



Access all areas

What can be done to ensure gender equality in the field of harm reduction? Sue Currie shared her thoughts with DDN ahead of chairing a conference plenary session on gender equality.

HISTORICALLY, HARM REDUCTION programmes have tended to operate on a ‘one size fits all’ basis, says Sue Currie. ‘They focus on the individual regardless of gender, and they don’t integrate – or take into account the circumstances of – women and families and children.’

The marginalisation of women is clearly an extremely complex issue, that varies between countries and communities. ‘It’s a cultural issue and a religious issue,’ she says. ‘There could be environmental circumstances, and for indigenous cultures there are other issues at stake as well – it’s important to try and identify all the potential barriers to accessing services.’

‘Access means different things. It means something very different if you’re a Muslim woman in Afghanistan than if you’re an aboriginal woman in northern Canada. Even if you’re in North America, accessing a programme might mean coming up against barriers for you and your family, like potential child protection issues.’

She is optimistic that things are starting to change, however. The conference gave a chance to evaluate examples of best practice from around the world, and show what works.

‘We’re highlighting positive inclusive programmes and strategies,’ she says. ‘We want to make clear that being inclusive of women and acknowledging gender doesn’t mean you’re exclusive of men, because quite often it can be perceived as an either/or situation. We have to be inclusive of everyone and create services that work for everyone.’

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Safety in numbers

Sex workers from different countries used the conference as an opportunity to share discussion of harm reduction at an international level

AN INTERNATIONAL Sex Worker Harm Reduction Caucus has just been formed by sex workers and their organisations from all over the world. A first statement from the group asserts that sex work is not itself inherently harmful, and should be recognised as ‘work’ to give sex workers safe working conditions.

‘We are resolute that any harm associated with sex work results from repressive environments in which sex work is not recognised as work, and because sex workers lack basic human rights and access to appropriate health services,’ says the group.

In the spirit of the service users’ slogan ‘nothing about us, without us’, the Caucus is also keen to encourage empowerment, which they say is essential to fight HIV and discriminations without stigma: ‘Sex workers are their own best resource – they should be

at the forefront of developing and implementing the programmes and policies that impact on their lives.’

Kitten Infinite from the Sex Worker Outreach Project (SWOP) in Chicago explained to DDN how sex workers can ‘work smarter not harder’ by managing their own risk.

‘An example is encouraging sex workers to share clients,’ she said. ‘Sharing information with another sex worker negotiates control over situations... it fosters community. Many sex workers experience isolation within their work and seeking out other sex workers to share the dividends creates relationships that keep sex workers safe.’

Research from St James Infirmary in the US



showed sex workers within a community experienced lower instances of violence, sexually transmitted infections and HIV. It also sent important messages to the client, Kitten Infinite pointed out: ‘Clients who acknowledge a sex worker has the support of community are less likely to exploit or harm them as well.’

More information about the Sex Worker Harm Reduction Caucus is at www.bestpracticespolicy.org/caucus.html.

SEX WORKERS DENIED DRUG TREATMENT

Sweden has changed its law to make sex work illegal – with the knock-on effect of excluding many women from drug and alcohol treatment.

'IF THERE ARE TWO TYPES of people who shouldn't exist in Sweden, it's drug users and sex workers,' said activist and international spokesperson for Swedish sex workers, Pye Jakobsson. The country's administration was becoming increasingly punitive and discriminatory towards both groups, she said.

A law had been introduced to make the purchasing of sexual services illegal, with a prison sentence of up to six months. 'Because this was so controversial, they put it in a package around violence against women so no one could be against it,' she said. 'But this forcing of victim status on us extremely stigmatising, and sex workers themselves were excluded from the debate.'

The end result had been to deny women access to vital services, she explained. There were very few clinics that dealt with sex workers and most existed to try and get the women out of sex work. All were hard to access, with strictly defined geographical boundaries for eligibility and little effective outreach work.

'Sex workers are routinely denied drug and alcohol treatment,' said Ms Jakobsson. 'They say "we will only help you if you stop selling sex" because the assumption is that we only take drugs because we can't stand selling sex. Often methadone will only be prescribed if the woman stops selling sex.'

The law also meant that free condoms were no longer allowed to be distributed to sex workers as this was seen as facilitating illegal activity. 'If anybody knows about HIV prevention, it's us,' she said. 'You can't get an apartment if people know what you do, because the assumption is you're going to start a brothel, and it's difficult to get insurance.' Child custody issues could also be a major problem, even long after someone had stopped working in the sex industry. Women – especially mothers – were extremely reluctant to report violence, as the police were obliged to inform social services that they were sex workers, she said.

'The social stigma is very isolating, and being isolated from society is extremely frightening,' said Ms Jakobsson. 'This is not just about sex workers' rights. This is about human rights, and how they are being violated in the EU in 2008.'

Hidden targets

Research from Eastern Europe demonstrates the layers of stigma obscuring drug using women from basic healthcare.

Reaching Russia's drug-using women

'Women injecting drug users are one of the most stigmatised groups in Russia,' said Peter Meylakhs of the Center for Independent Social Research in St Petersburg. 'Services specifically designed for them are scarce and not easy to access.'

He had carried out research to identify barriers that hinder women taking advantage of the services. 'The main barriers are any kind of costs – whether financial, time or emotional,' he said. 'Everybody understands financial costs. But what if a woman is sick, needs treatment but doesn't want to go to the doctor and be stigmatised?'

Barriers for women injecting drug users accessing treatment included a hostile social environment, active drug use, emotional dependence on partners, childcare, the fear of looking like a bad mother, and the fear of their HIV positive status being revealed.

Women could often see their drug use as their main and only problem and other health problems could be ignored, said Mr Meylakhs. There were also the analgesic properties of the drugs to be considered: 'Because they're on opiates, nothing hurts. So they only go to the doctor when things are really bad. They think "drug use is my main problem – I'll get off drugs first and then I'll go to the doctor"'. Another problem was the 'hierarchisation' of patients, he said, with rehab patients often treated better than detox patients.

Lowering institutional barriers would require changes in legislation and structural reform, he said. 'There's no point blaming individual doctors – they're often overwhelmed, overworked and burnt out.'

Ukraine and Georgia ignore epidemic

'The experience of getting healthcare for women who use drugs is not a very comfortable one,' said Sophie Pinkham, project officer at the Open Society Institute's public health programme, reporting on research carried out in Ukraine and Georgia.

The research was based on focus groups with users and providers, 'to listen to what drug users thought about their lives and the services available, as well as what providers thought.'

Ukraine was now facing a 'feminisation' of its HIV epidemic, with women accounting for 40 per cent of cases. 'It's not clear how much of this is down to drug use because data collection is very flawed,' said Ms Pinkham. 'But STI rates are through the roof and unsafe abortions – involving significant risk of death and infertility – are commonplace.'

Ukraine's National Reproductive Health Programme was often inaccessible and unfriendly towards drug users, she said. 'They don't consider drug users and sex workers to be target groups and the stigma towards them is intense. Women also reported extremely low levels of condom use, for the same reasons as all over the world – expressions of trust and the risk of violence from partners and clients.'

There were several layers of stigma that kept women from accessing services – stigma from health workers, self-stigma in terms of the way they expect to be treated and tangible barriers, such as the fact that STI diagnosis and treatment was not free. 'Community health centres do not do STI diagnosis,' she said. 'It has to be sent away to a lab, and there is a fee attached. You have to pay for everything – even confidentiality costs extra.' Most people found out they were HIV positive when in hospital for something else and were often treated in an uncompassionate way.

Women often had very little control over how they took drugs, she said. 'The men usually obtain and inject the drugs – after they have injected themselves – and there is lots of transitional sex.' The fact that women usually stayed at home and were dependent on men made them an especially hard to reach group, and there were significant issues of low self esteem and low educational levels along with physical and sexual abuse. 'Because of the intense stigma of women IDUs, they often have a very limited social circle and lose social contexts much quicker than men,' she said. 'There's no one for them to depend on except men.'

Barriers to access included the attitudes of male partners, children, geography, time and the fear of public exposure. In Georgia, meanwhile, only preliminary results were available because women were so stigmatised that they refused to participate in focus groups, even with trained female outreach workers.

Integrated and gender-sensitive services were needed, alongside improved provider training, according to Ms Pinkham. 'Providers are a huge part of the problem and they could be a big part of the solution,' she said.