Good Practices

in "HIV Prevention, Care and Treatment for Female Drug Users, Female Prisoners and Women living with HIV and AIDS in Nepal"
Preface

Since 2008 UNODC has been working in Nepal with Women who inject drugs (WID), Women who use drugs (WUD), female prisoners and women living with HIV and AIDS (WLHIV) in an innovative project that has pioneered approaches to meeting women’s special needs for programmes and services. UNODC activities and interventions include advocacy, capacity building and implementation support for services and interventions to address the HIV risk and vulnerability as well as the various forms of stigma that drug using women face on a daily basis.

Being an innovative project, UNODC considered it useful to commission a study which would allow to draw conclusions on the basis of the evidence of the practices of the project. The study, conducted in 2010/2011, gathered data on female drug users which were combined with observation and anecdotal evidence and thus allowed to develop a clear and comprehensive picture of the good practices that have evolved within the project. UNODC hopes that this guide does not only provide the sufficient argument to allow for the continuation of the project’s good course, but also that it be expanded, extended and replicated in other settings, for the benefit of all such vulnerable women, their families and the communities in which they live, in Nepal and maybe elsewhere.

UNODC would like to thank the many organizations and individuals who have helped bring this “good practice” paper to life by giving access to their activities and by generously sharing their time and their insights into what has worked best. UNODC is especially grateful to the staff and members of NGOs – DRISTI-Nepal, Naulo Ghumti, Women Concern Society, Community Support Group, Sneha Samaj and staff and female inmates of Kaski Prison.

Cristina Albertin
Regional Representative
The Central Bureau of Statistics, Government of Nepal has estimated in 2013 that there are 6,330 female current drug users in Nepal of a total 91,534 estimated users.
Introduction

Women who use drugs are a neglected, almost invisible group in most places in the world. Since male drug users generally outnumber women\(^1\), women who use drugs are often overlooked in research and frequently ignored in programmes serving men who use drugs. The assumption is that women who use drugs will find a way to fit into drug programmes for men and get their needs met somehow, as women do in so many other areas of life. But experience shows that instead women who use drugs tend to fall through the cracks in male drug programmes. They hide, cannot be contacted by the programme, come one time to a drop-in center or programme activity and never return, or simply refuse to come at all. Drug programmes designed for men simply do not meet women needs.

Nevertheless, research shows that women who use drugs needs are greater than men’s in many ways. Studies show, for example, that women who use drugs suffer from stigma and discrimination to a greater degree, they are more likely to commit suicide or to die from drug abuse. Women use different drugs that lead to special problems. In Nepal, they often choose to inject medically available pharmaceuticals with a high potential for addiction, overdose and vein damage. Women who use drugs have greater health and mental problems overall, and their problems are passed to the next generation through babies that are premature, underweight, usually unplanned and perhaps unwanted, or even born addicted. When women who use drugs are involved in sex work, their situation is even more tenuous, subject to greater stigma, and greater risk of arrest, causing them to stay away from programmes developed primarily for men.

The more difficult situation of women who use drugs makes strategic, intelligent programmatic responses imperative, and this calls for attention to pioneering programmes that offer gender-responsive, comprehensive drug prevention and care to women. One such programme is the UNODC Programme in Nepal\(^2\), funded by the Government of Norway since 2008. This programme has been praised for its innovative work with women who use drugs, women who inject drugs, female prisoners (many of whom are also using drugs), and women living with HIV and AIDS (WLHIV).
The Project’s goals are to foster a supportive policy and enabling programme environment for WUD; to involve WUD communities as active participants in programme development, design, implementation, monitoring and evaluation; to support linkages between civil society organisations and government agencies to strengthen their joint capacity. The Project provides a comprehensive package of services including: outreach and peer education; access to condoms, sterile needle and syringes, primary health care, Opioid Substitution Treatment (OST), voluntary counseling and testing (VCT), antiretroviral therapy (ART).

Currently, the Project partners with NGOs and networks are implementing the activities in nine districts throughout Nepal. The Project collaborates closely with the National Centre for AIDS and STD Control (NCASC) with guidance from the Ministry of Home Affairs (MoHA). It is aligned to the national strategic frameworks for HIV/AIDS and drug policy in the country.

Because dedicated programmes for women drug users are so rare, UNODC has invested time and effort in experimentation and innovation to find the solutions that work best to meet the needs of women drug users and take into account the special situations they face.

This paper focuses on eight essential principles of effective programming for women drug users which have emerged within the UNODC Nepal specific WID programme. They are:

1. Invest in original research to increase understanding of women drug users and provide the basis for an evidence-informed programme for them.

2. Ensure that drop-in centers are safe, “shame-free” zones, exclusively for women, and matching their perceived needs and preferences.

3. Foster, encourage and support community organizations run by WUD and WID themselves in order to reach previously unserved groups.

4. As a programme priority, ensure continuous, regular access to sterile needles and syringes for the most impoverished WID.

5. Include psycho-social support and other interventions to address the various forms of violence WUD face, including self-mutilation.

6. Recognize the drug use - sex work connection and provide access to condoms, lubricant, STI testing and treatment for WUD involved in sex work.

7. Work closely with prison and law enforcement agencies to improve the health, skills, social and psychological conditions of women prisoners.

8. Provide shelter, empowerment and skills to harness the energy of village women living with HIV (WLHIV).
In the following pages, each of these programming principles is discussed theoretically, with reference to international best practice, noting innovations by the UNODC are particularly noted. Finally each principle is captured in photographs and a concrete example from the field (see text boxes). The purpose of this best practice paper is to provide guidance to programme developers and funders, to ensure that high quality programmes for WUD and WID are recognized, so that good programmes can be supported, extended, expanded and replicated whenever possible, for the benefit of all women drug users everywhere.
UNODC’s study showed that the typical Nepali woman who inject drugs is 18-21 years old (60%), poorly educated (primary school or less, 66%), unmarried (53%) and living with family members.
International research showed clearly that female drug users are generally different from male drug users in a number of ways. The European Centre for Monitoring of Drugs and Drug Addiction, for example, has found for countries across Europe that women’s drug use begins at a slightly older age on average, that women use proportionately less of the more illegal drugs (such as heroin and other opiates); that younger women are more likely to use ATS and older women to use pharmaceuticals than men; and that the ratio of women to men drug users tends to increase as the prevalence of drug use increases in a community. Research also shows that most of the care provided by drug treatment services is for the users of opiates, cocaine and cannabis – problems for which male clients far outnumber women. In other words, present treatment programmes do not address women’s drug use patterns well. Most of these studies, however, come from other regions, such as Europe or the Americas. While experience suggests that the findings would be similar in Asia, it is important to study the female drug using population in any setting when setting up a programme to meet their needs.

In today’s fast changing HIV programming climate, with its reality of diminishing funding, it is not always practical to begin a programme with a major research study. However, knowing your audience is a solid programming principle. International experience and research findings are useful, but whenever possible, a programme should supplement that research with research done locally in the country-specific setting.

1. Invest in original research to understand women drug users and provide the basis for an evidence-informed programme for Women who Use Drugs (WUD) and Women who Inject Drugs (WID).

### An Evidence-Based Portrait of a Nepali Woman who inject drugs

- **Statistical data** from UNODC 2010 study on WUDs/WIDUs in Nepal gives a vivid portrait of Nepal’s women who use drugs and reveals their great vulnerability.

- The study showed that the typical Nepali woman who inject drugs is 18-21 years old (60%), poorly educated (primary school or less, 66%), unmarried (53%), and living with family members. She is likely to have no specific occupation (74%), or, if she works, it is only part time. When involved in sex work (25%), she is more likely haven’t finished primary school, and have moved recently into the community and to live alone.

- **She began having sex at 16 and has a regular partner who also uses drugs and alcohol.**

- **She began using drugs at 17 and injecting at 18.** She injects drugs at least once a day, usually buprenorphine mixed with heroin or other drugs, injecting with others, in a group.

- **She may also smoke or take drugs orally, and she drinks alcohol.**

- **Almost all of her available money are used to buy drugs and alcohol.**

---

3 See for example Differences in Patterns of Drug Use Between Women and Men, 2005, European Center for Monitoring of Drugs and Drug Addiction,
There are a number of ways this can be accomplished. First, it is often possible to include questions regarding women who use drugs in national health studies, or behavioral surveillance surveys that may be planned or done regularly. This involves good cooperation between civil society and government and among different ministries within government. In addition to “piggybacking” onto larger studies, a programme already working in the field can build in audience research into its ongoing outreach, through the strategic use of record-keeping forms, and through regular consultations among programme leaders, outreach and field workers and the clients themselves. A two-way, participatory feedback mechanism is not only useful in statistical and/or qualitative information on the beneficiaries but also generates programme ideas in which the beneficiaries feel a sense of ownership, resulting in a healthier, more participatory programme.

When possible, however, the best way to understand the female drug using population in any setting is to conduct a dedicated study to gather statistical data and if possible serological data from the beneficiaries.

UNODC conducted its biological/behavioral research on women drug users in 2010, two years after the programme had started. The advantage was that networks of WUD and WID were already established and served by NGOs. The NGO networks provided a broader access to a wide range of WID and WUD, made it easier to get their consent to take part, and provided safe spaces for the interviews and blood tests.

While the study was intended for WID only, when some WID could not be reached or declined to take part, some non-injectors were included as well. While not originally part of the original study design, including WUD enriched the study by allowing for comparisons or injectors and non-injectors. In the end, about 37% of estimated WID took part.

The study included both demographic and serological data to develop a profile of users’ age, education, marital status, livelihood, as well as their serostatus regarding HIV and other blood borne diseases. The study also examined drug and alcohol use patterns, especially injection; assessed the prevalence of risk practices for HIV and the level of awareness and knowledge of HIV; assessed the presence of symptoms that could indicate a STI; and analyzed the financial costs of substance use, legal problems and intimate partner violence.

A number of good practices are evident in the study methodology. One was to conduct individual interviews before the blood tests, in order to develop a level of trust and goodwill between respondents and interviewers. As a result, over 99% of the respondents (391 of 393) agreed to the blood test – a remarkably high acceptance rate for a serological study. Other good practices included: thorough pre-test counseling; STI treatment if the interviewee reported symptoms; test results provided confidentially on request to individuals only, based on identification numbers (not names); an option to hear results of some (not all) tests; and post-test counseling.

The care taken in this study, together with the strong liaison role with the participating NGOs, helped build the relationship between the programme and the beneficiaries. In addition, involving the NGOs in the study gave them a solid basis for their local programming decisions.
Drop-in centers are a key part of many programmes that serve most-at-risk populations. They are usually essential for peer communication activities, as they provide a place for trainings and meetings, as well as access to staff that support the peer communicators in the field.

Theorists have identified some key “best practice” factors that make a drop-in center work for any group of people. These include: member input and participation in determining the policies, activities and offerings of the center; realistic hours for the members’ life style, work and schedule; a discrete and central location with safe and easy entrance and exit; and, most important, tailor the services according to the needs of all clients.

For communities at risk such as WID and WUD, the focus of a drop-in center should be on mutual problem solving and activities of real interest, not lectures from experts on correct behavior, unless the members have requested them. If counseling is given, it should be voluntary, free, and on request.

2. Make certain that drop-in centers are safe, “shame-free zones” exclusively for women, matching their perceived needs and preferences.

An Afternoon at a WID Drop-in Center

- The drop in center of Naulo Ghumti, in Pokhara, looks and feels both like a club house and a day care center, with its floor mats and toddler’s gym, completed with slide. Photos of birthdays, and Tij, Nepal’s women's festival. “The women want to celebrate all the festivals here,” the Director tells us, “but we can only afford a few.”

- Today some of the women are sitting around, sharing life stories. They all are addicted to drugs, mostly injectors, some are sex workers, many working as peer educators for the WID project. They come here to get away from clients and especially from the police. “They take our mobile phones and money,” one woman says. “If they find a syringe, they arrest us for one night. They say ‘sex or arrest?’ They’re horrible creatures.” Because they feel safe here, everybody can enjoy a good laugh.

---

not imposed. Above all, there should be an atmosphere of acceptance both among the members and between the members and the staff. In short, drop-in centers should be friendly, homely, welcoming places where members want to go, and where they feel they can talk freely about their real concerns and be themselves. Experience shows that the more marginalized and stigmatized a population is, the harder it will be to get them to come to a drop-in center, and the more important it is for the drop-in center to reflect their priorities and address their comfort. WID and WUD, who are involved in sex work, are doubly marginalized and doubly stigmatized, and they often have ambivalent or difficult feelings about men. They are not likely to come to a drop-in center unless it provides an all-woman environment, as other development organizations have discovered.

What is more, if there are perceived differences among the women who use drugs based on the way they use drugs, their age or other factors relating to their self concept or situation, women who use drugs may not even be comfortable in the same all-woman drop-in center. This was the experience of the UNODC in Nepal. (See Principle 3).

The drop-in centers have adjusted their approach over time to match their clients’ needs and

---

5 See, for example, Risk Reduction Through Drop-In Centers and the ECHO Peer Education Model, at FHI Vietnam, www.fhi360.org

---

- It’s only here, in the drop-in center, where they feel truly safe, the women say. It’s a real woman’s space. There is a kitchen for cooking and catering for meeting, a balcony for smoking and talking. Sanitary pads are provided. Here they can get treatment for abscesses and wounds, STI examination. Counseling is available if they want it. The staff is present but stays quietly in the background. The drop in center belongs to the members.

- Some of these women plan to stop using drugs one day, so the program’s strategy is to help them and their partners stay healthy until that day comes. One woman tells us that she has been using drugs for 7 or 8 years. She is 23. “When I don’t get drugs, I feel like quitting. When I get them, I use,” she says, simply.

- “Why do you come to the drop in center?” we ask one of the women. She looks at us with surprise. “It’s fun here,” she says. “We get to meet our friends.”
preferences. As a result, these drop-in centers succeed as true community centers for the groups of women who use drugs they target and have been able to assume a central role in the project.

The drop-in centers around the country offer their members services such as regular primary health care and STI clinics, counseling on request, and skills-building and information sessions as requested. They feature child-friendly facilities, comfortable spaces to relax and talk, cook, as well as other facilities and services the members request.

An example is the drop-in center of NGO Naulo Ghumti, in Pokhara, described below. This center serves a group of long-time, women who use drugs, mostly injectors, who live alone or with families. Most have been in prison at least once.
The research show that women injecting drugs involved in sex work had the highest rates of HIV among all the women who use drugs contacted in the study.
Women who Use Drugs (WUD) and Women who Inject Drugs (WID) are often fragmented into specific, mutually exclusive subcultural groupings. Fearful of discrimination, women who use drugs tend to find comfort and security among their closest friends and may not venture out into other parts of society, even among other people who use drugs. This means that these women may not only decline to take part in existing male-dominated drug programmes, but may also be reluctant to associate with other women who use drugs even if activities are designed exclusively for women.

The lesson here is that people who use drugs, sex workers and other marginalized populations may be viewed by outsiders as all the same, but in fact they may be divided internally. This is an understandable response to stigma and discrimination. However, in practice, it means that in spite of a good and active NGO in a given site, there may be pockets of WUD and WID who remain outside of the programme’s net, who are unreached and therefore un-served.

One solution to this problem is for NGOs already working in that site to help small “out-lying” groups of WUD and WID form and activate their own networks. Members of a subgroup, such as a special category of sex workers, will be much more effective in reaching others in that sub-group, gradually bringing them into the programme. Several outcomes are possible: in some cases, a growing awareness of commonalities may allow the sub-group members to develop a sense of sisterhood with other FDUs or sex workers, and this can lead to joint activities, such as shared trainings, or a common drop-in center. In other cases, however, the differences between the subgroups are significant enough that the best solution may be to set up a community based organization (CBO) specifically to serve the needs of that subgroup.

There are precedents both internationally and in the South Asia region for NGOs helping sub-groups set up their own community based organizations (CBOs) and mentoring them through their difficult early days. Some of these CBOs eventually merge back into the parent NGO, while others go on to have a life of their own.

The Programme in Pokhara found it was unable to connect well with a certain subgroup of drug-using sex workers.
workers – the bar dancers – in spite of running a highly successful drop-in center for WID in the city. The Project learned that this group of WUD saw themselves as special and different from the WID involved in sex work, based both on their drug use habits (most were oral drug users and smokers, rather than injectors) and the type of work they did. In short, they did not identify with the WID involved in sex work, who came to the drop-in center and did not want to be associated with them.

The Project struggled with the question of how to reach the bar dancers effectively and finally decided to encourage them to organize themselves. A woman from among the bar dancers’ community was identified, trained and mentored in how to set up a community based organization (CBO). The new CBO, Women Concern Society, has now attained recognition and has members from more than a dozen clubs in Pokhara. It also now has its own drop-in center and peer communicators’ programme for bar dancers.

Women Concern Society’s seven peer educators provide information about drugs and HIV, referral for VCT, advice about avoiding pregnancy and other services to the dancers. Members are now asking for training in sewing, beauty parlor skills, and English.
A single injection with an HIV infected syringe or needle can transmit HIV. This means that an injecting drug user can be careful to use sterile equipment for years and stay HIV-free, then can be infected due to a single lapse.

Many studies show that the risks of HIV, other STIs and other blood borne infections among WID involved in sex work rise dramatically according to the length of time they have been injecting, and the number of clients they serve.

UNODC research on WUD/WID show that WID involved in sex work had the highest rates of HIV among all the women who use drugs contacted in the study. While HIV prevalence was 3.3% overall in the study, among injecting sex workers it rose to 7.9%, and among sex workers who injected daily, it was 10.6%. Hepatitis B past exposure corresponded to frequency of injection: it was 11.2% for respondents overall, for injectors 13.4%, and for daily injectors 19.2%. Hepatitis C rates rose both by frequency of injection and number of sex work clients; 15.2% of study respondents overall tested positive for Hepatitis C, 17.6% of daily injectors, 19.7% of injectors in sex work, and 21.3% of daily injectors in sex work.

4. As a programme priority, ensure continuous, regular access to sterile needles and syringes for the most impoverished Women who Inject Drugs (WID).

The Bottom of the Barrel – The Guest House Sex Workers

- There are dozen girls in the guest house – and they looked very much like girls rather than grown women – sat huddled together on the floor in dirty teeshirts and jeans with uncombed hair. They all said they were 19, but several looked barely adolescent.

- Of all the WID we met during our field visit, these looked the worst by far. Their misery was palpable; they looked like lost teenagers waiting for a bus ticket home, if they had homes to go to or even knew where they were. It was an astonishing sign of the Project’s success that we were there at all, guests of the owner, sitting on the floor surrounded by the sex workers and the Project’s Peer Educators, drinking Nepali milk tea.
The UNODC study found that the great majority (86.5%) of the WUD contacted say they spend half or nearly all of their money on drugs and alcohol. Poverty increases the HIV risk of WID involved in sex work by making both safe sex and safe injection more difficult. Sex workers may be tempted to have unsafe sex to earn more money, and addiction increases the money pressure they are under. Similarly, needles and syringes cost money a sex worker may not always have.

Some of the WID involved in sex work in the Project are so poor that they cannot afford to inject safely without sterile needles and syringes from the Project.

The WID involved in sex work who live and work in the guest houses clustered around Pokhara’s main bus station are among the poorest and most at-risk of the women served by the programme. Living as virtual captives in a brothel situation, they are at risk for economic exploitation, HIV, STIs, other blood-borne infections and unwanted pregnancies. They need condoms and clean needles and syringes and are unable to get them by themselves.

Without reliable access to clean needles and syringes from the Project, HIV prevention would be virtually impossible for extremely poor sex workers such as these. This underscores the need for continuous funding for projects. Funding gaps are not merely inconvenient, they are life threatening to very poor, bonded or deeply indebted WID sex workers such as these.

- The guest house sex workers are the lowest rung of Pokhara’s sex work ladder, the bottom of the barrel. Still they have shelter, food, basic protection and a steady supply of the drugs they crave. We know they give 50% of their earnings to the guest house owner, but we don’t know whether they are also charged for their food, shelter, clothes and drugs. Can they save anything at all, or are they bound in permanent, mounting debt? How did they get there? Who got paid for them? Did they come already drug addicted, or did they start using after they arrived? Are the drugs a cause or a result of the sex work? We realized we need to know so much more about them.

- We asked a few careful questions and smiled a lot, but the they didn’t have much to say. They didn’t feel comfortable as the owner was standing by. From time to time, one or two were called out to meet clients – the youngest seemed to get called out first. We saw them later on our way out, sitting at the table, chatting with their clients before, perhaps negotiating the
The steady supply of safe injection and safe sex commodities the Project provides to these women is literally saving their lives, day by day.

The programme has been able to gain access to these poor, captive sex workers with the cooperation of the guest house owners, who realize the economic advantage of keeping their women healthy.

The box describes a recent visit to one of these guest houses.

Contd..
Cross tabulating the incidence of physical violence with substance use patterns of regular sex partners showed that women with partners who used alcohol as well as drugs were four times more likely to face physical violence than women whose partners used either drugs or alcohol alone, or neither one.
It is commonly understood that sex workers are vulnerable to physical violence, however the programme has found that various forms of violence affect all women who use drugs, whether or not they are sex workers. This includes physical violence from their regular sex partners, and self-induced violence at their own hands.

The WID study found that over 90% of the sexually active women drug users had regular sexual partners. About 85% of these regular partners used alcohol, and about 64% used drugs. For injectors, 69% of their regular partners used drugs. When the partner was a substance abuser, more than half of the women reported verbal abuse, and more than a third reported physical abuse by their partner. Cross tabulating the incidence of physical violence with substance use patterns of regular sex partners showed that women with partners who used alcohol as well as drugs were four times more likely to face physical violence than women whose partners used either drugs or alcohol alone, or neither one.

In addition to violence from partners, there is also the self-injury. Self-injury is viewed by psychologists as an unhealthy way to deal with emotional pain, anger and

5. Include psycho-social support and other interventions to address the various forms of violence Women who Use Drugs (WUD) face, including self-mutilation.

Psychologists recognize that if a woman has been the victim of physical abuse, she may turn to abusing herself, either as an outlet for her rage, or as a mark of the low self-esteem she has developed due to frequent abuse. Similarly, a woman who feels trapped in a situation she feels powerless to change may take out her frustration on her own body by burning or cutting it.

This was the case with the WID involved in sex work at one Drop-In-Center supported by the Project. The fact that these women were highly paid call girls, beautiful, attractively dressed dancers, did not protect them from violence at the hands of their regular partners, or from other forms of abuse within their primary relationships.
frustration – not as a suicide attempt. The person (usually a woman) who cuts herself may feel momentarily calm and free from the intense emotions, but cutting is usually followed by guilt, shame, and eventually the return of the painful feelings. There is also the danger of serious injury, including loss of blood and infection.

Self-mutilation is evidence of underlying emotional problems and has no fast or easy cure. While the cuts can be medically treated and will eventually heal, the feelings of frustration and despair are not so easily treated. Because self-injury is often done on impulse, psychologists may consider it an impulse-control behavior problem, indicative of a range of mental illnesses, including depression, obsessive compulsive disorder and borderline personality disorder, all of which call for long-term therapy.

Several different interventions are called for in response to violence WUD face. They need primary health care for their wounds, referral or assistance getting medical care if the wounds are serious, skills to defend and protect themselves from violence from their partners, and psychological support through counseling, peer counseling and group discussions to build the women’s self esteem so that they understand that they do not deserve physical violence from anyone, including themselves.

During our visit, several of the women bared their inner arms to reveal a criss-cross pattern of scars – a shared badge of abuse, membership in a sisterhood of suffering.

“I’ve been punched by my boyfriend many times,” one said.

“I get so angry at myself about my boyfriend,” said another. “I can’t do anything about it, and I don’t know what to do, so I just slit myself up.”

These needs are being met primarily through the drop-in centers which include primary health care facilities, counseling and discussion groups. Outreach workers and peer communicators can also address violence in their individual contacts with WUD and WID.

Long-term therapy is beyond the capacity of counselors at a drop-in center to provide, but referrals can be provided. The essential starting point for any WID project is to recognize that whether or not they are sex workers, WUD and WID have special needs with regard to violence, both from regular partners and from themselves.

Contd..

The intersection of sex work and drug use is complex and often confusing. Some women who use drugs may start to do sex work to support their addiction, while others take up drugs to make sex work more bearable. “Imagine dancing naked in front of screaming men,” said one sex worker who said she took up to 30 diazepam a day. “How could I do it without that?”

Drug and alcohol use have a dis-inhibiting effect which makes unprotected sex more likely, leading to unwanted pregnancies and high risk of HIV and other STIs. While sex workers in general report using condoms with clients, WUD involved in sex work may have greater inducements to have sex without a condom if they need the money for drugs. Thus they are at special risk of HIV and other sexually transmitted diseases.

The UNODC study on WUD/WID found that about 33% of sexually active respondents had non-regular partners, and 37% reported doing sex work. HIV rates were higher among women who did sex work (7.9% among WID sex workers, and 10.6% among WID sex workers who injected daily). Evidence of syphilis (present and past exposure) was found in 6% of respondents overall, but in 10.5% of those engaged in sex work. Genital ulcers were also found in 11.5% overall, as well as growths suggestive of Human Papilloma Virus (HPV) in 16%.

Because some WUD are also involved in sex work, they need a comprehensive package of harm reduction services, including a steady supply of condoms and lubricant, access to STI testing and treatment. The UNODC team has also recommended giving presumptive treatment when there are symptoms suggestive of other STIs, such as burning on urination. These services are provided through the drop-in centers which provide STI checks and treatment through regular PHC clinics.

While sex workers report high condom use with clients, only about half of the sexually active WID and WUD involved in sex work used condoms with all their partners. The use of condoms with regular partners should be included as an important message in all communication with WUD and WID sex workers.
The use of condoms with partners of all types is especially important for drug using sex workers, not only for preventing disease transmission but also for preventing unwanted pregnancy. WID involved in sex work may be more likely to continue to sell sex when they are pregnant than other sex workers because of their continuous need to support their drug habits.
In the Central Prison in Kathmandu there are 170 female inmates. One-third of WUDs have been arrested for offenses relating to drug or alcohol use, the UNODC’s study found, and nearly 10% have served prison sentences for drugs or alcohol related crimes.
One-third of WUDs have been arrested for offenses relating to drug or alcohol use, the UNODC study found, and nearly 10% have served prison sentences for drugs or alcohol-related crimes.

The data on female prisoners and their HIV and STI prevalence is not readily available in Nepal. The total prison population in the country is approximately 8000, of whom approximately 500 are women. In the Central Prison in Kathmandu there are 170 female inmates. Generally the hygienic conditions in prisons are poor. Women have limited funds for and access to health information and health care including limited access to testing for HIV and STI’s.

UNODC found it challenging to work with women prisoners, since prison populations are highly regulated under the control of prison authorities. Nevertheless, their needs are diverse, and cover a full range of problems, including mental and physical health, educational, occupational, social and psychological needs.

Psychological problems are common among women prisoners, who are disowned and abandoned by their families. They face extremely high levels of stigma, even

7. Work closely with prison and law enforcement agencies to improve the health, skills, social and psychological conditions of women prisoners.

Inside the Women’s Prison in Kaski

- Thirty-six women sleep in the tiny room, mattresses lined up side by side on the floor. Each woman has a bag for her possessions; clearly security is hard to come by. The tiny courtyard is big enough for them all to stand, but not to move around. There is no privacy whatsoever. The sense of boredom inside the women’s prison is overwhelming. How much time can you spend washing your hair, cooking, eating and sleeping? Life seems to have gone into slow motion here.

- Visiting day. On the men’s side, the inmates hang on the gates, eager to glimpse the smiling family members and friends waiting outside. On special days, such as Bhai Tika or “brothers’ day”, the last day of Tihar festival when sisters wish long life to their brothers, the men’s courtyard is even more than usually packed with visitors.
compared to WUD involved in sex work. Their husbands remarry, their relatives reject them and feel ashamed of them. No one comes to visit. As a result, these women are almost totally isolated within the prison walls, where they lack facilities and programmes of all kinds. They need primary health care (PHC), education and skills-building opportunities, recreation and opportunities for income generation.

One essential principle in working with women in prison, the Project has found, is a close collaboration with prison authorities. Good relationships with the prison officials have proven to be a key to innovation for women in prison. In order to help prison authorities understand what women need, the Project has supported training for prison officials as well as study trips and attendance at international conferences on HIV and gender, prisons and harm reduction. The Project has also cooperated with the prison by working to benefit both the male and the female inmates. In Kaski Prison, for example the UNODC opened a Primary Health Care Clinic that serves prisoners of both sexes, providing VCT, PHC and DOTS.

In Kaski, UNODC partners with an NGO who also works with male inmates and has enabled them to expand their base to address the needs of women prisoners. Outreach workers and trained counselors offer health-related workshops and trainings and personal counseling to both women and men at the prisoners’ request. The needs for training too big is to be met, so the best strategy is to focus on those who are about to leave, the Project has found. Women benefit from income generating projects such as the mushroom farm (see photo above).

Peer communication has been an important innovation of the UNODC’s work with women in prison. Peer communication provides a double service to women inmates, as it gives the peer counselor a meaningful role and skills, while providing support to other inmates. “The project has demonstrated that women in prison settings can be active and supportive peer educators,” an independent mid-term review team found.
While most-at-risk groups such as sex workers and people who use drugs may get more international attention from HIV programmes, the wives of returned migrants in the west and far west of Nepal are in the grips of a rapidly expanding HIV epidemic. According to some studies, wives of returning migrants have higher rates of infection even than sex workers. In the Nepal country report to the 2008 UNGASS, the National Centre for AIDS and STD Control (NCASC) estimated that 41% of Nepal’s HIV infections are among seasonal labour migrants, and 21% among wives or partners of men who are infected.

According to UNAIDS, for example, in a study in four western districts in 2008, 3.3% of wives of migrants had HIV while among FSW in Kathmandu that year only 2.2% were infected. This may reflect the many interventions targeted to FSW, and their comfort with condoms, while village women may lack the knowledge, self efficacy, perceived risk of HIV or status within the family to insist on condom use.

Village women with HIV are usually poor, illiterate and married to older husbands who have worked as

8. Provide shelter, empowerment and skills to harness the energy of village women living with HIV (WLHIV).

Sneha Samaj Women’s Crisis Care Center

- Centers like Sneha Samaj in Kathmandu, supported by UNODC in Nepal, have found that WLHIV have tremendous energy for their lives, once they overcome their shame and fear and tap into their personal power. The Director of Sneha Samaj talked about the center.

“Sneha Samaj is proud of our women. When we see positive women with a lot of pain inside, who are lonely and sad, when we see them get happy, smile and laugh loud, that makes us happy. That’s the thing we want! They feel they are not alone. They remember the day they entered and compare. They get empowered, they want to have some kind of rights. They say ‘Now I want to get my property!’”

- The women also talked about the changes they have gone through living in the center.
migrants in other countries. If the husband is diagnosed with HIV, it is common for the wife to be blamed, and if he dies, she is likely to be expelled from the community, sometimes along with her children, because of the family’s shame or the community’s fear of HIV. If no shelter is available, these WLHIV will end up in the streets.

The programme supports shelters for WLHIV, such as Sneha Samaj Crisis Care Home in Kathmandu. In this temporary shelter, 25 WLHIV receive nutrition support, medical treatment including ART, counseling, skills-building and short-term care (up to 21 days) to regain strength. After three weeks, they are helped to find long term accommodation and jobs.

With diminishing funding for HIV in the past few years, several dozen such shelters in Nepal have reportedly been closed. However, these shelters are vital for the survival of WLHIV, and continuous funding is imperative for the survival of the shelters. While centers such as Sneha Samaj put effort into income generation, they also rely on consistent support of funders to perform their crucial role in saving the lives of village WLHIV.

An independent review team noted that “Gaps in funding, and consequently in the availability, of this type of activity can lead to reduced trust by the women affected and should be avoided. It is to be commended that UNODC was in a position to secure this activity.”
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>WID</td>
<td>Women who Inject Drugs</td>
</tr>
<tr>
<td>WUD</td>
<td>Women who Use Drugs</td>
</tr>
<tr>
<td>WLHIV</td>
<td>Women Living with HIV and AIDS</td>
</tr>
<tr>
<td>FSW</td>
<td>Female Sex Workers</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Government Organizations</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Treatment</td>
</tr>
<tr>
<td>ATS</td>
<td>Amphetamine-Type Stimulants</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organizations</td>
</tr>
<tr>
<td>FDUs</td>
<td>Female Drug Users</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
</tr>
<tr>
<td>MoHA</td>
<td>Ministry of Home Affairs</td>
</tr>
<tr>
<td>NCASC</td>
<td>National Centre for AIDS and STD Control</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/ AIDS</td>
</tr>
<tr>
<td>UNODC</td>
<td>United Nations Office on Drugs and Crime</td>
</tr>
<tr>
<td>ROSA</td>
<td>Regional Office for South Asia</td>
</tr>
</tbody>
</table>