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Women and the Health and Social Consequences of Drug Use: Implications for policy and practice

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Background paper for a Conference on Gender, Drugs and HIV

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Foreword

This paper was originally developed through a UNODC executed project for sub regional development of institutional capacity for demand reduction among high risk groups (C75). All countries of the Greater Mekong Subregion participated in the project, including China where adult women associated with harmful drug use and unsafe sexual practices were identified at particularly high risk of infection to Hepatitis C and HIV/AIDS.

This situation led to the development of a special conference on gender, drugs and HIV at Nanning from 15 to 17 February 2001. Numerous international experts in the area of gender and harmful drug use were invited to attend the conference, including Susanne MacGregor. We are especially appreciative of Susanne's work, since it has identified gender specific issues and strategies that are not only relevant to a more comprehensive response for women in China, but it also transcends national borders for potential consideration and application to other areas of Southeast Asia.

Support to the regional project activity was provided through partnerships with DFID UK, UNAIDS China, and national agencies connected to the National Narcotics Control Commission, including its provincial narcotics control commission counterpart that so ably managed the conference logistics.

The paper is reprinted as part of the UNODC contribution toward the World AIDS Day Campaign for 2004; raising awareness about the importance of gender within the context of harmful drug use and HIV vulnerability. The paper is highly recommended to any official concerned with the development of drug abuse treatment and rehabilitation programmes in Southeast Asia.

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"Reducing HIV Vulnerability from Drug Abuse"

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Note

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1 UNDCP leads and co-ordinates the work of the UN system in matters of international drug control. It addresses all aspects of the drug problem, inc1udingmeasures to reduce illicit supply, traffic and demand.

2 UNAIDS has been operational since 1996. Its mission is to lead, strengthen and support an expanded effort to prevent HIV transmission, provide care and support, reduce impact and alleviate individual and communal vulnerability to HIV / AIDS. UNAIDS supports operational research involving NGQs and community projects intended to minimise HIV risk among drug users and provides technical assistance in the design and evaluation of prevention projects.

3 The Drug Misuse Research Initiative funds 14 projects over the years 2000-2003 researching topics within the broad themes of dual diagnosis, waiting lists, and young people. Research designs include randomized controlled trials, review of longitudinal studies, and surveys of particular groups such as preteen drug users and long term cannabis users. Topics include the effectiveness of cognitive behavioural therapy, methadone maintenance and interventions with users of stimulants.

PART ONE: WHAT ARE THE ISSUES?

This section discusses the general situation regarding drugs and HIV. It goes on to consider the position of women in society and issues regarding women's health, especially with respect to drugs and HIV It looks at the key role of women in caring in the community.

The global problems of drugs and HIV

There is growing concern world-wide about problems related to both drugs and HIV/AIDS[4]. Drugs and AIDS are global problems[5]. AIDS impacts demographically on countries through effects on mortality, fertility, population growth and family structure. No state can be immune from these developments. All countries need co-coordinated, coherent policies that avoid internal contradictions[6].

In China, drug abuse has been rising steadily since the late 1970s.[7] This is thought by some to result partly from the economic reform and open door policy of the Chinese government, social and cultural changes, and the large amount of opium and heroin produced in the Golden Triangle and smuggled into Chinese territory[8]. The Chinese government's policy is to fight production, smuggling, and the transport of illicit drugs; and to establish treatment facilities and a national monitoring system. Some consider that 'the attitude [in China] toward drug addiction is changing gradually from a perception of drug users as criminals to that of patients in need of medical, social and psychological support'[9]. Serious problems remain - the relapse rate is high, owing to lack of essential rehabilitative facilities and psychological counseling[10] and health and prevention education for high-risk groups is deficient, especially in remote or backward areas. While efforts to control illegal drug use appear to be relatively successful and the HIV rate is low comparatively, drugs is currently the main factor in HIV in China. 75% of the known cases of HIV acquired the virus via injecting drug use (IDU). 'Especially for a large country with such diverse living conditions as China, international collaboration is necessary for better understanding of the problems of drug abuse, of new ways of treatment and of other countries' experiences in running treatment and rehabilitation

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4 At the end of 1999, the global HIV/AIDS estimates regarding children (under 15 years of age) were: Children living with HIV/AIDS =1.3 million; new HIV infections in 1999= 620,000;deaths due to HIV/AIDS in 1999= 480,000; cumulative number of deaths due to mV/AIDS=3.8 million.

5 World-wide, there are about 15,000 new HIV infections per day (1999 figures from UNAlDS), More than 95% are in developing countries; 1,700 are in children under 15 years of age; about 13,000 are in persons aged 15 to 49 years, of whom almost 50% are women; about 50% are 15-24 year olds.

6 for example, between the goals of prevention and treatment or between those of care and control.

7 See other papers available at this conference abstracted from chapters in UNAIDS/UNDCP 2000

8 Zhengyan et aI, 1998 p 253.

9 Op cit P 260.

10 ibid

services'.[11] It is hoped that this conference will play a small part in encouraging such collaborations.

The question of policy transfers

However, it would be foolish to think that policies and practices that work in one country should be or could be simply transplanted to another. Consideration of policy transfer needs to take account of the existence or non-existence of appropriate infrastructures into which to implant an intervention.[12] The general situation regarding the provision of social welfare and health and social agencies is critical in discussions of what are suitable interventions to consider as policy options. Additionally, in organising prevention and treatment, as well as control of supply, there must be cultural sensitivity to the values and views of each country and local communities. Drug treatment models applied successfully in one country cannot easily be transferred to another if core values, both clinical and cultural, are different from the values implied in the treatment model. Differences relate to views on what constitutes a good person (values), views on what is involved in being a responsible adult and on how identity can be changed through treatment (action)[13].

The role of research

Evidence-based (or evidence -informed) policy and practice is now the aim in many countries. But research and evidence-based policy and practice may be at variance with politicians' or the public's perception of what is the right thing to do. How can this gap be bridged?

Research can playa useful part in giving straightforward descriptive information on the natural history of conditions like drug use and HIV positivity and in providing basic epidemiological data. Research can be particularly valuable in making visible invisible social problems. It can provide information on hidden populations. Since a growing proportion of the world's population is hidden (such as migrants and illegal workers) this is of growing importance. Facts can also be used to influence resource allocation so that it is by need rather than on historic or other bases. .

In general, it is recognised that almost everywhere, there is a need to improve descriptive analysis and provide more epidemiological data on risk factors. In particular, it is now recognised that research needs to be more sensitive to gender.

Why drugs and HIV matter?

Drugs and HIV matter to all societies and cannot be ignored, however unpleasant we find discussion of these topics to be. We have to face up to these challenges because of the costs involved for society. These costs include costs to the taxpayer and demands on public revenues, especially through demands for health care. The presence of these conditions involves a risk to others and to the general wellbeing through the risk of contagion and through disorderly conduct. We also cannot ignore these problems

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8 op cit P 261

12 For example, needle exchange through pharmacies or other community based agencies may not be feasible if such agencies do not exist.

13 Cortese 1999

because as human beings we cannot help caring for others - at least, caring for children, for the next generation who are the future of our societies.

The appearance of epidemics

Both AIDS and drugs have been described as presently constituting 'epidemics' in many parts of the world. For example, the current situation in Russia has been described with regard to drugs and HIV as an epidemic[14]. Similarly there is potential for such epidemics in Cambodia[15]. The appearance of epidemics is important and it is useful to understand why they occur. Epidemics of many diseases are linked to social change and especially to social collapse. Risk groups include prostitutes, street children, the homeless and migrants. The focus of attention in epidemics has to be on the core cases - small groups who can be contained and controlled. The most effective use of scarce resources in these situations is to focus on the high risk-cases and their risk behaviours.

The potential for increases in drug-taking will always be there if a country is a route for drug trafficking, if there is increased population migration, social disruption, lack of infrastructure, lack of information and education about risks. Countries with at one time a small drug problem can see this rapidly escalate. Or within countries, areas which formerly had no problem can rapidly become problematic[16].

A common feature of drug epidemics is their association with the breakdown of traditional social protection and containment mechanisms. Where this happens, there is a need to develop new support mechanisms, such as outreach services and self-help and community organisations, with a stress on capacity-building and the rebuilding of social relations. Community workers, social workers and health workers can playa key role with public order workers in partnerships aiming at social reconstruction.

Why do people take drugs?

Many of those reluctantly drawn into these efforts find the situation perplexing. They wonder why people take drugs. Perhaps, more importantly, why do they continue to take drugs when the disadvantages are all too apparent? There are pleasures in drug taking: the biochemical effects - mood altering, giving confidence, floating on air, no pain; the companionship of the drug fraternity; the excitement of doing something secret and illegal; the feeling of being different and separate. These explain why people do what may seem to others to be an irrational act. Once you have broken the taboo on drug taking, it is so easy, so pleasant, so enjoyable, you carry on in spite of the dangers, the threat of being discovered and prosecuted, the cost. But the problem with drug taking is that the drug is addictive. It is not easy to give up once you have started to take heroin or cocaine or even amphetamines. Look at how hard it is to give up tobacco smoking or drinking alcohol or even eating too much - we all know the right way to live but it is easier to say than to do.

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14 Russia traditionally did not have a widespread problem due to ideological indoctrination of the population and tough societal controls. Social change has affected containment and social control and provided a window of opportunity for drugs to enter in. The Afghan War provided one catalyst for change as the Vietnam war had done for the USA.

15 cf Oppenheim 1997

16 For example, in Britain there was little problem with drugs until the early 1980s.

Because of these features, there is a high rate of relapse among drug takers as with other substance users. It is best seen as a chronic deteriorating condition in which interventions have to aim at stability and harm reduction - aiming at the most healthy life possible given the fact of previous or current drug use. It has been likened to diabetes or heart conditions - the risk of recurrence or deterioration is ever present but with healthy living and appropriate support, it is possible to maintain stability and reduce rates of relapse.

The key point about drug-taking is that after a while, problems begin to accumulate. There are initial risks involved in simply taking the drug - the danger of overdose, the danger of contamination; the risks involved in engaging in illegal activities. On top of these, others accumulate, such as poor nutrition, lack of sleep or disturbed sleeping patterns, inability to maintain normal routines and habits, lack of money, need to access illegal drugs bringing you into contact with more dangerous people and situations. In addition, there is the need for greater intake to achieve the same effect, increasing the cost and leading to the temptation to injecting. With injecting comes the risk of disease, HIV and Hepatitis C as well as more common problems of blood clots, damage to veins and skin and muscle tissue, and other infections. Accidents occur while under the influence. It is less likely that other hygienic habits will be adhered to - washing hands before eating, after going to the toilet, even washing at all, leading to risk of vermin and lice. Lack of money may lead to homelessness, lack of good habits to loss of employment; and changes of mood affect relationships. Hygienic approaches to sexual practices will be less likely to be adhered to, especially use of condoms or other barriers to infection. Under the influence of drugs, more promiscuity is possible, along with less healthy sexual practices.

For women, additional factors enter in. Understanding women's drug use means addressing women's socialisation; the social ~d familial context of dependence; the gender-specific pressures they encounter; the expectations made of women; and the punitive attitudes and actions that occur when women fail. Women face different risks when in recovery, which, if not managed effectively, can produce relapse.

Women in the world

Women's ordinary lives are different from the ordinary lives of men. 'They are the providers of food, fuel, water and often the whole family income - the sustainers and developers of their families, communities and countries. .. the fate of women is a critical determinant of the fate of whole societies.' [17] Everywhere, women are worse off than men: they have less power, less autonomy, more work, less money and more responsibility. Women everywhere share primary responsibility for having and rearing children, for forming and maintaining families and for contraception. But very real differences appear, of course, between rich and poor countries. Features' of women's lives rarely or much less experienced by men include domestic violence and death in childbirth; unpaid work in the household; rape and prostitution.

Social inequalities with regard to health are generally found to relate to material factors, employment relations and conditions, status, life style and prestige (self esteem, social supports, acceptable or fashionable behaviours). So these differences in men's and

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17 Margaret Synder of UN Voluntary Fund for Women quoted in Seager and Olson 1986: 7.

women's ordinary lives will affect their health experiences, including those of drugs and HIV. But unfortunately we know much less about this than we should because data which are collected routinely are not sensitive or relevant to the particular circumstances of women. Statistics on women are hard to come by - the invisibility of the situation of women remains a problem in many national statistical reports.

Of course, men and women also have much in common. But the differences are important. Agencies aiming to intervene in the process of drug taking, particularly in the process by which risks accumulate - including risk of HIV infection - need to be sensitive to these differences and design and manage intervention programmes with the needs and conditions of women in mind.

So we need to look at what we know about why women take drugs, how risks can be prevented and managed, and in particular what are the barriers to risk avoidance in the case of women. Programmes designed with men in mind may be inappropriate or ineffective when applied to women. We need a woman-centred approach[18]. What does research tell us about these issues?

Women and drugs

Gender can affect the choice of drug taken, where there is a choice. In some societies, the image of women projected through the media and consumer culture is of being slim, trim and full of energy. Some women are tempted to use cocaine (including crack) or amphetamines (as they are to smoke cigarettes) as part of a weight control strategy. Use of crack by prostitutes has been reported in a number of places as it seems to fit the needs of their occupation particularly well. Prolonged use of some drugs can suppress menstrual periods, leading some women not to recognise pregnancy when it occurs until a relatively late stage in pregnancy.

Research could consider how far gender roles and socialisation processes pose distinct risks for women of drug dependence (what might make them vulnerable e.g. child sexual abuse). It could also look at what aspects of these roles act as protective factors against drug dependence. It is still the case that it appears that women are less likely than men to engage in illicit drug use, although when legal medications such as tranquillisers are taken into account the imbalance is redressed. Overall, the evidence is that women of all groups use illicit drugs much less and much less frequently than do men and they stop after fewer experiences. But some do become dependent.

There is a clear need for interventions. But impediments exist to putting these into place. Impediments include legal constraints, social constraints, issues regarding minorities and lack of understanding.

The argument of this paper is that women need special attention. It is not enough just to blame them. Important influencing factors are poverty, power and sex. Key issues have to do with stigma, children and pregnancy.

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18 that is, an approach which places women at the centre of consideration, rather than in the background or as an add-on to services designed with men in mind

Women caring in the community

In addition, women who do not use drugs are affected differently than men who do not use drugs. In particular, women in their role as carers may be asked to bear the burden of caring for people with HIV and/or who are drug dependent.

In Edinburgh, in Scotland, in the first days of the drugs and HIV epidemic in the early 1980s, the seroprevalence rate among intravenous drug users was about 60%. The role of public policy in this development is instructive. Initially, Edinburgh was notable for its prohibitionist approach and lack of treatment services for drug users. ID use was concentrated in deprived areas and use of injecting rooms was common. Paraphernalia were shared by drug users buying their drugs and using, in the same location. A crackdown by police who broke up this enterprise resulted in a classic spread of infection across the city. Once Edinburgh had become notorious for its high rates of infection, new innovative services began to develop and critics of the existing system became more influential- in particular GPs (community medical practitioners) and NGO workers. Services developed especially community-based counseling services for drug users, their partners and families.

The effect of the arrival of HIV on this community was marked. Many mothers, partners, sisters, daughters and friends of those infected with HIV had to adapt and expand their existing caring roles to accommodate the needs of those with the Virus.[19] Many mothers of young infected adults with HIV brought their offspring back into the family home to provide virtually 24-hour care, despite previous estrangement due to chaotic drug misuse. A 'real illness' led to forgiveness. Others were too ashamed to extend care however and would not admit that a family member had the disease. But much caring and loyalty to family members did occur. Initially, they often had to do this without support from authorities and brave the condemnation of their neighbours, who at this stage were still terrified of AIDS. Over time, understanding of the disease among the general public has improved and the possibility of HIV+ people living in the community has become accepted.

Most of the emotional and medical care of people with AIDS takes place in the community, although there will be periods of time when hospital care is needed. The demands placed on families are high - washing, cleaning, providing food, managing arrangements. The bulk of this caring role falls on women. The family may have to bear the burden of stigmatisation from the rest of the community - being shunned and avoided. Mothers caring for young adults who have fallen victim to AIDS, especially when it appears self-inflicted through injecting drug use, feel a particular burden of guilt. They feel they have failed as mothers. This, added to the eventual loss of their child, is extremely painful and for the community represents the loss of this person as well as the loss of the person with AIDS. They rarely function as whole persons again - they are not the same after such an experience and it is hard to be as confident or optimistic or energetic as before.

In many communities, it is grandmothers who are taking on these roles.[20] Their daughters become heroin addicts and if they also become HIV+, it falls to the

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19 Wilson and Ramsay 1990

20 Dunlap 1995 and Dunlap et al 1999

grandmother to try to maintain the family and care for the young children of the heroin addict. These heroic women are playing a major part in maintaining deprived and weakened communities[21]. The question has been raised however, how long this can continue? These women are becoming older and frailer themselves. In the next generation, who will take their place? They represent the heritage of older ways of communal living, which are not being reproduced among their children. Their daughters may be singularly unable to play the same role in the future, if and when they become grandmothers. The role of these women in maintaining community life, social networks, child-rearing and socializing is the kingpin of social life and continuity. The potential for real collapse of these communities in future, unless some alternative networks are provided, is recognised to be great. Some have argued that because of these trends, if we cannot turn back the clock, in future intermediary organisations and support groups will be even more important, backed up by government funds. They will be needed to fill the gap left by not only the gradual decline of the family found in modernised economies but also in particular in these communities profoundly hit by drug-taking.

Given that these women are being called upon to fulfill the roles of nurses, counselors and carers for their afflicted children, it is important that they receive support and education about the conditions they are having to deal with. They need to be linked in to networks of doctors, support workers and others involved in dealing with AIDS-related conditions. Drugs agencies need to offer services not only for drug users but also for the partners, mends and families of drug users. Home visits and outreach can assist here. And, as with caring for all chronic and deteriorating conditions, there is a need for respite care to help carers to revive and allow them to return to the hard task of caring 24 hours a day.

A similar situation can arise with wives of HIV+ men who contract the virus through ill use. The issue of practising safe sex arises in addition with them. Questions of whether it is right to become pregnant arise. The desire for a child may be greater where the husband is known to have reduced life expectancy, in spite of the dangers of transmission to the woman and to the child. There is increased emotional strain on all the family at the prospect of greater loss.

Support for informal carers who are, across the world, primarily women is generally under-prioritised. In an area where the need for care arises from behaviours which are seen as at least partly self-inflicted, there is even less willingness in society to provide such care, even though those doing the caring may themselves be wholly blameless. They are contaminated by the stigma that attaches to drug use and HIV + status.

Doctors, nurses and community workers can playa key role in providing support for such women which is sympathetic and knowledgeable. They also have a role to play in educating the general public to be more supportive and sympathetic to their situation. In Scotland, since the first signs of these two twin epidemics {when the burden fell primarily on women in the community), there have developed a range of services to support them, inc1uding:- outpatient testing and counseling facilities; in-patient beds; needle exchanges; condom distribution; specialist counseling within the health service; services providing transport; and assistance with child care.

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21 a situation of this kind can be found on the Easterhouse estate in Glasgow, Scotland

PART TWO: WHAT CAN BE DONE ABOUT THESE ISSUES?

This section discusses what interventions have been developed to tackle the issues described in Part One. These may or may not be suitable options for policy and practice in China. This part looks especially at attempts to develop women-centred interventions.

Influences on the shape of policy and practice

Key organising principles

Key principles around which policy regimes are organised are the desire to effect social control, the desire to meet human need and the need to minimise harm from risks present in the environment. Three types or models can be identified: the criminal justice model; the medical model; and the public health model. Within these models, regime types may be crudely divided into those which are relatively pragmatic and those which are more moralistic. Differences are evident in the extent to which either abstinence or harm minimisation is stressed; and in the extent to which the authorities are willing to intervene in personal behaviour. Modes of service delivery also vary, partly dependent on total resources but also influenced by institutional arrangements. A key difference is whether drug users are dealt with mainly through a health and social care system or through the criminal justice system. Countries vary in the extent to which the drugs problem is visible or invisible, recognised or hidden, as well as in the real size of the problem.

There appears to be some convergence across the world in national drugs policies partly influenced by the American War on Drugs. Key features of many drugs policies include a focus on the control of supply; the aim to support those affected - especially youth and communities; and an increasing interlinking of criminal justice and health and social services. All national policies vary of course in terms of implementation. There is often a gap between the rhetoric of national policies and what happens on the ground.

Primary prevention efforts are considered to be an important aspect of most countries' drug control policies.[22]

The impact of HIV

The arrival of HIV has meant that services and agencies have had to alter their approach to drugs treatment and intervention. The goal of total abstinence, while the ideal, is equaled or even some would say surpassed in importance by the need to reduce the risk of infection to other drug users and to the general population. The first aim becomes one of stabilising the situation - containing the threat - and this may mean encouragement of safer and cleaner drug use in controlled situations. The most familiar aspect of these

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22 A study of drug education curricula in Bangladesh, India, Pakistan, Nepal, Bhutan and Sri Lanka came to the following conclusions. All countries conducted needs assessment in relation to the drug problem in schools. There has been little evaluation of the effectiveness of these programmes. There appeared to be a need to develop further interactive and experiential learning techniques. Many suffered from lack of trained personnel, lack of resource materials, fear of overloading the curriculum, lack of community support and lack of research based information. There was no reference in this overview to distinctive approaches that were gender sensitive (How 1997).

programmes has been the growth of needle and syringe exchange schemes and the provision of condoms: these now proliferate around the world although accepted to a greater or lesser extent in different countries. The arrival of HIV has also led to an increased emphasis on community-based services and multi-agency approaches to service provision. The aim is earlier intervention - as early as possible in the process of drug taking - and low threshold, more accessible, less daunting and threatening services are seen to be the answer. These may be led by community workers rather than doctors, and may involve peers as well as professionals, as drug users appear more receptive to interventions from such people.

Peer interventions have the potential to maximise contacts with hidden populations of drug users. The first aim is to draw the drug user into a net of containment and through this to maintain some control over the situation. The authorities are able to acquire basic information on the extent of the problem - key basic epidemiological information becomes available - and the aim is to maintain a constant monitoring and surveillance of the situation. Also, through building up relationships of trust, it is hoped to entice the drug user into treatment. In this situation, harmful behaviours may be minimised and the risk of an accumulation of damages reduced.

Key elements in this fundamental shift in the approach of drugs agencies has been to reduce their isolation from other services and encourage them to work more closely in partnership with others in health and social services, in education and in criminal justice arrangements.

The harm-reduction approach

This is the approach often referred to as a harm-reduction approach. In this paradigm, drug policy is regarded as part of broad social welfare and health policies that emphasise pragmatism and inclusiyeness.[23]

> 'Harm reduction approaches start by asking: How can we reduce the likelihood of drug users suffering overdoses; contracting infectious diseases such as HIV, hepatitis and tuberculosis, and developing abscesses and other drug user-related medical problems? How can we reduce the likelihood of drug users engaging in criminal and other undesirable behaviours? How can we increase the chances that drug users will act responsibly toward others, take care of their families, complete their education or training and become legally employed? How can we make treatment and rehabilitation services more available to those drug users who have indicated a desire to change their patterns of drug use or stop altogether?' [24]

In a harm-reduction framework, priority is placed on maintaining contact between illicit drugs users and health care providers. Harm-reduction is not just about clean needles and syringes and methadone, but also about counseling including for women advice on antenatal and childcare issues. While not universally accepted and in conflict with many of the principles of the international war on drugs, it is more commonly found around the world than in the days before HIV came on the scene. It is a pragmatic response to the reality of the threat facing populations from the 'AIDS epidemic.

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23 Nadelmann et al 1997
24op cit page 23

To say that a policy is pragmatic does not mean it is value free. The aim of harm reduction is the reduction of suffering. A better word than pragmatic might be realistic. Pragmatists have goals - desired ends and values - but they are pragmatic about how to get there. The first aim is the reduction of harm to the individual and to society.

The role of drugs agencies

The role of drugs agencies in this context is to intervene primarily to try to prevent people being tempted to take drugs in the first place - through control of supply and through education to encourage those (especially the young and vulnerable) who are tempted to take drugs. Secondly, to intervene with those who have taken drugs. The aim here is to encourage them to stop but firstly to stabilise the situation and prevent the accumulation of further harms - to establish the avoidance of further risks. Finally with more extreme cases, there will be a need for specific treatment to aid withdrawal from drugs and deal with the underlying causes that led to use of drugs in the first place and inability to desist even when damage becomes apparent.

In an era of HIV, drugs agencies are increasingly expected to place priority on tackling the spread of HIV infection. This implies changes to their working practices and policies and may involve developing clear policies on confidentiality and changing assessment' procedures.

What interventions exist across the world related to drugs?

The question of what interventions to encourage is a complex one and one which is hotly contested. Key issues in contemporary debates internationally revolve around such questions as 'what works and how can we measure effectiveness?' The range of interventions offered is wide and includes counseling; out-patient treatment; psychological interventions (such as cognitive behaviour therapy or motivational interviewing); methadone clinics; advice on safe sex and use of condoms. A current question surrounds the value of community involvement in policy and practice. What is the place of community care/care in the community in drug policy and practice? Is it realistic to aim at drug-free communities? What can be the role of community self -organisation and neighbourhood committees and how should these relate to policing? Is there a role for peer interventions/education? 'What is the value of compulsory versus voluntary treatment? Which is best inpatient or out-patient treatment?

The argument rages on these questions and the evidence, while growing, is not conclusive. In judging the evidence, the key tests for all innovations must be effectiveness, cost effectiveness, affordability, and acceptability.

The main distinctions within interventions are between those which are residential and those which are found within the community. Some services are in-patient while others are for out-patients. Some aim at abstinence and rehabilitation while others use substitute drugs like methadone aiming at detoxification or establishing either a maintenance regime or a gradually reducing prescription of the substitute drug. Other types of treatment include: heroin prescribing; injectable methadone prescribing; prescribing of buprenorphine; use of other drugs in treatment - such as naloxone or naltrexone. There are also 12 steps programmes (based on the original Alcoholics Anonymous concept);

street agencies; needle and syringe exchanges; and various approaches to offering primary health care.

Specific interventions: outreach

Outreach is a particularly valuable way of working, if the aim is to make contact with rural communities or with highly mobile groups. Other hard to reach groups best accessed through outreach work include young people, homeless people and illegal migrants and refugees. Outreach is an important part of any strategy aiming to develop interventions to prevent the spread of HIV infection. Mainly, to date, it has worked with individuals to help them to change their behaviour, gain access to services or become better users of services. It has been argued that this approach needs to be complemented by a community change model seeking to engender change in social habits and customs, the etiquettes of drug using groups. Focusing on these social networks can aim to target and encourage change among broader populations of drug injectors. Use might be made of indigenous advocates supported by outreach workers. [25]

Needle exchanges

With the arrival of HIV, syringe exchange programmes have been implemented in many countries throughout the world, although there is great variety in the ways they have been developed. There is no evidence that syringe exchange programmes lead to increased illicit drug use. Participants in these schemes report reduced HIV risk behaviour. Needle exchanges are often disliked by the public as they are by some drug workers. Few however see their role simply as handing out needles and syringes (it is important that attention is given to the whole set of paraphernalia involved in intravenous drug injection not only needles and syringes but spoons, cotton wool, water and so on). The point about these exchanges is that they provide an opportunity for drugs workers to make contact with drug users, possibly at an early stage in their career, and with a broader range of drug users than those seen by other services. Such exchanges (which also often provide condoms) have been particularly successful in establishing contact with prostitutes. Through this contact, the workers can provide specific information relevant to the client group. Here we are interested in the extent to which they can tell women about the effects of drugs on the menstrual cycle and on pregnancy and give advice on sexuality and safer sexual practices as well as safer and cleaner injecting techniques. Information about other services available could also be given, including referral where appropriate to drugs treatment agencies or to obstetric services.

Drop-in centres

Drop in centres can playa useful role in providing services to people who otherwise would not access them and in making links with previously hidden populations. Again they need to be run by people with an acceptable style and by people with integrity who can be trusted by both the clientele and by the authorities. It is a delicate relationship to maintain but can be done. These may link into wider networks of services including treatment and rehabilitation.

Prevention

As well as attention to treatment and care and control, attention is also paid to prevention. Generally the main focus for prevention activities is in school settings. The evidence base for prevention activities comes very largely from the USA and the emphasis is

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25 Stimson et al 1994

principally on effecting behavioural change (although this has been found harder to influence than information-awareness and attitudes).

Many prevention programmes rest on a concept of imparting life skills, which is the ability to resist temptations. The key concept here is that those who use drugs lack the skills to resist so they need to be taught these skills. The question arises as to whether some groups are more vulnerable than others to drug misuse and therefore whether special attention should be given to them. While this appears sensible, there is the danger that by targeting attention in this way, these vulnerable groups may be stigmatised and other problems created. Here we need to consider whether women are more or less vulnerable than men to drug use and HIV infection, and in what ways the relevant influencing processes differ between girls and boys, men and women.

Images and expectations of women

Few of these policy types or models take women seriously. They are largely constructed around notions of the public, the drug user, and society which are at best gender-blind. In this conference, however, we want to put women at the centre of attention. Before looking in more detail at those interventions which have been developed with women's' needs in mind, we should step back and look at the general context of women's lives. We should consider how women in general are viewed by society, since this influences the ways in which women involved in drugs are treated by agencies and authorities.

Responsibility for caring

As has been discussed earlier, in most societies, women are expected to take most responsibility for caring - for children, for older people, for disabled people, for other dependents. If the children go wrong, behave badly or get involved in drugs or crime, mothers may be blamed. They did not bring their children up correctly, they lacked parenting skills, they gave them too much attention or too little - and so on. It is odd how often men do not feature in these debates - somehow an absent father is also seen as the fault of the mother – she was not a good enough wife.

The consequences of deviance

One consequence of this expectation of women to be, if not perfect, then better than men, is that 'when a woman breaks the rules this is even less acceptable than when a man does so. A woman who kills is seen as more horrifying than a man who kills. If a woman is a criminal or mad, she is likely to be categorised as a more severe case than would be an equivalent male criminal or male patient. But often these women's symptoms or behaviours are more extreme. So it is with drug use. For a woman to take drugs is viewed as more morally reprehensible than for a man.

Why are we more forgiving to men? Is it because our expectations of women are higher with regard to their virtue, their care for others, their responsibility to family, community and society - so that when they stray they are condemned fiercely? Perhaps women are more important to society than men - but I will not pursue that point! It does seem however that it is commonly thought that women should not seek pleasure for themselves - they should put others first. So a self-indulgent behaviour like drug-taking is seen as particularly wicked and a woman who does this is condemned more vigorously than a man in the same situation would be.

All this relates to the nurturing role expected of women in most situations - even in the workplace and in management. The consequence is that mothers using drugs are particularly feared as a threat to society. All women because they are potential mothers are viewed in the same way. Women who lose control are viewed as especially odd - whereas such behaviour in men may be more often tolerated.[26] (Some people consider that with modernisation and increased equality between men and women, these differences may disappear - or be reduced so that similarly in the field of drug misuse, men and women may become more alike eventually in their ways of behaving).[27]

Barriers to prevention, treatment and care

This sense of revulsion and condemnation of deviant women is shared by health and service agencies and those who work within them. Women approaching these agencies report unsympathetic attitudes from staff. This may lead to neglect of basic health care needs.

Even where information is assimilated with regard to health care and the attitudes of women become supportive of healthy living and safe sex, they may not be able to put this knowledge into effect. This is because of the unequal relationships which exist between them and the men they come into contact with, including close partners. A key example has to do with condom use, where both parties need to agree to use this method for it to work. Situations influence how people behave and women's lower status often, means they are not in a position to insist on healthy practices if the man is not willing. [28]

There are a number of obstacles that bar women from changing their behaviour to better preventive practices and deter them from seeking help with regard to treatment and care. These include, as mentioned, their reduced power to negotiate changes in behaviour because of unequal relations between men and women. This is particularly difficult for women involved with drug-using men. They also involve the stigma associated with admitting to deviant behaviour such as drug use or sex work. There may be insufficient services in general, which means that more powerful people are more likely to access them, but the services that exist may be inappropriate for women also.

The stigmatising of women drug users as particularly deviant is shared by male drug users themselves, who may treat women they come into contact with in particularly harsh ways. It is always good to find someone who is inferior to yourself and women can perform this role for drug users. They are likely to be treated violently and harshly by male drug users as well as by male dealers, punters and pimps. They are seen as the lowest of the low and some get perverse satisfaction from treating them exceptionally badly. In the situation they are in they have few to protect them - they cannot call on the authorities, they may be isolated from other women and have long left behind their families and friends. These features of the drug scene support the argument for separate

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26 Green 1997 observes that men are in most circumstances both expected to take greater risks than women and are given greater leeway in experimenting with and becoming involved in risky behaviours

27 However discussion of male/female convergence in alcohol consumption has tended to conclude that, despite rising consumption among women, there is no evidence of widespread convergence in male/female drinking patterns.

28 Advice on safe sex often involves, as well as advice to use condoms, advice to engage in non-penetrative forms of sexual behaviour to reduce risk of infection and also risk of conception. However, because of women's lack of power in relationships with men, particularly the women who become drug users, they may not be able to influence the sexual relationship towards these less risky practices.

services for women where they can be protected from the abuse inflicted on them by other drug takers. The need is for safe and welcoming places for women to access when they decide they want to seek help. Details such as differences in hygiene requirements also argue for separate services and may be the beginning of women regaining some self respect. Where there are children involved the need for separate services is also important in protecting the children as well as the women.

Developing women-centred interventions

Drug services can play an important role not only where HIV + rates are high but also where they are low in maintaining this situation through an emphasis on prevention.

In most countries, drug treatment systems were originally designed for men and women were initially expected simply to fit into these systems. This presented problems for both the men and the women. Evidence appears to show that

> 'the background of women who become drug addicts differs from that of men; that addicted women behave differently from addicted men even in their efforts to quit; and that they have different needs when in treatment, needs that refer to treatment settings and' methods that appeal more to them than to men'.[29]

The influence of violence and sexual exploitation

A specific finding in studies of women addicts is the importance of the issues of violence and prostitution in their lives.

The variations found between men and women in different societies reflect differences in cultures and institutional arrangements so it would be unwise to generalise too broadly about details of patterns of drug taking, such as age of onset of use, preferred drugs, . patterns of injecting or help-seeking behaviour. However, it is worth referring to the frequent finding of women's subjection to violence, most often as sexual exploitation, in the backgrounds of women addicts where this has been researched.[30] 'The younger they are when sexual exploitation begins, and the more severe and long-lasting it is, the greater the risk of addiction. The risk also increases with the closeness in family relations of the exploiter; females who have been sexually abused in early childhood by members of their families are the most vulnerable to drug abuse and addiction in their teens. [31] 'Drugs offer a way of dealing with traumatising experiences, memories of cruelty, and learned helplessness and this paves the way to eventual addiction'. [32]

Research into violence, sexual exploitation and drug dependence is still at its beginning, More studies are needed. Violence is also a feature of the lives of street addicts as has been described extensively for crack dependent women in the inner cities of the United States. [33] The female role has been redefined in some places to become more like that of young men, for example as described for girl gang members in San Francisco by Hunt and his colleagues.[34]

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29 Vogt 1999 p285
30 Murphy, and Rosenbaum,1999
31 Ireland and Widom 1994; Pederson and Skrondal 1996 quoted in Vogt 1999 p285
32 Ladwig and Anderson 1989 quoted in Vogt 1999 P 285,
33 Bourgois 1989; Fagan 1992
34 Hunt et al, 2000

With regard to treatment outcomes, again generalisation would be unwise given differences in approaches to treatment in different countries. 'Nordic-country data support the Canadian and US findings that women on the average have a better chance of rehabilitation after treatment than do men[35]. Women with strong ties to the drug subculture however are at higher risk of relapse.

Sex Workers

Sex workers are a particularly important group in these discussions. With variations by area and locality, it is often found in some areas that a high proportion of sex workers take drugs. They may have taken to using drugs as a response to their situation – drugs being available in those situations, and to help them face unpleasant aspects of their work. Or they may be drug users who engage in prostitution to earn money to pay for drugs. The connection between sex work and drug using and dealing is a close and complex one. Women linked to dealers and users may engage in sex work to earn money nut just for themselves but for their male partners.

Surveillance of sex workers has tended to increase in some parts of the world as part of the public health need for information, monitoring and control. The provision of information for epidemiological purposes can be combined with provision of basic health, care checks provision of advice and information, access to health and social care and other facilities. Again the aim at containment, contact and harm reduction is the principle leading to change in the shape of services, along with a basic humanitarian concern for the wellbeing of those caught up in these circumstances. This may be formally recognised in law but more often takes the form of turning a blind eye, allowing or even supporting non-government agencies to provide the front line services with police and authorities keeping their distance - in return the authorities are informed about trends and any major changes in the situation. A pragmatic response again but one not often favoured if the matter comes to the attention of the general public, press or politicians.

One development in sex work that has resulted from the HIV epidemic is the increased threat to sex workers from HIV positive men. They may be asked to engage in harmful sexual practices and may be paid more for these services. More worrying perhaps is the tendency to favour younger women - virginal even - who are thought to be less likely to be HIV positive themselves. This has been a factor in the increasing concern around child sexual exploitation found across the world. The luring or abduction of children and young women into a life of prostitution and drugs is a major social issue which is also leading to changes in policies and practices as a result. In particular, the need has been recognised for police forces to work with social workers and community nongovernmental agencies to deal with these hidden and sensitive matters.

Policing and prisons

Prisons are an important location for work with drug users and sex workers.[36] Many police officers consider drug users undeserving of anything except imprisonment. They

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35 Berglund et al 1991; .Bjorling 1993 quoted in Vogt 1999 P 292

36 In Britain, between 1991 and 1997, the number of women in prison doubled. But still in 1998 women made up just less than 5 per cent of the British prison population. Black and other visible minority women are 15 percent of this group, although only 3 per cent of the British population. But when foreign nationals are included, black women account for 24 per cent of the female prison population (Heneghan 2000).

are unsympathetic to those who emphasise a treatment and rehabilitation approach to drug use. This hostility may be most marked towards visible minority women who experience a double stigmatisation. These women may he more likely to face imprisonment regardless of the effect on their families.

HIV rates are at least as high in prisons as in the general population and often much higher since prison populations are drawn from high risk groups. The prevalence of drug use and diseases may be high but it is often unknown. Rates of tuberculosis and hepatitis C as well as other diseases may be high and conditions in prison may encourage transmission and infection. HIV has wide-ranging implications for the prison service. While the prevalence of HN may be high, the use of harm minimisation techniques in prisons is low and generally resisted. The arrival of HIV has however emphasised the need to promote safer drug using practices. HIV counseling, prison staff training and discussion groups have all begun to appear. A few projects have focused their activities on making links with people in prison. This work may include training prison staff, giving HIV and drugs information, and running discussion groups for prisoners.

The situation of women in prisons is under-researched. The involvement of women drugs workers appears to be useful in directing services towards the specific needs of women and encouraging trust and confidence. Discussions of such matters as the effect of drugs on the menstrual cycle, pregnancy, HIV related issues, sexuality and safer sexual practices are often better received if they are given by women workers. But attention to women prisoners remains low. A high proportion of women in prisons in many countries are there because of drug-related crimes. Quite often these are women from overseas caught acting as drug mules. In many prisons, illegal drugs are available. Women partners may often provide the route into prison for drugs smuggled from outside - they do so not casually but often because of threats to themselves or to their partner if they refuse to deliver. Prisons in some cases provide an introduction to drug use.

Yet in, another sense, prison provides an opportunity for change if the appropriate services are available there.

Services need to link issues of drugs and HIV together. Sometimes use of such services is avoided for fear of being identified as a deviant by other prisoners and the risk of suffering violence from other prisoners as a result. Drug users have been categorised as the lowest in the prison hierarchy along with paedophiles and child murderers and have had to be segregated as a result. They may find access to other services denied them. Many find it better not to disclose their status as a result.

Treatment and rehabilitation

Other services dedicated to the needs of women are treatment and rehabilitation services. A number of services have experienced difficulties in attracting women to them and in keeping them in contact thereafter.[37] The main reason appears to be the fear of children

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Currently 4 per cent of women in prison report heavy use of or addiction to drugs. Drugs are freely available at times in some British prisons in spite of attempts to control the supply of drugs into prisons.

37 Anecdotal evidence suggests that women respond better to services (i.e. tend to access and remain engaged with them) which do not provide only treatment in the traditional sense. They are attracted by

being taken away. Along with this there also seems to be a particular difficulty for women in keeping appointments. Special issues concern pregnancy and prostitution among drug using women. .Where services aim to attract the most chaotic women to their services, they have found that they have to adopt a non-judgemental and nonpunitive style. This has required a shift in attitudes among some staff, which many find difficult to adapt to. However such changes can lead to improved success rates - for example reducing the number excluded from programmes because of failure to meet unrealistically high expectations. A more friendly, informal and flexible service seems better able to attract women into services and keep them there.[38] Changes in practices that can yield dividends include more flexible appointments systems, access to primary health care, advice on safer sexual practices and contraception, and special medical sessions for pregnant women.

The aim is to establish a stable and healthier lifestyle in the first instance. Links to infectious disease services are also useful. This increased informality does not mean that there are no rules. Patients are expected to adhere to some basic rules and flexibility has to work within some boundaries. Firmness and clarity and consistency around rules can be one way of encouraging confidence in the service and increase the woman's sense of security.

Drug- and alcohol-free units need also to think about the specific needs of women and the value of separate services. If it is possible to keep children with the women, this can improve the motivation to recover. Where psychological processes are part of the rehabilitation plan, then programmes have to take account of the role that gender plays in defining an individual's identity, coping style, skills and the opportunities available for living an alternative life. Routes out of drug-taking require the offer of alternatives and new opportunities as well as the willingness to change. In particular, women's self-image and the image of others that they are incapable of being good mothers needs to be addressed. There are many ways in which women fail to be perfect as mothers and drug taking is one but it is the most condemned of ways. For women who have worked as prostitutes and financed their habit through this, a part of their recovery from drug dependence may mean finding an alternative way of earning a living. In many cases world-wide, this can present the most difficult barrier to recovery. Many sex workers are ill equipped for the job market. Leaving the world of prostitution along with drug taking can mean leaving behind all one's friends, reduced standard of living, and the alternatives may seem unattractive, even boring, to some.

Pregnant women and mothers

Disapproving public attitudes can deter pregnant drug users from seeking and receiving the help they need. As a result, they can present late and not receive appropriate antenatal care. Deterrents to seeking help include guilt about the harm they may be causing to their baby, fear of what might happen to them on disclosure of drug use, and fear that other children might be taken into care. Risks from using opiates while pregnant include low birth weight, congenital abnormalities and premature birth. Other health risks include poor nutrition, poor general health, tobacco use, consequences of long term injecting and transmission of blood born diseases such as hepatitis and HIV.

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services which help them to relax and to enjoy, such as aromatherapy, massage, movement, dance, yoga, or acupuncture.

38 Ruben 1990

Pregnancy may provide the opportunity to encourage drug-using women to change their behaviour. Obstetric services may be the route in to treating problems related to drug use such as abscesses. The issue of how to deal with drug dependence in pregnant women is a difficult one with detoxification being one possibility and stabilisation through prescribing another. The effect of either on the baby requires the involvement of an obstetrician in the programme. If the pregnant woman earns her living through prostitution, the effect of prostitution on the pregnancy also needs to be taken into account. Admitting to involvement in prostitution requires trust between the patient and the doctor or midwife. Most importantly, pregnancy and contact with services offers an opportunity to provide counseling and support related to drug use. Harm reduction and stabilisation are important at this stage.

Joint working between drugs agencies and obstetric services is emphasised in the experience of those offering services for women~ Attention to parenting skills may also be important. Some research has characterised addicted women's parenting as involving a range of deficits, including neglect, physical and emotional abuse, excessive control and punishment, inconsistent discipline and lack of emotional involvement. [39] Some of these features might however be contextual and relate to such factors as poverty and low status. Research findings indicate the need for concerted attention to mothers' positive involvement with their children.[40] Children living with drug dependent parents are exposed to violence, crime and health hazards.[41] The extent of co morbidity (presence of other mental illnesses) among addicted women is also a feature increasingly recognised, which could in itself affect parenting patterns. This is an area where few services have yet demonstrated clearly what is good practice and what works. Being lectured at by worthy people seems sometimes to have the opposite effect to that intended and cooperation can be low on such programmes.

Mothers who use drugs are likely to run the risk that their children will be taken away from them. This may lead to their being more likely to remain hidden from services and authorities until later stages in the drug using career. If the assumption is that earlier intervention is preferable and more likely to be effective, then ways round this problem need to be found. Again intermediaries like NGOs can play a useful part here in delivering services to such women, maintaining confidentiality towards them but at the same time behaving ethically so that if the children are seen to be in danger they will act to protect the child. Safe fostering systems while mothers receive treatment and childcare support in the recovery and rehabilitation stages all have a part to play.

Self-help groups

Self help groups have played an important role in some parts of the world. These work well where there is a highly motivated group of people with personal experience of the situation, who are aware of the needs of the women involved and can act to endeavour to meet these needs or put pressure on other groups to provide such services. Support of such groups by governments or NGOs with advice or small financial grants can make a big difference. These groups are useful also in that their voice is more often listened to by authorities - they appear credible and authentic - they know what they are talking

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39 Mayes 1995
40 Luthar and Suchman 1999
41 Luthar 1999

about and can speak with passion and clarity: they can thus be more influential than professionals and semi-professionals, however well intentioned they may be.

Women are often leaders of these groups as they tend to be more active at the community level and have good networking and organising skills. Where the groups are concerned especially with the needs of women regarding drugs, HIV or sex work, they can play a major role in shaping local implementation and interpretation of drugs and HIV policies.

Self help groups are important in overcoming the isolation of drug users and HIV + women. They can be a key first point of contact for such women as it is often easier to trust and accept advice and information from someone who has been through similar experiences than from an expert. Self help groups have proved their worth in other areas, e.g. in mental health, physical disability, bereavement, alcoholism, men with AIDS – they can be equally valuable in this area too.

Reintegration into the community

Another feature of treatment where the needs of women should be given special attention is in rehabilitation after treatment or prison - reintegration into the community. What roles are open to the woman who has recovered and are there sufficient supports to help her maintain her motivation and avoid relapse? Practical issues such as where to live, housing accommodation, work and employment, and child-rearing need to be addressed. It may be that the woman does not have a partner to return to or a family to care for her. What support services exist in the community and are they sensitive to the particular needs of the woman? Return to the family may not be wise anyway, since problems in the family may have been part of the cause of the drug-taking originally. The prevalence of abuse or violence in the backgrounds of drug taking women has been a common finding in studies that have been conducted in various parts of the world. Abuse of alcohol, sexual abuse, and physical violence all seem to be present to a higher than average degree in the experiences of drug using women. Aspects of service provision that may be particularly relevant for women are suitable vocational training and education, assertiveness training, self defense, health education, and child care education.

Some examples of interventions

Even in a country like Britain, services for women substance users are rare and services for women users and their children in England are rarer still.[42] One project in Brighton in south England focuses on women only. It was set up because the Brighton and Hove area has the higher per capita rate of drug -related deaths in Britain. When such services are set up, the need for them is demonstrated by the numbers who then come forward who had previously not been in contact with services. Practical obstacles that were found to have prevented women in Brighton from accessing services included: not knowing services exist; not being able to afford to get to them; and not being able to fit use of services in with the demands of children and a drug habit.[43]

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42 Painter et a1 2000

43 The Oasis Project in Brighton offers outreach services, open access drop in services, a creche, telephone help-line, and publicity. It gives advice on hepatitis C transmission and support for pregnant mothers and new mothers. A midwife and outreach worker are employed. It also runs a sex workers service, providing

In Zimbabwe, there has been an abrupt and violent HIV epidemic with prevalence of HIV among adults in some cities nearing 30%. A project is underway aiming to target HIV prevention interventions through sex workers using community nurses and peer educators.[44] The aim is to promote safer sex and condom use and to have a particular impact on migrant workers and on their families and the wider community. It has been found that epidemics can be driven by commercial sex. If so, there is a need to use sex workers as part of public health and prevention strategies. Other approaches being used in Zimbabwe involve voluntary counseling and testing and primary health care at the workplace.

Other studies focusing on sub-Saharan Africa being conducted by staff at the London School of Hygiene and Tropical Medicine aim to explore whether the differences in rate of spread of HIV can be explained by differences in sexual behaviour. Influential factors as or more important than sexual behaviour were found to be male circumcision and ulcerative STDS.[45] The hypothesis that male circumcision may reduce the risk of acquiring HIV infection was first suggested early in the HIV epidemic. A systematic literature review was conducted.[46] The results showed that male circumcision is associated with a significantly reduced risk of HIV infection among men in sub-Saharan Africa, particularly among men at high risk of HIV.

Other research in this area also assumes that mobility is linked to the spread of the epidemic. Research is being conducted on the effectiveness of interventions in highly mobile populations. The aim of some of this action research is to increase the use of condoms by vulnerable and high risk groups. Findings indicate the value of face to face health promotion and the use of NGOs as intermediaries.

In South Africa, over 3 million people out of a population of 38 million are infected with HIV. Commonly cited explanations for the severity of South Africa's epidemic include social disruption, labour migration, gender inequality, and poor access to education, information and high quality services. It has also been concluded that there is a need to understand youth sexuality. .

These studies have identified a differential risk between men and women, girls and boys - there are higher HIV rates among young women in some areas of Africa as there are of STDs. Details of sexual practices are important in understanding and in developing effective prevention/education programmes but they are difficult to research.

In Malaysia, about 70% of reported HIV infection occurs among IDUs. The prevalence of HIV infection among IDUs in 1996 was estimated to be around 15%. There is a need for more epidemiological research and research which will help us to understand types of injecting drug use and sexual behaviour in these groups. There is a need for baseline data to track the epidemic and to monitor the effectiveness of prevention and control strategies.

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health and harm minimisation advice, self defense classes, an up-dated 'dodgy punters list', access to . specialist counseling, advocacy and onward referral. Other services include advice on contraception, exercise classes, parenting classes, and discussion groups.

44 Research by Hayes, Jaffar and Mabey at the London School of Hygiene and Tropical Medicine

45 sexually transmitted diseases

46 Research by Weiss et al at the London School of Hygiene and Tropical Medicine

In Mongolia, recent changes have led to increased risk of STD/HIV infections - changes such as urbanisation, increased travel, the spread of non-traditional values, the decline of the influence and support of the extended family, poverty and unemployment. It is felt that there is a need for school sex education programmes and better contraceptive knowledge. And a need for education to help young people develop the skills and resources to manage and avoid risky behaviour.

In Brazil, some projects build on key aspects of successful schemes developed in family planning in Mexico.[47] These involve peer led approaches, outreach strategies, and participatory techniques as well as use of marketing techniques.

Many parts of the world have developed street agencies in cities like Bogotá, Mexico City, Johannesburg and elsewhere. These agencies act as the first point of contact with drug users. Some but very few pay particular attention to the needs of women. Street agencies aim to provide advice and information, counseling and some basic primary care. Part of the reason for the lack of special attention to women is that street work is itself a dangerous activity and attractive only to a particular kind of person with particular skills. These are often men. Women engaged in street work should work in pairs and let base know where they are and where they are going at all times. Services for women are often focused on prostitution and some useful innovations have been tried in this area.[48]

Innovations in interventions

The main aim of all these networking developments is to prevent further exclusion of the drug user or sex worker or HIV+ person from society. The process of becoming deviant involves both the activities of the deviant but also the reaction of society. The secondary risks associated with the primary deviant act accumulate and exacerbate the condition of the miscreant. To reverse the situation, society has to reach out to the deviant and bring her back into the social net. The role of self-help groups, intermediaries, street agencies, harm reduction services, support and advice services is to make these contacts, make links with the excluded and gradually begin to reverse the process of secondary handicaps and deviance and exclusion from society. Stabilising the situation is the first aim and once trust and contact have been encouraged then further steps back can be made. For society, there is an immediate benefit if the risks of infection and further social harm are reduced at that stage.

The community groups and self-help organisations developed through these innovations need some financial support or equivalent to develop. Small grants can make a big difference. It is often found that once such a group is established, the numbers of people needing that service, in that category, appear to increase. That is, there is a large hidden

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47 by Gente Joven

48 Examples can be found in places as diverse as Bogota in Colombia and Tower Hamlets in London. In Holland, a Streetwalkers Project in a former prostitution zone (described by Ben Van de Wetering at the Going Dutch conference in Edinburgh October 2000) offers a drop in living room with medical facilities. 60 to 70 use it per night. Social workers and nurses are available. This is a low threshold facility - that is, it involves reduced barriers to access to services. The aim is to meet immediate needs. This project found that many of these women were using heroin and cocaine.

population and hidden problem that only becomes visible once such services are established. This knowledge is useful to authorities also - it is no use being blind to a growing problem that may blow up in your face one day - better to be informed and aware so that it is possible to devise policies to deal with the problem. These networks can also help to monitor changes in the shape of the problem - patterns of use, types of people involved and so on. They do not replace statutory services and agencies but complement them and extend their reach into previously unknown or hidden areas. This is particularly important where societies are undergoing extensive and rapid change and where features like migration and external influence and penetration are increasing those changes sometimes summed up in the word 'globalisation'.

PART THREE: CONCLUSIONS

This section identifies a number of questions which have arisen in the discussion of issues and interventions.

Five key questions have emerged in our review of issues and intervention options. These are:

1. *How to encourage safe disclosure of problem drug use and/or HIV+ status?*
2. *How to prevent further social exclusion of women drug users, especially those who are HIV+?*
3. *How to protect women caring for people with HIV or drug problems?*
4. *How to treat or intervene so as to address problems specific to female roles and female social identities and to take account of women's location in the social structure?*
5. *Who is responsible for caring and for service provision?*

These questions may be taken up in the conference discussions. I shall simply conclude this paper with a few key points which seem to me to be of relevance in beginning to try to answer these questions.

1. *These questions are more easily answered if we adopt a public health approach to policy and practice.*

Public health is 'the science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society'. Improving public health in today's world requires alterations in individual behaviours. This raises issues about the right balance between individual and state or social responsibility.

One particularly valuable aspect of the public health approach lies in the way it encourages us to see the interconnection between a number of issues, such as drugs and sex work, HIV and child abuse, domestic violence, poverty, and migration. The policies that result need to deal with the whole, not isolating out one issue and attempting to deal with this separately.

2. *Thinking about drugs and HIV can draw on the lessons of research on health in general*

Health research shows that early disadvantages influence a person's life-course and biography. The general findings of such research are that material circumstances, psychological factors and behaviours all influence health outcomes. Explanations for differences can be structural, genetic, physiological or behavioural. Each set can provide a list of potential risk factors. Such research also demonstrates that area matters - there are regional and area variations reflecting different influences and experiences. And ethnicity and gender make a difference.

It is also clear that policy frameworks make a difference. If we are to attain public health goals, understanding of pathways and processes is a first step and research can play a key role here.

These general findings in health research apply also to drugs and HN. These like many other diseases and illnesses have more than a single cause. Multiple causes can accumulate over a lifetime. Early life and early adulthood are important stages.

3. *The concepts of risk and protective factors are useful tools.*

It has also been found that people vary in the way they respond to the awareness of risk. People respond differently to warnings. The link between risk recognition and behaviour is complex and not easily predictable. People show ambivalence and uncertainty. They may have doubts about the scientific evidence. Myths also influence behaviour as well as anecdotal experience and what are seen as contradictions between evidence and experience. Crude health education tends to be dismissed if it does not fit with people's own knowledges and understandings about risk.

The lesson from such research is that we need to know about risk factors in targeting or devising health promotion techniques. Key concepts utilised in these approaches are those of risk and protective factors. The consequences of behaviour can differ between different social groups. Health promotion campaigns need to be informed by knowledge about different patterns.

4. *People who develop problems with drug-taking are not distinctly different from other human beings*

What we see with regard to drugs and HN are continuums of behaviours. There is not a clear dividing line between the normal and the deviant. The processes generating these conditions (drug misuse and risky sexual behaviour) are often familiar. They are observable in less extreme forms in many people and situations. What we find are differences in the intensity of risk and differences in people's ability to resist. These differences link to questions of power and resources. And as long as women are generally less powerful and have less money than men, differences in their health and in provision of services for them are likely to remain.

BOX 1: UNDCP programmes with a gender dimension

1 In Kenya, one programme aimed to integrate drug demand reduction activities with health and family planning services in urban slums. The aim was to integrate drug preventive education and abuse awareness training into the existing structures and activities of 100 Enrolled Community Nurses and 500 volunteer Community Health Workers in seven slum communities. It was a self help project. At the end of the project, the ambition was through training delivered via the nurses to the voluntary health workers, to have trained these volunteers in drug prevention and drug abuse awareness raising and that they would have been introduced to counseling techniques. .

2 Another project working in Africa aimed to use health publications such as 'Healthy Women Counseling Guide' to improve women's health in a holistic way. It developed a manual 'Helping Health Workers Change' to increase health workers effectiveness in working with and addressing the problems of their clients, especially women. The project was intended to provide direct support to institutions in the health field that lacked a drug control focus.

3 A project in Bangladesh includes within its aim to improve the capacity of government and non governmental organisations to formulate and carry out preventive strategies and programmes aimed at particular social groups vulnerable to drug abuse. One element aims to enable the Department of Women Affairs to include drug abuse education in its non-formal education programmes.

In a long list of projects funded in one year by UNDCP, these three were the only ones which I could see included any specific reference to women. Admittedly these were brief summaries of the projects and this does not mean women were not included in the broad objectives of other programmes. However, there seems a particularly gender blind aspect to the funding of these projects.

BOX 2 : UNNDCP PROJECTS FOCUSING ON COMMUNITIES

Often the work of communities is the work of women so projects focusing on community level work might be woman centred. More UNDCP projects include a community dimension. Excluding projects concerned mainly to develop education and information materials, to identify and support NGOs or to support resource centres to coordinate national or regional activities, a number included reference to community involvement.

1 A project in Afghanistan aimed *inter alia* to train key members of communities including staff of NGOs to become service providers in respect of referral, treatment, rehabilitation and social reintegration of drug addicts. Twelve Community Treatment and Intervention Teams would be established with trained staff. The aim was partly capacity building.

2 A project in Kyrgyzstan aimed to develop the capacity ofthe1ocal NGOs to support community level development work, offering an alternative to participation in the drug trade and drug consumption.

3. A project in India aimed to reduce drug abuse and its adverse consequences through the introduction of effective drug rehabilitation and social reintegration programmes as well as workplace based strategies. The immediate activities would be mobilisation of community participation; training of key drug rehabilitation professionals and NGOs, and training of professionals in developing prevention and assistance measures.

4 A project in the highlands of northern Thailand aimed to strengthen the capacity of these communities to deal with drug abuse at the village level. Workshops were organised to increase community awareness and train villagers and government staff in various approaches to prevent, treat and rehabilitate drug addiction; and to increase their self policing abilities. A particular aim was to stop the practice of injecting.

5 A project in Myanmar and Thailand included development of community based intervention strategies and public information through training trainers and other activities.

6. A project, which included China, aimed to establish and provide training on drug demand reduction and HIV/AIDS prevention among disadvantaged groups. The methods would include community based activities and production of a manual on community based approaches.

7 A project in Barbados aimed to strengthen institutional and human capacity of not only public but also private and independent organisations enabling a bottom-up approach and community empowerment, which, it was thought, would best ensure the relevance, impact and sustainability of the activities. Sharing of experience between communities would also be encouraged.

8. A project in Colombia aimed to reduce risk factors associated with drug abuse through an education strategy to strengthen the family unit and protect young people.

9 Another project in Colombia included in its aims to help municipal bodies in the development of community based activities which would educate and inform the public on drug prevention and drug addiction, partly through setting up a network in the community to disseminate information.

10 Another Colombian project focusing on Cali aimed to fortify family and community resistance to drug abuse. Activities would centre on active community participation and interaction with and support from the pertinent authorities and NGOs.

11 A project in Jamaica aimed to train communities in all fields of drug abuse control. The strategy was to assist selected community organisations to become NGOs thus enabling them better to tap international, national and community based resources, including the private sector.

12 Another in Jamaica aimed to support 15 community drug awareness committees in the implementation of the economic component of their community development plans, aiming to create strong and active steering committees, community employment agencies, a community data bank and skills training.

The aim of many of these projects is the strengthening of the community infrastructure and protection systems in whatever way is appropriate to that country or locality. It is quite likely that those most actively involved in these developments in many areas will be women who, across the world, take most responsibility for community life. Involving these networks in raising awareness about the link between IDU and HIV is likely to be a maior aspect of their work.

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