us about the disease, provide condoms and advises on HIV testing. But we are not given needle-syringe packets as men get.' [FGD 1 Participant# 3]

'For FIDUs, treatment options through drug de-addiction in Champai and due coverage under the harm reduction programmes not existed. FIDUs are reluctant to go to oral substitution clinics attended by men; as there is no provision for safe space for women'. [KI-ARTC female counsellor]

Most of the KIs cited lack women-specific service rendering in the harm reduction programme. While female KIs opined that women's position in Mizo society was weak and therefore their needs were not considered by policy makers.

Social exclusion and stigma limit opportunities for change-

Within communities, female drug users face stigmatization based on traditional family norms and contradictory power dynamic at play in gender role norms. This stigmatization becomes all the more concerning for FIDUs with HIV positive status.

'I think especially for women doing IDU, it's hard because we're expected to be a play mother's roles, take care of everything, always be happy, and not care for ourselves as much as we care for everyone else'. [FGD respondent-8]

'Females are discriminated within the husband's family if both of them held HIV positive status. Females are often blamed for the death of her husband/male partner, even if the male had been diagnosed HIV positive earlier.' [KI-CSC functionary]

Gender role expectations, about what it means to be a woman, also result in women who do drugs experiencing more stigma than young men. As one FGD participant noted, 'you are no longer seen as a [proper] woman' [FGD 1, respondent# 4]. They also gave examples of how they were mistreated by community members because of their drug use and HIV positive status, notwithstanding the fact that in most cases they get into drug use and injecting habits and acquire the infection from their male partners. As one participant stated, 'As a HIV positive female, I become very sensitive to what people say and how they treat me. I feel 'endwang (looked down upon)'. [FGD-1 respondent 2]

Stigma was also evident in participants' descriptions of interactions with service providers. They gave examples of how they were meted with differential treatment in general healthcare settings.

'I was referred to gynecologist in the hospital for sexually transmitted infection that didn't subside with presumptive treatment at ART centre. The doctor at the hospital noticed my ARTC green booklet (patient treatment history book) pulled his chair back and hurriedly jotted down some medicine and asked me to leave without explaining anything'. [FGD-1 participant#6]

'Should health service staff know that one is an addict, they send the patient backward on the queue or tell the person to go and come later'. [FGD-2, participant#13]

While stigma emerged as an important theme in the FGDs, most of the KIs reported that so far, no case of FIDUs being discriminated at healthcare facility has surfaced and asserted that anticipated stigma among FIDUs were dominant. However, two of the KIs acknowledged that there was a lack of person-centered care that FIDUs with HIV positive status may have experienced:

‘What PLHIV injecting drug users say to us, the feeling is that they are not treated in a person-centered approach.’ [KII, ARTC doctor]
According to another KI, ‘the health care workers did not understand why and how they need to serve female drug users’. [KII, CSC functionary]

Negative social capital hampers health service use-

Participants described how lack of employment opportunities and poverty in their communities set up a system of negative social capital in which community members acknowledge the presence of drug peddling and drug markets because these provided economic opportunities for young people.

Champai’s geographical location proximate to porous international border and influx of Chins tribe folks of Myanmar, stereotyped as drug peddlers, giving elevate to quandaries of drug trafficking and human trafficking. (11).

In all of the FGDs, participants noted that many young people got involved in the sale and distribution of trafficked drugs as a means of financial survival. According to one KI, “easy accessibility of illicit heroin pushed young males and females to narcotic use, and the benefits made from smuggling the precursors, provided them the financial support. [KII-CSC functionary]

The accredited social organization as Young Mizo Association or the Churches in north-east were either bereft of suitable knowledge on harm reduction and HIV or adopted narrow moral angle that added to the stigma manifestation [12].

Most of the FGD participants stated that these contextual factors diminished their desire to seek treatment. Many KIs recognized these high levels of social disorder.

Systems are unresponsive to the needs of FIDUs-

In Champai, for female drug users the scope for drug deaddiction, nor the focused harm reduction services existed. However, FIDUs with HIV positive status have access to Antiretroviral Therapy and symptomatic sexually transmitted infection treatment. FGD participants described their unpleasant experiences at the general healthcare settings. Said one participant, ‘Health care staff at the clinic have a queer look at us, and whisper among fellow staff on my doing drugs and injecting habits’. [FGD-2, respondent#14]

The KIs described how distance of health centers and their navigation to various sections for sexual health and HIV services pose problems given the transport costs and other logistic barriers faced. The KIs depicted how the Ministry of Health and Family Welfare is liable for harm reduction including sexually transmittable infection, while the Ministry of Social Justice and Empowerment gave sedate deaddiction treatment administrations. Having two diverse national divisions answerable for these administrations, each with their very own guidelines and authoritative prerequisites, without proper inter-department coordination affect proper service delivery to drug users.

‘So, the outcome of that is you get a very restrictive approach around where substance abuse treatment services must be and where HIV testing and counselling must be, and the two are not in the same system. Also, health staff at the centres lacked proper training to handle female drug users.’ [KII, CSC NGO functionary]

Despite these different perspectives, both the FGD and IDI participants agreed that negative perceptions among FIDUs had a negative impact on their health seeking behavior.

Discussion:-

This study has identified important structural and contextual factors that need to be considered for re-strategizing the preventive interventions and foster improved linkage among health service set-ups for Female drug users of Champai and may be for other vulnerable districts of Mizoram state.

Notably, harm reduction interventions through IDU TI NGOs were required to be guided for covering FIDUs in addition to male IDUs, with clear guidelines and budgetary provisions provided. Similarly, in Drug Deaddiction Centres run under the control of State Social Welfare Department and Churches need to provide in-house treatment facilities for Women drug users.

Societal gender inequality also has had an impact on how young women drug users are treated in communities and the health care system; consequently, interventions to reach and link FIDUs to health services must consider how to reduce the social exclusion of women drug users.

Treatment facilities are scarce in Champai as like other districts of Mizoram, as observed. They are often inaccessible and service providers are not oriented to the needs of the FIDUs. Our findings indicated that proper orientation of health staff on the needs of female drug user with community and health system-wise mobilisation efforts are required to address gender norms and role expectations.

The FIDU participants in our study were literate, all above middle school education level, yet found lacking in the negotiation power with men, either as partner or in conjugal life. They are socially excluded from opportunities to reduce their HIV risks through education, employment, or access to health services by virtue of their gender and drug use.

Our findings show that lack of income opportunities fosters an environment where negative social capital flourishes. This led to the emergence of trafficking of human and illegal drugs that run an underground economy and provide community members with a source of income. Due to high levels of social disorder that accompany the drug trafficking, young women, either directly or at the behest of male partners, get involved in drug peddling and consequent drug chasing or injecting practices under peer influence. They are compelled into sex for money or drugs. These findings suggest the potential value of community-based interventions for supporting women in their attempts to reduce their risk behaviours and encouraged to use health services.

In addition to these contextual interventions, structural and systemic interventions are needed to ensure that the health system is responsive to the needs of women drug users. The National AIDS Control Organization has in place a strong gender sensitive interventions guideline, but slow implementation at the ground levels in different states and not suitably integrated with large National programmes of health, education and social security have not yielded the desired outcomes, so far.

Despite overwhelming evidence of the structural and contextual factors that drive women's risky use of drugs, the KIs thought that young women had personal agency and could overcome their circumstances and context if familial and social support are meted to them.

Limitations and future direction:-

Several limitations of our findings should be noted. Firstly, our FGDs involved FIDU participants who were receiving antiretroviral therapy, and linked to a care and support NGO under NACP. Their accounts and experiences of stigma and inequality may differ from other women. It is indeed possible that our study may be underestimating the impact of gender inequality among female injecting drug users, because our purposively sampled participants were already accessing some psychosocial and ART services. Secondly, we were unable to assess the strength of the relationship between their encountered barriers and service utilisation. Consequently, future quantitative studies are needed to examine the relationship between these variables and service use.

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Conflict of Interest:- None.

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