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Appearances of Gender Inequality and Its Impact on Health Service Use among Female Injecting Drug Users: A Study in Champai, Mizoram

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Abstract

Gender inequalities tend to influence women's utilization of health services and those with intravenous drug use with human immunodeficiency virus (HIV) are the worst hit. Drug use and drug peddling plague the region and sharing of injecting equipment caused the rising HIV infection among users resulting Mizoram topping among States with 2.04% infection rate. The qualitative study, bracing relational theory and context of gender equality framework, aimed at understanding how Female Injecting Drug Users (FIDU) of Champhai district of Mizoram experience gender inequality and discrimination and how the same impacts their health service uptakes. Individual interviews with service providers as Key Informants (KI) and focus groups with HIV positive FIDUs formed the base of data collection with literature review. Snowball sampling was adopted to recruit participants given the hidden nature of FIDUs. Data analysis was done using the framework approach and informed by theories of risk environments. A summary of socio-demographics with drug use patterns of participants was generated using Microsoft Excel systems. Transcripts were analyzed through QAD MINAR software and codes were generated. This study identified important structural and contextual factors that affect the uptake of the preventive health services by FIDUs. The findings suggest systemic interventions that reduce community deprivation and social disorder likely to yield important benefits.

Keywords*: FIDU, Gender Inequality, HIV, Health, PLHIV, Stigma, Discrimination.*

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Introduction

The Human Immunodeficiency Virus (HIV) infection is on the ascent among women in certain states of India, most likely because of complex social and social issues influencing ladies (1). HIV positive women in India keep on confronting disparities with health, social and financial consequences (2). Among the North-Eastern states, Mizoram tops with the virus "strike rate" with 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 circumscribing Bangladesh and Myanmar has struggled drug trafficking and abuse for quite a while. 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 the 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 people is higher for males as compared to females and the average out-of-pocket expenses is also substantially higher for males. (7) This is maybe a pointer of characteristic inclination in the general public's impression of women's health wherein ailment among males is given more significance and substantially more money is spent on the treatment of men compared to that of women. The current study, conducted in August and September 2019 focused on the needs and aspirations of PLHIV 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 the National AIDS Control Organization through the State AIDS Control Societies in India. But the major service components of the harm reduction program remain inaccessible to FIDUs of Champai, as observed. This study is qualitative in nature and has 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, conducted in August and September 2019, was conducted among HIV positive (PLHIV) Female intravenous drug users (FIDU) on Antiretroviral Therapy (ART) for more than two years. The data were collected through focus groups with PLHIV FIDUs and individual interviews with Key Informants (KI) involved in providing services to this population. Two focus groups with participants were conducted with experienced local moderators and note takers conversing in Mizo tawng language. The interviews were semi-structured consisting of a series of broad open-ended questions. Four individual interviews with KIs done with the objectives to obtain their 'views on FIDUs' experiences and perspectives. The study had the approval of Mizoram State AIDS Control 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 16 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 19 FIDUs were approached, of whom 2 females declined to participate stating time constraints. Only 16 females consented to participate in the focus groups organized. 4 Key Informants (KI) 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. Interviews lasted between 60-75 minutes. A summary of socio-demographic studies 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=16) and years of IV drug use, PLHIV status and ART regimen are summarized in Table. Survey of literates and records prompted the understanding that indications of gender inequality in Mizo society are somewhat different. Those can be grouped into four conditional groups- modern, transitional, conservative and traditional (9) The modern type being mild, is respectful toward women's individuality, but the level of her autonomy and freedom is, however, an issue of negotiation with a man. In the transitional type the inequality is more highlighted and in which man takes a woman's opinion into consideration, often helps her in housework, however, the main decision maker in the family is the man. In conservative type customary division of roles with highlighted male dominance becomes a highlighting factor, though involvement of women in decision making and their respectful treatment are typical attributes. Violence is not spread but cannot be ruled out theoretically. In the fourth- traditional type- gender inequality is tradition-based relationship. The tradition endows a man to dominate and women to follow submission roles. Some forms of violence are witnessed in this type. One important aspect of this study is that in all the stated types women's sexuality restrictions are innate as she is perceived in the roles of mother only. This means that woman's sexuality is valued in the context of reproduction, rather than her individual happiness. One vital side of the stated types is that woman's sex restriction is innate 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 next to no affirmation of the importance of providing harm reduction services for FIDUs. The non-accessibility of needle-needle exchange programme with safer injecting practices knowledge and dearth of their accessing the male-dominated opioid substitution therapy by FIDUss their significant impediment in deflecting HIV disease.

'Female outreach workers meet us to inform us about the disease, provide condoms and advise 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 did not exist. 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]

A large portion of the KIs referred to the need for women-specific service rendering in the harm reduction programme. While female KIs opined that women's position in Mizo society was feeble and in this manner their necessities 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 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 against 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 a gynecologist in the hospital for a sexually transmitted infection that didn't subside with presumptive treatment at the ART centre. The doctor at the hospital noticed my ARTC green booklet (patient treatment history book) and hurriedly jotted down some medicine and without explaining anything*'.[FGD-1 participant#6] *'Should health service staff know that one is an addict, they attempt to send the patient backward on the queue or tell the person to go and come later"*.[FGD-2, participant#13]. Both the verbatims tend to indicate the felt experiences of respondents.

While stigma rose as a significant subject in the FGDs, a large portion of the KIs revealed that up until this point, no instance of FIDUs being segregated at healthcare facilities has surfaced and declared that anticipated stigma among FIDUs were prevailing. In any case, two of the KIs recognized that there was an absence of individual focused consideration that FIDUs with HIV positive status may have encountered: *'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 depicted how absence of employment opportunities and poverty in their communities set up an arrangement of negative social capital in which community members recognized the presence of drug peddling and drug markets on the grounds that these gave monetary chances to youngsters. Champai's topographical area proximate to permeable international border and influx of Chins tribe people of Myanmar, offering hoist to binds of drug trafficking and human trafficking. (11).

In 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 the north-east were either bereft of suitable knowledge on harm reduction and HIV or adopted a 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-

Female drug users of Champai observed not to possess the scope for drug treatment centers, nor the targeted intervention under harm reduction. However, those with HIV positive status have access to Antiretroviral Therapy and treatment of sexually transmitted infection. FGD participants described their unpleasant experiences at the general healthcare settings. Said one participant, *'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 logistical 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 de addiction 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 counseling 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 distinguished significant auxiliary and logical variables that should be considered for re-planning the preventive interventions and cultivating improved linkage among health service set-ups for Female drug users of Champai and might be for other weak locales 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, Drug Deaddiction Centres run under the control of the 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 users 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 partners 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 absence of income opportunities fosters an environment where negative social capital flourishes. This prompted the development of trafficking of human and illegal drugs that run an underground economy and provide community members with a source of income. Because of significant levels of social issues that go with that accompany the drug trafficking, young women, either straightforwardly or at the command of male accomplices, get involved in drug peddling and consequent drug chasing or injecting practices under peer influence. They are constrained into sex for cash or drugs. These findings propose the likely estimation of community-based interventions for supporting women in their endeavors to diminish their hazardous practices and encouraged to use health services. Notwithstanding these logical interventions, auxiliary and fundamental intercessions are expected to guarantee that the health system is receptive to the necessities of FIDUs. The National AIDS Control Organization has set up a gender sensitive interventions guideline, yet moderate usage at the ground levels in various states and not appropriately incorporated with enormous National projects of health, education and social security have not yielded the ideal results, up until now. 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 were meted to them.

Limitations and Future Direction

Several limitations of our findings should be noted. Firstly, our FGDs included FIDU members who were receiving antiretroviral treatment, and connected to a care and support center. Their records and encounters of stigma and discrimination may contrast from other ladies. It is without a doubt conceivable that our investigation might be thinking little of the effect of gender inequality among female drug users, in light of the fact that our purposively sampled participants were at that point getting to some psychosocial and ART administrations. Secondly, we were unable to assess the strength of the relationship between their encountered barriers and service utilization. Consequently, future quantitative studies are needed to examine the relationship between these variables and service use.

Conclusion

These findings propose community-based interventions for supporting women in their endeavors to diminish their hazardous practices and encouraged to use health services, for which targeted intervention on harm reduction in the state should incorporate covering FIDUs. Capacity building of healthcare staff and community members on gender sensitive issues, as well as stricter implementation of gender mainstreaming norms be followed across health, education and social security structures of the state.

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