NARRATIONS OF WOMEN WHO USE DRUGS: TOWARDS A GENDER SENSITIVE APPROACH TO DRUG-RELATED SERVICES IN SLOVAKIA

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ABSTRACT

This thesis explores the life story narratives and experiences of women who use illicit drugs in Slovakia. Based on content analysis of outreach reports, semi-structured interviews with women who use drugs and outreach workers from the NGO Odyseus, a wide variety of themes was identified. Women viewed themselves as failing in traditional femininity, which is described in terms of motherhood, housekeeping, heterosexuality and abstinence from drugs. Life stories were mostly narrated in a very negative and self-blaming way. Women who use drugs were mostly uncritical towards existing drug-related services in Slovakia, although according to their life stories, many of their needs are not met in these services. Still, they tend to view their failures in treatment programs as their own fault. The need for gender sensitivity in drug-related services in Slovakia was recognized, emphasizing that these programs work with stereotypes about women as well as about men and services with focus on transgender people is completely missing. Considering intersectionality, challenging gender stereotypes, showing acceptance and respect, and developing a process-oriented approach and comprehensive service were found to be the key aspects of creating effective, gender sensitive drug-related services in Slovakia.

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An idea to realize research on women who use drugs in Slovakia came to my mind almost two years ago. That time, it was only one of the thousands plans I had on my "what to do in the distant future list". I am grateful that this idea could be realized in such a short time, thanks to the possibility of studying at Central European University with financial aid.

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TABLE OF CONTENTS

LIST OF ABBREVIATIONS

CSAT –Center for Substance Abuse Treatment

EHRN - Eurasian Harm Reduction Network

EMCDDA – European Monitoring Centre for Drugs and Drug Addiction

GSVMDZKD - Generálny sekretariát výboru ministrov pre drogové závislosti a kontrolu drog [General Secretariat of the Board of Ministers for Drug Addictions and Drug Control]

HIV – Human Immunodeficiency Virus

IDPC - International Drug Policy Consortium.

IHRA – International Harm Reduction Association

IHRD - The International Harm Reduction Development Program

IPA - interpretative phenomenological analysis

OSF - Open Society Foundation

OSI – Open Society Institute

SAMHSA - Substance Abuse and Mental Health Services Administration

SAV – Slovenská akadémia vied [Slovak Academy of Sciences]

SNSĽP - Slovenské národné stredisko pre ľudské práva (SNSĽP) [Slovak National Centre for Human Rights]

ŠÚ SR – Štatistický úrad Slovenskej republiky [Statistical office of Slovak Republic]

STDs – Sexually transmitted diseases

UNODC - United Nations Office on Drugs and Crime

ÚVVM - Ústav pre výskum verejnej mienky pri Štatistickom úrade SR [Institute for public opinion research, Statistical Office of Slovak Republic]

INTRODUCTION

"Understanding gender issues in drug use and drug addiction in Europe is a critical requirement to developing effective responses."

(EMCDDA[1], 2011, March 12)

It was the year 2009, when I started to work as an outreach worker in the non-governmental organization Odyseus in Bratislava (Slovakia), which works with people who use drugs and/or work as sex workers. During my work, I often faced the fact that there was a gap in drug-related services which could offer help for women in Slovakia. For example there are very limited possibilities to find cheap accommodation for women (and especially for women who take care of their child(ren)). From my personal experience as an outreach worker, I saw that women were less likely to enter treatment programs. When I decided to learn more about the specific issue of women who use drugs, I realized that these differences, difficulties, structural inequalities and stigma are well known and discussed in European and American research.

From the beginning of addiction research, studies were conducted mostly with men and addiction was mostly understood as a male dominated field. Similar to other science disciplines, addiction studies faced criticism because of their dominant male orientation from feminists since the 1960s and the 1970s, too. Although from the early 1980s, "Females were added to samples, but no gender-related concepts were used" (Anderson, 2001, p. 286). Drug-related services have been criticized for their ignorance of women's needs for many years (see e.g. EMCDDA, 2006; Ettorree, 1994; Pinkham & Malinowska-Sempruch, 2008). One side of the problem is the ignorance about the lives of women who use drugs. The other is the fact,

[1] European Monitoring Centre for Drugs and Drug Addiction.

that the first well-intentioned services for women in the 1970s only reinforced existing stereotypes about women, mostly related to their sexuality and reproductive functions (Campbell & Ettorre, 2011). Unfortunately, this trend of working with stereotypes and assumptions about what women who use drugs need continues (Seddom, 2008).

Since in Slovakia, specialized services that would focus on women who use drugs are missing and this topic is absent in Slovak research, too, I decided to conduct research about women who use drugs and explore the situation of drug-related services in Slovakia from the perspective of gender. As my intention was to do community-based research, rather than conducting research on a big group of drug users, I decided to focus exclusively on a community of women who inject drugs and live in Bratislava.

My thesis aims to reach several goals. First of all, it explores life stories and experiences of women who use drugs in Slovakia, in order to understand problems and needs which should be addressed in gender-sensitive programs. Life stories and voices of women who use drugs are the cornerstones of my research. The second aim of my research is to look at the existing system of drug-related services and via interviews with women who use drugs and outreach workers from the NGO Odyseus evaluate the gender-sensitivity of existing services. The last aim the thesis is to offer recommendations for drug-relative services in order to achieve gender sensitive approach.

In my thesis I am using the term “women who use drugs”. This has several reasons. First of all, it is my intention to put the person in the first place and as the subject – I am not using e.g. the term female drug users since I believe these women are more than drug users. The other reason is the problematic usage of terms of addiction, dependency and drug/substance abuse and differentiation of these terms, since often they are used interchangeably. Moreover, there is only one word for addiction and dependency in Slovak language. Addiction/dependency is usually diagnosed by a psychiatrist, so I am rather using

the term “drug use” since I cannot and even do not want to conclude a diagnosis. However, the term drug use is very broad – in the case of my research, I was conducting interviews with women who inject/injected drugs – mostly heroin and methamphetamine.[2]

I had to face other instances of terminological confusion around the usage of the terms women-friendly or women-oriented program and gender sensitive programs. Often, studies I am presenting in my thesis are using the term gender sensitive even though the services were addressed only to women. In my opinion, women-oriented programs are part of gender sensitive programs but gender sensitive programs include the consideration of all gendered identities (women, men, and transgender people). Studies presented in my thesis deal mostly with women-oriented programs without special emphasis on men or transgender people. In my thesis, I prefer to use the term “gender sensitive”, although my focus is exclusively on women who use drugs. I rethought this decision several times while conducting and writing my research and this process of narrations gathering convinced me that even exclusively “women’s issues” should be addressed in complex, gender sensitive programs.

Chapter 1 discusses some findings which demonstrate a broad discussion about women who use drugs, deal with stigma, vulnerability, sex/gender differences, motherhood and questions related to drug-related services, which would offer a gender sensitive approach. Studies presented in this chapter come from the US and European contexts (except for one, which was conducted in Iran).

In Chapter 2 I briefly explain the situation of drug use in Slovakia. I present some representative public opinion surveys on drug use and the national strategy which deals with drugs and drug use in Slovakia in order to demonstrate dominant discourses about drugs and

[2] Drug injecting and long-term term use of opiates, amphetamines and cocaine is classified as problem drug use by EMCDDA (2010). According to EMCDDA’s classification, I was conducting research with women who are or were “problem drug users.”

drug use in Slovakia. Then I introduce the existing drug-related services and point out the missing gender aspect within drug-related services.

Research design and methodological perspectives are discussed in Chapter 3. Here I explain why I decided to use a life story approach for data gathering and discuss the problem of memory embodied in broader historical, social and cultural contexts. I draw attention to the question of validity of qualitative research and some ethical problems which came up during the research.

Chapter 4 introduces narratives of women who use drugs, exploring their life stories and experiences with drugs. It offers a description of themes mentioned during the interviews and offers several interpretations related to female gender, intersectionality, identity and the ways in which whole as well as partial stories are narrated.

In Chapter 5, I show the experiences of women who use drugs with drug-related services in Slovakia (syringe exchange programs and drug treatment programs). According to the life stories, several needs are identified. I evaluate the existing services in Slovakia and offer several recommendations which were concluded from the interview analysis. These recommendations cover the key aspects which would, and, I argue, should be part of gender sensitive drug-related services in Slovakia.

In the last chapter I conclude my key findings and compare them to the existing recommended principles of gender sensitive services. Limitations, implications and future recommendations are discussed. I hope that my research can be used as a starting point for advocacy of gender sensitive services in Slovakia and that I will have a chance in the future to implement some of the findings soon in NGO Odyseus.

CHAPTER 1 - DRUG USE AND WOMEN: IDENTIFYING THE PROBLEM

1.1 Traditional vs. liberal approach to drug use

It is impossible to introduce the history of drug policies on a few pages. However, the most prevalent and the most discussed approaches must be presented in order to understand drug use as an issue in broad contexts (biological, social, cultural, historical...). For the purpose of this thesis I have chosen Campbell's and Ettorre's (2011) classification, which distinguishes a classical mode of knowledge and a postclassical mode, or using the words of Ettorre's (2004) earlier work, a postmodern approach.

According to Campbell and Ettorre (2011), the classical mode is associated with the neuroscientific understanding of addiction. Addiction is defined as a brain disease (Vrecko, 2010), as a chronic and relapsing illness (Campbell, 2010). The critique of this approach states that what at the first glance was presented as scientific, value-free and rational facts must be revised (Vrecko, 2010).[3] The first criticism is related to the political grounds of drug research. Specific social and political context (mostly) in the US must be considered. In 1961, international treaty, The Single Convention on Narcotic Drugs was adopted, which defines drug addiction as "a serious evil for the individual" which "is fraught with social and economic danger to mankind," and calls for "[the] duty to prevent and combat this evil" (United Nations, 1961, p. 1). Since 1960s, continuing panic around drugs use resulted into the war on drugs. Drug use was defined as something immoral, dangerous, and what must be strictly controlled and punished (Cheung, 2000). Vrecko (2010) points out, that value-free neuroscience of addiction must be problematized – since most of the funding came from the policies related to the war on drugs.

[3] Unfortunately, I have not found any study which would offer similar critique of European addiction research. It could be explained by the fact that the US have had a "bigger problem" with drugs than Europe and because in Europe, even today, uniform approach towards drugs and drug use is hard to achieve, since European countries have their own – and quite different - national strategies how to deal with drugs and drug use (Prinz, 1997).

The second criticism of classical approach points out its inability to explain the role of social factors (Campbell, 2010) and its ignoring of socially and culturally (re)produced meanings of drugs and drug use (Weinberg, 2002). Ironically, neuroscience explains most of the symptoms of drug addiction through social and cultural maladaptations, but the essence of addiction is put into "bodily pathology, deficit, or vulnerability" (Weinberg, 2002, p. 1).

With postclassical approach, the ideas of human rights and the importance of social inequalities re-emerged (Ettorre, 2004; Campbell & Ettorre, 2011). This approach critically reflects the limits of theory of addiction as a brain disease, and emphasizes social and cultural contexts. Special emphasis is put on gender sensitive approach and acknowledgement full human and citizen rights to drug users regardless of their intentions to continue or give up drug use (Campbell & Ettorre, 2011). The principles of harm reduction philosophy are highlighted as a fundamental part of postclassical approach (Ettorre, 2004; Campbell & Ettorre, 2011).[4]

The rise of harm reduction programs begins in the late 1980s "which represented a shift from the legal sanction debate to public health principles" (Cheung, 2000, p. 1699). According to the International Harm Reduction Association (IHRA) (2009), "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" (p. 1). Non-judging and humanistic principles are characteristic of this approach (Cheung, 2000). Harm reduction strategies in drug issue consist of different programs such as: substitution treatment, syringe exchange, drug injecting rooms, testing for HIV, overdose prevention programs, and many others (Einstein, 2007).

It must be added that the rise of harm reduction has not diminished the use of the prohibition/repression approach (Cheung, 2000). However, the call for the promotion of

[4] However, this does not automatically equate harm reduction and gender sensitivity. Lack of gender sensitivity within harm reduction programs will be discussed below.

human rights and harm reduction principles are considered to be a fundamental part of effective drug policy development in international context (IDPC, 2012).

1.2 Women within drug use discourse

Several studies emphasize that drug addiction treatment programs and other social and health services for drug users are designed for men and they do not consider women's needs (Pinkham & Malinowska-Sempruch, 2008). Until the 1980s, drug addiction studies were conducted mostly among men. After the 1980s, although women participants were involved in research, this did not guarantee using gender to challenge conceptual frameworks about drug misuse, "[t]he result was that women's and men's drug use were viewed through a male lens." (Anderson, 2001, p. 286). Also, clinical psychology became a target of critique focusing on psychoanalytical concepts, psychiatric labeling and questioning of drug prescription. Concerns related to drug prescriptions were mainly about misprescription and overprescription of psychoactive drugs without researching women's response to such drugs (Marecek & Hare-Mustin, 1991). Ettorre (1994) stated in the 1990s: "[T]he field of addiction studies urgently needs to develop a greater sense of public visibility, especially for women" (p. 83).

In this section I present the main discussions related to women who use drugs such as stigma, vulnerability, sex and gender differences and panic discourses about drug using mothers. Then I move to a discussion about programs for people who use drugs and to the question of gender within drug-related services.

1.2.1 Stigma, vulnerability and sex/gender differences

There is no doubt that the use of illegal drugs is a stigmatized topic. According to Ettorre (2004), who has been researching and debating the intersection of gender and drug use, applying a feminist approach for years, "[a]s a form of 'embodied deviance', drug use

'marks' bodies of individuals and determines their low social status and lack of moral agency" (p. 330). This is especially true for women - women who use illegal drugs face double stigma and discrimination - as drug addicts and as women (OSF, 2007). This understanding of double stigma is confirmed by other studies conducted in Finland, the United Kingdom and the United States, which show women who use drugs face bigger stigma and stereotypes than men who use drugs (Ettorre, 1994; Luck, Elifson & Sterk, 2004; Kearney, Murphy, & Rosenbaum, 1994; Simpsons & McNulty, 2008).

The issue of vulnerability of women is in fact embodied in the assumption about sex/gender differences.[5] The patterns of vulnerability are mostly explained "on the basis of gender differences in 1) physical vulnerability, 2) social control and labeling, and 3) internalized sex role norm" (Robbins, 1989, p. 117). Different aspects of drug use have been associated with biological differences. Just to mention some examples, one study based on animal experiments shows the importance of estrogen in behavioral response and drug senzitization in relation to cocaine and amphetamine use (Becker, Molenda, & Hummer, 2001) and one research review concludes that "it is apparent that sex influences the behaviors induced by drugs, as well as the pharmacological responses to drugs" (Lynch, Roth, & Carroll, 2002, p. 133). Such a conclusion is of course problematic, since there are studies which show no gender differences in referring to being high (Kosten et al, 1996) or in cardiovascular response/heart rate in cocaine use (Kosten et al, 1996; Mccance-katz, Hart, Boyarsky, Kosten, & Jatlow, 2005).

Perhaps an even bigger discussion is devoted to the psycho-social gender differences in context of drug use. Women who use drugs figure as high risk groups in terms of developing psychiatric disorders (depression, anxiety and suicidal thoughts, post-traumatic stress

[5] Sex differences used to be related to physical and biological differences and some of the cited research papers use the term sex differences. However, since I prefer to approach this thesis through the lens of postclassical approach according to Ettorre's classification, I will use term gender differences, by which I situate all differences – biological, psychological, social – into social contexts.

disorder) in the US contexts (Kubiak, 2004; Rowan-Szal, Chatham, Joe, & Simpson, 2000; Weisner, Mertens, Tam, & Moore, 2001) but also in Europe (Germany) (Eiroá-Orosa et al, 2010). Measham (2002) shows that "women are more likely to be involved in the high risk, low-reward aspects of drug culture with resulting health, financial and legal implications" (p. 346). The UNODC (2006) reports that women who inject drugs are at greater risk of HIV, high risk sex and drug-related harms. Female gender was also found to be an important factor in increasing risky behavior in term of sharing injection equipment (Barnard, 1993; Evans et al, 2003; Rafiey et al, 2009). One study carried out in Glasgow, found out that women are less likely to attend syringe exchange programs or go to the pharmacy because of the shame. This does not necessarily mean they always share injection equipment, but the risk of sharing may be higher, since it makes women less independent in their supplies and they must rely on someone else (Barnard, 1993). Another explanation was offered by a study conducted in San Francisco, where the combination of injecting and having a sexual relationship with another drug injector meant higher risk of needle sharing for women (Evans et al, 2003).

In terms of vulnerability, the issue of violence must be discussed. It was found that women who use alcohol or drugs are more likely to face violence in their lives in general (El-Bassel et al, 2003; Pinkham & Malinowska-Sempruch, 2007; Testa, Livingston, & Leonard, 2003). Drug use was reported to be a frequent cause of interpersonal violence (Stuart et al, 2008) and some studies emphasize that drug use can be a response and a way how to deal with an experience of interpersonal violence (Hedtke, et al, 2008; Kilpatrick, et al, 1997). Specific issues of violence and control can be found among drug using couples: some women do not know how to inject drugs, so their partners assist them. This can be understood as a form of trust, but also as a form of abuse. In such cases the male partner has total control over the dose and the injecting process (Wright, Tompkins, & Sheard, 2007). It was found that

women who use drugs may stay with their abusive partners because they supply them with drugs (James, Johnson, & Raghavan, 2004).

According to the Eurasian Harm Reduction Network (EHRN, 2010),

> Domestic violence is a frequent occurrence in the lives of women drug users, and can contribute to increased drug use and greater vulnerability to HIV. Unfortunately, services for women who have experienced domestic violence are rare in Eurasia, and women who use drugs are often excluded from those that do exist. (p. 7)

The other issue which must be addressed is the issue of structural factors and structural violence. Marginalization, social exclusion (Byqvist, 2006), unemployment (Maremmani et al, 2010; Rowan-Szal et al 2000), poor and limited housing conditions or homelessness (Nair, Schuler, Black, Kettinger, & Harrington, 2003; OSF, 2011) are reported as common factors among women who use drugs.

Research findings presented above are just some of many. I discuss them here in order to illustrate the debate about women who use drugs and gender differences within drug use. However, these findings should not be read without critical consideration of the methods used and thinking about different cultural contexts. As Robbins (1989) states, "female psychological vulnerability derives from internalized sex role norms rather than from the physiological effects of alcohol or drugs" (p. 126). I would suggest that all of the presented findings should be considered in relation to social, cultural and historical meanings of gender (and drug use, too). On the one hand, it is the female gender which has an impact, as I have demonstrated in this section, but on the other hand, drug use has its implications for female gender, too. According to Measham (2002), drug use can be seen as a tool of challenging traditional femininity. It is a mutual interaction between "doing gender" – "doing drugs" (Masham, 2002, p. 335), which should be taken into account.

1.2.2 Moral panic about drug using mothers

A huge debate is focused specifically on drug use during pregnancy and on drug using mothers. Gomez (1997) discusses the public panic and discussion about so-called crack mothers in the 1980s in the US related to the media presentations and medical discourse. Gomez describes what she calls the discovery of crack babies and crack mothers which only reinforces the ongoing trend of blaming mothers and adds another argument into the discussion about the dangers of the changing roles of women in the US society. Crack mothers were seen as those who had lost their maternal instincts because of drug use and the war on drugs was articulated in connection to fetal rights. Campbell and Ettorre (2011) characterize the situation of panic about pregnancy within drug use as follows:

> The relentless focus on babies projects blame onto the women who give birth to them – the production of 'soiled' babies through 'polluted' mothers sullies ideological notions of the 'innocence of babies' and of 'sacred motherhood'. Because these women have been 'poisoned' or 'tainted' through their use of drugs, motherhood is not seen as their right. Their very status as human beings and as political persons is called into question by those who advocate for the rights of the foetus against those of the pregnant women [...]. (p. 159)

The facts that there were a lack of treatment programs for women, no access to prenatal care in the country and "the fact that many women, through their own agency, quit or reduced their drug use and engaged in other adaptive behaviors went unheralded" (Zerain & Banks, 2002, p. 5). Strong repressive approaches were discussed in the US, but finally instead of punishment efforts, an institutionalization approach (in hospitals and treatment centers) became prevalent (Gomez, 1997). However, discussion about the criminal responsibility of pregnant women who use drugs is not over. According to the media analysis, ideas such as forced sterilization or fetus abuse prosecution are still offered as possible solutions (Charles &

Shivas, 2002). Even after 30 years, the repressive discourse is present: a report from the US shows that pregnant women who use drugs are still afraid to seek help and they do not receive adequate care (e.g. methadone treatment). Panic around addicted babies is still present, although time has shown that the fear of consequences was exaggerated ("Babies aren't 'addicts'", 2012).

It is important to note that the construction of dangerous mothers has not been connected only to gender, but class status and race were important, too (Gomez, 1997; Litt & McNeil, 1997; Zerai & Banks, 2002). So the repressive actions were mainly oriented towards women of color who lived in poverty (Roberts, 1991; Zerai & Banks, 2002).

In fact, beside the problem of stigma towards pregnant or mothering women who use drugs, studies also reported that women are often in a situation when they have two choices: drugs or children (Van Olphen, Eliason, Freudenberg, & Barnes, 2009). "Concerns about child custody and the welfare of children are among the most important barriers to women seeking care, particularly drug treatment" (EHRN, 2010, p. 3).

Although public discourse around these women is very negative, studies show that women who use drugs can be good and loving mothers (Baker & Carson, 1999; Kearney, Murphy, & Rosenbaum, 1994; Luck, Elifson, & Sterk, 2004). Moreover, pregnancy and mothering can also be a motivator for women to give up drug use (Martin, 2011). Drug use does not mean immediate complication for parenting; for some women, drug use is a moment of relaxation (Kearney, Murphy, & Rosenbaum, 1994) or a way of coping with permanent stress related to parenting responsibilities (Baker & Carson, 1999).

The reason why I address the issue of pregnancy and mothering in this section is its close relation to the discussion of treatment programs. In comparison to the ideas of punishment, treatment seems like a good way to deal with pregnant or mothering drug users. But in fact, as Young (1994) emphasizes, treatment is often just another way of disciplining

and controlling targeted women. The first specialized programs for women who use drugs in the 1970s were in fact designed for mothers and pregnant women and treatment process was based on projecting dominant social gender roles on these women (Campbell & Ettorre, 2011). Seddom (2008) points out that dealing with female sexuality and reproductive functions may be important to address, but service for women should not be limited to these stereotypical assumptions about women's needs. The question of drug-related services for women is discussed more in the next section.

1.3 Drug-related services and women

As I mentioned earlier, the critique is that drug-related services tend to ignore women's needs (Pinkham & Malinowska-Sempruch, 2008). The EMCDDA states that drug addiction treatment centers usually reflect the needs of men, because they are the majority of their patients (EMCDDA, 2006). Another point of view on women in drug use discourse is suggested by Seddom's (2008) historical analysis of drug use and harm reduction during the 20th century in the United Kingdom. He points out that women were part of the harm reduction discourse from its very beginning. He claims that harm reduction, as a method of social regulation, is a strategy to control women's bodies and mainly their reproductive potential. He supports this idea with the fact that many harm reduction policies are focused on pregnant drug users – and this is the moment when one can see that harm reduction works with taken for granted assumptions about what is the best harm reduction for women, focusing on reproduction and women's bodies.

Here I would like to refer to Anderson (2008) again, just to recall that adding women into research did not automatically mean taking gender into account and, similarly, that drug-related services should be rethought even though women were involved in these services years ago. As I have already pointed out, first attempts to focus on women were limited to pregnancy and motherhood (Campbell & Ettorre, 2011), so critical work on gender and drug

use calls for a move from the focus on pregnant women to more broader understanding of women's issues needs and experiences (Murphy & Rosenbaum, as cited in Ettorre, 2004; Seddom, 2008).

At this point, I must discuss two terminological difficulties. First, it is the use of the terms harm reduction programs, syringe exchange programs and drug treatment programs. The sources I am presenting in this chapter usually call these drug-related services harm reduction programs and drug treatment programs. The problem is that methadone maintenance is a harm reduction and treatment program, so there is an overlap between these two groups. The problem is that some studies do not specify what they mean for example by harm reduction programs – only syringe exchange programs, or methadone programs, too?[6] I decided to use the terms which were used by the concrete presented study and where it is possible, explain what kind of services are discussed.

The second problem I had to face when writing this section is a confusing use of the terms women-friendly or women oriented program and gender sensitive programs (as I mentioned already in introduction). Often, a study was using the term gender sensitive although the program was addressed only to women. Again I use terms which are used by the studies, but I prefer to use the term "gender-sensitive" programs. Studies presented in this section deal mostly with women-oriented programs without special emphasis on men or transgender people.

The most addressed themes related to women who use drugs were drug injection, involvement in sex work, sexual risks, pregnancy, motherhood and violence (Pinkham & Malinowska-Sempruch, 2008). A good practice from Ukraine, where harm reduction oriented

[6] Which can be influenced by the fact that in some countries, there is restricted or no access to methadone maintenance programs. For example, in Russia it is clear that harm reduction programs mean syringe exchange programs, since methadone treatment is banned in Russia.

towards women was implemented, suggests an approach that includes services as well as advocacy activities. Several aspects of women-friendly harm reduction were developed: promoting sexual health (low-thresholds HIV and STDs testing), orientation towards parenthood and family (support for health and social service for a whole family, consultations about family-related issues), free legal help, social support and network of professional service. Leaflets with gender-specific information were developed and distributed and special social housing was created for women who use drugs (Pinkham & Shapoval, 2010). A report from Russia shows that creating safe and only for women drop-in centers, distribution of variety of supplies for women and children and involvement of female and peer workers resulted in increasing of female clients in their harm reduction programs. Comprehensive approach is a must in order to make harm reduction programs easier to access by women (OSF, 2011).

Pinkham and Malinowska-Sempruh (2008) claim that in order to promote a gender sensitive approach, the following changes are needed:

- policies that encourage women to seek drug treatment and harm reduction rather than punishing or stigmatising them for drug use during pregnancy or motherhood;
- increased availability of medication-assisted treatment;
- incorporation of sexual, reproductive health, and other women's services into harm reduction programmes;
- flexible, low-threshold services[7] that are more convenient for women with children;
- and links between harm reduction, drug treatment, women's shelters and violence prevention services. (p. 173)

[7] Low-threshold services represent services which are easy to access (free of charge, no registration and regular participation needed).

The EMCDDA (2009b) also emphasizes a need for comprehensive and holistic services for women who use drugs. What does this mean in case of drug treatment programs? The Center for Substance Abuse Treatment (CSAT) (2009) which is part of The Substance Abuse and Mental Health Services Administration (SAMHSA)[8] offers a clear review of principles which should be addressed in gender sensitive treatment programs:

1. Contextualize women's drug use in socio-economical borders.
2. Understand cultural differences and focus on intersectionality.
3. Understand of the importance of women's relationships.
4. Recognize unique aspects of women's health.
5. Address age-related and developmental issues
6. Recognize the importance of women's care-giving roles and other social and cultural roles related to gender.
7. Work with trauma.
8. Focus on empowerment.[9]
9. Adopt a multidisciplinary approach in order to address bio-psychosocial and cultural aspects of women's lives.
10. Gender-sensitivity must be part of every partial service within comprehensive care.
11. Programs must be implemented by trained and supervised professionals with focus on gender.

I would like to present some studies in order to demonstrate how these principles work in practice. For example, in the US it was found that 36 treatment programs focusing on women who use drugs failed in providing comprehensive service. It was especially visible

[8] SAMHSA was found in 1992 by the U.S. Congress, focusing on improvement of mental health and substance abuse services in America. (SAMHSA, 2012, April 20).

[9] This principle is described in more details in the next section.

among programs focused on pregnant women, where services were limited only to pregnancy-related issues (Uziel-Miller & Lyons, 2000). What is interesting is the fact that when I was looking for some results about gender-sensitive treatment, gender sensitivity was often associated with programs which are open *only* to women and then compared to gender-mixed programs (see e.g. Claus et al, 2007; Greenfield et al, 2007; Greenfield, et al, 2008; Hser, Evans, Huang, & Messina, 2011; Prendergast, Messina, Hall, & Warda, 2011).[10] These studies show some significant differences in successfulness of programs, however, I am not sure to what extent it reflects the usefulness of a gender-sensitive approach, since often it is not clear what principles of gender sensitivity these women-only programs follow. Programs only for women and gender-mixed programs can but at the same time do not have to work with principles for gender sensitivity, so the target group cannot be a way to evaluate the programs' gender sensitivity.

What is more, a study from North Carolina shows that gender-mixed programs may be similarly effective as women-only programs (Kaskutas, Lixia, French, & Witbrodt, 2005). A huge evaluation study in the US shows that a need for additional health care services, social programs, mental health care programs, family, housing, vocational and financial help services is reported by women as well as by men (Marsh, Dingcai, & Hee-Choon, 2009) and that complex services, for men as well as for women, are associated with better results in treatment process (Marsh, Cao, & Dtaunno, 2004).

I have presented only a limited number of studies from one part of the world (the US), so uncritical conclusions cannot be made. However, I would like to suggest that the methodological limits of such studies should be considered again and that although it looks like the effectiveness of gender-sensitive programs can be questioned, it does not negate the first arguments for the revision of drug-related services with gender dynamic in mind (or

[10] All of the mentioned studies were realized in the US.

intersectionality). The fact of missing statistical evidence does not mean that establishing gender sensitive programs or programs with some aspects of gender sensitivity does not bring positive qualitative results.

1.3.1 Empowerment within gender-sensitive programs

Although I have already mentioned that empowerment is an important part of the principles of gender-sensitive programs, I believe more space must be dedicated to this issue, since the understanding of empowerment in gender sensitive programs differs. The issue of having and not having power in one's life, being able to cope with problems or change drug habits are particularly strong among women who use drugs (LaFave & Echols, 1999). CSAT (2009) highlights empowerment as an important part of the principles of gender sensitive services and it defines it as:

> A strengths-based approach [which] builds on the woman's strengths and uses available resources to develop and enhance resiliency and recovery skills, deepen a sense of competency, and improve the quality of her life. These strengths may include personality traits, abilities, knowledge, cultural values, spirituality, and other assets; while resources may involve supportive relationships, environments, and professional support. (p. 6)

Young (1994) suggests that empowerment issues should be raised at different levels. First, they should be addressed in dialogue, through consciousness raising, where professionals from drug treatment programs help women identify structural inequalities which negatively influence their lives. Further, women should actively participate in treatment programs, for example, rules should be created together with them, and programs should be flexible according to regular evaluations and feedback from targeted women. Also, creating networks of women is viewed as an important part of the empowerment process. Pinkham and

Shapoval (2010) address the issue of empowerment in harm reduction services mainly though peer work and creating advocacy groups where women who use drugs were involved.

In my opinion, raising the consciousness about gender stereotypes and structural inequalities should be a cornerstone of gender-sensitive programs. Dozens of different services can be offered with a focus on women, but if the personnel do not work with the idea of empowerment, I believe it loses its effects. I believe all the services, from treatment itself to skills training or legal support, without addressing the issue gender through empowerment perspective will probably just continue reinforcing stereotypes and controlling women's lives, as was the situation at the beginning of women-oriented services (see Campbell & Ettorre, 2011).

CHAPTER 2 - DRUG USE SITUATION IN SLOVAKIA

Illegal drug use became an issue in Slovakia after the fall of the socialist regime. Although illegal drug use was present in Slovakia also before the November 1989, it was not at least publicly visible in the media (Ústav pre výskum verejnej mienky pri ŠÚ SR (ÚVVM) [Institute for public opinion research, Statistical Office of Slovak Republic], 2006). Until 1989, drugs that appeared among the Slovak population were mostly alcohol, tobacco products and illegally used prescription drugs or volatile inhalants (EMCDDA, 2004). Nowadays, there is a growing prevalence of use of illegal drugs as well as growing concerns about drug use in Slovakia (ÚVVM, 2006).

In this chapter I briefly present policies and public discourse related to drug use in the Slovak context. I demonstrate to what extent is the issue of gender present in these discussions. But why is it important to discuss the situation in Slovakia? I agree with Fedačko (2006) who calls attention to the fact that the meanings of drug use and drug problems are not objective and are culturally different. This can be especially true since Slovakia is one of the post-soviet countries, where the growing prevalence of drug use was a new issue to deal with. Since my research was realized in Slovakia, I believe it is important to understand the context in which my research and my research participants were situated.

2.1 Public and political discourses related to drugs and drug use in Slovakia

Probably the most important documents about drugs and drug use in Slovakia are the national documents defining strategies to be used in approaching drugs and drug use in Slovak society. Fedačko (2006) emphasizes the interactive relationship between drug policy and the understanding of drug use. How drug use is perceived has an impact on creating national drug policy and at the same time drug policy shapes the understanding of drug use within the country. What I would like to point out is the simple fact that in Slovakia, instead

of drug policy, important national documents use the term "anti-drug policy" (see for example national anti-drug drug strategy GSVMDZKD[11], 2009). Furthermore, Preamble of Slovak National Anti-drug Strategy for the Period 2009-2012 describes drug use as follows:

> The drug phenomenon affects the essence of the existence of society as such, disturbs its moral foundations, economic links and legal system and negatively affects the level of public health. It has become a serious social issue (GSVMDZKD, 2009, p. 37).

The survey conducted by the State institute for public opinion research using a representative sample of Slovak population found that in public discourse in Slovakia, drug users are dominantly seen as sick, eccentric persons or criminals. Drugs are seen to be connected with criminality, the spread of HIV and STDs or deficient personalities of drug users. For example, most of the respondents stated they would not continue an intimate relationship with a person who was involved in the past in treatment program although she or he succeed in getting off drugs (ÚVVM, 2006). Džambazovič (2008) believes that such results may indicate distrust and stigma related to drug treatment in Slovakia. The survey also found that "people" believe that repressive strategies, police reinforcement and strict laws related to drugs are a good way to stop spreading of drug use (ÚVVM, 2006). Here, Džambazovič (2008) offers a critical view, highlighting that questions about the strategies were not neutral but more negative and that their formulation may have had an impact on respondents' answers in a way which supports repressive policies.

Although the Slovak legal system recognizes the difference between drug users and drug dealers, according to focus groups with personnel from drug-related services in Slovakia, police often prosecute drug users, since it is easier to found and arrest a drug user than a dealer (Masaryk & Miklíková, 2008).

[11] Generálny sekretariát výboru ministrov pre drogové závislosti a kontrolu drog [General Secretariat of the Board of Ministers for Drug Addictions and Drug Control].

The presented results suggest that drug use and drug users are often treated as criminals and this approach is supported by the public. However, national anti-drug strategy does not promote exclusively repressive approach. On the contrary, this strategy officially calls for an integrated, multi-level and comprehensive evidence-based approach to drug use, however without a clear definition of such approach. The document defines the main priorities for Slovakia: reducing demand, reducing supply, coordination and cooperation, international cooperation, awareness, research and evaluation (GSVMDZKD, 2009). The problem is that although drug users are defined as the most vulnerable group, concrete strategies which would address the complex risks related to drug use and strategies for social inclusion are missing (Džambazovič, 2008). The above mentioned research conducted among professionals from drug-related services identifies a medical model of addiction[12] as the dominant one, while harm reduction approaches are mostly identified among outreach workers of harm reduction syringe exchange programs (Masaryk & Miklíková, 2008). Harm reduction, as I presented earlier, an important part of postclassical approach to drug use, is not prevalent in the Slovak context. Even in the national strategy, minimalization of harms related to drug use is not a separate strategy, but a part of the priority concerning reducing demand (see GSVMDZKD, 2009). However, this is not a surprise, since the implementation of harm reduction programs has been more or less problematic in post-soviet countries (Coffin, 2002). The International Harm Reduction Development Program (IHRD), established by the Open Society Institute (OSI), faced many challenges when they wanted to implement harm reduction strategies, although, according to Coffin (2002), this was not a case in Slovakia, where methadone program was working without major problems. However, this cannot be said about other harm reduction programs in Slovakia – syringe exchange programs are realized by non-governmental organizations which receive some state funding, but every year

[12] The study does not specify what they mean by the medical model. My assumption is that this model assumes a neurochemical approach, or understanding addiction as a disease.

their existence is threatened by lack of financial resources. The implementation as well as retaining of harm reduction programs in Slovakia is not as smooth as it seems from Coffin's (2002) study.

2.2 Drug-related services in Slovakia

In this section, I will offer a brief presentation of existing drug-related services in Slovakia.

In Slovakia there are five harm reduction NGOs (Odyseus, Prima, Storm, Pomocná ruka [Helping hand], Centrum dobrovoľníctva [Centre of volunteering]), which provide outreach work, focusing mainly on syringe exchange. These harm reduction NGOs provide outreach work in six cities in Slovakia (while Prima and Odyseus work in Bratislava) and services such as syringe exchange, condoms and educational materials distribution and various types of counseling (about drug use, safer sex, other social services) are offered by outreach workers. The only state program of syringe exchange is provided as a part of the services of the methadone maintenance program in Bratislava. All of the above mentioned services are free of charge; methadone treatment is covered by the state health insurance. Although syringes can be bought in pharmacies, a lot of pharmacies do not sell them in order to deter clients who use drugs, or do not want to sell them to people who use drugs.[13]

Drug treatment programs are mostly offered free of charge, but sometimes there are waiting lists. Methadone programs are offered only in two cities in Slovakia: Bratislava and Banská Bystrica (Okruhlica, 2010). Resocialization centers are not covered by the state compulsory health insurance in Slovakia.

[13] As part of the project Hľadá sa ihla v kope lekární [Looking for a needle in a heap of pharmacies], workers and volunteers found that only 13% of pharmacies in Bratislava sell the type of syringes that is dominantly used by people who use drugs and the attitudes of employees towards the clients who ask for syringes is negative and judgmental (Žilinská, 2011).

These are the basic services offered to people who use drugs in Slovakia. Of course, there are some others services with a broader scope of target groups (for example social help provided by municipalities) that may also work with people who use drugs, but in my thesis I am oriented mainly towards harm reduction programs and drug treatment centers.

2.2.1 Gender within drug-related services in Slovakia

According to the latest survey in 2008, the estimated number of problem drug users in Slovakia was from 8,200 to 33,500 (with a median estimate of 10,500) in 2008 (Šteliar, as cited in EMCDDA, 2009a) and the reported male-female ratio was 1.5:1 in 2009 (Okruhlica, 2010).[14] Fewer women access this type of program and even less seek help from treatment programs; in 2009 it was 77% of men and only 23% of women (Okruhlica, 2010).

However, after two years of working in this field, my impression was that nobody pays special attention to gender. When I was searching some empirical data, I came to a similar conclusion. I found three works which deal with gender (or women) and drug use in Slovakia. One of my former colleagues deals with women and drug use in her master thesis, but only on a theoretical level (see Krafčíková, 2011). The other paper is a fact sheet created by the NGO Fenestra, which deals with drugs in relation to violence against women. This paper states that the issue of drug use and violence must be addressed simultaneously, which unfortunately is not the case in Slovakia, where shelters for women do not accept women using drugs (Oleárniková, 2006).

The third document which pays attention to gender is a section in the national report from Slovakia for year 2004, which presents a survey realized among drug-related programs in Slovakia. It shows that many of these drug-related services do not offer gender specific programs or approaches, although they see the need for them. Moreover, the most reported

[14] The estimate prevalence and the male-female ratio were calculated from the data provided by the harm reduction NGOs.

gender specific approach was related to sexuality – to prevention of STDs, which again promotes the stereotypes related to women who use drugs as those who transmit diseases. Offering feminist approaches was one of the least addressed issues by the drug-related services. Harm reduction NGOs in Slovakia reported quite a high rate of gender sensitivity, but that is probably caused by the fact that most of them deal with women (sometimes with men, too) who are involved in sex work (EMCDDA, 2005).

Unfortunately, these are the only sources of information I found in relation to drug use and gender in Slovakia. The statistical data I have discussed demonstrates a low rate of women's involvement and I believe that the explanations should not be limited to the assumption that fewer women than men use drugs. Although I have shown that gender, with special emphasis on women, is identified as an important topic in the drug field, it is not the case in Slovakia. Gender is not even mentioned in the national strategy (see GSVMDZKD, 2009).

CHAPTER 3 - METHODOLOGY

In this chapter I describe research design of my thesis. My main goals were to explore life stories of women who use drugs with focus of drug-related services in Slovakia. What are the experiences of women who use drugs and what are the needs which should be addressed in gender sensitive programs? Then I aimed to look at the existing system of drug-related services in Slovakia and offer some recommendation in order to create or develop gender sensitive approach. Are drug-related services (mostly harm reduction syringe exchange programs and treatment programs) gender sensitive? What needs to be addressed in order to offer gender sensitive approach within drug-related services?

To answer my research question, a qualitative approach to data collection and data analysis was used in my research project. I did not use quantitative methods since those put emphasis on standard measuring, frequency and internal and external validity (Denzin & Lincoln, 2003) and such an approach was not suitable for my project. First, I was working with a specific group of people, where a representative sample would be hard achieve so I decided to rather use a small sample and look for deeper personal narratives. Second, I am not interested in frequency or intensity of the phenomena I researched, but in daily life, social and situational contexts and how the interviewed people construct and present meanings of reality, and these aspects of research are more accessible through qualitative approaches. I was inspired by the principles of feminist research during my research, which uses lived experience, dialogue to gain data, incorporates analytical categories of gender, race and class to its analysis and uses reflexivity as a main criterion for research evaluation (Denzin & Lincoln, 2003). Following the principles of feminist research, I wanted to realize research

with women, to try to involve them in a process actively, working on their empowerment[15] and respecting their experience and knowledge (Reinharz, 2002).

3.1 Participants

The interviews were conducted during April 2012. I interviewed six women who currently use drugs (mostly poly-drug abuse of heroin and methamphetamine by injecting for a period longer than one year) and two women who are currently involved in a methadone maintenance treatment program (while one of them were still using methamphetamine and occasionally heroin). The interviewed women were 25-34 years old, mostly lower class (most of them unemployed and without stable place to live), four of them were Romani[16] women.

I was looking for interviewees with the help of the harm reduction NGO Odyseus, which provides syringe exchange. During the outreach work, I was talking with people who came for syringes about my research. If a woman agreed to take part in my research, I stayed with her in the street (after outreach shift finished) to talk. The important factor is that I was mostly asking women for interviews in a street well-known as a place frequented by sex workers. Because of that, all of the interviewed women were or had been sex workers. However, these two issues cannot be uncritically connected. I contacted several women, who have not worked as sex workers, but they did not have time at that moment, and later appointments failed. Some women were contacted through the snow-ball method, overall, more than fifteen women agreed to participate, but the final meetings for an interviews were managed only with eight women.

The second groups of my interviewees consists of eight outreach workers from the NGO Odyseus (one was a worker coming from the community as a sex worker and one was

[15] My intention is to use gathered narratives as a starting point for creating gender sensitive programs and advocacy groups for women who use drugs.

[16] I did not ask directly during the interviews, however, I knew these women for a longer time and I know they identify themselves as Romani when they are asked.

a former employee with experiences at a drug treatment centre). All of them were young women, non-Romani and most of them middle class and with higher education. Interviews were conducted in the office of the NGO and all of them were recorded, with informed consent conveyed orally by the interviewees.

All names of women who use drugs and outreach workers used in this thesis are pseudonyms.

Beside the interviews I gained information from the content analysis of 85 outreach reports.[17]

3.2 Methods

I decided to use triangulation in order to find answers for my research questions. Denzin (1970/2009) describes triangulation as a combination or multiple methods, considering different sources of information, using different theories or methods or working with more investigators during research into one single phenomenon. In my case I used two methods – content analysis of texts and semi-structured interviews; and three sources of data – outreach reports, women who use drugs and outreach workers.

At the first stage of the research project, I analyzed 85 outreach work reports from the NGO Odyseus, which provides its services in Bratislava. I did content analysis of these outreach reports to get basic ideas about how to develop questions for my interviewees and find out what are the most discussed topic in relation to women who use drugs.

I conducted semi-structured interviews with women who use drugs and with outreach workers (see Appendix 1 for the sample of the interview questions). Women who use drugs

[17] After every outreach shift, outreach workers have to write a short report about the services they offered and about their clients so other colleagues can continue with the interventions next time.

were asked to tell me their life stories and then I asked them questions related mostly to the drug-related services in Slovakia and what they would change, with focus on female gender.

All women were informed about the research and agreed to participate. Most (six) of them agreed to be recorded. The interviews with women who use drugs took between 25 minutes to 1 hour and all of them were offered a small material (not cash) incentive (e.g. chocolate). The longer interviews allowed me to get really in-depth understanding of women's life stories.

The life story represents a cornerstone for my analysis, since the narration of women's experiences – with drugs, drug-related services, etc. – is situated in a complex story. According to Atkinson (1998), "A life story is a fairly complete narrating of one's experience of life as a whole, highlighting the most important aspects" (p. 8). Life stories gave me a chance to listen to the women who use drugs and let them express their lives and experiences in the way they preferred.

I let women choose where they prefer to be interviewed, only two women were interviewed in the office of NGO Odyseus. Often, we ended up on a bench, where we were interrupted by other people (mostly drug users or sex workers). On one hand, interviewing in the streets or park does not create an atmosphere of safety and the interviewees were often confused because of the interruption and did not remember what the topic was before. On the other hand, I had a chance to observe dynamic interactions between the interviewees and other people from drug using and sex work community. Two times, the interruption turned into small focus groups or the person later participated in my research, too.[18]

The interviews with outreach workers were conducted in the office of NGO Odyseus and were slightly different and more structured. The outreach workers were asked about their work with women who use drugs, what is the typical woman who uses drugs like, what kind

[18] All people who interrupted the interviewing process were informed about the ongoing recorded interview and agreed to be recorded.

of services exist in Slovakia and what are the attitudes towards drug users (with emphasis on women) in the public sphere and among drug-related service providers. At the end, each outreach worker was asked whether she had heard about gender sensitivity and what she thought this term means. Then, they were asked to evaluate existing drug-related services in terms of gender sensitivity.

3.3 Validity of memory and experience

Since my focus was on experiences of women who use drugs, I need to clarify what I understand when I use the term experience. According to Scott (1991), using experience as evidence can be problematic. She emphasizes the discursive nature of experience and argues that "experience is at once always already an interpretation *and* something that needs to be interpreted" (Scott, 1991, p. 797). So, my analysis of transcripts was not only a thematic analysis – I had to look at the wider context of these narrations. First of all, I was aware that reported experiences were results of interaction between me and an interviewee (Portelli, 1998). Furthermore, an interviewee's memory and presented experience were also situated within "the memory field" - social, cultural and historical contexts and meanings (Maynes, Pierce, Laslett, 2008, p. 84). For example, Liz Stanley claims that information about the selves we got from an interview are influenced by the cultural representations which 'dictate' how selves should look like (Stanley as cited in Lynn, 2010, p. 57). I had to take these normative and hegemonic representations into account (for example those connected to gender stereotypes).

3.4 Data analysis: Interpretative phenomenological analysis

Fourteen interviews were recorded and transcribed, two interviews were not recorded but I took notes during (and after) the interviews. I decided to approach my data using interpretative phenomenological analysis, which I found suitable in order to deal with

questions of validity of my data. Larkin, Watts and Clifton (2006) understand interpretative phenomenological analysis as an approach to data, rather than method of analysis. They emphasize two levels of analysis; the first one is focus on phenomenology – experience of participants, with the need of critical reflection, because this experience is already co-constructed between interviewee and researcher. The second focus is on interpretative analysis, "which positions the initial 'description' in relation to a wider social, cultural, and perhaps even theoretical, context." (Larkin, Watts, & Clifton, 2006, p. 104).

In my case, I contextualized the experiences of women who use drugs, first into their life story narration. Then, I situated their stories into the information from outreach workers, which served as discursive contexts towards drug use, criminality and gender.

3.5 My position as a researcher

Reflexivity of my position within the research was a great part of research process. I understand that "[n]eutrality is not an option because we are part of the story" (Lynn, 2010 p. 58). My background in psychology and gender studies, my feelings, opinions, the fact that I had previously worked as an outreach worker are just a few things that have been influencing my research project – from writing the proposal to the writing final thesis and oral defense. I know that trust is an important part of the interviewing process but unfortunately, because of lack of time, I could not build the kind of relationship I would have liked to. My strategy to get closer to the women who use drugs was through the outreach workers, since these women know them and believe them. So the moment, when some of the women recognized me as one of "these outreach workers" or even remembered me from the past, created an advantage for me. At the same time, of course, it also influenced their narratives – they mostly saw me as an outreach worker, an authority. I reflect on these moments several times when I am discussing my results.

The fact that I was conducting interviews with my former colleagues also strongly influenced my research process. First, none of the outreach workers refused to take part in my research, which could be influenced by the fact that they know me and some of them are my friends. Knowing me as an 'expert' from the field influenced the way in which they presented information about drug users and to what extent they presented their own opinions vs. the shared opinions of the organization.

Last but not least, the issue of power relations must be considered when reading presented narrations and interpretations. I would say the relations with the outreach workers were more or less equally balanced. But the relationships with women who use drugs varied, and factors such as age, ethnicity, the fact that I am a woman and an outreach worker took part in creating different levels of relationships.

3.6 Ethical considerations

Several ethical questions came up during the research. The first one is related to the interviewed outreach workers and the question is to what extend I can guarantee anonymity for the outreach workers who know each others. Relating to women who use drugs, there are even more ethical problems. Some women, for example, were obviously intoxicated during the interview and some of them probably used drugs before the interview, but I just could not be sure. To what extend did they understand what it means to take part in the research process and to what extend drug intoxication influenced their life story narration? Thinking about this question, I was wondering whether I should not ask women who are obviously intoxicated for an interview, but then would it have been ethical to exclude such woman from my research? Since I am a former outreach worker, who support harm reduction principles, I do not judge drug use as such and I believe, drug use does not negate the ability to think and decide. That is the reason why I finally decided to ask women regardless of possible drug intoxication and I

was very careful in explaining research ad question related to anonymity and safety in participation in my research project.

One of the ethical problems I was often exposed is related to what I would call human suffering. Many of the women I have contacted and met were homeless, thirsty, hungry and depressed. I was often asking myself what are my responsibilities as a researcher, a former outreach worker and as a human. These questions remained unanswered. I tried to be very sensitive in my research but not to get involved too much. In cases of serious problems, such as talking about suicide, I recommended the interviewees places where they can seek help.

CHAPTER 4 - WOMEN WHO USE DRUGS: LIFE STORY NARRATION

In this chapter, I explore life stories of women who use drugs, situating their experiences in context, which is mostly drawn from the interviews with outreach workers. After repeated reading of the interviews with women who use drugs and outreach workers, as well as internal reports from outreach work, using interpretative phenomenological analysis (IPA) I have identified several themes and ways in which the stories were told, which are discussed bellow.

4.1 Thematic analysis of life stories

The very first aim of my thesis is to explore drug-related experiences of women who use drugs in their life history and social contexts. In this part of the analysis, a huge amount of information was gathered. To make this exploration of life stories clear, I am offering a brief table of identified themes (see Figure 1). Presented themes are the representations of what women are experiencing in their lives as drug users.

Although this classification of the themes is full of categories, it can hardly represent the complexity and variations of women' life stories. Each topic was presented with different quantity, intensity and emphasis. In addition, trying to understand the experiences of women who use drugs, interaction and interrelation of the themes must be considered.

That is the reason why I do not discuss each theme separately. Such description would be limited and therefore limit the possibilities for interpretation. In order to better understand the complexity of experiences of women who use drugs, I move from descriptive thematic analysis to the interpretations, looking at the ways in which the themes and whole life stories are narrated and in what contexts.

Figure 1: Themes identified in life stories of women who use drugs

Major themes	Sub-themes	Examples
Drug use	Initiation	Lack of information about drugs
		Curiosity
		Offered by friends
	Injecting	Do not know how to inject themselves (need help from partners)
	Reasons for using.	Drug using social networks
		Addiction (to prevent pain because of the withdrawal syndrome)
		To be able to survive hard living conditions
	Overdose	Reporting experiences with overdose
	Drug treatment	Motivation for treatment
		Barriers (do not have insurance card, proper clothes, waiting list)
		Failed because of the strict rules of the centre
	Prison	Immediate drug use after returning from a prison
Health	Drug-related health problems	Abscesses, vein damage
		Appearance
	Barriers to health care system	Fear to seek help
		Bureaucracy (do not have insurance card, health insurance debt)
		Lack of information where to go for help
Relationships	Intimate partners	Love, gaining help and support
		Partner as a pimp
		Interpersonal violence
	Family	Limited contact because of the blame
		Drug using relatives
Pregnancy	Drug use during pregnancy	Control of drug dose because of the pregnancy and child
		Motivation for stop using drugs
		Run-away from hospital after delivering the baby (withdrawal syndrome)
	Limited control	Unexpected and late diagnosis of pregnancy
		Barriers for seeking gynecologist
		Expensive abortion
Motherhood	Barriers to mothering	Drug use
		Poverty, unemployment, homelessness or poor living condition
		Lack of support from partner or family, stigma
	Loosing custody of (a) child(ren)	Depression, hopelessness
		Drug use increased
	Self-image	Need for being a good mother
		Acceptance of the consent of (a) child(ren) adoption
Structural factors	Poverty	Poor living conditions or homelessness
		Unemployment
		Involvement in sex work
	Repressive policies	Legal consequences, human rights violation
		Facing bullying from police
	Low access to service	Lack of health care, social and legal support
		Illegal housing
	Stigma and discrimination	Drug use must be a secret
		Shame, self-blaming
		Rejection (by people, institutions)

4.2 The meanings of narrated experience in personal and social contexts

In general, women who use drugs were firstly unsure what I wanted to hear from them. They repeatedly asked me to ask them direct questions, but at the end, all women were able to tell me their stories (except interviewee Rebecca, but I decided to work with her interview during the analysis, too, since her specific narration was very useful). Usually women who use drugs did not spend a lot of time speaking about their childhood – their childhood was only a step before the story of drug use. Stories were told in very simple way, often with signs of depressed thoughts and self-blaming.

During the interviews with outreach workers, interviewees had problems with answering questions where some level of generalization was needed (e.g. How the media presented women who use drugs?). Their generalizations were always linked to the uncertainty or statements such as - this is only my feeling/opinion, there are many variations. Information gained from outreach workers are mostly used for situating and contextualizing the stories of women who use drugs.

In the next paragraphs I present several aspects and phenomena which came out of the interviews. I analyze the category of gender and the ways in which events, experiences and whole life histories were narrated.

4.2.1 Notions of femininity

Several studies emphasize the link between drug use and gender roles. Malloch (1999), in her study of imprisoned women who use drugs, found the following:

> While illicit drug use may be defined as a "deviant" activity, perceptions of drug users are determined by socially constructed images of gender. Although the women are involved in an activity depicted as transgressing social norms, they remain affected by images and behaviours derived in gender relations. (p. 356)

Measham (2002) states that drug use is also a way of "doing gender" (p. 351) – so, in the case of women, drug use can be seen as a tool for challenging normative and dominant notions of femininity.

However, in my research, explicit identification of the category of gender within life stories was hard to find at the first glance. What one can hear were two categories: drug users and those who do not use. The category of a drug user was on the top of everything and categories of gender were somehow forgotten or implicit. Narration of the possibility of working as a sex worker and motherhood were the only moments where womanhood as such was explicitly taken into account without my questions. But after asking directly what they thought about gender, similarities, differences, and specificities, the interviewees started to talk more in gendered terms. I can offer two hypotheses in order to explain such behavior. First, the Slovak language is in general very male-oriented; there are different words to describe roles and attributes for men and women, but default forms, which are dominantly used are male forms. So when the interviewed women were using a word "junkie", they were using a male form of the word – "*feťák*", although female form also exists – "*feťáčka*".

The second hypothesis is related to the role of the drug user. During the interview with one of the outreach workers, asking her a similar question about gender, she answered:

> Well, of course, there are differences. But what I think... in our society people don't think this way. If you are a 'junkie', you are a 'junkie'. Nothing more and nothing less.
>
> Barbara, outreach worker

So I have noted in the interviews with women who use drugs, where the category of being a drug user was primary and dominant, the outreach worker believed a similar pattern could be identified in Slovak society. Moreover, she (the outreach worker) also used the male form of the word junkie.

Women who use drugs narrated feminine roles in the drug context in several ways. Some women reported that thanks to their kind and modest behavior ("women's behavior"),

the police were nicer to them and drug dealers were willing to wait longer for the money owed. They presented a belief that because they were women they had better communication skills, which made their life easier.

On the other hand, women also narrated their drug use as a sign of improper and untraditional femininity. They felt the stigma related to their drug use and sex work. Their drug use, assertiveness and aggression, sex work and relative financial independence (often a man has to rely on her female partner financially) were aspects which were challenging traditional notions of femininity. When they reported one of these aspects, I had an impression they were proud that they had a possibility to make their own money or were able to protect themselves (as they know how to fight).

> I think women have an advantage [compared to men]. You can go and make your own money and it's legal. You are independent. While men, they usually can't do this [sex work], so they steal and then, they have troubles with police. Or they collect scrap metal.
>
> Elizabeth, woman who is currently involved in methadone maintenance program and still using heroin and methamphetamine, (around 27 years old)

Of course, some women were aware of the limits of independence in their lives:

> Streetwalk, yeah you have your own money and you don't have to rely on somebody else... but you know, on the other hand, it's unfair... everyone thinks it's great but it's not, when a girl must work and a boy is "looking after" her...
>
> Alex, 28 years old woman who uses drugs

When these women talked about a future, it was automatically related to the life without drugs. And abstinence from drugs, it was associated with "normal" life and finally, with "normal" female behavior.

> Future – I think about it a lot... I will give it up, I will have a boyfriend, I will have a normal life... but it is hard. We are learnt to live this way and it's hard to change... probably, something must happen, something big... you know, I even can't cook or clean... yeah, I'll have to learn it one day, but when?
>
> Alex, 28 years old woman who uses drugs

The woman quoted here referred to normal life, which meant no drugs and having a boyfriend. This is particularly interesting, since this woman firstly identified herself as a

lesbian, or, using her words, “maybe bisexual”, but in her “normal” future, she was projecting herself with a boyfriend. Moreover, she was referring to activities she should know such as cooking and cleaning. So being “normal” was described as an abstainer from drugs, heterosexual and a housekeeper. Alex did not associate her future life with having children, but she mentioned earlier that she was happy she did not have children, since it was a huge responsibility. However, from other interviews, I learned that being with (a) child(ren) was an important part of recovery plans for women who already had (a) child(ren).

Emphasis on the body was also identified in relation to gender. Malloch (1999) found that women who use drugs in prison relate their concerns about femininity mostly to their appearance. This appeared during my interviews, when women spontaneously asked me how they looked and whether I could recognize that they inject drugs.

The other issue related to the feminine roles was motherhood. The issue of motherhood was present in all interviews. Those women who use drugs and did not have children narrated their childlessness as a blessing. Their image of being drug using mothers was associated with catastrophe and they could hardly imagine taking care of (a) child(ren) in their current situation. On the other hand, women who use drugs and did not have any children considered pregnancy and motherhood as important life moments which would maybe make them change their drug habits. But they stayed skeptical since they saw other women who were mothers and continued in their drug use.

Women who use drugs and reported to have (a) child(ren) mostly lost custody of them or decided for adoption (except one interviewee). During pregnancy, they remembered their plans to get better and start to live as “normal” people, but usually, their plans failed because of poor housing conditions, unemployment, drug addiction and mostly, because of the co-occurrence of these problems. Women also run away from the hospital after delivering a baby

because of the withdrawal syndrome, which meant their drug use was uncovered and children were taken from their mothers.

However, their relationship with their child(ren) was a sensitive topic. The interviewed women had a need to narrate themselves as responsible and caring mothers regardless of their drug use. They emphasized that they wanted the best things for their child(ren), hoping the child(ren) would not have any hereditary characteristics after them (in relation to drug use). They were worried that their child(ren) would repeat their mistakes – falling into drugs. Another concern was related to possible prenatal harms on their child(ren) because of their drug use. This type of worries – that their child(ren) would use drugs in future or about harms caused by drugs were found also in other studies (Baker & Carson, 1999; Haight, Carter-Black, Sheridan, 2009).

According to the interviews, narrating themselves as good mothers was important for their self-image, even when it was evident from their life stories that they did not spend a lot of time and energy on their child(ren).

One interviewee, after agreeing to participate in the research, when she was asked about her life story, started to repeat:

> They took my child....I wanted to change, but they took her/him. I have nothing to live for. What can I tell you about my life? My life is nothing, misery, 'cause I don't have my child...
>
> Rebecca, 25 years old woman who uses drugs

Although the interviewee was contacted several times, her life story narration was "limited" only to her regrets about losing her child. There was nothing else she wanted to tell me.

The interviewed outreach workers were well aware of this motherhood issue among their female clients.

> Women in our society are seen to have the only function. To become a mother. Of course, you get some education, have some career but it always ends up with our reproductive functions. We should be mothers, this is our role and we

> are respected and honored as mothers. And then someone completely failed in this role. I don't think there is something more terrible than being an addicted mother.
>
> Mary, outreach worker

So one must ask to what extent these narrations of drug using mothers have been influenced by a dominant discourse that dictates motherhood as the important role in a woman's life. I do not doubt these women liked their child(ren) or could not be good mothers. I believe and according to the stories, most women appeared to be motivated to change for their child(ren) and failing to do so was associated with drug use increase and depression. The failure, often narrated as one's own fault, is often a consequence of difficult socio-economical conditions. These barriers to mothering and negative reactions to the loss of child(ren) are also emphasized in the studies from the US (Kearney, Murphy, & Rosenbaum, 1994). This also confirms the findings of another study realized in the US, where researchers found drug use is not the only important factor which influences possibility to take care of one's child(ren). Possibilities and limits of mothering are associated also with psychological health, family size, homelessness and domestic violence (Nair et al, 2003).

4.2.2 Changing self – we and they

I have mentioned that the category of a drug user was significant in life stories of women so I would like to develop this idea. The studies emphasize that drug use and recovery have a significant impact on the changing self or identity during the life course among drug users (Grant, 2007; Etherington, 2006). During my research, I found that identity of women who use drugs was constructed mostly in relation to drug use. Women were narrating their stories often in the plural: "we junkies". But this "we junkies narration" could be identified only among women who currently used drugs. One interviewee who was involved in a methadone program and was not using drugs, narrated herself in relation to "we who are trying to give up drugs" and she was describing drug users as "they". She was not part of

"them" – drug users anymore. Interestingly, the other woman who was involved in a methadone program but still used methamphetamines and sometimes heroin, was narrating her identity within the borderlines of 'we junkies' and 'we who are trying to give up drugs'. She was using both terms, which could indicate an ongoing process of identity transformation.

4.2.3 Intersectionality

Another issue which must be addressed is related to the intersectionality of gender, ethnicity and class. The interviewed women who use drugs mostly referred to their difficult socio-economical conditions which impact their lives. Women who were homeless usually narrated their lives in a more negative and depressive way in comparison to women who had at least some more or less stable place to live. Drug use was a way to cope with such harsh conditions. Usually, drug use was not narrated as a cause of these conditions, it was the other way around – living conditions had an impact on drug use.

Half of the interviewed women were Romani, but usually they did not put a lot of emphasis on their ethnicity during life story narrations. These women did not see their ethnicity as an issue and they explained stigma they experienced through reference to drug use and, more rarely, to gender, but never to (Romani) ethnicity. However, I did not focus on or ask about ethnicity during conducting interviews, so it is hard to conclude, what the silence about ethnicity is about. It is especially interesting, because the findings from representative survey conducted in Slovakia reports growing social distance towards Roma. Just for illustration: respondents in Slovakia in 2008 reported they would not want to have a neighbor who is - the most reported category was a drug user (88.6%), the second most reported was a Romani person (82.4%) (Kotvanová, Chaloupa, & Müncnerová, 2009). How is it possible, that stigma and discrimination related to drug use was narrated, but not the stigma of ethnicity? Although, it was not said by the women who use drugs, the interviewed outreach workers told me that the fact of being a Romani woman just multiplied the stigma which was

related to women who use drugs. Being a Romani woman who uses drugs and being pregnant or having (a) child(ren) was narrated as the most vulnerable position by the outreach workers. In my previous work, I found out that the Slovak press mostly represents sex workers as Romani women who are poor, addicted to drugs and immoral (Žilinská, 2010). Such a woman –Romani woman, who use drugs and is a sex worker will probably face bigger discrimination everywhere.

4.2.4 "These other women"

An interesting phenomenon was identified during conducting interviews. This was possible only thanks to the fact that lots of the interviewed women knew each other and interviews were often interrupted by other drug users who needed talk with "my" interviewee.[19] Negative experiences – such as stealing clients and facing violence from partners were narrated as the problem of "these other women" – not the interviewee's. After completing several interviews I realized the interviewed women had attributed these negative features to each other all around.

> I don't have a pimp... these other women have... actually, those pimps are their boyfriends... but I don't understand it, they are not nice, and they beat their girlfriends...I mean, there is love, don't get me wrong. But... well, it's hard.
>
> Veronica, 25 years old woman who uses drugs

One man, who joined me and one interviewee at the end of the interview, told when the interviewee left:

> These loves, these boyfriends of these girls... is this love? When you, as a man go with a woman and let her sell sex and you are her pimp..? She gives you money and you beat her, because it is not enough. Is this love? These girls, all of them, do not want to admit these men just exploit them...
>
> About 30 years old man, former heroin user

Women also liked to emphasize that they always used condoms, did not sell sex under price, did not steal money from their clients and behaved responsibly when they injected

[19] All people who interrupted the interviewing process were informed about the ongoing recorded interview and agreed to be recorded.

drugs - they used their own syringes and did not share them. In terms of sex work, offering cheap sex without using condoms or stealing was narrated as the fault and mistake, again, of "those other women". But after listening to the interviews, my impression was that all these activities, narrated very negatively, were a ubiquitous practice. According to the principles of safer drug use, as a former outreach worker I am well aware of the fact that syringe exchange programs hardly cover the real needs of injecting drug users. An ethnographic study in the US shows that drug users learnt the right answers to questions about their injecting habits, but that does not mean they behave according to these answers (Campbell & Shaw as cited in Carroll, 2011). Also Malloch (1999) identifies the difference between what is stated by the drug users about injecting process and what is really done (in terms of sharing and not sharing syringes).

My hypothetic explanation for such a hiding behavior is similar to the one from the mentioned ethnographic study. Although my position was a researcher, the interviewees still could see me as an outsider, an outreach worker – an authority. And they recognized me as a non-user who probably could not completely understand their world and life and as someone who could judge their mistakes. This kind of behavior can be a sign of limited trust between me and the interviewees.

But I would also like to consider, what it means for an interviewed woman to narrate herself as a thief or a victim of interpersonal violence. Outreach workers highlighted that typically, drug users were seen very negatively, as criminals. Women described a variety of negative' behaviors, so they probably wanted me to know, as a researcher, that violence and stealing exist in their world. Maybe, they did not want to tell their personal experience, because of the stigma in which they lived. Not admitting victimization and criminal behavior could be a defense mechanism, a way to live in an environment where such behavior is strictly judged as immoral (in relation to stealing) and as one's own fault (in relation to being a victim of interpersonal violence).

4.2.5 A life to regret and self-blaming

Drug use was often narrated through the attitudes of regret and self-blaming. Besides regretting, the issue of pleasure and enjoyment was completely absent. Although some studies report pleasure linked to drug use (Malloch, 1999; Measham, 2002; Valentine & Fraser, 2008), dominant discourses around drugs erase pleasure and highlight risk and pathology (Moore, 2008) and even in the harm reduction approach, the issue of pleasure is rarely present (O'Malley & Valverde, 2004).

The attitudes of regret and self-blaming were especially strong among women who were/had been involved in treatment process or were trying to get into the methadone maintenance program. According to interviews with outreach workers, self-blaming and these negative narrations of drug use habits are reproduced and reinforced by dominant discourse related to drugs. Just for an example, most drug treatment programs in Slovakia are based on total abstinence and on a renunciation of the previous drug lifestyle, not in its acceptance as a part in one's life history. Drug use is seen as something that can hardly be accepted or enjoyed. The interviewed outreach workers stated that the mass media were also reinforcing this idea of guilt in the drug context, so internalized stigma – self-stigma – is a natural reaction to such pressures.

> I really regret that I use... you know, that you don't open the window and it's cold because of the weather...not because of the cold turkey [withdrawal syndrome]. It's great when you wake up and you don't feel pain.
>
> Alex, 28 years old woman who uses drugs

> These people...we are not humans... we are junkies.
>
> Dominica, 33 years old woman who uses drugs

> Twenty years of using... I didn't enjoy anything. Drugs destroyed my life, my everything, health, life, family relationships... I can't see anything positive about it. But it's my fault. Only my fault.
>
> Kate, 33 years old woman who is currently involved in methadone maintenance treatment

The signs of depression and suicidal thoughts were also highly prevalent. The failures in treatment, in maternal roles, hard living conditions and self-stigma were always narrated in a depressed way. But what are the functions of such narrations? Is it a reaction to living in a stigmatized and judgmental environment? Is it the internalized dominant discourse or is it the only way they can understand their life experiences? Maybe, the verbal presentations of suicidal attempts can be understood as an attempt to make others (me) sorry and less judgmental.

The negative attitudes towards the drug using lifestyle were even strengthened by claims about the interviewees' future. Each woman narrated her future plans without drugs as living a "normal" life. Some day, they will live the way they should live as "normal" people.

4.2.6 Childhood as a positively narrated experience

In comparison to the bleak stories about women's drug using careers, childhood was often narrated as a positive memory. Women who use drugs often described themselves as having a happy childhood and everything they wanted. The interviewed women grew up in a variety of environments, with one or two parents or were raised by their grandparents. Childhood was always a great contrast of happy time in comparison to the days after their first drug use experience (during the time of adolescence).

However, after they continued in their narrating, traumatic experiences from childhood typically surfaced – divorce, alcohol use within the family, the suicide of one of the parents, sexual abuse or spending the majority of their life in specialized re-educational centers.

> I had a beautiful childhood... every child has, no? My mother gave me everything I needed... [...] well, my dad, he drank a lot, sometimes, during the night, my mother just took me and ran away from our house... That wasn't nice...
>
> Veronica, 25 years old woman who uses drugs

But why is childhood narrated so uncritically positively? The childhood of the interviewed women was for sure not without troubles. Many experienced emotional or physical abuse, and many had to take part in maintaining the household and caring for younger siblings. In some cases, their parent(s) left them in re-educational centers. So what does it mean to remember and claim happy childhood? The first hypothesis is related to the already discussed notion of self-blaming. These women do not blame their parents of a lack of caring or love, even if they could. The other explanation can be that childhood is a memory about the time when they were not using drugs. But then, most of the interviewed women tried to stop using drugs in the past and many of them did not use for a longer time period after relapsing. But the periods of abstinence were not described in such a positive manner; they were not described at all, just mentioned.

Most of the women narrated a shift from being a good child with a good life into "a bad girl". This shift was a moment when their life stories started to be narrated in very negative way. Childhood was narrated through nostalgia during the interviews, as something nice in their hard lives. My impression from their narrations was that, maybe, nostalgia needs to be preserved in order to promote at least some positive elements with one's self and life experience.

4.2.7 Agency and hardiness

So far, my results repeat many findings (presented in Chapter 1) about women's vulnerability and life experience. However, I would not like to reproduce a victimization narrative about women who use drugs. Although their stories were full of negative events and emotions, trauma might be interpreted also in terms of hardiness. These women experienced a

variety of unpleasant situations and injustices, but they were still alive and they tried to do their best.

Situated in poverty, discrimination, stigmatization, lack of services and influenced by drug use, their life choices might be viewed as very limited. And sometimes their situation seemed to be hopeless with no way out. Here, I would like to bring in Bandura's (1999) understanding of human agency. He puts human agency into dynamic interactions between personal and environmental factors (Bandura, 1999). The interviewed women might be limited by withdrawal syndromes, cravings, experienced trauma and structural factors, but that did not mean they could not act as agentic persons. For example, some of them reported that they could easily control their drug use:

> I can overcome the withdrawal syndrome... when I want to, I use, when I don't want, I don't use.
>
> Kristina, 31 years old woman who uses drugs

The interviewed women often narrated their lives, in spite of the many structural barriers, as lives which could be better. They tried and failed. Over and over. They knew the barriers but they also knew and believed in their strength of motivation. Maybe they did not try to change their lifestyle at that time, but they believed they would be able to do it later. Some of them were able to accept the current situation and decided to accept their drug use.

> If you want to give it up, first of all, you must really *want* it. And then you can do it. I have not stopped using, because, to be honest, I don't want to. One day, when I will really want to stop, I surely will.
>
> Veronica, 25 years old woman who uses drugs

Another example of patterns of agency and empowerment I identified was their narration of sex work. Although many of them would prefer to do something else and told me that sex work was hard and often dangerous, they never referred to themselves as to prostitutes or "whores". They called themselves "sex workers". The impact of consciousness raising about sex work by outreach workers was evident.

> So my name is Veronica, I am 25 years old, I am from Bratislava, I use heroin and meth... well, and I am a sex worker... [smiling], right? This is the way how you [outreach workers] taught us, that we are sex workers [smiling].
>
> Veronica, 25 years old woman who uses drugs

> Yeah, sex work, I mean, I would prefer not to do that one day, but it's good money, I mean, some days are worse and some are better, but you can always make some money and it's better than to be for example, a cleaner. Yeah, sex work, damn it, you [outreach workers] are right, it is work, too, and it's a honest work. I could steal but I rather sell sex, so what?
>
> Alex, 28 years old woman who uses drugs

Even in narrations of despair, the notions of agency and self-advocacy appeared:

> You go to the hospital, you need something, but everyone looks at you [thinking] 'you are a junkie' and blames you... they don't see we are sick... Damn it! Addiction is an illness, but they don't understand, although, doctors... they should understand. We are sick people. We use drugs but we are not trash!
>
> Dominica, 33 years old woman who uses drugs

I found it important to point to these empowering aspects, self-efficacy and agency itself, because drug use is often associated with losing control over one's life (Levy, 2006). Although drug use has its impacts on behavior and body, narrations of these women showed that drug use should not be understood in the limited terms of losing control.

In this chapter, I have demonstrated that the life story approach towards women who use drugs brought up a lot of information about their lives and experiences with drugs. I have identified several themes related to drug use, health, relationships, pregnancy, motherhood and structural factors and I have focused on the ways in which the stories were narrated considering gender, class and ethnicity. Although the negative narrations and self-blaming were very prevalent in the life stories, agency and hardiness were identified even within harsh conditions.

In the next chapter, I pay attention to the narration of women's needs and to their experiences and opinions about drug-related services in order to assess the extent of gender sensitivity in drug-related services in Slovakia.

CHAPTER 5 - NARRATING EXPERIENCES WITH DRUG-RELATED SERVICES

As the second part of the interviews, women who use drugs as well as outreach workers were asked to describe their experiences and opinions with drug-related services, which were basically divided into 2 groups – syringe exchange programs and treatment programs (mostly methadone maintenance and other types of treatment programs). The interviewees were also encouraged to think about ways of improving these programs in order to make them more effective and accessible. In the interviews with outreach workers, special emphasis was put on gender sensitive aspects of such programs (whether they exist in Slovakia and what they actually look like).

First, I describe the experiences with the services by women who use drugs, adding some explanations and contextualization using data from the interviewed outreach workers. I highlight several aspects of the experience narrations – mostly how women who use drugs perceived services in Slovakia – and then I identify some of the gendered needs which came up from the interviews.

In the second part, I specifically focus on the idea of gender sensitive services: what it is and how it differs from women-friendly services. Then, I illustrate how this plays out in Slovakia. The end of my analysis consists of recommendations for how gender sensitive services should look.

5.1 Experiences and opinions on drug-related services

All of the interviewed women who use drugs were visiting in the harm reduction program of the NGO Odyseus, or had been visiting in the past.[20] Just to remind, two of the interviewed women were currently involved in methadone maintenance program and five of

[20] I did not ask my interviewees whether they have experience with the second harm reduction NGO which provides service in Bratislava. However, I expect most of them use its services, too, since places of outreach work of these two NGOs are overlapping.

them had some experience with different treatment programs (so they had "failed" during the treatment process or relapsed). The rest of the women did not use treatment programs although they reported some periods of abstinence during their drug use lifetime (in prison or abstinence without any professional help). One of the interviewees (Rebecca) did not give me information about drug-related services, since she was not able to continue with the interview after she described and expressed her despair related to the loss of her child. I asked her a week later whether she would like to continue with the interview but she refused because she was experiencing withdrawal syndrome.[21]

During the interviews, besides the life stories, I paid special attention to the experience with drug-related services of these women. If they did not mention as a part of their life style (what they usually did), I asked them, if they had any experiences with such services. Were these experiences negative or positive? What happened when they "failed" in treatment programs? Finally, they were encouraged to think about the ideal and perfect services and describe it.

5.1.1 "It must be that way"

The interviewed women who use drugs were engaged to criticize and use their imagination in order to describe what could be better in drug-related services. However all women expressed satisfaction with current outreach work services which is being offered by the NGO Odyseus and did not criticize a lot. They told me they liked the offered service as well as the outreach workers as the extract from the interviewee demonstrates:

> I like the needle service... [the outreach workers are] nice to us... I would appreciate food distributions.
>
> Alex, 28 years old woman who uses drugs

[21] Because of this, I 'excluded' her interview from this part of analysis.

The important factor which enters here is the fact that all of these women were aware that I was somehow connected with the NGO. In the previous chapter, I brought up one study, in which researches found that drug users report the type of behavior which is expected from them – in that case, that drug users do not share needles in order to avoid infections. However, in everyday life, they share needles, even when they were observed by the researches (Campbell and Shaw as cited in Carroll, 2011). The outreach workers interviewed for my research also claimed that drug users usually liked them and they did not want to disappoint them. Such a relationship then creates a situation when a drug user is also saying what she or he believes is expected from her/him. It is possible that a similar pattern of behavior appeared in this situation, too. My interviewees were associated me with outreach workers and some of them even remembered me as an outreach worker, so it could have been difficult to criticize the service in front of me.

A similar pattern which occurred during interviews was what I would call humble thanking. The extracts above illustrate how the interviewed women narrated "us", outreach workers (and although they did not refer especially to me, they included me in the group of these "perfect outreach workers") as the only people who are willing to help them.

> I think, Odyseus is good... *you* [outreach workers] do for us much more than these junkies actually deserve.
>
> Kate, 34 years old woman who is currently involved in methadone maintenance treatment, (emphasis added)

> Nothing... nothing [to change]. *You* [outreach workers] do the best, nobody else cares about these junkies, *you* [outreach workers] do.
>
> Dominica, 33 years old woman who uses drugs

With such attitudes towards outreach workers and influenced by the fact that they saw me as one of the outreach workers, one could hardly expect the interviewed women would complain about the services offered.

In comparison, the comments to drug treatment system in Slovakia were more critical (which could be again influenced by the fact that I am not currently involved with treatment

programs). The most addressed theme was the fact of strict rules. For example, residential therapy was criticized because of its strict rules about creating closer relationship within the centre.

> Well, what should I change in treatment [programs]? They should allow them [drug users] to smoke more, so they won't be restricted so much.... And then you cannot be with a man there, you cannot talk with men... actually that's what I heard about it...
>
> Kristina, 31 years old woman who uses drugs

> The rules of the residential treatment programs are set very strictly. You have a strict regime of your day, when to exercise, when to do group therapy, when to work, when to deal with problems, when to smoke if you are a smoker, etc. And at the end of the day, people are terribly tired. During a day people don't have extra time to think about themselves, they are doing something all the time. The question is, when they can think about themselves? And the answer is, during the activities. Rules in the residential treatment program make sense, though they can appear too far away from the real life. Rules prepare them to live in the real world, for example to stand up when you fall down, don't give up, to be responsible for your own behavior. But definitely, this type of system does not fit everyone. I mean it is really, really hard, even I had problems to live that way [within strict rules and regime] when I was [working] there.
>
> Laura, former outreach worker with working experience within a residential treatment programs

> Interviewee: I wish I could bring something personal there... a photo of my daughter or her old toy... something that can give you some hope when you're feeling alone.
> Me: Do you mean, you cannot bring your things there?
> Interviewee: No. Not even a hair clip.
>
> Emma, 31 years old woman who uses drugs

From the statements selected, I would point out the fact of misunderstandings and inability to deal with this type of system and regime within residential treatment programs. On the one hand, the rules and regime are indeed strict, inflexible and hard to deal with, mostly if a person was experiencing a "chaotic lifestyles" of drug use for years before. On the other hand, this type of rules and the regime had some meanings and philosophy as to why they were important and what was the goal of learning to live within such system. According to Laura, who had working experience in a drug treatment centre, these rules were intended to prepare people to live "normal" life with set regime Then, I must critically ask: do "we" really

expect an ex-drug user to stay in a treatment process, when she or he is forced to live in a way without a sense of meaning to it?

I do not want to problematize this type of treatment programs in Slovakia as such. What I argue is the fact that the interviewed women did not understand the treatment process in its complexity and this issue should be carefully addressed. My impression was, that these women narrated drug use as something what was hard, but they could handle it, because they knew "what's going on in this drug world". Drug treatment was also seen as hard and they were not sure, what was the logic and what was the goal. For example, many of them tried methadone maintenance treatment, which is a long term treatment (possibly for the rest of patient's life), but they believed after a few months, they would be magically treated and would not want drugs anymore, which was not a case among these women. I believe every patient has the right to know and understand the details about her or his ongoing treatment process. I believe a deep understanding of the problem/disease is an important part of treatment because it helps a patient to cooperate as well as to be able to freely and responsibly choose the direction of the treatment process (to continue or to stop). Having information – and an understanding of the treatment process could probably bring better cooperation between women and personnel of drug treatment centers.

As I presented in the previous chapter, moments of self-blaming and stigma internalization came up even during the discussion of drug treatment services in Slovakia. The statement above describes a situation of one woman who was attending methadone maintenance program. Drug users in Bratislava have go to the centre every day to get methadone, while the service has certain working hours and methadone will not be given outside of opening hours. The interviewed woman was late for her methadone dose and that was the reason why the centre cancelled her participation in the treatment process. Without a

dose of methadone, she experienced painful withdrawal syndrome and she started to inject heroin again.

> Interviewee: So I was late for methadone... they kicked me out and I am using again. It's a never-ending story.
> Me: So you are saying that if you got your methadone, you probably wouldn't be using now, right?
> Interviewee: Yeah, but... but... You know, when you are working with junkies, you must be strict. We need rules!
>
> Emma, 31 years old woman who uses drugs

The outreach workers reported similar never-ending stories about their clients, too. Their clients were dealing with doctors in order to be involved in the methadone maintenance program (what takes at least one week on preparation and initial examinations). But after breaking the rules, they were excluded. They started to use again and later, if they were motivated, they attended and had to complete the same involvement process again.

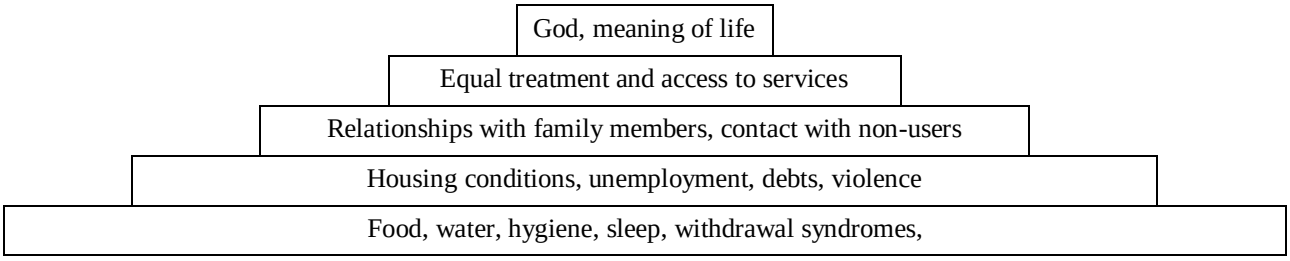
The problem was that rules in classical treatment programs had their justification and they only followed the goals of abstinence and inclusion into "normal" life. The rules in methadone maintenance program had their sense too, however the difference was that the methadone maintenance program was actually a harm reduction program. The goal of the harm reduction programs is not abstinence but reducing risks; getting methadone instead of injecting street heroin for sure decreases some risks. Harm reduction programs should be easy to access and open to the drug users' specific needs. Although I am well aware of the fact that every drug-related program faces its own limitations (legal, personal, financial,...), the non-stop access to the methadone dose or non-stop access to clean syringes and injection equipment would be fundamental in drug users' lives, although such an ideal situation (non-problematic access to methadone or to syringes) was never addressed by the interviewed women who use drugs. My impression from the interviews was that these women were keeping their feet on the ground. They saw themselves as those who were constantly failing and they did not deserve anything better unless they changed. They did not mention structural

factors during their narration of own experiences with treatment centers. Even though, I identified moments of resistance when these women felt they had rights for the access to health care services, where drug treatment was part of it (probably after years of consciousness raising by outreach workers).

5.1.2 The narration of needs

The real challenge of my thesis was to find an answer to the question of women's needs without projecting social stereotypes on the one hand, and without idealization through the lens of my own feminist perspective on the other hand. Identifying the needs of interviewed women was even harder since, as I have already mentioned, many of them accepted services as it is. So I also looked at the life stories and for the moments where these needs were mentioned. The needs which were explicitly or implicitly reported fit into the classification created by Maslow (1943), who defines hierarchy of human needs: physiological, safety needs, love and belonging, esteem and self-actualization. Inspired by the Maslow's hierarchy, I clustered the needs on women who use drugs in hierarchy, too (see Figure 2).

Figure 2: Hierarchy of needs reported by women who use drugs



First, I discuss the needs on the level of physiological needs. Women who use drugs often reported that sometimes, they faced lack of food or water. The problem was that although thanks to sex work, they can earn money, but if they felt withdrawal syndromes, they preferred to invest money in to drugs, not in food or water, but that did not mean they were not hungry or thirsty.

> I know it sounds like we are stupid, you can think: so go and buy food and not drugs. Well, this isn't so easy at all. People can't imagine, what it is like, the cold turkey [withdrawal syndrome], that pain. So then some junkies for sure decide to buy drugs not food, because with drugs, you solve several problems at one: the cold turkey, hunger, thirst and bad feelings. But...you know. You still need it [water and food].
>
> Alex, 28 years old woman who uses drugs

Since several of the interviewed women who use drugs were living with friends, or in temporary cottages or tents without gas, electricity and water, for many of them, the need for basic hygiene was addressed. This was especially acute for women who were working as sex workers where proper hygiene is necessary in general.

> Ok you live where you can... but often you do not have a place to take a shower or wash your clothes and that's hard. And especially for women on the street [meaning sex workers].
>
> Emma, 31 years old woman who uses drugs

Another group of needs is related to the need of safety. The most discussed topic was related to accommodation or living conditions. The interviewed women reported poor living conditions (such as illegal cottages without gas or water, temporary dormitory) or homelessness. Outreach workers emphasized that cheap dormitories in Bratislava were full and often offered only to men (as in dormitories for manual workers), shelters for homeless had fees and there are only limited numbers of beds for women. The problem was getting bigger, if a woman faced violence from her partner or family member, because shelters for abused women were not open to drug users or even women attending treatment centers. I argue that, although good housing conditions are important for both women and men, in the Slovak context, the issue is gendered in a way that women have worse access to cheap accommodation.

The problem of housing and unemployment was especially emphasized among women were trying to give up using drugs.

> Definitely, [there is a need for] sheltered housing and jobs, most of us have a criminal record, cannot write a CV...and if you are getting drug treatment,

> housing is essential, because if they are in the street or in some dealers' flats and if you want to give it up, this is not a good environment for you.
>
> Kate, 34 old years old woman who is currently involved in methadone maintenance treatment

The additional never-ending problems were the debts which these women had in insurance companies or in public transport' provider. With debts in insurances companies, doctors might deny help and only urgent care is provided. Debts also meant a problem if women were trying to find a work, since employers generally prefer not to deal with debts of their employers.

The fact that many of these women did not have a place to go was related to their relationship with family members. All of them could go and ask for help from their families, but they did not want to. Their families did not believe them anymore, every time these women met some of the family members, they faced only blaming and misunderstanding. One of the interviewee told, as I was explaining her the principle of anonymity in my research:

> I don't care, you can use my name... maybe if my Mum read it she would finally understand that this [drug use] isn't so easy... that it is not like, you say – stop using drug and I will stop... it's a complicated world. And every time I meet her, she blames me – and she believes that will help me, but of course, it makes things even worse.
>
> Elizabeth, woman who is currently involved in methadone maintenance program and still using heroin and methamphetamine, (around 27 years old)

And even though women did not mention good or better relationships with family members as a need which they would need to fulfill, according to their life stories, it was always mentioned in very emotional way, with signs of regret and anger. Probably, they would appreciate a family where they could get emotional support (ideally material help – accommodation, too) or at least someone within their family who would accept them as they are – women who use drugs. The dynamics of family relationships can have an impact on women's self-perception and well-being as the extract from the interview with woman who grew up with her grand mother while her father was in jail (because of car stealing):

> You know, my grandma, I cannot visit her anymore, because then, she won't let me go. And then I feel terrible. But my Dad, I mean he wasn't happy when he found out about drugs and sex work... but he doesn't say that all the time as I am with him, he simply accepted it and that's great. The relationship is much better.
>
> Alex, 28 years old woman who uses drugs

Other relationships which were discussed were relationships with people who do not use drugs. This was especially important if women attended drug treatment program and wanted to stop using drugs. Stable contact with drug users meant a challenge for someone who was trying to give up drugs. One women described her experience while she was in prison and she was preparing for return:

> I was in a prison, not using... and I was sure I wouldn't do that anymore. We had groups and we were discussing that, one day, you will go home and you will see it [drugs, drug using friends] and you will say "No!" ...but then... you are back. Nowhere to go, you have no money so you go to the street to make some money, you see it [drugs] and you are back again.
>
> Veronica, 25 years old woman who uses drugs

The problem of permanent contact with drug users during the treatments was often connected with the already mentioned issues such as housing and unemployment. Woman who was at that time involved in methadone maintenance program and still was using heroin and methamphetamine described her situation as follows:

> Still in the same environment, shooting, what can I do [in the sense of how to achieve abstinence/control of drug use]? So I went for methadone, but I don't have a stable place to live, no job, so I make money by streetwalking to have money for the dormitory... and then, I see them, I talk with them [drug users]... and can't resist [craving].
>
> Elizabeth, woman who is currently involved in methadone maintenance program and still using heroin and methamphetamine, (around 27 years old)

The often addressed problem was that these women were not motivated to seek for help, since they had bad experience with most of the institutions – health centers, police, and social workers. I defined this situation as the need for equal treatment and access to services. I guess, because of self-stigma, believing that they did not deserve better, they did not mention a desire for not judging attitudes from these institution. But, listening to their stories, I found

out that these women were trying to solve their problems on their own. Many of these women for example had painful abscesses but they did not go to the doctor for treatment. These women often told me that they rarely called the police when they were victims of violence. They tried to avoid contacting these institutions, so they did not have to hear that they were trash and all their problems were their own faults.

But the problem was exceeding discrimination and stigma itself. For example, some services (which would be needed) were completely missing. There were no doctors with focus on pregnant women who use drugs, no programs for mothers who use drugs. However, needs related to pregnancy and motherhood were rarely addressed by women who use drugs. But that does not mean this kind of services was not needed. The outreach workers often expressed a regret that many women were asking help from them when they were pregnant but they had only limited possibilities to help. It is especially interesting, because as I mentioned in Chapter 1, services with focus on pregnancy and motherhood were the very first services for women (see e.g. Seddom, 2008, Campbell & Ettorre, 2011). In Slovakia, even such a basic service with a clear (although limited) focus on pregnant and mothering women is missing.

The very last needs which were identified are according to Maslow (1943) related to self-actualization. Facing so many problems and pain, women were often asking if their lives had any meaning. Some understood their addiction (they identified themselves as addicts) as a task, something what will make them stronger. Others were sure that they destroyed their lives and life "mission" (more in spiritual sense) with drugs. Also questions related to the existence of God appeared, for example one woman whose boyfriend committed suicide and both children died during childbirth, stated:

> I believed in God! F***, there's no god! My children, innocent children, they didn't do anything bad, I did, they didn't and they both died! What kind of god would allow that? Such innocent souls...
>
> Dominica, 33 years old woman who uses drugs

I cannot say to what extend these needs – transcendental needs were addressed for example by charities. But according to the life stories, questions related to the meanings of one's life and God are also parts of the lives of women who use drugs.

Overall, women who use drugs did not talk about drug-related services a lot. This could be because of the aspects I have already discussed: my position as a researcher and as an outreach worker, beliefs that they did not deserve it, and seeing failure in treatment as only personal mistake. Another reason can be the fact that questions related to the services were addressed in the second part of the interviews and if women wanted to finish the interview as soon as possible without rejecting me, short and quick answers might be the way to do it.

I identified several needs using the life stories and organized them into the hierarchy inspired by Masllow's pyramid (1943). I would like to point out, that most of the needs should be considered as interrelating. Again, gender aspects of their needs was not primarily reported from them (as was the case during life story narration), however, the needs I identified through their narration had some gendered aspects and were influenced by gender identity.

5.2 Gender sensitivity in drug-related services in Slovakia

In this section I examine gender sensitivity in drug-related services. First, I address the current situation in Slovakia, using mostly interviews with the interviewed outreach workers and then, since all of them where asked to evaluate and think critically about gender sensitivity and "women's issues" in the NGO Odyseus, other syringe exchange programs and drug treatment programs in Slovakia. Based on the interviews with women who use drugs and outreach workers I draw an illustration of gender sensitivity, answering the basic question:

what does it mean to be gender sensitive within the drug use issue? The findings in fact create recommendations for future development of gender sensitive drug-related services for drug users (not only for women).

5.2.1 Critical evaluation of the current situation in relation to gender sensitivity

In fact, in evaluating gender sensitivity, the interviewed outreach workers were very critical. Mostly, they talked about the stereotypes and the very sexist setting in Slovak society in general, so call for a gender sensitive approach for drug users was seen as hard to achieve or even tried to assimilate within existing services.

> Access to any service [health, social, legal] in Slovakia is hard. And it is especially hard for women because it is not adapted for them and not at all for women who use drugs. [...] Daily interactions, media, show me that women are humiliated, her dignity is devalued. [...] There is a permanent mockery that women are emotional, that they are hysteric...
>
> Mary, outreach worker

Overall, as an earlier survey from 2004 about gender sensitivity within drug-related services in Slovakia showed (EMCDDA, 2005), my analysis also found a lack of gender sensitivity or women-orientation. After 8 years, drug-related services have not registered a noticeable change to move towards gender sensitive programs. Although harm reduction programs providing outreach and syringe exchange had special focus on sex work and usually address female sex workers, this can hardly be seen as women-friendly or a gender sensitive approach. I would compare it to the first attempts of doing drug treatments centers and harm reduction programs for women, which in fact only reinforced stereotypes about women's needs, since they paid attention only to pregnancy or mothering (see e.g. Seddom,2008; Campbell & Ettorre, 2011). Women who use drugs faced different problems and complex situations which should not be limited only to pregnancy, motherhood or sex work. Of course, these issues were part of their lives, but not the only important ones. I do not criticize focus on sex work (or pregnancy, motherhood), but if this focus is identified as women-friendly

approach, it ignores the complexity of women's lives and it can even re-enforce the stereotypical automatic connection of drug use and sex work among women.

> Service is not set for women. Just an example, we [drug-related programs Slovakia] do not deal with the issue of reproductive rights, sexual health, often we don't go beyond the issue of sexually transmitted disease within sex work.
>
> Mary, outreach worker

As the interviewed outreach workers reported, even the issues that could be labeled as stereotypically associated with women, such as motherhood, pregnancy and violence were often not highlighted in drug-related services.

5.3 Recommendations for gender sensitive approach in drug-related services

The outreach workers were asked what they understand when someone says gender sensitive program. The identified aspects are described below.

5.3.1 Gender sensitive versus women-friendly program

The interviewed outreach workers almost automatically differentiated between women-oriented program and gender sensitive programs. Some of them had not thought or read about these issues before, but they nevertheless came to a conclusion about the difference.

> Gender sensitivity? I think it can mean that you try to reflect gender differences... Special programs for women, mothers, pregnant women... something that is flexible and can reflect women's lives. But now when I am thinking about it, I don't believe that for example drug treatment programs reflect men's needs either. I guess we all work with stereotypes and we are really overwhelmed with many issues so somehow, gender is not reflected even it's there.
>
> Andrea, outreach worker

Trying to involve "women's issues" was seen as an important part of gender sensitivity and it was also narrated as a first step in implementation of gender-sensitivity in Slovak drug-related services. But finally, the interviewed outreach workers all concluded that gender sensitivity meant revision, which would affect women, men and transgender people,

too. According to the interviews, I highlight several aspects which were identified as cornerstones of a gender sensitive approach. Since the outreach workers indicated, that the ideal situation would be to have gender-sensitive programs, not only women-friendly programs, from this point I will be referring to people who use drugs regardless of their sex/gender.

5.3.2 Intersectionality and gender as context

In connection to the previous issue, which addressed gender sensitive approaches not only to women, the issue of intersectionality was also emphasized.

> If the programs want to be effective, they must reflect the needs of women, men, and transgender people and within these categories also look at young people, ethnic minorities. Good service just must fit.
>
> Mary, outreach worker

The interviewed outreach workers at some point started to referring to gender as a living context, not an identity category. In other words, being a woman was not perceived as a set of women's needs related to the embodiment of her gender or sex. For them, being a woman meant to live in certain context and meanings that were enriched by other factors, such as class, ethnicity, sexuality, drug use, (non)involvement in sex work or number of children. All these factors works in interaction, so one can say that class, ethnicity, or even a type of drugs which are used and others factors are gendered (and gender is in turn affected by these other factors). I have already, briefly discussed intersectionality in the discussion about crack mothers and gender-sensitive programs. The authors presented, that panic about drug using mothers were mostly related to poor and Black women (Gomez, 1997; Litt, & McNeil, 1997; Zerai, & Banks, 2002). According to the CSAT (2009), "effective treatment will depend equally on attention and sensitivity to the vast diversity among the female population, including overlapping identities of race, class, sexual orientation, age, national origin, marital status, disability, and religion" (p. 5)

5.3.3 Challenging stereotypes and stigma

Gender sensitivity meant to uncover and talk about stigmas, even when applied to oneself. But again, although I previously stated that women face multiple forms of stigmas, this aspect is again related to women as well as to men or transgender people. It was addressed when outreach workers realized that so-called male oriented services actually did not deal with stereotypes about men, which could be very, very hard to live with.

> We talk with women about sensitive topics a lot. But I – I don't know about others – do not deal with masculinity and how it affects men's experience with drug use. Men are forced to be the strong ones and protectors of their [female] partners, so what does it mean for a man when he is getting money from his girlfriend and directly or indirectly allows her to be a sex worker... Men who use drugs, let's say, fail in the traditional masculine roles as a protector or bread-winner but I have doubts that someone [within drug-related services] addresses this issue.
>
> Andrea, outreach worker

Raising consciousness about human rights, challenging gender and ethnic stereotypes and offering an approach which would be different from the rest of the social environment was understood to be an important part of gender sensitive approach.

> I often consult the issue of self-image. Me as a female drug user, me as a sex worker, because it's a lot about self-esteem, about what is she like, I try to challenge and emphasize women to look at themselves not as trash but in other ways, too. Of course, I don't force her, but I don't emphasize the concept of self-stigma.
>
> Mary, outreach worker

This quote demonstrates, that gender sensitivity can reached actually though very simple dialogue, accepting and emphatic behavior from the side of outreach worker, who wants to encourage women in their self-esteem.

5.3.4 Acceptance and respect

According to the outreach workers, a humanistic and respectful approach to people who use drugs should be a fundamental part of gender sensitive programs. The problem, described by outreach workers, was that treatment programs often in order to achieve lifelong

abstinence used methods by which people who use drugs were forced to reject and feel guilty about their periods of drug use. The narration of drug use experiences mostly (or only) in negative terms was well represented within the life stories of women I collected. The interviewed outreach workers inclined rather to the approach of acceptance towards drug users. They saw people who use drugs as human beings and drug use as acceptable part of life. The outreach workers reported that they still were reflecting their work, were working under supervision in order to combat their own prejudices. Moreover, they pointed out that often women had to face barriers and choices which were far away from respecting them as human beings. For example, both, the outreach workers and the women who use drugs talked about moments when women involved in treatment had to choose between a drug using partner or their child(ren) and the treatment process. These moments were described as typical and unfair, but women who use drugs had to face them very often. The conclusion from this critique is that gender sensitive approach should respect the conditions and relationships in which women (but also men and transgender people) who use drugs live.

5.3.5 Process-oriented approach

> Drug treatments are simply focused on duties/achievements, not on the ongoing process.
>
> Mary, outreach worker

This statement came in answer to the question of why women are failing in the treatment process. This implies that the way how the treatment process is in general organized simply does not fit women who use drugs. I would like to relate this question to the previously discussed issue of strict rules and regimes, where the former outreach worker Laura stated that this type of treatment programs, which were very strict were not for everyone. These programs were designed to get up, eat, exercise, work at a set time and ordered way, so the orientation for achievements was clearly there. How I interpreted the statement above is that if a drug user, and especially women, could not or it was hard for them

to live and achieve these requirements, it was seen as a failure, in stead of asking why they failed, what they felt, how they understood the process, and how they behaved. All the situations a drug user faced during the treatment process are not only about the final effect, but had broader implications, which were ignored, as the outreach worker implied.

5.3.6 Comprehensive services as an effective response

I have already mentioned that gender sensitive programs are seems to be effective when they reflects the needs of target group. Comprehensive services, networks of, and cooperation among programs were the key issues in this discussion. As women who use drugs repeatedly emphasized, the treatment process was especially hard because of unemployment and poor living conditions.

Here, following the principles of harm reduction as well as of abstinence oriented programs, drug users cannot make changes without resources to access and use. What was recommended was a holistic and flexible approach and working *with* drug users. Drug-related services should take into account the context in which drug users live, that it is not only drug use that influences its lives.

> Look. Let's take a 'classic' scenario. A woman, about 30 years old, who is injecting drugs, recently realized she is pregnant. She is a sex worker, living in some illegal cottage without gas or water. Her partner, who also uses drugs, is sometimes violent, but in fact he helps a lot, too. Oh yeah, and there is a 50% chance that she is living with hepatitis C. And she comes, talks to you and she is motivated and wants to change. And sure, recommending her methadone is a reasonable choice, but what about a bunch of other things? No job, no shelter, many barriers. Yeah, then, sure drug users really desire to change their lives (sarcasm).
>
> Julia, outreach worker

This example was "classic" although the outreach workers did not like the idea of describing a "typical" woman who uses drugs. This illustrated, that women faced variety of problems and situations, which should not be solved separately.

5.4 The NGO Odyseus in the context of gender sensitive harm reduction programs

At the end of the interviews with the outreach workers I asked them: Do you think that Odyseus is gender sensitive?

Mostly, the very first answer was – no. Critically reflecting on its own services, all outreach workers saw limits of their own work and limits of the organization itself. However, some aspects of gender sensitivity and aspects of women-friendly programs were reported.

The NGO Odyseus was, for example, strict about the language – language used in their brochures and magazines for drug users and even casual conversation is marked by gender-sensitivity, using suffixes related to men and women. This approach can be seen as a sign of gender sensitivity. This type of language is rarely seen in mass media or public talks (unless they are organized by feminists organizations), but there is a growing tendency in using gender sensitive language among some academics and some NGOs in Slovakia,

Some of the "women's" issues were addressed, too. NGO Odyseus created brochures about special topics, mostly about sex work, pregnancy and drug use with a focus on women. They did HIV, syphilis and tuberculosis testing and for example provided their clients with male and female condoms.

The outreach workers reported that they were talking about "women's" issues a lot. They were talking about motherhood and problems related to it, pregnancy, violence from partners or men buying sexual services and discussing themes, which I would call themes with feminist backgrounds, such as empowerment, inequalities, challenging self-stigma and negative self-image of women who use drugs and offering emotional support. Several outreach workers mentioned they probably discussed these issues with their clients because they were women, themselves.

> I think women's topics are addressed here. And maybe, it's because most of us working here are women, which is actually a problem. I mean, sure you can

> work with men and deal with intimate and delicate topics... but it's better when a client can choose whether [she or he] wants to talk with a male or female outreach worker.
>
> Andrea, outreach worker

However, one of the outreach workers denied that Odyseus is dealing with women's problems because of the fact the most of the outreach workers are women:

> We deal with that [women's issues] not because most of us here are women, but because a lot of us are feminists. Elsewhere [for example social services] there are mostly women, but that doesn't mean they are sensitive toward gender.
>
> Mary, outreach worker

It is especially interesting, because other outreach workers did not define themselves as feminists but probably some level of feminist attitudes or emancipatory goals is shared among workers anyway. What I need to add is the fact that NGO Odyseus is not officially feminist organization and gender sensitivity is not addressed among the principles of the organization. However, gender sensitivity was for the outreach workers something, what should be part of good effective programs so they were trying to involve it in their services within the financial and personal limitations. Although they did not see Odyseus as gender sensitive, this approach was a part of their work. The outreach workers described themselves as reflective and self-critical towards their own stereotypes. They identified their mutual goal – to reflect clients' individuality in its complexity and to accept their clients as they are and not to force them into changes.

In this chapter I presented women's experiences with drug-related services. Their narrations were mostly very uncritical towards harm reduction syringe exchange programs. Treatment programs were seen as too strict in their rules, but even though this criticism was downplayed. I identified that women who use drugs did not understand or see the sense of treatment programs' rules and again internalized their fails in treatment programs as their own faults. Then I presented a range of several needs which came up during the life stories

narration, which should be addressed by drug-related services. Then I moved to the analysis of gender sensitivity in Slovakia. As the results of my analysis, drug-related services in Slovakia seemed to lack of gender sensitivity, the difference between gender sensitive programs and women-friendly programs were recognized and several important aspects of gender sensitivity were highlighted, such as intersectionality, acceptance, challenging stereotypes, process-oriented approach and need for comprehensive and holistic services. At the end of the chapter, I looked closer at the gender sensitivity within the NGO Odyseus, which was identified as organization which tried to be sensitive towards gender and its programs used some of the principles of gender sensitivity.

CONCLUSION

My thesis aimed to explore the life stories of women who use drugs and evaluate drug-related services in Slovakia from the perspective of gender sensitivity. As the first part of my analysis I have identified several themes which were brought up during the interviews with women who use drugs, the outreach workers and from the content analysis of outreach reports. Then the analysis moved from description into more interpretative perspective. The ways in which experiences were narrated were demonstrated, focusing on the category of gender (more concretely femininity in its diverse representations) and intersectionality. I emphasized that the category of drug user was very significant in their life stories and in fact, these women did not put a lot of emphasis on the fact of their sex-gender, unless I asked. Then, the various notions of femininity were reported, mostly connected to pregnancy, motherhood or sex work. Women often narrated their drug use as something what negated their (traditional) femininity. These women narrated "normality" in terms of abstinence from drugs, having a heterosexual relationship and being a housekeeper (and some cases – mother). Since I found that the category of being a drug users is significant, I must add that that changes in narrations of self and identity were closely related to not only drug use, but also to the recovery process.

The narrations must also be considered in relation not only to drug use and gender, but also to the fact that the interviewed women who use drugs are mostly lower class and half of them were Romani women. Poverty and harsh conditions were mentioned often, however, the category of ethnicity stayed invisible and Romani women did not pay attention to their ethnicity. However, the important fact is that my focus was not on ethnicity and I did ask if their experiences are somehow influenced by the Romani ethnicity (which I also did for the category of gender). I would suggest that in future research, more attention should be paid to exploring the narration and experiences of ethnicity.

I found that there were several ways in which life stories were narrated. On the one hand, internalization of blame, guilt related to drug use was often narrated, on the other hand, some phenomena, for examples stealing, sharing needles, selling sex under the standard prices or not using condoms is highly externalized – it was generally other women who did those "bad things". Interestingly, childhood experience was always narrated in a positive way, although late in the story, it was obvious that their childhoods were not so perfect, since most of the women faced alcoholism, divorce, violence or suicide within the family when they were children. Still, women emphasized that their parents were not responsible for their drug use and they were loving and caring parents (even for those women who spent most of their childhoods in re-educational centers).

Beside the self-blaming and very negative narrations, moments of agentic perspective, hardiness and self-advocacy came up. Although it is obvious that stigma related to drug use is strongly internalized, these women still have the ability to look at themselves as "people" who deserve better treatment. These women should therefore not be described only in terms of victimhood – victims of drugs, violence, or stigma – but as agentic persons who can advocate for themselves.

In the second part of my analysis I focused on women's experience, needs and opinions related to drug-related services. Women who use drugs were mostly uncritical about existing services, they were grateful for harm reduction programs (syringe exchange). When they were describing various treatment programs and their experiences, they were reporting strict rules which were often the reason why they failed and returned to drugs. Women usually did not see the point of these rules, but even so, they internalized the blame of failing, saying that as drug users they need strict rules. According to their stories, I would suggest that drug treatment programs need to address this issue – for example rethinking existing rules or if the rules are important, be sure that their patients understand the importance of the rules.

Several needs were identified, inspired by Maslow's hierarchy of needs (Maslow, 1943). Looking at the women's life stories and experiences with drug-related services, deprivation of needs was found on every scale, from the scale of basic physiological needs to the need of self-actualization. Unfortunately, none of these needs was fully addressed by the existing drug-related services. The interviewed women who use drugs rarely reported needs related to the pregnancy of motherhood. However, outreach workers claimed that this kind of service was needed, because pregnancy and motherhood were not addressed in existing services. Although these issues were not reported in terms of needs, pregnancy and motherhood was narrated as a significant part of women's stories, so the fact that they did not report any need related to it could be connected to the fact that they have very low expectations from existing service in Slovakia.

The last part of my analysis, dealt with gender sensitivity within existing services in Slovakia. I found that a gender perspective was missing in drug-related services. Focusing exclusively on the NGO Odyseus, several aspects of gender sensitivity were identified, however, its outreach workers believed that this issue should be addressed more and not only related to women, but also to men and transgender people. Several key aspects that should be part of gender sensitive services were outlined: intersectionality and understanding gender more as a context rather than identity, challenging stereotypes and stigma, showing acceptance and respect, developing a process-oriented approach (as an alternative to an approach that focuses on achievements and developing comprehensive services and a network of professionals.

Developing a process-oriented approach is the only one principle, which does not appeared in the earlier recommendation of the principles of gender sensitive services which were developed by the CSAT (2009). Other principles which I found can be found in the CSAT's list (2009). But why did the process oriented approach come up during the interviews

in Slovakia, but was not identified in other studies? It is hard to say if this is a result of some cultural specificity, however, this idea of developing approach focused on process rather than achievements may be a reaction to a very strict system with inflexible rules of drug-related services which is characteristic for Slovakia.

I am aware of several limitations of this thesis which must be reflected upon. The very first one is the lack of time for conducting research, which resulted in my inability to build real relationships with the interviewed women who use drugs or to meet them for more than one interview. Also, I was looking for the participants in a very specific place (a street well-known as a place frequented by sex workers) which was the reason why all of the interviewees were currently (or in the past) sex workers, which created an uncritical image of automatic connection of drug use and sex work among women. Similarly, because of lack of time, I did not contact for example workers from the other harm reduction NGOs in Bratislava or from the state drug treatment programs. I believe information from more workers could enrich my interpretation and understanding. Furthermore, my research could go more into depth and look closer at other categories such as ethnicity, age, marital status or sexual orientation. For future research I would recommend to focus on these categories and maybe also pay attention from a feminist perspective to men and transgender people who use drugs.

Despite these drawbacks, I believe that this research is somehow unique, since it is the first one which applies feminist perspective and the issue of gender in drug use in the Slovak context. I do not want to call my participants, women who use drugs, an invisible group, but access to them was not easy at all. I know one interview would probably not cause any major change, but I saw that the first suspicions of women who use drugs changed into satisfaction that someone was interested in their lives and wanted to hear about their experiences and opinions. Although I am personally critical towards the feminist notions of “giving voice”, this research may be the first step in advocacy activities focused exclusively on women who

use drugs. My research clearly demonstrated that gender sensitivity needs to be implemented by drug-related services in order to provide effective services. I would like to conclude my thesis with a quote by one of the outreach workers:

> Gender sensitivity should not be something special. It should become an automatic part of every professional service.
>
> Mary, outreach worker

APPENDIX 1

Interview questions for women who use drugs

Could you tell me your life story?

- childhood, school years, relationships in the family

Can you describe when and how did you start using drugs?

- reasons, experience with treatment (reasons for relapses)

Can you describe for example your ordinary day in that period?

Do you think the fact that you are a woman somehow influenced your experience and life at that time? What about other women who use drugs?

Have you experienced any kind of discrimination or prejudice (because you are a woman and simultaneously a drug user)?

What do you think about syringe exchange programs and treatment programs in Slovakia?

- critique, recommendation
- Is there a focus on women' needs? What do women need?

Now imagine that you can change laws, politics, and drug-related services in this country. What would you change?

Interview questions for outreach workers

When I say 'a woman who uses drugs' - what are your first associations?

Do you think there are any gender differences in the drug use in general?

What are the main problems of these women, which are different from the problems of men?

Imagine "a typical life story of a woman who uses drugs". What would it look like?

Think about official institutions, such as police, health care system (with the emphasis on treatment programs), social system, NGOs – what problems do women who use drugs face when in contact with these institutions? Is it different for men?

What are the differences in the public/general attitudes/opinions on men and women who use drugs?

- mass media, law, personal experience with prejudice of friends

Have you heard of the gender-sensitive drug/related services?

- If so, could you define them (services plural)?
- Could you find such services in Slovakia? What about Odyseus?
- Are they necessary?

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