Editor’s Welcome

If you are a frontline worker, there is a two-in-three chance that you are a woman. There is also a good chance that you see twice as many male clients as female. Do these numbers mean that services are better suited to help men? Do male and female clients present different issues that require specific responses?

The Australian Government’s recently released discussion paper on the Development of A New National Women’s Health Policy aims to “improve the health and wellbeing of all women in Australia, especially those with the highest risk of poor health”. The Government has also announced a series of community consultations that will assist in the development of the first-ever National Men’s Health Policy.

It is too early to say what these policies will mean for injecting drug users. However, they do acknowledge that differences between men and women exist. As such, services need to cater for these differences in service delivery design. The NSP sector is accustomed to dealing with complex issues, polarised views and long-standing controversies. Adding gender into any discussion can simply make matters more complicated. In this issue, we examine how the sector’s work is affected by the perceived and actual differences between male and female injecting drug users. We investigate the relationship between sex and drugs and ask how gender influences the acquisition and use of drugs. We also profile those who have particular experience dealing with these issues on a daily basis.

Feedback

We received passionate feedback regarding the ‘Way Out West Article’ in our last edition (Vol 7 Ed 3). The article looked at the recent review of the needle exchange model operated by WASUA and WAAC in Western Australia. Readers were affronted by the “bland” views expressed:

“The WA exchange policy appears to be a punitive and controlling exercise. Making people pay 25 cents is more like a pathetic gesture in this day and age, rather than a genuine revenue making measure. The thought of people having to scratch and scrape a few coins together is, well, frankly degrading (what if you only have 4 five cent pieces... will they give you a new syringe?!).”

“Where is the consumer voice? I wonder if this really is the type of service clients see as positive or whether they have just been programmed and downtrodden over time?”

These views are reflected in recent recommendations made to the UK government by its Advisory Council on the Misuse of Drugs to minimise barriers to accessing injecting equipment. The Council have called for needle and syringe provision to be expanded so that equipment is available for every injection i.e. the client can get as many syringes as they need when they visit an NSP. The Council also recommended methadone and other opiate substitute prescribing programmes provide access to injecting equipment.

We would like to thank all contributors to this edition. If you have any observations about issues raised, please write to me at j.ryan@anex.org.au.
Anex’s vision is for a society in which all individuals and communities enjoy good health and well-being, free from drug-related harm. A community-based, not for profit organisation, Anex promotes and supports Needle and Syringe Programs (NSPs) and the evidence-based approach of harm reduction. We strive for a supported and effectively resourced NSP sector that is perceived as part of the solution to drug-related issues.

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news briefs

UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION ON ILLICIT DRUGS (UNGASS) 2009

A good deal of press comment has recently heralded a ten-year review of the 1998 UNGASS at the Commission of Narcotic Drugs meeting in Vienna. Many observers, both nationally and internationally, were hoping that harm reduction would become a larger part of the next policy draft. The Hon. Bob McMullen, who led the Australian delegation at this meeting, delivered a statement that reinforced Australia’s commitment to harm reduction strategies:

“Harm reduction is the second pillar of our strategy. We have a decreasing number of those dying from overdoses. We tackle the problem of IDUs passing on HIV, through needle exchange and harm reduction campaigns.”

Twenty-six countries, including Australia, collectively echoed this commitment via a statement delivered by the German representative. It stated:

“We regret very much that [the Draft Political Declaration] does not explicitly mention the term “harm reduction”. But we think that the essence of this approach is covered by what the Draft Political Declaration calls “related support services”. We hope that the unnecessarily controversial discussion about the term “harm reduction” will be closed and that the whole debate and find a consensus on the substance of this concept, its principles, its limitations and its place in a comprehensive anti-drugs strategy within the framework of the international drug control treaties”.

Unfortunately, as recently posted on the NSP forum: “Despite the efforts of many, including all those involved in the Beyond 2008 Vienna NGO Committee to represent the views of the drug and alcohol NGO sector across the world, to see the new declaration reflect a broad approach to illicit drugs that encompasses both demand and harm reduction, as well as supply reduction, a consensus could not be reached.”

FUNDING CHANGES AFFECTING NSPS

The budget that was proposed by the Federal Labor Government demonstrates the difficult times in which we find ourselves. Just over a year ago the predictions were for a $20 billion surplus, an economy that would need reining in, and interest rates on the rise, nearing ten per cent.

The situation which confronts policy makers and financial bodies charged with managing the nation’s finances is now starkly different. The contraction of the Australian economy is a response to the contraction in the world economy. It reminds us that we are not an island economically, even if we may be one in other ways.

So what does the budget mean for workers in the NSP and broader alcohol and drugs sector? There was a reduction in the funding allocated to the National Illicit Drugs Strategy. This is primarily funding that was directed towards “research in the areas of psychostimulant use, treatment of drug users and those with mental health problems, and research by states and territories into drug related issues”. The Government has indicated that rather than the Department being responsible for the disbursement of funds for these activities, the National Health and Medical Research Council is better placed to call for tenders on research related activities and oversee the resulting research and any outcomes.

ABSTRACTS DEADLINE: 5PM FRIDAY 26 JUNE 2009

Frontline workers deal with the day-to-day reality of hard times – a reality that is often complex and extends beyond issues of drug use. The Australian Drugs Conference – Drugs in Hard Times will focus on improving the ability of frontline services to respond to the complex issues that affect people who use drugs illicitly. It will be relevant to all frontline services, policy makers, service providers, researchers, health and medical professionals and many other stakeholders who want to broaden their knowledge of the evidence, the issues and innovative responses.

Visit the www.australiandrugsconference.org.au now for more information about the conference and how to submit an abstract.
Looking after children is hard work and, at times, can be overwhelming. For women who use illicit drugs, and in particular opiates, and also have a primary caring role, this further complicates their position. Fortunately, the success of pharmacotherapies has helped many women stabilise their lives and enabled them to continue to care for their children as well as have safer and healthier pregnancies.

Mary’s story

Mary is a 20-something-year-old mother who started injecting heroin at the age of twelve initiated by an older friend from the homeless refuge where she was living. At 17, Mary fell pregnant. Ignoring advice to abstain, she continued to use heavily and engage in criminal activities. After the birth of her first child, Human Services (the jurisdictional government department) gave Mary an ultimatum – stop using, start treatment or lose your baby. Mary chose heroin.

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However, pharmacotherapy treatment, including methadone, is a long-term journey and can only ever be part of a process and, as Mary admits, she still uses heroin occasionally.

“When I made the decision that I was going to keep the baby and Chris said the methadone would play a big part in stabilising everything.”

Drug treatment facts

- Around 42% of recent (last 12 months) illicit drug users are female.
- In 2007, there were 13,754 female pharmacotherapy clients nationally, which is 35.4% of all pharmacotherapy patients.
- Female clients account for the majority (67%) of treatment episodes where treatment was sought in relation to someone else’s drug use.

Methadone and motherhood

Heroin use during pregnancy can be associated with a number of risks. One of the greatest risks is that of miscarriage arising from sudden cessation of the use of opiates. For this reason, pregnant women who seek assistance from a GP or other health service will be placed on methadone maintenance treatment (MMT) immediately. Also, they should be provided with supportive care and monitoring during their pregnancy to ensure that the health needs of the baby and mother are being met. The introduction of MMT early in the pregnancy provides a degree of stability in the pregnant woman’s life, as well as being medically safer than the injection of illicit drugs.

These risks are:
- Miscarriage (associated with sudden withdrawal).
- Poor nutrition.
- Low birth weight babies.
- Risk of bacterial and blood-borne virus (BBV) infection.
- Lack of adequate antenatal care.
- Risk of overdose.
- Unplanned withdrawal.
- Foetal/ infant dependency.

As a result of the negative effects of illicit drug use and the sometimes chaotic nature of their lifestyle, many women opt to enter opioid pharmacotherapy treatment to bring stability into their lives and provide better care for their children.8 Experiencing judgemental attitudes from healthcare staff and the involvement of child protection services are the two major reasons why women who use drugs give for not accessing antenatal care.9 To ensure that the needs of pregnant women are met, healthcare service staff need to provide care and referral in a non-judgemental way. This will encourage clients to continue to be open with service providers and ensure that the most comprehensive referrals can be provided. In the case of pregnant women who are injecting illicit opiates, this means providing referral to a GP and an MMT program with encouragement and support to access this program as soon as possible.

The two drugs that are currently most commonly prescribed for the treatment of opioid dependency are methadone and buprenorphine. Methadone is most commonly used in pregnancy and while a woman is breastfeeding because its safety has been well-documented.10 In fact, methadone is always used, unless the woman who becomes pregnant is already on buprenorphine.

Anex spoke to Mary* - a mother of three who is currently caring for two children who has been receiving treatment in the methadone maintenance program for some time. Mary’s story demonstrates the important role that services such as social work and drug treatment provide in supporting and enabling people to regain control of their lives.

Nonetheless, treatment is not without its challenges which can be compounded when a pregnant woman is seeking to enter a MMT program for the first time, or has other young children to care for as well. Some of the difficulties in obtaining treatment include the requirement for daily attendance for dosing. This can make it difficult for women to manage caring for young children and obtaining or maintaining employment. However, take-away doses can ameliorate some of these difficulties. Other challenges include the cost of pharmacotherapy and a shortage of prescribers and dispensers in some geographical areas.

However, with adequate support, access to services and supportive care women who are pregnant and mothers can be provided with care that enables them, in turn, to care for their children. This means more stability in their children’s lives and better outcomes in the longer term.

When asked what the biggest reward was for being on pharmacotherapy, Mary responded by saying: “The ability to just enjoy raising the kids … just watching them grow up … to enjoy them unconditionally and to help other people to deal with their issues with drugs.”

*Names have been changed.
Influential factors

Gender plays a pivotal role in the geography, markets and economics of sex work in St Kilda, and these factors directly influence income-generating capacity and drug-using behaviour.

Female workers are able to work in a market that operates 24 hours a day, seven days a week, spread over a large locality. This makes these women highly visible, much complained about and heavily policed.

Male sex workers are less conspicuous. They use a park (away from the female workers) that is utilised by the general public during the day. This limits the time that men can work to the hours between dusk and dawn. They stay out of view until clients drive up to the park.

Transgender workers use a public car park that operates 24 hours a day, seven days a week, spread over a large locality. This makes these workers highly visible, much complained about and heavily policed.

Female workers have a flexible fee-for-service arrangement because they have a much higher turnover of clients. Male workers have less time to make more money, and transgender workers have even less time again based on the hours that they work outlined above. Street-based sex workers charge by service, and not by time like legal sex workers do. Market dynamics are such that workers self-regulate and limit the market to capitalise on demand, secure prices and ensure that all workers use condoms 100% of the time.

Christian suggests that recent changes in the economy have also affected sex workers, particularly the females: “As the moment; we see a strained solidarity within the community, with girls not supporting each other as much as they used to. It is up to the girls themselves to maintain prices and uniform condom use, but there is a risk to this now in uncertain financial times and there are increasing concerns for the health and safety of workers.”

The RhED Experience

RhED is a program of the Inner South Community Health Service providing health information and support for Victorian sex workers. Although the RhED centre is only open during the day they have developed an innovative drop-in program called Hustling 2 Health [H2H] that serves the needs of male and female workers who work at different times of the day. H2H involves an after hours drop-in on Friday evenings and is a dedicated “sex worker” space. Both the service user and staff profile are made up of sex workers. A nurse from the Melbourne Sexual Health Centre is also available and food is provided free by local businesses. Staff also do outreach on foot and produce a H2H newsletter.

The program manages the inherent differences experienced by male, female and transgender street-based sex workers and the way they access services. According to the data that H2H collects, 67% of H2H participants are female, 10% male and 3% are transgender which Christian notes is fairly reflective of the gender breakdown on the St Kilda scene.

Christian says that the gender differences between the workers, work practices and locations combine to impact on service delivery.

RhED has needed to think creatively in order to engage clients. While the service is open and accessible to female workers during the day, when they are working, male workers are working when the main services are closed and are harder to access. One of the strategies RhED has used in the past is to engage with male clients in the park through outreach in order to offer information, support and access.
Sex Workers’ Drug Use

Patterns of drug use are not fixed and there are many factors associated with the drug-using habits of street-based sex workers. Two obvious considerations are cost and availability. Both of these factors directly impinge on how much time male and female workers will have to spend working in order to earn sufficient funds to maintain their drug use.

Christian explains:

"The availability of drugs has been considered one of the most important aspects for the continued practice of sex work. For many workers, the only way they can maintain their drug use is by working."

Christian also suggests that the quality of drugs available at any given time has a large effect on behaviour and can put workers at greater risk of harm:

"...as the quality drops other problems arise. For example, sex workers using ice and unsatisfied with the quality will continue to work until they can score more, meaning they may be out on the street for longer periods than they would want to be. This leads to increased frustration, decreased alertness and an undermined sense of confidence that is needed to maintain good working practices including sticking to prices and safe sex standards."

Given the potential for ATS use to lead to a ’binge’, safer-injecting techniques can be further compromised by poor injecting technique including rushing while injecting, re-using equipment or neglecting to rotate injecting sites.

Sex Workers and Safe Injecting

The MSIC is Australia’s only supervised injecting centre and has been operating since 2001. The centre is located close to the many strip clubs and bars of Sydney’s Kings Cross area, and MSIC figures show that around 8% of its clients are sex workers. Of registered clients, 26% are female and 74% are male (less than 1% transgender) and approximately 30% of actual visits are by women. People under the age of 25 only make up about 11% of visits, but amongst this group, 55% of visits have been by women.

The MSIC’s location means that sex-workers and other clients do access the centre. Staff foster a safe environment with codes of conduct which ensure that clients can avoid some of the risks associated with street usage. As Clinical Services Manager, Colette McGrath explains:

"We don’t allow discussions about money and dealers in the MSIC. This helps people feel safer, knowing that they won’t be stood over and robbed which is more likely to occur on the street."

MSIC staff observe that many female sex-worker clients work to support their drug habit. They also report that the two issues that cause most concern are a lack of knowledge about health care, especially sexual health, and the fact that women are often subjected to controlling behaviour by male partners or pimps (some sex clubs pay female workers with drugs). As Medical Director Dr Marianne Jauncey explains:

"For me the main thing(s) that spring to mind are men who control the women, that they develop their drug habit as a result of their relationship with their male partner, that they often ‘go second’ when using and so may reuse needles, that they become entrenched in their drug habit really as a result of a relationship."

"[Many] young female clients never learn to inject themselves, but have always had their partner inject them. One case I remember particularly was a young woman whose partner left to score and never came back, having been picked up by police and ending up in jail. She had been living with him in a hotel, and so promptly became homeless, homeless and dependent without the ability to self-inject, and with no idea about how to source/buy drugs – what a nightmare!"

Colette says that staff are very mindful of these power issues and have several strategies that help,

Not allowing people to enter who are not injecting – for example, clients of sex workers.

• Not allowing users to inject each other.

• Separating couples, where appropriate, in order to have a chat to find out what is going on.

• Where indicated, not allowing partners to sit together (if appropriate) to ensure the woman is not being taken advantage of.

"I remember one woman required emergency medical assistance and her male partner attempted to stop staff assisting her because he wanted to ensure she went back to work (sex work). He was told that similar behaviour would result in a sanction (time out of the service) and that the police would be called if there was a reoccurrence."

Find out more at www.sydneymsic.com
Women and Men

Getting and Using Drugs

Injecting drug use is an activity in which both men and women participate. However, research demonstrates that there are differences in the way men and women acquire and use drugs. Women may continue to require help with injecting, may share equipment with a friend or partner, and often may inject after that friend or partner has used the equipment – thus increasing the risk of women acquiring blood borne viruses (BBVs).

These differences in drug use raise some important questions when we think about protecting women – and men – from blood borne viruses. Why do women use injecting equipment after it has been used by a friend or partner, given that it is no longer sterile? How do we ensure that women are vested with greater power to ensure that they inject safely and with sterile equipment each time? What do our health promotion messages need to do differently to make this happen?

To gain a greater understanding of the role that gender plays in drug use, Anex spoke to Maurine Steel, a Harm Reduction Officer at Parramatta NSP. Maurine’s experience confirms the complexity of the issue of initiation:

“...You do see young women get initiated by older male partners but it is a fallacy that they are always being forced. They are often led by their own curiosity, they have a desire to experience what their partner is experiencing, and they want to get to know him better. I have come across young women who are actually proactive in finding a partner who is using because they want to try it.”

Australian research suggests that some women are active participants in their initiation into drug use and some actually facilitate the entry of other women into injecting.

“Equal proportions of women and men (approximately 30%) obtained the needle and syringe for themselves and injected themselves at initiation, which is evidence that some women are not pushed into drug use by others but, rather, have an active intention to inject drugs.”

However, this research also suggests that, in the main, “drug use is an activity dominated by men” and that “women are more likely to borrow needles and ancillary equipment, usually from their sexual partner”. The information is confirmed by the data from the finger prick survey, the IDRS, NMDS. These data describe the injecting drug demographic as predominantly male.

There seems to be a gendered division of labour in obtaining drugs and their subsequent use. Commonly, “it is men who are responsible for obtaining and paying for the drugs and equipment and doing the injecting. This division of labour reinforces men’s position as the active participants in drug using, whereas women’s initiation to injecting comes about as a product of their passive involvement in men’s initiatives.” This division of labour and the consequent power it grants to the male partner is likely to lead to female users taking a secondary position in the drug-taking relationship and therefore using equipment that has first been used by their male partner.

Maurine explains:

“It’s hard to generalise. Some women feel disempowered, but some don’t. I have one female client who knows nothing about injecting even though she’s been doing it for years. There is sometimes a specific division of labour; the guy will go and score and the girl will come and get injecting equipment from the NSP. I have heard some strange arguments from men about why they use first, stuff like ‘I need to use more because I’m bigger’ or ‘I need to go first because she’s got smaller veins’.”

While the factual basis of such claims can be debated, what these arguments demonstrate is that there are justifications made for the order in which drugs are used in some relationships. This can further entrench a power imbalance that already exists. In many instances in heterosexual relationships, it is women who are using second, and this can often be with equipment that has been used by their partner.
GENDER, DRUGS, CRIME AND PRISON

The relationship between illicit drug use and crime is complex. At the very least we can say that illicit drug use is an important factor in criminal offending for both men and women. Studies suggest that many offenders attribute their own offending to drug or alcohol abuse. Do the drugs come first or does the crime? This question remains, as yet, unanswered. Obviously illicit drug possession, use and distribution are themselves crimes, but other crimes are also linked to drug use. For example, property crime has the strongest association with illicit drug use, just as violent crime is strongly associated with alcohol.11

A 2004 study by Holly Johnson at the Australian Institute of Criminology surveyed 470 female prisoners12 found that:

- The female prison population is relatively impoverished, with 33% from public housing and 5% living on the street before entering prison.
- The majority of female prisoners are mothers with children.
- 62% of women surveyed were drug users at time of arrest and 39% were poly-drug users.
- Indigenous women are over-represented, accounting for 46% of the one-quarter of the women interviewed.

Other interesting facts about the prison population that provide some insight into its features are:

- 93% of the Australian prison population is male, 7% is female.13
- 60-80% of men detained in Australia tested positive for illicit drugs.14
- 29% of males and 15% of females attribute their offences to being intoxicated with drugs or alcohol.15

This demonstrates that while the majority of the prison population is male, those who are imprisoned are more likely to have a history of drug use and may have been poly drug users at the time of their arrest.16

“We really need to see needle and syringe programs operating in prisons like those in Europe, moral courage is long overdue on this issue.”

Although crime rates are much lower for women, there is equally a belief to be more closely related to their drug use than it is for men.17 Research consistently finds high rates of problem drug use among women offenders. The physical and emotional health of women prisoners is significantly worse on all measures than women in the community. Hepatitis C prevalence is higher among women injectors compared with men (76% versus 58% in 2007).18 Amanda George, from Flat Out, explains: “Syringes are used, sharpened and reused many times in women’s prisons and this has enormous health implications for women inside and, on release, for the entire community.” When asked what she would like to see happen in prisons to alleviate these issues, Amanda is unequivocal:

“Men are released from prison around September 2007 after their fistcustodial sentence of five months. She was released on methadone, with possible diagnosis of ‘Acquired Brain Injury (ABI)’ and ‘Mild Intellectual Disability (ID)’ and with no family or community support. Her history of drug use and violent relationships meant that she lost custody of her three-year-old daughter who is now in the permanent care of the paternal grandmother. Emily has been transient or homeless since she was 12 years of age when her mother disowned her and told her to no contact with her family now, which is a source of much distress and sadness for her. She has spent long periods of time either sleeping on the streets, squatting or couch surfing. She has been able to maintain independent housing for long periods of time and finds the isolation and loneliness associated with independent living too much to bear. She also has a history of child protection issues, involvement with the juvenile justice system, and a long history of being sexually and physically abused from childhood into adulthood. Emily also has a history of sexual assault from a very young age, which has led to her being involved short-term with crisis services, but her transience has meant that she lacks links to a service for any long period of time.”

Upon release, Emily was housed in a transitional property supported by Flat Out. She was linked in with a local and community counsellor and psychologist for generalist counselling as required by parole. Five months later, only one month short of completing her parole, she was re-incarcerated with a possible one-to-two-year sentence.

Working with people who are highly vulnerable and caught up in exceedingly chaotic lives requires a huge amount of time. Emily really needed face-to-face contact at least three times a week, and intensive support, such as help getting to all of her appointments to avoid re-offending.

Compiled by Amanda George, Prison Advocate, Lawyer and Activist, Flat Out and Brook Shearer, Intensive Case Management Initiatives Worker, Flat Out.

The complexity of BBV transmission and the different risks posed by unsafe sex and needle-sharing are not easy messages to get across in a one-page poster or a catchy brochure on an information stand in a busy secondary school. Beyond monogamous sexual relationships, perhaps the simplest message in this instance is best—‘use a clean (sterile) fit each time AND use a condom every time you have sex’.

GETTING SERVICES TO FEMALE USERS

How do we ensure that women who appear to be disempowered and marginalised in many injecting drug-use relationships have greater access to services so they can better protect themselves?

Vending machines offer 24-hour access to sterile injecting equipment, but as they are not available in all regions, their ability to reduce the structural barriers experienced by women in accessing sterile injecting equipment is limited. Outreach programs can be an effective way to connect women who may be isolated from services by virtue either of their not knowing about them, or thinking that they don’t need them because they acquire injecting equipment elsewhere.

Perhaps we need to go back to basics to answer this question more fully. Services need to:

Think about how women find out about services and access them.

Be sympathetic in their service delivery model, and in some instances, this will mean providing a women only environment.

Work with other women specific health organisations in their jurisdiction to raise awareness of services available.

Consult female clients about what they need from their services.

Provide women with information about female specific issues as such reproductive health.

Make sure that concerns about confidentiality are fully addressed.

Female drug users can be extremely marginalised as a result of their drug use. As the Burnet Centre Harm Reduction Fact Sheet notes: “Women carry the added burden of heightened shame with the perception that they have failed in their traditional roles of wives, mothers and nurturers of families. Research shows the stigma associated with drug use is more keenly felt by women and they are more likely to conceal their drug use”.19

This statement is echoed by Maurice: “Certainly there is a view that women ought to be staying home looking after kids. There’s also a little more of a ‘that’s just what women are made to do’ attitude to men’s drug use. The thing is, women are taken on board the ‘evil for using’ message and reflect it back”.

When asked if gender needs to be thought more about when delivering services, Maurice answered: “Definitely needs to be thought about. Stereotypes sometimes aren’t relevant, these days you see young women take on male characteristics, being one of the boys, women are playing different roles to the ones they used to”.

While debate may continue today about what a ‘traditional role’ for a woman is, and how reasonable that is, this does not reduce the isolation that female injecting drug users may experience. Women who are mothers – and also inject drugs – often receive special attention from the media as they are so removed from the usual representations of women. To counter this isolation a number of peer organisations have established mothers’/parents groups so that men and women with an understanding of drug use and parenthood can meet and support one another.

Women are at risk of acquiring blood borne viruses if they are injected by another person or use equipment after another person has used it – even if they are having unprotected sex with that person. When women access services, being mindful of the complexity of the messages around blood borne viruses and injecting and conveying them to service providers, can be a start in expanding the message of blood borne virus prevention.

In Australia, most hepatitis C is transmitted through injecting drug use and most HIV is transmitted through sexual activity. There are multiple genotypes of hepatitis C and sharing injecting equipment exposes those who are already hep C positive to another type of the virus – the immunological equivalent of a new virus being introduced to the body.

There are different kinds of risks associated with sharing injecting equipment on the one hand, and having unprotected sex in a stable, monogamous relationship on the other. Often people in such relationships assume that there is no risk in sharing injecting equipment between themselves and their sexual partner because they have already exchanged bodily fluids through unprotected sex. But this shows that they do not understand how different BBVs are transmitted.
Workforce (Im)balance?

Surveys undertaken by the National Centre for Education and Training on Addiction (NCETA) suggest that two-thirds of the Alcohol and Other Drugs (AOD) sector workforce is female. There are no figures available for the NSP sector, but it is anecdotally assumed that they mirror those of the broader AOD sector. Surveys also suggest a roughly equal split at management level and a higher proportion of females in a workforce predominantly comprising nurses, general AOD workers, psychologists, counsellors, social workers and other medical and allied health professionals. As Dr Ken Pidd, Deputy Director (Research) at NCETA explains:

“The AOD workforce is overwhelmingly female; it’s also older than most other groups even within the health sector”.

When asked whether this creates tensions around high transition rates due to factors such as maternity leave, Ken responded:

“You could argue that, but you could also argue the opposite. That the part-time, casual and short-term contract nature of much of the work in the AOD sector suits a predominantly female workforce.”

He went on to explain:

“It’s a two-way street. Large numbers of women will have an impact on transition rates, but part-time opportunities make it easier for women to keep re-entering the workforce”.

Does this mutually reinforcing relationship between the sector and the workers that it attracts compound the stereotype that ‘caring’ professions are traditionally composed predominantly by women? Ken explains:

“It’s a cultural relic, all the caring professions such as education, health and child-care are seen as female professions”.

The AOD workforce has an average age of forty-six. This presents its own two-sided coin, as Professor Ann Roche, Director of NCETA explains:

“It’s a boon to have workers with experience, maturity and life perspective. On the other hand, having fewer younger workers means that we sometimes cannot offer younger clients someone to identify with. A more recent issue is the challenges that increasingly aggressive clients can present to workers’ safety, especially for women”.

NCETA

The National Centre for Education and Training on Addiction is an internationally recognised research centre that works as a catalyst for change in the AOD field. The promotion of Workforce Development principles, research and evaluation of effective practices is NCETA’s core business. Visit www.nceta.flinders.edu.au/ to find out more.

Profile

Professor Ann Roche

Ann is Professor and Director of NCETA. She has over twenty-five years’ experience in the field of public health and has worked as a researcher, educator and policy analyst in various public health areas and has held academic posts at Sydney, Newcastle and Queensland Universities. For the past 15 years her interests and professional activities have focused exclusively on alcohol and drug issues.

Anes spoke to Ann about her career, her work, her current role and her views on women in the workforce.

How did you get started in public health?

I did a Masters in Education before becoming a Tutor at Newcastle University. This led to working for the Health Commission as a Health Promotion Officer. Various roles followed in Migrant Health, Research and Planning – a stereotypically convoluted route.

What do you do day-to-day?

My days are busy and fragmented – everything from tracking down funding information, research planning meetings, policy advice, teleconferences with partners, media interviews and commentary – it’s tremendously diverse.

What do you love about your job?

The diversity, the challenge and the problem-solving opportunities presented by negotiating funding pathways or planning research, it really allows me to be creative.

What is the most challenging part of your job?

Not enough money, not enough time. What has been your most satisfying career achievement to date?

Establishing the Queensland Alcohol and Drug Research and Education Centre (QADREC) from the ground up. Also, changing the strategic direction of NCETA from a training to a research function. It was a huge challenge to articulate the new direction to funders and partners and to encourage a conceptual mind-shift that workforce development is more than just training.