UNODC
United Nations Office on Drugs and Crime

Country Office Pakistan

Female Drug Use in Pakistan

Mapping Estimates, Ethnographic Results & Behaviourial Assessment

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List of ACRONYMS

AIDS	Acquired Immunity Deficiency Syndrome
ANF	Anti Narcotic Force
CBO	Community based organizations
DIC	Drop In centre
DUs	Drug users
FDUs	Female drug users
FIDU	Female Injecting drug users
GIS	Geographical Information system
HASP	HIV AIDS Surveillance project
HIV	Human immunodeficiency virus
HR	Harm reduction
IDUs	Injecting drug users
KIs	Key informants
MARP	Most at risk populations
NACP	National AIDS Control Program
NGO	Non Governmental Organizations
NSDA's	National surveys on Drug abuse
QA	Quality assurance
SD	Standard Deviation
STI	Sexually transmitted Infections
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
VCT	Volunteer Counseling and testing

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Acknowledgments

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Last but not the least, the cooperation from female drug users, their spouses and families is immensely valued.

Vision Statement

UNODC aims to counter the sinister trilogy of drugs, crime and terrorism and help strengthen the virtuous triad of peace, security and development. In short, UNODC aspires to be the world's conscience on drugs and crime, reminding States of their commitments and raising awareness about the need for drug control and crime prevention. UNODC provides technical services to assist States and communities in preventing, resisting and reducing these threats.

Due to this comparative advantage within the United Nations system, UNODC has been given the responsibility to lead the UNAIDS response to HIV among injecting drug users and in prison settings. UNODC is mainstreaming HIV/AIDS into its activities globally and at regional and country levels, and is helping countries and civil society organizations to develop and implement comprehensive HIV/AIDS prevention and care programmes. UNODC also has a special mandate for facilitating the development of a United Nations response to HIV for people vulnerable to human trafficking. These most-at-risk marginalized populations are often subject to discrimination and violations of their human rights. Only few have access to HIV prevention, treatment and care services.

Executive Summary

This study is a part of the overall operational research which includes mapping and size estimation of female drug users, which forms the first key step in developing targeted interventions for this highly vulnerable key population. The results of this mapping study will assist in understanding the drug using scenario among female populations, which will ultimately form a baseline for service provision based on which service providing organizations will develop targeted interventions within a specific geographical setting. In addition to identification of geographical areas where these populations congregate, this study also provides valuable information on overall drug use situation in the targeted communities, economics of drug use, treatment history, criminal justice history, availability of treatment services and various religious and cultural barriers to accessing information and services among the target group.

The entire approach focused around involvement of the target community individuals, peer groups and key stakeholders of the project. Although data was collected by an independent research team, the project staff including peer group was involved in the data collection process. The basic approach was largely based on a geographic mapping approach which identified key locations where key population members were found and quantified. In addition to identifying the key locations, individual drug users were contacted through peer group members and supplemented by tracing contact chains from identified drug users to reaching other drug using females in a given location. This study was conducted in all cities where subsequently a service delivery programme through the project "HIV/AIDS prevention, treatment and care for FDUs and injecting drug users", was to be placed. After distributing each target site into zone, information on drug using populations was collected through Tertiary and Secondary Key Informants in each Zone to generate a list of Spots where FDUs could be found in this phase. Various drug treatment centers and rehabilitation programs in each city were also visited to obtain contacts of FDUs in that community. Pharmacies were also visited and information was gathered about various females, who have been buying non prescription drugs regularly. In addition locations where drug users could be found including graveyards, open spaces, shrines, darbars etc., were also visited. The basic objective in Phase one was to develop an exhaustive list of all FDUs in all zones within each city, which was later validated in Phase 02, by visiting each spot and interviewing female drug users and asking for contacts of their peers involved with drug use. Once contact information for other FDUs was provided by a subject, the social mobilizers along with the field team members traced that subject, and an interview with that subject was subsequently conducted.

The mapping study was followed by behavioral assessment, and the main data collection strategy involved face to face in-depth interviews of randomly selected FDUs in each site. A total number of 1,391 interviews were conducted in all 13 cities under study, and information obtained through these interviews was recorded in a pre-designed, pre-tested questionnaire. Data management was done by the data management team, and questionnaires after field editing were double entered in a data base designed in MS Access. Data set was thoroughly edited and cleaned, and data analysis was conducted using statistical software SPSS version 12.00. A total number of 3,538 interviews were conducted with both Secondary and Primary Key Informants.

Based on the data collected during Phase I and validated in Phase II, an estimated number of 4,632 FDUs spread over 2,479 locations were estimated in the 13 cities where mapping was conducted. As expected, the highest number of FDUs was estimated to be 1,213 in Karachi, followed by Lahore and Faisalabad, where the numbers were 593 and 511 respectively. On an average 1.8 ± 1.7 FDUs were reported from a single location, and 65.2% of the locations reported having a single FDU present. Unlike male drug users who congregate and use drugs with other drug users, drug use is a discreet, hidden and more of an individual activity for female drug users. Charas was the most common drug used by FDUs all over the country and 28% of the interviewed drug users reported that they used it in the last one month. Bhang was the next drug of choice reported, which was used by 14.2% of the FDUs interviewed. A fairly high proportion of females (13.6%) also reported to be using Heroin, while use of Pharmaceutical drugs was reported by 12.6% of drug users. Our study confirmed the available anecdotal information, that injecting is not a common route of drug intake among drug using females. A total of 71 female injecting drug users (FIDUs) were identified among the total estimated number of 4,632 FDUs, which calculated a prevalence of 1.5% of IDU among female drug users. Further to this, injecting drugs was reported from only 05 cities out of the 13 cities surveyed.

For behavioral assessments, a total number of 1,391 interviews were conducted. The mean age of the FDUs who participated in this study was reported to be 32.8 ± 9.6 yrs (median 32 yrs), while the maximum proportion (nearly 72%) of the drug users were between 21 to 40 yrs of age. Majority of the FDUs were illiterate; 66% of the FDUs interviewed did not receive any formal schooling. Nearly 60% of the interviewed females were currently married, while 15.6% reported to be never married. The remaining 24% were either widowed, or divorced/ separated from their husbands and were living separately. Ninety one % of the subjects interviewed belonged to the same city where they were interviewed and the majority was Punjabi speaking (45.3%).

Charas (Hash) was the most common drug used by FDUs all over the country and 58% of the interviewed drug users reported using it ever and also in the last six months. 42% reported that they had used it in the last month as well. Pharmaceutical drugs were the next drugs of choice followed by Heroin and Bhang. The behavioral data is in agreement with the results of the mapping study conducted in phase one, which also showed similar results on drug use and injecting drug use, which was reported from only 05 cities, with very few numbers of females reported to be injecting drugs. 41.5% of the injectors reported that they had been injected daily, while another 32% informed that they have injected at least once a week in the last 6 months. Although 30% of the injectors have been injecting alone, the remaining had been injecting in groups with other IDUs. Nearly half of the subjects informed that they had been sharing syringes with other IDUs.

The mean age of 1st sexual intercourse was reported to be 18.5 ± 3.7 yrs. A fairly high proportion were reported to be sexually active, with high numbers of sexual partners in the last 6 months (4.9 ± 16.2), suggesting they were sexually involved with a fairly large number of men. 13.5% of the FDUs reported to have sex with another male IDUs, and 25% reported selling sex for drugs or money. Only 3.7% reported that they always used a condom during the last 6 months.

Approximately 44% of the FDUs interviewed had ever heard of the disease called HIV/AIDS. Knowledge of sexual intercourse as a mode of transmission of the disease was prevalent among 40% of FSWs, but only 22% knew that HIV can be transmitted by sharp instrument/needles and syringes. 19.5% knew that HIV can spread through blood transfusion, while knowledge of mother to child transmission was still lower (9.8%). While the correct knowledge of HIV transmission was fairly low, a few misconceptions about transmission of HIV were also reported. While 17% of the respondents interviewed were aware of where they could be tested for HIV, nearly half of those had been tested for HIV. Thirty one % of the FDUs interviewed knew that there are diseases which spread because of sexual intercourse.

A very low proportion (13.2%) of the respondents reported that they have been treated at least once for drug use. The maximum proportion of drug users informed that they utilized private clinical facilities for treatment. This was followed by treatment services provided by NGOs and government hospitals which were 32% and 31% respectively. Nearly 11% of the FDUs interviewed that they have tried home based treatment for drug use as well. 73% of the respondent suggested that they need to be treated and showed a willingness to participate in a treatment program if offered.

Only 4.3% of the respondents reported that they were arrested for reasons such as drug use (60%), drug pushing (30%), sex work (5%) and other minor petty crimes (5%) e.g., theft etc., This study addressed some of the critical issues related to women drug use, which have not been dealt adequately in previous research conducted in Pakistan. Apparently, the problem drug use in women might appear insignificant and trivial when comparing the numbers of female drug users to the enormous number of male drug using populations in the country. However, drug use occurrence among women has an impact that goes beyond the individual and affects the entire social network of families with greater negative impacts on children.

Based on the conclusions of this research, an effective targeted response is necessary in order to promote safer behavior, improve access to effective health and social services, and to address the underlying structural and occupational dimensions of vulnerability. More research is warranted to gain more in depth understating of the populations, conduct more reliable size estimations and recognize the personal, environmental and social factors which lead to drug use among women. Efforts to minimize the stigma should be given high priority. Activities which

involve and facilitate collective actions, such as developing associations/unions and networks, and involving the media in a positive way should be encouraged. Families of FDUs should be focused to provide support for treatment and rehabilitation. Legal assistance should be provided to FDUs to manage drug offences, petty crime and issues of violence and harassment.

There is a need to broaden the focus of existing service delivery programs to address a broad and long-term perspective, and should incorporate "community based" and "women-centered" approach. The provision of *Drug abuse treatment services*, *comprehensive harm reduction services* through developing drop in centers, and providing *outreach services* through use of female outreach workers should be the broad focus of these services.

Special emphasis should be laid on meeting the mental health needs of the target population. Depression, isolation and a feeling of being useless is a fairly commonly characteristic shared by most women. While efforts are needed to improve the mental state of the individual, family members especially spouses need to be focused to provide a supporting mechanism for the recovering FDUs.

There is a need to building the right capacity within implementing organizations which equips the staff and resource personnel to deal with the issues of drug use among female using a professional and technical approach. Finally, a monitoring and evaluation framework is desired, followed by development of tools which are more user friendly and less punitive. The entire monitoring system should be managed by a management information system to provide timely and cost effective information for decision making, and effective management of the a.m., project in a systematic and timely manner.

Background & Introduction

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Chapter 1

1. Background and Introduction

1.1 Drug use in Pakistan a brief history

Pakistan has always confronted with a drug abuse problem ever since its existence and today, the country has the largest heroin consumer market in the south-west Asia region. While the entire region suffers from the drug trade in South Asia, Pakistan appears to be its worst victim. Opium and poppy have always been cultivated in the Northern parts of Pakistan[a]. Opium has been sold in licensed shops for decade's prior partition. After independence in 1947, the same laws were followed by the government until 1979, when the "Hadood' ordinance was passed. The ordinance placed a ban on the cultivation, production, sale and use of narcotics within Pakistan, which led to the closing down of legal outlets for drug, nevertheless, illegal availability of drugs continued. It was not until early 1980's, when Heroin infiltrated through the drug using scenes of Pakistan. Pakistan became a major exporter of heroin in the 1980s, following a massive influx of Afghan refugees in 1979. The major consequence of this has been a significant increase in domestic consumption of heroin in Pakistan. As a proportion of drug abusers, heroin users increased from 7.5 percent in 1983 to a shocking 51 percent in 1993[b,c,d]. Since then Heroin use has reached epidemic proportions in Pakistan affecting nearly every socio-economic group. Like many of other human development problems, the issue of drug abuse touches the most vulnerable: the majority of drug users in Pakistan belong to the poorest strata of society.

1.2 Recent drug use situation

The most recent drug use data available in Pakistan was collected through National Assessment of Problem Drug Use in 2006[e]. This study was conducted in 23 districts to update information on the patterns and trends of problem drug use in the country. The study estimated around 628,000 opioid users in Pakistan, 77 percent of who were heroin users (484,000). The highest prevalence of opioid use is in Baluchistan, followed by NWFP, Punjab and Sind. However in terms of absolute numbers with an estimated number of 200,000 the highest number of opioid users is in Punjab. While the majority of opioid users used heroin, the remainder were using opium and other opiates. Most of the opioid users were multiple or poly drug users, i.e., they were using more than one substance at a given time or during a day. Therefore many opioid users were using tranquilizers, antihistamines, and other opiates along with heroin as their primary drug of abuse. Among the opioid users, cannabis was most commonly the first substance ever used, usually at an age of around 18 years. However, many drug users had also initiated their substance use with other drugs such as alcohol, opium, heroin, benzodiazepines, opiates, tranquilizers, and inhalants.

A total number of 125,000 injecting drug users were estimated in the country. An alarming trend is that the estimated number of injecting drug users in Pakistan has doubled since 2000.

1.3 Drug use among females

Although addictive disorders have been the subject of widespread concern, relatively little is known about the causes, treatment, and prevention of these disorders in women. While substance abuse is more often reported by men and research to date has focused mainly on male substances users and abusers, substance abuse has generally been thought of as a problem of men. In many developed countries, drug abuse however, is no longer an exclusively or predominantly male activity. In general, male and female drug use patterns seem to be more even in industrialized countries. There is, however, hardly any information on abuse among women from developing countries, where official data suggests that drug abuse referrals are almost exclusively a male phenomenon. Yet,

a. Ikram ul Haq. Pakistan: from Hash to Heroin. Annoor Printers and Publishers. Lahore, Pakistan. 1991
b. National Survey on Drug Abuse in Pakistan. Narcotics Control Board, Islamabad. 1983
c. National Survey on Drug Abuse in Pakistan. Narcotics Control Board, Islamabad. 1989
d. National Survey on Drug Abuse in Pakistan. Narcotics Control Board, Islamabad. 1993
e. Problem Drug use in Pakistan. Results from year 2006 National Assessment. UNODC, Pakistan. 2007

there is growing evidence that it does appear that there is an overall increase in the numbers of women using drugs globally. One of the major factors which favor the increase of drug use among women is the transition of women from the traditional roles of mother and homemaker to that of an economic provider for the family. Although this can be considered a positive gain it can also impose greater levels of stress, and drug use is a possible response in the absence of other coping mechanisms[f].

There is a growing evidence that the effects of drug abuse and addiction do not always impact men and women in the same manner and the biological mechanisms involved in drug abuse and dependence are not identical in males and females. As happens generally with drug abuse, its occurrence among women has an impact that goes beyond the individual[g]. Research increasingly suggests that women may be more vulnerable than men to particular consequences of drug abuse, including addiction. This greater vulnerability may stem from gender-specific differences in motivations for drug use, differing sensitivities to drug effects, and a host of other biological and environmental factors. On the other hand, females who use drugs are more likely to be stigmatized by society than male drug users because their activities are considered to be doubly deviant: It is generally considered that drug use violates social norms of behavior, and many feel that drug use by females is even worse, as it diverges from the traditional expectations of women as wives, mothers, daughters and nurturers of families. Because of this stigma, females are more likely to conceal their drug using behavior, and working with FDUs becomes a very difficult area of public health intervention.

The drug use scenario among women is not different for Pakistan as well. The magnitude of substance abuse among women have either been "masked by national denial" or largely constrained by lack of an intelligent research approach which would have focused equal attention on substance abuse by women. All National surveys on Drug abuse (NSDA's) until 1993 were constrained in the matter of interviewing women because the interviewing teams consisted exclusively of male researchers who were, therefore, not able to find easy access to women as a result of Pakistan's segregated society[h]. Thus only a limited number of FDUs were interviewed and, due to their small number, it was reported that "the proportion of interviewed female abusers was negligible". The same pattern continued for many years until the 1993 NSDA revealed that nearly 3% percent of the drug users in Pakistan comprised of women. Some attention was therefore brought to the subject and a study on female drug use in Pakistan was launched by UNODC in 2000. Since then, while a number of research studies have been commissioned in Pakistan, however the subject has not been dealt with detail among female populations using drugs and a search of available research data reveal that not much information is available on drug abuse by women in Pakistan.

If an informed public policy is to be developed to better understand and combat addictive disorders in women, it is critical to gather updated information, ranging from the burden of the disease to diagnosis and from treatment to prevention. Recent advances in the field of scientific modeling of research data and a few size estimation studies conducted in Pakistan, do provide some rough estimates of drug using populations in the country, however with a missing gender focus, the exact number of FDUs in Pakistan is not known. Although there is a tendency to believe that the number of FDUs in Pakistan is far less than that of men, the actual situation may be concealed by an inadequate representation of women in all research activities conducted in the recent last.

1.4 Project Introduction

Owing to the unavailability of services for FDUs in Pakistan, the United Nations Office on Drugs and Crime in auspices of Ministry of Narcotics Control Project initiated the *"HIV/AIDS prevention, treatment and care for FDUs and female prisoners"* as a precursor to Join programming under 'One UN" initiative.

This project contains significant importance as is the only project specifically targeting female DUs/IDUs in the country. The primary goal of this project is to enhance the quality of services available to female injecting and non-injecting drug users (including those involved in sex work and spouses of male drug users) in the community and in prison settings by improving female access to existing harm reduction services and developing new female-specific

f. Denise B. Kandel, Lynn A. Warner and Ronald C. Kessler. 1994. The Epidemiology of Substance Use and Dependence among Women. National Institute of Drug Abuse.

g. MacGregor S. 2001. Women and the health and Social Consequences of Drug Abuse: implications for policy and practice. Background paper. Conference on Gender, Drugs and HIV. Guangxi Autonomous Region, China.

h. National Surveys on Drug Abuse in Pakistan. Narcotics Control Board, Islamabad. 1983 to 1993.

services and effective referral systems to female health service providers. Primarily the services are Volunteer Counseling and testing (VCT), Hepatitis B and C diagnosis, reproductive health care, STI prevention, diagnosis and syndrome management, psychosocial counseling, basic health care and hygiene services.

Following are the key outputs of the project:

- **Output 1:** To determine the characteristics and service needs of female injecting and non-injecting drug users, spouses of male injecting drug users and female prisoners, for provision of comprehensive HIV prevention, treatment care and support.
- **Output 2:** To develop an enabling environment, which provides conditions that support gender and culture sensitive approaches to HIV prevention, treatment, care and support services to female injecting and non-injecting drug users and female prisoners
- **Output 3:** Establishment of physical infrastructure for female injecting drug users.
- **Output 4:** Capacity building and training for medical practitioners and service providers from governmental and civil society organizations, in provision of gender-sensitive services to female injecting drug users and spouses of male injecting drug users.
- **Output 5:** Direct service provision of the comprehensive package in a gender and culture - sensitive manner.
- **Output 6:** Service delivery to female prisoners.
- **Output 7:** Monitoring and Evaluation

The novelty of this project is multifarious as it is the first ever effort to address HIV prevention, treatment and care for female IDUs and female prisoners in Pakistan. The project determines to sensitize the policy makers also to enhance the capacity of service providers, peer educators and prison staff. Through the course of this project, service providers will avidly learn important lessons about how service delivery needs to be tailored to the specific needs of women, especially in areas of access and approach and addressing broader concerns of FDUs health and family issues. Availability of Gender specific baseline drug related HIV data, regular access of female DUs/IDUs to gender-responsive Harm Reduction services and increased utilization of HR services with the change in risk behaviors being observed will contribute to achieving goals towards success of this project.

Last but not the least, this project proves its significance through avid acceptance by the community and recognition by other stakeholders. Strong outreach, establishment of gender harm reduction services, their linkages with other health services and quality services to female IDUs/DUs and female prisoners played vital role in its success.

1.5 Research Objectives

This study is a part of the overall operational research which includes mapping and size estimation of female drug users, which forms the first key step in developing targeted interventions for this highly vulnerable key population. Experience in diverse settings of South Asia has shown that structured mapping can provide accurate estimates of the size and location of key populations and thereby provide guidance for the scoping and targeting of HIV prevention programs and services. The results of this mapping study will assist in understanding the drug using scenario among female populations, which will ultimately form a baseline for service provision based on which service providing organizations will develop targeted interventions within a specific geographical setting. In addition to identification of geographical areas where these populations congregate, this study also provides valuable information on overall drug use situation in the targeted communities, economics of drug use, treatment history, criminal justice history, availability of treatment services and various religious and cultural barriers to accessing information and services among the target group.

Following are the key objectives of the study:

1. To conduct mapping of FDUs in the targeted cities, and develop a map of locations where FDUs could be reached.
2. To provide an estimated numbers of FDUs in the target city based on the results of mapping.
3. To conduct an ethnographic study among female drug which includes an analysis of the overall drug use situation in the targeted communities, drug use patterns, economics of drug use, treatment history, criminal justice history, availability of treatment services and various religious and cultural barriers to accessing information and services among the target group.

Methodology (Mapping)

2

Chapter 2

2. MAPPING Methodology

2.1 The basic approach

Drug use among women differs from that among men due to factors such as the reproductive role of women and the societal expectation of women to conform to a traditional role as opposed to engaging in deviant behaviors. From a methodological viewpoint, FDUs are more "hidden" than their male counterparts.

The entire approach therefore focused around involvement of the target community individuals, peer groups and key stakeholders of the project. Although data was collected by an independent research team, the project staff including peer group was involved in the data collection process, which served the following purposes:

- Ownership by the project staff in baseline data collection activity;
- Involvement of the peer group;
- Providing an efficient mechanism to develop initial contact with project beneficiaries and target populations to be followed up by service delivery;
- Capacity building of the project staff on research methodologies and data collection;
- Quality assurance of field data collection;

Box 1. Operational definition of Female drug users

For the purpose of this study, female drug users were defined as *"any female, currently living in the target area, who has used any sort of drugs for non therapeutic purposes in the last 6 months, at least once weekly"*

The main data collection strategies utilized in this study therefore involved a number of qualitative and quantitative techniques to gather data which will help in development of programmatic approaches to combat drug use and HIV AIDS. The basic approach was largely based on a geographic mapping approach[a] which identified key locations where key population members were found and quantified. In addition to identifying the key locations, individual drug users were contacted through peer group members and supplemented by tracing contact chains from identified drug users to reaching other drug using females in a given location. The final stage of information consisted of data triangulation and developing a city wide estimate through combining zonal estimates and removing duplicates.

The data collected through the Mapping approach[1] described above was supplemented by ethnographic data collection to have in-depth understandings in specific social contexts of female drug use.

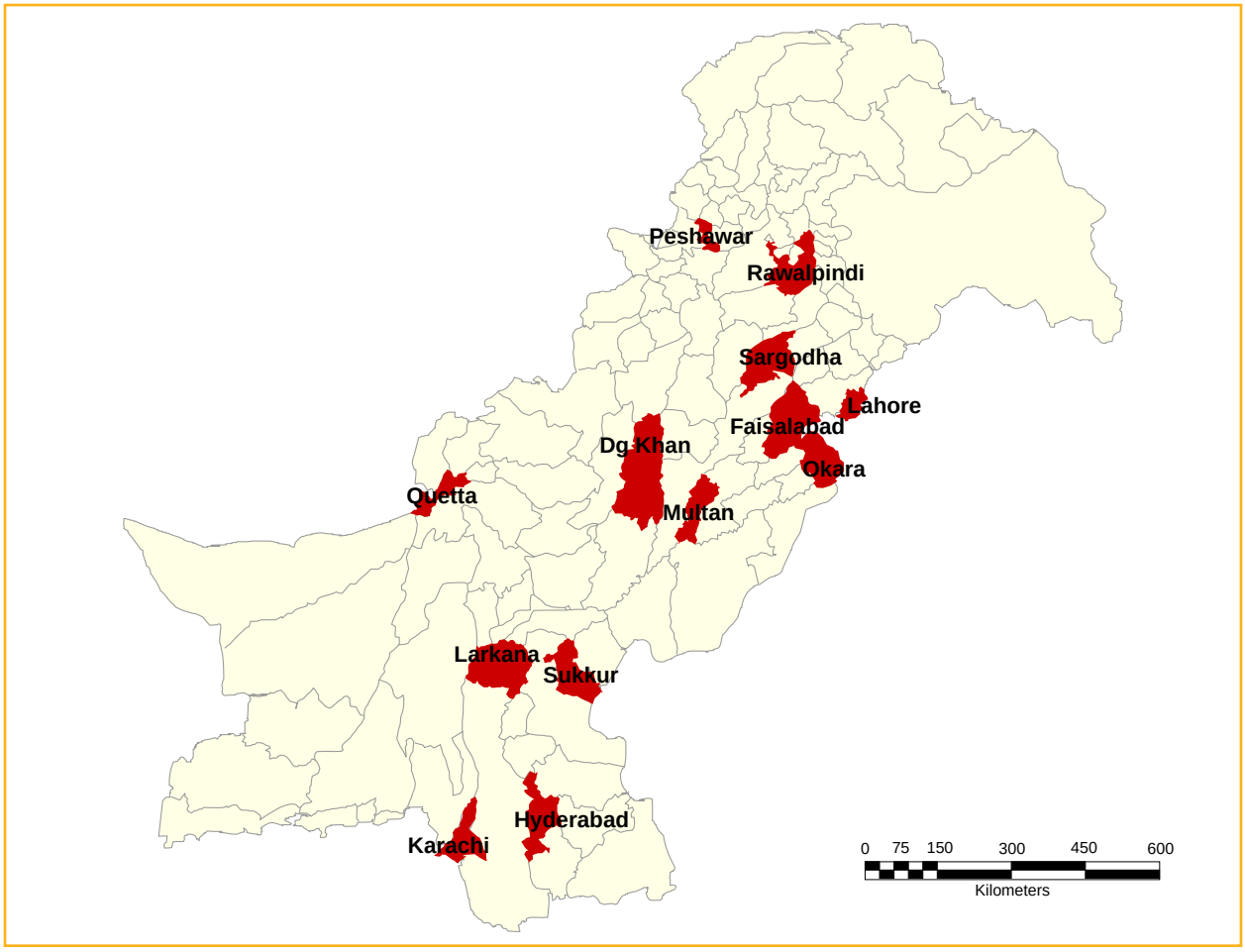
2.2 Target area selection

This study was conducted in all cities where subsequently a service delivery programme through the project "HIV/AIDS prevention, treatment and care for FDUs and injecting drug users", was to be placed[b].

a. The mapping approach was adapted from the geographical mapping approach devised by the Centre for Global Public Health - University of Manitoba (CGPH-UofM) and has been successfully implemented with MARPs including drug using populations in Pakistan, India, Sri Lanka, China, Afghanistan and Bhutan.

b. The cities selected for this study were identified from the HIV AIDS Surveillance Project data,

Fig 2.2a Map of Pakistan showing target cities for mapping and behavioral assessment



Names of the cities where this research was implemented are given in Table 2.2a

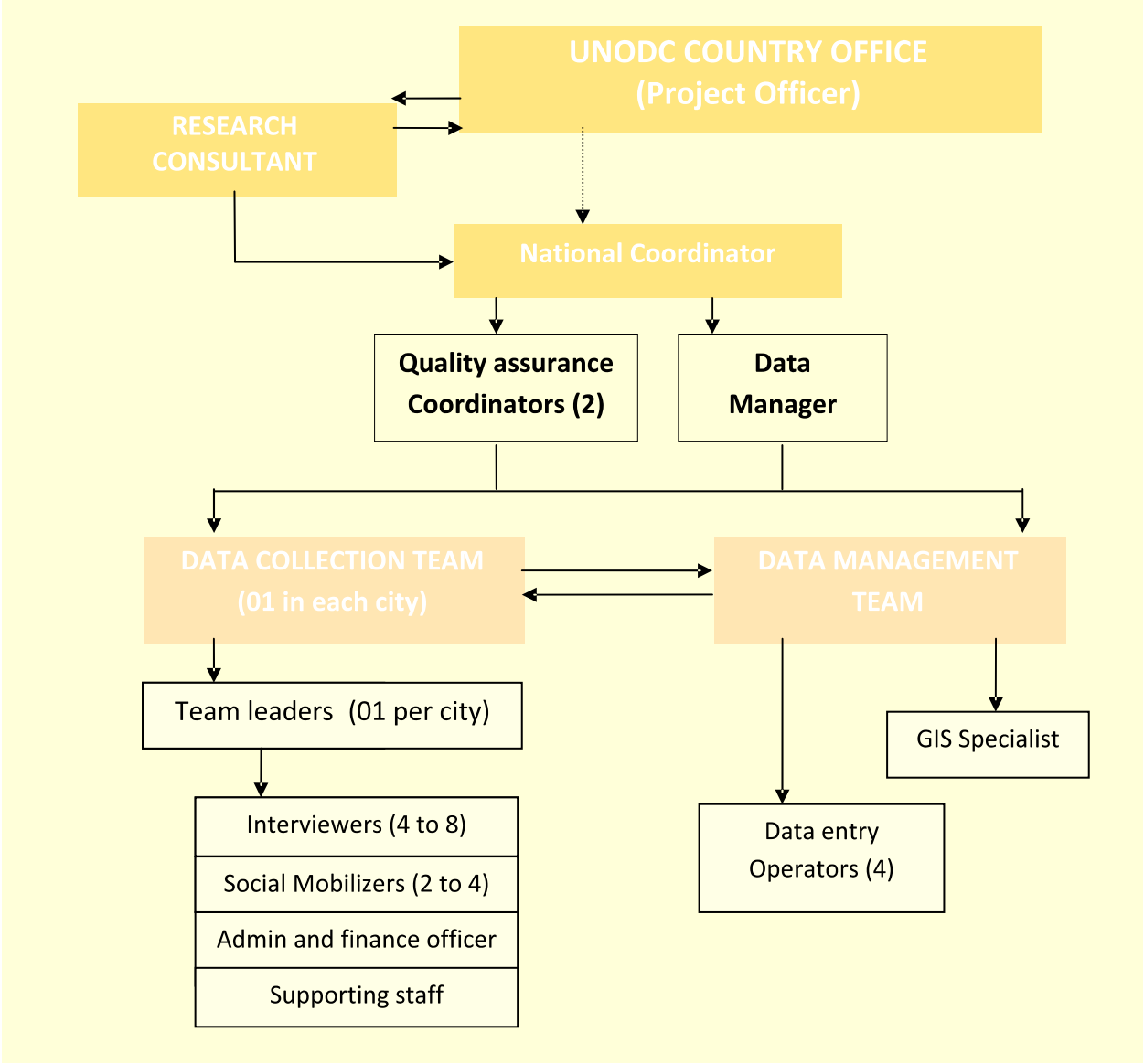
Table 2.2a Cities where mapping studies was conducted

Punjab	Sindh	Balochistan	Khyber Pakhtoon Khwa
Lahore	Karachi	Quetta	Peshawar
Faisalabad	Hyderabad		
Multan	Sukkhur		
Rawalpindi	Larkana		
Sargodha			
Okara			
Dera Ghazi Khan			

2.3 Project Implementation & Field teams

UNODC country office Pakistan took a lead role on conducting this research, and was the chief implementing body for this study. A technical research consultant (Epidemiologist) was hired having a wide range of experience in conducting similar mapping and behavioral studies of most at risk populations in Pakistan and South Asia. The consultant provided technical support to the project, while field data collection was done by a research organization, which worked in close collaboration with local NGOs and Community based organizations (CBOs) who had a fair bit of experience working with the targeted population. A number of meetings were held between the research consultant and UNODC project staff to delineate the scope of the research, define objectives and finalize the operational methodologies. Followed up with these technical meetings with UNODC, the Research Protocol for the mapping study and ethnographic study was developed by the research consultant and after approval by the Project steering committee, the operational work plan was finalized and selection of field teams was done. An organizational structure of the field team is provided in Fig 2.3a.

Fig 2.3a Organizational structure of the field team



Field work was implemented by the research organization and a National coordinator along with two Quality Assurance coordinators supervised the field work. Supportive technical support was provided by the technical consultant and UNODC project officers coordinated the overall study. Team leaders were hired within each city, who managed a field team comprising of field researchers /interviewers and social mobilizers. Social mobilizers were members of the key population themselves, who supported the field researchers in developing contacts with the drug using populations and facilitating the interview process. The National coordinator along with quality assurance coordinators were responsible for the overall planning and implementation of field work, as well maintaining the quality of data collected. In addition to the field teams, a Data management team worked under supervision of Data manager, who worked with a GIS specialist and 04 data entry operators for the data management of the research study.

2.4 Field Operations "The Premapping Stage"

The pre-mapping exercise served as a preparatory activity to establish the necessary logistical and conceptual foundations for the mapping data collection. The key aspects of the pre-mapping exercise included:

2.4.1 Training of the field teams

The core field staff participated in a three day "Master trainers workshop" organized by UNODC from 7th to 9th January 2010 in Islamabad. The "Master trainers" included the National Coordinator, QA Coordinators, Data Manager and Team Leaders from all cities. The core staff training was conducted by the Research Consultant and UNODC project staff, and focused on providing information and points of clarification to the interviewers on issues such as:

- Understanding mapping and basic concept of geographic mapping
- The overall mapping methodology
- Basic interviewing skills with special emphases on interviewing about drug use
- HIV/AIDS: facts and myths
- Ethical issues including confidentiality
- Communication, values and attitudes
- Risk mitigation and conflict resolution
- Different aspects of field work
- accessing vulnerable groups
- explaining the rationale and objectives of the study to the subjects
- getting consent for interview
- the interviewing process
- probing and translating information on formats

In addition to training on the technical working methodology, preparation of job descriptions for the staff, development of a field monitoring process and a detailed work plan for field work were also key activities undertaken during the pre- mapping phase. Following were the dates of field activity in both districts an operation field plan was also developed in consultation with the Team leaders. A working time line was also decided.

2.4.2 Acquisition of maps and Geographical zoning of the target area

The next step was dividing the target area under study into smaller data collection geographical units referred to as "Zones" which was followed by acquisition of detailed city maps from the Geological Survey of Pakistan and District Council Offices. The cities were divided into zones on the basis of the distribution of the population, and all zones were marked on the physical maps. In addition to the physical maps, GIS maps were also developed by the GIS specialist and the data base manager.

2.4.3 Involvement of stakeholders

The populations under study are difficult to reach and in order to get meaningful cooperation from them it is crucial to develop a rapport. The entire approach of this study focused around involvement of the target community individuals and peer group members at every stage of the study, thus gaining their support and endorsement. A number of these individuals (peers) were hired for our research activity as social mobilizers, which helped open doors to the more hidden segments of these populations.

2.4.4 Field Operations Phase One

Field researchers collected information from Tertiary and Secondary Key Informants in each Zone to generate a list of Spots where FDUs could be found in this phase. As already mentioned, interviewers teamed up with members of the high risk community to gather information on the various spots where high risk activities are conducted. This included visiting various spots of drug activity, and inquiring about any FDUs found at any of the spot. In addition to inquiring about FDUs at the spots, male drug users were inquired if they had any female associates, friends or family members involved in drug use. Various drug treatment centers and rehabilitation programs in each city were also visited to obtain contacts of FDUs in that community. Pharmacies were also visited and information was gathered about various females, who have been buying non prescription drugs regularly. In addition locations where drug users could be found including graveyards, open spaces, shrines, darbars etc., were also visited. The basic objective in Phase one was to develop an exhaustive list of all FDUs in all zones within each city, which could later be validated in Phase 02. Phase 01 interviews began as a casual conversation with the secondary KI to build rapport and later to discretely gather information on FDUs. Where time allowed, snowball sampling methods were followed. Verbal consent was obtained from the secondary KIs during the interview.

2.4.5 Field Operations Phase Two

The next step in data collection involved meeting female drug users, and gathering information from them through detailed focused interviews and asking for contacts of their peers involved with drug use. This was an extremely strenuous activity, which started from tracing a FDU from information available through phase one activity, developing a rapport with the target community and gathering key information about the subject on key socio-demographic variables, drug use history, injecting drug use and also asking them to provide more information on their drug using peers. The entire process of locating drug users and convincing them for participation in the study was facilitated by the social mobilizers. Local FDUs who were willing to support the field teams in this research were recruited as field staff members, who played a pivotal role in getting the field work done.

Once contact information for other FDUs was provided by a subject, the social mobilizers along with the field team members traced that subject, and an interview with that subject was subsequently conducted. In many of the instances FDUs accompanied field teams to introduce them to their peer group members. Therefore, phase two was conducted with a much greater involvement of the drug using communities themselves, and a very high level of cooperation from FDUs was noticed. The contact chains thus formed were traced by the study team, until no further contact could be traced, or one of the FDU already interviewed was referred by a fellow peer member. The process therefore resembled much like a snow ball approach where contact chains were followed by the study team. Within the available time of the study, the research team was able to validate information on nearly half of the FDUs identified. The validation was much higher for FDUs in smaller cities in comparison to the larger cities, where distance and commuting time was the biggest limiting factor.

2.5 Data management and analysis

Pre-set data forms were field edited by the field team on a daily basis and corrected for any missing information. Field edited forms were then transported to the data management unit in Lahore, where entire data set was entered on Excel spread sheets. The data management was done under supervision of a qualified and experienced data base manager, who worked with site based team leaders in managing project data.

The final analysis was conducted the research consultant. The data set after entering was edited and cleaned, duplicates were removed and final data was used for generating final estimates and lists of locations. To obtain this, the estimate ranges for each site and location were rolled up for a zone and finally added up produce estimates for a city.

Results (Mapping)

3

Chapter 3

3. Results of the Mapping study

3.1 Number of interviews conducted

A total number of 3,538 interviews were conducted with both Secondary and Primary Key Informants. As mentioned earlier, Secondary KIs are people who are in an indirect contact with FDUs and included a variety of people. Thus secondary KIs for this study included male drug users, pharmacy owners, drug pushers, hawkers, beggars, street hawkers, taxi/rickshaw drivers, NGO staff as well as various medics and paramedics. A total number of 1,239 such interviews were conducted in phase I of the study, when information on spots, and drug using networks were obtained.

Since the methodology used for mapping demanded direct contact with FDUs for contact tracing and validating information, a higher number of interviews (2,299) were conducted with the Primary KI's i.e, female drug users. Details on the interviews conducted with FDUs and secondary KIs is provided in Table 4.1a.

Table 4.1a No of interviews conducted in the target cities

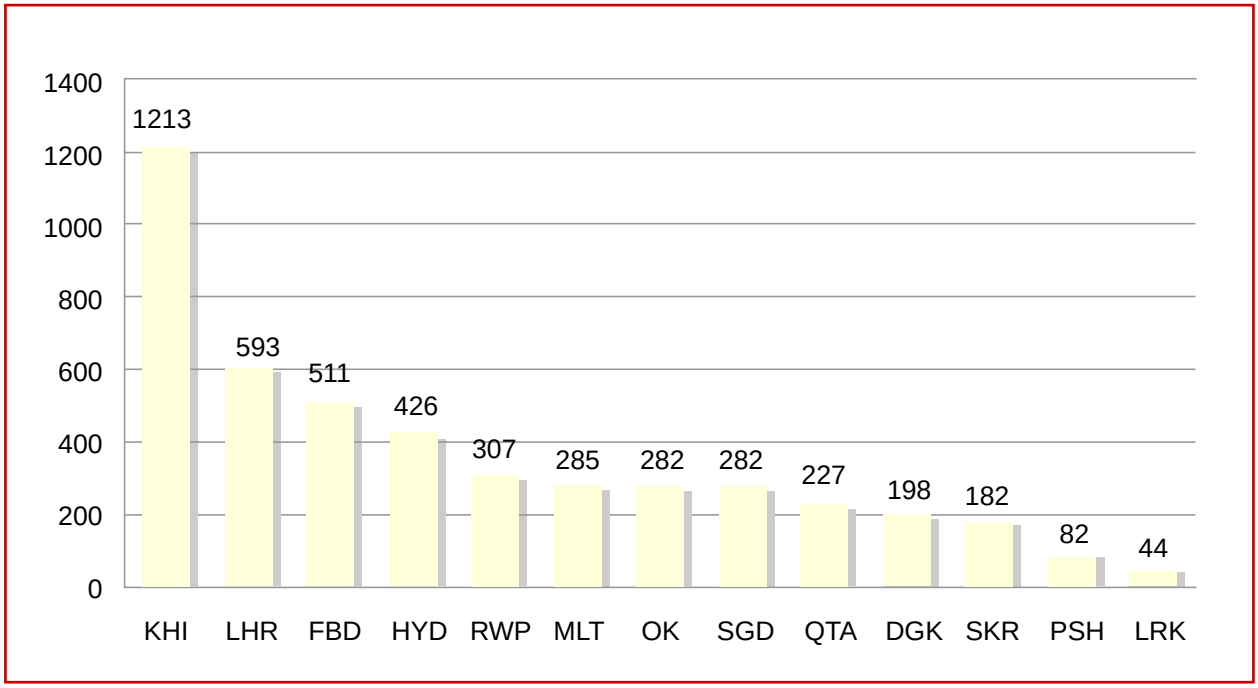
City	Secondary KI Interviews	Primary KI Interviews	Total number of interviews	Validation %
DGK	48	172	220	86.9
FBD	121	157	278	30.7
HYD	87	163	250	38.3
KHI	268	535	803	44.1
LHR	227	331	558	55.8
LRK	32	27	59	61.4
MLT	76	175	251	61.4
OK	66	143	209	50.7
PSH	32	63	95	76.8
QTA	44	197	241	86.8
RWP	143	101	244	32.9
SGD	64	95	159	33.7
SKR	31	140	171	76.9
OVERALL	1239	2299	3538	49.6

The table also provides information on the proportion of data which was validated. Validation means that these were the numbers of FDUs who were actually tracked by the data collecting staff and were met in person by one of the member of the data collection team.

3.2 Total Estimates of FDUs

Based on the data collected during Phase I and validated in Phase II, an estimated number of 4,632 FDUs spread over 2,479 locations were estimated in the 13 cities where mapping was conducted. As expected, the highest number of FDUs was estimated to be 1,213 in Karachi, followed by Lahore and Faisalabad, where the numbers were 593 and 511 respectively.

Fig 3.2a Estimated number of FDUs in targeted cities in Pakistan



The minimum number of drug users was reported to be 44 from Larkana. Although being a large city and the provincial capital of Khyber Pakhtoon Khua province, (formerly known as NWFP) Peshawar, also reported a fairly lower number of drug users. In comparison to other cities, Okara and Sukkhur though considered as small towns showed a fairly high number of drug using females.

3.3 Zone wise Distribution of FDUs

As discussed earlier each target city was divided into further smaller geographical units called zones, and data were collected within each zone. The following table presents the number of zones in which each targeted city was divided into, and the number of FDUs estimated for each zone.

Karachi was divided into 19 zones (18 towns and 1 Cantonment area), while Lahore, Multan and Okara were divided into 8, 7 and 5 zones respectively. Faisalabad, DG Khan, Hyderabad, Rawalpindi and Quetta were divided into 4 zones each while the number of zones in Peshawar, Sargodha and Sukkhur were 2 each.

Estimates generated within zones showed interesting findings which have wider programmatic implications. Geographical distribution of FDUs in Karachi is shown in Fig 4.3a. The maps are color coded in a manner which shows zones with higher concentration of FDUs in darker color. Thus zone 8 (Gulshan-e-Iqbal) and zone 11 (North Nazimabad) have the highest concentration of FDUs. No FDUs were reported from the cantonment areas which are therefore shown as the lightest color zones in the distribution maps.

Table 3.3a Zone wise Distribution of FDUs in target cities

City	No of zones	No of FDUs	City	No of zones	No of FDUs	City	No of zones	No of FDUs
KARACHI	1	42	DG KHAN	1	60	LAHORE	1	94
	2	49		2	33		2	46
	3	40		3	53		3	22
	4	59		4	52		4	50
	5	50	FBD	1	33		5	59
	6	71		2	286		6	178
	7	65		3	103		7	8
	8	63		4	89		8	136
	9	111	HYD	1	143	LARKANA	1	16
	10	77		2	99		2	12
	11	84		3	87		3	16
	12	65		4	97	MULTAN	2	33
	13	105	OKARA	1	45		3	3
	14	38		2	47		4	17
	15	65		3	32		5	145
	16	71		4	40		6	61
	17	51		5	118		7	26
	18	52	RWP	1	93	QTA	1	71
	19	55		2	105		2	67
PSH	1	15		3	53		3	57
	2	67		4	56		4	32
SKR	1	9	SGD	1	170			
	2	173		2	112			

Likewise in several cities including Faisalabad, Hyderabad, Rawalpindi and Multan, fairly high numbers of FDUs were reported to be concentrated within specific zones. Thus zone 2 in Faisalabad which inhabited more than half of the overall number of FDUs in Faisalabad and suggests that this zone should be the focus of major preventive services. Likewise in Multan zone 5, and zone 5 in Okara should be the centre of preventive activities of any service delivery program[k].

The distribution map of Lahore (see Fig 3.3b) also presents a similar picture, in which zone 7 and 8 are darker areas showing higher concentration of FDUs in these zones. Zones which formed Cantonment and Wagah area did not report any FDUs. Remaining zones showed varying numbers of FDUs as shown by darker colors in the map.

k. Maps for all cities are presented in annex 01 at the end of this report.

Fig 3.3a Geographical distribution of FDUs in Karachi

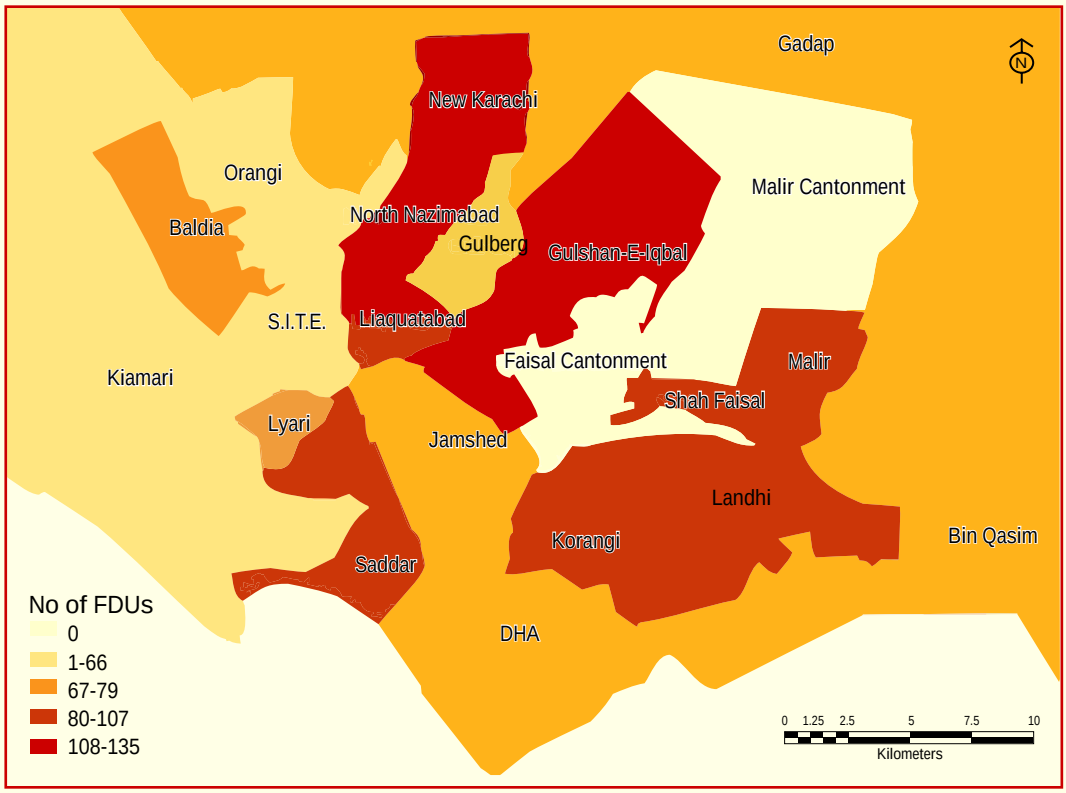
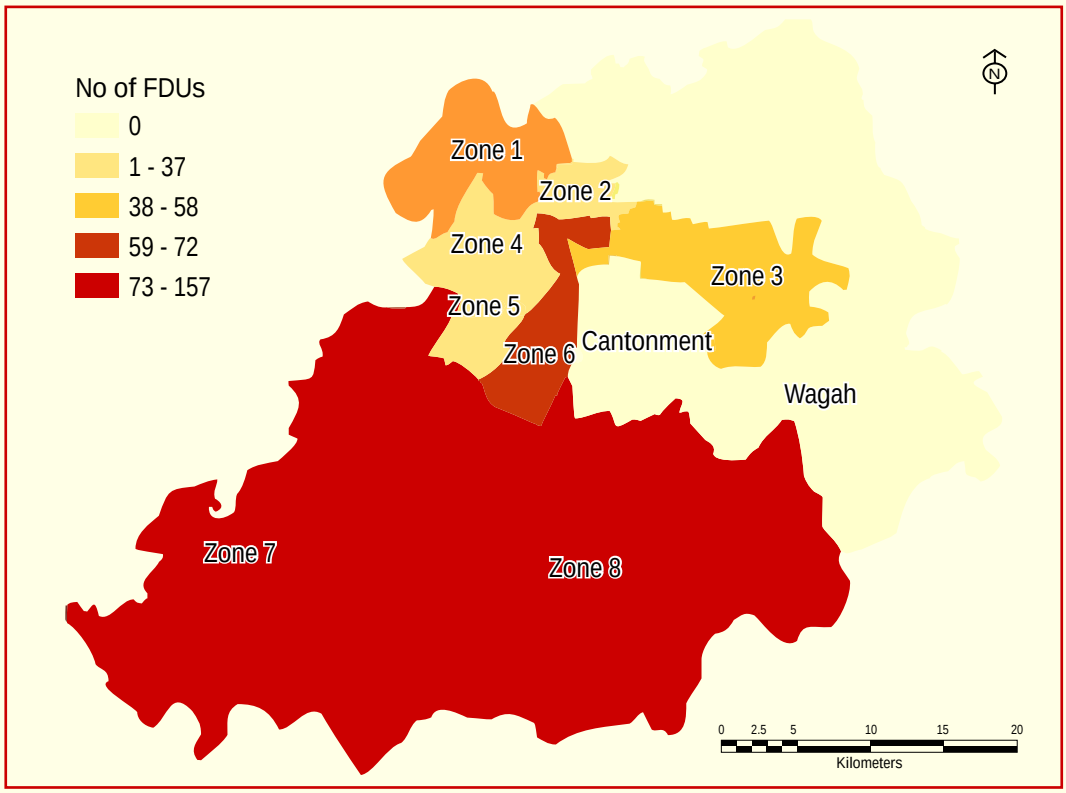


Fig 3.3b Geographical distribution of FDUs in Lahore



3.4 Locations[1] of FDUs in targeted cities

Table 3.4a provides details on the estimated number along with the number of locations where these drug users are found in each city. The table provides mean number of FDUs reported at each location and the proportion of locations which reported a single FDU. A total number of 4,632 drug users identified in this study were reported to be spread over 2,479 locations. On an average 1.8 ± 1.7 FDUs were reported from a single location, and 65.2% of the locations reported having a single FDU present.

Table 3.4a Estimated Numbers and Locations of FDUs in target cities

City	Estimated Number	Locations	Mean ± SD FDU per location	Locations with single FDU
DG Khan	198	99	2.0 ± 1.9	55.6%
Faisalabad	511	397	1.3 ± 0.7	82.1%
Hyderabad	426	203	2.1 ± 1.9	54.7%
Karachi	1,213	610	2.0 ± 1.9	67.4%
Lahore	593	272	2.2 ± 1.9	54.4%
Larkana	44	24	1.8 ± 1.9	70.8%
Multan	285	139	2.0 ± 1.7	55.4%
Okara	282	127	2.2 ± 2.1	56.7%
Peshawar	82	33	2.5 ± 1.9	36.4%
Quetta	227	146	1.5 ± 0.9	65.1%
Rawalpindi	307	195	1.5 ± 1.0	68.7%
Sargodha	282	203	1.4 ± 0.8	74.4%
Sukkhur	182	31	5.8 ± 5.4	22.6%
OVERALL	4,632	2,479	1.8 ± 1.7	65.2%

These results reveal that large spots and locations for FDUs do not exist, and drug use among females is more of an individual activity. Thus the male drug use and female drug use in Pakistan operate in different cultures and unlike male drug users who congregate and use drugs with other drug users, drug use is a discreet, hidden and more of an individual activity for female drug users. No large intercity variations were noticed except for Sukkhur, where large number of FDUs (5.8 ± 5.4) were reported to exist at each location.

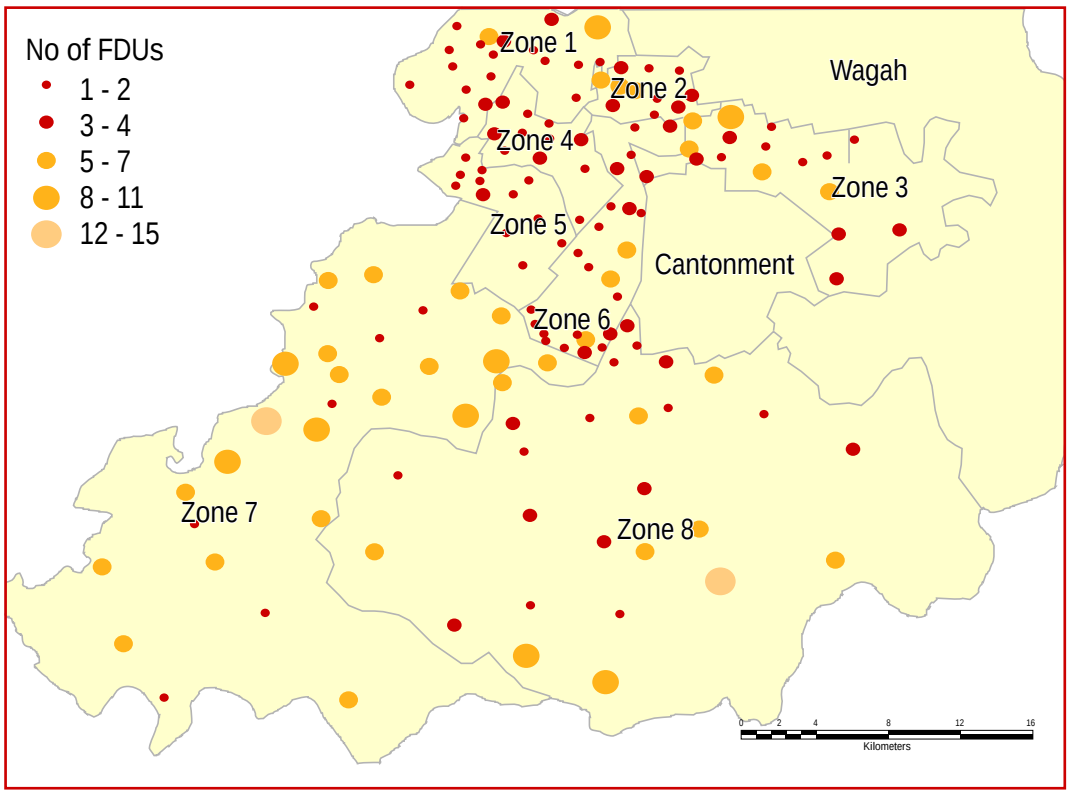
We further developed spot maps for all the cities that were mapped. Generally the maps entail that drug use among females is a geographically dispersed activity and have larger implications for provision of service delivery.

Fig 4.4a shows the spot map for Lahore. The spots are seen to be more concentrated in the Northern part of the city, while are more dispersed in the southern part. However it is worth noting that although more spots are located in the Northern part, the size of these spots is smaller and lower numbers of FDUs are seen at each spot. On the other hand spots in the Southern zones are large and higher numbers of FDUs congregate at these spots.

Spot maps of the other cities where this study was conducted are given in annex 1.

I. A list of locations/spots where FDUs are reported is not provided in this report due to Confidentiality issues. This list of these locations is available with country office UNODC Pakistan, which can be contacted for availability of this information.

Fig 4.4a Geographical spots of FDUs in Lahore



3.5 Types of drugs used

Further analysis focused on the various types of drugs used by female drug users. The drugs evaluated were Heroin, Hashish; locally known as Charas, as well as various Pharmaceutical drugs which are freely available in Pakistan "over the counter". This group included various Antihistamines, Benzodiazepines, Antipsychotic and Narcotic analgesics. The study also looked at the use of Afheem; Opium and Bhang; Cannabis in these women and gathered information on the use of inhalants which largely included locally available glues and adhesive solutions.

Fig 3.5a Types of drugs used by FDUs in Pakistan

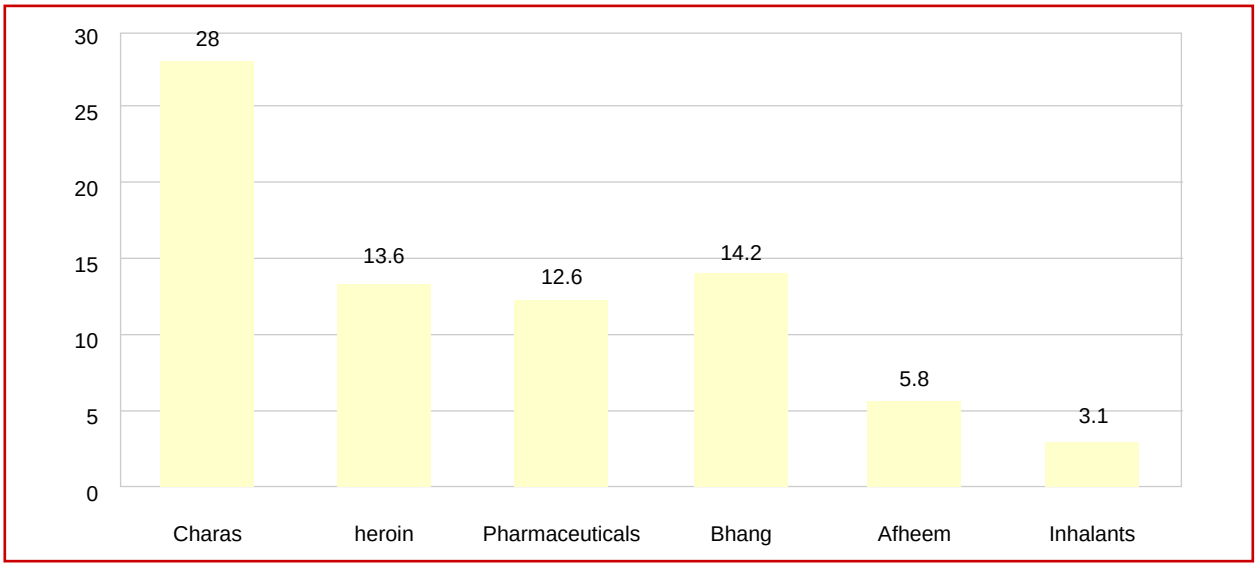


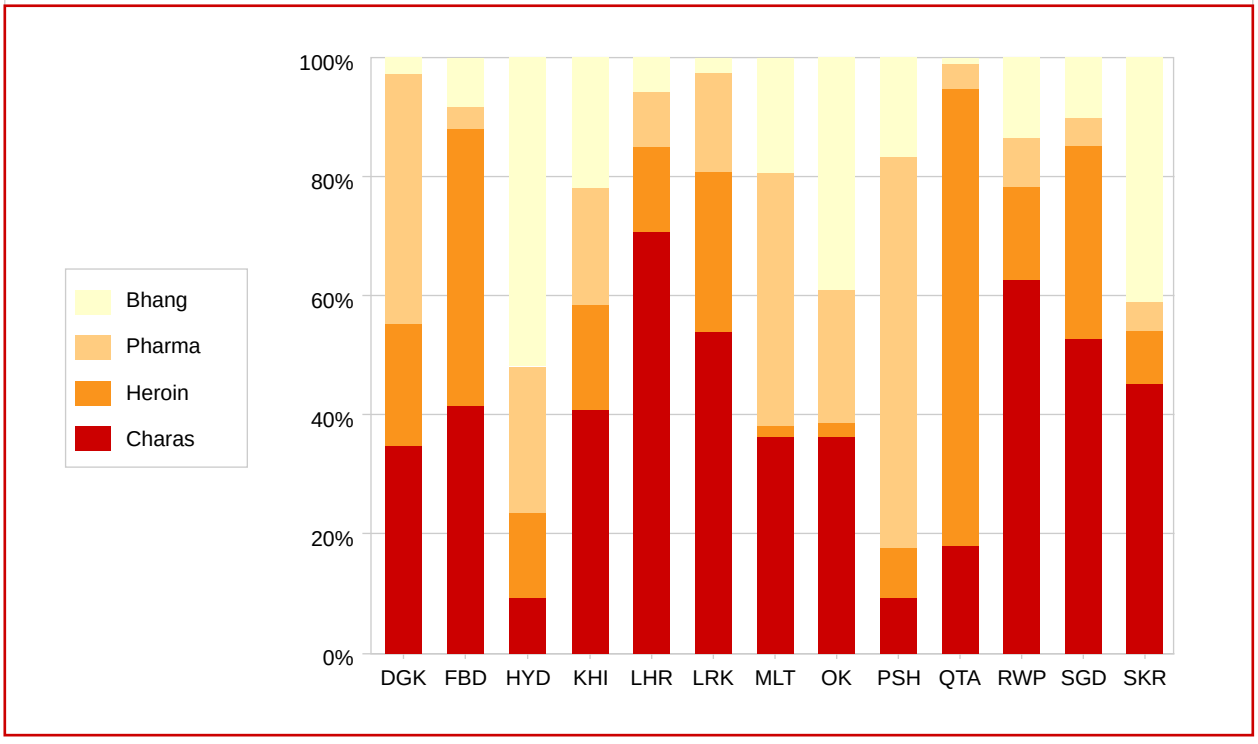
Fig 3.5a shows the proportion of various drugs used by drug users interviewed for this study. Charas was the most common drug used by FDUs all over the country and 28% of the interviewed drug users reported that they used it in the last one month. Bhang was the next drug of choice reported, which was used by 14.2% of the FDUs interviewed. A fairly high proportion of females (13.6%) also reported to be using Heroin, while use of Pharmaceutical drugs was reported by 12.6% of drug users.

We further looked at drug use by stratifying data by various cities. This analysis was done for the 04 major drugs used by FDUs, which included Charas, Heroin, Bhang and various Pharmaceutical drugs available over the counter.

Charas was reported to be the major drug of choice in most of the cities from where data were collected. Nearly all cities in Punjab and Sind other than Hyderabad had high number of females who were using Charas on a regular basis. The next most used drug was Bhang, which also showed a relatively higher presence in nearly all cities surveyed except DG Khan, Lahore and Larkana. The highest proportion of Bhang users were reported from Sukkhur, while Okara, Multan, Karachi and Hyderabad also reported substantial use of Bhang among females. Heroin use, which is regarded as the drug with the highest deteriorating impact on the life of drug users, was reported to be most prevalent in Quetta. While some presence of heroin was reported from each city the larger numbers were reported from Faisalabad, Larkana, Karachi and Sargodha. The use of Pharmaceutical drugs which is a relatively new phenomenon in Pakistan was also reported from most cities in Pakistan. These drugs were reported to be used by a higher number of females in DG Khan, Hyderabad, Karachi, Okara and Multan. The highest numbers of Pharmaceutical drug users was reported from Peshawar.

We further compared the drug use scenarios among various provincial capitals, to understand the major differences in drug use across major cities in Pakistan. Karachi, which is the largest city in Pakistan and inhabits the maximum number of drug users in all cities showed a relatively equal distribution of all drugs which were evaluated for this analysis. Thus Karachi presents a fairly complicated drug use situation, where all drugs of concern are in use. In comparison, Lahore has a much higher numbers of Charas using females (more than half of the drug using females are addicted to the use of Charas), followed by heroin and Pharmaceutical drugs. Quetta and Peshawar however showed a contrasting picture to that of Karachi and Lahore. Results from Peshawar were fairly surprising, as the largest drug using populations were

Fig 3.5b Type of drugs used by FDUs in the targeted cities



using Pharmaceutical drugs available over the counter. This information was further triangulated with the service providing organizations in Peshawar, and similar results were notified. Quetta on the other hand reported to have the highest proportion of Heroin using females all across the country, which warrants a much critical and grievous situation, demanding urgent attention.

3.6 Female Injecting drug users (FIDUs)

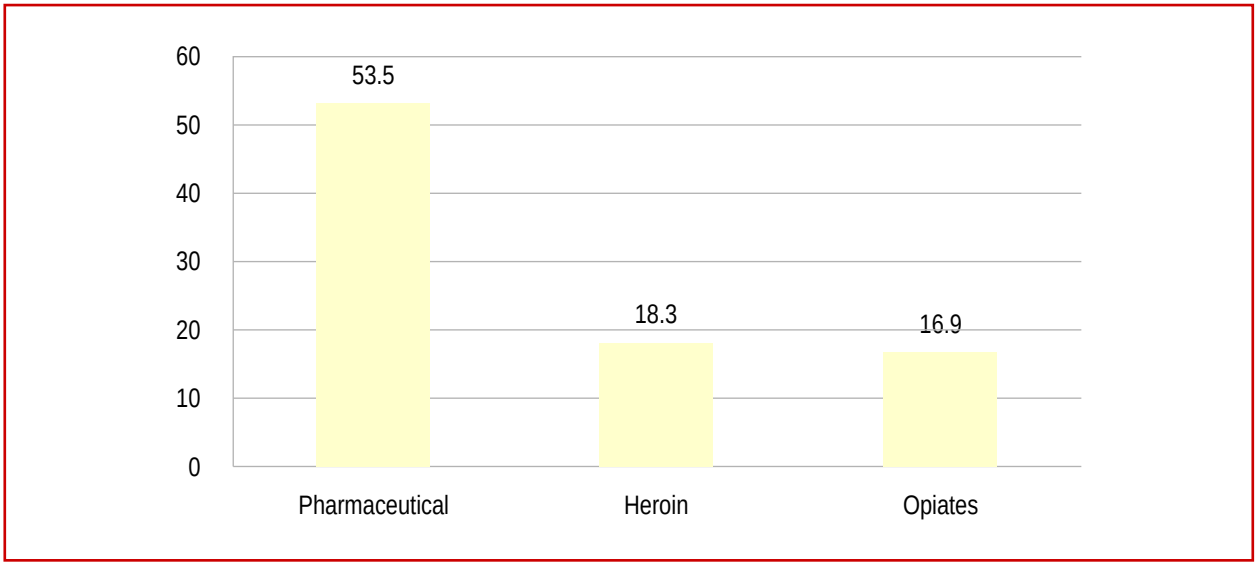
Since Injecting drug use (IDUs) is not a very common phenomenon among female drug users, we collected information on IDU as "ever injected drugs", which is presented in this section. Our study confirmed the available anecdotal information, that injecting is not a common route of drug intake among drug using females. A total of 71 female injecting drug users (FIDUs) were identified among the total estimated number of 4,632 FDUs, which calculated a prevalence of 1.5% of IDU among female drug users. Further to this, injecting drugs was reported from only 05 cities out of the 13 cities surveyed. The results are shown in Table 3.6a.

Table 3.6a Estimated number of FIDUs in the targeted cities

City	Estimated No of FDUs	Estimated No of FIDUs	% IDUs
Hyderabad	426	08	4.9%
Karachi	1,213	28	5.2%
Lahore	593	12	3.8%
Quetta	227	13	5.7%
Sukkhur	182	10	7.1%
TOTAL (in 13 cities)	4,632	71	1.5%

We further looked at the various drugs which have been mainly used for injection. Pharmaceutical drugs are the most common drugs injected, which were reported to be used for injecting by 53.5% of the FIDUs. This was followed by Heroin and opiates which were injected by 18.3% and 16.9% of the FIDUs respectively.

Fig 3.6a Types of drugs injected by FDUs in Pakistan



Methodology (Behavioral Assessment)

4

Chapter 4

4. Methodology of Behavioral Assessments

4.1 The basic approach

As mapping was done, the field data collection approach for collecting behavioural information also focused around involvement of the target community individuals, peer groups and key stakeholders of the project. At most of the sites, data were collected by the research team, with involvement of the project staff (wherever project is being implemented) and included peer group members in the data collection process.

The main data collection strategy involved face to face in-depth interviews of randomly selected FDUs in each site. Information obtained through these interviews was recorded in a pre-designed, pre-tested questionnaire. Data management was done by the data management team, and questionnaires after field editing were double entered in a data base designed in MS Access. Data set was thoroughly edited and cleaned, and data analysis was conducted using statistical software SPSS version 12.00.

4.2 Sample size & sample allocation in target cities

Sample size for behavioural assessment was determined using the following formula:

$$n = \left(\frac{Z_{a/2}}{E}\right)^2 pq$$

Box. 4.1a Case definition of FDUs

For the purpose of this assessment, the following case definition for female drug users was used "any female, currently living in the target area, who has used any sort of drugs for non therapeutic purposes in the last 6 months and at least once weekly"

Sample size was calculated based on assumptions in which baseline prevalence and expected change in prevalence were varied to get a maximum sample size:

P = estimated prevalence at baseline was set at 0.5

E = bound on the error was set at 0.04

Z_1 = 95% level of significance

Based on the calculations, a total number of 601 individuals were required for this study. This sample was multiplied with a design effect of 2 and further inflated by 10 % to adjust for non response and data entry errors. The final sample size calculated for this study was found to be 1422.

The number of FDUs to be interviewed at each site was determined by the number of FDUs identified at each site through the mapping study, and a proportionate allocation of the sample size of 1422 was done as shown in Table 4.2a.

Table 4.2a.	Proportional allocation of sample for behavioural assessments		
City	No of FDUs	Sampling Weight	Sample required
KHI	1213	0.26187392	372
LHR	593	0.12802245	182
FBD	511	0.11031952	157
HYD	426	0.09196891	131
RWP	307	0.06627807	94
MLT	285	0.0615285	87
SGD	282	0.06088083	87
OK	282	0.06088083	87
QTA	227	0.04900691	70
DGK	198	0.04274611	61
SKR	182	0.03929188	56
PSH	82	0.01770294	25
LRK	44	0.00949914	14
TOTAL	4632		1422

4.3 Project implementation & field teams

The behavioral survey was a follow up to the mapping study which was conducted in the earlier phase of this research, and field data were collected by the same research team. For organizational structure of the field team which collected behavioral data, see Fig 2.3a (section 2.3).

4.4 Training of the field teams

Field staff was trained on the implementation of questionnaire in a two day "Master trainers workshop" in Lahore. This training was supplemented by local trainings conducted by the "Master trainers" at each field site before implementation of the behavioural assessment study. The training focused on providing information and points of clarification to the interviewers on issues such as:

- understanding HIV/AIDs: facts and myths;
- sampling strategy;
- basic interviewing skills with special emphases on interviewing about sex and injecting drug use issues;
- values and attitudes;
- different aspects of field work;
  - accessing FDUs ;
  - subject selection and recruitment process;
  - explaining the rationale and objectives of the study to the subjects;
  - Ethical issues including confidentiality;
  - acquiring informed consent ;
  - debriefing and referral process;

4.5 Data collection instruments

Data were collected by trained interviewers using a structured questionnaire which was designed in English and subsequently translated into Urdu; the Urdu versions were used to collect the required data. The questionnaire included questions on socio-demographic and personal characteristics, as well as a core set of risk behavior indicators to monitor the behavioral patterns in the population under study. Following are the principal variables for which data were collected:

- *Socio-Demographic variables:* age, education, living arrangements, marital status, family information, income, migration status, work related information etc;
- *Sexual practices :* Age of initial sexual intercourse, Number of sexual partners, regular and causal partners, condom use, anal/oral intercourse etc;
- *Drug using Practices:* Types of drugs used/injected, length of drug injecting careers, drug use in group/sharing;
- *HIV & STI knowledge;*
- *Available health services and its utilization;*
- *Barriers to utilization of health and treatment service;*
- *History of arrest, imprisonment etc;*

4.6 Data collection procedures

As mentioned the mapping results led to the development of a sampling frame from which FDUs were selected randomly to participate in the behavioral assessment study. Once the mapping study was over, the data manger randomly selected a list of FDUs which were to be sampled for the behavioral assessment study. Interviews were conducted at the homes of the FDUs or at the field office as per the convenience of the subjects.

Selected FDUs were approached by interviewers with the assistance of peer group members and Informed consent was read aloud for the eligible consenting subject. The consent form provided participants with an overview of the objectives of the study, the confidential nature of the interview, the right of the participants to refuse to answer questions, as well as the right of subjects to end the interview at any time. This was followed by a face-to-face interview conducted by a trained study interviewer. The interview took 15 to 20 minutes and after the completion of the interview, a debriefing session was held with participants so as to allow the interviewer to respond to any questions that the participants may have had. Information was also provided to participants during this session on the modes of spread and prevention of HIV infection, on the service packages available.

4.7 Data management and analysis

A data management unit was established at the office of the lead NGO in Lahore, and the data management team worked closely with the field team in close collaboration. Data forms were field edited by the field team on a daily basis and corrected for any missing information. Field edited forms were then transported to the data management unit in Lahore, where entire data set was entered on a data base specifically designed for this study in MS Access. The entire data management process was supervised by a data base manager, who worked with site based team leaders in managing project data. The electronic data was password protected and only authorized officials of UNODC, and the research team including the Research consultant had access to the data files. In addition, all data forms were assigned a unique study code; no personal information accompanied these records. All hard copy data were stored in a secure room at the NGO office, which were handed over to UNODC after completion of the study.

The data after double entry in the data base were edited and thoroughly cleaned. The final data analysis was conducted by the Research consultant using statistical package SPSS version 12.00.

4.8 Project monitoring and quality assurance

A comprehensive monitoring system was designed, delineating roles and responsibilities of each monitoring team member and ensuring quality of data collected. At the field level, at the end of every day, the team leader ensured eligibility, completeness and consistency of the completed questionnaires. The team leader also field edited all forms and supervise at least 5% of the interviews randomly. The questionnaires were discarded if gross errors were observed.

The National Coordinators also provided ongoing monitoring support to the field teams at all field sites. The National coordinators and QA coordinators travelled extensively during field activity and paid monitoring visits to all the cities during different phases of field activity and checked the quality of data.

In addition to these internal monitoring procedures put in place, monitoring of field activities were also done by the Research consultant by visiting various field sites and providing ongoing support to the data collection team. Monitoring visits were also made by UNODC senior staff members and external reviewer of the project.

4.9 Ethical considerations for the study

This survey was designed to meet international ethical guidelines, specifically addressing the following ethical issues:

- *Safety of researchers: Field team met with the police and Anti Narcotics Force in each province before initiation of the survey to inform them of the nature and purpose of this research so that any queries from the local police could be addressed. Regular updates about this study were provided to them.*

- *Informed consent and voluntary participation:* Recruitment of participants was conducted only after describing the study procedures and obtaining informed consent. During the process of obtaining informed consent, prospective participants were clearly informed that participation was voluntary and that non-participation would have no negative consequences in terms of access to programs or services.

- *Confidentiality:* Considerable effort was taken to maintain the confidentiality of participants. This included non-disclosure of participants' identity and the use of a non-identifying coding system to track study data. The electronic data was password protected and only authorized members of the research team and UNODC had access to the data files. The final report does not contain identifying information and spot information which can lead to identification of places where MARPS congregate. This information is separately provided to UNODC which can be used by project staff for planning and providing services organizations.

- *Debriefing and referrals:* After the completion of the interview, a debriefing session was held with participants so as to allow the interviewer to respond to any questions that the participants may have had. Information was also provided to participants during this session on the modes of spread and prevention of HIV infection, on the service packages available.

Results (Behavioral Assessment)

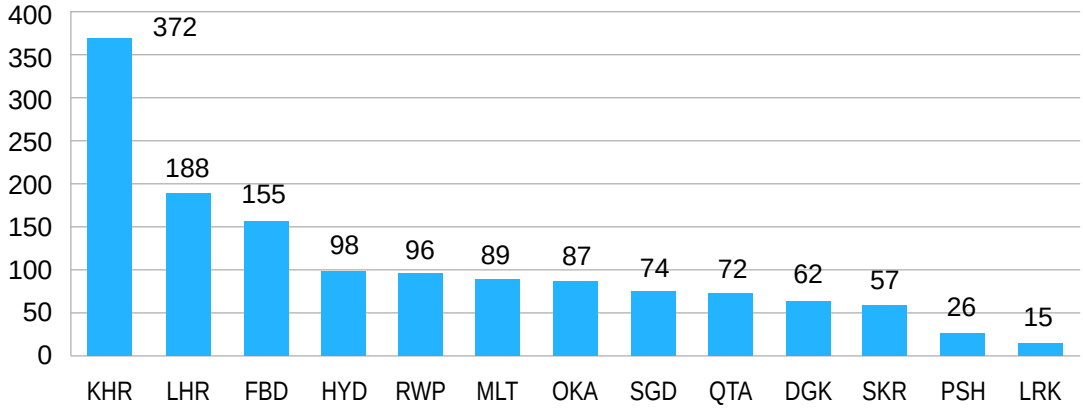
5

Chapter 5

5. Results of the Behavioral Assessment

A total number of 1,391 interviews were conducted in all 13 cities under study. As already mentioned in section 3.2, the number of FDUs interviewed at each site was determined by the number of FDUs identified in the mapping study, and a proportionate allocation of the sample was done, as shown in Fig 5.1

Fig 5.1 Number of behavioral interviews conducted in each city



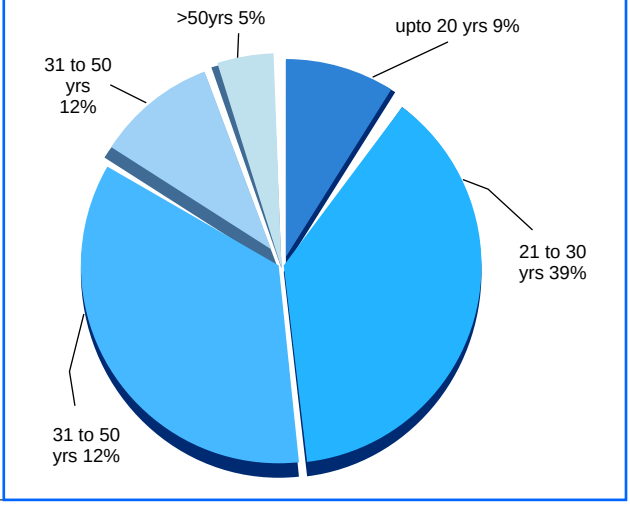
5.1 Socio-demographic information

This section provides the socio-demographic information of the study subjects.

5.1.1 Age

The mean age of the FDUs who participated in this study was reported to be 32.8 ± 9.6 yrs (median 32 yrs). The maximum proportion (nearly 72%) of the drug users were between 21 to 40 yrs of age, which is the prime reproductive age for women and forms the most productive component of the community. Fig 5.1.1a shows the distribution of FDUs in various age groups. No significant differences were seen in the mean age and distribution of age in various age categories across various cities and most of the FDUs in nearly all cities were between 21-40 yrs of age.

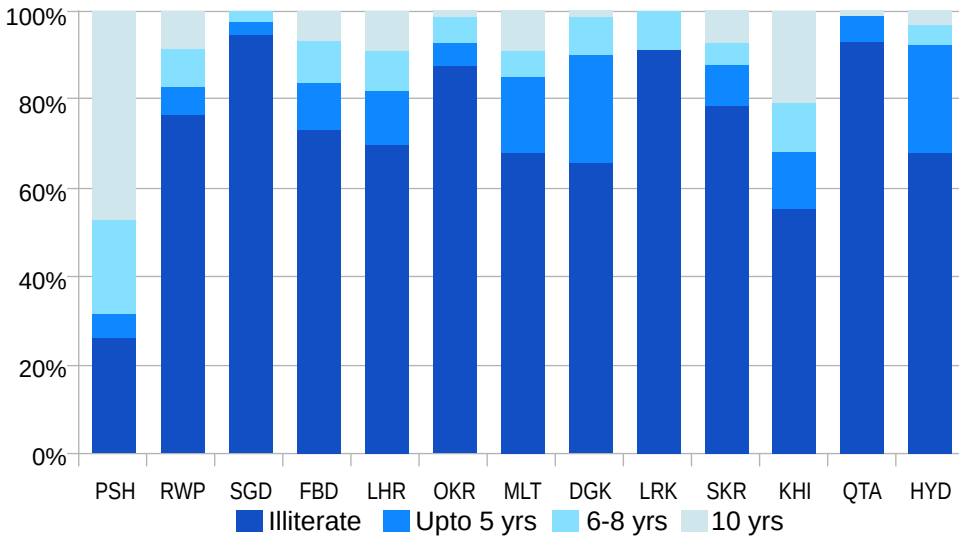
Fig 5.1.1a Age distribution of FDUs in Pakistan



5.1.2 Educational status

Majority of the FDUs were illiterate, which is in conformity with overall picture in the country. Nearly 66% of the FDUs interviewed did not receive any formal schooling. 11.2% of the respondents had schooling upto primary level, 7.5% had 6 to 8 yrs of education and 9.5% had 10 years of school education. Only 5% of the FDUs had an education of more than 10 yrs

Fig. 5.1.2a Education attainment of FDUs stratified by cities



The level of education of FDUs was further stratified on cities. Nearly all cities showed a similar picture which was in accordance with the overall National picture, with the higher proportions of

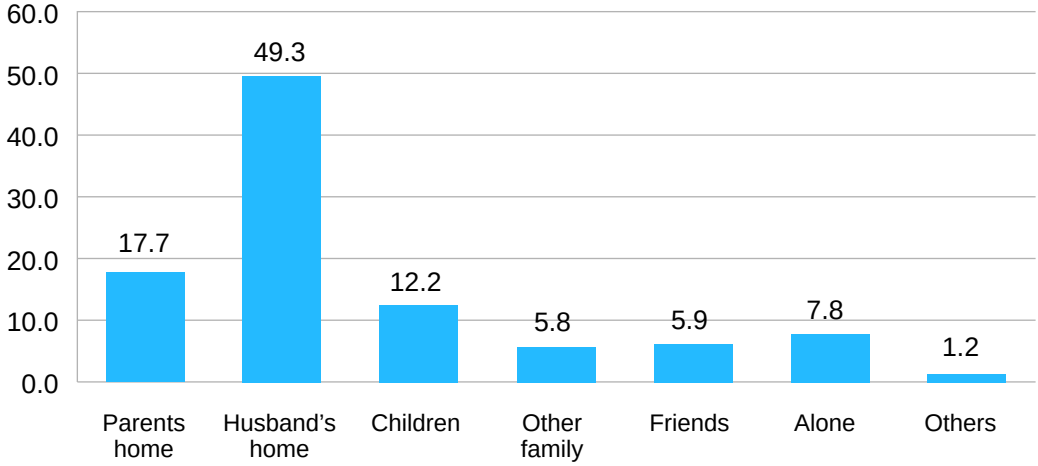
FDUs being illiterate. Peshawar however showed a different picture, where a high number of drug users were reported to be well educated. Nearly 50% of FDUs interviewed in Peshawar had more than 10 years of education, which shows that drug use was seen in educated women in Peshawar.

5.1.3 Marital status and living arrangements

Nearly 60% of the interviewed females were currently married, while 15.6% reported to be never married. The remaining 24% were either widowed, or divorced/ separated from their husbands and were living separately.

Further analysis revealed that nearly 50% of the FDUs interviewed lived with their husbands, 17.7% lived with their parents, 12.2% lived with children and 5.8% were living with other family members. Only 8% were living alone. See Fig 5.1.3a.

Fig. 5.1.3a Living arrangements of FDUs in Pakistan



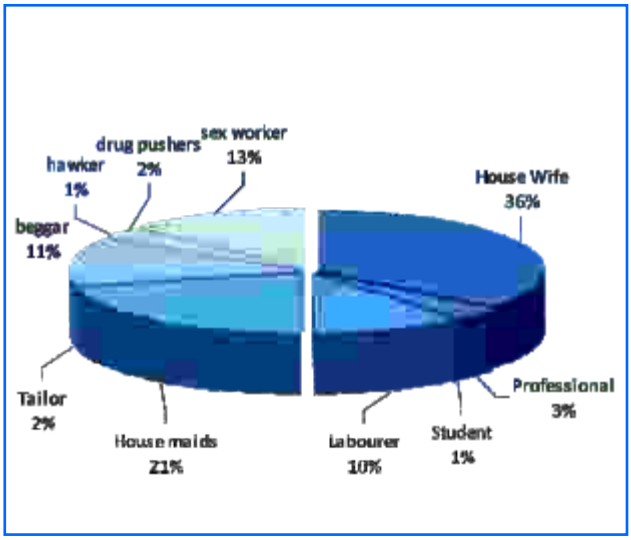
5.1.4 *Ethnicity and Migration status*

Nearly 91% of the subjects interviewed belonged to the same city where they were interviewed. The majority of FDUs were Punjabi speaking (45.3%), followed by Urdu speaking females (27.7%) and subsequently Sindhi and Pushto speaking females whose proportions were 8.3% and 4.7% respectively.

5.1.5 *Occupation*

Analysis conducted to look at the various professions that FDUs are involved with showed interesting results. The maximum numbers were housewives and were not attached to any profession. Being a House maid was the next most reported category as the occupation of the FDUs interviewed. It is important to note that a fairly high proportion of subjects (13%) reported to have been working as sex workers. Further occupational categories included beggars (10%) and laborers (10%). A few professionals (e.g., teachers, nurses and doctors) were also reported to be involved in drug use. 2% of the FDUs interviewed reported that in addition to using drugs themselves they are also involved in drug selling business.

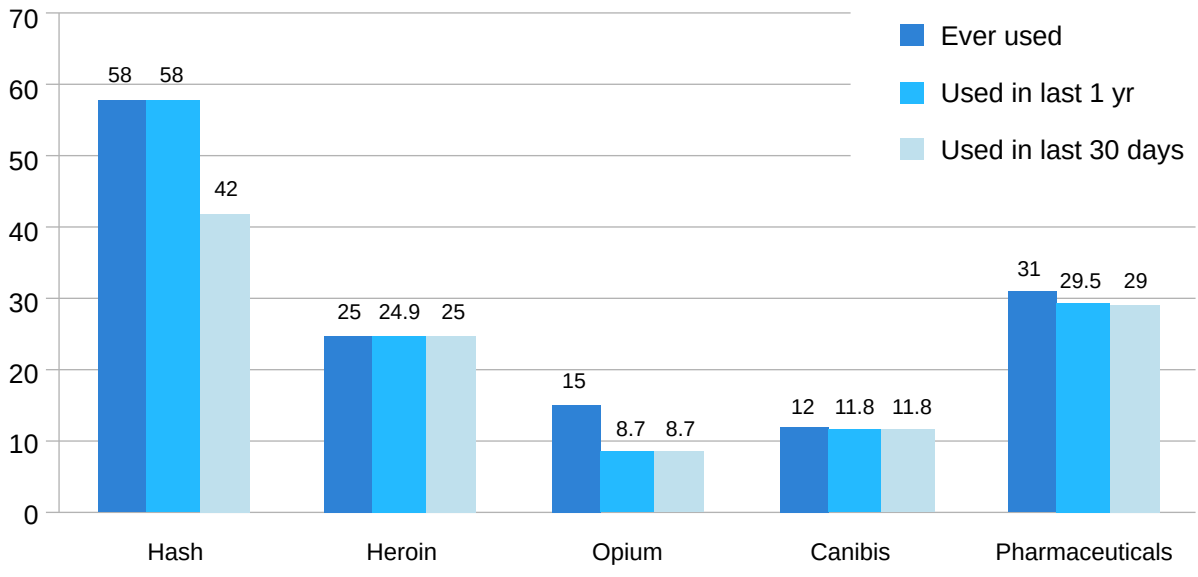
Fig 5.1.5a Occupational Categories



5.2 Types of drugs used

The analysis was further extended to evaluate the types of drugs used by female drug users. We collected information on ever use of drug in life, use in the last 6 months and regular use of the drug in the last month. The drugs for which information was collected for included Heroin, Hashish; locally known as Charas and Pharmaceutical drugs which as mentioned previously are freely available in Pakistan "over the counter". This group included various Antihistamines, Benzodiazepines, Antipsychotic and Narcotic analgesics. Use of Opium; locally known as Afheem, and Cannabis; locally

Fig 5.2a Types of drugs used by FDUs in Pakistan



known as Bhang and inhalants which largely include locally available glues and adhesive solutions was also asked for. Hashish was the most common drug used by FDUs all over the country and 58% of the interviewed drug users reported using it ever and also in the last six months. 42% reported that they had used Hash in the last month as well. Pharmaceutical drugs were the next drugs of choice followed by Heroin and Cannabis. (See Fig 5.2a for further details).

Another important finding which emerged from this analysis was that the proportion of FDUs who reported lifetime use of Heroin and Pharmaceuticals was not different from life time use. In contrast the numbers of FDUs who used Hash in the last month (current use) were much lower than who reported its lifetime use. This indicates that in contrast to drugs like Hash and Opium, once a person starts using Heroin and Pharmaceutical drugs it is much difficult to discontinue its use.

Table 5.2a Mean age of initiation of various drugs used by FDUs

Type of drug	Mean age of initiation	SD
Tobacco (Cigarette)	20.7	6.1
Hashish	22.1	6.1
Opium	22.7	6.3
Heroin	23.3	7.1
Alcohol	23.7	5.9
Pharmaceuticals	28.8	8.5

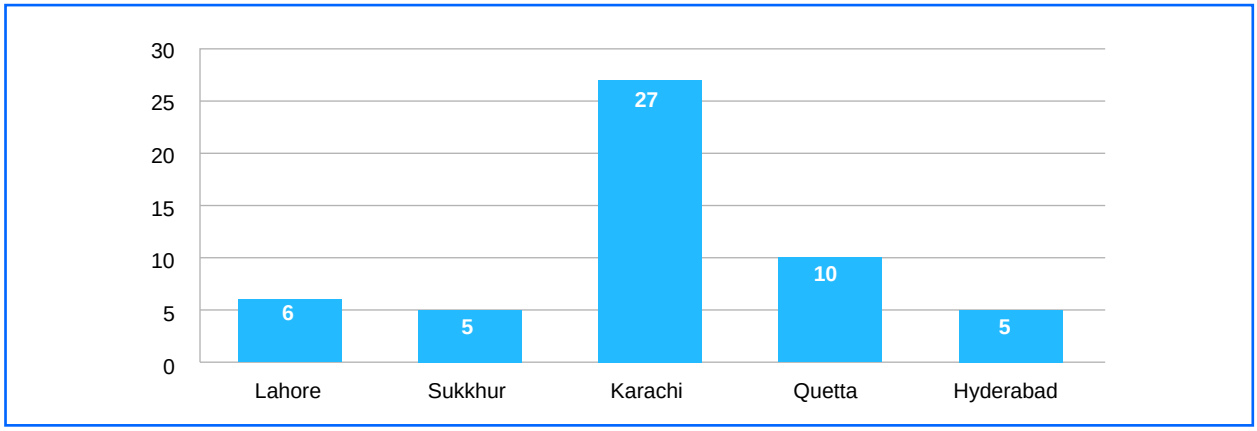
Additionally the average age of initiation of various drugs including cigarettes and Alcohol, as shown in Table 5.2a. An interesting finding emerged with Cigarette smoking having the minimum mean age of initiation. The mean age of initiation of Hash and Opium was nearly 2 years greater and Heroin and Alcohol was another 1 yr. The analysis shows the trends of progression from cigarette smoking to Hash and finally heroin or pharmaceutical drugs, which is a much newer form of drug use in Pakistan.

5.3 Injecting drug use

Ever injected drugs	53
Injected in the last 6 months	49
Injected in the last month	49

Of the 1392 subjects interviewed, only 53 reported that they had ever injected any form of drug. We further inquired whether they have been injecting drugs during the last 6 months and last month as well to ascertain the current status of injecting. 49 out of the 53 subjects informed that they have injected drugs in the last 6 months as well as during the last month also. Further analysis revealed that injection drug use was only found in 05 out of the 13 cities where this study was conducted. Thus the behavioral data is in agreement with the results of the mapping study conducted in phase-I, which also showed similar results and injecting drug use was reported from 05 cities only, with few numbers of females reported to inject drugs. (also see section 3.5)

Fig 5.3a City wise distribution of FIDUs in Pakistan



The study further looked at the injecting behaviors and practices of the female IDUs, are shown in Table 5.3a. Nearly 62% of the FIDUs interviewed have been injecting various Pharmaceutical drugs. Sosegon, Avil and Valium/Diazepam were reported to be the most frequently injected drugs.

Table 5.3a	Injecting behaviors and practices of female IDUs		
Variables		N	%
Drugs injected	• Heroin	30	56.6
	• Pharmaceuticals	33	62.3
No of times Injected	• 3 -4 times in a month	10	18.8
	• At least once weekly	17	32.1
	• Daily	22	41.5
Usual place of injection	• Home (self)	24	45.3
	• Home (relatives/friends)	12	22.6
	• Open space	13	24.5
	• drug seller's place	4	7.5
Group injecting	• Never	16	30.2
	• Sometimes	28	52.8
	• Always	4	7.5
Shared syringe	• Never	22	41.5
	• Sometimes	24	45.3
	• Always	2	3.8

Nearly 41.5% of the injecting drug users reported that they had been injected daily, while another 32% informed that they have injected at least once a week in the last 6 months. Although 30% of the injecting drug users have been injecting alone, the remaining had been injecting in groups with other IDUs. Nearly half of the subjects informed that they had been sharing syringes with other IDUs.

5.4 Sexual behavior and practices

The mean age of 1st sexual intercourse was reported to be 18.5 ± 3.7 yrs. A fairly high proportion were reported to be sexually active, with high numbers of sexual partners in the last 6 months (4.9 ± 16.2), suggesting they were sexually involved with a fairly large number of people. (See Table 5.4a).

A total of 13.5% of the FDUs reported to have sex with another male IDUs, and 25% reported selling sex for drugs or money. Only 3.7% reported that they always used a condom during the last 6 months. These specific behaviors have long term implications with regard to the spread of HIV and were stratified to look at city wise distribution of these behaviors. Other than Peshawar, data from all other cities showed that FDUs have been involved in providing sexual services in return of money or drugs. This explains the high number of sexual partners reported by FDUs in the last 6 months, and also suggests a possible route from where HIV can spread from this highly vulnerable population to their clients and further into the general population.

Table 5.4a	Sexual behaviors and practices of FDUs in Pakistan

Variables		N	%
Mean Age at 1st sexual intercourse (mean ± SD)		18.5 ± 3.7	
Had sex in last 6 months		1024	71
Mean Number of sex partners (mean ± SD)*		4.9 ± 16.2	
Sex partners*	• one	288	28.1
	• 02 to 05	35	3.4
	• 06 to 10	14	1.4
	• 11 to 30	22	2.1
	• more than 30	40	3.9
Use of condom*	• Never	561	54.8
	• Sometimes	377	36.8
	• Always	38	3.7
Had sex with a male IDUs*		188	13.5
Sold sex for money/drugs*		259	25.3
Condom use at last sex		134	9.6
Last sex partner	• Husband	835	60.0
	• Friend	243	17.5
	• Client	92	6.6
	• Other	9	0.7

*Information related to last 6 months

Fig 5.4a	Total number of FDUs and number of FDUs selling sex

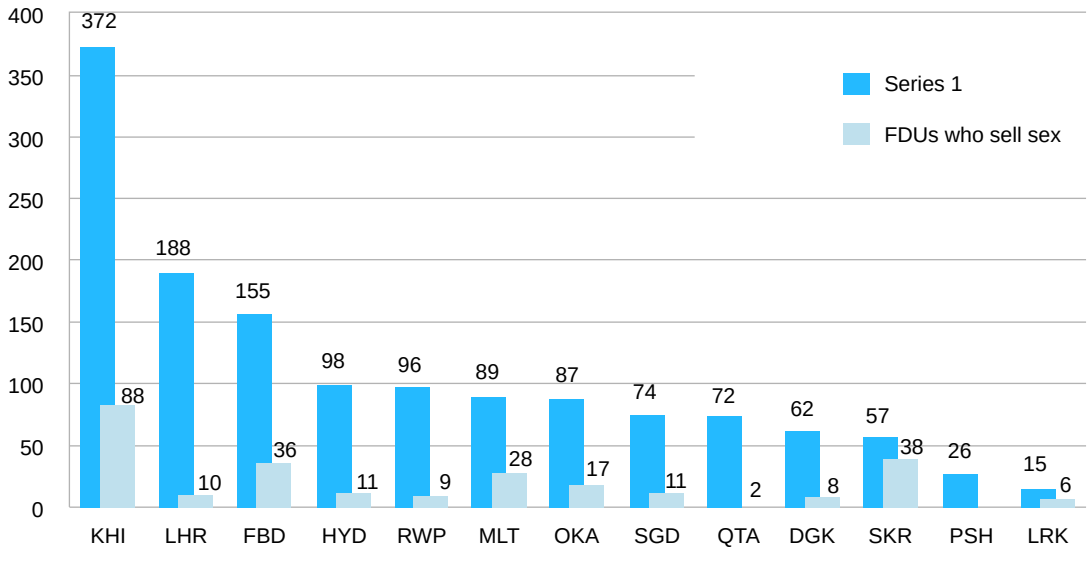


Fig 5.4b FDUs who had sex with an IDUs

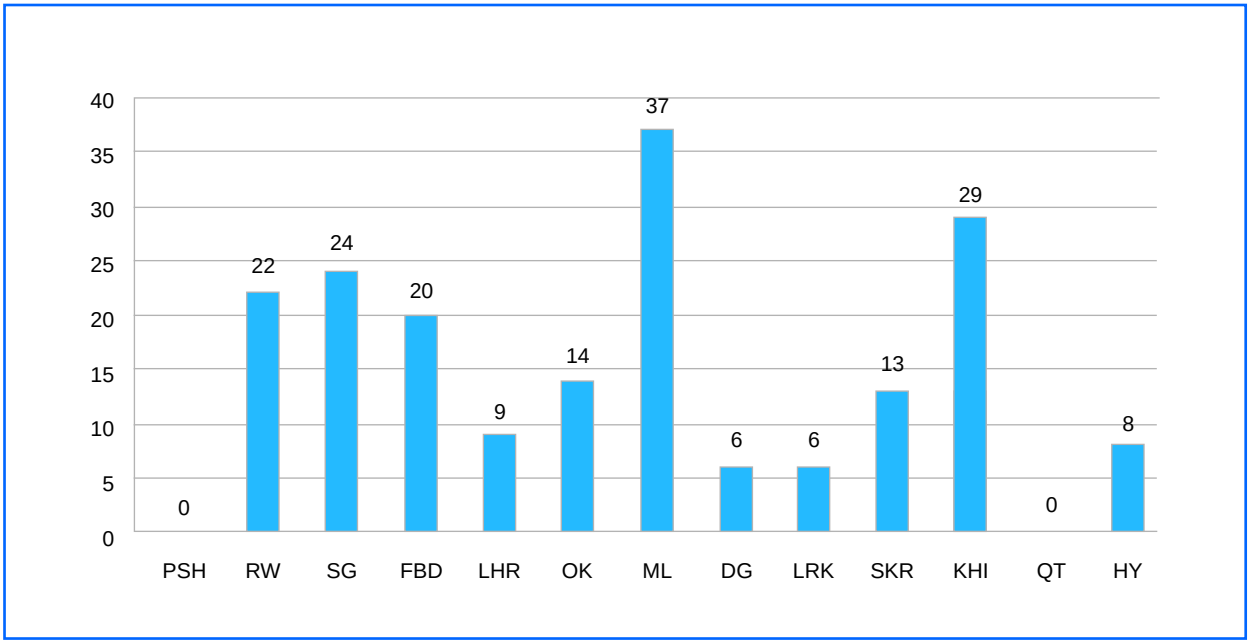


Fig 5.4b provides numbers of FDUs who reported to have sex with male IDUs from each city surveyed. Other than Quetta and Peshawar, FDUS from all other cities, reported to have sex with male IDUs in the last six months. This is an extremely important finding, and suggests a very risky situation through which HIV can transmit from infected male IDUs to non infected FDUs and further to the general population.

5.5 Knowledge of HIV and STIs

Approximately 44% of the FDUs interviewed had ever heard of the disease called HIV/AIDS. To further evaluate the HIV related knowledge, we inquired about the modes of transmission of HIV and also asked about the ways how transmission of HIV can be protected.

Knowledge of sexual intercourse as a mode of transmission of the disease was prevalent among 40% of FSWs, but only 22% knew that HIV can be transmitted by sharp instrument/needles and syringes. 19.5% knew that HIV can spread through blood transfusion, while knowledge of mother to child transmission was still lower (9.8%). While the correct knowledge of HIV transmission was fairly low, a few misconceptions about transmission of HIV were also reported. Thus eating together with HIV infected people, hugging or touching them were reported to be associated with HIV transmission. A few FDUs believed that one can acquire the virus from staying unclean, and from animals. (Table 5.5a).

Sexual abstinence and using a condom were reported to be the ways by which one can keep safe from acquiring the infection.

While 17% of the respondents interviewed were aware of where they could be tested for HIV, nearly half of those had been tested for HIV.

The FDUs were further inquired about the knowledge of sexually transmitted infections among the study subjects. Nearly 31% of the FDUs interviewed knew that there are diseases which spread because of sexual intercourse. We further asked how many of the respondents had any sort of STI during the past 6 months. It needs to be mentioned that the information on past STI was based on self reported data and many of the respondents answered based on the symptoms of STIs which they experienced (genital rash, itch, foul smelling discharge, burning micturation with increased frequency etc.). See table 5.5a for further details.

Table 5.5a Knowledge of HIV/AIDS and STIs among FDUs in Pakistan

Variables		N	%
Have heard of HIV		613	44
Knowledge of how HIV spreads·	• Sexual intercourse	557	40
	• Sharp instruments/syringe	307	22.1
	• Touching/Hugging/kissing	54	3.9
	• Eating together with patients	72	5.2
	• Mother to child	137	9.8
	• Blood transfusion	272	19.5
	• Staying unclean	35	2.5
	• From animals	10	0.7
Knowledge of how HIV can be prevented·	• Using condom	364	26.1
	• Sexual abstinence	377	27.1
	• Using new syringe	307	22.1
	• Safe blood transfusion	250	18
	• Staying clean	66	4.7
Knowledge of where to get an HIV test		238	17.1
Tested for HIV		114	8.2
Knowledge of STIs		430	30.9
Had an STI in last 6 months		68	4.9
Got treatment for the STI		57	83.8

5.6 Treatment history & Service Provision

A total of 13.2% respondents reported that they have been treated at least once for drug use. Out of these 184 respondents, nearly half of them had been in a treatment program once. 31.5% had been treated 2 to 3 times, while 13% were treated 4 to 6 times.

The maximum proportion of drug users informed that they utilized private clinical facilities for treatment. This was followed by treatment services provided by NGOs and government hospitals which were 32% and 31% respectively. Nearly 11% of the FDUs interviewed that they have tried home based treatment for drug use as well.

Out of all, 73% of the respondents suggested that they need to be treated and showed a willingness to participate in a treatment program if offered.

5.7 History of Arrest

History of arrest as well as the reasons why they were arrested is given in Table 5.7a. Only 4.3% of the respondents reported that they were arrested for reasons such as drug use (60%), drug pushing (30%), sex work (5%) and other minor petty crimes (5%) e.g., theft etc.,

Of the 60 FDUs who reported a history of arrest and jailed, 36.7% informed that they were using drugs even when they were arrested. Nearly 12% also informed that they had sex while they were arrested.

Table 5.6a	History of drug treatment among FDUs in Pakistan.

Variables		N	%
Ever treated for drug use		184	13.2
No of times treated	• Once	91	49.5
	• 2 - 3 times	58	31.5
	• 4 - 6 times	24	13.0
	• > 6 times	11	6.0
Facility where treated	• Govt Hospital	57	31.0
	• Private Clinic	68	37.0
	• NGO	59	32.1
	• Home	21	11.4
Needs treatment		1015	72.9

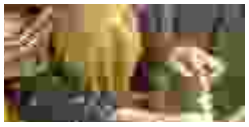
Table 5.7a	History and reasons of arrest among FDUs in Pakistan.

Variables		N	%
Ever arrested		60	4.3
No of times arrested	• once	34	56.7
	• twice	18	30.0
	• > twice	07	11.7
	• Drug use	36	60.0
Reasons for arrest	• Drug pushing	18	30.0
	• Sex work	03	5.0
	• Petty crimes	03	5.0
Used drugs in jail		22	36.7
Had sex in jail		07	11.7

Ethnographic Results

6

Chapter 6



6.1 Ethnographic from field

Drug use is stigmatised in all societies, but it is frowned upon even more when the user is a woman. To have in-depth understandings of these societal phenomena, in specific social contexts of female drug use, the mapping study was complemented by an ethnographic research component. Our goal for the ethnographic study was to obtain a detailed understanding of the life patterns of FDUs and the operational dynamics of drug use and residents. Ethnographic data were collected from 08 cities, including Lahore, Faisalabad, Multan, Rawalpindi, Quetta, Peshawar, Karachi and Hyderabad. Separate field researchers who had a rich experience in working with most at risk populations including drug users were hired for this component of the study.

Within each city 6 to 8 FDUs were identified, to participate in the study. The selection of these participants was based on the subject's willingness to participate in a detailed in depth interview, and consent to allow field researchers to participate in the lives of the subjects by spending 4 to 6 hours in a day with them in their households. As the quality of ethnography is determined by the quality of the relationships developed during fieldwork. The field researchers spent ample time with the participating individuals and established mature relationships in a sensitive social context. Observations and semi-structured interviews were the key procedures through which ethnographic data were collected. In some instances, the research team consulted with family members of drug users as well.

The results of the ethnographic study are provided under the following main themes identified:

- Consequences on the family and personal lives;
- Consequences on employment and work;
- Mental health issues ;
- Drug use initiation and availability;
- Sex work;
- Violence and arrest.

Chronicle from field - 1

For Nasreen, a simple puff of a cigarette ignited a path to slow poisoning. She started smoking at the age of 17 after she got raped by her father's friend. Like other girls, Nasreen wanted to learn new things, loved to make-up herself. Her father was a drug addict. Her mother was responsible to earn bread for family and drug to her husband as she worked as house maid. In her absence, Nasreen used to take care of brother who was mentally retarded. While telling her life story, her sparkling eyes clearly showed her dreams which she once dreamt to be like other girls going to school, wearing good cloths etc.

Her father always called his friends, who were also addicts, at home. One day life turned down for Nasreen and all dreams broke down, when one of his father's friends raped her at her home. After that, her father sold her to his friend who forced her to work as sex worker to bring money for his drug use.

During all this, she gave birth to a baby boy without knowing who his father is. To forget all this one day Nasreen smoked cannabis and found it very relaxing. She has become a consistent drug user of heroin ever since her first encounter with drugs. No one showed any interest in her or imparted awareness, now her drug use led her to injecting drug use. Now she lives on street with her son. She wants her son to be a good citizen and wants to send him to school.

Consequences on the family and personal lives

In addition to facing various health and social consequences of drug use, the disintegration of family appears to be the most widely reported consequence of drug use among females. As most families are supported and cared for by women. They frequently play a key role in teaching the young, ensuring that education and provision of health-care and maintaining links within family relationships. With involvement of a woman with drugs, the entire family structure is reported to be disturbed with the highest impact on children. Children of most families with females involved with drugs are under-nourished, improperly cared for and mostly uneducated. The overall environment within the house is reported by researchers to be filthy, unorganized and in a bad condition. Since females are responsible for managing the everyday household activities. And those involved with drugs are not able to perform their everyday household activities, their entire family setup was found disturbed.

The use of drugs has severe consequences on the personal lives of the women as well. Most of the females using drugs have no set patterns in life. They usually sleep or stay in bed during most part of the day and use drugs mostly at nights. They have disturbed sleep patterns and never enjoy a peaceful sleep. Two types of FDUs were observed by the field researchers: females, who work, usually go to work in the morning after taking their drugs, return in the afternoon and get involved with their drugs. The non-working type relies on the family support for purchase of drugs and follows a different routine.

Their involvement with other family members was reported to be minimal and most of them are isolated from the rest of the family.

Jab dil chahta hay sau jatay hain, hum zinda ya murda haun,
ghar kay logon ko farq nahin parta,
(I sleep whenever I feel like, whether we are alive or dead, nobody cares.... A drug user)

Most of the subjects informed that they suffer from Anorexia, and don't have a desire to eat. This was more so reported from females using Heroin, that they don't take regular meals and don't feel hungry at all. Most of them reported a craving for sugar and sweet.

after taking Heroin I wish to eat any type of sweet; (a heroin addict).

On the other hand those who regularly take Hash presented a completely different picture, are fond of eating and feel hungry at short intervals of time. Most of them like tea with lot of sugar.

Ziyada takat chahiyay hai na humain, is liyay mithi cheezain khatay hain
(we need more energy, therefore we need to have more sugar and sweet things... a drug user)

Some of them have affinity for God, but they feel that they are not pious enough to stand up in front of God. A few of them offer their prayers regularly, are devotees of saints and regularly visit shrines. On the other hand, according to some, they do not commit any sins and will not be held accountable to God.

Consequences on Employment and work

In addition to social isolation by the society, known drug users also find it very hard to attain long-term work. Businesses are reluctant to employ users, and tend to sack people when they hear they use drugs. A large number of FDUs work in as house maids, but once someone recognizes them as a user, they are immediately thrown out of their jobs. In case when begging is the source of income reported, both husband and wife go out for begging and sometimes the children also accompany them. Some of them have informed of having jobless husbands so they do different types of labor work on the roads, factories and in houses. In most instances the women get money from the husband for the daily household expenses but in other instances some are involved in sex work and get money from their clients.

Khud Sara din ghar pay para rehta hai aur kehta hai key mein jo bhi kuch karon...isay bhi khilaon aur bachon ko bhi.. aur apni poori bhi laoon

"my husband is lying in the home all day and expects me to bring food for him as well as the children., Now whatever I do, I have to bring food at the end of the day, plus my drugs"

Chronicle from field - 2

At a tender age of 16, Rabia, a medical nurse by profession, was introduced to psychotropic medicines by her friends. Rabia belongs to disturb family setup suffering from lot of tension and poverty. Being a nurse they weren't hard to come to get psychotropic medicines. Rabia gradually progressed from oral to injection of narcotics analgesics.

Rabia, now 22 years of age was reluctant to quit. At first the injecting drugs induced a soothing effect on her nerves but the after effects included prolonged body pains and choking. "The drugs give me relaxation and escape from harsh realities of life" said Rabia. One day when her mother got seriously ill and hospitalized and at that point Rabia thought of quitting the drugs. Rabia, approached the UNODC funded project but request the staff to treat her secretly as it will be a catastrophe if her relatives and neighbors find it out, as being drug addicted is some kind of a sin hence she was afraid of facing a major acceptance dilemma. The project provided her home based detoxification with follow-up and after care. Now Rabia is working in a local clinic as a nurse.

Mental health issues

Further information from ethnographic research suggested a number of psychological problems faced by FDUs. The relationship between mental health illnesses and drug use can be complex. Mental health problems can be a risk factor for substance use problems, and substance abuse can be a risk factor for mental illness. Drug use or withdrawal can induce or worsen psychiatric symptoms such as depression, hallucinations or paranoid thought patterns.

Drug abuse makes Central Nervous system (CNS) effects, which produce changes in mood, levels of awareness or perceptions and sensations. Females using drugs are usually reported to be depressed and many do consider their lives useless and meaningless. Some of the drug users did report of suicidal thoughts.

"Zinda rehnay ko dil tou nahi hai, lekin kambakht mot bhi nahi aati"
(I have no reason to live, but even death doesn't embrace me ..... a Heroin user)

A high level of social isolation has been reported by drug users, and there is a lesser tendency to mix up and share with other family members and friends. They usually stay alone, spend most of the time of the day in their rooms or beds and complain of no psychological support or encouragement from any of the family members or friends.

Drug use initiation and availability

Qualitative data collected suggested that there were multiple reasons why women got involved with drugs. A large number of women got involved with drugs because of some male family member, usually husband or brothers. A few suggested that they started using drugs out of curiosity and later got addicted to it.

Herion chakney chakney main zindigi hi chakha dali ... a heroin user

A few women who were using Pharmaceutical drugs informed that they started these drugs as a medical treatment for anxiety and depression which was prescribed by medical doctors. They continued with those medicines and later got

addicted to it. The medically-prescribed consumption of pharmaceutical drugs in the secrecy of private life is much easier and lesser of a taboo, deeming this a 'normalised' practice for many FDUs.

(mein apnay maslon kay liyay relaxin laity thi... ab yehi sab say bara masla hai)
I treated my tension by taking "relaxin", now I have the biggest tension how to get rid of this ... (a student from Lahore).

In most instances, the FDUs are not buying drugs for themselves and usually have a male who brings drug for them. When there is a male drug user in the family, the drug is bought by the male member and FDUs don't need to know or be socially connected to the dealers to buy drugs. Users generally use drugs with one or more members of the family, they pool their resources and the males do the drug dealing. Females, who work outside of their home, are more empowered and get drugs by themselves. In many cases they have friends who bring drugs to them. Most of the time this drug is in exchange for providing sexual services.

Mera dost kafi saara mal la kay daita hai Afghanistan say. Kuch din rahta hai phir chala jata hai aur naya maal lay ata hai

My friend from Afghanistan brings me ample quantity of drug. He stays with me for a few days and leaves. When he comes back he brings my next quota ..... A drug user from Quetta.

Instances have been reported in which drug pushers come to the place where drug users are in majority especially in squatter settlements (Jhugian) and sell drugs by going door to door. FDUs on pharmaceutical drugs informed of taking drugs from the local medical stores and face no problems in getting the same. However some of them have old prescriptions of Valium and other such drugs and buy it easily from the market.

Sex work

Although there is an established link between drug use and commercial sex work, the existence of this relationship in itself does not imply causality. It is not clear whether substance abuse is one of the factors that push FDUs into prostitution or whether it is prostitution that caused their drug involvement. However, it is also known that selling sex for money or drugs is a common occurrence and many FDUs support their habit by working as sex workers; often a times barter a dose in exchange of sex.

Results from this study have also revealed that although not admitted publically, but many of the FDUs informed the field researchers that they are into providing sexual services to a limited number of people for cash and for drugs. Most of them are sexually exploited by some friends and in some cases strangers. A few of them reported that they were not into sex trade before using drugs, but now they don't mind providing sexual services to a limited number of people for getting money to purchase drugs. Some of them keep boyfriends who could pay them money for purchasing drugs or even bring drugs for them in exchange for sex. It is important to note here that FDUs who are involved in providing sexual services to clients do not consider themselves as sex workers, which secludes them for participating them in any of services available for sex workers. This warrants separate services for these populations which provides them services required for

Hum randian thori hain kay kisi kay saath bhi so jayen. Bas eik do dost hain ... hum un ki zaroorat puri kartay hain aur who humari... is mein kya burai hai.

"We are not like those women who sell sex to everyone. We just have a few people whom we know and there is no sin giving them what they need and getting what we want"... a drug user

Violence and arrest:

Violence was a major consequence reported by most of the FDUs who participated in this study. Various forms of violence from abuse to physical beating and even arrest by police was reported and seems to be one of the major issue faced by FDUs. Family members especially male family members.. especially brothers and husbands are reported to be consistently abusing them and even physically beating them Their behavior is reported to be aggressive and harsh. One FDU from Hyderabad reported that she was beaten by her sons.

> *Gaalian aur maar tou humari qismat hai. Mian, bachay, bhai.. sab ka ghussa hum payhi nikalta hai.humaray tou bachay bhi humara mazak uratay hain...*
> Violence and abuse is our fate. We are beaten by our spouses, brothers, children etc Even our children make fun of us ..... A drug user.

A few drug users also reported that they have been raped by acquaintances, police, and even family members. One of the females reported of being raped by her father and brothers.

Harassment and violence was reported by various FDUs from the law enforcement agencies esp. police. Many of them found the police to be very judgmental. Users tried to limit their visibility to police, but most felt the police could find out and arrest them if they want to. According to them the law is used against them by the police to make money and not to control the law and order situation. The drug users told that if they keep paying some money to the police, they don't disturb them, but if money is not paid to the police, they arrest us. Once arrested, you are asked to pay heavy amounts of money and then you are set free. Drug users who have relations with police officials, never get arrested. History of rape by police officers was also reported by some FDUs.

Chronicle from field - 3

Saira, 36 was dragged into drugs at the age of 19 due to destitution. Heroin was the drug she was impressed upon by her friends and her husband. The same drug that made her feel better at first now had awful repercussions on her health. She started to experience severe body pains, vomiting, diarrhoea along with spells of anger. Now it has been almost 16 years since saira has been sniffing heroin. During this period her family members desperately persuaded her to quit drugs and even beat her up at times but she consistently refused to quit.

Saira feels no difference as a woman because she believes that the situation for both a man and a woman is pretty much the same. Her situation is execrable nowadays as her family has no money for food, no clothes to cover themselves, neither electricity nor gas.

She appreciated the treatment and aftercare services provided by UNODC. Saira understands her situation and is sympathetic towards other women facing the same consequences. Even an addict, Sania has future plans; she wants to learn embroidery from the center. Saria, peer educator, UNDOC project.

Conclusion & Recommendations

7

Chapter 7

7.1 Conclusions

This study addressed some of the critical issues related to female drug use in Pakistan, which have never been dealt in the past. The findings of this study provide scientific and concrete evidence that drug use is taking a serious toll on the health and well-being of females and their families. The growing morbidity rates from the addictive disorders in women are preventable, demanding greater attention in research, service delivery and public health policy.

Apparently, the problem drug use in women seems like an insignificant and trivial public health issue, when comparing the numbers of female drug users to the enormous number of male drug using populations in the country. However, drug use occurrence among women has an impact that goes beyond the individual and affects the entire social network of families with greater negative impacts on children. Research has increasingly suggested that women may be more vulnerable than men to particular consequences of drug abuse and a quick urgent response is warranted.

The estimated number of 4,632 female drug users spread over 13 cities mapped, highlights the presence of a fairly large number of women involved with drug use in Pakistan. While the numbers are fairly large in the large cosmopolitan cities including Karachi and Lahore, the drug use problem among women is not only restricted to the large urban centers and smaller towns and cities also illustrate a similar magnitude of problem. Unlike male drug users who congregate and use drugs with other drug users, drug use is a discreet, hidden and more of an individual activity for female drug users. Results reveal that large spots and locations for female drug users do not exist, and drug use among females is more of an individual activity. Owing to the hidden nature of the activity, the huge stigma attached with the status of a woman labeled as a drug user, and absence of large drug using networks, the point of concern is that the actual numbers of female drug users in these target areas would be larger than what this study was able to reveal. However, within the short time frame allowed for the study as well as the extremely hidden nature of the subject under study, this research has done a commendable job in providing evidence to highlight a fairly significant public health problem in the country. Further investigation is required for a clearer insight into whether or not number of women using drugs is underrepresented in this study is desired.

Nearly 3/4th of the drug users were between 21 to 40 yrs of age, which is the prime reproductive age for women and forms the most productive component of the community Moreover, majority of the FDUs were illiterate, which is in conformity with overall picture in the country. While Hashish is the main drug used by drug using women is important, large numbers of females were found to be using hard addictive agents such as Heroin and synthetic drugs which are readily available over the counter at most pharmacy stores. Research conducted with male drug users has highlighted similar findings and the drug availability scenario in the country is not significantly different for males or females. This study also confirmed the available anecdotal information, that injecting is not a common route of drug intake among drug using females. A total of 71 female injecting drug users (FIDUs) were identified among the total estimated number of 4,632 FDUs, which was reported from only 05 cities out of the 13 cities surveyed. Although injecting drug use is not found to be common among FDUs, there have been other behaviors which put them at a substantial risk of acquiring blood borne infections such as HIV & HCV have been significantly noticed. A high proportion of FDUs were seen to be involved in providing sexual services to clients, including male IDUs, which suggests a possible route through which they can get infected themselves and can also pass over the infection to their clients and further into the general population. Worldwide, the combination of sex work and women IDUs is increasing. Once drug dependency is established, sex work can become a mean to sustain it, and a vicious cycle is established. Women DUs can trade sex for money or drugs, and the craving for drugs may overwhelm the ability to negotiate safer sex with the client. Female DUs/IDUs who exchange sex for drugs or cash may not identify themselves as at risk of HIV because they do not identify themselves as sex workers.

Female drug users are a difficult population group to reach as the community considers women's drug use to be more deviant than men's. Drug use is extremely looked down upon and breaks the social norms of what is considered

acceptable behavior and the stigma associated with drug use is more strongly felt by women who in turn are more likely to conceal their drug use to try to avoid public disapproval. The stigma associated with drug use often produces overwhelming feelings of shame and guilt among female drug users, and gives rise to significant mental health problems. Many female drug users suffer from low self-esteem, loneliness, depression, a sense of isolation and often feel powerless. In an attempt to minimize the stigma, FDUs do not seek assistance, and do not utilize services available for them which further complicate the situation.

Women problem drug users have specific experiences and complex needs which are not always recognized or met by some existing drugs services. Women face particular barriers that restrict their access to drugs services. The study therefore presents a fairly complicated situation among female drug using populations, which significantly increases their vulnerability to HIV, and presents a wide range of adverse health, social and economic consequences, which requires a range of effective responses and interventions.

7.2 Recommendations

Based on the conclusions of this research, an effective targeted response is necessary in order to promote safer behavior, improve access to effective health and social services, and to address the underlying structural and occupational dimensions of vulnerability. Following are some of the recommendations:

7.2.1 Conducting further research to improve understanding of female drug use

Understanding the issues and the complexity of substance use and addiction behaviors among women can come only from a multidisciplinary perspective in which biological, psychological, and sociological factors are taken into account. Such a comprehensive approach must be conducted in tandem with the collection of longitudinal epidemiologic data, which, not only generates insights into the dynamics of drug use among women, but will also enhance the understanding of the service providers regarding the connection between drug use patterns and their proximal and distal consequences. Although this study has provided valuable insights into the drug using women populations, however the initiative can be further extended to gain more in depth understating of the populations, conduct more reliable size estimations and recognize the personal, environmental and social factors which lead to drug use among women. The existing services for this population segment can provide an excellent ground, which can be utilized to further conduct research with this group, and provide evidence to make programmatic decisions.

7.2.2 Reducing stigma, discrimination and violence

Drug use is extremely looked down upon and the stigma associated with drug use often produces overwhelming feelings of shame and guilt among female drug users. In an attempt to minimize the stigma, FDUs do not seek assistance, and do not utilize services available for them which further complicate the situation. Challenging social attitudes through developing advocacy forums and self-help groups has shown to help overcome problems of isolation and self-esteem caused by marginalization and stigmatization. Activities which involve and facilitate collective actions, such as developing associations/unions and networks, and involving the media in a positive way contribute to an improved awareness of the society and can favor attitudinal change. Most importantly, the families of FDUs should be focused to provide support for treatment and rehabilitation. Development of Forums where FDUs can come together as a community and develop as self-advocacy forces can actively challenge human rights violations and causes of vulnerability. Legal assistance should be provided to FDUs to manage drug offences, petty crime and issues of violence and harassment. This can be done through providing advice sessions, developing guidelines on legal issues relevant to drug use and/or developing legal support services to assist drug users whenever required.

7.2.3 Designing services with a "women-centered", and a "need-based" approach

An effective targeted response is necessary in order to promote safer behavior, improve access to effective health and social services, and to address the underlying structural and occupational dimensions of vulnerability. The multi-component structure of these services should be developed in response to clients' expressing their unmet needs, through an active involvement of the drug using communities. The key underlying principles are being "community participation", "women-centered", adopting a "needs-led" approach and having an understanding that problem drug use cannot be tackled in isolation from women's other needs. There is a need to broaden the focus of existing programs to address a broad and long-term perspective, and the programs should incorporate a community-development

approach built into their basic framework. Building trust and confronting confidentiality issues and empowering drug users at the individual, community and societal level is a vital component of addressing their vulnerability.

Some of the approaches that can be used include:

- Providing *Drug abuse treatment services*, especially for women more engaged with hard core drugs such as Heroin and Synthetic drugs should be made widely available and accessible. These services should be non punitive, friendly and gender sensitive. Most of the drugs services currently available in the country mainly focus on the needs of male drug users and do not effectively address the health needs, both physical and mental, and family problems of their female clients. Initiating women centered programs would deploy treatment services including design, content and strategies which are more women friendly, including steps such as employing female counselors, female staff and or workers and having women-specific need based programs. When required, also extending children support services.

- Developing *comprehensive harm reduction programs* to specifically target their situations and vulnerabilities, through developing drop in centers. A participatory design process with FDUs involved should be promoted. While the essentials of peer education/outreach, provision of safe spaces, and clinical services remain the same, the way these are carried out can best be decided by FDUs themselves. Following could be some of the key components of the harm reduction program.

- *Provision of HIV/STI information and knowledge focused to improve attitude towards prevention and their own risk of HIV henceforth changing their high risk behaviors;*
- *Primary health care facilities and basic medical treatment, including management of STIs;*
- *Syringe and needle exchange;*
- *Promotion of effective condom use including increasing their skills related to condom use and negotiating condom use with their sexual partners;*
- *Condom & lubricant provision;*
- *Voluntary counseling and HIV testing;*
- *Provision of enabling environment;*
- *Psychological counseling and support ;*
- *Empowerment initiatives that allow members of the vulnerable populations to feel they have greater control of their lives;*
- *Legal aid services;*
- *Education and other forms of child support;*
- *Referral for drug abuse treatment;*
- *Linkages with vocational training program;*

- Providing *outreach services* targeting women drug users through use of female outreach workers. Outreach work is described as a way of delivering services to women who are unable to access centre-based services. FDUs need to be approached at their homes to provide basic information and, possibly syringes (for IDUs) condoms, lubricants and basic medical services. One to one awareness through counseling should be provided through engaging peer group members, who can play pivotal role in providing out reach services to fellow group members.

7.2.4 Addressing mental health needs

Drug use is linked with a substantial cost for the individual who experiences them and also for their families and communities. These costs are not only financial but are also manifested in terms of role functioning and quality of life. Negative outcomes for women that stem from substance use and its concomitant behaviors range from instability in family and marital relationships to poor physical and mental health and restricted social integration. Results from the ethnographic research have shown that depression, isolation and a feeling of being useless is a fairly commonly characteristic shared by most women. Special emphasis should be laid on meeting these mental health needs of the target population. Individual sessions of counseling as well as creation of a women's support group as a move towards empowerment and improved self-esteem should be conducted by project psychologists on a routine basis. While efforts are mainly directed towards improving the mental state of the individual, family members especially spouses need to be focused to provide a supporting mechanism for the recovering FDUs.

7.2.5 Capacity building

One of the major issues of any public health service in the country is the capacity of those who are providing services. Since drug use among females is a complicated field of work, and needs to be dealt using a professional approach, there is a need to building the right capacity within implementing organizations which equips the staff and resource personnel to deal with the issues of drug use among female using a professional and technical approach. The key areas where capacity should be developed including:

- Project management;
- Peer Outreach;
- Counseling and managing mental health needs of the clients;
- Behavior change communication strategies;
- Operations Research;
- Data collection and utilization.

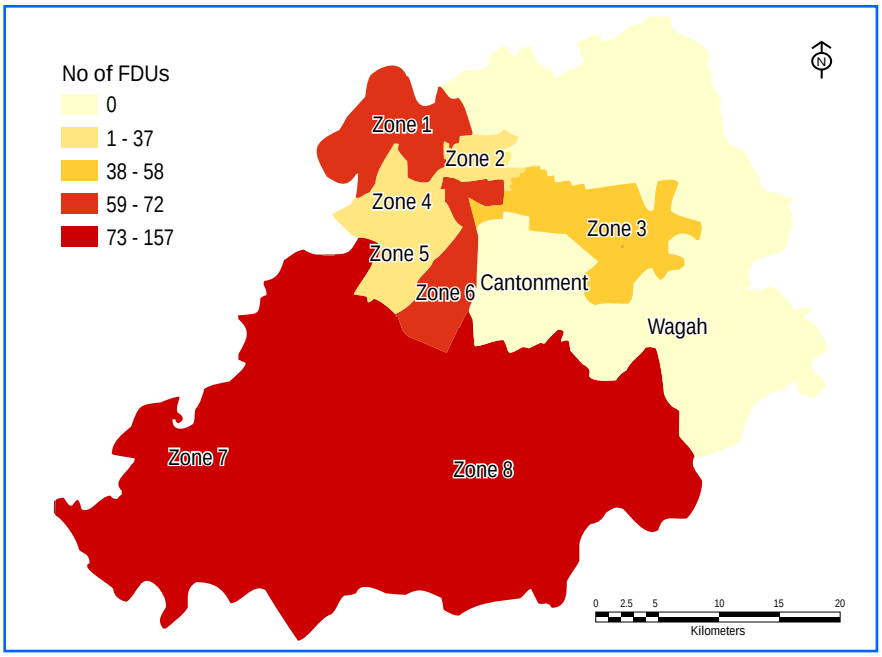
7.2.6 Monitoring and Management Information System

Once the project services are fully implemented, a monitoring and evaluation framework is desired, followed by development of tools which are more user friendly and less punitive. The entire approach of monitoring should be designed as a supportive process for the staff rather than a judgmental activity. The target group itself should be given a stronger role to play in the overall monitoring of activities, through designing the monitoring framework from the perspective of the drug users themselves. Since the project is a multi-site based activity, for better management a management information system is recommended, which should be used to provide timely and cost effective information for decision making, and effective management of the a.m., project in a systematic and timely manner. The System should be designed in a manner to provide operational updates to project management staff in the planning, monitoring and implementation of strategy.

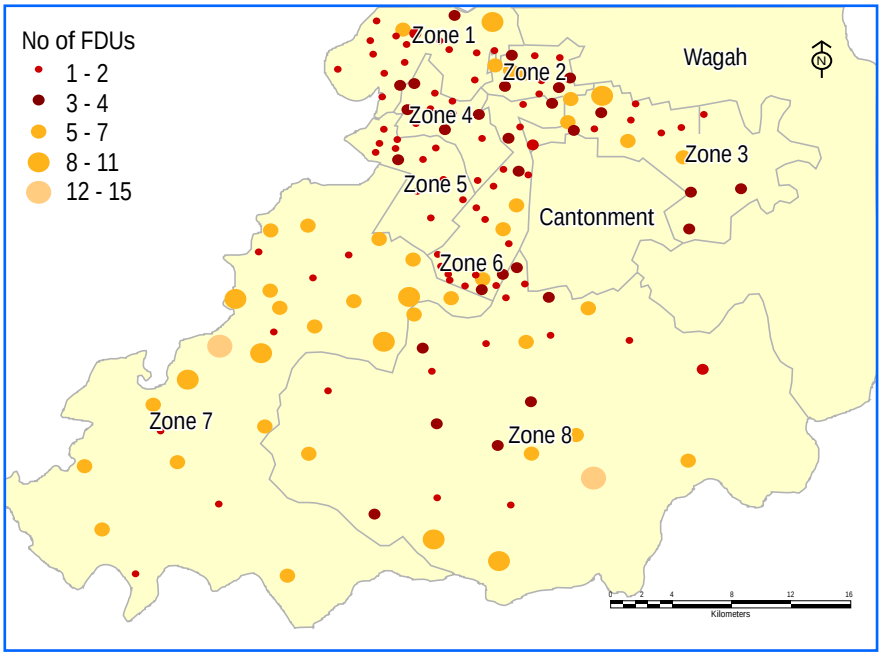
Annexures

Annex 1

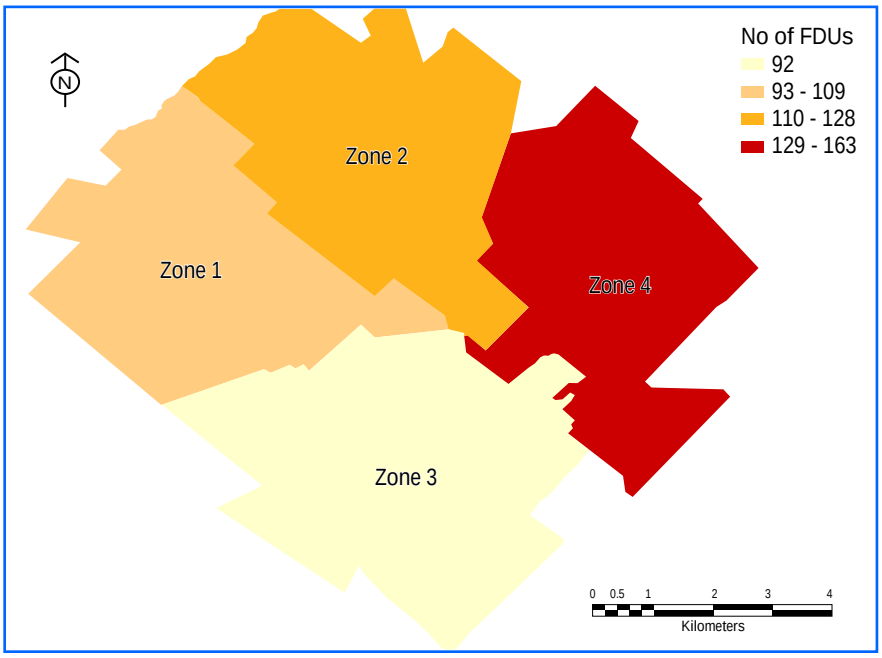
Geographical distribution of FDUs in Lahore



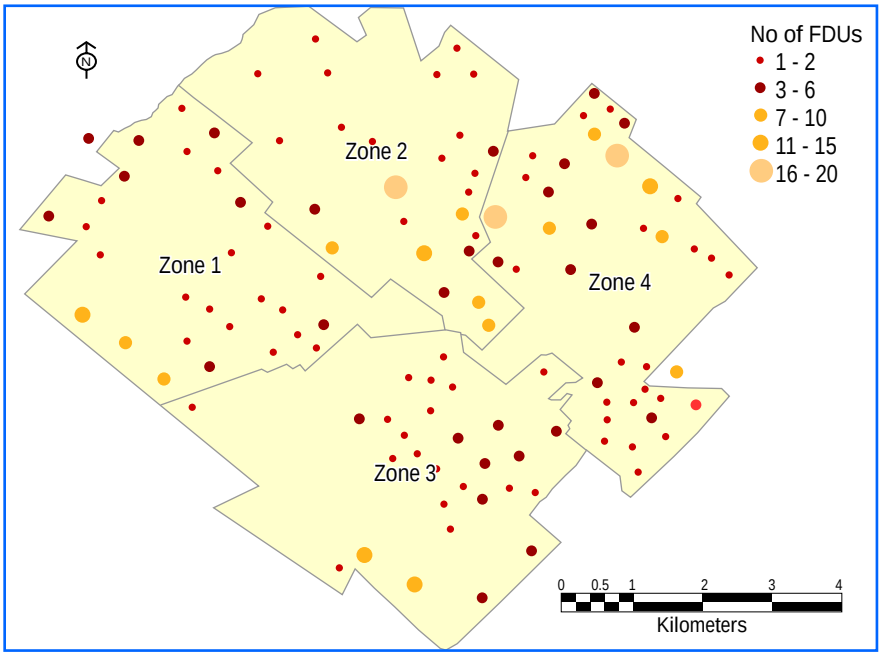
Geographical spots of FDUs in Lahore



Geographical distribution of FDUs in Faisalabad

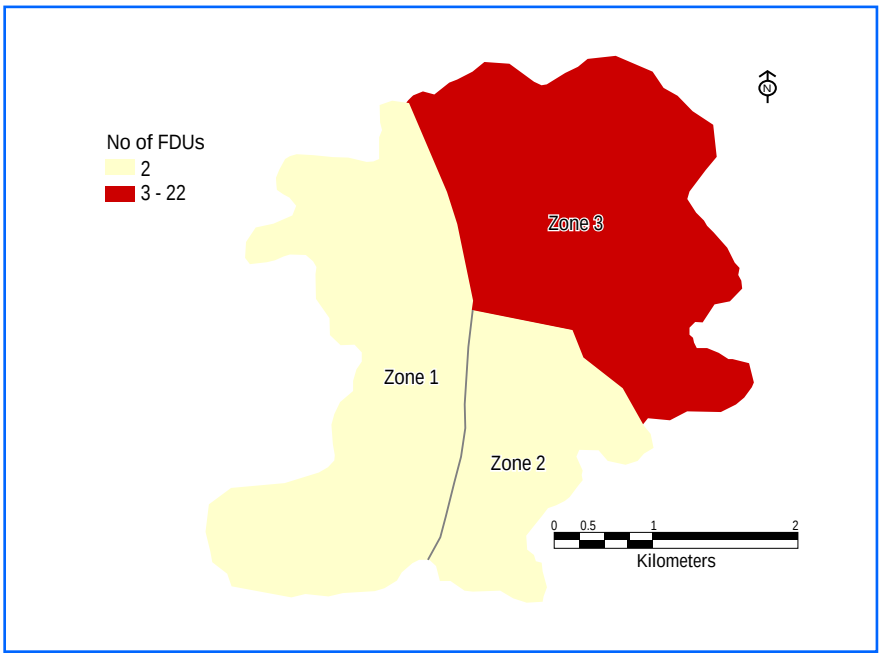


Geographical spots of FDUs in Faisalabad

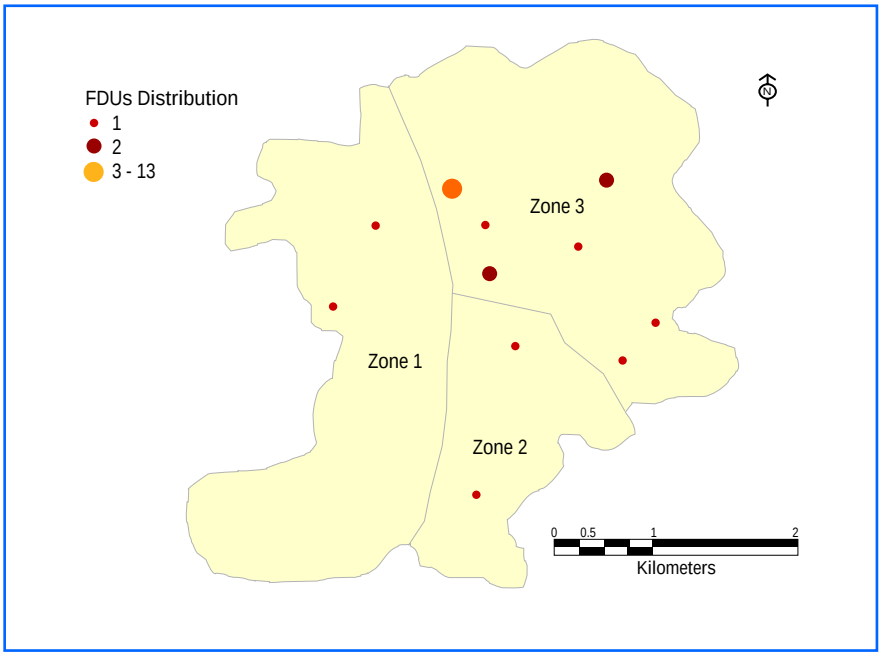


ANNEXURE 1

Geographical distribution of FDUs in Larkana

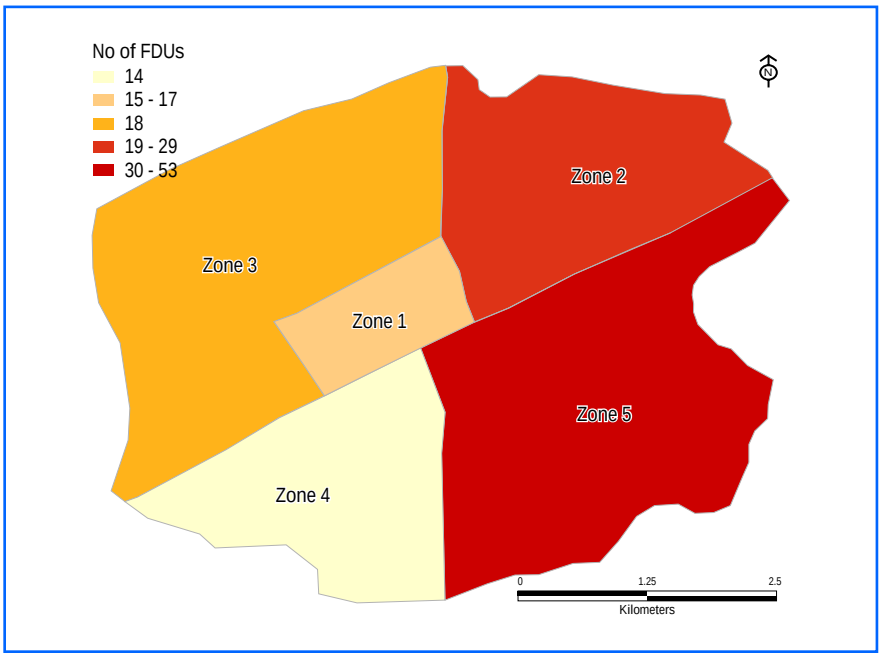


Geographical spots of FDUs in Larkana

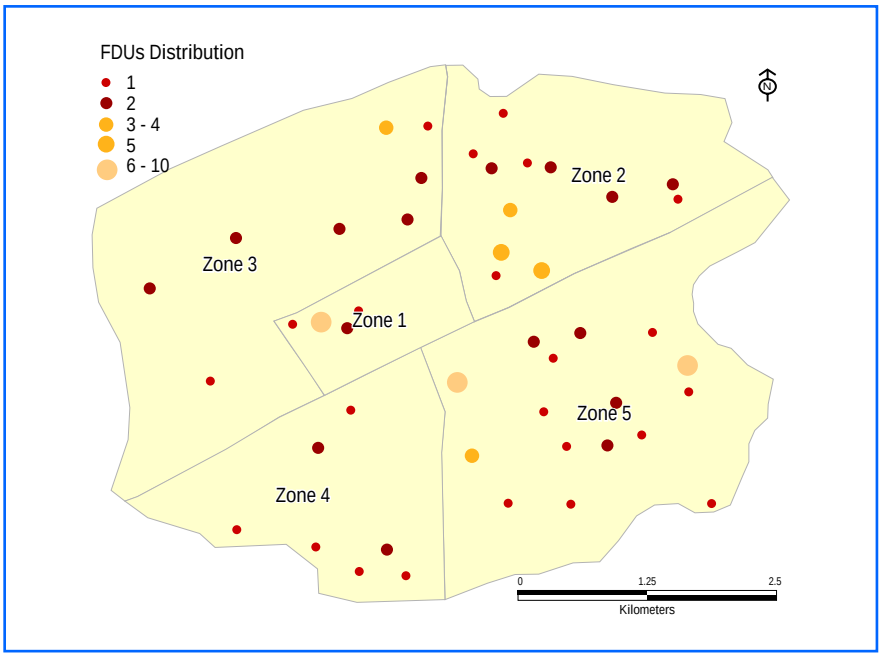


ANNEXURE 1

Geographical distribution of FDUs in Okara

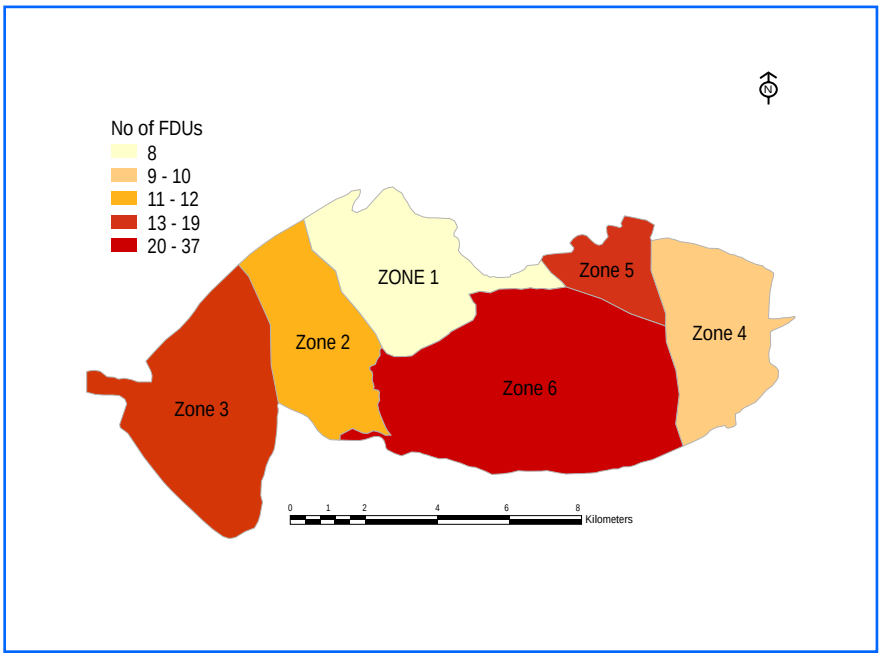


Geographical spots of FDUs in Okara

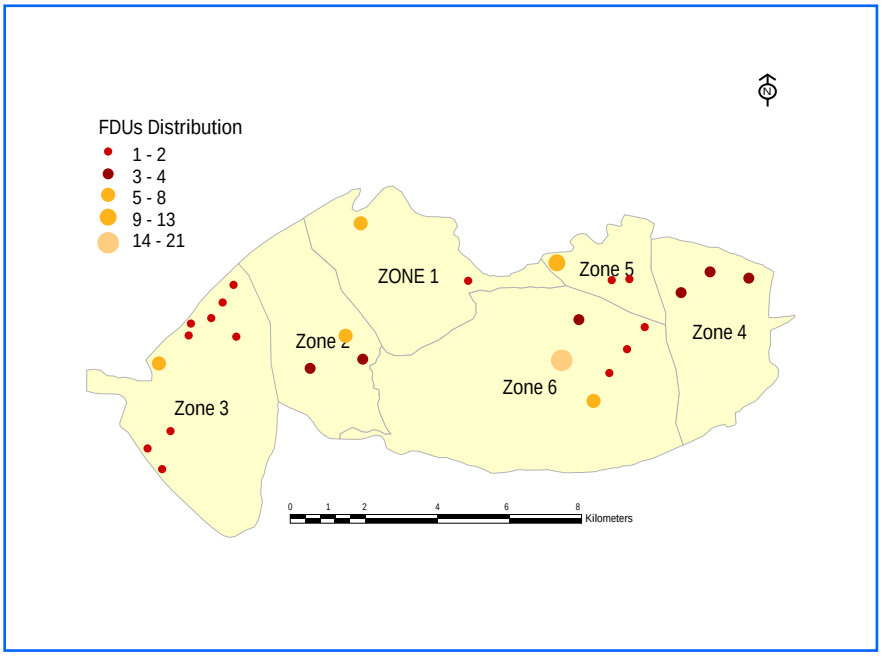


ANNEXURE 1

Geographical distribution of FDUs in Peshawar

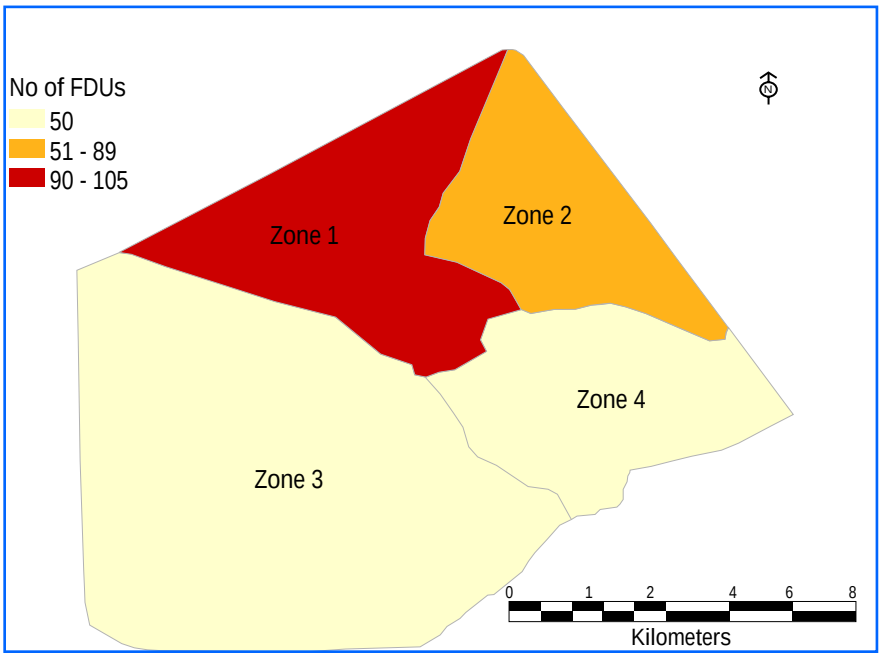


Geographical spots of FDUs in Peshawar

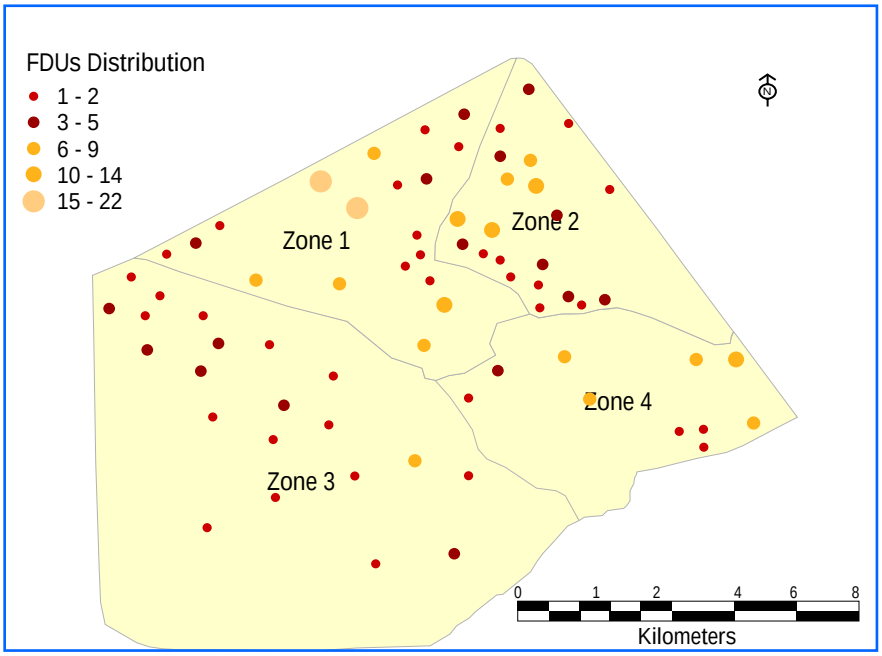


ANNEXURE 1

Geographical Distribution of FDUs in Rawalpindi

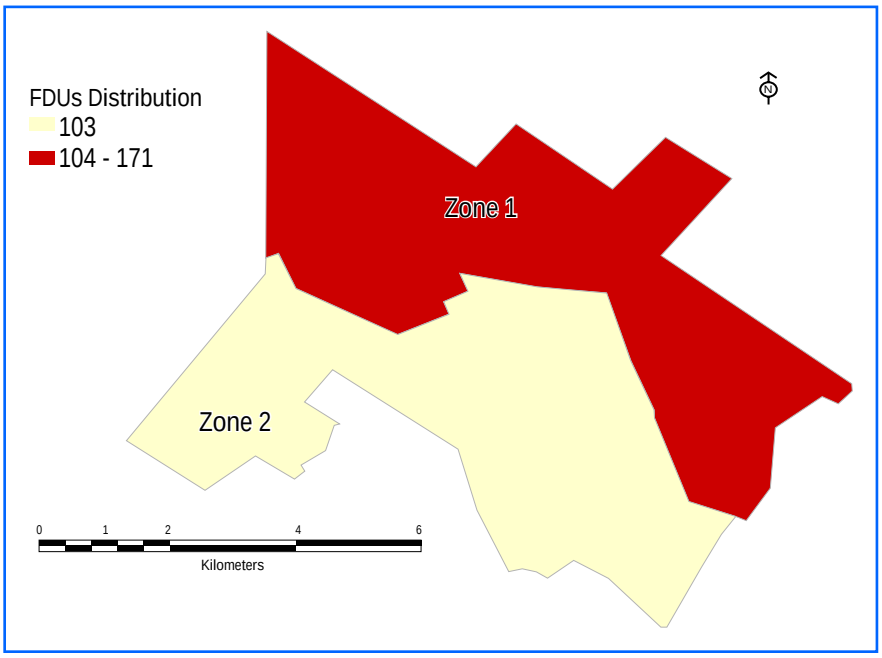


Geographical spots of FDUs in Rawalpindi

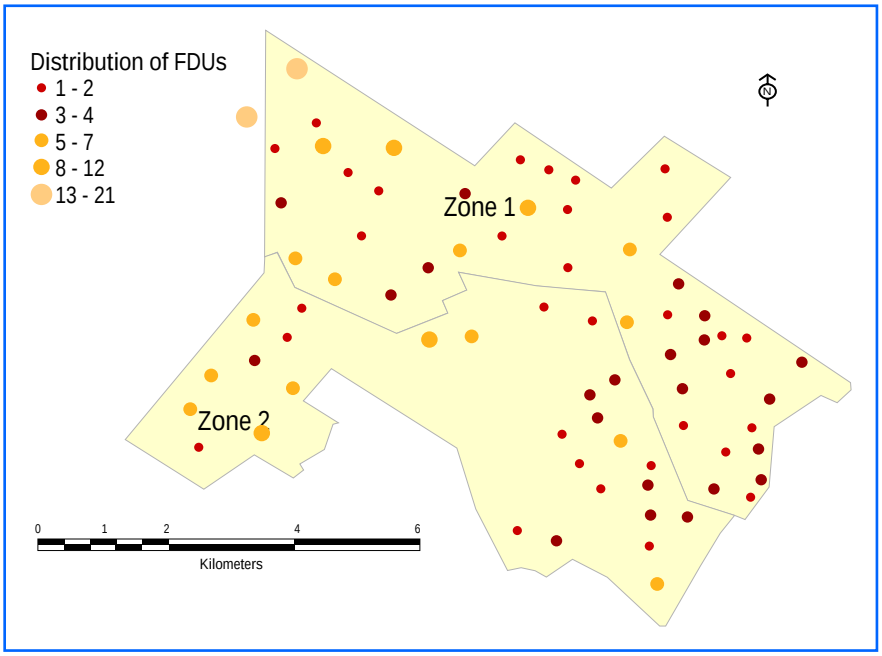


ANNEXURE 1

Geographical distribution of FDUs in Sargodha

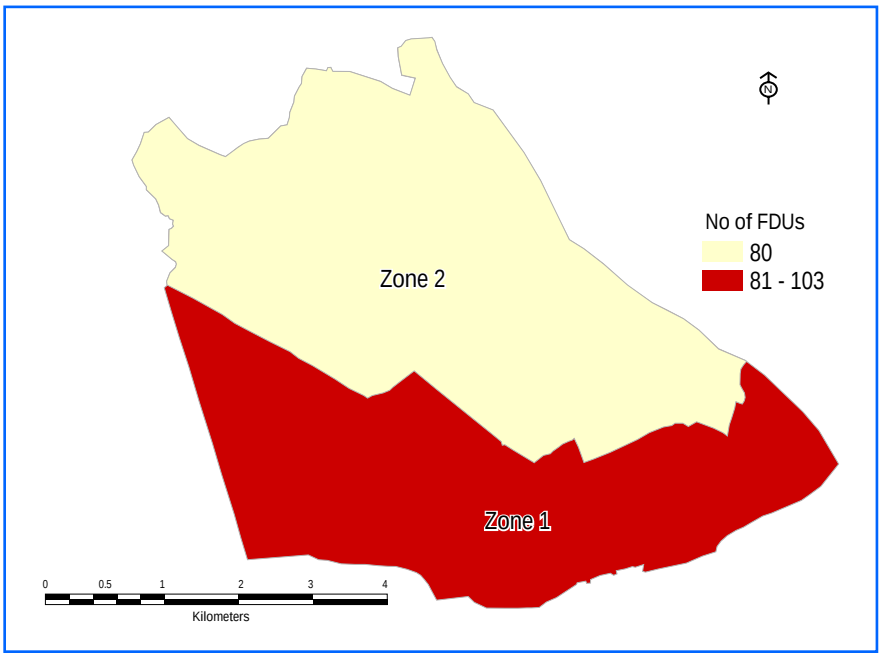


Geographical spots of FDUs in Sargodha

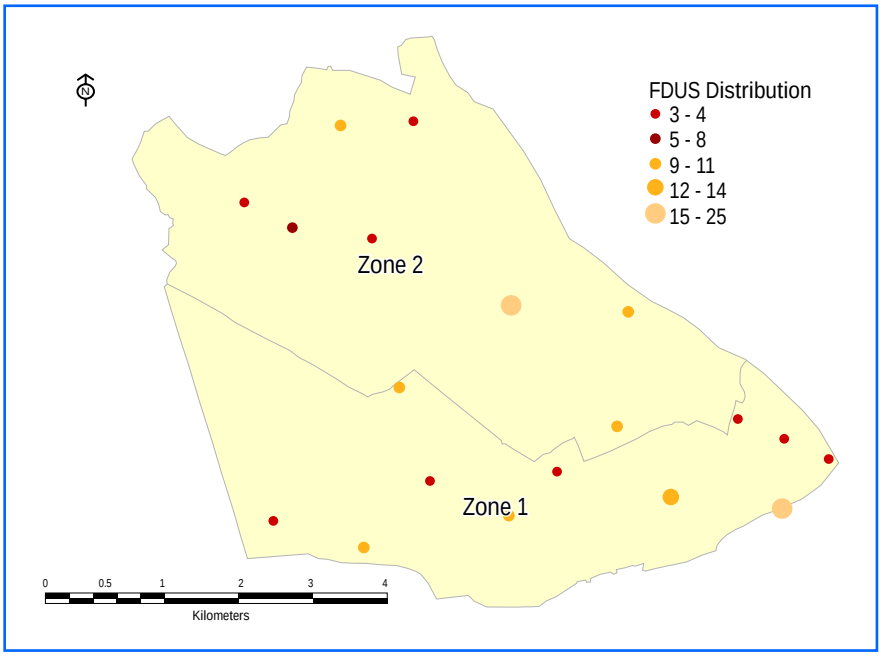


ANNEXURE 1

Geographical distribution of FDUs in Sukkhur

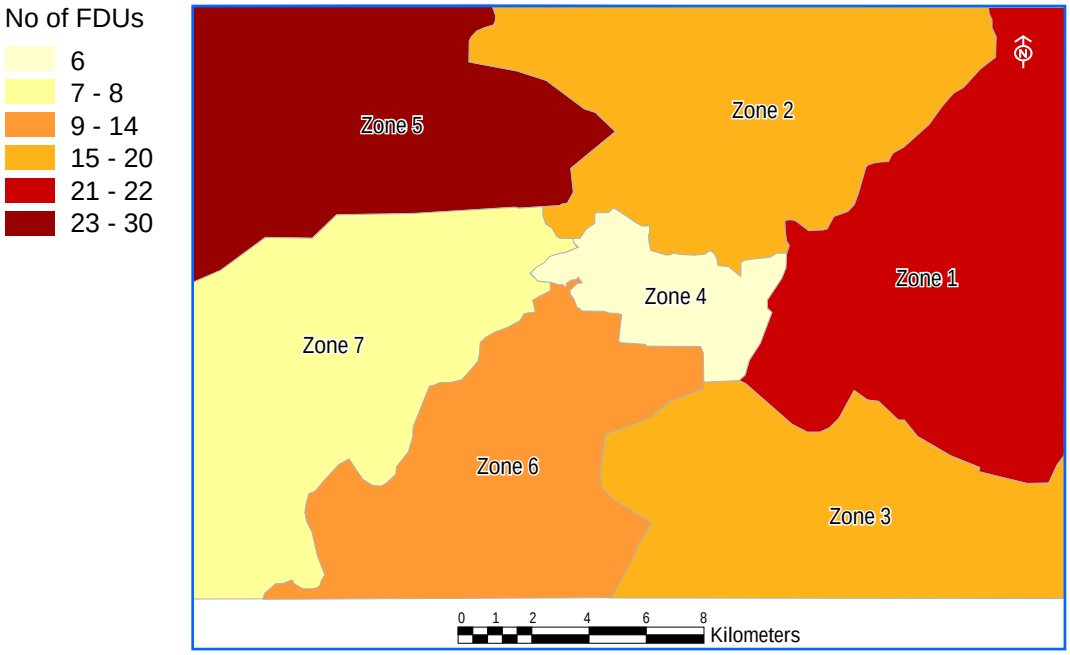


Geographical spots of FDUs in Sukkhur

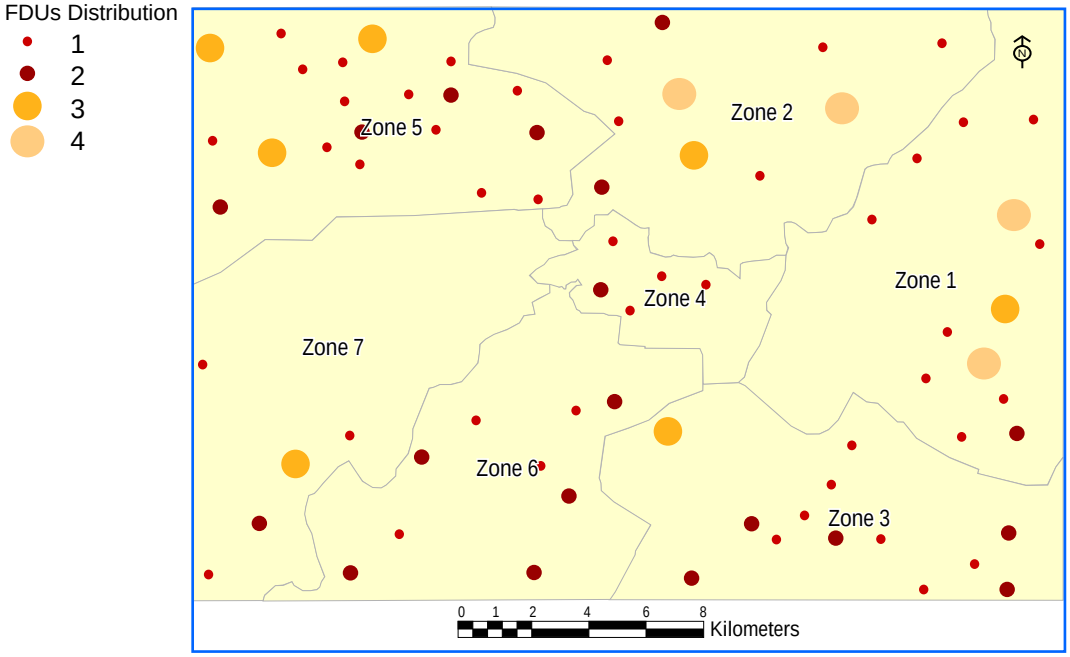


ANNEXURE 1

Geographical distribution of FDUs in Multan

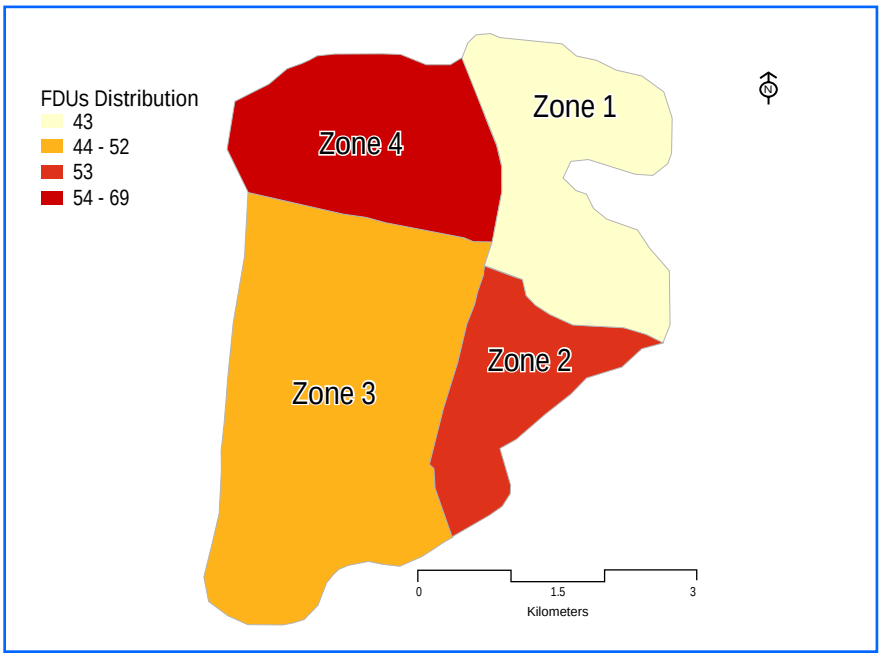


Geographical spots of FDUs in Multan

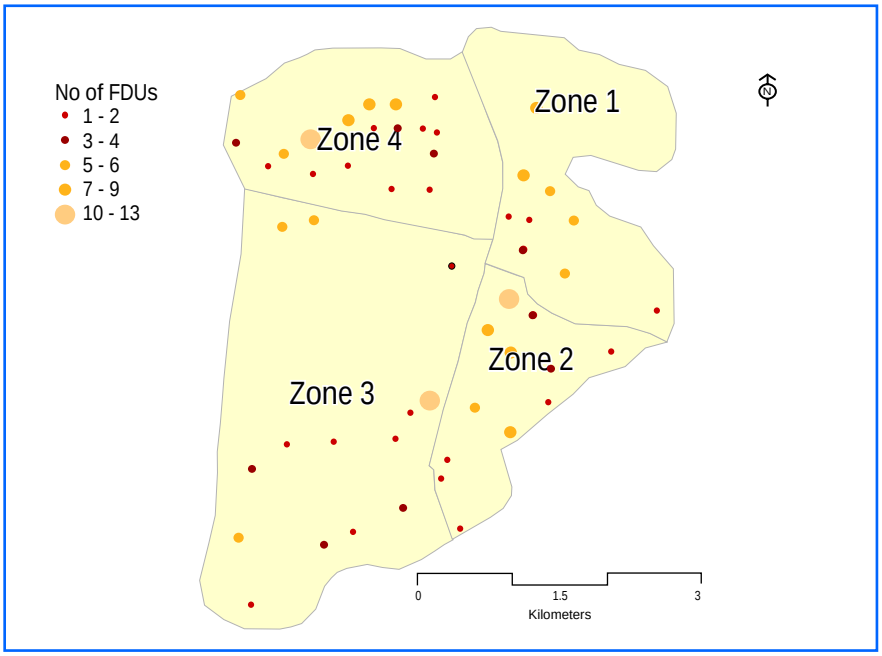


ANNEXURE 1

Geographical distribution of FDUs in DG Khan

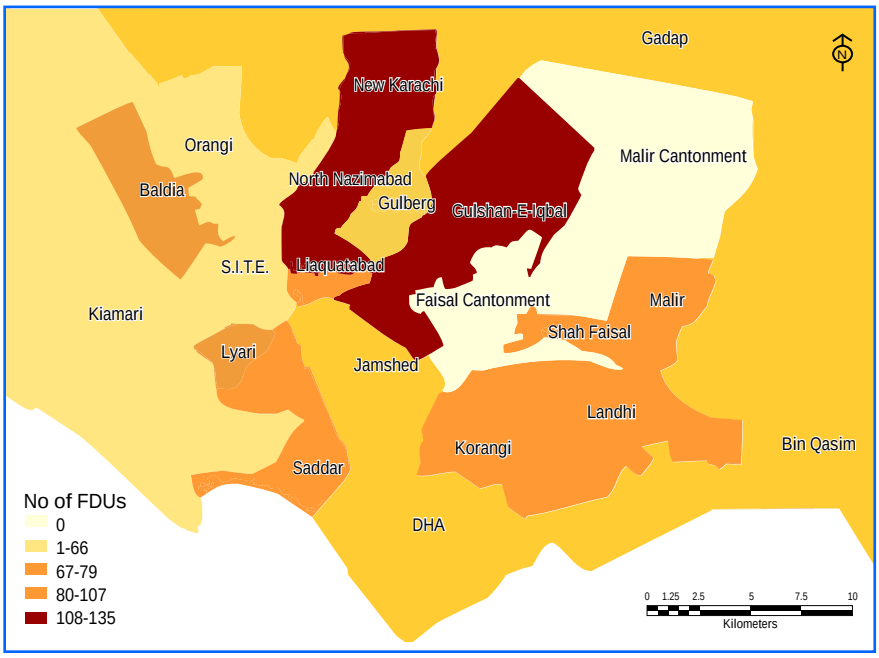


Geographical spots of FDUs in Quetta



ANNEXURE 1

Geographical distribution of FDUs in Karachi



ANNEXURE 1

Annex 2

UNODC
United Nations Office on Drugs and Crime

Form No: ☐☐☐

Mapping of female drug users in Pakistan
QUESTIONNAIRE

DATE OF INTERVIEW: ☐☐ . ☐☐ . ☐☐ **(DD/MM/YY)**

City: ☐ **Zone:** ☐☐ **Time taken for the Interview** ☐☐ **min**

INTERVIEWER: (Name)..... **Sig:** .....

SUPERVISOR: (Name)..... **Sig:** .....

This information is related to the female drug user who is interviewed

Age ☐☐ in yrs

Education ☐☐ yrs of education

Name ☐☐ 1st name initials

☐☐ 2nd Name initials

Address

IDUs (ever) ☐ IDU (current) ☐

Drug used in past one month

Charas, Hashish	
Heroin	
Opium	
Synthetic Opiates (e.g., Morphine, Bueprnorphine)	
Methamphetamine/Ecstasy	
Anti histamines	
Benzodiazepines	
Hallucinogens (LSD, PCP)	
Solvents/Inhalants	
Others	

Information for other Female Drug Users

No	Zone	1st name initials	2nd name initials	Age group*	Contact info	IDU / DU	Contacted
1							
2							
3							
4							
5							
6							
7							
8							

*Choose from 1=below 20 2=21 to 30 3=31-40 4=41-50 5=more than 50

Annex 3

UNODC
United Nations Office on Drugs and Crime

Reg No: ☐☐☐

Behavioural Assessment of female drug users in Pakistan

DATE OF INTERVIEW: ☐☐-☐☐-☐☐ (DD/MM/YY)

City: ☐ Zone: ☐☐

TIME TAKEN FOR THE INTERVIEW: ☐☐ (in mins.)

INTERVIEW DETAILS

INTERVIEW ID: ☐☐

INTERVIEWER: (Name)..... Sig: .....

SUPERVISOR: (Name)..... Sig: .....

DATA ENTRY INFORMATION

Form received on : ☐☐-☐☐-☐☐ (DD/MM/YY)

DATA ENTERED BY : (Name)..... Sig: .....

DATA SUPERVISOR: (Name)..... Sig: .....

BEFORE STARTING THE INTERVIEW, PLEASE READ THE FOLLOWING TEXT ALOUD TO THE RESPONDENT:

"This interview is part of a country-wide research study on the prevalence of drug abuse among females. The interview should not take long to complete. The questions cover various aspects of your drug use history, treatment history, legal involvement, sexual behaviour and other personal information. The interview is confidential and anonymous. Nothing that you tell us can be traced back to you as an individual. It is important that you understand that your participation in this interview is entirely voluntary, there are no risks involved and you are not obliged to answer all or any of the questions if you do not wish to and you may terminate the interview at any point.

Before we start, do you have any questions that you would like to ask me?"

SECTION 1: SOCIO-DEMOGRAPHICS

First of all, I would like to ask you some general background information about you.

1.1. How old are you? ☐☐ years

1.2. How many years of education have you completed? ☐☐ years

1.3. What is your current marital status?

1	Single never married	2	Married	3	Divorced	4	Separated
5	Widowed	7	Other	(Specify)			

1.4. Where did you mostly live in the last 6 months?

1	House	2	On the street	3	Other (specify)

1.5. With whom did you (mostly) live in the last 6 months?

1	Parents	2	Spouse & Children	3	Children only	4	Other family
5	Friends	6	Alone	7	Other (specify)		

1.6. What do you do for living _____

1.7. Please tell me all of the ways in which you have financially supported yourself in the last 6 months: ***[read all the answers and check all applicable]***

1	Wages / salary	2	Casual work	3	Family/lover
4	Friends (partner)	5	Benefits/Pension	6	Begging
7	Selling drugs	8	Thefts	9	Pick pocketing
10	Prostitution / sex for money	11	Other (specify)		

1.8. What language do you mostly speak at home

1	Urdu	2	Punjabi	3	Sindhi
4	Pushto	5	Other (specify)		

1.9. Which city do you belong to

1	This city	2	Other (name of the city)

SECTION 2: DRUG USE HISTORY

I am now going to ask you about your use of drugs. Remember that this is a confidential interview and your answers will in no way be linked to you.

2.1 Types of drugs used

Drug Type	a) Ever used	b) Age at 1st use	c) Used in last 12 months	d) used in last 30 days*
	Tick (✓) if yes, leave blank if no			
1 Cannabis (Charas, Hashish)				
2 Heroin				
3 Opium				
4 Other Opiates (e.g., Morphine, Codeine, Buprenorphine etc.,)				
5 Methamphetamine/Ecstasy				
6 Barbiturates				
7 Benzodiazepines (specify)				
8 Hallucinogens (LSD, PCP)				
9 Solvents/Inhalants				
10 Alcohol				
11 Cigarette (tobacco)				
12 Others (specify)				

2.2 Of all the drugs we have talked about, can you tell me which was the ONE DRUG that has caused you the most harm or problems? ☐

2.3 Have you ever injected drugs? : 1 Yes 2 No

IF NO, GO TO SECTION C

2.4. How old were you when you first injected any drug ☐ years

2.5. In the last six months, on the average, how often did you inject drugs?

1	Once a month or less	5	Four to six days a week
2	Two to three days a month	6	Everyday
3	About once a week	9	Don't know
4	Two to three days a week		

2.6 In the last six months, which drugs did you inject? *(write names of drugs used)*

1.
2.
3.
4.
5.

2.7 On a typical day when you injected in the past 6 months, how many times did you inject drugs?

1	About once a day	3	More than four times a day
2	Two to four times a day	9	Don't know

2.8 In the last 6 months where have you injected most often

1	Place where you live	5	Abandoned building
2	In a lover's/sex partners home	6	On the street/park/public place
3	Friend/ relative place	7	Jail
4	Dealers house or apartment	8	Other specify

2.9 In the last six months, how often have you injected in a group where other people have also been injecting?

0	Never	1	Rarely
2	Sometimes	3	Often
4	Always	9	Don't know

2.10 In the last six months, how often did you inject with a needle or syringe after someone else had used it?

0	Never	1	Rarely
2	Sometimes	3	Often
4	Always	9	Don't know

2.11 In the last six months, how often did you require services of a another drug injector or a professional injector/street doctor?

0	Never	1	Rarely
2	Sometimes	3	Often
4	Always	9	Don't know

Now, I am now going to ask you about the last injection you took. Please try to recall the time when you injected the last time and answer the following questions.

2.12 In the last six months, when you injected drugs, how often did you use any of the following items with other people or after other people had used them?

		Yes(1)	No(2)	DK(9)
a	Drawn drugs from the same cooker (bottle cap, spoon etc)			
b	Used the same cotton swab			
c	Used the same rinse water (to clean injections, needles)			

2.13. When did you inject the last time?

1	Today	4	More than a week but less than a month
2	Yesterday	5	More than a month ago
3	Last week	9	Don't remember

2.14 With whom did you inject the last time?

1	N/A only injected by self	4	With people you don't know
2	With a sex partner (spouse, boyfriend)	9	Don't remember
3	With friends or acquaintances		

2.15 The last time you injected, did you inject with a needle or syringe after someone else had used it?

1	Yes	2	No	9	Don't remember

2.16 The last time you injected, did you sought help from another drug injector or a professional injector/street doctor?

1	Yes	2	No	9	Don't remember

2.17 The last time you used a new syringe, where did you get it ? ***(tick one answer only)***

a)	Wife husband, girlfriend, boyfriend, lover or sex partner	
b)	From a family member or a relative	
c)	From a friend or an acquaintance	
d)	From a pharmacy	
e)	From a outreach worker	
f)	From a DIC	
g)	From another injector (needle dealer)	
h)	From a drug dealer	
i)	Other (specify)	

2.18 Do you know where you can get a new syringe free of charge?

1	Yes	2	No	9	Don't remember

SECTION 3: SERVICE UTILIZATION

Now, I am going to ask you questions about your treatment history. Please think now about all the treatment you have EVER had for drug problems, if any.

3.1. Have you ever received treatment for a drug problem? **IF 'NO' go to Q 3.9**

0	No	1	Yes

3.2 In total, how many times in your life have you been treated for drug problems?

_____ No of times treated

3.3 Of the times you have been treated, were you treated at *[check all applicable]*

		If Yes (tick)
a.	Private clinic by a doctor	
b.	Drug Treatment unit in Govt hospital	
c.	Private Clinic	
d.	NGO run treatment facility	
e.	At home	
f.	Abroad (specify)	

3.4 To what extent would you say that you are currently in need of treatment for your drug use problem?

1	Urgent need	2	Some need	3	No need

3.5 Have you ever wanted to get help/treatment for drug problems but was unable to?

1	Yes	2	No

3.6 Are you aware of any DIC/similar services for prevention of HIV/AIDS in your area?

1	Yes	2	No	***If "NO" go to Q 3.9***

3.7 In the last 6 months have you ever used any of these services?

1	Yes	2	No	***If "NO" go to Q 3.9***

3.8 In the last 6 months how many times have you used these services? _____

3.9 In the last 6 months have you ever been in contact with an outreach worker ?

1	Yes	2	No	***If "NO" go to next section***

3.10 In the last 6 months when you were in contact with an outreach worker, mostly what services did you receive *[ask as open ended question and check the relevant code]*

A	Exchange of needles / syringes	
B	Condoms	
C	Prevention kit, e.g., Chlorine	
D	Leaflets / booklets on prevention of HIV/AIDS	
E	Counselling for behavioural change	
F	Overdose prevention	
G	Referral to DIC	
H	Referral for other services	
I	Other specify	

SECTION 4: PRISON HISTORY

INTERVIEWER: I will now ask you some questions about your arrests and imprisonment, i.e. if you have been arrested or imprisoned. Again, as I have said before, all of our discussion will be anonymous and confidential.

4.1. Have you ever been arrested for a drug-related offence?

1	Yes	2	No ***IF NO go to next section***

4.2. How many times in your life have you been arrested for a drug-related offence?

4.3 In total, approximately how much time have you spent in prison during your lifetime?

☐☐ Days ☐☐ Months ☐☐ Years

4.4. Which of the following offences have you ever been arrested for?

INTEREVIEWER: READ ALL OFFENCES AND CHECK ALL APPLICABLE

A	Possession of illegal drugs	B	Selling illegal drugs	D	Using drugs	E	Burglary
F	Prostitution	G	Shop lifting	H	Theft	I	Other (specify)

		No	Yes	DK
4.5	**Have you ever injected while you were in any of these institutions?**			
4.6	**When you injected in one of these institutions were you ever able to get new needles?**			
4.7	**When you were in one these institutions, did you ever have sex?**			

4.8 When you had sex while you were in these institutions, did you ever use condoms?

1	Never	2	Rarely	3	Sometimes
4	Often	5	Always	9	Don't know

SECTION 5 SEXUAL HISTORY

We are now almost at the end of our questionnaire. In the previous sections I asked you questions about your injection drug use and sharing. As sexual lifestyle can also be risk behaviour for HIV or Hepatitis infections, in this section I will ask you some questions regarding your sex lifestyle. As I had said in the beginning of the interview, if you do not feel comfortable in answering any of the questions in this section, you may refuse to answer them.

5.1 How old were you the first time you had sex? _____ years

IF NEVER HAD SEX GO TO NEXT SECTION

5.2. Was this person your… *(read all the choices)*

1	Husband	4	raped
2	Boyfriend	7	Other specify
3	Acquaintance	9	No reply

5.3 Have you ever had sex with other people who use drugs or inject drugs?

1	Yes	2	No

Now, I would like to ask about your sex activity in the lat 6 months

5.4 In the last six months, how often have you had sex?

0	None	4	Two to three days a week
1	Once a month or less	5	Four to six days a week
2	Two or three times a month	6	Everyday
3	About once a week	9	Don't know

5.5. In the last six months, how many men have you had sex with _____
(If none write 00, if unknown write 99, if refused write 88)

5.6 In the last six months, how often did you use a condom?

0	Never	1	Rarely	2	Sometimes	3	Often	4	Always	9	DK

Read each question and write responses

		Yes(1)	No (2)	DK(9)	No of partners
5.7	**Did you receive drugs to have sex?**				
5.8	**Did you receive money to have sex?**				

ANNEXURE 3

5.9. How often did you or these partners use condoms while you were having sex?

0	Never	1	Rarely	2	Sometimes	3	Often	4	Always	9	DK

5.10 How would you describe your relationship with the last person you had sex with? Was this person a..

(READ ALL OPTIONS, CHECK one category)

1	Steady partner such as a spouse, boy/girl friend or lover
2	Casual partner
3	Paying partner (paid you with money or drugs
4	Charging partner (you paid with money or drugs
5	Other (specify)
8	Refused
9	Don't know

5.11 The last time you had sex, did you or the person you were with use a condom?

1	Yes	2	No	8	Refused	9	Don't know

SECTION 6 KNOWLEDGE OF HIV/AIDS

6.1 Have you ever heard of HIV or the disease called AIDS?

1	Yes	2	No	8	Refused	9	Don't know

IF 'NO' GO TO NEXT SECTION

6.2 Do you know how HIV can be transmitted from one person to another
(Don't read the list, tick the answer which the person knows)

A	Sexual intercourse	
B	Sharp instruments/syringe	
C	Insect bites	
D	Kissing, Touching, Hugging	
E	Eating & drinking with patients	
F	Mother to child	
G	Blood transfusion	
H	Staying filthy	
I	Through Animals	
J		
K		

6.3 Do you know how HIV can be prevented
(Don't read the list, tick the answer which the person knows)

A	Using Condom	
B	Refraining from sex	
C	Staying Away from pts	
D	Staying clean	
E	Transfusing screened blood	
F	Using clean/new syringes	
J		
K		

6.4 Do you know where can people go, if they want to do an HIV/AIDS test?

1	Yes	2	No

6.5 Have you ever been tested for HIV/AIDS?

1	Yes	2	No

6.6 Do you know that there are diseases that can spread through sex?

1	Yes	2	No	***IF 'NO' GO TO NEXT SECTION***

6.7 During the past 6 months did you suffer from any disease that can spread through sex?

1	Yes	2	No	***IF 'NO' GO TO NEXT SECTION***

6.8 If yes did you get any treatment for that disease?

1	Yes	2	No	***IF 'NO' GO TO NEXT SECTION***

6.9 If yes where/from whom did you get treatment ?*(CHECK one category)*

1	Doctor /Hospital
2	Self Medication
3	Dispensary/TBA
4	Hakim/ Homeopathic
5	Pharmacy

Thank you very much for your kind cooperation and spending your valuable time with me.

Ask participant if s/he has any questions. Provide risk reduction counselling as appropriate. Give referrals/ information re nearby HIV testing and counselling services. Provide information on local health social service agencies if appropriate.