DOI: 10.5455/msm.2015.27.434-437
Received: 01 September 2015; Accepted: 15 November 2015

PROFESSIONAL PAPER Mater Sociomed. 2015 Dec; 27(6): 434-437

CHALLENGES AND SUCCESSES OF HARM REDUCTION SERVICES IN WOMEN'S DROP-IN CENTRES: PERSPECTIVE OF VULNERABLE WOMEN

Minoo Alipouri Sakha[1], Parvin Afsar Kazerooni[2], Hamed Zandian[3], Hamid Ravaghi[4], Hakimeh Mostafavi[3], Sajjad Delavari[3], Mohammad Hossein Ziloochi[3]

[1]School of Public Health, Tehran University of Medical Sciences, Tehran, Iran
[2]Shiraz HIV/AIDS Research Center, Shiraz University of Medical Sciences, Shiraz, Iran
[3]School of Public Health, Tehran University of Medical Sciences, Tehran, Iran
[4]School of Health Management and Information Sciences, Iran University of Medical Sciences, Tehran, Iran

Corresponding: Minoo Alipouri Sakha. School of Public Health. University of Medical Sciences, Tehran, Tehran, Iran.
E-mail: sakha_minoo@yahoo.com

ABSTRACT

Background: The objective of this study was to shed light on the challenges and successes of HIV/AIDS services delivery as perceived by Sex workers. **Methods:** Face-to-face semi-structured interviews were conducted with 20 IDUs and Sex workers in drop-in centers in Shiraz. A thematic analysis of these qualitative data was conducted by the authors. **Results:** Participants identified major challenges and successes of HIV/AIDS services delivery. Access services, services delivery in terms of challenges and the successes concept were classified. **Conclusions:** Our study demonstrates that while there is greater availability of HIV/AIDS services, this does not equate with greater accessibility because multiple, complex and interrelated barriers to HIV/AIDS service utilization at the service delivery level such as Stigma, discrimination, violence, harassment and social equity issues are critical concerns of FSW.

Key words: Service delivery, Harm reduction, DIC, Female sex workers.

1. INTRODUCTION

According to the World Health Organization, there are an estimated 34 million people who are living with HIV worldwide in 2012 (1). It is estimated that 60 million more HIV infections will occur by 2015 if current trends continue, but half of all infections could be averted by delivering comprehensive HIV interventions to the right people at the right scale (2). Iran's Ministry of Health has reported over 27014 cases of HIV/AIDS infections to date Until September 2013 (3). It is estimated that nearly 300 000 people who inject drugs are living in Iran (4). The most common mode of HIV transmission among male intravenous drug users is sharing injection needle and syringe. However, due to the large group of young adults and low average age of the patients, this mode has been shifting to sexual contacts (5, 6).

Recent Statistics shows a gradual increase in HIV-infected people through sexual contact which has been increased from 4.2% of newly identified cases in 2001 to 21.1% in 2012 and at the same time the number of women living with HIV from 4.69% in 2001 to 8.5% in 2012 (7, 8). HIV prevalence in female sex workers is 4.5% in Iran (3).

Sex workers play a critical role in the epidemic spread of HIV/AIDS (9). Need to expand access to and coverage of HIV/AIDS prevention programs to highly marginalized and stigmatized groups like the homeless, injecting drug users (IDUs), sex workers (CSWs), prisoners and other high-risk groups is globally accepted (2, 10) .

Harm reduction strategies as any effort that attempts to minimize risks and the negative consequences associated with substance use without requiring the cessation and elimination of such use (11) have been successful over the years, especially in reducing the spread of infectious diseases (12) drug use, crime,unsafe injection behaviors and improvements in employment and interpersonal relationships among IV drug users (13).

In the early 2000, Iran government officials began in response to ongoing harms associated with injection drug use and epidemic of HIV, as an alternative to traditional means of dealing with substance abuse to change their drug policy towards harm reduction and have established methadone maintenance treatment facilities and Drop in Centers (14).

The Islamic Republic of Iran provides a good example of

the scale-up of HIV prevention, treatment and care (15). The Iran government initiated pilot DIC and triangular clinics. It has since expanded into a nationwide program and serving some substance users (3). Substance users and sex workers can obtain information on safer Injecting techniques, primary health care, counseling, and referrals to health and social services (6).

Very limited researches have explored to date the challenges and successes of harm reduction policy from the viewpoint of sex workers in Iran. The purpose of this review is to elucidate and evaluate the views of sex workers toward harm reduction services in order to provide a picture of the current situation, challenges and successes of this initiative.

Specific objectives of this study were to evaluate the success of harm reduction interventions, the barriers to access collecting opinions and recommendations of users in order to facilitate and strengthen the capacity of these centers to achieve their goals.

Our contribution to the literature is to explore what are the challenges and successes of HIV/AIDS services delivery that sex workers face in attempting to access and utilize drop-in center-run HIV/AIDS services.

2. METHODS

2.1. Study setting and participants

Data drawn up from face to face semi-structured interviews conducted with sex workers in Shiraz in 2014. Participants were recruited through random allocation from 3 Drop in centers in Shiraz and Marvedasht. A total of 20 women sex workers participated. All interviews were conducted in consultation rooms within service provider premises to maintain anonymity and confidentiality.

2.2. Data collection

Before the interview, informed consent was administrated. Ethical approval for the study complying with the Helsinki Declaration was approved by the Institutional Review Boards of the Iran University of Medical Sciences and Shiraz University (reference 22484). The semi-structured interviews lasted approximately 60 minutes. Interviews continued until data saturation. All interviews were audio -recorded for analysis. Interviews were executed according to specific guidelines. The topic guide included both open-ended and structured questions. The interview guide targeted the following domains: 1) Identify the projects' successes and achievements (2) Identify challenges or barriers experienced. (3) Difficulties of access and service uptake; and (4) Suggestions for better delivery of services, provision options for future developments and sustainable expansion

2.3. Data analysis

After interviews were completed, the digitally recorded interviews were transcribed. To reduce bias and enhance the internal validity of the synthesis an investigator triangulation approach was adopted and a research team member contributed in phases of analysis and interpretation of data. A content analysis approach was used to analysis the data. The five-stage process of qualitative data analysis was done: understanding (familiarization), identifying a thematic framework (thematic), coding (indexing), charting and mapping and interpretation do will.

A first draft of the code list and common themes was developed based on the interview guidelines and content of interview transcripts. The code lists were revised throughout the analysis process.

3. FINDINGS

In this study two thematic headings were identified; challenges and achievements. The concept of challenges was grouped into three subthemes: a) Stigma, discrimination and lack of confidence b) Access c) Resource limitations and poor services. The main concept of achievements was grouped into two subthemes including: a) The physical and financial effects and b) Mental and social support.

3.1. Challenges

Stigma, Discrimination, Lack of confidence

The women experienced a number of social problems like stigma, discrimination and rejection by families, spouses and health workers. Feelings of offensive behavior, rejection, embarrassment, shame and scandal were frequently mentioned. Drug users and sex workers reported that these problems were often of much greater importance to them than their issues and physical health problems. They stated that health service providers believed that their situation is the direct consequence of their drug use and life style.

"There is the feeling that we are responsible for our situation. We are scolded. I feel humiliated. I think if they were forced to work as a sex worker, do this unethical, unlawful job, they never would treat us like this" (P 17)

According to interviewers, social stigma in health care centers and hospitals is one of the main barriers to receive services by participants and causes them not to follow their treatment completely and postpone it.

"The health staffs treat us indifferently in comparison with ordinary people. They are not friendly to us. Once they find out that you are referred from a Drop in center, they shun you and they consider you to be an unclean thing" (P 13).

The perception of looking down and treating unkindly and discriminatory was also confirmed by some of the participants. Health staffs mock them because of the type of clothes disheveled and sloppy appearance so as a result some of them go to hospital without referral form and hiding their identity. This is an important concern of them.

"When I enter hospital with referral form in my hand, they look down on me, as I am a sinful and offender, they blame me I had to resort to prostitution after failing to find other work. If I didn't ran away the house I would not be a miserable creature" (P 4)

According to some interviewers, some clients are reluctant to attend in sites because of lack of trust and confidentiality. They believed that although harm reduction is a licensed program but police crackdown against drug dealing around the drop-in center every now and again make them feel an uneasy feeling about the program and negatively affect their trust to harm reduction initiative. The law enforcement officers' punitive and disciplinary action against women creates dilemmas whether to attend centers and rely on outreach peers or not.

"I don't trust them. I am worried about how to tell them that I have these needs and problems. I am afraid of revealing my secrets."(p14).

Access:

Some of the participants that live in suburb and remote

areas stated that almost all the centers are centralized in urban areas or in city center hence commuting to the centers regularly is difficult. Geographic proximity to a Drop in center has been shown to be a major determinant of service utilization and women who live farther from the centers are less likely to use it regularly (16). Some participants alluded that they did not use the services because of long distance although outreach groups ,to some extent ,have solved this problem, but because of the continuous changing in the location of these women, consistent delivery of services are somehow hard.

"It happened so many times that because of long distance I prefer not to follow up their advisement" (P 18).

Resource limitations and Poor services:

The women indicated that although they are paid or offered to pay drug treatment fees but this assistance did not remove financial barriers to costly medical and dental care. Almost all of them stated that the primary reason for non-receipt of medical and dental care was financial barriers. Their expenses are mainly due to medicine, lab tests, transportation. With regard to their actual service needs, demand was greater for provision of dentistry, treatment services and clinical check-ups. In fact, lack of different medical services offered in these centers has caused reluctance and unwillingness to attend the centers.

"Why they don't cure us in this center, we can't go centers outside because we do not have enough money. I have dental problem but there is no dentist here…This health plan does not provide access to Lab tests like Pathology or CT Scan .I think if there was a doctor in the center it would be better to all" (P 13)

Many participants also commented on the program's restricted hours of operation. As a drop-in center open only 8 hours in a week, some of the participants stated that they do not provide them with safe place to sleep. Other gap in service delivery is the lack of opportunities for vocational services. Many participants commented on income-generating activities.

"If they don't want to give us a job and a place to sleep so why they have established this center?"(P20).

3.2. Achievements

The physical and financial effects:

Based on interviews, most of their health, social and training needs are met by harm reduction services. This initiative provides prevention health care and some limited medical services such as blood tests, Pop Smear, HIV tests, physical examination, methadone therapy services in a non-judgmental, safe space. Health education sessions are held on topics like safer sex, training about hepatitis and sexually transmitted diseases and reproductive health care. DICs provides access to harm reduction materials like clean needle and syringe and condoms, VCT, food, clothing, information, some medicines for preventing of STDs and as a whole they provide a comprehensive range of services as international standards and criteria. One of the most successes of DICs is to attract female sex workers to come to these centers .Their concern on acquiring STIs and regular screening of STIs caused early diagnosis of STIs infection.

"I regularly come to the center for check-ups; I don't want to get infected with STIs. This center is excellent, if they didn't give me methadone I couldn't quit drug."*(p 11)*

Mental and social support:

Interviewers reported that the program provided many opportunities to empower them to recognize their problems and avoid the risks in the future. These centers supported a sense of self-esteem and gave them social support to feel a sense of personal accomplishment, personal transformation and decrease their sense of rejection in the society. Many participants stated that harm reduction service providers relationships with them were respectful and friendly and discussed their experiences of supportive environment and opportunities to express themselves. They explained how service providers encouraged them to solve their problems, by inspiring a feeling of value they can choose a different life and make positive changes

"We are estranged from our families…. I do not have a family. Here they give me self-esteem and a good sense of being in a family. They are supportive. Here I feel they are my own family….how lucky we are to find each other and that we jelled so well together. I can tell we're going to be good friends…. it sure changed things for a lot of us. "(p 18).

4. DISCUSSION

The concept of harm reduction and applying its principles to sex work is widely accepted in Iran and. The mission of harm reduction in this field is to reduce existing vulnerability amongst sex workers and to ensure that sex work does not cause further vulnerability (17).

This qualitative research described drop- in -centres' challenges and success from the perspectives of the sex workers. Findings of this study are consisted of two main concepts including shortcomings and achievements of DICs four sub-themes emerged from the shortcomings concept (a) lack of confidence stigma and discrimination (b) access (c) resource limitation and poor services. Success theme also is grouped in to two sub-theme: a) the physical and financial effects and b) mental and social support.

Lack of confidentiality, stigma and discrimination are nuisances which women are being encountered. Some argue that sex work should be forbidden, using penalties against sex workers (17). Illicit status of sex work and the police punitive and disciplinary action against them creates dilemmas for women whether to rely on service providers and as a consequence they change their place repeatedly and inaccessibility to services will increase. In a similar study in Cambodia despite the approval of harm reduction programs by government, the police had never awareness and dominance over harm reduction programs and unaware of their role in performing the program (18). Stigma is one of the main barriers to receive mainstream services in hospitals and pharmacies and causes women not to follow their treatment completely (19). To diminishing stigma and discrimination it is suggested that service providers should be educated about communication skills and human rights (18). It seems that harm reduction could be greatly strengthened through an expansion of training and various organizations activities.

Service related problems such as the distance of the service centers and clinic. Opening hours are other factor that hinders the utilisation of services. This research has revealed the fact that some clients who live far from the centers face

challenges in accessing them. These findings are similar to studies by Lira Huq and Tandukar (9, 20). This was clear from our interviews that one of their most demanding health needs, alongside the provision of harm reduction materials, was increased availability of medication-assisted treatment and diagnostic and therapeutic services. Most of sex workers can't afford to use private health care and look for cheaper and wide-ranging services. In a similar study one of the most important criticisms to NGO clinics was limitation of services. Generally, Sex workers request for wide-ranging services especially maternal and child healthcare because of unwanted pregnancy (9).

Expanding health services and establishing new centers is often challenging, given the financial resource constraints, transient nature of lifestyles and wide geographic distribution of this vulnerable group. It seems that integration of harm reduction approach into sexual and reproductive health, women's shelters services and drug treatment will decrease difficulties experienced in accessing healthcare services and retaining clients, consequently increase clients' return rate and frequency of their service utilization. In Iran we have a good example of successful integration of harm reduction services into primary health care services in rural areas (21).

Despite these challenges, several successes emerged in this study. The commitment and dedication of harm reduction service providers to deliver outreach services, counseling, STI services, as well as educational, training and skills programs are appreciated. It was declared that preventive and treatment services helped in early detection of STIs and decreased their prevalence among sex workers who attended DICs. This finding is in agreement with the findings of other studies (9).

Social support is of one of the main strategies that improve women's quality of life through life skills training and psychological support. These centers have created a safe and supportive environment which distancing them from risky behaviors while simultaneously support them financially for recovery treatment. There is considerable evidence indicating harm reduction interventions promote self-esteem, self-efficacy. Previous research has demonstrated that this initiative was an appropriate intervention that addressed the structural factors underlying sex work careers include low self-esteem, childhood neglect, family fragmentation and youth deviance (17). A study suggested an increase in sense of achievement, pride, and value by letting women in DICs had the authority to theatrical play, run the show, and dance (22).

CONFLICT OF INTEREST: NONE DECLARED.

REFERENCES

1. Joint United Nations Programme on HIV/AIDS (UNAIDS) 2010. UNAIDS Report on the global AIDS epidemic 2010. WHO Library Cataloguing-in-Publication Data [Online]. 2010. Available from: URL: http: www.unaids.org.
2. Global HIV Prevention Working Group. Bringing HIV Prevention to Scale: An Urgent Global Priority2007. Available at: http:// www.globalhivprevention.org/pdfs/PWG-HIV_prevention_ report_FINAL.pdf. Accessed: January 2015
3. AIDS Response Progress Report,monitoring the 2011 United Nations Political Declaration on HIV and AIDS. UNAIDS.2014, Ministry of Health: Tehran.
4. Razzaghi EM, Movaghar AR, Green TC. Profiles of risk: a qualitative study of injecting drug users in Tehran, Iran. Harm Reduct J. 2006; 3: 12.
5. Shannon K., Bright V, Allinott S, Alexson D, Gibson K, Tyndall MW. Community-based HIV prevention research among substance-using women in survival sex work: The Maka Project Partnership. Harm Reduction Journal. 2007; 4(1)): 20.
6. Sakha MA. et al., Effect of an educational intervention on knowledge, attitudes and preventive behaviours related to HIV and sexually transmitted infections in female sex workers in southern Iran: a quasi-experimental study. International journal of STD & AIDS, 2013; 24(9): 727-735.
7. Islam MM, Topp L, Day CA, Dawson A, Conigrave KM. The accessibility, acceptability, health impact and cost implications of primary healthcare outlets that target injecting drug users: A narrative synthesis of literature. International Journal of Drug Policy. 2012; 23(2): 94-102.
8. Haghdoost Ali Akbar. Modelling of HIV/AIDS in Iran up to 2014.AIDS HIV Res J. 2011; 3(12): 231-239.
9. Huq NL, Chowdhury ME. Assessment of the Utilization of HIV Interventions by Sex Workers in Selected Brothels in Bangladesh: An Exploratory Study The Qualitative Report. 2012; 17(38): 1-18.
10. Ghanbarzadeh N, Nadjafi-Semnani M. A Study of HIV and Other Sexually Transmitted Infections among Female Prisoners in Birjand. Journal of Birjand University of Medical Sciences. 2006; 13(3): 69-74 [In persian].
11. Darlene J. Harm reduction policy background paper. Alberta: Alberta Alcohol and Drug Abuse Commission (AADAC). 2007.
12. Moetamadi Hadi. Prioritize vulnerabilities and social issues. Social Welfare Quarterly. 2008; (24): 327-347[In Persian].
13. Hobden KL, Cunningham JA. Barriers to the dissemination of four harm reduction strategies: a survey of addiction treatment providers in Ontario. Harm Reduct J. 2006; 3(35): 1-20.
14. Razzaghi E. et al. HIV/AIDS harm reduction in Iran. The Lancet. 2006; 368(9534): 434-435.
15. UNICEF, WHO and UNAIDS, Towards universal access: scaling up priority HIV/AIDS interventions in the health sector: progress report, April 2007.
16. Cooper HL. et al., Geographic approaches to quantifying the risk environment: drug-related law enforcement and access to syringe exchange programmes. International Journal of Drug Policy. 2009; 20(3): 217-226.
17. Cusick L. Widening the harm reduction agenda: From drug use to sex work. International Journal of Drug Policy. 2006; 17(1): 3-11.
18. Chheng K. Harm reduction in Cambodia: a disconnect between policy and practice. Harm Reduction Journal. 2012; 9. 30.
19. Gurnani V, Tara SB, Parinita B, CFAR Team HLM, Srinath M, Reynold W, Shajy IBMR, Stephen M, James FB. An integrated structural intervention to reduce vulnerability to HIV and sexually transmitted infections among female sex workers in Karnataka state, south India. BMC public health, 2011; 11(1): 755.
20. Poudel-Tandukar K, Poudel KC, Macdougall C. Factors influencing women's use of health services for Sexually Transmitted Infections in eastern Nepal. Australian Health Review. 2003; 26(1): 116-123.
21. Mojtahedzadeh V. et al. Injection drug use in rural Iran: Integrating HIV prevention into Iran's rural primary health care system. AIDS and Behavior. 2008; 12(1): 7-12.
22. Catherine M. Ladies' night: Evaluating a drop-in programme for homeless and marginally housed women in San Francisco's mission district. International Journal of Drug Policy. 2008; 19: 113-121.