The Need for Gender- Responsive Programs
A Qualitative Study

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With Curtsey to: K*haneh Khorshid*

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Summary

The objective of the study is to provide criteria of good gender-responsive social support programs for female drug users and evidence based information on current practices to be checked against the criteria and inform policy makers on the needs of female drug users for social supports.

The challenges of drug treatment and HIV prevention programs in Iran are:

- Women are invisible in statistics; they are not counted and reported.
- Very little is known about the injection drug behaviors and HIV prevalence among women.
- Harm reduction programs are mostly designed for men and treatments rarely focus on the women's problem holistically.
- Health sector has initiated many programs and interventions are implemented at the individual level, isolated from the socio, economic context.
- The recommended multi-sector approach for effective drug treatment and HIV prevention, although understandably important, does not seem feasible in our societies.
- Women drug users' treatment programs are underfunded.
- Female drug users face specific risks of HIV infection.
- Women drug users have specific employment, housing and health needs.
- The current services do not meet women drug users' needs.

The present HIV services for women drug users – although very limited in number- have helped in reaching important goals such as decline in spread of HIV through injection but it seems the more critical issue is delivery of specific services on drug treatment which seems to be missing and needed. Also collecting sufficient data on target population of the future programs (women injecting/non-injecting drug user and sex workers) who constitute two out of four most at risk populations (MARP) is very essential for any service delivery and social supports system.

Gender responsive program is defined as "creating an environment through site selection, staff selection, program development, content, and materials that reflects an understanding of the realities of women's lives and addresses the issues of the participants. Gender responsive programs are multidimensional and address social (e.g. gender inequality, poverty) and cultural factors (e.g. gender role and responsibilities) as well as therapeutic interventions" (Bloom and Covington 2000: 11).

Identification of good gender responsive practices requires data that reflects the previous situation of target population and changes after going through treatment processes, which could represent the outcome and effectiveness of the program. However in this study, lack of impact evaluation and information on program's effectiveness, as the major obstacle in identifying good practices, remains to be solved in the future.

Therefore with the application of qualitative research method and three techniques of data collection; review of literature, data extraction from the records of the treatment institutes and semi-structured interview with service receivers and providers, we try to show the socio-cultural context of female drug users (injecting and non-injecting) and how their priority concerns and needs are identified and responded in the present treatment practices.

The study's findings show there are two groups of women drug users with major differences in their support needs; higher and lower socio-economic groups..

In the higher socio-economic status group; they have started drugs use with their husband and now some attending treatment with their spouse. Reaction of key family member to their drug use has been supportive, by providing the costs of drugs and treatments. They have had dissent job and if not working, spouses have supported the family. However in the lower socio-economic group; husband is lost, in prison or dead. There is no family or not always supportive. For supporting their lives, they have reported selling drugs, doing menial jobs, begging in the street or in the last resort engaging in survival sex work.

Comparing the two groups show that women drug users in our study in south of Tehran are the most vulnerable group. Lacking education, failed marriages at very young age, family drug exposure, very limited resources to take care of family and un-healthy relationships with the children leaves them with not too many options. The striking issue is that younger generations of these families are facing the same problems.

Study's findings show that risk factors for women's initiation to drug are:

1. Family history of drug use
2. Family instability
3. Social disadvantage (lower socio-economic status)
4. Marriages at very young age and early sexual experience
5. Young age of first illicit drug use
6. Sexual abuse
7. Violence experiences (domestic and in the society)
8. Social network of drug user/sex worker
9. Mental illness& suicide attempts
10. Social isolation (e.g. staying at home women , housewives)

In society which risk factors are social and culturally rooted, along with negative attitudes towards women's drug users and their financial dependency, women find it difficult to enter and remain in treatment. Reintegration with the community and living independently is more difficult when they posses very limited resources in terms of education and employment and there is no social support.

The women drug users in south of Tehran could not comprehend the question on their social support needs and with more explanation (not manipulating), we had two different sets of responses: (a) *whatever we have and we receive from DIC is very good and enough and (b) we need a room (a place to live) and income (work).*

For more information, we prepared a list of 9 most important supports based on literature, UNODC's call for proposal, interrelations of support activities and our previous interviews. Those who were literate were able to read and tell us which ones are needed and for illiterate women we read it to them .The responses was in this order: *employment and income, housing, vocational trainings and health (physical and psychological)*. Very few (n=2) mentioned education and nobody mentioned they need legal assistance, protection against violence and child care.

Women drug users are facing five major types of risks in the labor market:

- Risk of disclosure of their drug use and its consequences
- Risk of harassments by other employees
- Abuse by employer
- Discriminatory low wages and long hours of work
- No contract for work and insurance

Access to descent housing influences incentive of women drug users to join treatment programs. Investment and efforts of drug treatment is lost without solving the problem of accommodation during treatment and at least few months after. Homelessness strongly deters the health situation physically and mentally and increases the risk of unsafe sexual relations of women drug users.

There a widespread consensus among doctors, midwife, psychologists and all service providers that majority of female drug users have personality and psychological problems and they need a long term psychological support probably for 2-3 years. It seems they have not lost only their National ID card but they have lost their self-identity and provision of mental health services in the treatment processes is an urgent need.

The number of unwanted pregnancies is so immense that all service providers are very seriously concerned. They believe these women's pregnancy is unplanned and the babies are not wanted. Service providers think they should give pills or injections for controlling their pregnancy along with methadone program. Condom for HIV prevention must be left to male Drop-In Centers and men should take some of the responsibilities.

Based on the findings of the study and learning from practices in other countries a wide range of gender-responsive programs should support women drug users to move towards recovery and reintegration into society. The followings are their most urgent needs and our recommendations:

Building motivation: Women drug users feel powerless and hopeless. Enhancing motivation is critical to their recovery.

Appropriate accommodation: The availability of stable accommodation is a critical factor in the treatment process and is a foundation to encourage their employment. Experiences prove that accommodation for maintaining motivation is much more important than drug treatment.

Mental and physical health: In addition to physical health services such as reproductive health , mental health issues of women drug users are so severe that psychological support must be included as part of drug treatment programs.

Vocational training: Provision of basic skills training as well as more practical vocational qualifications are needed. The trainings need to relate to the job opportunities in the market.

Work trials: Women drug users experience in short term trials (for certain period) will help them to practice and learn soft skills. The low level of wages in any sort of income generation activities (home-based, employment, workshop) is a serious disincentive to their treatment and reintegration.

Mentoring and support: Women drug users need mentoring and support in their workplace. This would make all stakeholders confident that problems of new labor would be dealt with before it creates problems for employee or employers and other co-workers.

Finally, to learn lessons and measure improvements in the women drug users' situation and effectiveness of the program, an evaluation mechanism should be developed at the planning and budgeting stage of any vocational trainings and job creation activities. Lack of capacity to document the process and outcome of the implemented programs may lead to incorrect judgments about women drug users' incentives and abilities.

1. Introduction

The world's knowledge about the hazard of HIV infection and related risk behaviors and determination to prevent its spread throughout the developed and developing countries has been a turning point in health sectors' programs. Evidence based researches in the identification process of the most at risk populations, recognized the male population as those who are carrying the burden of its spread through drug injection and sharing equipments. Men's well being, majority in number of drug users and decision making structures, have been the focus of attention and target population of health and drug treatment programs.

Injecting drug has been identified as a major mode of HIV transmission second only to sexual transmission (WHO 2004:29), as the result the health programs has turned to female population when it was acknowledged that the roots of infection diffusion is gradually changing from injection to sexual behaviors and from male injecting drug users to their female sexual partners. Women are included in the programs, sometimes as residual to the programs for male injecting drug users with the same vision, structure and functions. However, in the process world is learning that there are challenges and issues specific to women which need to be addressed.

1.1The nature of challenges

Some societies consider drug users in general and female drug users in specific less deserving of compassion than others and women drug use behavior is judged as a moral or personal failing. It is believed that their health problems are self-inflicted (Beyrer et al 2010). In such environment brimful of moral judgment, marginalization of female drug users make their identification very difficult .Thus the size of female drug users is underestimated and they continue to remain invisible.

In the Middle East as in most countries of the world, few reliable data are available describing the size of injecting drug use population either male or female (UNODC 2004). However the data on those women drug users, who have been identified, show the trend of growing number of female drug users worldwide. Rapid increase in the portion of injecting drug users who are women especially in Asia and Eastern Europe is a critical information for planners and policy makers (International Harm Reduction Program 2007:5).

With the little information collected on drug users, gender disaggregated data on female injecting population is not reported. Therefore the extent to which women injecting drugs are at risk of HIV as the result of their sexual behaviors and/or unsafe drug using practices is not known (Anchara 2005:1).

Most studies about gender differences on injecting drug users' risk behaviors are conducted in so-called developed world and generalization of the findings to other countries is a major concern (UNODC 2004). However scattered studies in different countries show a more or less similar pattern regarding women's risk behaviors with different intensity of prevalence. Studies in nine European countries show that the

average HIV prevalence among women who inject drugs is 50% higher than among men who inject (Alliance 2010:25), and studies in China and Kenya also demonstrate higher HIV prevalence amongst women injecting drugs (International Harm Reduction Program 2007).

HIV infection continues to rise in drug-involved women and these women are doubly at risk for HIV infection via unprotected sex and unsafe injections. But their needs have not been met (El-Bassel et al.2010, Kramarz 2009). Most harm reduction programs are designed for men and while intimate partners' violence has been distinguished as a major factor in HIV infection risk, programs put the onus on women to insist on safe sex, thus increasing their risk of physical and sexual abuse. Actually few evidenced based HIV prevention program address these complex interactions holistically.

Drug treatment, harm reduction and HIV programs for women are nearly universally underfunded despite evidence of efficacy (International Harm Reduction Program 2010).

While mostly health sector is responsible for the provision of prevention, treatment and care services for women and men drug users and those living with heath problems (e.g. HIV+, Hepatitis, STI,..) World Health Organization has recognized that the outcome of these activities will improve if additional supports are provided including psychological, financial, legal, employment, counseling as well as assistance with housing and living in an enabling environment (WHO 2005). However in most of the developing countries a multi-sectored partnership approach between health sector, social security , justice system, welfare organizations and drug control systems,… if not impossible, is very difficult. The self- interests of organizations make coordination, even in most primary activities such as agreement on protocols' content or data sheets for drug users in drop in centers, a futile experience.

Achievements of the health sector in harm reduction coverage does not disguise the tendency of drug treatment field to place more emphasize on the individual drug user(woman or man) rather than drug user in a larger context of social and community level. The changes are not always in the hands of women or family but are often influenced by context and depend on structural policies, laws, and economics and supports systems. There are numbers of studies (Simon 2006, UK Drug Policy Commission 2008, BCCEWH 2009, Alliance 2010, Shaditalab and Vedad 2010) indicating that recovery process of drug users depends largely on intimate partners, family and social context and attention should be given to the complex needs of drug users (male or female) in the programs and specific gender related needs of female drug users.

Female drug users' priority concerns

Female injecting drug users differ from their male counterparts and the importance of this population is emphasized due to their significantly higher mortality rates, increased likelihood of facing injection related problems, faster progression from first use of dependence, higher rates of HIV and increased risky injections and/or sexual behaviors (UNODC 2010:8)

Recent documents on practices mostly related to health issues and HIV/AIDS prevention, treatment and care, agree that treatment and recovery for women drug users needs to be approached from a perspective that includes the context of the women's lives and their needs and priority concerns.

To identify these needs and priorities, assessment studies on female drug users (injecting or non-injecting) have been conducted which reports some common needs (, WHO 2005, EHRN 2010, UK Drug Policy Commission 2008, British Colombia Center of Excellence for Women's Health 2010, CHR 2010, International Harm Reduction Program 2007) but priorities are mostly shaped by the structural and socio-cultural factors in each society.

Most of the studies show access to following are more in need: Food, clothing, shelter, job counseling and training, legal assistance, educational opportunities, parenting training, couple counseling. medical care, child care, mental health care, assertiveness trainings as well as learning to cope with difficult emotions, maintaining treatment gains, coping with fear of losing children, negative stereotypes, disrespect, financial challenges and living with safety concerns.

To summarize the challenges of drug treatment and HIV prevention programs:

- Women are invisible in statistics; they are not counted and reported.
- In most developing countries very little is known about the injection drug behaviors and HIV prevalence among women.
- Harm reduction programs are mostly designed for men and treatments rarely focus on the women's problem holistically.
- Health sector has initiated many programs and interventions are implemented at the individual level, isolated from the socio-economic context.
- The recommended multi-sector approach for effective drug treatment and HIV prevention, although understandably important, does not seem feasible in some developing societies.
- Women drug users' treatment programs are underfunded
- Female drug users face specific risks of HIV infection
- women drug users have specific health needs
- The current services do not meet women's need

1.2 Objectives

The objective of the study is to provide criteria of good gender responsive social support program/practice for female drug users, specifically injecting drug users and evidence based information on current practices to be checked against the criteria of gender responsive good practices and finally inform policy makers on the female drug users' needs for social supports. It is believed that programs aimed at getting female injecting drug users socially functional, needs to be studied in order to identify and spread good practices and prevent potential unintended negative consequences.

To fulfill the above objective the following specific objectives could be envisioned:

- Design of indicators and criteria for screening good practices
- Collect relevant information on practices related to support provision measures to female injecting drug users and document evidences of good programs and practices in Iran
- Review available literature on good practices of other countries and incorporate lessons learned in the study's report.

Meeting the objectives of the study requires an understanding of the women drug users' circumstances at the societal level and their needs and situation in order to adapt services and include relevant supports.

1.3 Drug policies in Iran

To control drug abuses' impacts on individuals and society, the government agencies in charge have designed drug policies consistent of reduction in drug supply, drug demand and harms. The strong emphasis on health (HIV, hepatitis, sexual transmitted diseases …) and individual responsibility (drug user) are essential characteristics of these policies.

To reduce the supply of drugs, war on drugs which started after Islamic Revolution has been implemented with different intensity through the last three decades. It seems authorities perceived death sentence for reduction of drug supply as one of the most effective strategies in combating drug problems .

With the experience gained from supply reduction policy's implementation, government decided to combine punitive policies as one the major responses to drug use with demand reduction policy. Since 2002, changes in the national drug policy shifted towards a new approach and government have increased emphasis on demand reduction activities (WHO 2008:18). This new paradigm is geared to reducing consumers' drug demand, eradicating availability of drugs and reducing the harms of drug use to the individual drug user (Ohiri et al. 2006).

The shifts in policies and government achievement in control of infectious diseases and costs of drugs to the society is commendable.

In the process of policies' implementation, different mechanisms for treatment and care, mostly for male drug users, have been envisioned. At present, many types of residential or outpatient, short or long term, abstinence or drug substitution treatment programs through private sector and non-governmental organizations are available.

In recent years , women-only treatment institutions based on state's gender segregated ideology supported by studies' findings which have reported better outcome for women attending women-only treatment centers or sessions (UNODC 2004:12) have been established to respond to the needs of women drug users.

1.4 Drug dependence treatments for female drug users

Rapid situational assessment of drug use estimated 6% of the 800,000-1,200,000 substance drug users were women. Common substances were opium, opium residue, Heroin (brown) and cannabis. Only 5% of women drug users reported injecting drugs –mainly women aged between 22 and 30 years and involved in sex work (UNODC:2004:7).

The latest Rapid assessment reports the share of women has decreased to 5.2% and gender disaggregated data on the patterns and types are not reported. (Narenjiha et al. 2008)

Assuming the estimate of female drug users (5.2% of total) and injecting ones (5% of women drug users) are near to accurate, there is no reliable data on the number of female drug users entering treatment centers, so the extent of coverage of treatment system is not known. Also there is no consensus on the number of sex workers in Tehran and no information is available on the overlaps between women drug users and sex workers. We do not know the actual number of homeless women as well, which adds to the complexity of the women drug users needs for support (e.g. accommodation). Also there is no information on the effectiveness; relapses, and outcomes of any types of treatments. Therefore with the ambiguity of target populations' size (female injecting/non-injecting drug users) their drug use behaviors and socio-economic situation, the study of treatment institutions activities and the needs for further support programs is not an easy task.

With such difficulties in mind, non-governmental treatment institutes supported financially by the government (Drug Control Headquarters through the Ministry of Health, Medical Universities or the State Welfare Organization) and obliged to follow certain rules and regulations are identified and classified into two main groups; those with drug substitution approach in treatment and those aiming at abstinence of drugs use by women.

Drug substitution approach

The policy on establishment of treatment centers with drug substitution program (Methadone treatment) first was introduced in the 1970s (1354) but the idea was abundant after Islamic Revolution (Narenjiha 2008:11). However in 2005, HIV surveillance's findings showed the critical situation of concentrated epidemics and prevalence of HIV among injecting drug users. The major risk factor of injecting drug users was a history of sharing injecting equipments especially in prison.

Therefore treatment institutes (notably Drop-In Centers as low threshold services) with drug substitution approach were established. Methadone Maintenance Treatment (MMT) program of these institutes is a public service and free of charge. However it requires the client to meet the main criteria to access services which is injection experiences.

With the achievements of drug substitution program to control HIV infection and drug demand, based on the Law of Fourth Development Plan (1385-1389/ 2006-2010) article 97, government is responsible for preparing a comprehensive plan to control and reduce social harms with emphasis on prevention of drug addiction.

In addition to the Ministry of Health, the State Welfare Organization (*Behzisti*) as a government body takes charge for the establishment of appropriate structure for the fulfillment of the Fourth Development Plan's objectives. Cultural and Prevention Deputy of the organizations in the guidelines for the "Establishment of Harm Reduction Centers" has defined harm reduction as "the policies and activities designed for the reduction of social, economical and health problems resulted from drug use and risk behaviors" (1387:1) .Thereby harm reduction takes a social and medical approach in Iran (Shaditalab &Vedad 2010).

These institutes first were established for male drug users and developed to reach mainly street based (homeless) and injecting drug user men. Priorities of male drug users could be due to their larger share in drug user community (95%), the harms of their behaviors to the society and negative attitudes towards female drug users.

As highlighted during 2008 United Nations General Assembly, it is essential that HIV programming be responsive to gender disparities (USAIDS 2009:2) and to reduce gender-based violence, integrating gender considerations throughout all programming areas is a major concern. It is recommended that survivors of sexual violence should have access to necessary HIV and health services and costs of services should not impede survivors' ability to access these services.

The changing mode of HIV infection transmission and taking note of these recommendations, led to National AIDS Committee's emphasize on the need for Drop In Centers for women and in its latest report (2010:29-32) few gender sensitive policies envisioned such as HIV prevention education for spouses of prisoners and young boys and girls in high schools.

As a result low threshold services are implemented to maximize contact and access of women drug users by not requiring them to stop drug use. These institutions (two in the south and close distance from each other and 1 in south- east of Tehran) are located in areas where female drug users congregate.

The oldest institute of *Khaneh Khorshid (the name has the meaning of " house of sun")* has been working in the area over 5 years and recently has moved to a new building provided by the municipality. Its establishment is supported by Welfare Organization with the same protocol and amount of budget for male DICs in Tehran and is faced with long delays in fund provision. The other two of *Mikhak* and *Mikhak sefid (the name of these institutes means carnation & white carnation)* have started working in last two years: one with MMT and the other one waiting to receive the drugs for distribution any day. These are affiliates of a well established NGO, active in population and family planning field for more than 12 years (Family Planning Association).They are financially supported by Medical Universities and Ministry of Health.

These institutes are working with highly vulnerable groups of female drug users with multiple health and /or psychological problems. While at the beginning their target population was female injecting drug users and/or homeless women drug users , due to lack of services for sex workers and overlaps between the two groups' risk behaviors these institutes are offering services to sex workers with drug use problems also.

Access to services of these institutes does not require identification papers and they do not impose too many rules on women drug users. They have tried to pick buildings with discrete entrances and exit so women drug users can come and go without being noticed by the general public. The institutes are open in hours convenient to female clients and run mostly by those who can relate to drug users due to their educational background and individuals' interests.

Based on the general objectives of these types of treatment institutes' with drug substitution approach, their goal is the reduction of drug demand, drug related harms and HIV incidence among female drug users resulting from the sharing of needle and syringe and/or unprotected sexual behaviors. Access to information and education on safe injection and sex in a friendly environment helps carrying out designed interventions, and management tries to ensure women's access to treatment, care, and some limited support services for those in urgent need.

One of the main activities of these institutes is to contact street based injecting drug users through outreach activity. These services are operating mostly by recovering drug users and for protection purposes a female outreach is usually accompanied by a male ex-drug user.

According to international organizations' long experiences in harm reduction, a range of key interventions is suggested to be delivered to female drug users:

1) Needle and syringe program
2) Opiate dependency therapy (OST)
3) HIV testing and counseling
4) Antiretroviral therapy (ART)
5) SHR services, including STI and PMTCT
6) Vaccination, diagnosis and treatment of hepatitis
7) Behavioral change communication
8) Prevention, diagnosis, treatment of TB
9) Basic health services
10) Services for drug users in prison
11) Advocacy
12) Psychological support
13) Access to justice/ legal services
14) Children and youth program
15) Livelihood development /economic strengthening

It is believed that a program should be extensive enough to offer many of these interventions or to be coordinated as part of an overall plan for comprehensive service delivery. However planners of each country, taking account of their situation and priorities , can choose certain services from this list but the experience has proved that

rarely individual intervention work on their own (Alliance 2010:53).At least essential harm reduction interventions ; needle and syringe, drug substitution and peer education needs to be included in the program.

Planners in Iran have chosen the essentials in addition to few other services for drug substitution treatments (delivered in Drop-In Centers for male or female clients) which include information and means to reduce harms of shared injections to women drugs users and their sexual partners:

- Offering food, bath ,a place to rest
- Promotion of safer injecting practices
- HIV prevention information and education
- Needle and syringe program (Exchange and/or distribution)
- Voluntary counseling and testing
- Condom promotion
- Substitution treatment with methadone
- Primary health care

Therefore drug substitutions approach for women drug users similar to men, promote a socio-medical intervention. However based on the list of key interventions, services can go beyond health sector and include other services as in practice institutes providing services to women drug users and/or sex workers with relatively more experience in service delivery, have initiated new activities to fulfill some very critical needs of their clients such as vocational trainings, adult literacy classes[1], and primary health care to the children of drug users' family.

Abstinence approach

Two different types of abstinence- based treatments are in this category; residential and outpatient abstinence treatment.

Residential treatment includes detoxification services, self-help groups and therapeutic communities based on Narcotics Anonmous"12 step" approach. While the evidence for these types of treatment is not compelling in terms of effective HIV prevention, it has a wide appeal to governments, parents and former drug users.

In Tehran, there is only one residential detoxification treatment institute (*Chitgar Camp*) for women. The rehabilitation camp is established in 1381/2002 by an NGO (Rebirth Charity Society) and supported financially by the State Welfare Organization. Municipality of the region has provided the land with a sole divided into six rooms. It is located in the west margin of the capital.

[1].*There are some differences between institutes' services depending on the protocols, supporting government agencies as well as managements' decisions and financial capacities of the institutes such as provision of child care services, facilities for vocational trainings and full time midwife.*

Camp has voluntary and involuntary residents. The cost is 90,000 Tooman ($90) and duration of stay is 4 weeks. Submission of certain documents and identity card is necessary for entries. While volunteers are introduced and supported by family members (husband for married women and one of the parents or sisters and brothers for unmarried women is required), state pays for the involuntary residents who are arrested by police or picked up by municipality officers.

It is not easy to trace female or male ex-residents, especially the involuntary ones and there is no published information on the outcomes of these types of treatments for women in Teheran but international agencies report the modest success rate of these programs (Alliance 2010:41).

There is another residential institute in south of Tehran established by *Saray Ehsan NGO* (Institute has a different name in English; "Social Victims Institute") supported by multiple government agencies which have two separate sections for male and female residents. This institution is mainly for chronic psychiatric patients who are homeless. Among 140 female residents of this institution few were (17 women, young and old) problematic drug users in the past. The institute provides mostly medical and individual or group counseling services in addition to provision of basic needs. Also tries to reconnect patients to their families whenever possible.

The second type of treatment within abstinence approach is a non-residential long-term (11 months and more) agonist–assisted detoxification therapy through gradual drug substitutions (opium syrup) with the goal of abstinence at the end of the treatment program.

Women drug users are not required to stop drug use on the first day or month of entry. They change from their past drug to opium and decrease its amount gradually through as many months (not less than 11) as woman needs.

To start the program women are allowed to choose between two options (a) to purchase opium from market (illicit drug), or (b) to receive the medicine (licit drug)[2]. In the second alternative women are introduced to either of the two centers:

- The outpatient clinic of the Iranian National Center for Addiction Studies in south of Tehran. They have developed a follow up program which would enable the government to decide on the effectiveness of Opium syrup as a substitution to illicit drugs.

- The other institute[3] (*Congress 60*) is an NGO and has been active for more than 14 years. It was until some years ago, mainly providing services to men drug users. After 2-3 times of unsuccessful trials with women drug users, finally by setting up certain rules and regulation for clients, it is now running the same program for men and women drug users. The rules are upholding and

[2] *Opioid agonist therapy in the form of opium tincture treatment was conducted as a pilot in several centers including the above.*

[3] *Jameyat Ehya e Esani, (Human Revivification Society) /Congress 60.*

confidentiality by women drug users. No women client should provide any personal information (phone numbers, address, family issues) to the others in their group or institute.

The main characteristic of the treatment in this institution is peer/self-help education. An organizational structure with top-down approach is developed. Those who have been successful in quitting drugs and passing exams are promoted to different levels of guidance positions. They take responsibility for new entries and drug users pick their Guide (*Rahnema*). Drug users are given the opportunity to change their Guide (for any reasons) only once during the program.

Drug users (men or women) called "Traveler" (*Mosafer*) and by first name attend a social group (with7-12 members) and listen to the teaching of the day. Their education (reading educational materials as well as attending sessions) continue through treatment process and passing 14 stages (*Vadi*) of the programs. The content of 14 steps and education programs are more on women's spiritual beliefs, knowing herself, God and purposes of life as well as thinking and selecting the right path for their lives. They have one session each week for listening to interpretation of verses of Holy Koran by one of the experienced peers.

The family members who come to support their relative and institute can participate in the meetings and are called "Co-traveler" (*Hamsafar)*.

In addition to education, there are sport activities in 2 days of the week and going to park on arranged days to get women to socialize and practice.

The treatment is free and participants can share any amount they like (voluntarily and anonymously) after each session.

The founder of the NGO strongly believes (ex-drug user) drug use is a physical disease; it is curable given the necessary time for rebuilding the lost functions of brain due to drug use. The gradual substitution of drugs with medicine or opium (smaller amount every three weeks) helps the women feel normal and prevents withdrawal symptoms. It reduces the incidence of risk behaviors and the need for drugs. [4]

In summary government has responded to drug use' negative impacts on the individuals and public by application of different policies and treatments. The efforts to take a balanced approach have resulted in focuses on drug suppliers (large and/or small), while working on demand reduction and educating community about HIV prevention and promoting mostly health concerns.

The present combinations of drug substitution or abstinence treatments for women drug users – although very limited in number- may have helped in reaching certain goals such as decline in spread of HIV through injection but it seems the more critical issue is keeping women in treatment and free from drugs. Also knowing the target population of the future programs (women injecting/non-injecting drug user, women

[4] *In this study we have focused on non-private treatment and care services which are treating only women or have allocated few days of the week to women. Private sector's activities and drug prevention intervention is beyond the scope of this study.*

sex workers) who constitute two out of four most at risk populations (MARPs) is very essential for any service delivery and supports system.

1.5 Female drug users in treatment institutes

Understanding women drug users life experiences and social context requires collection of data on their socio-economic characteristics, living situation, history of drug use, risk behaviors, needs , drug use patterns and …. And this could be possible if we had the opportunity to gather information at least on those who are entering treatment institutes in Tehran.

With the study's time and budget limitation, the only source of data on women drug users was the files of the clients in treatment institutes. The research team with the sincere cooperation and supports of the management of 3 treatment institutes could gain access to some data. The staff of the institutes helped to take out few pages of application or assessment forms while leaving out the names, addresses and other personal information. As a result some data have been extracted from available forms within three treatment institutes with complete confidentiality of the files.

Regarding the study's objectives among two approaches of substitution and abstinence; three types of treatment programs were selected: *Khaneh Khorshid* with drug substitution treatment (MMT) program, *Chitgar* Camp carrying out residential abstinence program and Congress 60 as an out-patient abstinence treatment.

The information of these institutions on 3 types of treatments is important for the understanding women drug users' situation and their different needs for support services. Also since they are located in 3 different regions of Tehran; *Khaneh Khorshid* in South, *Camp* in the West and *Congress 60* in the center of the city, it could reflect the different socio-economic categories of women drug users.

Demographic data and drug related items on women referring to drug substitution treatment program (*Khaneh Khorshid*), detoxification/residential (*Camp Chit*gar) and non-residential abstinence (*Congress 60*) are extracted on those drug user women who have entered the treatment program in the year of 1389/2011.

Since in the substitution treatment program almost the same group of women are receiving methadone every day and some for many months or years, therefore the files of 95 women who have taken medicine in the month of *Bahman* (two weeks of January and two weeks of February) were selected. To make the data comparable, the residents of the same month in *Chitgar* Camp was selected and data on 71 women was extracted from their files. In the outpatient abstinence program the number of those referring to the institute in the month of *Bahman* was only 15 which were not enough for any analysis. Therefore the data of the whole year was collected on 149 women drug users.

Since these 3 institutes are running completely different treatment programs, their files and assessment forms are very different. We had the least information on women drug users in outpatient abstinence program (*Congress 60),* therefore comparison are only possible on shared items between the three. However available information on

women in MMT program (*Khaneh Khorshid)* and detoxification (*Camp*) helps to have a better understanding of female drug users' situation in Tehran.

Regarding the main target group of the study - female injecting drug users- the method of drug use as a key variable have been a major concern throughout the study. In this stage of data collection their information and comparison between injecting and non-injecting women drug users is discussed.

Socio –economic characteristics

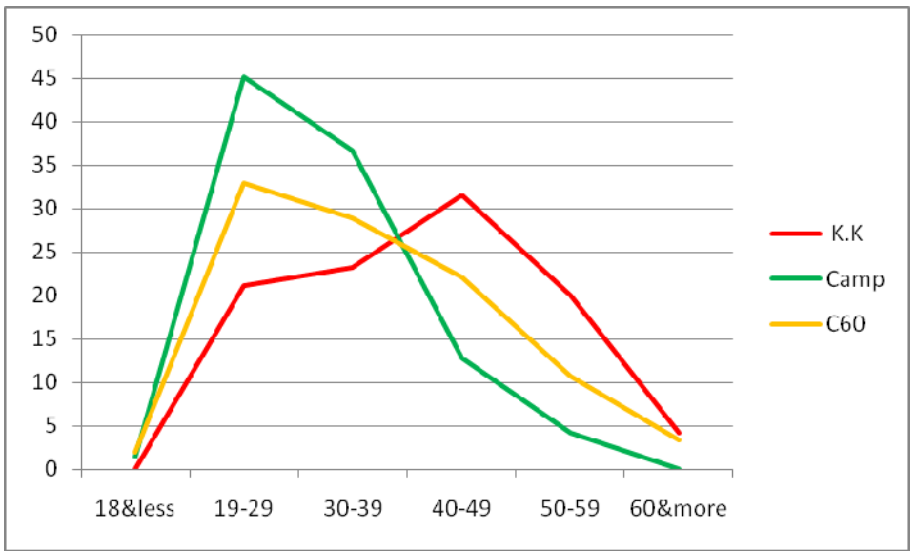
All three institutes have included certain questions on social attributes of women drug users in their application forms. Data on 8 shared items demonstrates how social background of women who refer to different types of treatment programs differs.

Generally clients (women drug users) of the *Khaneh Khorshid* (MMT) are old such as 78% are older than 30 years of age (n=75) and 24% of them (n=23) are older than 50. Considering 19-29 as young population, 21 percent of MMT clients are young women.

There is a significant difference between MMT clients and residents of camp. 45% of camp's residents are (n=32) in the age category of 19-29 (young). It seems abstinence treatment in short term (4 weeks) has more attraction to the younger drug users. Probably for them the difficulties and pains of intensive abstinence from drug seems feasible, while the older drug users might prefer a method with less pain and pressure or prefer a stabilizing drugs rather than stop using drugs.

Comparing the age variable of *C60* with the other two, data shows that long-term abstinence attracts more women in the middle age group of 30-49 and older (n=76). Although the younger women referring for outpatient abstinence treatment is much larger than MMT program (35%, 21% respectively).

Diagram 1. Age comparison of female drug users in 3 types of treatment



Based on the women drug users' self- report on their level of education, almost half (46%) of the clients of MMT program are either illiterate or can read and write (n=44). The share of illiterates in *Camp* is 7% and a little more than 15% have education at the primary level (n=11). In *Congress 60* the share of illiterates and primary education drops to 4% and 9 percent (n=6 & 13 respectively).

The most astonishing data is on higher education. 23% of women drug users(n=34) in treatment program of *Congress 60* which aims at long term abstinence from drug and almost 10% (n=7) in residential detoxification *(Camp)* are graduates from universities. Comparing the 3 institutes, it seems MMT program in South of Tehran has the older and less educated clients while long term outpatient abstinence's clients are relatively younger and much more educated.

Such a significant different on the level of education could be due to their types of treatment. Educated women probably working, cannot attend residential treatment and prefer to stop drug use but without withdrawal symptoms. Also it could be due to their residential location. Women drug users in the *Shoush* Street are from relatively poor families and have limited resources, however probably women living in the central part of Tehran are financially better off.

Table 1. Educational level of female drug users in 3 types of treatment

Educational Levels	*Institute*		
	K.K	*Camp*	*C60*
Illiterate	22.1	7.0	4.0

Elementary (reading & writing)	24.2	15.5	8.7
Guidance	24.2	0.0	14.8
High School	8.4	26.8	3.4
High school diploma &more	21.1	39.4	45.0
University degree		9.9	22.8
No- response	0.0	1.4	1.3
Total	100.0	100.0	100.0

On the marital status of women drug users entering treatment institutes the majority are married once or more. 60% in C60 are married, 80% in *Camp* (n=56) and 95% in *Khaneh Khorshid (n=90)*. However of the 95% married clients in *Khaneh Khorshid* only 32% are presently married and the others (63%) either are divorced, separated, widow and a small group(8%) are temporary married (the duration is not reported). Therefore in reality approximately 70% of *Khaneh Khorshid's* clients are living on their own. The same pattern is more or less true for the Camp's clients, i.e. 40% are either single or divorced and separated. No temporary marriage is reported in other institutes.

Therefore marriage experiences and mostly failed, is much higher among *Khaneh Khorshid's* clients than the other two treatment institutes.

Occupational situation of women and thereby their economic dependency is a critical factor in women's life in general and female drug users' in particular. More than one fourth (n=25) of the *Khaneh Khorshid's* clients, that is women drug users in south of Tehran have not provided information on their occupation (the application forms are completed by staff members) and approximately 16% are unemployed(n=15). Looking at the distribution of unemployed among marital status categories, it shows they are mostly in the groups of women who are living alone (divorced, separated, widow, single). At the same time a group of women drug users (31%) are working which includes divorced and widows in addition to a large group of married women. Interesting enough the share of married women working is one third of total employed women. This means although they are married and living with their husband, they are not supported financially and have to work to provide at least part of the expenses, if not all, of the family.

The same pattern is reported among women drug users in *Camp*. Data for residential treatment clients shows 44% of women are housewives (n=32)and not working and 31% are unemployed (n=22)which includes divorced, separated, widow, and those never married groups. Among employed women (18% of all women), 4% are divorced and separated and 14% are living with their husband. Therefore similar to MMT clients, permanent marriages in these groups of women does not mean that the man of the house is financially and fully supporting the family.

In the outpatient abstinence treatment type (*C60)* only2% has used the term of "unemployed" to describe their situation (n=3) and over 80 % considered themselves housewives (n=120) or staying at home and not looking for job (56% married and 24% single) . From the total clients 17% are working and large majority of them are singles (14%).Only 4% of married women are working which could mean that the head of household (husbands) is providing the cost of living at the expected level.

The types of occupation among three groups of working women are also very different. While MMT clients and Camp are working as maid, cleaner, care taker of elders, cab driver, dealer , peddler, working in beauty saloons ,unskilled labor ,and beggars, working women in *C60* have not mentioned such economic activities and mostly are in the white collar jobs or self-employed.

With the types of works among women drug users in *khaneh Khorshid* the mean of income is reported almost 92,000 *tooman* ($90) a month and in Camp a higher level of income for 15% of residents is reported (7% 100-200,000 and 8% more than 200,000 a month.
With such low level of income in addition to higher unemployment rate among women drug users, over one third (34%) MMT programs clients' incentive for entering substitution program has been (Diagram 2) financial reasons.

Table 2. Employment status and type of economic activities

Jobs	*Institute*		
	K.K	*Camp*	*C60*
Unemployed	15.8	31.0	2.0
Housewife	26.3	45.1	80.5
Worker[1]	12.6	5.6	0.0
Peddler [2]	11.6	5.6	6.7
Staff, Retired	2.1	5.6	7.4
Student	0.0	1.4	2.7 [3]
Beggar	5.3	0.0	0.0
No response	26.3	5.6	0.7
Total	100.0	100.0	100.0

1. Maid & Cleaning Jobs mostly
2. Including; tailor, hairdresser, craftsman, cab driver & taking care of aged
3. Mainly university students

It seems methadone and detoxification clients are relatively similar on their occupational status. A larger group of women are working (even married) and a larger portion has stated that they are unemployed. This situation could mean although women drug users in *C60* are not working (married or single), they have a family (husband or father, or…) who can support them financially and those working probably due to higher level of education and types of work earn a better income.

As a result women drug users in south of Tehran seem the most vulnerable groups with very limited resources (education, income, age) and few have supporting family member (husband or…) among clients of 3 institutes.

Drug use related behaviors

The available information on drug use behaviors as related to the objectives of the study was extracted from the files of 3 treatment types. Information on the initiation age, family drug history, types of drugs consumed, relapses and drug users' perception of the reasons for relapses seemed more relevant.

The ages in which women have started drug use are questioned in all 3 institutes. In *Khaneh Khorshid* almost 34% initiated drug use when they were younger than 18 years of age (n=32) and exactly the same share is reported for *Camp(n=24)* but entries to Congress 60 have started drug use in later ages and the share of the 18 years of age and younger is 18% (n=27). Almost half of the women drug users in outpatient types of treatment (*C60)* initiated drugs in their twenties. Initiation of drug use in the age groups of over 40 is equal or less than 10% of total women drug users.

The younger age of drug use in *Khaneh Khorshid* and Camp could be a sign of drop outs from school, early experience of joining drug users' society and higher level of vulnerability to different health problems.

Table 3. Initiation age of drug among female drug users of 3 types of treatment

Age	*Institute*		
	K.K	*Camp*	*C60*
18& Less	33.7	33.8	18.1
19 – 29	38.9	45.1	49.7
30 – 39	16.8	7.0	23.5
40 – 49	8.4	2.8	7.4
50 – 59	2.1	0.0	1.3
60& more	0.0	0.0	0.0
No response	0.0	11.3	0.0
Total	100.0	100.0	100.0

Among women drug users in drug substitution program of *Khaneh Khorshid* 70.5% have claimed that they have used only one type of drug (n=67), 38% in *Camp* (n=27)and 57% in *C60* have reported (n=85)that they have consumed one type of drugs in their life time. Remaining women drug users have stated that they have used two or more types of drugs in their life.

The most prevalent drugs in all three institutions are Crack-heroin, Methamphetamine (*Shisheh*) and Opium. The large share of those using Crack-heroin in *Khaneh Khorshid* is astonishing. Almost half (48%) have used crack-heroin and now turned to methadone. Almost 15% were Opium users and 13% Meth. Similar to MMT program's clients, residents of *Camp* have reported Crack-heroin and Meth almost with the equal share of 23% and opium in the third position of 15%. However in Congress 60 the share of Opium users has the highest rate of 33% and Met 24% has the second position. Next to these two drugs are Crack-heroin and Pills with almost equal share of 13%.

Therefore in first two institutes' clients are more tuned to using Crack-heroin and Meth, while in the C60 opium users constitutes the larger share of clients. Such a situation could be due to potential substitution of methadone for Crack-heroin in *Khaneh Khorshid* and in outpatient abstinence program due to women drug users' habit in consuming opium and the desire of moving through treatment process with the same drug.

Looking into age categories of drug users and types of three drugs with the largest consumption show that Crack-heroin in *Khaneh Khorshid* (14%), Crack-heroin and Met (each 10%) in Camp and Met with 11% share in *C60* has the highest attraction among the young drug users in their twenties. Opium is used relatively more by older women in the age group of 40 and over. Generally the number and share of those using Met and Crack-heroin is twice the number of opium users in total women drug users in all 3 institutes which is a critical data for planners and policy makers.

Table 4. Types of drugs and age of female drug users 1

Institute	*Drugs used*	*Age groups*						*Total*
		18 &Less	*19 - 29*	*30 - 39*	*40 - 49*	*50 – 59*	*60&More*	
K. K	*Opium*	0.0	3.1	3.8	1.5	4.6	1.5	14.7
	Crack-heroin	0.0	13.9	8.5	18.6	5.4	1.5	48.0
	Methamphetamine	0.0	3.8	3.1	5.4	0.7	0.0	13.1
	Heroin (brown)	0.0	0.7	0.7	2.3	1.5	0.7	6.2
	Opium residue	0.0	0.0	0.0	0.7	0.0	0.0	0.7
	LSD & …	0.0	0.0	0.0	0.7	0.0	0.0	0.7
	Methadone	0.0	0.0	2.3	1.5	3.8	0.0	7.7
Cam	*Opium*	0.0	6.5	4.8	3.8	0.5	0.0	15.7
	Crack-heroin	0.5	10.3	9.2	2.7	0.5	0.0	23.3

	Methamphetamine	0.5	9.7	9.7	2.1	1.0	0.0	23.3
	Heroin (brown)	0.0	3.2	1.6	0.5	0.5	0.0	5.9
	Opium residue	0.0	4.3	3.8	2.1	0.5	0.0	10.8
	LSD & …	0.0	4.2	3.7	0.5	0.0	0.0	8.4
	Methadone	0.0	2.1	1.6	0.5	0.0	0.0	4.3
C60	*Opium*	0.0	5.5	9.3	9.7	6.0	2.3	33.0
	Crack-heroin	0/4	7.4	4.1	0/4	0/4	0/4	13.4
	Methamphetamine	0.9	11.1	9.3	2.3	0.0	0.0	23.7
	Heroin (brown)	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Opium residue	0.0	0/4	1.3	0.9	0.0	0.0	2.7
	LSD & …	0.0	5.5	1.8	4.2	1.8	0/4	13.9
	Methadone	0.4	0.0	1.3	1.3	0.0	0.0	3.2

1. Major drugs used by clients (drugs with over 4% of use at least in one institute)

The method of drug use which is the major variable in this study shows that drug injection among women drug users in treatment institutes is less than the reported figure in the latest available data (UNODC 2004,). Among the group of injecting drug users 2 individuals (total women drug users, N=315) have used their drugs "only by injection "and in total less than 4% have reported prior to entering treatment have used injection method and/or alongside other methods of drug use . Is such a diminishing rate due to changes in the types of drug ,cost of drug , or stigma of injection in society ,even among women drug user, is an issue to be studied.

In *Khaneh Khorshid* 8 women drug user out of 95 (8.5%) and 4 women in 71 residents of *Camp* (5.6%) and non in *C60* have stated that they have used injection in combination of non-injection methods of drug use. It seems among 3 institutes women living in the central sections of Tehran never used injection method and women drug users in south of Tehran probably have experienced drug injections in their life time (11%) more than other groups. [5]

Based on available data 17% of residents of the Camp and 10% of C60' clients have not tried any abstinence treatment prior to their entry to present treatment. However there is no such group among MMT clients of *Khaneh Khorshid*. And they all have tried to stop drug use many times.

Therefore majority of women drug users in their life time have tried different methods of treatment from home-based to pharmacological, going to different doctors and herbal treatment. Taking into account the non-respondents and those who have never tried to stop drug use, doctors (medical treatment for abstinence) have the highest share among *Khaneh Khorshid* and home-based treatment is the second in order and the same is true for Camp's resident. While in *C60* stopping drug use at once has the

[5] *There is no gender disaggregated data in the latest Rapid Assessment on injecting drug users.*

highest rate and doctor /medicine is the second and detoxification is the third type of treatment.

The data although not with the same terminology[6] shows that doctors and medicines are the first options and detoxification have been tried by a large group of those who are looking for different types of treatment in *Khaneh Khorshid* and *C60.*

The reasons for relapses is not known for outpatient abstinence treatment but for the other two institutes (for those responded to this question), a combinations of reasons have been reported. Psychological problems and temptation in MMT program with equal share (30.5% each) are the most important reasons. Psychological issues and family problems are the first two important reasons for *Camp* residents and temptation is the third position for this group. Whether there is a causal relationship between psychological problems and drug use and whether drug use is prior to psychological disorder or vice versa is left to experts of drug psychology to study and respond.

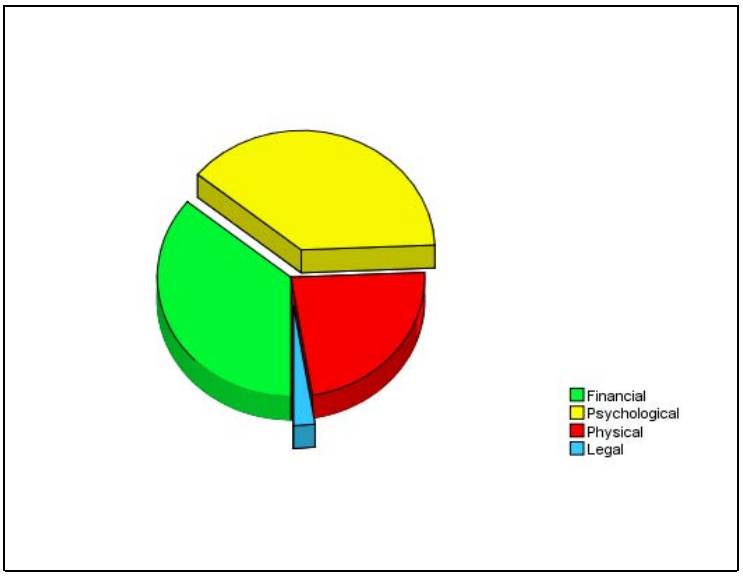
However the data shows in the cases of serious psychological problems the women drug users have referred to hospitals and almost 6-8% of respondents who were willing to talk about their relapse related problems, have stated that they have been hospitalized in mental hospitals.

Female drug users in south of Tehran

Based on the collected data from the files of the women drug users in *Khaneh Khorshid* and Camp, it could be concluded that they are most at risk population for their individual and family situation. 39% have entered methadone and abstinence treatment for psychological issues and 34% for financial problems.

[6] *Different terminology is used by clients and we have translated as is written with no interpretation.*

Diuagram2. Reasons for entering treatment institute of K.K.



It seems these groups of drug users are mostly coming from families with drug use experiences. Among MMT program's clients almost 73% are coming from family drug users and almost 5% have had a relative or close friend who was drug user. The same pattern can be recognized among Camp's residents. It seems initiation of drugs starts within family (78% in *Khaneh Khorshid* and 68% in *Camp).*

The number of women drug users who have been married at least once in their life in *Khaneh Khorshid* is 90 (of the total of 95 women) and in *Camp* are 57 (out of 71). However at present the number of those stayed married is 30 and 43 respectively.

Data on their sexual relations shows some of those never married legally have sex and some of those married are having sexual relations with men other than their husband. Among those married clients 10% have not responded to this question in *Camp*, and 11% have acknowledged extra-marital relations.

Regarding their concern for safe sex 53.5% in Camp and 56% in *Khaneh Khorshid* have stated that they do not use condom and between 10-18% have not responded to this question.

A large majority of women drug users (81%) who have married once have one or more children. More than 50% have one or two child and few have more than even 4 children. In total 188 children are born to 82 families of *Khaneh Khorshid* clients. But not all of these children are living with their parents. 12% of mothers (divorced, separated, widow and even those married at present) have acknowledged that their child is taken care by Welfare Organization. The largest share of this group of mothers is among separated group.

The share of those mothers among residents of Camp is 65% and almost 60% have one or two children. Total number of children in 46 families is 92. The smaller size of

the family could be due to the younger age of camp's residents and the number of unmarried women drug users in this treatment institute.

Regarding women drug users living conditions , those who are receiving drug substitution services in *Khaneh Khorshid* , the available information shows a large majority (92%) are not owner (personally or their husband, father…) of a place for living. 59% pay rent , 19% are homeless , 5% are living in shelter and 7.5% are living with families and friends. The very large share of 24% homeless women (19+5%) within a Muslim community with so much concern for women's and family's safety issues in the city of Tehran are unbelievable.

A problem which might be related to homelessness is the lack of identification cards in these groups of women; approximately 37% do not have identification papers (*Shenasnameh*). According to the files of clients in *Khaneh Khorshid* either they have lost it or given it to dealers for drug. Since they do not have identification papers and permanent resident address most of them have not been able to request national ID card.

As the result whenever an identification card is required such as renting a room, going to bank, referring to probably hospitals or insurance agencies and claiming subsidies, they are not able to do so.

The situation is somewhat different for Camp residents. A large number are single, therefore living with their parents. 25% rent a place and only 4% are homeless. Also a group is living with in-laws and 20% own a place.

1.6 Female injecting drug users

Generally the number of women injecting drug users who at least once in their life have injected drugs is very small. Among entries to 3 treatment institutes, the figure is 12 out of 315 (0.4%). Although this figure cannot be generalized to total women drug users, it shows that injection never have been a favored method among female drug users. Also with such small number any analysis should be read with very discretion, sometimes the shares and percentages might be misleading. Thus in comparison the trend or pattern is more logical.

Looking in more details in this small sub-group shows majority of them (7/12) are in the middle age group of 40-49 and the young group in their twenties(19-29) constitute 25% of the injecting drug users (3/12).

Half of them (6/12) are divorced and those in permanent marriage (4/12) constitute 50% and 33% of injecting women drug users respectively. Majority of them have one to four children (10/12).

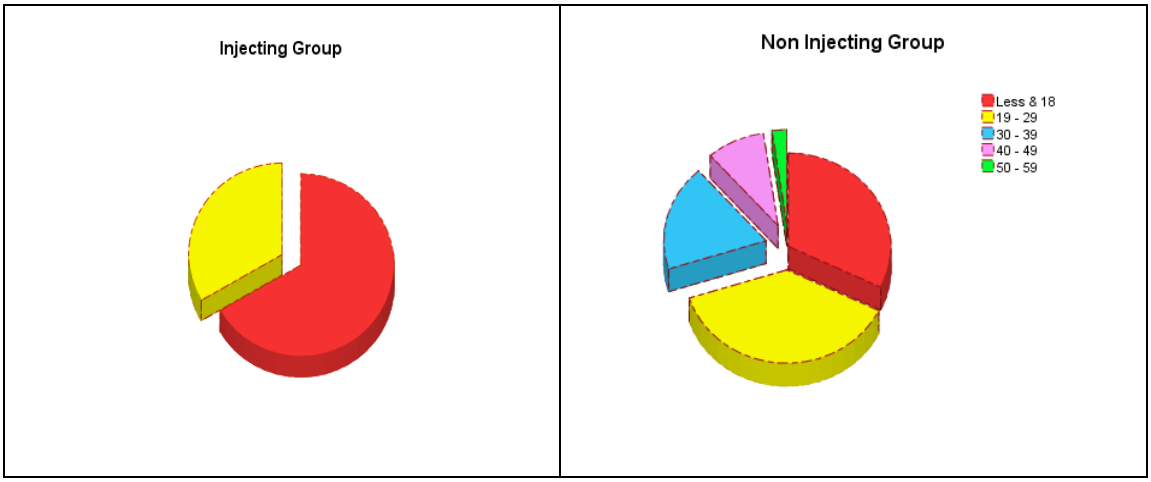
Four of them are unemployed or housewife and 3 of them are working as cleaner in people's houses (25%). Comparing their marital status with the non-injecting drug users' shows a lower rate of presently married and housewife and a higher rate of divorced among them.

The rate of illiteracy among them is 8% (1/12) and the share of those with high school diploma and more education is 25% (3/12) which is higher than non- injecting drug users of *Khaneh Khorshid*.

Almost half of injecting drug users (6/12) have injected one drug and the other half have used combination of drugs injecting or non-injecting. As in all women drug users' types of drug, Crack-heroin has the highest rate (37%) and *Shisheh* and Heroin (brown) have been used each by 15% of women. Opium is not among the first 3 used by injecting drug users,

In all of their families one or more individuals have been drug addict and the most shocking information is the age of their initiation. 58% have injected (7/12) when they were actually a child (less than 18 years of age) and the remaining in their twenties. The experience of drug use in the age group of 18 and less is almost double comparing to non-injecting groups.

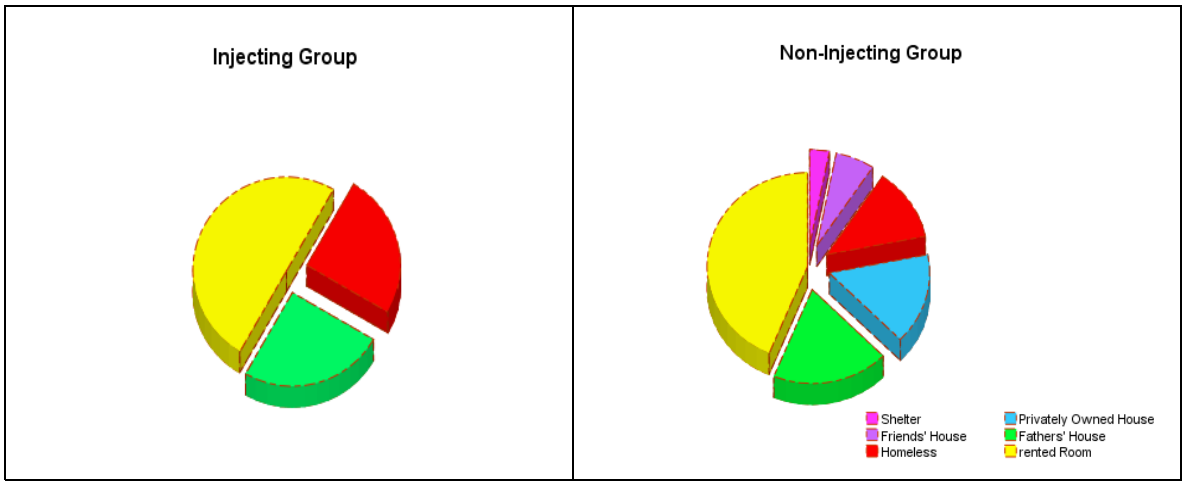
Diagram 3. Initiation age of drug use among Injecting and Non-injecting groups



Similar to the larger non-injecting groups they have tried different treatment to stop drug use. Doctors and medicines has been the most common type of treatment, home-based treatment is the second. The preference of home-based methods for women is an issue to study. Also similar to the non-injecting drug users psychological problems but with larger share is mentioned as main reason for relapses (7/12). Second to mental issues is family problems and temptation (28%, 17% respectively).
The rate of hospitalization for mental disorder in this group is larger than non-injecting drug users (8% compared to 6 %).

Comparing the housing situation of female injecting drug users with others show almost similarly they rent a place and the share of homelessness among them is 25% (3/12). The share of homelessness in this group is much larger than the non-injecting drug users (12%).

Diagram 4. Housing situations of Injecting and Non-injecting groups



How much are they aware of the risk of HIV infection and whether they have been tested or not, we do not know. But regarding their safe/unsafe sexual relations, for 17% there is no responses to this question in their records and 58% have said: "they do not use condom".

In summary injecting female drug users in treatment institutes of south of Tehran are mostly (58%) in the age group of 40-49 and they initiated injection mostly at the age of 18 and less. They married at least once and half of them are divorced. They have education at the level of Guidance school and those working are mostly in cleaning jobs.

1.7 Structure of the report

In the first section of the report the rationale for the study and objectives in addition to data on 315 women drug users in 3 different institutes as a profile of women drug users in Tehran is presented. This section of the report describes the basic elements of the Iranian drug dependence treatment policy and the current drug treatment system implemented in capital city of Tehran for female drug uses.

The review of literature on good practices and gender responsive program is presented in section 2 and 3. Section 4 includes the procedure and techniques of data collection, and data analysis. The findings of the study are discussed in two sections of 5 and 6. The section 5 describes women in drug culture and tries to show how women drug users in the relationships with family, children, and sex partners' live and what are the bonding factors and what her experience in living with violence. In section 6 two sets of social supports are discussed; those supports which women drug users do not mention and do not see any urgency in its provision and those social supports which they need them to improve their treatment and reintegration into society.
The last section (7) makes a summary of the main findings, the need for gender responsive principles, and most relevant and practical suggestions for implementation of a good gender responsive program.

2. Good Practice

Providing criteria of good gender responsive support programs which are applicable to current services delivered to Iranian women drug users is the aim of this section of the report. To address this objective, the accessible literature published mostly by international agencies (WHO, UNODC, Alliance, UNAIDS, USAID International Drug Policy Consortium, International Harm Reduction Program**)** on the good and gender sensitive programs is reviewed.

The review shows that different terminologies have been used in the discussions of good practices. Concepts such as best, good, promising, and effective are applied to emphasize the positive outcome of the programs. The documents also have presented their discussions at different levels of system, program, practice, actions and services. Sometimes they have referred to the principles, standards or criteria of a good system, program and/or practice.

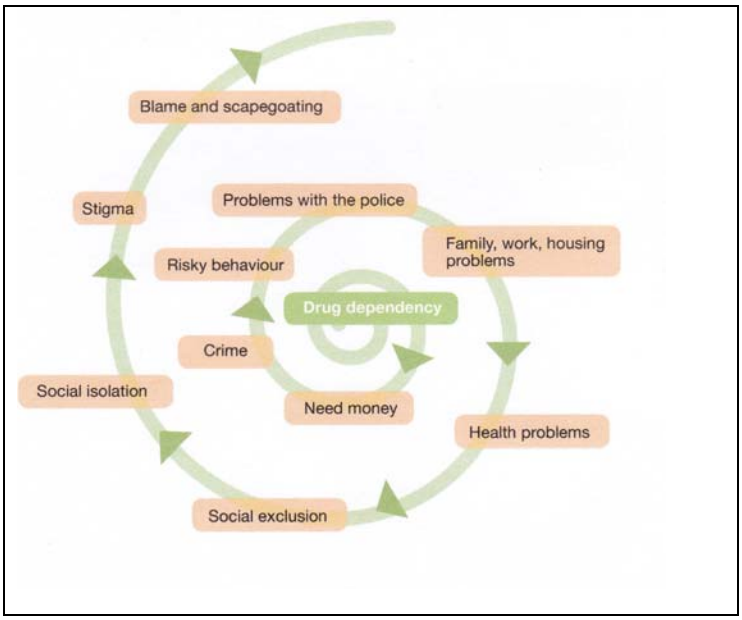
For the purpose of the study we need to clarify that "best practice fall on a continuum ranging from those practices that are well established and have clearly demonstrated their effectiveness to those that show promise or may be exemplary, but have yet to be fully evaluated and their results documented" (cited in Pettway 2006:1 from Wilkinson 2003).

While all types of literature related to drug use, health, HIV and support system of good, best, promising,….,of well established organizations and programs is reviewed, we prefer the concept of standards for programs and criteria for practices (services). A standard is an agreed-upon level of [activities] and quality, it is measurable and evidence-based (Alliance 2010:.88) and criterion is the types and level (quantity and quality) of actions taken to implement the program's standards.

According to the complied documents in different reports at the turning point of health sector's programs and focus on HIV related risk behaviors, attention to the experiences of other countries and learning lessons from good practices to meet the needs of the most at risk population including drug users have got its momentum (UNODC 2004, www.aidsalliance.org, UNODC 2010 and www.AIDSTAR-one.org.). The impact evaluation and monitoring outcomes of addressing problems of drug users are the main components in setting up criteria's of good practices.

To control the harms of diversified problems of drug user population arising from their interrelated issues of drug dependency and risk behaviors to the individuals' well being and society at large is the goal of drug dependence treatment programs.

Diagram 5. Spiral of problems arising from drug dependency



Source; Alliance 2010:17

2.1 Drug dependence treatment system

Addressing problems of drug users is a process which -as a system- involves multiple institutions and requires comprehensive interventions at different levels. Based on successful experiences, three key stages of an effective drug dependence treatment system (Schatz et al. 2011) with strong emphasize on the integration of the three stages is discussed.

Stage 1: identification and assessment

An efficient process for identifying drug users who are in need of treatment, assessing their problems and referring them promptly to the appropriate services constitutes the activities of the first stage in a treatment program.

The process of drug users' identification normally consists of a mixture of street and outreach services and mechanisms to be set up in different locations such as police stations, hospitals and social services.

Screening and assessment are important to obtain an accurate diagnosis and determine appropriate treatment for each drug users. Screening helps to determine if a more thorough evaluation and referral is needed and probably drug user has psychological problems, risk of doing harm, history of interpersonal violence, and….

Assessment involves a detail examination of several areas such as drug users' possible co-occurring disorders; mental disorder, eating disorder, mood and anxiety, as well as drug user's strengths, coping style, available support systems, through health

assessment and medical exam. Actually assessment is an ongoing process through which counselors of the organizations form a better picture over time of the client's issues and improvements.

At this stage service providers should be concerned with drug users' cultural beliefs and values, language, level of literacy and emotional ability.

Usually it is assumed that service providers who are in direct contact with drug users at the individual, family or community levels are trained for the responsibility and have the necessary qualifications. Also it is perceived that service providers will deliver services without judgment, discrimination, prejudice, or negative attitudes towards drug users. However the experience shows the otherwise. Therefore it is necessary to ensure:

- Service providers are trained and educated to work with drug users without judgmental attitudes
- Services are accessible to drug users, different ethnicities, male or female, without discrimination
- Educational programs are available for capacity building of service providers
- Service providers know effective ways to respond to drug user' needs

Stage 2: Provision of treatments

As the nature of the problems faced by each individual drug user is different and changes over time, it is important that a "menu" of treatment services; encompassing low and high intensity options, and abstinence or substitution based models in a range of settings (out- and in-patient) are available.

Some treatment systems are dominated by a single method and this leads the drug users into one-size-fits all model of treatment, which limits the success rates of the program.

Diversification and availability of treatment provisions is a structural factor and largely depends on the decisions at the policy making level. Policies for management of drug issues (supply, demand and/or harm reduction) and its consequences on individual and public have significant impact on the menu of treatments and types of services within each treatment.

At this stage, treatment system should be concerned with the options of treatments and services and the protection of drug users:

- How policies on drug shape the treatment system and services?
- What options are available to drug users?
- Is there structural factors restricting the access to services?
- Whether gender issues are mainstreamed in the policies and laws?
- How legal issues related to drugs protect them?

Stage 3: Reintegration

The ultimate objective of a good drug dependence treatment system is to reintegrate individual drug users into their own communities. This is the stage where the values, norms and social factors impacts drug users live and their relations with the families and communities.

In some societies moral judgment about drug users denies their rights for reintegration and even access to treatment and services. Community's hostility towards drug users marginalizes and intensifies their psychological problems. Stigma and discrimination of drug users, even by health service providers or police, results in drug users closed circle contact and loosing the chance of reintegration.

Social factors could hinder the successes of treatment programs and lead to ineffective costs in the system; therefore there is a critical need to address following questions at this stage:

- How drug users are treated by the community?
- To what extent community offers assistances to drug users?
- How these affect drug users' access to services?
- Have institute educated police and authorities on drug use and drug users?
- Have institute educated communities on drug users' needs?
- What social spaces are available and used by drug users?
- Does the system challenge stigma by community education?
- Have institute mobilized community to act together?
- How are drug users connected to each other and what networks have drug users?
- What effects these networks have on their drug use?

Important elements in any treatment system in addition to educating communities, is provision of facilities that help marginalized drug users to get access to stable accommodations, prepare for work and/or education, and to rebuild relationships with their families. Attention to these issues helps to improve the rates of sustained recovery from drug dependence.

For a good drug treatment system and reintegration of drug users' different stakeholders should take responsibility such as health care providers, police, housing corporations, justice department, 24 hours emergency services, night shelters, training and education, health insurance and social benefit agencies. Involvement of community members and local support in the program could take different forms (CBOs) and focus on individual self-sufficiency through intensive supports.

2.2 Program standards

For moving from system to program we need to learn from the experiences of well established programs and organizations. AIDS Alliance aiming to support HIV and harm reduction programs in developing and transitional countries has developed different guide books (www.aidsallaince.Org.). Each guide book looks at researches

in these countries, practices and the principles underlying those practices. As the results of these efforts, standards are proposed for different programs. Of course standards are different depending on the objectives and target recipients of the services (Alliance 2010).The guide for good practice on HIV and drug use proposes 8 standards:

1. Whether organization uses a harm reduction approach to drug use and HIV.
2. Whether organization promotes and provides access to clean injecting equipment, condoms, and information about safe injecting and safe sex for people who use drugs and their sexual partners.
3. Whether organization promotes and/or provides access to antiretroviral treatment, Tuberculosis prevention and treatment, opiate substitution therapy, and HCV for drug users and their partners
4. Whether organization promotes and/or provides access to psychological support services to meet the priority needs of people who use drugs and their sexual partners
5. Whether people who use drugs participate in our programming and decision making
6. Whether programs targeting people who use drugs are part of a local network of services and programs
7. Whether programs address stigma and discrimination related to HIV and drug use.
8. Whether programs targeting people who use drugs are gender-sensitive and include interventions for the sexual partners of drug users.

Guide book explains each standard extensively along with suggested implementations and markers of progress. For the purposes of this study a summarized and modified version are presented in the following table which are standards and criteria for mainly drug substitution approaches in drug dependence treatment (Alliance 2010:1-96).

Standard & descriptions	*Actions to be taken*
1)Whether Org. uses harm reduction approaches to drug use: *Reduces the adverse health, social & economic consequences of drug use * Ending drug use is not necessary *Drug users have the rights to services and confidentiality	* Design of harm reduction policy on target population, goals, types of services, requirements for entry(if any); identification process and registration, age restrictions, cost and payments, provision of basic needs such food, shelter, clothing, safe place ….) *Identify reduction features of the organization's work for drug users
2) Whether Org. provides access to clean injecting equipment, condoms & information about safe injection and sex for drug users and their sexual partners: *Preventing the transmission of HIV	* Provision of sterile injecting equipments(on site or through outreach) * Provide condoms (on site or through outreach) * Develop educational materials on safe injection &safe sex appropriate for the level of target population's educational level * Develop peer-based behavior change program

&HCV &…. *Promotion of safe sex * Acceptable quality of commodities *Commodities accompanied by information * Peer education and peer outreach	*Provide safe disposal facilities * Educate community to improve access * Check the quality of commodities by consulting drug users
3) *Whether Org. provides access to ART, prevention and treatment of TB, Opiate substitution therapy & Hepatitis C treatment for drug users and their sexual partners:* * Program directly address HIV,TB &HCV treatment needs of drug users OR works in partnership with agencies that do * Opiate substitution therapy is available * If treatments are not available, advocacy for access these services are in place *If services are denied to drug users, advocacy and education activities are in place to improve access	*Develop HIV,TB & HCV testing and treatment services in the organization or through referral system * Provide sexual transmitted infection testing and treatment (in the organization or referral system) *Develop opiate substitution therapy *Partnership with other providers of health and other related services *Advocate for access to ART,TB and HCV treatment
4) Whether Org. provides access to psychological services for drug users and their sexual partners: *Psychological support needs of drug users including: -need advice on drug use, sexual relationships , health and mental health - adherence support for HIV,TB,HCV and drug treatment * Wives, widows & sexual partners need information, advice on health, mental health &sex relationships	*Educate and support drug users to adhere to drug dependence treatment * Educate and support drug users to adhere ART and TB treatment *Provide psychological support services *Provide counseling prior and after HIV testing * Provide psychological support and referrals for mental health * Provide support groups for psychological needs *Advice drug users on safer sex * Educate and support skill building for safer sex *Support those who want to stop using drugs to access abstinence treatment services *Provide counseling for ending drug use, preventing relapses and counseling for overdoes
5) Drug users participate in Org. programming &decision making: *The meaningful involvement of drug users in assessment, planning, implementation and evaluation	*Establish a program advisory group made up of drug users and their sexual partners *Support development of drug users network *Ensure drug users participation in organization's governance structure *Support hiring drug users on staff at different

*Set up of drug user program reference group to act as a regular advisory group to programmers	levels
6) *Whether programs targeting drug users are part of a local network of services and programs* *Coordinate the activities with other local agencies *Position the services among a range of others Org.s responding to the needs of drug users for a comprehensive service delivery	*Assess drug users needs and changes in their needs for a range of services *Map available service network for drug users *Establish or join local multi-stakeholder committee *Build on and maintain relationships with local service providers *To ensure quality referral systems and to avoid duplication
7)Whether programs address stigma and discrimination related to drug use and HIV: * Stigma acts as barriers to drug users access to health services (e.g. primary ,HIV prevention, mental ,…), education & employment *Stigma could lead to violation of drug users rights by police and other authorities *Drug users right to participate in family life and community should be respected	*Educate communities on drug use & harm reduction *Advocate for improved access to services *Educate police and other authorities on drug use and harm reduction *Support drug users to form networks * Advocate for human rights protections for drug users *Support drug users network to advocate for their rights
8) *Whether programs are gender-sensitive and includes interventions for drug users sexual partners:* * Identify gender-specific needs of women drug users through assessment * Women drug users need to access prevention, treatment and health services (HIV,HCV,TB) *Opiate substitution therapy must be accessible to women drug users *Improving access to sexual and reproductive health services	*Involve women in community assessments on drug use *provide opiate substitution therapy *Provide HIV &TB test, prevention and treatment *provide HCV treatment *provide or refer to sexual and reproductive health services *Provide support services for pregnant women *provide support services for parents such as child care services

The change of behaviors and life style is not always fully in the hands of individual drug users or families but is often influenced by socio-cultural context in which they live. Some structural factors beyond the individuals could enhance or hinder drug

users' decision for change in their behaviors. Policies, legal system and laws as well as the economics of the society are important major but gender as acknowledged in last standard (number 8) of the program is probably the most important socio-cultural factor which could significantly impact the availability of treatments to women drug user, and their access to needed services.

3. Gender responsive programs

Programs for women and men exhibiting the same problems of drug use behaviors must be cognizant of relevant physical differences as well as differences in the pathways to drug use and challenges faced by women drug users (Pettway 2006). This crucial factor is under minded by difficulties in comprehending gender differences and providing a sufficient range of treatment services to meet diverse gender needs.

Gender matters in drug use programs because:

- Drug use is influenced by gender norms in different culture. Women's expected roles and responsibilities in general population impacts significantly women's status in drug users' community too. In the societies in which women are thought that men are the superior being, for example, women should have their meals after the men of the house, using last drops of drugs or injecting last seems very normal.

- Women experience multiple vulnerabilities. Women drug user usually looses family's supports when their drug use is disclosed. Negative attitudes of the community towards women drug users and feeling of shame, marginalize them and increase the risk of exposure to violence at home and in the society.

- Women have fewer resources. Their economic dependency affects their risk behaviors and seeking treatments. Engaging in sex work and unsafe sex relations mostly is due to limited economic resources of women

- Women uses drug as a coping mechanisms for the physical or psychological problems, it is mostly perceived as a solution to their problems

- Women relapses for different reasons and more likely in situation of experiencing negative emotions and interpersonal conflicts

- Women have particular vulnerabilities to HIV related due to injecting drug use and sexual relationships with their husband and/or multiple partners

- Drug use in women is motivated more by emotional issues and psychological distress while in men usually stems from social and behavioral problems. Women are more likely to suffer from psychological trauma

- Women drug users due to socio-cultural factor in their life usually have lower self-esteem and self –confidence

- Generally women are not in the position of negotiating on safe sex, and without necessary services for pregnancy prevention, unwanted pregnancies turns them to unprepared mothers

- Women mostly take the responsibilities of children and sometimes in the absence of father; they are care takers and breadwinners of the family

Consequently treatment programs being responsive to female drug users' needs requires acknowledging the realities of women's lives including the culture to drugs and the relationships that shape their lives.

While most services for drug users are developed by men and directed towards the needs of men drug users, gender responsive programs emphasizes consideration of the female drug users' needs in all aspects of their design and delivery including location, staffing, program development, programs content and materials (UNODC 2004)

Gender responsive program is defined as "creating an environment through site selection, staff selection, program development, content, and materials that reflects an understanding of the realities of women's lives and addresses the issues of the participants. Gender responsive programs are multidimensional ….and address social (e.g. gender inequality, poverty,.) and cultural factors (e.g. gender role,…) as well as therapeutic interventions" (Bloom and Covington 2000: 11).

Five long term goals of gender responsive programs are:

1) increasing awareness in the community of women's specific needs
2) supporting women in taking steps to escape from the role of victim
3) supporting women in their efforts to establish a small supportive network
4) enabling women to develop perspective for an occupation and employment
5) promoting health awareness among women

Achieving these goals depends largely on the understanding of gender differences and socio-cultural circumstances that determines women's status in health and influences drug treatment seeking behaviors. Lack of protocols and programs specifically designed to fit women drug users' situation and meet their specific needs is a major structural barrier. Policy makers' unawareness or insensitivity to women drug users' need leads to under funding and unavailability of array of services needed by women/mother/sex worker drug users.

To plan for moving towards long term goals and overcoming gradually some of the barriers following guiding principles for gender responsive programs are proposed:

- Acknowledge that gender makes a difference
- Create an environment based on safety, respect and dignity
- Develop programs that are relational to significant others, connecting women to family, children, community.
- Address the mental health issues

- Provide opportunities to improve women socioeconomic conditions
- Establish a system of community care with comprehensive collaborative services (Pattway 2006:2).

Practical application of these principles at three stages of treatment system's processes; identification and assessment, provision of treatment and reintegration would be designing the activities of three stages from gender perspective and highlighting where and how gender matters.

Stage1. Identification and assessment

Women drug users' awareness of their stigmatized behavior stops them from coming forward and prefers to remain invisible in the community. Therefore for female drug user population, outreach could have many functions in addition to what they carry out for male drug users.

Outreach workers usually a former or current drug users who are role models of success, provide services beyond the usual boundaries of institutes in order to reach out and engage individuals who are at risk of drug related health problems. For women drug users it can be an effective way of reaching women who are living in a society with strong cultural taboos against drug use by women.

Outreach can deliver services:

- By home visiting particularly for pregnant women or those with children
- Provide pre-care and after-care for women preparing to enter residential treatment
- Deliver services aimed at sex workers
- Work with local communities providing drugs related services
- Helping women who are involved in court process (UNODC 2004: 40-41).

At this stage assessment ensures the development of a women-centered treatment plan that is consistent with women treatment goals and choices. In assessment of women drug users' situation upon their entry to the treatment program, in addition to information on all drug users' problems, information on women specific issues for screening and provision of services is necessary for successful treatment:

- Current relationships with family members, sexual partner,
- Family responsibilities ,care of children, elders, …
- History of physical and sexual abuse or other trauma, sexual assault
- Mental health status
- Suicide risk and other self injury behaviors
- Current domestic violence
- Pregnancy, at present and in the past
- Employment, skills, financial situation
- Accommodations and housing
- Perceived barriers to engaging and remaining in treatment

Gender responsive programs are more effective in women-only organization with autonomous management. To maximize the safety of the female drug users, they usually have only female personnel as staff. Positive discrimination against ex-drug users in employment is helpful in getting peers to the positions of educator, administration, outreach and management. Such environment does not put women drug users at risk of harassment by men (e.g. male staff) and creates more friendly and comfortable space to work.

Training on cultural norms, values and gender roles and responsibilities , gender based violence, discriminations, gender gaps and gender differences in the pathway to drug use for service providers is required. Such trainings would enhance their capacities and skills to have a better understanding of women drug users' life.

Service providers with or without university degree often lack knowledge about drug use and do not possess skills to work effectively with women drug users who might be sex workers too. Competency of staff depends on their non-judgmental and positive attitudes towards service receivers and trainings on women's life circumstances, and important issues such as sexuality and body control, the impact of trauma, health issues, and parenting role.

Stage2. Provision of treatment

As a general rule treatments should not disrupt the client's life (least disruption) therefore different types of treatments; long and short term, outpatient and in-patient should be provided in the system. For women drug users due to their gender roles and care responsibility, it is always difficult to stay in residential treatments.

Women seeking treatment are more likely than men to be living with dependent children. Women drug users who do not have a family to take care of their children and also do not possess financial resources to pay for the costs of childcare could not join the treatment program. Lack of childcare is probably the most consistent factor restricting women's access to treatment service. [7]

Withdrawal from drug may take place in hospitals, home detoxification, residential, non-residential, with child care/without childcare facilities and outpatient treatment settings but in any case duration of treatment is important for women drug user too. It is more difficult in residential treatment usually without childcare, but it is also difficult in outpatient treatment, when the treatment institute is in far distance from their community and the burden of transportation costs for many months in addition to carrying children for a long distance would not be an encouraging factor.

Aftercare or continuing care is a component of ongoing supports to drug users especially those completing an intensive residential treatment who are returning to their communities. The need of after care services which can be by telephone or

[7] *In Drop in Centers for men in Tehran, we never saw any children while in women's dropping centers (when children are allowed to enter) they are running, playing and crying in the hallways*.

regularly scheduled sessions is much more important for women, especially when women have no choice except going back to a family and residence with drug use members.

Some women may not see their drug use problems for a long time, or postpone their treatment for household responsibilities; children, costs of treatment and some women may prefer abstinence treatment while there are very few options of low cost treatment programs. The two more available types of treatments; either are abstinence or harm reduction while it seems there is a need for other types of treatment as a continuum.

Therefore in provisions of treatment menu, it is not only the diversified types of treatment which is important but there are a range of women specific needs attached to treatment provision:

- Whether there is a childcare facility?
- Are there services for pregnant women?
- Where is the location and how far it is from women's residence?
- What is the cost of treatment and how difficult it is for women to provide?
- How rigid is the schedule of drug substitution services?
- Is there a waiting list for drug substitution?
- Is there any reasons for denial of admission; age, lack of ID card, husband permission for entry, lack of guarantor?
- Is physical safety for women drug users/sex workers provided?
- Are different services accessible and coordinated?

Stage 3.Social reintegration

This is part of aftercare phase and the focus is on training, education, development of skills, employment and housing. The opportunities to learn employment skills, promoting income-generating projects and providing transitional housing are the most important factors in the lives of women drug users. Securing a stable housing is often a key focus for female drug users.

Also learning skills to develop new friendships and activities that provide alternatives to drug use are important. For encouraging women to seek services for their drug use problems and maintaining their treatment we need to work at individual and family level as well as community levels.

At this stage service providers should be concerned with:

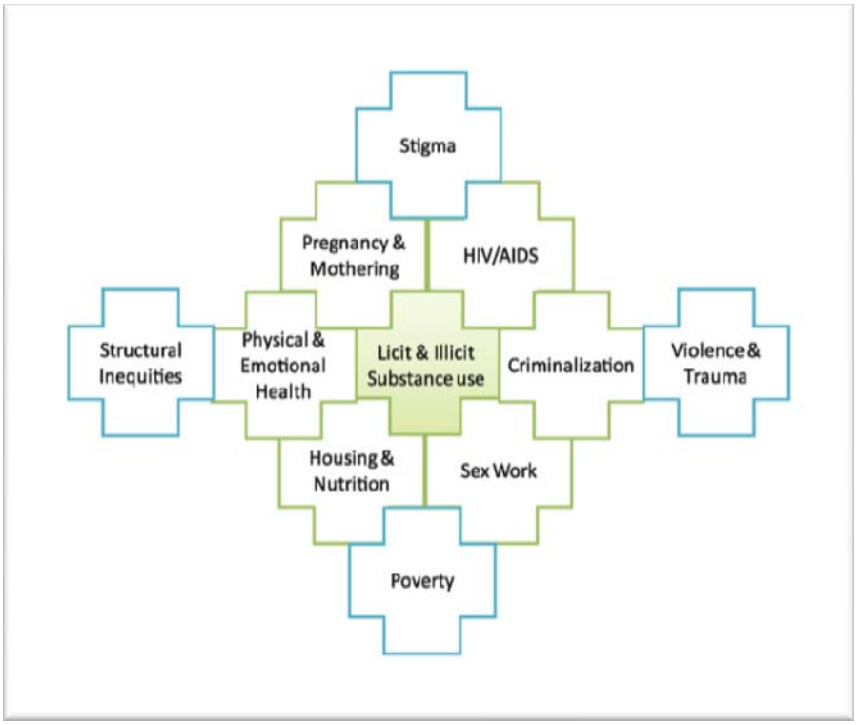
- Involving community stakeholders (men and women)in the program
- Enhancing the awareness and knowledge of the family and community members on women drug users' problems and needs through educational programs

- Networking and linkage between drug use treatment services and other services e.g. prenatal and obstetric /gynecological services, shelter, crisis services, sexual

assault services, mental health providers, child welfare system and…to respond to women drug users multiple needs.

As a result, understanding drug dependence treatment programs from gender perspective is crucial to successfully attending to the needs of women drug users and to advancing the effectiveness of treatment programs. To emphasize the complexity of the needs and required services, diagram 6, is presented in the report of "Gendering the National Framework for Action" in Canada.

Diagram 6. Women centered harm reduction



Source; Center of Excellence for Women's Health 2010:3

Development of standards for promoting gender-responsive services (GRS) for women drug users should take note of principles of such program, guidelines in 3 stages of treatment, complexity of women's needs and the importance of their reintegration in the society.

These standards and practices are developed based on the results of considerable experiences in providing treatment to women in developed countries (Canada, Germany, United States, Netherlands, Switzerland) and developing countries in Asia and Africa such as Pakistan, India, Gambia, South Africa, Angola, Tanzania and newly independent countries of Ukraine, Kyrgyzstan, Azerbaijan and Georgia. Practical application of these standards and criteria to present services would help to adjust accordingly existing non- gender responsive services.

Standards	*Activities*
1) Does Treatment Institute communicate with those in the position to support women drug users to access services	**Identify and communicate with community leaders, religious leader* ** Health care management & health providers* ** Join the local community organization and meetings* ** Raise community awareness of services by posters in stores, health centers, …printed materials (brochures, pamphlet,….) in drug stores, clinics*
2) Addressing stigma and discrimination related to female drug use	**Educate communities on drug use and women drug users* **Educate police and other authorities on women drug users' problems* **Support drug users to form networks* ** Advocate for human rights protections for drug users* **Support drug users network to advocate for their rights*
3)Create a safe, supportive and women-nurturing environment by hiring staff that reflect the client population in terms of gender, recovery status, and other attributes	**Involve ex-drug user women in service, staff member, volunteers* ** Provide a forum for women drug users to discuss their concerns* **Hire only female staff* **Involve trained, qualified staff & gender sensitive* ** Provide mentors , female role models that reflect cultural background of the clients*
4) Provide low threshold services/harm reduction which fits women needs and daily responsibilities	** The service is located in short distance from drug users community and in a discrete location* **Working hours are according to women's daily schedule and probably in the evening & weekends,* ** Provide free or low cost services* ** Outreach for accessing marginalized women* **Home visits for those unable to come to the Institute* ** Minimal rules and daunting paperwork* **Provision of basic needs; food,….* **Provide women information and education on HIV/AIDS ,TB and HCV prevention* **Provide testing for HIV,….* **Availability of drug substitution treatment in flexible schedule* ** Arrange for take home doses of methadone for pregnant women or those with small children* **Dispensing of NS , condom for women and men and*

	sanitary protection **Provide showering and washing facilities* **Accompany women to medical care services* **Provide access to antiretroviral and tuberculoses treatments* ** Receive women's feedback by staff*
5) Incorporate sexual and reproductive health into program of harm reduction	** Identify needs of women drug users and its changes through on-going assessment* **Provide an examination room for gynecologist* **Arrange for regular visit of gynecologist at least few hours a week* **Inform women about the service and presence of doctor and gynecological consultation* **Provide STI test and treatment* ** Promote women's regular visit with doctor and checks for STI, Cancer,…* **Arrange for mentor or staff accompany women to the doctors, especially those with mental health issues or chaotic lives* ** promote and provide access to female and male condom* ** Educate women on planning for pregnancy*
6)Provide education, counseling and psychological support services for women drug users and their partners	*******Counseling on health relating issues by doctors* ** Counseling on pregnancy, nutrition and stress management and STI by gynecologist and psychologist* **Counseling on HIV, hepatitis* **Counseling and support women after HIV diagnoses* **psychological support and counseling on mental health (depression, disorders,..)* ** Counseling on family problems and relation with children* ****** *Arrange activities to focus on self-efficacy* ** provide education and counseling on communication skills and life skills* ** Refer women to psychiatrists and mental hospital, if needed*
7) Provide violence prevention education, counseling and treatment services for women and their partners	****** *Educate violence reduction skills* ** Provide education on domestic violence and women's rights* **Enhance women's knowledge on threatening relationships* **Provide counseling & treatment for those experiencing sexual abuse and assaults*

	** Create a link with local police, crisis center and support women for reporting (if they felt they want to report)* ** Provide access to a safe shelter* ** Provide social support for violence mitigation*
8)Provide education and services for pregnant women, mothers and children	**Ensure MTCT for pregnant women* ** Provide education on child development* ** Provide education on nutrition and safety of fetus* ** Consider priority of pregnant in MMT list* ** Provide information on drug use and its impact on the fetus* ** Promote and educate pregnant to use methadone* **Provide prenatal care* **Encourage childhood immunizations* **Inform pregnant on the importance of breast feeding milk* ** Provide infant formula and food for certain period* **Provide on site child care facilities* ** Educate good parenting skills* **Educate healthy relationships with children* ** If possible, try to reunion with family and children* **Provide age appropriate activities for children*
9)Provide opportunities to develop a range of educational and vocational skills for income generation	** Assessment of women's drug users capacity to work* **Provision of psychological support to be prepared for work* **Provide vocational trainings based on their interest and market demand* **Provide adult education (if needed)* **Educate soft skills necessary for working women* *******Provide access to micro-finance*
10)Create a strong referral system and networking with other services	**Linkages to community based health services, HIV/AIDS,HCV,TB & maternity hospitals & mental health services* **linking to agencies for shelter , transitional accommodation & housing* **Linking to police for support* ** Linking to employment agencies & job placement* **Linking to child welfare Org.* ** Linking to violence crisis centers* **Linking to peer support groups* **Linking to other drug treatment institutes*
11) Support peers	** Provide gender responsive and culturally competent*

involvement and develop a educational program for on-job training of staff on the most relevant issues to women drug users and/or sex workers	*in-service staff training on drug use/ sex work* ** To support peers education by selecting the right people* **Assign tasks to peer educators with supervision* **Appropriate use of educational materials* **Staff should be trained on adult learning principles*

Developed based on; UNODC 2004, UNODC 2010, International Harm Reduction 2007 &2010 and Alliance 2011

4. Methodology

Identification of good practices requires a baseline data that reflects the previous situation of target population and changes after going through treatment processes, which could represent the outcome and effectiveness of the program. The indicators and collection of information needed for the selection of good, best or promising program has to be incorporated into the design of the treatment program prior to its implementation.

To meet the objective of the study, sets of indicators relating to the "social support practice" as the unit of analysis was proposed including:

Process indicators which measure what is being done and how it is carried out?
Impact indicators which measure the outcome of the treatment program and how results are being achieved:

- The improvement of physical health status
- The improvement of family relations
- Decline in domestic violence
- Increasing capacity to cope with legal problems, marital, child custody
- Gains in employment and income
- Acquisition of vocational training skills
- Improvement of self esteem
- The ability to self protection and non-domestic violence
- A decrease in criminal involvement
- Improvement in housing
- Increasing ability to cope with stress and mental health problems

Also collection of information on indicators which shows improvement in heterogeneous groups of female drug users' situation (injecting, sex worker or …) and illustrate the fulfillments of service providers' objectives was suggested.

However at the preliminary stage of identifying treatment institutes, congregate communities of female drug users and key informants we understood similar to the

cases of male drug users, no evaluation indicators are envisioned on outcome, recovery rate and cost effectiveness of the drug treatment services.

Therefore in the first step, discussions was held with the people active in the field of drugs treatment and support services (researchers, government managers, general doctors, psychiatrists, criminologist, female counselors of male drop in centers, private drug treatment centers) to find some data and gain an overview of all the activities and tasks being carried out in the present services.

In the absence of such data, and disaggregated statistics of the latest Rapid Assessment report, research team efforts resulted in compiling valuable information (although limited) on the demographic and behavioral attributes of more than 300 female drug users, extracted from their records in 3 treatment institutes.

The collected data illustrates the share of female injecting drug users is very minimal at present. Therefore the study target population is extended to all female drug users regardless of their method of drug use. Actually it seems there are large groups of women non-injecting drug users who might be able to live a healthy life and reintegrate into their community if supports are provided.

Second major information from the file of 315 women drug users indicates that there are groups of female drug users who are married, housewives and not involved in sex works. They are mostly from middle class and are quite different in their drug use experience and needs for support

Therefore with the application of qualitative research method and three techniques of data collection; review of literature, data extraction from the records of the treatment institutes and semi-structured interview with service receivers and providers, we try to show the socio-cultural context of female drug users (injecting and non-injecting) and how their priority concerns and needs are identified and responded in the good treatment practices.

We take the definition of good practices as Wilkinson defines it : “best practice fall on a continuum ranging from those practices that are well established and have clearly demonstrated their effectiveness to those that show promise or may be exemplary, but have yet to be fully evaluated and their results documented” (cited in Pettway 2006:1 from Wilkinson 2003).

Application of qualitative method in distinguishing good practices could face few challenges:

- The language usually used for reporting tends to be very emotive ,therefore to focus on defined criteria for good practice is not easy
- Social support services are described in the form of incidents. One or two cases of provided services are highlighted. This leaves researcher with the impression of service delivery but they say very little about the establishment of a system and effectiveness of scale
- There is no option except keep ignoring the numbers reached of the target population

This is not to belittle the efforts of the treatment institutes and the difficult work of service delivery with limited budget, but to remind those in charge that for good practices we need a system and actually incidents may deter us from further enquiry and learning. Therefore lack of impact evaluation and information on program's effectiveness in bring up positive changes in the women drug users, as the major obstacle in identifying good practices remains to be solved in the future.

4.1 Target population

Female drug users are not a homogenous population. Crossover between sex work and drug use is an assumption supported by some studies in Asia. Tasnim's (2006) research in India shows that among 130 female injecting drug users, 63% were sex worker and fewer sex workers than non-sex workers lived with their families.

Therefore drug use and sex work are not mutually exclusive and among four most at risk populations (MARPs); (a) injecting drug users, (b) commercial sex workers, (c) MSM and (d) clients of sex workers, the present study would deal with the practices and supports provided for the first strata (and non-injecting drug users) while there might be some overlaps between first two groups.

Female drug user in this study refers to any women who has used or is using one or more than one type of illicit drugs for non therapeutic purposes in their lifetime. Definition applies to a range of women; those who are free of drugs for long time (probably years) and those who are currently drug user and have joined drug substitution program.

This definition helps to include the experiences of those who have been through treatment and recovery process and are maintaining their free of drug status , so we learn about the supports they have received in the process and those who have taken a step and entered any treatment program; drug substitution or abstinence type of treatments.

Based on the information of the women drug users files we are facing with a cluster of female crystal methamphetamine users who might exhibit high-risk behaviors but an absence or low prevalence of blood-borne pathogens at present. Therefore understanding the heterogeneity of women drug users in high- risk groups may be particularly relevant for those behaviors that persist despite the establishment of structural interventions such as distribution of male condom.

4.2 Study sites

At this stage the research team identified the services that are used by women or are designed and implemented for women. The services could be categorized based on different variables such as in and out patient, residential / non-residential, women-only service or women-only sessions, drug substitution or abstinence treatment.

On the levels of treatments experts suggested six different types:

- Pretreatment or early intervention

- Detoxification
- Outpatient treatment
- Intensive outpatient treatment
- Residential and inpatient treatment
- Medically-managed inpatient treatment

Although the drug substitution treatment is not listed as a treatment, probably due to its non-abstinence approach, the research team decided to add female Drop In Centers as a supporting services to women drug users.

We are aware that women drug users refer to private clinics and the number of these types of drug treatment center has increased substantially. But the share of women referring to these clinics is not known and the information of their clients considered very confidential.

As the result discussions with drug research centers, treatment clinics in private sector and Welfare Organization and non-governmental organizations were carried out. 16 different institutes which their activities directly or indirectly could function as supports to drug user women were approached. Finally treatment institutes in the south, east, west and central part of Tehran were listed.

With the limiting number and newly established service centers for women drug users in total 7 institutes which their activity directly related to women drug users were visited and interviewed.

There are three Drop-in Centers for women in south and east of Tehran. *Khaneh Khorshid* has been active for more than 5 years. Two non-governmental organizations of *Mikhak* and *Mikhak sefid* affiliated and supported by Family Planning Association and Ministry of Health have started their activities by focusing on health and reproductive related issues of drug users and recently have added drug substitution to their program (MMT).

Congress 60 (non-governmental organization) have started to support women's abstinence by providing outpatient, long term (11 months) substitution treatment, two days a week. This is a free of charge treatment and follow up program have been designed in cooperation with Iranian National Center for Addiction Studies.

Aftab Society (i.e. *Sun society*) is another drug treatment institute serving male and female drug users; it has the option of in-patient residence and out-patient. According to available information women constitute less than 3-4 percent of their clients. They charge the patients based on government defined rates.

The Social Victims Institute as a charity organization operates residential services in south of Tehran (*Saray Ehsan*) for male and female patients. Their activities are mainly for chronic psychiatric patients who are homeless. 5-7% of the female residents have been problematic drug users in the past.

Tavalod Dobareh (means Rebirth) non-governmental organization (Narcotic Anonymous) with the government's support has established the first low cost female

residential treatment services in Tehran. The institute is working with the nominal capacity of 40 women drug user.

The same NGO with the support of Welfare Organization have established a shelter in close distance to the Drop-in Centers in the south and accommodates 20 female drug users.

With identification of the locations and institutes, key informants and peer groups of ex-drug users helped to access target population

4.3 Information and data collection

Literature review

For literature review we utilized both electronic and manual search methods to locate relevant peer-reviewed articles mostly in low and middle-income countries. However we expanded our inclusion criteria to all countries regardless of the level of development. Our searched paired the terms “female drug users”, “sex work” ,”social support”, “empowerment “ “women drug use” with the following using various combinations: “Injection drug use”, “employment”, “social net-work”, “most-at-risk, family”, “commercial sex work”, “addiction”, abstinence, “Health”, “HIV”, “best practices”, “gender”, “good practices”, “harm reduction” ,”children”.

The study faced a number of semantic challenges ; first the definition of treatment, recovery, rehabilitation and the concept of system, programs, practices, activities as well as the term sex work which is profoundly unclear in social science literature.
As the result we decided to use the concept of standards for programs and the term of treatment for all services offered to female drug users in different institutes.

Compiling evidences from the files

The research team with the cooperation of the management of 3 treatment institutes could collect some data on their clients. The staff of the institutes helped to take out few pages of application or assessment forms while leaving out the names, addresses and other personal information. As a result some data have been extracted from available forms within three treatment institutes with complete confidentiality of the files.

Regarding the study’s objectives among two approaches of substitution and abstinence; three types of treatment programs were selected: *Khaneh Khorshid* with drug substitution treatment (MMT) program, *Chitgar* Camp carrying out residential abstinence program and Congress 60 as an out-patient abstinence treatment.

The information of these institutions on 3 types of treatments is important for the understanding women drug users’ situation and possibility their different needs and

services. Also since they are located in 3 different regions of Tehran; *Khaneh Khorshid* in South, Camp in the West and Congress 60 in the center of the city, it could reflect the different socio-economic categories of women drug users.

Demographic data and drug related items on women referring to drug substitution treatment program, detoxification/residential and non-residential abstinence are extracted on those drug user women who have entered the treatment program in the year of 1389/2011.

Since in the substitution treatment program almost the same group of women are receiving methadone every day and some for many months or years, therefore the files of 95 women who have taken medicine in the month of Bahman (two weeks of January and two weeks of February) were selected. To make the data comparable, the residents of the same month in *Chitgar* Camp was selected and data on 71 women was extracted from their files. In the outpatient abstinence program the number of those referring to the institute in the month of *Bahman* was only 15 which were not enough for any analysis. Therefore the data of the whole year was collected on 149 women drug users.

Considering these institutes' completely different treatment programs, their files and assessment forms could not be the same and we had to be satisfied with what we can access. The least information on women drug users in outpatient abstinence program *(Congress 60),* therefore comparison are only possible on shared items between the three institutes.

Selection of respondent and interview

The study includes two groups of respondents; service providers and female drug users. The sampling strategy was purposive. The main criteria for selecting respondents are:

- Experience of injection; based on the objective of the study we tried to include women who is or have experienced injecting drugs (in the past) as much as possible.
- Marital status; they should be selected from both types of marital status: single (never married) and married women
- Those women who have children
- To be selected from two age groups of less than 29 and above
- Consent to interview

At present four groups of female drug users are living in the society: (a) those who have decided to continue their drug use and use Drop In Centers hygiene services, food, tea, and if are injecting users can receive needle and syringe and condom, (b) Those who are receiving methadone and using/not using other drugs, at the same time they can use services of Drop In Centers. The third group is those who have decided to join abstinence program (out or in patient) and finally(d) those who are ex-drug users and are living a healthy life but are working at drop in centers to help women drug users in the process of their treatment.

Generally female drug users' especially injecting ones are well hidden in the society largely for fear and stigmatization. The female drug users (if married) are mostly not living with their families (abundant, divorced, and separated) and very difficult to expect them to concentrate on a subject for interview.

Those who are taking methadone for more than few weeks (with or without other drugs) are more stable and able to participate in a discussion. The women in out-patient abstinence program and ex-drug users were selected and interviewed. Therefore the samples are on a continuum of illicit drug use, or those taking methadone, with or without other illicit drugs and those who are completely free from drugs.

As a social study we face challenges inherent to such studies while addressing two stigmatized behaviors of drug use and possibility of sex work. This problem was not easy to overcome and the groups of female drug users have little or no incentive to expose their experience as sex worker. Complete denial among middle class and better off groups to those applying the concept of temporary marriage "*Sigheh*" to their behavior and those women who reported their activities in the sex market constituted another continuum in the study.

According to grounded theory, the number of interviewees would depend on the repetitions of information by the latter respondents. We actually reached to the point of data saturation after 10 interviews; they reported very similar life experiences and services which are receiving. Female drug users are not necessarily homogeneous and each has some unique characteristics but when it comes to their drug use behaviors they are very similar and on the supports they need, two groups could be identified. Therefore we could stop interviews after 5 interviews in each of the two groups of female drug users in south and central part of Tehran. We have interviewed 48 individuals; 26 service receivers and 22 service providers.

Probably the major differences between interviewees are due to drug users' socio-economic class and the rules of the treatment institutes. In *Congress 60* women drug users are not allowed to disclose their personal information to the other members of the group and permission from the Guide is required for talking to outsider.

Similar decision was taken by the Guide in NA resulted in eliminating one interview and the other members of the group asking the Guide to allow them to interview. The logic behind such rules is staying anonymous and any interview can jeopardize that. Also when personal information is used by unknown people management and women have faced unpleasant experiences. Interview with 22 service providers in seven institutes helped to gain some information about female dug users and explanations on the issues raised by the clients.

Interviews

Female drug users were the subjects of the study and we seek their consultation throughout the research. The social workers, psychologists, and outreach group members of the institute were key informants and helped to achieve a high target

group coverage and credible information. They selected drug users primarily based on the information in their records.

All interviews were carried out by three researchers and recorded (Only in one of the Institute manager did not allow recording). We were concerned that interviewees might be reluctant to talk about their drug use behaviors. However we learned in south of Tehran with the assurance provided to them by trusted members of the institute, they were willing to discuss their private life. But in the institutes located in central part of Tehran they, even service providers, were very conservative on discussing their drug use experiences and related problems.

Available data from the files of treatment institutes and socio-economic attributes of the interviewees shows female drug users consisting two distinct groups in south and central part of Tehran.

4.4 Characteristics of women

Approximately 85% of female drug users have been married once. More than 30% were divorced and 15% have reported their marriage status as "temporary marriage". Among interviewees 23% are living with their husbands now and none has reported any experience of injection.

Almost 27% of methadone treatment clients have drug injecting experience in some point of their life and the share of those injecting drug users is almost 11 % in total interviewees in 3 different institutes.

Nearly 30% of women drug users were younger than 29 years of age and 30% in each of the age groups of 30-39 and 40-49. In the time of their marriage majority married at the age under 18. All of them have agreed to their marriage, even in those marriages decided by parents, they have gained her consent before marriage.

There is an 11% illiterate woman among interviewees and 30% of them have few years of primary school or Literacy classes. A large majority has attended few years of secondary school and 25% have high school diploma.

Majority of women drug users are working either as the employees of Drop In Centers (11%) or as unskilled labor in packing workshops or peddler in the street (30%). Cleaning is another type of income earning for women drug users. Almost 10% of women are working voluntarily in treatment institutes. Therefore women drug users are mostly working in informal sector of economy.

Among all interviewees 15% and among women drug users of *Khaneh Khorshid* approximately 35% reported that they work in sex market.

4.5 Data Analysis

A detailed description of interviews along with thematic analysis and coding was conducted to develop an analytical framework that accommodated the objectives of

the study. To ensure the validity of data internal validity was addressed through double checking of data by conducting interviews with larger number of female injecting drug users (Crabtree and Miller 1999) Therefore repeated visits to cooperating DICs and interviewing members of different groups helped to enhance the internal validity of the data. Also all the interviews were reviewed by researchers many times and consensus was reached on the identified theme, coding an analytical framework (Meadows and Morse 2001).
On external validity no previous study was found on the theme and populations under study.

The report illustrates the findings of the multi-method qualitative study, mostly through the respondents' narratives, and few percentages have been used. Narratives reveal the facts and experience of injecting drug users' and their spouses' lives. In cases some lengths from our discussion have been quoted to provide better understanding of the respondent's situation.

4.6 Ethical concerns

Measures to ensure anonymity and confidentiality were strictly observed during interviews, data analysis and extracting information from the files of the institutes.

Potential women drug users were approached by a well known service provider or a peer whom they trusted. The women were approached by the research team and objective of the study was explained. With the consent of interviewees in-depth interviews were tape-recorded.
No cash remuneration was provided to the participants, however, a gift was offered after the interviews to the service receivers.

5. Women in drug culture

In sociological perspectives life develops in the network of relationships and individuals grow to maturity in the processes of interactions with others. The fulfillment of the need to build a sense of connection with others and satisfying relations are the roots of the individual's self-worth.

In a relational approach to women's drug use behavior we can see how building up, maintaining and continuation of relationships could have positive and negative impacts in their life.

Women may initiate and use drugs to stay in relationship. Women drug users feel fewer stigmas in trusting relations, while disconnection from relationships can enhance their low self-esteem. Women try not to disclose their drug use to family and relatives for maintaining their respected interactions. Sometimes they get along with their spouses' drug use behavior, just to continue the relationship, even when it is characterized as abusive (*Noori* et al.2008, M*alaierikhah 2007, Mohamadkhani 2008*) and they might take drug to relive from the pain of bitter relationships.

Women usually are expected to perform their gender roles of caring for maintenance of the relationships. While using drug could have the function of performing this role its use also can be a mechanism to fill the void left by a failed relationship.

In this model of looking at the relationships we can articulate the problems as well as the strength arising from women's interactions with others. Incorporation of relational perspective into analyzing female drug users' situation in the society under study would help to gain a deeper understanding of the problems stemming from women's network of relationships.

Recognizing the significance of relationships in women's life, in this section of the report we look at the nature of these relationships and how affects their drug use history. How connectedness and need for respect defines women relation with children in the family. How failures in relations pushes women to more unpleasant situations and risky behaviors. How partnerships and gender roles are formed in a patriarchal drug using culture and how bonding with peers results in women drug users living in a drug culture different from men.

5.1 Family relationships

Many factors affect reasons and motivations of women's initiation of drug use. Some factors are similar to men but some are more prevalent or different in nature for women than men.

The exposure to drug within family structure might be the one factor shared both by men and women (*Shaditalab* and *Vedad* 2010) and no gender differences were significant in predicting the effect of family drug use on initiation to injection. It is general knowledge that the exposure to drugs in family leads to acceptability of behavior although in conflict with societal norm and values (UNODC 2004). Findings of our study present ample evidences that in a large number of families, this is not the only factor for drug initiation behavior. Socio-economic status of the family could be as important and significantly affecting familial norms and women's drug use.

Based on the interviews, in majority of families one or both of the parents were drug users and daughter has initiated drugs within the family. In our society with patriarchal culture it is the fathers who stand up against girls' wrong doings and has the authority to educate them and even to kill them. However in these families fathers knowledge about drug use of the women in the house, especially daughters have not created many problems. *Raheleh* 29 years old, born in Tehran and living in *Darvazeh Ghar* with high school diploma describes her experience:

My parents were drug addicts. They both used opium. I learned to take small pieces from them without their knowledge. After taking drugs I would go to gym for sport with a lot of energy. And I wondered why my mother is talking about withdrawal while I am feeling so good. I started using Hashish with my cousin who lived in the same house with us. I liked very much the feeling and being high. I turned to Crack-heroin when I was 23. My parents knew I am using drugs by that time. I brought Crack (heroin) home and my father used Crack (heroin) for two years. He paid the cost of drugs for all of us.

Fereshteh 21 started injection when she was very young:

I have four brothers and no sisters, my father was truck driver and my mother used to take care of aged people. I remember when I was a child my parents were using drugs and two of my brothers too. They all used Crack (heroin) and Shisheh, but I started with injecting Tamchizak. I was 16 when I initiated injection.

With the large size of households and too many children, even when parents are not involved with drugs, sometimes a family member who has taken the initiator role is the women's older sister or brother. *Sima* a young 26 years old have started drugs when she was in guidance school and 16 years old. They lived in Eslam Shahr. She is now in the processes of recovery and by joining NA has stopped using drugs for 3 months. She explains how she started, why, and who encouraged her:

My older sister and her husband were drug users. She still is but her husband has left her with the kids. I was gnawing my nails and she thought drugs would help. I still gnaw my nails. My father was using opium. I started with Hashish, then alcohol, then opium and then Heroin (brown). My sister paid the costs of my drug until I got married….. I was involved for 10 years and in last four years I used Crack (heroin), Shisheh and Ghors [pill]. Last year in spring I went to Camp but after two months I started again.

As a qualitative study we cannot generalize the findings but it seems parental drug use increases the chances of prevalence of drug among children of the families. However in addition to such factor, problems arising from unhealthy relationships in unstable family and violent household could relate to drug initiation.

Studies show that women are motivated more by emotional issues and psychological distress in drug use while in men this behavior usually stems from problematic social and behavioral problems. Probably for inexperienced young girls, based on their understanding of stressful situation in a chaotic family, the best solutions is either running away or consent to marry at early ages of their lives.
Vida 27 years old is living with the friends and has given her only child to her older brother because the tension is too much in their home.

I was 5 when my father died. My mother had 7 children from two marriages .She has been working in the streets and selling things like napkins, toilet papers [peddler]. I am illiterate because my mother could not afford the costs for so many children's education. I remember vividly that when I was a kid I used to go and buy opium for my step father. My brother is drug addict and all the time is asking for money. He beats my mother when she does not provide. He forces me to go out and do certain jobs, so I can pay for his drug. That is why I do not like to stay in our home.

Ziba in her fifties, mother of 7 children and *Setareh* 30 years old describe; what were the conditions of their lives and why they married when they were only 13 years old:

My mother died when I was 7, my father got married for the second time. I went to school only one year and my step mother did not let me go. My uncle was trying to sexually abuse me, in that time I did not understand the meaning of his behaviors but

now I know. My aunt's daughters would go to school and I was working like a servant. I was too young for marriage, but my father changed my ID to 14 [prior to revolution] and I thought this is the best way to leave that family.

My mother died when I was 6 months old and my father was truck driver. He injected drugs and died from overdose when I was 11. My uncle took me to their home but his wife did not allow me to play with her children. Probably she was concerned that they might want to marry me. I was 13 when finally I got out of that home and married a man who was 32 years older than me with 6 children. I was his second wife.

It seems the shared variable among large number of interviewees in addition to family's drug exposure and living in a chaotic environment, is the young age of drug initiation and poverty. Except the general impression of what interviewees have given about their families' financial situation, few women drug users like *Vida* talked very bluntly about the level of family's economic hardships, which even have affected her education in apparently free public schools.

Roya, 40 years old with education at the primary level talks about her life's story:

My father had two wives and he had two children from the first one and four from my mother. My father was too old and died long time ago. My mother had to work all days. When my older brother died, from his inheritance we could get a place in Kian Shahr. We lived in real poverty and misery. My father died but actually we did not have mother too. She never was at home and never learned how to show her affection, you can think that we never had a father and mother. I married when I was 15.

Monireh's life has been characterized by poverty too. Now in her forties, remembers that after the death of her father, her mother used to work in other people's home and wash their cloths. They were 5 children and only the first child (girl) of the family could go to school. She was forced to marry when she was 12. Her other two sisters got married in early ages too. Her marriage lasted only 5 months because her husband was drug addict and pushed her to go with strangers.

Probably the early age of marriage in majority of female drug users of our study could be a sign of the families' socio-economic status. The parent's (mostly mother in the absence of the father) decision to marry their daughters at early ages was mainly for decreasing pressure on the families' economic and expecting somebody else to take the responsibility.

In contrast to the public impressions that Iranian girls always married at very young age, the statistics show that at least in the last 50 years, before and after revolution (even when the age of marriage dropped to 9) only less than 2% married their daughter in the ages under 14 (Shaditalab 2005). Therefore early age of marriage has not been endorsed by parents. However, most of the women drug users (in south of Tehran) have married at very young age and contributed to the "less than 2%" of marriages.

The first impact of early marriages, similar to many Muslim societies, is limited knowledge of sexual relations. Experience of sexual relations at the age of 12-15

could increase risk of sexual abuse and probably being infected at a younger age. Source of this increased disease risk stem from increased sexual behaviors, younger initiation age of drugs and/or risky injections.

Based on the data from the files of 315 women drug users the drug initiation is mostly in younger age group and majority of injecting drug users started at the age of less than 18 (Diagram 3). The same pattern is true among the samples of this study. The number of injecting drug users before joining methadone treatment is very few (n=3) and started their first initiation while were very young.

While interviewees reported several reasons for their drug use, we find similar motivations in men and women such as curiosity, desire to experiment and more pleasure and those who reject injection (men and women similar) mostly fear of needle and disease are main reason and negative attitude towards injection for women.(UNODC 2010: 44-45).

However there is probably a gender difference in one of the motivations for drug initiation. A large number of women drug users indicated that they had begun to use drugs for relief from pain. As *Shabnam* who married at 12 and her monthly menstrual started after almost 4 year of living with her husband explains:

My addiction started with a pain in my stomach. I was very young and my husband took me to so many doctors. He was a good man. He was drug users but used to hide it from his parents. When he was not at home I tried it [heroin] and it relieved me from the pain, so I continued. He is dead now and I should be truthful; he never encouraged me to use drugs.

Sara married at the age of 14, her husband was not drug users but after returning from two years of military service he was addicted. In her family no body used drugs but in his family almost all were drug users. She used to do so many different works, weaving carpet, packing and many other duties. Due to sitting for carpet weaving and working long hours... she had pain in her feet all the time and her husband suggested trying opium for pain relief.

Another sample with pain relief motivation for drug use is the case of *Parvin.* Now she is at her late forties and have raised 5 children .She married at the age of 13 (she had step father) and children were all born when she was younger than 27. With the encouragement of her husband, she started drug use (opium) for pain during her period. It was only once a month and seemed fine. But then it increased to twice a month and every week and days.

Not surprisingly almost all interviewees reported daily drug use and majority opium Crack (heroin) and *Shishseh* (Methamphetamine). There is very small group (n=3) of injecting drug users.

Other gender biased factor is the stigmatization of female using drugs which affects her relationships with family and community. Women drug users are more stigmatized than men by their family members. They are less likely to be

acknowledging their habit of drug use and other risk related behaviors. Therefore they go unrecognized, under represented and their problems are not understood.

Fereshteh 21 with 8 years of schooling describes how she runs away from her husband's home and went to her parents, both drug addicts. Father was in prison for few months. They blamed her for drug injection and her separation from addicted husband. While everybody in that house was drug users, they were only nagging her. She thinks they did not really care for her. Finally she took off, with taking 50,000 Tooman from her father's pocket.

Sima 26 life story illustrates the significant gender gaps in society's reactions to women drug user and her situation with a drug user husband and male dominated family of in-laws:

My husband and his father were both drug users but in my husband family they did not like women to use drugs. To them it was acceptable for men but not for women. My husband used to hide his drug use from me but I knew it, because I was one of them. I also hided my drug use from him and In-laws. Finally when he got to know, he first was angry and against it. But as a drug user could get it. So we started using together and not disclosing it to my in-laws.

Another major difference between men and women related to stigmatization and male dominated culture is the reaction and supports from family.

In lower socio-economic status drug user parents are too busy with their own problems and usually let her go, particularly when they do not need her for the family support. But non-drug user parents due to stigmatization, try not to disclose their children's drug use but when are frustrated of unsuccessful attempts, women drug user are rejected and not welcomed to the family.

While any attempts from male drug users for treatment either drug substitution or abstinence is an event for celebration and he is accepted to the family, usually this is not the case for women drug users. They are not welcomed to the family either because they think she has jeopardized family's reputation or are economic burden to the family. The share of homeless drug users or women, who admit that they do not have a family, could be an indication of such complicated relationships which needs further study.

Coming from lower socioeconomic status families and family exposure to drug in addition to experiencing chaotic environment and young age of marriages, are factors related to drug use and injection. The lack of opportunities to gain social capital such as education and skills puts this group of women in a socially disadvantaged position.

In contrast, some other groups of women drug users try to maintain respected relationships with parents. Knowing of their disapproval they have tried not to disclose their drug habits and when it is told, family's reaction is quite different. Family tends to hide it from larger society around them, at the same time support their treatment and recovery. Therefore stigmatized behavior is a major concern in this

group too but looking for solution rather than rejection is different reactions. In these families also father or brother are drug users.

Simin 30 year's old started drugs after marriage. Her father used opium but she never saw using it. The kids knew about his drug use from her mother's nagging and complaints. After marriage they moved to Tehran. Couple was working and very successful. They started drugs for fun and out of curiosity. They used drugs for more than 5 years, only opium. They tried very hard not to let her parents know. They would change their method of use when traveled to their family's resident. She was very concerned for disclosing their drug use. Finally they attended outpatient treatment and after a year both are free of drugs now.

Shokat 34 years old who was in love with her husband describes her situation and how she started:

There is no drug user in my family. I am the only one. We had a trip to North with friends and started for fun with cocaine. I hated drugs and everybody knew it. We moved to Shisheh later on, when things got worse and I could not stop using drugs, I moved to my parents. They are very understanding. They have supported me psychologically and financially. They do not like to tell to all relatives and friends, however they probably know. I have told my family:" you have suffered so many years, give me another year". I prefer outpatient and not intensive treatment. I need time and I am getting better.

Molouk in her late twenties a university student explains that in their family only her mother was using opium and she stopped drug use by outpatient treatment. *Molouk* was very depressed. Going to different doctors resulted in her intensive addiction to pills. She had to stay in two hospitals for more than a month. Her mother supported and encouraged her to try the same treatment. She is almost in the mid of her treatment now. She has gone back to the university and this is her final term.

Drug culture is prominent in women's life from beginning of drug use and continues to influence her health status, help seeking behavior and treatment. However it seems there is not only one homogeneous culture but sub-cultures of drug use.

Based on the women drug users narratives which corroborate study's findings and research team's observations, there are two distinct groups of women drug users in this study; one group lives in the south (south west and south east) of Tehran and the second group are those coming from the central or north(north east and west) parts of Tehran. To put it in more qualitative context, there are two groups of women drug users; one with lower level of socioeconomic status compared to the other.[8]

To compare the two groups:

- In the second group most parents have not been aware of their daughters drug use, while in the first group parents were aware that they are using drugs and in most cases they had to leave if not been thrown out of their home.

[8] *We assume individual women drug user's status as synonyms to family's status.*

- In the second group they started drugs with their husband and now attending treatment with their spouse. In the first group husband is lost, in prison or dead.
- In the second group they have had dissent job, making good money and if not working, spouses have supported the family. In the first group for supporting their lives, they have reported selling drugs, doing menial jobs, begging in the street or in the last resort engaging in survival sex work.
- Reaction of key family member to their drug use in the second group has been support, by providing the costs of drugs and treatments. However in the first group there is no family or not always supportive.

5.2 Inter -generational relations

While the general beliefs is that drug users are indifferent to how their family, children and people perceive them, few studies' findings suggest this might be a stereotype and they are concerned about their reputation, opinion of parents, peers, to a lesser extent society (Archana 2005:20). Such culturally sensitive issue needs further in-depth study and in this section we try to present some of the life experiences of mothers and show whether female drug users are indifferent and how disconnectedness and failed relationships with children affects them.

Children of drug users and sex workers face many risks in the society such as risks of stigma and discrimination. There is not much information on their needs and sources of resilience and probably these children's vulnerability is associated with physical and mental health of parents and family context.

Starting from the first days of pregnancy, taking drugs and lack of prenatal care put the life of the child in danger. Preterm labor and early delivery have been mentioned in the content of interviews by 20% of mothers.

It is believed that a drug user women's interest in the baby is often the healthiest part of her life. But this interest is double-edged sword that can exacerbate feelings of failure as much as provide impetus to begin drug substitution or enter rehabilitation program (Bearad et al. 2010).

In the interviews with mothers who were legally married we had cases that mothers continued their drug use with or without consultations with doctors. *Simin* a young mother describes her case:

I married to a man whom I choose when I was 18 and had finished high school. My husband was not drug users but we had few friends around us. I started drug use with my husband for fun and out of curiosity. We used opium for 5-6 years. Our families did not know about our drug use and were encouraging us to have a child .I did not like to have a child in that situation. We both were working and had enough income. We went to doctor and got medication to stop drug use. It was not truly effective, doctor was making money and just gave us another types of drugs. I went back to opium. I used opium in my pregnancy and during breast feeding. My daughter is 4 years old. She is healthy and very intelligent.

However many others such as *Sima* 26, *Parvin* 48, *and Sara* 30 claimed that they have not used drugs during their pregnancy but when the child was born, have started again.

Gender roles in the society defines that care giving is the duty of mother and mothers might stop using drugs for their care responsibilities. However in our study the entire mothers of both socioeconomic groups continued their drug use while raising the children. In lower socioeconomic group very few mothers shared their methadone with the child and malnutrition of the child could be easily observed.

Probably as physical aspect of the child is important, so is their identity. With the absence of fathers; sometimes he is not known, in some occasions they disappear or are legally divorced, children are left as the mother's responsibility.

I was temporally married to a man for 99 years. I was pregnant and in maternity hospital when he disappeared. I do not know where he is. Now I have a 20 years old daughter. I could not get ID for her, so she could not go to school. I worked and paid for tutorial to teach her at home just at the elementary level. I raised her with such difficulty. I have done everything from sewing to knitting and when there was no work I would go for sex work. She is living with me and knows what I am doing.

Based on the experiences of interviewees, when the mother is not psychologically or/and financially capable to keep the child she faces few options:

- Leaving the child in the hospital, so the child will go to Welfare Organization
- Finding a family and giving them the child (sometimes for some money)
- Keeping the child

Any of these options have its consequences on drug user mother and the child. The first two options which have happened for many of the mothers of the first group (living in south of Tehran) resulted in disconnectedness with the child and have affected their self-esteem and guilt feeling. As such many of them talked about their children with sadness[9] and preferred to emphasize that their child is living with a relative or good family.

I have married three times. The first time I was two months pregnant when I got divorce. He was in prison when my daughter was born. She is 28 years now and living in the United States. The second time it was a temporary marriage. I had a girl taken care by my mother. When I was arrested she was 5 years old and when I was released she was 11-12. The third marriage was a temporary too and I had a boy. But I did not keep him. I gave it to my sister in- law's family (my brother's wife). He had heart problem and I could not take care of it. He is 8 years old now. I used to go and see him from a distance but I have not done it for the last 2-3 years.

Setareh 30 years old, who married at very young age with a man 30 years older and he has died recently talks about her children:

[9] *In one case in which giving the child to Welfare Organization was written in her file, she did not like to mention it to interviewers*

I have two daughters of 14 and 7. My older daughter is married now. After the death of my husband landlord asked me to move out because I was widow and single. I could not keep my daughter, I live in shelter, and we are not allowed to take children with us. There was a good family they agreed to keep her for a while then I will get her back.

Raising children is not easy sometimes they are malnourished, improperly cared and mostly under educated (UNODC 2010: 37). Also in some families their cognitive development is at stake. These children due to neglect, numerous forms of deprivation, and issues arising from witnessing their mothers' drug use and/or sexual interactions with clients face serious difficulties.

A story told by one of service providers shows how significantly mother's living situations affects the child:

Mother did not have anybody to take care of her daughter so she had to take her while going after clients. They had very small room under the stairs and sometimes client would come to their home. She had witnessed their sexual relations and she could not understand why they are trying to suffocate her mother. She looked scared all the time.

Children run the risk of entering the profession of sex workers; they either learn from their families or are forced to do so. Drug use and sex work is often handed on from mother to child as the family trade, in some cases out of real or perceived options.

Elham says her mother was sex worker and drug addict. When she was 12, her mother actually sold her for three nights to a rich man for 3 million Tooman. Her mother believed that she had the right and the need to do so. She lost her virginity and left with no option except temporary marriage. At age 14 she married her cousin who was 28 years old. His family did not approve their marriage. So they run away and rented a room. When they could not pay the rent moved to a park with her baby. He did not work and she had to go begging and doing other jobs….He was arrested for drugs and is in prison. He is not her husband any more. The time of temporary marriage is over. Now she is left with a 4 years old daughter who has problem in talking and *Elham* does not want to leave her with her grandmother at all.

A drug addict who is free from drug for more than 7 years talked what has happened to her relations with children. *Ameneh* whose son is in prison describes:

I married to escape my step mother at very early age. I was 18 when my husband died. I was left with one girl and one boy. I started using white drug (Heroin) to forget my husband and after 6 month I was really addicted. I was working day and night, finally my employer got to know and tried to help me. And after 24 years of drug use and many relapses I am free from drugs now. I raised two kids but I failed one of them. I was worried always for my daughter. I thought she is the one which in danger. She is happily married now.
But my son got addicted, is in prison and waiting to finish his sentence and then execution. He used to beat me asking for money. He would ask me to go to do things to provide his drug money. I am the one who should be blamed.

There are women drug users who have raised their children successfully without the support of a father. In the society with negative attitudes towards women's work in general, and stigma against female drug users, these women have worked very hard and now relationships with children seem very gratifying and boost their self- respect.

Pari 45 years old with a 20 years old son talks how she has done it and is happy.

I have given birth to five children but four of them died. They lived just few months. For the last one I prayed to God, asked for help…. We both used opium; he was the one that encouraged me. When my last son was 6 months, I got divorce. We had fights every day; he would beat me to death. His mother took the child but later returned it to me when he was 3 years old. I thought I should take good care of him. I sent him to school. His school was paid by my brother. Now he is healthy and working.

Ziba is another example of mothers who have successfully raised 7 children; five girls and 2 boys. After divorcing her husband when he was in prison, she did not marry again but loved a man. He did not tell her that he is married and when she knew he is married, they separated. Losing his love was the reason of her drug use.

My father was driver and got me married at age 13. My husband was a violent man. Since I was very beautiful [she is very beautiful even in her fifties] my husband tried to have many children so I will stay in his life. My kids have finished high school and few have graduated from university. I am almost illiterate (have reading and writing ability) but I used to have beauty saloon also I am a good saleswomen. The children are married except the last one .They love me and it is very satisfying.

There are mothers who regret putting their children in so much pain and agony. As an example *Parisa* 40 years old talks about her drug use experiences:

After marriage, I understood that my mother-in law is addicted. My husband has his construction company and used opium once a while just for fun. I was ashamed for what they were doing and kept complaining. I used to have very bad headaches and my mother in-law persuaded me to take very small pieces of opium. I did and felt better. I used drugs for 17 years. I have 3 children and one of them university student. I smoked when they were at school or put it in my tea. I lost the best years of my children's life. I did not see them growing. Now that I am free of drugs, they are very happy. I enjoy being with them. The kids had very hard time.

As other studies show, our respondent reported conflict with their children over their drug use (Kai 2010). This attitude towards parents drug use was more prominent among the second socio-economic groups of women drug users and only one sample in south of Tehran. The research team witnessed a daughter who came everyday to DIC to see her mother who had left the family. Also in one of the sessions, we shared the discussions of two daughters looking after their mothers' abstinence. They accompanied her to the institute.

As the discussion was open to everybody, one young girl complained that for New Year's trip to Thailand her mother had drug with her, she was arrested at the airport and it was really a blow to their reputation and New Year holidays.

Another younger girl was suggesting that she (was married) would keep her mother in their home and try to take good care of the mother with healthy nutrition as long as needed, only if she decides to stop drug use.

But the concern of children about parents drug use is not always very civil. *Parvin* 48 years old married for more than 30 years and have 5 children talks very bitterly about her sons' attitudes and behaviors towards their drug use.

I started drinking with my husband for fun [before Revolution] then we moved to opium. The children know that we are drug users and do not like it at all. One of my sons was using drugs for a short period but the others never did. Now all are clean. The four sons do not respect me, it is true that I used drug but I was a good mother too. When I have withdrawal symptoms my sons get angry and in one occasion told me very nasty words. They want us free from drug. I like to stop taking drugs for the kids but my husband does not stop and it is temptation…

Pasrvaneh the daughter of *Parvin*, 20 years old says she is ashamed for what her brothers are calling and doing to their mother. She says the parents both were really *Tablo* [looking very bad] but since the mother is taking methadone she looks better. She believes it is her father's fault because he encourages her to take drug as pain reliever.

The conflict between mother and daughter is not always on drug use but sometimes the cost of living. *Raheleh* 29 who is drug user living with her mother and sick brother is responsible for the cost of their household. She did not go home for two nights and left them without money and now mother is angry and nagging her. Mother and daughter both are taking methadone.

We cannot generalize the findings but evidences indicate that mothers in our study are not indifferent to their family and children, the life experience of *Farzaneh* show that they are concerned about family members but also their reputation in the community of drug users. She is 23 years old and the only child for her mother. Her mother is drug users and taking methadone. Her mother used to live with her because her father had a second wife. But now the mother is staying in shelter.

I was 14 years old and, he was 36 years when we married. I had my first daughter in 15, now she is 6 years old. I started using drugs with my husband. He was arrested for drugs. I fell in love with the landlord. The man whom I love had wife and children but I did not care, I loved him anyway. He was not drug users and tried to help me stop using but now he is drug user too.
I am temporarily married to him and pregnant. Since using drug affected monthly menstrual flow, I did not know that I am pregnant and when I knew it was too late to do abortion. He has taken me to live with his first wife and 3 children. His first wife is very upset and …I have tried to respect her. I cannot keep this baby. His wife thinks this is not his child and is telling everybody in the neighborhoods but I will go to hospital and when the baby is born, I will insist on the test to prove that it is his child. My reputation is at stake.

Women drug users in our study in south of Tehran are very vulnerable. Lacking education, failed marriages at very young age, family drug exposure, very limited

resources to take care of the family and un-healthy relationships with the children leaves them with not too many options. The striking issue is that younger generations of these families are facing the same problems.

5.3 Bonding factors

Women drug users similar to other members of a society have different types of relationships. They are particularly affected by their relationships with family, children, sex partners, peers and co-workers. The nature and extent of their relationships depends on bonding factors such as status of partnerships between two opposite sex, number of children, drug use habit and degree of dependency, similar or complementary needs. Bonding factors might overlap based on women's individual cases.

Partner relationships

The status of partnerships can take many forms and probably based on the social context of our country; it can be categorized into three major groups: legal marriage, temporary marriage and sex work including steady partners, commercial and transactional sexual relations. Of course the rights and obligations of these statuses are different and to some extents depend on the nature of the relationships between partners. For some, it might be love, legal obligation, protective role, in few it could be more short term and responding to urgent needs.

Whatever the nature of the relationships, there is always a socio-cultural factor with its norms and values which defines gender roles and responsibilities. In the culture which enhances gendered power structure in any relations, the women drug users are no exceptional. However looking into the intersection of continuum of drug use (presently free from drug, using only licit drugs, licit +illicit and only illicit drug) and status of partnerships (married and not married; temporary and sex work) norms and expectations' intensity might differ to some extent.

Studies suggest that women's initiation into drug intersects with wider social factors, family in addition to sexual relations with male drug users and sharing norms within women's social network including peer groups (Kai 2010).

Women more often than men have been introduced to drug and continue to use with their spouses. Women's subordinate position in drug culture and power relations between women and men often create dynamics where women are more vulnerable to men's behaviors and less able to insist or negotiate on his desires. This is a fact in and out of marriage, in shorter and longer term relationships and in commercial as well as non-commercial sex.

In a large number of the cases in our study women started drugs with their husband after marriage; either for pain relief, fun, or curiosity. Husbands' role in women drug initiation is shared by both groups of socioeconomic status.

Parvin in her late forties when married was too young, only 13. Her husband was 12 years older and was known as a powerful man in the community "*Gardan Koloft Mahal*". In her interview she kept calling him "*Aghamoon* ", which is very common among lower socio-economic groups and could indicate her perception of man's authority.

He encouraged me to drink alcohol; he said it gives us good feeling. It was before Revolution .We drank on Thursday night [weekend night]. His mother and brothers all smoked opium, it was very luxurious. He used to go to bars and when was back I was the one taking the blame and beaten. He encouraged me to take opium for the pains which I had every month, that is how it started.

Afagh is her forties have 3 children. The oldest son is 29. She married when she was 14 years old. Nobody in their families was drug user.

My husband started drug use after 10 years of our marriage, just for recreation. Once when I had monthly pains, he encouraged me to try few smokes and I did. It was like a pain reliever at first. But I continued using for 15 years and now I am free from drug. I attended outpatient treatment. He is still using but I do not mind. He will get to his senses and would come for abstinence one day.

The younger women drug users have similar stories of men's role as initiator of drug use:

I am 21 and married at 16. My family were drug user and I saw them injecting. My father was in prison and we were living in a room of a husbandry as Guard. He was in charge of construction. When he saw me, he sent his family requesting our marriage. He was not addicted in that time. He started Heroin (brown) for fun and he brought Tamchizak home. I had pain in my body and he encouraged me to try just few drops. At first I was afraid of needle but he injected very slowly. I liked it very much, it was good feeling. The first week he injected, and then I learned how to do it.

Maliheh 35 years old has married two times; divorced from the first and is widow of the second husband. She has two kids, one from each husband. The first one is with her father and the second one, a boy, is taking care of by Welfare Organization. She has been arrested many times for drug use. She describes how the first husband got her addicted to opium by encouragement and being nice to her. But he was going out with sex workers and she could not tolerate finally she got divorce. She explains her drug use with the second husband:

I went back to my parents after divorce and while working married with one of the co-workers in the factory. I told him that I am taking opium and he did not mind because he was injecting Heroin (brown). He was 2 years older than me. I started injection to get along with him. He used to bring his friends home but I never injected with friends. He was arrested for selling drugs and died in the prison. Since then I have been homeless.

As the cultural norms affect every aspects of our life, it influences mate selection among drug users too. In Iranian culture men always try to marry a girl with no or least experience in sexual relations. For men who have tried drugs and are addicted,

the family including him prefers non-drug user girls and often hides their drug use from the bride's and her family (Shaditalab & Vedad 2010). Such a decision could have different reasons; it might be due to stigma attached to female drug using behaviors. *Sima's* life experience is one example. She was 16 when got married. She did not know her husband is drug user and did not tell him she is too. She understood that his family is very much concerned that drug use is a male behavior and not appropriate for a women.

Our culture also promotes the breadwinner role of the men in the household and women's economic dependency. Drug users women in south of Tehran, due to their financial needs would tolerate the most difficult situation, to maintain the relationships and in the cases of failed marriages they are left with very limited resources. An example is the situation of a women whose husband has brought home his second drug user wife (temporarily married) with 6 years old daughter from her first marriage and pregnant to a child , to live with her and their 3 children in 2 rooms.

However in drug using culture against the norms, sometimes men due to drug addiction are economically dependent to their drug user wife and expecting her to support both of them. *Monireh* explained how when she got married in 12, her husband and his family were drug addicts and was expected to go with other men and make good money.

Women living with drug using partners often maintain traditional gender role and fulfill the gendered roles expectations. All married women among interviewees have played their roles as wife and mother. However, sometimes caring and financial burden for male drug user falls on women too. *Pari* 's life story shows that when she got tired of not being able to convince her husband to stop drug use, even by reporting to police , she got along and started using with him. Since he was not working, role displacement occurred. She started working and used to take the drug in the morning before work and in the evening after coming home from work. She had to support the cost of their drugs and household expenses.

In the group of lower socioeconomic status, while women exploited by their husbands to provide financial resources for their drug use, have not been supported by men to undergo treatment. As *Fereshteh* explains why she run away from her husband;

When we were both addicted to Tamchizak, my mother used to bring it for us; that was easier and cheapest way. We sold everything for drug. My husband lost his job. When I decided to stop drug injection, my family who were drug users tried not to come to my house so there wouldn't be any temptation. But he did not like the idea of treatment. He was against it. My mother encouraged me to get divorce, but he did not agree. Finally I run away.

Not all the men are against their wife's treatment and nor for the same reasons. There are men, mostly in higher socioeconomic group of our interviewees, who completely supported their wives drug treatment.

Shokat describes that she got frustrated of drug use and decided to stop. She thought the best treatment is going to intensive residential treatment. She knew as long as she

stays with him, it wouldn't be possible. So without his knowledge, went to *Chitgar Camp*. Her older sister had to come for registration and as guarantor. She was there one week. But as soon as her husband got to know, he came after her and they had to release her. He thought she deserve better than Camp, which is for homeless women.

Another example from higher socioeconomic group is the case of *Parisa*. She is 40 years old who did not know her husband is using drug in the time of marriage. She appreciates her husband for giving her the chance to continue her education and providing opium as much as she needed. After 17 years of drug use when she decided to stop using, they both came to outpatient treatment and both have been free from drugs for more than a year now.

There is one exceptional case that one woman has encouraged her husband to drug use. She says

We were living in Turkey for 10 years. I have five children from 10 to 24. He was working in Turkey and I came home for visit 12 year ago. A girl friend of mine encouraged me to take opium for my pains. That is how I started. We all came back home and he started using drugs with me. Honestly I encouraged him. Five years ago when we were Crack (heroin) users, I decided that it is enough. I have been taking methadone for 5 years and he has started very recently.

In our society as many others, norms around femininity and masculinity create expectation for women to be monogamous while not discouraging multiple relationships for men. Such norms also mean that women are less likely to disclose extramarital relations and reluctant to talk about their activities in sex market. Among all women drug users in our study only 4 in south of Tehran and none among higher socioeconomic group in central part, acknowledged their activities as sex worker.

Regarding 3 categories of partnerships, there is a group among our interviewees who presented their status as "temporary marriage". They did not remember or not willing to provide information on the length of the marriages but acknowledged, they have had few in their live time. Almost 30% of women in total women drug users in south of Tehran (6/19) talked about their multiple temporary marriages. For a deeper understanding of their status we provide quotations of these women.

Ameneh 50: *When my husband died I was 18 with 2 kids. I was not sex worker but for example when a drug dealer would tell me that he will provide my drug for a year for temporary marriage, I accepted.*

Elham 30: *My first marriage was a temporary one. In order to support my ex-husband and now my child, I work in cemetery, doing cleaning job, begging,…Two months ago, one of the women in DIC told me that if I do three injections, she would take me to a place that I can make 100,000 Tooman a night. I did the injections but I got sick and had to be hospitalized for a month.*

Sara 37: *After my divorce, I have been temporarily married very few times [with smile] for two months. I had a child from him but the child died.*

Vida 27: *My first and only marriage was a temporary one. My father had died and my mother thought it is better if I get married.*

Farzaneh 23: *I have been temporarily married to a man for one year. The time of our marriage is over but I am pregnant now. He has promised to renew it.*

It seems when female drug user is involved in providing sex to a steady partner do not consider herself sex worker. Such a perception could be due to their desire to present legally and socially acceptable behavior or they really get married based on *sharia* law. Also few of them who are on methadone program and in more mentally stable situation, probably prefer to change their self- perception.

To present evidences of those four who voluntarily talked about their work in sex market of south of Tehran, without any generalizations it seems there is two common variables among them; (a) need for money and (b) need for shelter.

Monireh 44-45 years old says:

I have stopped sex work or declined extensively the number of clients because I do not need money as much. I am staying in shelter, have food in one of the two DICs, they give me cloths and I do not need money for drug because I have been taking methadone for over 4 years. I need money for cigar which I can earn it by selling condom to those female sex workers who do not want to come to DIC, because they live in this area and people know them.

Fereshteh is 21 and very young. As other women drug users who less likely than men inject alone and more likely to be pressured by their partners to share equipment (Health Canada 2003) she started injecting with her husband for more than 2 years. But *Fereshteh* thinks she have not shared needle or injection equipment with others because she was concerned that used needle is not sharp enough and it hurts the vein in injection. She explains that she did not know what is condom and unsafe sex at all and have not used condom in her sexual relationships. When she talks about her sex work, she emphasize that she hates all men;

I have done it only for money. Mr. Asghar a friend of family always helped me, I do not know much I was making a month but I did not go every night .Whenever I needed money for drugs, when there was no other option. I have stayed in friends and shelter in Shahr Ray which is closed now. I have taken HIV and hepatitis tests 3 times at DIC. I have gone to gynecologist in other DIC but these things were not important at all for me.

According to literature on female drug users, women who use drug are more likely to have a partner drug user (UNODC 2010; 76-77). Based on the findings of our study, this is true with permanent marriages and steady partners but when women is drug user and sex worker she does not have much choice regarding the selection of clients as much as she does not have choice on safe sex, location and time of exchanges. When sex is survival strategy selection and choice is a luxury concept.

When women drug users are poor and dependent on drugs, they are more likely to exchange sex for money, shelter and food. The drug and sex makes women more

vulnerable, because sometimes they have to do it in secret, in hurry and usually without protection.

Soudabeh is from the west of Iran and during the war migrated to Tehran. She has high school diploma, at age 19 was temporarily married to a man for 99 years but he stayed only one year and left her with a child. She describes what has happened to her;

I have done many different jobs, whatever I could to stay alive and take care of my daughter, sewing, cleaning. We did not have anybody to help. We lived in the street with my daughter. Once I went to visit my family. With the suggestion of my brother I got my 11 years old daughter married to his son. Their marriage did not last long, now she is living with me.
When I do not have money I go to work during the night, from 10 to 3-4 in the morning. I go up town to Satar Khan; I do not do it around our community. I used to go to men's house but now I do not dare. We have sex in the car or in a rented room [In south of Tehran rooms are rented 1000 tooman for half an hour] or in my place. I do not know if they are drug users; sometimes are and sometimes are not.

Maliheh in her thirties calls herself "*Tak Par*"; a sex worker who prefers steady partner and goes with one person at a time. She is 35 and has been using drugs almost for 20 years. Her last husband was injecting drug user. They shared needles and he was the first in injection and injected her too. He was arrested and died in prison. Since then she is homeless. She describes how she lives;

I stay with a man for 2-3 years. He helps me as much as he can with my drug.
I would go with men who have a place for living. These men are good, they understand me, and I have seen 4 or 5 of them in my life. They think of me as their Namous and protect me. Otherwise I have to live in the parks and streets.

She is a transactional sex worker who trades sex for the most important necessities of her life. It seems transactional sex occur with fewer individuals and often is known to the women. To her providing shelter and sometimes drug are more a sign of caring for and a friendly gesture of men. She explains that she did not use condom with her injecting drug user husband but she uses now. However it is difficult to insist on protected sex when they are so understanding and protective.

She has tried to stay in shelter but they annoyed her and her cloths were stolen two times and she does not like to stay with other women drug users. She believes they are not honest and cannot be trusted.

All four women drug users who acknowledged their work in the sex market (in south of Tehran) are survival sex workers (4/19).They started at very young age and 3 of them have been injecting drug users too. This very small number is the only injection drug users in total interviewees (3/26) who have been sex workers some time in their life.

With such limited number of sex workers and injection drug users we can cautiously summarize that probably sex work among young female drug users is an indication of increased risk of unsafe sexual relations. Also while for women in marriage

partnership status, unsafe sex is interpreted as a sign of trust and loyalty, it seems in all types of partnerships it is more an indication of gendered power structure. Therefore sex workers could be subject to dual risks of unsafe injection and unsafe sex.

As the results, many women begin drugs (non-injection or injection) in the context of sexual relationships:

- They often share the drugs with their partners
- Are dependent on their partners to obtain drugs
- Women usually inject after men
- Do not negotiate on safer sex or sex in general
- Engage in commercial sex to provide money for living
- Transactional sex is for shelter
- They take risks in sex work because there is no other option

Social network

Marriages and sexual relations are not the only bonding factors for women drug users. Women share common attributes with other female drug users. They form networks and build up relations not based on sex but other needs. Women perceive initiation and maintaining these types of relationships as supportive and protective in their life. Peer group supports fulfill needs for social support in the face of economic hardship, social alienation, accessing health or other services (Pivnick et al.1992).

Social network of drug using women consists of people who provide constructive support that they need; individuals who enable their drug use (Falkin & Strauss 2003).Women success in treatment may be attenuated because some of the people who provided social support prior to treatment enabled their drug use and now she has to change her network and peers.

Development of social network requires social capital which is people's skills, structures and beliefs. Social capital could help to create a collective action. There are different types of social capital; such as bonding social capital between people who are similar and have a shared purpose, for example a group of female drug users who are living in the street and strive to stay alive. There are indications of such network in the society of this study, but its nature and extent need to be studied.

Drug could act as a bonding factor in relationships. The same is applicable to the methods of drug use. Due to cultural norms female drug users and particularly injecting groups are more likely to be stigmatized by society than male injecting drug users. Since their behavior diverges from the expected gender role of caring are considered deviant. When women internalize these attitudes, then it is part of drug culture which leads to a network of women injecting drug users. This group of women is more isolated, stigmatized even among female drug users. Therefore their social network comprises more male injecting drug users and probably fewer female friends. This network is very small in size and probably with new types of drugs in the market, is in the diminishing process.

Sex work could be a bonding factor among women drug users too. Sex workers with injecting drug use method constitute high risk social networks which are doubly deviant. The bonding factor provides the opportunity of information exchange on certain clients or the possibility of violence with some. Among few sex workers and those who defined their partnerships as" temporary marriage" indications of such network is present although without structure.

There is some overlap on drug use network and sexual network .Memberships in these groups depends on the choice between maintaining relationship and ceasing injection or drug use or sex work. When the bonding factor is removed the relationship is lost.

Another type of bonding factor is the history of incarceration and relationships developed in prison; the experience of being in prison at the same cell and the same\mutual understanding and closer relationships. *Monireh* explained in her more than 50 times of arrests, she always found new and good people whom they continued their relations after release. *Maliheh* talks about her 13 times prison experiences for drug use and at the same time using drugs in prison. She says:

There are a lot of drug in prison, all types. We shared costs with other women and used Crack (heroin). When we were released I wanted to go after my son and I did not have any place to stay. One of the women in prison, now a friend said: "let us go to my place". Later we all agreed to share the rent.

Mutual acceptance and understanding the life style, needs and difficulties of illegal activities and desire to overcome the feeling of loneliness provides bonding factor for socially excluded women. They are living in the conditions of deprivation and vulnerability; such as poverty, inadequate access to education, health and other services. They are a group as Wallerstein (2006:17) describes in destructed social capital with the larger society and isolation.

5.4 Living with violence

Violence is embedded in everyday life experience of women, drug user or not. This phenomenon simply defined as psychological, physical and sexual coercion is even promoted in some societies by law. Learning violence starts within family, when the children are thought to be submissive and obedience to the father, big brother.,…or not to let others to take advantage of their politeness .We are all socialized to tolerate violence when we are not in the position to stand up for ourselves and do the same thing when the opportunity is provided.

We experience violence or witness its occurrence objectively in the society; in the relationships of police to people, in drivers tone talking to passengers, in teachers' behaviors in the school. Therefore we live in the world of violence and drug culture is no exception, particularly when mistakenly drug is used as justification for violence.

Intimate partners experience violence in and out of marriage. However, the type and intensity of violence among drug users might be different. A meta-analysis of the current study found that the intimate partner aggression are approximately three times greater when drug users are included (UNODC 2010). The low social status and

stigmatized drug user women may give their drug /sexual partners greater entitlement to abuse them.

Violence in drug users' partnerships may take different forms:

- Physical violence
- Psychological abuse, humiliation, disrespect,
- Unprotected sex
- Sex with multiple partners
- Sexual transmitted infection due to multiple partners
- Economic violence; not providing money for household or drugs
- Food deprivation
- Forced to engage in sex work for money or drugs

Male drug users may be the subject of violence too. But the perpetrator and reaction to violence are different in genders. Male drug user similar to general populations do not like to report their violence experience due to humiliation attached to its reporting and goes against their masculinity perception. Also sources of violence for women are mostly men; fathers, brothers, partners and male clients but for men probably are more strangers or drug dealer.

Based on the findings of our study violence against women in drug culture differs among two socioeconomic groups. Quotations from two interviewees as samples of domestic violence show the situation of the higher socio-economic group.

Shokat 34 years old who classifies her family's socio-economic status as middle-high and has married twice and is living with her parents at present describes her experience.

I married at 18 after finishing high school. I really did not love him. I was told I will love him after marriage. But it never happened. He was drug addict but did not tell me prior to our marriage. He was physically abusive. Finally I got divorce for his drug use and violent behaviors. I was working in a private company and fell in love with the second one. He was a civil engineer and not drug addict. We started drugs together. He is physically violent more than the first one. I am in treatment and have separated for a period.

Mansoureh raised in well educated family, married a wealthy man and much older. Now is divorced and living with her daughter in parents home and is supported by all family members, explains her experience.

I got married without my father full consent. The first year it was very good and I was happy that I am out of my family's discipline. We had two trips abroad and I understood he is taking drugs. Then he started going with other women. He brought them home and would ask me to leave the house. It was humiliation every day. But I could not go back to my parents. It was my wrong choice. I start drinking to cope with his behavior and I got addicted. I did not want my parents know but, finally my father took care of everything and I am back now.

In a large number of female drug users of the higher socio-economic group, violence is limited to their spouses' relationships and mostly domestic violence. But in the

lower socio-economic group, women experience violence within family as well as society. General public witnesses their engagement in the illegal and stigmatized drug use behavior/ sex work and prefer not to see such behaviors in the society. Women's deviation from the norms and values cannot be tolerated by the community and those in charge of public order. Although male and female drug user both are subject to violence in the street but drug dealers and male drug users take advantage of women drug users' lower social status in the society.

An experienced service provider who is trusted very much by women drug users has so many memories of women drug users' abuse. She remembers once:

One of the women drug users, who used to come and receive methadone, had a 14-15 years old daughter. She used to bring her to DIC but one day she did not. One or two hours later, she came back crying with her daughter in blood. While she was gone, the sons of the landlord raped her, they had anal sex and she was really in bad situation. I could not do anything.

Ziba a middle age lady who married at 13 and got divorce when husband was in prison, now in the process of treatment describes her life experience:

Since the first day of my marriage, I did not have a good day. In those days we had to go to public bath but every time when people asked me what has happened to your body I would bring ridiculous excuses such as falling from stairs or from tree. I thought they believe me. Now I know they did not. He liked sex with violence. He would keep my hands tight and do it. Also he had extramarital relations with other women and brought them home.

Women drug users get involve in extra marital sexual relations too but they do not dare to talk about it. The story of a woman is told by a service provider in the residential treatment center;

They were both drug users but the husband had stop drug use 6-7 years ago also he had done vasectomy. Woman continued using drugs and she was raped by drug dealer (Saghi). Of course her husband did not know.
Now she is brought by husband to treatment center and when we did pregnancy test, she was pregnant from the dealer. We could not tell her husband, just asked her to leave the center.

Probably the most bitter violence experiences are those of sex workers. *Soudabeh*, who married at 19 with high school diploma and now engaged in sex work in addition to whatever she can do to support their living, has many stories of experiencing clients' violence,.

I went with a man last week. He had a white car. It was late at night. We talked in the car and agreed on the cost. He took me somewhere more quite. Tightened a belt to my neck, he was really killing me. He did his sex and took all the money I had in my bag.

Also long time ago, when I used to provide services at a place of clients' choice, a man asked me to go to his place and I really preferred because I did not like to bring them home, where my daughter was. He trapped me one week in his place and

brought other men, they raped me and he got the money. After one week he throws me out. That is why I do not go to men's places anymore.

Monireh in her forties who now is homeless and is in and out of shelter tells her experience of sexual violence;

I had rented a room and I did not pay the rent for two months. My landlord asked me to move out or pay it as soon as possible. I could not work very much so it was getting difficult. Once he asked me to go to their room to discuss the issue. When I went there, he kept me in the room and start brining men for sex. When he got equal amount to his rent, he let me free.

A large number of women drug users do not like to stay the nights in park. In winter it is for cold weather but more often for violence they experience. Service providers told us; in many occasion women drug users come to DIC early in the morning without any cloths on, only a chador. They are usually raped and beaten by men in the park.

Sometimes negative attitudes and violence towards drug users and sex workers extends to the authorities who are in charge of order. *Monireh* tells us that she was sitting in bus stop just passing time. The police got suspicious and questioned her. She told them: "I just want to sit here. I do not want to go anywhere". But he took her to a place for homeless people. They shaved her hair, kept her for a night and the next morning let her go.

Shabnam a middle age woman who has stopped drug use for more than a year, likes very much to work and stay independent but she complains that nobody understands women drug users and there is no support, except from DIC service providers. This is how she has tried to earn some money for living:

After the death of my husband, I decided to live on my own. I knew I can sell tea in the bus terminal in south of Tehran. I bought cups, tea, and sugar cane and started. First I had a small table in a corner of the street close to the station but municipality did not allow me to stay there. I got a cart for few years but then they did not allow me moving around and selling tea. Finally I got a basket but last week he grabbed it from me and throws everything in the large garbage can in the street.

Shabnam was accused of public order disruption and violation of pedestrians' rights and probably regulation enforcement officer from municipality was applying the rules to everybody but for women drug users it seems they are more under pressure not to be present in public and this deprives them from their social rights.

A service provider tells us how a mother and daughter wanted to go to movie and probably have 2 hours quality time. They bought the ticket but they were refused the service. The guy in front of the door did not let them to enter. He has said that they are drug users. He could distinguish their drug use from the mothers' teeth.

The stories of unkind behaviors of authorities do not stop at the men in cinema or municipality's officers. Sometimes police is not very supportive too. Service providers have experienced these attitudes so many times. Based on past experiences they have declined their contacts with police to minimum level.

They told us; one of the DIC clients came and asked us for help. She said: "two men came for a night but now do not want to leave ". She could not throw those strong men out and did not know how to force them to leave. They were not paying and she needed to work. So the director of DIC wrote a letter to the head of the police station, asking for help. The client delivered the letter. After reading the letter, he throws it in the basket. So director called him and he said: "You should tell me; how they got in, at the first place?!!"

The consequences of using drugs and working in so difficult conditions are enormous harms and psychological pressures to the point of suicidal thoughts and attempts. Among the interviewees of the study *Raheleh* 29, with high school diploma taking care of her mother and sick brother and doing cleaning job with her mother talks about her decisions to stop living.

I am so tired of this life that I do not see any reason to continue. I have attempted suicide two times. Once I drank 5-6 small glasses of industrial alcohol. My mother took me to hospital. I was in coma for two days. The second time I took whatever drugs I could get hold of. They took me to hospital and they saved my life. But it is useless.

Therefore women drug users interviewed in this study, face many socio-cultural factors which have acted as risk factors for their drug use initiation (injection or non-injection).

Table 5. Risk factors for women's initiation to drug

1. Family history of drug use
2. Family instability
3. Social disadvantage (lower socio-economic status)
4. Marriages at very young age and early sexual experience
5. Young age of first illicit drug use
6. Sexual abuse
7. Violence experiences (domestic and in the society)
8. Social network of drug user/sex worker
9. Mental illness& suicide attempts
10. Social isolation (e.g. staying at home women and housewives)

In society which risk factors are social and culturally rooted, along with negative attitudes towards women's drug users and their financial dependency, women find it difficult to enter and remain in treatment. Reintegration with the community and living independently is more difficult when they posses very limited resources in terms of education and employment with no social support.

6. Gender disparities in social support programs

Various studies have contributed to the body of literature on the important factor of social support and its positive relationship to well being, health and coping with emotional stress of the individuals. Contemporary social support researches have extended to a variety of health related issues such as addiction as well as array of mental health related outcomes (e.g. recovery time, relapses). Of particular interest are the studies investigating social support within the rehabilitation context (Chronister et al. 2008).

Social support is a broad set of measurement which approaches drug issue with integrated activities, collaborative partners and focusing on effectiveness of treatment and care. Social support programs aim to guide vulnerable groups such as drug users; homeless people often suffering from psychiatric disorders get into system of care and treatment including housing, employment, reintegration, social benefit and medical care ".The target groups benefiting from these supports are expected to be self-reliant and independent again (International Drug Policy Consortium 2011:6).

Women drug users have special needs and face challenges due to their physical attributes and socio-cultural milieu which defines gender roles and responsibilities.

It is possible for drug dependent women to overcome the illness of drug addiction. However sometimes it is difficult for them to enter treatment process and their transitioning from treatment to after care or continuing care is always more challenging. Society's acceptance and social support network is essential for remaining in treatment and relapse prevention (Ibrahim 2009:472). As for treatment outcomes, women could have comparable abstinent rates with men, if they are helped by an established recovery-oriented support program.

The review of women's status and relationships in drug culture (previous section) and socio- cultural risk factors in women's drug use initiation (table 5) helps us to have a deeper understanding of why and how programs supporting women drug users either to reduce the harms or drug abstinence treatments and reintegration into community need to focus more on socio-cultural variables. Stigma as an overarching factor is presented briefly and each main components of social support program will be discussed to show the needs and the extent of services provided to women drug users.

6.1 Powerful stigma

Women's drug use behavior as diverted from the norms and role of good wife and mother are perceived as deviant behavior. As such they are judged by the family, community members, law enforcement officers, employers, co-workers, and everybody out of drug users' networks.

Negative and hostile attitudes towards women drug users promote humiliations and disrespect even by their own husband and children. Sometimes women drug users are exposed to harsh judgments from service providers such as the male service provider

in public health center who stated:" *we should throw them to the crocodile to be eaten"*.

Stigma entitles others to abuse women drug users in partnership relationships or commercial and transactional sexual relations. These women tolerate various types of violence and are less likely to report.

Internalization of stigma leads women drug users to believe that they deserve abuse and enhances their low-self esteem. The abusive relationships combined with stigma against them results in their isolation and more marginalization.

Stigma affects all aspects of women drug user/sex worker's life. Few evidences from interviews with neighbors and grocery stores in the close distance to Drop-In Centers and shelter illustrate the importance of considering "stigma" as an umbrella to all the components of social support programs.

Shelter is located in south Khayam Street and in a very narrow and long alley within many spirals. Houses are eroded and municipality is renewing the area. New apartments are built and there are new buildings on two sides of alley but almost empty. Only windows of one apartment have curtains and a man was watching us talking to the neighbors. The side wall and top of entrance door were fumed and we understood somebody (s) has put it on fire.

On the right side of alley, there is a small old house which two families used to live but the son with his wife and children moved out due to the shelter. The old man with his wife is still living in the house. We had an opportunity to talk to the son and his wife (both in the middle ages).

We had to move out of the area. I have young daughter and son, what would happen to them if every day they see sex workers and drug users in the alley. Shelter operates from 3:00 PM to 8:00 AM, and they are really nuisance. They fight and use dirty words, shout, and we could not stand it anymore, my father and mother are living here yet. But they are too old, do not hear very well and do not come out of their house.

When we asked do they remember "*Shahre Now*" in the same street, the husband responded:" *Yes, I do remember but it had tall walls separated from others. It was covered within the walls.*

Both had similar solution to the neighbors' problem: "*We understand these are human being but take them out of town. Somewhere that nobody would see them. Build a building for them in the wilderness"*.

We also talked to the owner of a grocery with two young men at the age of 28-30. They both were against DIC and its activities. They said:" *this is disrespect to the families who are living in this area.*

When we explained people in these small crowded houses are mostly drug users, their response was:" *we know it is a problem but rather than solving it, now sex workers are added to it on the day light. It is shameful for everybody.*

And the suggestion to the problems was*: "take them out of town"*.

Women drug users/ sex workers have difficulties renting a room. When *Setareh*'s husband died she was asked to move out because she was single now and the landlord had a grown son and son-in-law.

Fereshteh the 21 years old women told us when she released from prison and wanted to rent a room, her father had to come and sign the papers. Another interviewee, *Ziba* with 7 children was happy that her husband's name still is in her ID, so when she goes to rent a place, they think she is married.

Stigma affects women drug users' access to health although Drop-In Centers in south of Tehran are active. In one DIC a room is allocated to doctors but they do not find a female doctor to come for few hours a week. As a result they had to hire a male doctor for methadone program. Also a female gynecologist who used to come voluntarily could not continue her cooperation because her husband was against coming to DIC and working for these women.

In another DIC dentistry unit has been purchased but no dentist has been found yet to attend and help women drug users serious teethes' problems.

The story of *Soudabeh* and police reactions to two offenders to her privacy and not leaving her room shows how stigma affects their life and the attitudes of those in charge of security and order.

Stigma impacts women drug users' attempt for employment, while taking methadone or when are free from drugs. Service providers of the Drop-In Centers have many stories of introducing these women to work to different workshops and the employers' or co-workers' harassments.

Stigma attached to women drug use/sex work has resulted in men's entitlement to abuse women in the street on the day light. On *Farvardin* 14th, 10:00 AM (April 3th 2011) two of the researchers were asked by men to get in a car, even by looking in their face and seeing the white hair of one of them, still were insisting to have a ride. Such violence and insecurity have led to unwillingness of staff in one of the DICs, not to walk from their workplace to the metro station (less than 3 minutes walking distance) and have signed contract with nearby car agency to take them to the station every day.

In such environment to motivate women drug users and/or sex workers to make life changes and facilitate reintegration could not be possible without an active social support system.

6.2 Social support's components

There are growing numbers of evidences on the functions of family and peer supports and the outcome of treatment and rehabilitation. However, evidences regarding importance of family as a universal myth and the only positive force for treatment are questioned and the supports of other institutions taking into account gender differences are emphasized (International Harm Reduction Program 2007).

In the cultural milieu of our country and based on study's findings, in addition to family support, women drug users most benefit from drug treatment and recovery through a social support program. Components of such program could be a wide range of supports:

-Food and clothing
-Job counseling
-Legal assistance
-Family therapy
-Parenting training
-Child care
-Social support (family, community)
-Psychological help and mental health
-Assertiveness training
- Employment
-Violence prevention and management
-Day activities
-Shelter and housing
-Vocational trainings
-Literacy and educational opportunities
-Couple counseling
-Medical care
-Social services
-Life skills training
-Family planning services
-Income generation
-Transportation facilities
-Social benefits

In this study, in the processes of data collection through semi-structured interviews, women drug users were asked to discuss the supports which could help them to continue their treatment and have a healthy life. Also those who were already free from drugs for many years were asked; what had helped them to stay in treatment. In the group from central section of Tehran with higher socio-economic status without exception their responses were:

"When I am free from drugs, there is no difference between me and other women. I can do whatever they can do and I have to do it myself. Even I am stronger because I have been educated in the sessions of drug treatment".

The second group of women drug users in south of Tehran could not comprehend the question and with more explanation (not manipulating), we had two different sets of responses: (a) *whatever we have and we receive from DIC is very good and enough" (b) we need a room (a place to live) and income (work).*

For more information, we prepared a list of 9 most important supports based on literature, UNODC's call for proposal, interrelations of support activities and our previous interviews. Those who were literate were able to read and tell us which ones are needed and for illiterate women we read it to them .The responses was in this order: *employment and income, housing, vocational trainings and health (physical and psychological)*. Very few (n=2) mentioned education and nobody mentioned they need legal assistance, protection against violence and child care.

Table 6. Priorities of social support's components……

	Women drug users	*Service providers*
Higher socio-economic	*Nothing*	*They can decide themselves*
Lower socio-economic	*Housing*	*Housing*
	Income &employment	*Income*
	Vocational training	*Mental health*
	Health	*Physical health*

6.3 Supports not mentioned

From the researchers' point of view women drug users decision on major components of a social support program does not mean that they do not have legal or child care problems, but either they do not perceive it as a problem or with urgent needs, it does not have any priority.

Therefore in this section based on the content of interviews, some of the supports which are not mentioned (directly or indirectly) by women are presented. Of course these are researcher's perception and not women drug users' needs and priorities.

Child care

Treatment institutes have their own rules. Residential treatment, shelter and two of Drop-In Centers do not allow children to the building. However in one DIC, a room with a label on its door is allocated to children. Since they do not have personnel to work and take care of children, they are playing in the hallways. The friendly relations in DIC give the children a place to have fun and it seemed they are happy to be there.

In the treatment institute in the central part of Tehran, no child care facility is envisioned. Mothers with babies, few weeks or few months old were attending the sessions and meetings. The help of Guides and too many drug free peer groups seemed very helpful and friendly.

Shelter's rule of not allowing to keep children (Of course there is no appropriate space too) has resulted in few mother's leaving their children to Welfare Organization. They are promised that whenever they have a job and a room they can get their child back. But when this would be possible and what happens psychologically to a child separated from mother is an issue which probably is the choice between bad and worse.

Legal assistance

Among all the divorced and separated interviewees, only one of them mentioned that she likes to keep the custody of her son but the husband do not agree and she probably needs a lawyer to defend her.

Women drug users have some legal problems when they are arrested by police or officers of the municipality. A large number of women drug users do not have any identity papers. They have sold their only economic assets for drugs or it is stolen in the park and lost. Since they do not have permanent residence address, majority of them do not have national ID, therefore are among the lost population who do not receive subsidies while are most in need.

Based on the experience of one of the service provider who wanted to help a young drug user in abstinence treatment to get her ID, she was asked to submit a home's dead to the police station. But when she did, police was not accepting the dead because it was an apartment outside *Shoush* region.

However, in very few cases service providers had received legal advice from a lawyer who is in jail now, for attempt against national security.

Violence protection

As was discussed in pervious sections this phenomenon is so embedded in women's life, particularly women drug users, which they are used to it. They have accepted and socialized to men's violence in any relationships.

While based on service providers experiences sexual assaults happen every day, women are not willing to report. It seems those in charge of public order and probably in legal system have a different definition of violence and different attitudes towards women drug users/sex worker, therefore service providers are also disappointed and do not see any points in reporting.

Education

For women drug users who have been disconnected from learning institutions very early in their age and have so many difficulties to survive, it is not strange if do not mention education as a need. Also they are participating in trainings for safe injection, HIV prevention, mother to child transmission, Hepatitis, STI and few other educational program on anger management, problem solving…probably they think they get the most important information for their present life's situation and there is no need for further education.

6.4 Supports needed

Taking into account the interrelations of some of the support services and those most mentioned by women drug users in their interviews (directly and indirectly) 3 major components will be discussed in more details in following orders and combinations:

- Employment: income generation and vocational trainings
- Housing: rental, shelter, transitional accommodation
- Health: physical, psychological, reproductive /pregnancy

Employment

Drug involved women face economic difficulties; unemployment rates are high, job access is limited and little skills to compete in the market. The evaluation of programs of health sector for HIV prevention reports after twenty five years into the epidemic, economic empowerment activities are not one of the main drivers of the current response and income generating interventions are rarely incorporated into services (El-Bassel et al. 2010, Cornmen 2010).

Regarding the two main groups of population most at risk and drug/sex related behaviors, such evaluation means health sector should move beyond medical interventions and recognize the importance of socio-economic and cultural factors.

Economic aspects of our life are also engendered. Generally amount and types of resources women have at their disposal is limited, employment opportunities is scarce and drug use itself contributes to worsening pre-existing gender inequalities and social relations. In economically and socially dependent relationships a women's ability to leave an abusive husband or a high-risk sexual relationship and/or negotiate safer sex with a non-monogamous partner usually is compromised and leaves her more vulnerable to violence.

Gender inequalities affect women's life during drug use and after. Drug user male when faced with the costs associated with drugs, typically cope by depleting meager savings, borrowing money from others, taking on debt or disposing assets but for a large number of women drug users restoring to other alternative means of procuring income, is participating in sex market.

While gender alone could define women's economic status but the combination of gender, unemployment and poverty increase women's vulnerability by limiting their schooling years, knowledge and opportunities to find employment. Resources women drug users need for earning a livelihood and choose among alternatives income generation activities is restricted.

Many studies show while a range of reasons were reported by sex workers for entering into sex work, close to one-third of them entered this profession mainly due to economic pressure and while some women sex workers expresses their desire to come out of this profession, many others wondered where they would go and find work(Anil Kumar 2004: 79).

A project in India that provided micro enterprise training to produce and market canvas bags reduced the number of clients they had and enhancing their economic well being. Loan of $133 to project participants including sex workers in Kenya, after one year resulted in 17% of sex workers leaving sex work and for those who remained average number of clients declined by two-thirds (Kai 2010:10).

A study which is carried out to show how access to a "help employment" and its maintenance can be successful in rehabilitation of ex-drug addicts reports factor of financial income and financial motivation to be more determining than the setting under substitution therapy (Kammoun et al. 2009).

Given that economic problems play a role for many women drug users' initiation and continuation of drug use and sex work, review of literature shows that programs which offer alternative income options are underutilized in most of the harm reduction and support programs.

There are two different approaches to the women drug users' economic empowerment which could be related to underutilization of income generation activities:

(a) Their capabilities to learn and work has diminished
(b) They are able to work, given the means and opportunities.

The first group's debate is based on the effects of drugs on brain and its function. They believe the effects of opiates which include morphine and the synthetic derivatives such as Heroin (brown), codeine as well as methadone and.... can result in:

- Depressing the central nervous system so individual's functions are slowed down
- A feeling of euphoria and a subsequent sense of profound wellbeing
- Pain relief
- Drowsiness and lethargy

Amphetamine type substance stimulants quicken the heartbeat, breathing rate and brain activity. It can lead to feelings of confidence, energy and alertness for a period but withdrawal leads to tiredness, irritability and depression (Alliance 2010:11-14).

Therefore when individuals take drugs their ability to make rational and sensible judgments about their health can be compromised; the most obvious example is their inability to use condom. Due to brain's malfunctions for a long time they would not be able to participate in vocational trainings and work.

One of the more experienced service providers who is working very sincerely for women drug users and has supported them in most private issues of their life describes her experience of delivering services to this group.

I do not think drug users can make income and support their life. They do not change drastically. In my almost 5 years' experience, we have records of 800-900 drug users. I have worked with at least 150 of them very closely and tried to help them but the truth is; not more than 5 of them are working. I do not know how employer has been able to work with them.

We have women who have learned knitting or sewing in prison or other skills but they do not like the memories of prison so do not like to do it here (DIC) or any other places.

A young psychologist who is working with women drug users for almost 3 years and has attended many short term training workshops on drug addiction, hotline, motivational interview, in response to our question regarding the attitudes of drug users towards work and whether they like to work, explained:

70-80% of them like to work. They prefer to work rather than doing sex job. They love to know that they are able to rent a small room by their income. But still do not like to wake up early in the morning and come to work at 10. Women in this DIC are taking methadone at the same time are taking illicit drugs. If we focus only on those who are taking methadone or abstinence treatment, then we need some time for their stabilization, probably 6 months. The number of women who are taking only methadone in this DIC is very small. Almost all of them take both. Therefore they are not able to work.

Those who are taking methadone, they need the work psychologically but physically are unable to do it. Psychiatrists and psychologists have to work with them 2-3 years.

Probably they want to be on time, but with so many years of addiction they are obsessed. They wash their face many times, they check everything many times, and therefore they are late to work. They have lost the ability of time management. Also they have low self-confidence and think cannot do anything.

A service provider with university degree and long experiences of working with people of the area for municipality , and diploma in sewing, toy making, first aid from Vocational Training Organization (government) is in charge of vocational trainings in one of the Drop-In Centers explains her experience .

We have sewing machine, netting machine, carpet weaving, toy making, needle works, and making things with beads. These equipments are purchased based on need assessment.

I think less than 20% might be able to sit in a place for few hours. They do not learn. I teach them something today; repeat it so many times and many days in row, but the next week it is completely forgotten. It is like they never heard of it.

Some women drug users have learned a skill when were young and probably not drug user or at the beginning of their drug use. They remember that one and use it in workshop. But for most of them coming to workshop is not to learn something but to pass the time. They talk; sometimes get into fight and sometime cry for what has happened to them.

We really cannot introduce them somewhere to work, they steal things …..Our workshop here is more a group therapy but few can make some small amount of money by doing handicrafts.

Among those who have learned a skill in their childhood and like to work, physical and psychological problems affects their work and are not able to continue. *Roya* in her forties, whose name have been mentioned as most successful women drug user in the Knitting workshop, is not working anymore. She describes the reasons:

My childhood was not a good one; we lived in poverty without father and mother working all day. I had psychological problems from the old days. I was hospitalized for a month in Razi and they derived me crazy. I was doing OK before hospitalization. I have many skills and worked in the workshop. I made 800,000 in last four years. But

now I cannot sit and work. I do cleaning job in people's apartments but I do not want my kids to know.

On the capacity of women drug users to learn a skill and work, another service provider explains that she thought probably they should start with very simple things like sewing a straight line. So she tried to let them sew a bed sheet. She thought them everything. But they could not cut a straight line and sew it. She concludes that with all the trails: "*they do not have ability to work*". Her suggestion for the work of drug users in south of Tehran is:

….*probably we should be happy with o*ne less unsafe sex, or one less sex. *Probably we should subsidize their work and look at it as occupational therapy for harm reduction. When she is busy with doing the simplest things, she thinks she is employed. We should not expect anything serious to be done. We can pay their food and rent and perceive it a harm reduction.*

The second group with more optimistic approach to women drug users' ability to work, believes methadone stabilizes the individual and they are able to do certain jobs and for those free of drugs, problems would decline through time and after long term treatment they can be economically active similar to others.

There are few initiatives for job creation and employment, which we can learn lessons. A service provider with extensive experience in the area of social works and enthusiastic to provide job opportunities explain their experience regarding income generation and vocational trainings:

After need assessment, we established the workshop and hired somebody experienced for vocational trainings. Women drug users in the assessment had said: "they like to do sewing". Probably they did not know or had not seen anything else. We implemented the project but I know we are not very successful. They do not concentrate on doing something like knitting .Probably we had to get something easier like punching belts, but then we need investment and market. Now they are making toys which are not too bad.

Her solution to the problem of women drug users' unemployment is stated as a wish*:*

I wished we could have a place, we could do many things. I have talked to the municipality but so far no help. In that place, probably we could get beans or vegetables to clean and pack. But we have to be aware; people might be concerned with food items cleaned and packed by drug users and sex workers. I know women like to do sometime in short time and receive their wages as soon as possible.[10]

Women drug users in labor market

There is a significant economic variation among women drug users and they are not always poor. Among our interviewees there are two socio-economic groups of drug users; relatively higher ones who are mostly supported financially by family and

[10] *Unsuccessful vocational trainings and income generation activities was told by DIC's in Shiraz and municipality's in east of Tehran.*

lower socio-economic group who are less educated, no family support and live in south of Tehran. In general, regardless of their status, the scale of the challenges facing women in drug treatment and labor market is considerable. Working women drug user perceives five major types of risks:

- Risk of disclosure and its consequences
- Risk of harassments by other employees
- Abuse by employer
- Discriminatory low wages and long hours of work
- No contract for work and insurance

Our data shows a large number of drug users from both socio-economic groups have been working in a period of their life and some have experienced one or more of these risks.

Afagh 43 years old, with 3 children who is not working now describes her work experience.

I had my own business; it was a Meson, a good business with too many customers, which I could not catch up. For New years I had so much work which I had to stay all night with my workers. I used drugs for the pains of monthly menstrual. However it helped me to work more. The money I earned was for my own needs. But I would give my kids whatever they wanted. Probably I was bribing them for what I was using. As my drug use progressed, I could not hide it from workers and customers. I tried to work less and finally closed the Meson.

Shohreh a university student at 29 had experienced the risk of harassment by one of her colleagues. She describes how she got involve with drug in her workplace;

I was secretary of a private company, at the same time student of the university. In my family nobody was drug user, they hated smoking. One day when I was very tired running between university and workplace, a male staff gave me a pill to relax. I took it without questioning. I felt good, and then I asked for another one the next day, then I bought it from drug stores myself. I turned to Shisheh and lost my job and stopped going to university too.

There are many examples of women drug users (with or without skill), who were working for many years but without contract and insurance. *Maryam* young women divorced from two husbands, mother of two sons, have stopped drug use by joining NA, talks proudly about successes in her works.

I worked in the company for wedding arrangements and catering job. 10 years ago, I was very successful and easily could make 7-8 million Tooman a month. For some reasons I changed my job and worked in beauty salon. I created new styles of hair cut and I was doing very well. But I started taking Shisheh. Girlfriends convinced me that it does not have addiction. It was for losing weight and I lost everything.

A second example of this group, is 35 years old *Maliheh* who is homeless now. Her second husband died in prison and her son is taking care by Welfare Organization. After her first divorce she lived with her father and worked for 7 years in a factory

and that was the place she met her second husband. But she did not have insurance and contracts were for very short terms.

Sometimes for the support of women drug users, they are referred to employers by DIC's staff. It is like a reference letter so she can be trusted. However it might not work always in her favor and still they face many of the five risks. *Fereshteh* a young girl in her twenties describe her story of vocational training and work.

I know they would teach many arts here [DIC] but I did not have the patience to do those things. I was free from drugs for 3 months when I was referred to a shoemaker. He was paying by shoe; the more shoes, the more money I could receive. I worked one week and earned only 2000 tooman.
I learned that there is a clothing workshop looking for worker. I stayed there 5 months and they paid me 120,000 a month. I found another secretarial job and now I am working for 300,000. It is a Plastic company.
I did not tell them that I have been drug user. But they all got to knew. In the last place, I was talking to a friend, and a male staff heard me using the vocabularies which are known to NA people…. ….
Usually when men know our drug experience, their behaviors change but I mentioned firmly, that I am free and I am doing my job. The employer is satisfied and that is important. So he has stopped harassments.

Female drug users tend to be more risk averse and to work in low wage workshops or industrial sector activities such as garment, food, and clothing. Low wages works as disincentive for others to join the labor market. Not surprisingly, a large majority of drug users/sex workers even when decide to work, they are not able to manage their life at the minimum level from the meager income they get. Of course based on our few interviewees with women drug users who acknowledged their work in sex market, they are not making good income these days too. We were told they receive 2000 to 5000 tooman from each customer. It used to be higher but with new subsidy program; their price has been cut down too!!!

Employers' concerns

Many employers appear to hold negative perceptions of female drug users and are extremely reluctant to recruit drug users. Stability is a fundamental requirement for employers. Few employers prefer to hire drug users who have been free from all drugs for many years. Employers understandably face four types of risks:

- Risk associated with the management of drug use and the need to go to DIC or somewhere to take drugs
- Risk to the reputation of business and employer which is more related to the employment of sex workers/drug users
- Risk to other employees
- Risk of instability which include irregular presence and time-keeping / un-timeliness.

Our discussions with two employers, who had history of hiring drug users and their reactions to our questions regarding their ability to work and the reasons for low wages is reflected in following quotations:

I have one employee who has recovered and is living free of drug for 8 years. We have not been able to teach him to come on time. Or when he is not coming, call and let us know. He does not call and lies about his absence. The problem is they do not have timeliness and regularity

I would never work with women drug user. We have two requirements here: no drug user, no sex worker. I believe prevention is better than treatment. Once we hired one of them and they were persuading other young and inexperienced employees to join their club, and it was really dangerous for others.

Regarding the low level of wages, it is very strange to hear from a faculty member, it is a Capitalist system.[employer was not supportive of capitalist system]. The profit of employers is the most important thing. The wages of all workers are low. When they start working, they do not know anything, they learn by doing and they get probably 80,000 Tooman a month and work 10 hours a day.

….in some clothing workshops they get drugs to be able to work more and when they are addicted, they are fired and some of them end up living in south of Tehran.

The impact of work

With all the risks and difficulties, work has been shown to be an important component of treatment, reducing the likelihood of relapses and helps reintegration into society. The life experiences of DICs 'staffs are good examples.

I am free from drug for over 5 years now. I started using with my second husband. We injected Heroin (brown) for 5 years. I have five children and stopped drugs when my sons were ridiculed by neighbors' kids due to my drug use. My husband died from drugs. I went to camp, and NA. I have finished 12 steps. We were told that it is a triangle; family, work and NA meetings. All these three should be balanced .One would not work without the other. Now I work as DICs outreach and I think I am giving service to those most in needs and this gives me satisfaction.

Zibai was able to work in beauty salon and as business women would go to *Astara* [in north-west of Iran] and *Geshm* [in south] and bring cloths. She raised 7 children with her work and talks about them with pride. *Ameneh* was drug addict for 24 years. She has been free from drugs for more than 7 year now. She supports many female drug users in abstinence treatment as a Guide and is providing outreach services to those in the streets.

Another drug user 45 years old, divorced with a son, describes her life and work experiences.

I *have worked all my life, now I am working in bag making workshop. They pay me a certain amount for each bag. I have rented a room for 100,000 tooman. My 20 years old son helps with the rent and I cover the other household expenses. I am happy. I am taking methadone for 5 years now. I wished they [DIC] could give me for a week so I do not have to come every day.*

Most female drug users have been leading chaotic lives focused around obtaining drugs. Once in recovery they need to fill days that in the past would have been spent sourcing ad using drugs. *Mansoureh* an educated woman believes unemployment will frustrate drug users and the likelihood of relapses increases.

After divorce I went back to my parents. My family is taking good care of me and my 4 years old daughter so I do not need money. But I did not have anything to do all day. I would go from first to second floor many times and were really frustrated. Now I am working as staff member in DIC. I feel very good. I learned painting on T shirt. We painted many and sold.

Having something meaningful to do gives women drug user confidence and has positive benefits for their well being. It has worked as a vital factor in recovery from problematic drug use and reintegration into society. However it can be a long term challenge to get some of drug users fit the job. They are most challenging groups to help but equally the benefits of doing so will be considerable to women and society.

The chances of income earning and work encourages those in treatment to increase their recovery capital; improving their self-esteem, self-confidence but with low amount of wages, the need for better access to stable accommodation is left to be met.

Housing

The housing needs are often overlooked in harm reduction strategies and treatment programs. Unstable housing conditions are associated with poorer physical health, mental disabilities, fewer social supports, minimal education, and little employment history as well as vulnerability to HIV infection (Health Canada 2003). Housing for women drug users is more important because homelessness has various consequences and the most obvious, experiences of humiliation and violence.

Among interviewees of this study, the group of higher socio-economic status, probably due to their family support and types of educational program in 11 months of treatment (to be satisfied with what they have), no one had any comments on their residential situation. When the issue was raised, their response was: *"it always could be better but we are satisfied"*. In contrast, for women drug users in south of Tehran, housing was one of the two main support services in need.

The degree of its importance depends on their present situation; (a) being able to rent a room or (b) living in shelter or park. Each of the two situations has different difficulties but generally women drug user/sex worker have housing problem for many reasons:

- The types of houses and rooms available to rent
- The amount of rent
- Forced to move out and looking for new one repeatedly
- The expectations of neighbors
- The possibility of relapses with addicted neighbors
- The expectation of landlord (when works as a pimp
- Insecurity

The amount of rent is a serious problem. With the low level of wages and earnings from sex work, they are forced to provide services to many costumers in order to be able to cover living expenses, drugs and rent.

Elham with mother and brother drug users was sold by her mother to a rich man when she was 12, does not want to live with them. She has rented a room for 70,000 Tooman and lives with her 4 years old daughter. She was hospitalized for a month and was not able to pay her rent for 3 months. Landlord had asked her to move out. DIC talked to landlord and had to help her to stay.

Setareh was unable to rent a room after the death of her husband and moved to shelter. They did not allow keeping her 7 years old daughter and unwillingly give her to a family [*welfare*]. She sells toilet papers and …in the street and makes 2000-3000 tooman a day. She likes to see her daughter but was advised by counselor not to do so. She hopes to rent a room and bring her back.

Insecurity in the houses with too many drug dealers and addicts as dwellers is another problem, particularly for those women who are in abstinence treatment.

The story of two sons of a landlord who raped 15 years old daughter of the drug user, while the mother was in DIC receiving her daily methadone, is one of the most shocking violence which probably never reported and nobody kept accountable.

Monireh in her forties is homeless now. She talks about the last room she had rented.

I rented a room in a house which landlord worked as a pimp. I was not feeling good and did not work much. I did not pay the rent. One day he kept me in his room for 3 days and brought customers, to the point that he made the amount equal to his delayed rents and then let me free. I could not walk for few days. I moved out and now I stay either in shelter or park.

Sometimes the landlord makes an agreement with female drug users to receive part of their income in addition to the monthly rent. We met a mother with two daughters who all were drug users and sex worker. For each customer they would pay 5000 Tooman to the landlord and the rest was theirs.

A service provider describes the experience of one of the women drug user who is 25 years old; just to show the significance of housing in their life:

… She was pregnant. It seems she had found a family to sell her baby and got one million Tooman. She gave the one million to a man so she can stay in his room. She is

taking methadone now and we heard that the man expects her to take other women to his place.

One of the interviewees explains that when landlords are not drug addict or active in sex market, they usually do not live with their family in the same house. Somebody rents the whole house (recently Afghans) with down payment and then rent it to others. The rent of a room is between 50 to 80 thousand Tooman depending on the location and other facilities.

Part of the continuum of housing needs for female drug users is shelter. There is one shelter in south of Tehran but there used to be a half-way housing and another shelter in *Shahr Ray*. The last two are closed down at present. The research team interviewed the counselor and two of the female drug users working in half-way housing. We were told building was provided by the municipality, was old and not safe to stay.

A service provider describes an event leading to the establishment of the first shelter.

Few years ago in winter, when I was leaving DIC five in the afternoon, it was really cold and snowing. A young drug user kept asking me: where I have to go tonight? In that time there was no shelter here. And I told her go somewhere, find a place. So I left. In the morning when I came she was frozen to death. I could not believe what has happened. I was screaming, crying, calling Welfare Organization…. finally after few days the first shelter was running.

The shelter has a supervisor and a resident manager. We visited the shelter and interviewed both of them. Supervisor explains the history, rules and regulations of the shelter.

Shelter was established 3-4 years ago by a NGO with the support of Welfare Organization. NGO had to find few places and Welfare made the final selection. The *shelter is an old two story building which we are not allowed to use the second floor. I think it is not in an appropriate location. We preferred a building near by the street so women would not be under all the neighbors' supervision. We understand their concerns. Due to complaints from the neighbors; we admit women not later than 8:30 PM .They have to leave before 9:00 in the morning. There is a dress code enforced for less attraction. They are not allowed to use drugs in the shelter. Also children are not allowed to the shelter.*

There are four rooms in the building; one for resident manager, one for those women who are free from drugs and two for those who are using drugs with or without methadone.

According to the regulations of NGO and Welfare Organization those free from drugs should not stay in shelter. Although they might be defined as role models but shelter is for drug users and they have to move out.

Supervisor of the shelter explains their situation:

These are the group who do not want to go back to their families (family is addicted or they are rejected by the family) or sometimes there is no family indeed. Their wages is 180,000 to 220,000 but if employers know that they are living in shelter then probably that will be the end of their work. In this area, the abuse is very high by employers and others. They can rent a room for 100,000, and then nothing is left from their income. They probably could rent a place together but our experiences show it is not helpful. If one relapses, the all will relapse. Also landlords would not rent a room to four people.

Sara 37 years old who is cook in the shelter is free from drug for less than two years. Has married two times and has an 8 years old daughter in Welfare. Her parents encouraged her to stop drug use and they took her to camp but it was useless. She started again to the time she was arrested for carrying drug. She does not want to go back to her family .She has left them long time ago. She prefers to stay in shelter and explains with 50,000-60,000 Tooman wages that they pay in these packing workshops for 10 hours of work, they cannot do anything.

Monireh who is not able to rent a room any more explains that one of the problems of the shelter is the fights between women on drugs, lost items or anything.

I am taking only methadone now and I feel much better. I do not like to stay in shelter but the other alternative is park which I do not like that one either. In shelter they fight, even my two sisters who are taking methadone and Shisheh, shout and scream .I cannot tolerate their behaviors. So I move to park for few nights and then I cannot stand park and move back to the shelter. This is the problem of all of us. I wish there was a place at least for people who are only on methadone.

It seems women living in shelter face following problems:

- No children is allowed
- Stealing things from roommates
- Using drugs
- Violence

The resident manager has been drug user for 18 years. Her husband and older son died from drug overdose. She is free from drugs for two and half years and in last 9 months has been working in shelter. She describes the difficulty of shelter management.

We have space for 30 women, but in winter there are many and they sleep on the floor. They are not allowed to use drugs in shelter but they use before entering shelter. Those who use Shisheh and come to the shelter are very difficult to manage. Sometimes they are psychologically sick. There was one who used to talk to wall. She would sit in front of the wall and talk about whatever she remembered. Probably it was illusion but we had to admit her. Sometimes police brings women in the middle of the night, we have agreed to admit them but usually they do not stay long. We serve dinner and tea and I think living in shelter at least means some order in women drug users' life.

In the interviews with service providers all mention extreme cases of violence in the park and streets during the night. They believe men experience violence too, but they can defend themselves. However, when a woman is raped, she is not able to fight back. Such incidents justifies using drugs while in methadone treatment. They believe without drug women cannot survive the night in the street.

Maliheh 35 years old explained why and how she stays in the street and park:

I loved my second husband. After his death, I was homeless living with my son in the rail road; municipality arrested me and sent to jail. They took the child to Welfare Organization. I could not [she starts crying]….He is 7 years old. I used to go and see him but they have changed the place and I do not know where he is now. I prefer to stay with a man who has a place; otherwise I sleep in the street. I have many blankets and when it is raining I use a plastic cover over the blankets. I wished the situation could change as such that I could live with my son.

…

The supervisor of the shelter thought the best way out for these people particularly the young drug users, is work and transitional accommodation. She believed drug users during treatment would be more safe and active if they find jobs in workshops that the workers and employer are female. She emphasize that work has great positive impact on them if they have a place to live. She discusses the experience of one of the DICs as a good practice.

Women were given hook and thread to make filament and for each one, they could receive 500 Tooman. They continued knitting during the night. Sometimes they could make two a day. There were prizes for those who made very clean and nice ones. I know working all day for 1000 Tooman is not good enough and they make 10,000 a night by sex work, but self-esteem is very important.

A service provider once said: "*Home is like a cloth which covers your body. When there is no home you are always naked"*. The service providers in shelter and residential treatment (*Camp)* with the experience of working and supporting different groups of women in abstinence treatment or methadone substitution and illicit drug use strongly suggest:

We have to separate those women who are free from drugs and those who want to stop but due to housing problem, do not get into treatment. We need a place similar to university students' dormitory. They can pay monthly rent and have a safe place to live. At least we should support them in transitional period. This is a period that they should be trained for job. This is the duty of Welfare Organization.
We should focus on younger group. There are 20 years old girls who are free of drugs but no place to live.

Access to descent housing influences incentive of women drug users to join treatment programs. Investment and efforts of drug treatment is lost without solving the problem of accommodation during treatment and at least few months after. Homelessness strongly deters the health situation physically and mentally and increases the risk of unsafe sexual relations of women drug users.

Health

Evidences of the link between injection risk behavior, sexual relationships and HIV infection have resulted in drug treatments' focus on health sector. Achievements of drug substitution treatment and harm reduction is a worldwide phenomena, however lack of affordable services and effective referral system leaves a large number of drug users' health problems untreated.

Women health determinants intersect with their drug use behaviors and treatments. Access to qualified services on physical, psychological and reproductive health can in turn support their treatment experience.

Among the women drug users in our study most of them have initiated or were encouraged to initiate drug for their physical pains and few for psychological problems. Assuming they are not justifying their behavior and blaming others, it means women are more vulnerable to pains and psychological pressures. They also postpone treatment of the health problems for limited awareness, incorrect perception of illness, financial problems and traditional attitudes towards gender role; therefore they live many years of their life without health.

Women drug users, particularly injecting drugs, experience a wide variety of health issues, including high prevalence of HIV, hepatitis C and B, sexuality transmitted diseases, a variety of chronic and acute physical health concerns.

Most of the interviewees in our study have experienced one or more health problems in recent years (during or after treatment) but service seeking behavior is not common.

Sima 26 years old has been drug user for almost 10 years. She has a four years daughter who is living with her father. She explains her health problem.

I started at 16 and have consumed almost every kind of drugs. I used to gnaw my nails and thought drugs would help which did not. I have tried abstinence in Camp but I got back to drug again. Now I am is abstinence treatment for two and half months. I cannot stay at home because my father is annoying me and I come to DIC just pass the time. I have heart problem and had to take pills. It got worse when I was using Shisheh. Last night I had pains two times. Doctor has told that I need to do few tests but I could not do it .It costs 80-90 thousand tooman. I went to Imam Khomeini hospital but with no insurance they did not do it for free.

Ziba in her late fifties have used drugs for over 15 years. She does not believe in methadone and has been trying abstinence treatment for 7 years without success. She describes her medical problems

I could not breathe and doctor told me I have serious problem with my lungs and should not smoke anything. I stopped drug use for 2 months but relapsed for something that happened to one of my sons. Last year I felt I am dying. I was hospitalized for 3 days and doctors told me I have gastric problem. I paid only 7000 only for one of the pills. I thought probably I will be reimbursed by DIC but they did not. So I could not continue my treatment.

Based on interviews, respiratory and kidney problems is very common among women drug users but usually it is left untreated.

The country's policy on HIV prevention is very well reflected in 3 women DICs activities. Among interviewees, women with injection experiences have taken the test of HIV, HCV for at least 3 times. Those women without injection can take the test when they are ready or counselor and doctor has advised them to do so.

The more experienced DIC (*Khaneh Khorshid*) has the possibility of doing a primary test and based on its results women will be referred for further tests and treatment to other relevant clinics. But the next steps in HIV test are not easily done. This is the experience of two of the service providers:

With HIV final test, our problem is timing. Women drug users come to DIC 10-12. If we want to do blood test, we have to get the blood to Blood Transfusion Organization [Enteghal Khoon] before 2:00 which is almost impossible. We have had many arguments with them. I wish there was a closer clinic in south of Tehran to do the test.

A second problem with HIV test is that women drug users do not want to take the test. These are three different cases:

Woman was not willing to take the test while with positive results of our primary test we were concerned that it is a HIV+ case. She was pregnant and had already few children. An intern was specifically helping her. But finally she did not take the test and we could not force her.

There was a woman, who was not drug user but sex worker and HIV+. She participated in our educational programs. She was pregnant. Our counselor and doctor talked to her. We gave her a letter to take to maternity hospital. She lost the letter 3 times. Finally she went to hospital without the letter and she had a natural birth.

We had a 17 years old girl drug user and HIV+. I sent her to hospital with social worker for the final test and they confirmed that she is positive. I tried to convince her to take her drugs and to do surgery (Sezarein) for child birth. Finally she went to hospital without telling anybody. She was breast feeding her daughter.

The necessity of developing a referral system has been recognized by all 3 women Drop-In Centers but it seems different factors are affecting the extent of this system:

-The experience of delivering services to female drug user and working in the area
-The interpersonal relations
-The budget limitations and fund raising
- The focus of Welfare Org. and Medical Universities.
    The first one promotes more social approach
    The second one promotes more medical approach

Therefore all three are focused on health issues but the extent of services and referrals are very different. The two DICs affiliated to Family Planning Association and

supported by Ministry of Health /Medical University have full time midwife. One of them actually is located on the second floor of a public clinic and the second DIC located in south of Tehran has not developed a referral system yet (only one pharmacy is cooperating for drugs). Both of these institutes are sincerely supporting women drug user based on their mandates and financial capacity. Their effectiveness needs few years to be recognized.

The more experienced DIC have developed a policy for their financial management and a referral system mostly based on personal relations and local organizations' acknowledgement of their activities. A member of the management team explains:

Donors do not pay us directly, they transfer the money to clinic's or pharmacy or hospital' account and we send the patients with letter and doctor's order. We work with a 24 hour clinic which has all the services. Therefore the visit and drugs are free. When women need to go to ophthalmologist, after doctor's visit, if she needs glasses we pay 20-30 thousand Tooman and they have to pay the rest.
We used to have midwife and gynecologist and there is a room and equipment but sometimes it is difficult to find professionals who are willing to come to this area and work with these groups. So there is a public clinic with gynecologists on Tuesday and we refer women to those doctors.
Of courses all the educational program for health such as HIV prevention, safe sex, STI symptoms and prevention and personal hygiene is carried out by experts once a week.

One of the experienced service providers explains their difficulties when health is involved with legal issues. For example when women need surgery, they are facing serious problem; husband or a close family member should permit and sign the papers before surgery. Or when they do not want to get pregnant, to do Tubal ligation they need husband's permission and sometimes there is no man as husband.

A daughter of our client was pregnant with neighbor's son. She brought her ID and we got one year insurance for her so at least she can use it in maternity hospital but the boy who claimed are temporary married did not want her to have insurance. It is in my drawer now. Why? Probably he thought it will be used as a document against him for taking responsibility of the child.

Service providers also appreciate the support of some of the doctors who help them voluntarily. They talked about a married drug user who had hepatitis and was pregnant. She needed treatment and finally they found a doctor who helped her and did not receive anything. It could cost over 400,000 Tooman.

In the interviews with services receivers and discussing their access to health services, they all were appreciative for what they have received. For example *Elham* who has taken tests of HIV, HCV explains:

They help us a lot. When my 4 year old daughter does not feel good I bring her to DIC for doctor's visit. I have done it many times; I do not take her to other doctors. When I injected those things and was acting crazy, they called ambulance and sent me to hospital. I was there for one month. I feel better now.

Fereshteh another client of DIC with injection experiences said:

I have taken the test of HIV and HCV three times. I do not know the results but I guess I was healthy. I went to gynecologist in other DIC [Mikhak]. But these things were not important at all. I did not care. I did not use condom, never.

Service providers try to hold educational classes close to lunch time and midwife or psychologists explain the danger of unsafe sex but it seems there are some problems.

We try to convince them to use condom but their sex partners does not like it and a women who gets 4000 Tooman for sex how can convince the men to use condom ? When men use drugs, they mostly lose their desires for sex but when women use it seems they get high and when they are high, they cannot stop unsafe sex.

Providing dentistry is the most difficult services. The management of DIC explains that it has been really 4 years which they have been looking for a dentist or clinic. They are concerned that the patients from DIC are HIV+.

Now we send them to a Clinic for pooling teeth only. But they do not know that we are working with female drug users. Morally I do not send HIV+ women to the clinic. With very limited budget we cannot send all those in need.
Once I told to a male dentist: "How do you know all those who are coming to your clinic are safe and not HIV+? When you do not know it, women from DIC are just like them".

Vida a very young women, 27 year old, illiterate, living with a friend had very bad tooth pain the first day we met her. Almost all her teethes were black and broken. She told doctor of the DIC has given her antibiotic and a letter to go to clinic.

Addiction to drugs results in serious chronic health problem for both men and women. However for women drug users with negative attitudes towards their behavior and community's stigma added to psychological problems, there are different challenges to health and may require different treatments and support.

Mental health

The profile of women drug users who come to treatment is different from men in terms of severity of associated problems. A history of abuse, assault and violence can increase the risk of drug use and mental health problems. Whether psychological disorder is prior to drug use or after, more likely for women precede the drug use while for men it is more likely a consequence of drug use (UNODC 2004:9-10).

Women may have higher concurrent disorders and more mental health problems than men (Health Canada 2003). Therefore women report higher rates of psychiatric symptoms than men such as anxiety, depression, eating disorder and suicide. Among 19 interviewees in south of Tehran one case of recent suicide attempt and one case of self-burning in the past is mentioned.

Shabnam in her forties, married once, takes the responsibility of her drug addiction and shows us her body and describes bitterly what had happened to her.

I was very young when I married only 12-13 years old. I was not getting pregnant for many years and my mother in-law was blaming me for not being a good wife and God do not see me worth having a child. So one day when my husband was not at home, I took 20 liters of gasoline and burned myself. The neighbors came to help, I was survived. But after so many years you can see my burned hands, elbows and neck.

Raheleh a young girl at her twenties, not married yet and taking the responsibility of her mother and sick brother has attempted suicide 2 times. She does not see any good things coming from this type of life. She does cleaning job with her mother in people's houses. She has high school diploma and many other certificates. She explains how her father was sick in the hospital and got lost. She thinks she will attempt suicide again.

The story of few drug users with extreme psychological problems living in shelter was known to everybody. Probably the flights and dragging in the shelter is much more understandable considering the life time depressions and psychological pressures of most isolated and excluded women drug users.

Sometimes unhappiness and anxiety encourages women to use drug with the assumption that it would help to get over the hard times. *Molouk* a young girl from a middle class family explains how drug use led to more mental problems and hospitalization.

I was very depressed at the same time aggressive. I went to many doctors. I really thought everything is finished. I used LSD. I had to be hospitalized two times for few months. They wanted to give me shock but my mother did not agree. Now I am in outpatient treatment [Congress 60]. It is unbelievable, a genuine miracle. I have changed .I am more close to God now. I understand we have power to change and move to a higher status. I have passed through darkness and depression. I do not think God is responsible for what happens to us, it is us. I have learned to be a good human being and enjoy the beauties of the life.

Among interviewees there was another woman in her forties on methadone treatment who explained her psychological problems from childhood and the effect of poverty in their life. She was hospitalized in *Razi* for a month which she thought was the worse experience of her life. She described how patients were treated badly and impolitely. She thinks it did not help her at all and she feels worse.

There was a green thread on her wrist. Out of curiosity we asked why she has put it on. She explained that somebody had brought it from Imam Reza's shrine and she hopes that would help her psychological problems.

Regarding the services of mental health the DIC manager explains:

We have close contact with Razi hospital for psychiatric help. We make the appointment and send the patient. We usually have students of social work for their internships who help women by visiting their home.

Based on the interviews with all service providers and psychologists, cost is an issue in mental treatments too.

While they have mental problems when we refer them to public hospital, they are asked to down pay 70,000 Tooman and an MRI for 100, 000, .how she is able to pay such money? We pay a part of it and for the rest she has do sex work, isn't that sad?
…
The managers of DICs are usually graduates from the psychology discipline and take the responsibility of counseling too; otherwise psychologist and/or counselor are hired to work with women drug users individually or in group.

Among our interviewees and the files of those in residential and methadone substitution treatment, the history of abuse in childhood by father, brother or a close relative was mentioned. Experience of abuse in adulthood by partners regardless of their relationships status was almost a common attribute

Counseling on violence and sexual assaults is a critical component in determining quality of care for violence survivors. One of the psychologists with few years of experience explains the types of supports she provides for clients.

I have counseling session with those who want to talk to me. Also I have weekly sessions with those who I think they need help. The truth is they all have problems. We have group therapy with 12 of them. Sometimes they need somebody to talk to. I try to teach them life skills. I interview all the new comers, if I recognize they need medical support, I refer them to psychiatrists and other professionals.

From my experience sex workers are more under pressure. I have talked to all of them; they do not like what they are doing. But they do it for living expenses which includes drugs too.
Some of them have experienced extreme violence; sold by their own mothers, raped by father or brother,… They are also depressed for rejection by family, their partners. They are aware that they are not accepted by community.
Men can go back to life whenever they decide but women sex worker/drug users are at the end of the line that is why they do not care for their health.

There a widespread consensus among doctors, midwife, psychologists and all service providers that majority of female drug users have personality and psychological problems and they need a long term psychological support probably for 2-3 years. It seems they have not lost only their National ID card but they have lost their self-identity and provision of mental health services within treatment institutes is an urgent need.

Reproductive health

Women who use drugs and are pregnant need extra support. In fact, drug using pregnant women and their unborn babies are more likely to experience problems relating to malnutrition, lack of sleep, lack of medical care. (Alliance 2010:26)

It seems in the network of women drug user in Tehran reproduction is more a cultural issue than a health concern. Some of the women drug users' monthly menstrual is disrupted and for irregular menstruation they do not approach health services; therefore they are not aware of their pregnancy for few months.

A midwife explains the services which are available to women drug users:

We have free service for family planning. Also we provide 2 pills for cases in which condom is torn. Since last year we have offered an injection which prevents pregnancy for 3 months. Only 3 or 4 young sex workers have accepted to have this injection. Women drug users should use condom for HIV and not pregnancy prevention.

The number of unwanted pregnancies (an indication for no condom use) is so immense that all service providers are very seriously concerned. They believe these women's pregnancy is unplanned and the babies are not wanted, so the health of baby is not important for them. They think we should give them pills or injections for controlling their pregnancy with methadone. Condom should be left to male DIC. We should let men to take some of the responsibilities. One of the service providers explains

We have so many unwanted pregnancies and we cannot do anything. They come to us after pregnancy but we cannot help. We hear that she has sold the baby or left it somewhere. At best it is left in the hospital. If they know who is the father, men do not take responsibility for the baby. We try to help them to prevent pregnancies by taking pills or injection every three months. We wonder why with all these supports, still they get pregnant not once but every year.

However, there have been few cases in which young unmarried sex workers have planned pregnancy with the goal of keeping the men in close relationships and possibly marriage. One of the service providers described the case of the relationship between a very young sex worker and a young man from very religious and traditional family.

His family got him married to a girl from their own. He would not leave the drug user girl. I talked to him and advised him to stay with his wife who has come to his home with so many expectations. But he would not let her go, he said: "his wife does not know what and how to do sex but drug user would do whatever he desire". The girl loved him and finally got pregnant. She really wanted to keep the child but sonography showed the baby is not healthy and she had to do abortion with the permission of doctors and in the hospital. She really wanted the baby for making him not to leave her.

There is another case of traditional approach to pregnancy and bringing a baby to the family for keeping men interested and loyal to women. *Mansoureh* who is divorced now explains how it happened to her.

He did not want baby but since he was going out with others I was advised to bring a child so that might change him. When I told him I am pregnant, he beat me to death. She was born; not only it did not get any better but was much worse.

Pregnant women facing with compounded problems of drug use, financial insecurity and physical and emotional health. To assist pregnant women to reduce harms associated with illicit drug use, prenatal services are provided and they are given methadone two times a day, half in DIC and the other half is take home dose. They are referred for free of charge sonography to clinics but according to reports sometimes they do not use the opportunity.

The mother's health could be in danger due to sexual transmitted diseases. In two DICs (*Khaneh Khorshid and Mikhak Sefid)* they are referred for free or very low costs of STI but it is not possible for the third DIC (*Mikhak*). The midwife explains:

The STI test is expensive. In cases that they have to pay all or a section of the cost and are introduced to a cheaper clinic, they do not go. Mostly we start drugs for infection by seeing the symptoms. When drug user women have STI, we advise them not to have sex, sometimes they do not listen. They need money and continue their sex work with or without condom.

Drug user pregnant women are thought that drug use and poor nutritional status can result in low birth weight and early delivery. Also ensuring HIV+ pregnant women to access prevention of mother to child transmission, with all those education and counseling not always are successful.

Among our interviewees many women continued using drugs when they were pregnant. Some think it has not harm the baby even *Simin* a 30 years old mother who is free from drug now and serving other women drug users as a Guide explains

I did not stop using opium during my pregnancy. Doctor told me it is OK but better not to use drug. I used opium all 9 months and during breast feeding for 2 years .I believe my daughter is healthy and more intelligent than other kids in the nursery.

However *Sara, Monireh, Sima Sakineh* and many others women drug users have different experiences from the impacts of their drug use during pregnancy. Mostly we were told: "*My child died because of drug"* or "*I had so many miscarriages"*.

Service provides acknowledge that the services is not comprehensive, they need much better Para clinical and more importantly psychological supports but cannot afford it. What they are doing is far beyond the funds provided by the government. Unfortunately with the privatization of health sector and cutting the subsidies, costs of services are more critical gender issue now. Since women have limited resources, they are unable to pay for services or are deterred by the prospect of having to pay and as a result may not seek services for their physical and mental health problems or during pregnancy.

7. Conclusion & suggestions

Two groups of women are involved with drug problems:

1) Spouses of male drug users
2) Women drug users

The focus of this study is on the second group whose number and share among drug user society due to powerful stigma is always underrepresented.

As a qualitative study 26 women drug users entering different treatment institutes and 22 service providers have been interviewed in residential and outpatient treatment for abstinence and 3 Drop In Centers in south (east and west) of Tehran.

There are women drug users seeking treatment in all socio-economic classes and they can be categorized into different groups. Based on the most relevant variables affecting their support needs and the intersection of drug use and sex work, the following distribution is observed among interviewees of this study.

	Illicit drug user	*Illicit plus licit (e.g. methadone)*	*Methadone*	*Free from drug*
Sex worker (1)	-	****		
Non-sex worker	-	*******	****###	****####

1) Women who acknowledged their activities in sex market
2) # Women from higher socio-economic group

The data and content analysis of interviews show the importance of four types of relationships in women drug users' life:

- Relationships with others : family, children, co-workers, social network , control over resources (material, human, financial)
- Relation with sexuality: husband , steady partner (temporary marriage), clients and their image and control over their body
- With self: self-image, self-confidence, coping skills and assertiveness.
- Relations with spirituality: God and super natural forces.

It seems treatment institutes mostly invest on one or two of these relationships, and support programs which women drug users need, is very much affected by the type and effectiveness of the treatment. For instance outpatient treatment of Congress 60 works mainly on the last two relations. In 11 months or more, women go through processes of change by peer education. The whole program is based on:

1) Self determination and educating women to acknowledge their rights to control and improve their own situation. Take ownership over processes and outcome of the treatment.
2) Developing networks among peer groups to tackle their problems
3) Upholding privacy and confidentiality
4) Education on believing in God's supports and their own decisions in life.

Women drug users in the recovery from dependent drug use are constructing a non-addict identity. The importance of such new identity is obvious in free from drugs groups' discussions on their past, sexual relations and temporary marriages. The narratives of their recovery process shows they are seeking to achieve this new identity by:

- Reinterpretation of aspects of their drug using lifestyle
- Providing convincing explanations for their relapses and recovery
- Reconstruction of the sense of self

Such an attempt of re-construction is reflected in the common concepts and vocabulary they use in their narratives. Shared terminologies indicate that the new identity might not be so much the result of the intrinsic nature but a product of interactions between drug users and service providers and recovered peers working with them.

The role of significant others in treatment and self efficacy through psychological empowerment in addition to family supports have resulted in positive changes based on most interviewees' reports in this type of treatment.

However for the second group of drug users in methadone treatment or abstinence in Camp psychological empowerment cannot be a stand-alone strategy, it needs engagement of different organizations for gaining internal skills and overcoming structural barriers to accessing resources. For this most vulnerable group "Power within" should be integrated with social supports of education, legal assistance, childcare, violence protection and the most important supports for them; economic (employment, vocational training & income generation)and housing (shelter and transitional accommodation) and health.

Reviewing the services provided to the latter group (lower socio-economic) and on methadone maintenance treatment (from perspective of service receivers and service providers) shows that these institute are very young (2-5 years of work) and have not been able to deliver a comprehensive service programs yet. The more experienced Drop In Centers is providing services to most vulnerable groups of drug users/sex workers and with budget limitation and unwillingness of professionals to work with this group of female drug users, they are trying very hard to help.

As was discussed in methodology section application of qualitative method in distinguishing good practices could face few challenges:

- The language usually used for reporting tends to be very emotive, therefore to focus on defined criteria for good practice is not easy
- Social support services are described in the form of incidents. One or two cases of provided services are highlighted. This leaves researcher with the impression of service delivery but they say very little about the establishment of a system and effectiveness of scale
- There is no option except keep ignoring the numbers reached of the target population

This is not to belittle the efforts of the treatment institutes and the difficult work of service delivery but to remind us that for good practices we need a system and one or two good incidents may deter us from further learning. Therefore impact evaluation and information on program's effectiveness in bringing up positive changes in the women drug users' life and for identifying good practices remains to be solved in the future.

As a trial we can apply the developed framework of good practices for gender responsive program (section 3) and learn the gaps in the framework or services. This is not an evaluation of the Drop In Center and those marked "Yes" are exactly based on incidents reported to research team. There is always possibility of incidents which are missed and interviewees forgot to mention.

Standards	*Activities*	*Yes*	*No*
1) Does Treatment Institute communicate with those in the position to support women drug users to access services	**Identify and communicate with community leaders, religious leader*		✓
	** Health care management & health providers*	✓	
	** Join the local community organization and meetings*	✓	
	** Raise community awareness of services by posters in stores, health centers, …printed materials (brochures, pamphlet,….) in drug stores, clinics*		✓
2) Addressing stigma and discrimination related to female drug use	**Educate communities on drug use and women drug users*		✓
	**Educate police and other authorities on women drug users' problems*		✓
	**Support drug users to form networks*		✓
	** Advocate for human rights protections for drug users*		✓
	**Support drug users network to advocate for their rights*		✓
3)Create a safe, supportive and women-nurturing environment by hiring staff that reflect the client population in terms of gender, recovery status, and other attributes	**Involve ex-drug user women in service, staff member, volunteers*	✓	
	** Provide a forum for women drug users to discuss their concerns*		✓
	**Hire only female staff*		✓
	**Involve trained, qualified staff &,gender sensitive*	✓	
	** Provide mentors , female role models that reflect cultural background of clients*		✓
4) Provide low	** The service is located in short distance from*	✓	

threshold services/harm reduction which fits women needs and daily responsibilities	*drug users community and in a discrete location* **Working hours are according to women's daily schedule and probably in the evening & weekends,* ** Provide free or low cost services* ** Outreach for accessing marginalized women* **Home visits for those unable to come to institute* ** Minimal rules and daunting paperwork* **Provision of basic needs; food.* **Provide women information and education on HIV/AIDS ,TB and HCV prevention* **Provide testing for HIV,….* **Availability of drug substitution treatment in flexible schedule* ** Arrange for take home doses of methadone for pregnant women or those with small children* **Dispensing of NS , condom for women and men and sanitary protection* **Provide showering and washing facilities* **Accompany women to medical care services* **Provide access to antiretroviral and tuberculoses treatments* ** Receive women's feedback by staff*	 ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓
5) Incorporate sexual and reproductive health into program of harm reduction	** Identify needs of women drug users and its changes through on-going assessment* **Provide an examination room for gynecologist* **Arrange for regular visit of gynecologist at least few hours a week* **Inform women about the service and presence of doctor and gynecological consultation* **Provide STI test and treatment* ** Promote women's regular visit with doctor and checks for STI, Cancer,…* **Arrange for mentor or staff accompany women to the doctors, especially those with mental health issues or chaotic lives* ** promote and provide access to male and female condom* ** Educate women on planning for pregnancy*	 ✓ ✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓
6)Provide education and counseling and psychological support	**Counseling on health relating issues by doctors* ** Counseling on pregnancy, nutrition and stress*	✓ 	 ✓

services for women drug users and their partners	*management and STI by gynecologist and psychologist* **Counseling on HIV, hepatitis* **Counseling and support women after HIV diagnoses* **psychological support and counseling on mental health (depression, disorders,..)* **Counseling on family problems and relation with children* ** Arrange activities to focus on self-efficacy* ** provide education and counseling on communication skills and life skills* ** Refer women to psychiatrists and mental hospital, if needed*	 ✓ ✓ ✓ ✓ ✓	 ✓ ✓
7) Provide violence prevention education, counseling and treatment services for women and their partners	** Educate violence reduction skills* ** Provide education on domestic violence and women's rights* **Enhance women's knowledge on threatening relationships* **Provide counseling & treatment for those experiencing sexual abuse and assaults* ** Create a link with local police, crisis center and support women for reporting (if they felt they want to report)* ** Provide access to a safe shelter* ** Provide social support for violence mitigation*	 ✓	✓ ✓ ✓ ✓ ✓
8)Provide education and services for pregnant women, mothers and children	**Ensure MTCT for pregnant women* ** Provide education on child development* ** Provide education on nutrition and safety of fetus* ** Consider priority of pregnant in MMT list* ** Provide information on drug use and its impact on the fetus* ** Promote and educate pregnant to use methadone* **Provide prenatal care* **Encourage childhood immunizations* **Inform pregnant on the importance of breast feeding milk* ** Provide infant formula and food for certain period* **Provide on-site child care facilities* ** Educate good parenting skills* **Educate healthy relationships with children* ** If possible, try to reunion with family and*	 ✓ ✓ 	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

	children **Provide age appropriate activities for children*		✓
9)Provide opportunities to develop a range of educational and vocational skills for income generation	* *Assessment of women's drug users capacity to work* **Provision of psychological support to be prepared for work* **Provide vocational trainings based on their interest and market demand* **Provide adult education (if needed)* * *Educate soft skills necessary for working women* ***Provide access to micro-finance*		✓ ✓ ✓ ✓ ✓ ✓
10)Create a strong referral system and networking with other services	**Linkages to community based health services, HIV/AIDS,HCV,TB & maternity hospitals & mental health services* **linking to agencies for shelter , transitional accommodation & housing* **Linking to police for support* * *linking to employment agencies & job placement* **linking to child welfare Org.* * *linking to violence crisis centers* **Linking to peer support groups* **Linking to other drug treatment institutes*	✓ ✓ ✓ ✓	✓ ✓ ✓ ✓
11) Support peers involvement and develop a educational program for on-job training of staff on the most relevant issues to women drug users and/or sex workers	* *Provide gender responsive and culturally competent in-service staff training on drug use sex work* * *To support peers education by selecting the right people* **Assigning tasks to peer educators with supervision* **Appropriate use of educational materials* **Provide training for staff should adult learning principles*		✓ ✓ ✓ ✓ ✓

Based on the findings of the study and learning from programs and practices in other countries a wide range of gender responsive programs should support women drug users to move towards recovery and reintegration into society. We need to:

- Build motivation & aspirations
- Treat physical & mental health problems
- Stabilize drug use (only licit drugs)
- Provide appropriate stable accommodation

- Develop soft-skills through volunteer works for public
- Vocational training and skill development
- Work trials for a short period with the cooperation of employers
- In-work support

The needs of those women drug users' who are more isolated and have been disconnected from learning institutions and job market for a long time or do not have any work experience must be met in treatment and rehabilitation centers.

Motivation

A large number of women drug users feel powerless and hopeless. Change in lifestyle, relationships with significant others, addressing all the issues that led to drug use is not easy process. Enhancing motivation is critical to their recovery which should be carried out through psychological and counseling supports. Educational programs on enhancing self-confidence and self-esteem has proven its usefulness in Congress 60's programs. Peer groups provide great incentive however greater use of incentive and change could be explored.

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Accommodation

The availability of stable accommodation is a critical factor in the treatment process and is a foundation to encourage and facilitate women drug users' employment. Difficulties with the housing situation in south of Tehran; high rent and very limited number of shelters and no accommodation during transitional period is affecting the efforts and incentives of ex-drug users. Women drug users free from drug are avoiding to live with other drug users and some cannot or do not want to go back to their family. Experiences of other countries prove that accommodation for maintaining motivation is much more important than drug treatment. Appropriate and affordable accommodations for women drug users on methadone treatment programs are very critical.

Mental and Physical health

Psychological problems of women drug users whether predated their drug initiation or are the consequences of drug use needs a long term support of psychiatrists and psychologists. The mental health issues of women drug users is so severe that it should not be left to only counselors and young psychologists. There is full consensus among service providers that Psychological support must be included as part of drug treatment program.

Women drug users physical health problem are mostly direct outcome of drug use, such as heart or lungs problems, damage to veins due to frequent injections, HCV …Their physical health needs supports which with the DICs health orientation and an effective referral system it could be achieved.

The provision of affordable and accessible health services will have consequences for women drug users training and employment.

Family and social network support

In our culture, family support (financially and emotionally) is the most important social support for drug users in treatment. However some women drug users due to their bitter experiences of abuse, violence or drug addiction of family members are not able to receive any supports from family. Therefore in drug culture family can be a part of solution for some and sometimes family may be part of the problem. In these cases support from service providers is very critical.

Peer support group such as those in Congress 60 or NA, can play an important role throughout the treatment and rehabilitation process. The family, service providers and peer groups' support is critical in maintaining motivation and confidence for education and engaging in labor market and employment.

Vocational training

Many female drug users have dropped from school and disconnected with learning institutions when they were very young. Therefore they need provision of basic skills training as well as more practical vocational qualifications.

The vocational trainings offered need to relate to the job opportunities in the area. Probably gender roles and traditional skills could be transformed by the diffusion of ideas on new skills and woman's practical experience in short term trails.

Work trials

Taking note from the experiences of other countries, and for creating motivation in women drug users to maintain their treatment, they should not be perceived as free labor. The duration of trial should be clear from the start of the program.

The low level of wages (one fourth of minimum wage defined by government) due to profit seeking private sector in Iran (probably everywhere) and ignoring the rights of labor and responsibility to provide minimum living expenses has resulted in women drug users more economic exploitation. Such low wages is serious disincentive for entering treatment programs. Probably employers (hopefully) females could be more sensitive to their employees' situation and willing to support them by better payment.

Mentoring and support

Women drug users who have not participated in labor market or have left job market for a long time need mentoring and support in their workplace. Probably first group of women drug users at work can take the responsibility of mentoring and coaching the new employees. With mentoring and support employers might be more concerned to the labor's situation ,at the same time confident that problems of new labor would be dealt with before it creates problems for employer or other workers.

Limitations of the study

We acknowledge that as a qualitative study the interviewees (samples) are not representative of all female drug users in Tehran. However Drop-In Centers for women and treatment institutes of non-governmental organizations most active are covered.

As the study were limited in time, the demographic and some socio-economic data were extracted from the files of new entries and service receivers of one month (except Congress 60) which could be extended to all the records of the institutes. We learned that assessment forms (application) of different centers do not cover similar information; therefore common variables were identified based on the available data.

Finally cultural and legal barriers restricted the amount of information on activities in sex market, particularly among higher socio-economic group.

Definitions

Best Practice fall on a continuum ranging from those practices that are well established and have clearly demonstrated their effectiveness to those that show promise or may be exemplary, but have yet to be fully evaluated and their results documented" (cited in Pettway 2006:1 from Wilkinson 2003).

Drug rehabilitation is a term for the processes of medical and/or psychotherapeutic treatment, for dependency on psychoactive substances (e.g. prescription drugs,…) and so-called street drugs such as amphetamine, Heroin (brown) .The general intent is to enable the patient to cease substance abuse ,in order to avoid the psychological, legal, financial, social, and physical consequences that can be caused, especially by extreme abuse.(Wikipedia 2011).

Female drug user refers to any women who have used one or more than one type of illicit drugs for non therapeutic purposes in their lifetime. Definition applies to range of women; those who are free of drugs for long time (probably years) and those who have joined drug substitution program.

Female sex workers who solicit their clients on street (park, bus-stand,) and provide services at a place of client's choice (Alliance 2006: 7)

Gender **r**efers to the economic, social, political, and cultural attributes and opportunities associated with being women and men. The social definitions of what it means to be a woman or a man vary among cultures and change over time. (IGWG, USAID, 2009).

Gender equality refers to the principle that, where the needs of men and women are different, resources and programmatic attention should be in proportion to those needs, equal opportunities should be ensured, and if necessary differential treatment and attention should be provided to guarantee equality of results and outcomes and redress historical and social disadvantages experienced by women or men. See http//www.unfpa.org/gender/index.htm (Kai 2010)

Gender responsive program is defined as "creating an environment through site selection, staff selection, program development, content, and materials that reflects an understanding of the realities of women's lives and addresses the issues of the participants. Gender responsive programs are multidimensional and address social (gender inequality, poverty,) and cultural factors (gender role,) as well as therapeutic interventions" (Bloom and Covington 2000: 11).

Gender responsive programs are those, that consider the needs of women in all aspects of their design and delivery including location, staffing, program development, program content and program materials (UNODC 2004:vii)

Gender sensitive refers to Policies and programs and practices responsive to the differences between men's and women's needs, roles, responsibilities and constraints (USAID 2009:1).

Gender mainstreaming refers to the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels (UNAIDS 200000:29)

Gender norms refer to learned and evolving beliefs and customs in a society that define what is "socially acceptable "in terms of roles, behaviors and status for both men and women (UNAIDS 2007).

Livelihood: is a means of living and the capabilities, assts (including human capital), financial, social, physical and natural capital and activities required to sustain these assets.
A livelihood encompasses income, as well as social institutions, gender relations, property rights and access to state-controlled education, health and other infrastructure services (Cornmen 2010:4).

Microfinance plus : is defined as microfinance project that focus on finance and other development issues such as linking credit with skills building and education (cited from (cited from Dunford 2001 in Cornmen 2010:6)

Outreach services are those services provided beyond he usual boundaries of agency activity in order to reach out and engage individuals who have or are at risk of developing a substance use or related health problem (UNODC 2004:40)

Relapse defined as a process to going back to the same unhealthy actions that would enrich the reusing of drugs (Ibrahim 2009:472).

Social exclusion is defined as living in conditions of deprivation and vulnerability; such as poverty, inadequate access to education, health and other services; .destruction of social capital and social isolation, alienation or powerlessness (Wallerstein 2006:17).

Rehabilitation is the process of assisting the drug dependent patient to find back to the society and secure his abstinence (his means male) important components of rehabilitation are: psychological counseling, HIV/AIDS counseling, social/labor reintegration and self-help groups (UNODC, Drug and crime situation in Iran 2011).

Relapse defined as a process to going back to the same unhealthy actions that would entice the reusing of substance of drugs (Ibrahim 2009:472)

Risk refers to the probability that individual become infected with HIV. The degree of risk depends on many factors, such as, the HIV status of sexual partners, sharing injecting equipments, whether contains traces of blood from an HIV-infected person (Alliance 2010: 32)

Sex work can be defined as exchanging sexual activities for money, drugs or other items (UNODC 2010:76).

Sexual violence refers to any attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality using coercion, threats of

harm or physical force, by any person regardless of relationship to the victim, in any setting including but not limited to home and work (WHO 2002 cited in UNAID 2009:7)

Vulnerability refers to the range of factors outside the control of an individual or community that reduces the ability to avoid risk. Such as lack of information, lack of access to services, Stigma, discrimination… increase individual vulnerability making them to be excluded from society r secretive about SW and/or DU (.Alliance 2010:32)

Social capital is the skills, structures and beliefs individual have in order to form scial network, or the glue that helps social networks or communities work together (Alliance 2010:35)

Demand reduction refers to interventions that reduce the demand for drugs through education or treatment (Alliance 2010:39).

Harm reduction refers to policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.

Survival sex [Transactional sex] defined as sexual activities which are traded directly for necessities such as shelter, food or protection. It is assumed that transactional sex occurs with fewer individuals and often known to the women (UNODC 2010: 29 &76).

References

Anil Kumar K. (2004). Economic aspects of sex work, can economic empowerment dissuade women from entering into and continuing sex work? The Journal of Family Welfare, Vol.50, Special Issue. Tata Institute of Social Sciences, Mumbai, India. Pp: 79-82.

Archana Oinam (2005). Exploring the links between drug use ad sexual vulnerability among young female injecting drug users in Manipur. Health and Population Innovation fellowship programme, working paper No. 6.

Beard J.,Biemba G.Brooks M.Costello J. Ommerborn M. Bresnahan M., Flynn D. and Sion J. (2010), Children of female sex workers and drug users: a review of vulnerability,resilience and family-centered models of care.
http:// www. Biomedical.com/content/pdf/1758-2652-13-S2-info.pdf. and
http:// www. jiasociety.org/supplements/13/S2

Beyrer C., Malinowska-Sempruch K., Kamarulzaman A. and Strathdee S. (2010).
12 Myths about HIV/AIDS and people who use drugs.The Lancet, Vol. 376. Issue 9737.*Pp:* 208-211. July.

Bloom,B. and Covington S. (2000). Gendered justice: Programming for women correctional settings. Paper presented at American Society of Criminology, USA (November).

Bogart M.A.,Kral H.A., Scott A., Anderson R.,Flynn N.,Gilbert L.M.,and Bluthenthal N.R. (2005). Condom attitudes and behaviors among injection drug usrs participating in California syringe exchange programs. AIDS and Behavior, Vol.9.No.4, December.Pp:423-432

Chronister J., Chin Chou Chin ,Frain M., and Cardose E. (2008). The relationship between social support and rehabilitation related outcomes: a meta-analysis. Journal of Rehabilitation. April- June.

Cornmen H. (2010). Microfinance, HIV, and women's empowerment. AIDSTAR-One. Technical brief USA. September. www.aidstar.com

Center of Excellence for Women's Health (2010). Gendering the national framework, women-centered harm reduction. British Colombia, Canada.www.coalescing-vc.org

Crabtree, B.F. and Miller W.L. (1999). Doing qualitative research .Thousand Oaks, CA: Sage Publication. Center for Addiction and Mental Health.

Covington S. and Surrey J.(1997). The relational model of women's psychological Development: implications for substance abuse" in Wilsnack and Wilsnack (eds) New jersey .www.stephaniecovington.com

El-Bassel N. Terlikbaeva A.B.and Pinkham S. (2010). HIV and women who use drugs: double neglect, double risk. The Lancet.Vol 376, Issue 9738.Pp312-314 (July)

Falkin P.G. and Strauss M.Sh. (2003). Social supporters and drug use enablers :A dilemma for women in recovery. Addictive Behaviors.Vol.28. Issue 1. January-Fenruary .Pp: 141-155.

Health Canada (2003). Best practices; early intervention, outreach and community linkages for women with substance use problems. www.hc.gc.ca.

Ibrahim F. and Kmar N. (2009). The influence of community on relapse addiction to drug use: evidence from Malaysia. European Journal of Social Sciences,Vol.11,No.3.Pp: 471-476.

Interagency Gender Working Group of USAID (2009). Gender and reproductive health 101 training module , Washington DC,USA .
http:// www.igwg.org/training gender 101.aspx.

International Harm Reduction Development Program (2010). Making Harm reduction work for women. The Ukrainian experience Open Society Institute. New York. USA.

International Harm Reduction Development Program (2007). Women, harm reduction, and HIV. Open Society Institute. New York. USA. (September).

International HIV/AIDS Alliance (2010). Good practice guide, HIV and drug use: Community response to injecting drug use and HIV. www.aidsalliance.org/publications (last accessed March 2011).

International HIV/AIDS Alliance (2006). Key indictors for frontiers prevention project: Report on baseline study in Andhra Pradesh, India. (Updated February 20006) www.aidsalliance.org/publications (last accessed March 2011).

Kammoun F.M., Zerrouki K. and Laqueille X. (2009). P01-04 predictive for successful rehabilitation of the drug addicts: “Ligne de vie” association experience. France .

Kramarz P. (2009). Developing harm reduction services for female injection drug users, a training for service providers, Department Health, Education and Social protection GTZ Germany.

Lancet (2005). Sex-Work Harm Reduction. Vol.366, Review, 17/24/31. December Pp:2123-2134. www.thelancet.com.

Longwill A. (2007). Delivering gender equality, “Rough Guide” to gender proofing your service. Care Services Improvement Partnership (CSIP), West Midlands Development Center. UK. http://www.westmidlands.csip.org.uk

Malaierikhah,Z. (2007). Research on the problems of spouses of drug addicts referring to Treatment Center in East of Tehran. Unpublished MPH Thesis, Tehran University of Medical Science. Iran (in Persian).

Memoona Hasnain (2005). Cultural approach to HIV/AIDS Harm Reduction in Muslim Countries. Harm Reduction Journal 2:23doi:10.1186/1477-7517-2-23.http://www.harmreductionjournal.com.

Mirahmadizadeh AR., Majdzadeh R.,Mohammad K. and Frouzanfar Mh. (2009). Prevalence of HIV and
Hepatitis C virus infections and related behavioral determinants among injecting drug users of Drop-in Centers in Iran. Iranian Red Crescent Medical Journal, 11(3):325-329.

Mohammadkhani , P.(2008). The Personal relationships problems and psychological status of women who had addicted husband. University of Welfare & Rehabilitation, Tehran, Iran (in Persian).

Management and Planning Organization (2005). Fourth Development Plan of Islamic Republic of Iran. Tehran, Iran (in Persian)

Matheou J.A. (2008). Violence and sex work. Learning from the results of monitoring and evaluating community led violence response among female sex workers in India. Alliance.

McFarland Degan H., Myers J.B.,Williams-Petersen G.M., Knisely S.J. and Schnoll S.S. (1993). Drug and Alchol Dependence.Vol.32, Issue 1.March .Pp:37-44

McIntosh J. and McKeganey N. (2000). Addicts' narratives of recovery fro drug use: constructing a non-addict identity. Social Science &Medicine .Vol.50.Issue 10. May. Pp: 1501-1510.

Meadow,L.M. and Morse, J. (2001). Constructing evidence within the qualitative project. In J.Morse,J.Swanson, and A.J. Kuzel (Eds.),The Nature of qualitative evidence (pp.187-200).Thousand Oaks, CA: Sage Publications.

Narenjiha H., Rafiey H., Baghstani A.,Noori R.,Ghafori B.,Solaimani L.,Shirin Bayan P., (2008). Rapid Assessment Situation of Substance Abuse and Dependency in Iran. University of Social Welfare and Rehabilitation. Tehran,Iran.

National AIDS Committee Secretariat (2010). Islamic Republic of Iran Country Report on Monitoring of the United Nations General Assembly Special Session on HIV and AIDS.

Nissaramanesh B., Trace M., and Marcus Robert (2005). The Rise of Harm Reduction in the Islamic Republic of Iran. The Beckley Foundation Drug Policy Program. Briefing Paper Eight. (July)

Noori R. Rafeiy H. Narenjiha H.,Solaimani L.,Ghafori B. and Mirabi P, (2008), Recognition of consequences of addiction on women with addicted spouse. University of Social Welfare and Rehabilitation. Substance Abuse and Dependency Research Center. Tehran, Iran (in Persian).

Ohiri k., Claeson M., Razzaghi E., Nassirmanesh B., Afshar P., and Power R., (2006).

Pettway C. (2006). Best practices tool-kit: Gender responsive strategies.
Ohio Department of Rehabilitation and Correction (DRC), Ohio.

Pivnick K.E., Jacobson A.,Small S.,Templeton V.,Palmer V., and Drucker E (1992). The women's center: A peer support and family therapy program for HIV infected ex-drug users in the Bronx. Paper presented in International Conference on AIDS, July 19-24. (Abstract No.PoB 3412) New York.

Schatz E., Sciffer K., Kools J.P. (2011). The Dutch treatment and social support system for rug users. Recent developments and the example of Amsterdam. The International Drug Policy Consortium (IDPC). Netherlands.

Shaditalab J. and Vedad A. (2010). Gender determinants of HIV prevention among injecting drug users. UNODC,Tehran

Shaditalab Jaleh (2005). Iranian women: rising expectations. Journal of Critique: Critical Middle Eastern \studies, 14(1):35-55.

Silver man J., Decker M., Saggurti N., Balaiah D., and Raj A. (2008). Intimate partner violence and HIV infection among married Indian women. Journal of Americam Medical association. Vol.300,No.6, August.Pp: 703-710

Simmons J. (2006). The interplay between interpersonal dynamics,treatment, barriers, and larger social forces: an exploratory study of drug-using couples in Hartfrd,CT. http://.www.sunstanceabusepolicy.com

Spratt Kai (2010). Integrating gender into programs with most-at-risk populations. Technical brief. United States Agency for International Development (USAID).

Souradet Y.Sh., Shah L., Jolly M.A., and Wylie L.J.(2008). Identifying heterogeneity among injection drug users: a cluster analysis approach. American Journal of Public Health. Vol.98, No.8 (August) .Pp: 1430-1437.

Tasnim Azim, Chowdhury E.,Reza M.,Ahmed M.,Uddin T.M., Repon Khan,Ahmed G., Rahman M.,Khandakar I.,Khan Sh., Sack A.D., and Stratdee A.S. (2006). Vulnerability to HIV infection among sex workers and non-sex workers female injecting drug users in Dhaka, Bangladesh: evidence from the baseline survey of a cohort study. Harm Reduction Journal. 3:33(November). www.harreductionjournal.com/content/3/1/33.

UK Drug Policy Commission (2008). Working Towards Recovery. Getting Problem Drug Users Into jobs. London (December). www.ukdc.org.uk/reports.shtml.

UNAIDS (2000) Gender guidance for national AIDS responses, PCB (22)/08.3.

UNODC (2004). Substance abuse treatment and care for women: Case studies and lessons learned. Vienna. www.undoc.org.

UNODC (2006). HIV/AIDS prevention and care for female injecting drug users. Vienna. www.unodc.org.

UNODC (2010).Female drug use in Pakistan. Mapping estimates, ethnographic results
& behavioral assessment . www.unnodc.org

UNODC (2010). Women who inject drugs: A review of their risks experiences and needs. Secretariat of the Reference Group to the UN on HIV and Injecting Drug Use. Sydney.

US Agency for International Development (2009). Gender-related barriers to HIV prevention methods: A review of post-exposure prophylaxis (PEP) policies for sexual assault. Help Policy Initiative, USA.

Wallerstein N. (2006). What is the evidence on effectiveness of empowerment to improve health? WHO Regional Office for Europe(Health Evidence Network report). February. Copenhagen.

WHO (2004). Harm reduction among injecting drug users. Report on the second Bi-regional partners meeting. Myanmar (13-14 August 2003).