WOMEN IN THE CIRCLE OF DRUGS

Report on a Needs Assessment of Female Injecting Drug Consumers and Female Partners of Injecting Drug Consumers in 8 Cities in Indonesia, 2007

Yayasan Galatea Medan, Yayasan Stigma Jakarta, PKBI DKI Jakarta, Yayasan Grapiks Bandung, Indonesian Drug Users Solidarity Association, Cadres of PKM Kassikassi Makassar and PKM Pancoran Jakarta, Yayasan Sadar Hati Malang, Yayasan Kembang Yogyakarta, Yayasan Kesehatan Bali, Yayasan Hatihati and Yayasan Matahati Denpasar, PKBI Nusa Tenggara Timur, Yayasan Metamorfosa Makassar, and Ikatan Perempuan Positif Indonesia. Supported by IHPCP-AusAID

PREFACE

The Ministry of Social Justice and Empowerment and the United Nations Office on Drugs and Crime, Regional Office for South Asia have been engaged in addressing the issues which face women drug users and women partners of drug users. It is imperative that the special gender concerns are appropriately recognized and specific interventions are developed for women in order to provide a comprehensive package of services for prevention of HIV among women affected and infected by drug use.

The project, viz. "Reducing substance use related HIV vulnerability among fermale drug users and female partners of male drug users", is a pilot initiative in this regard. The data collected by NGOs in various states from women respondents is important, as it indicates the various aspects and dimensions in which future work can be taken up. We recognize that it is a multi dimensional problem and requires multisectoral response.

It is critical that gender sensitive services appropriately designed towards women are provided by service providers in addressing the increasing vulnerability of women to HIV and dual burden of drug use as a user and partner. The report provides a qualitative insight into the minds of women afflicted and affected by drug use through the life narratives. The fact that so many women have shared their life stories shows a new aspect of the comumunity where women are now courageously coming forward to claim their rightful place in society and it is incumbent on all of us to ensure this.
Dr. Arbind Prasad Joint Secretary (SD) Ministry of Social Justice and Empowerment

Nafsiah Mboi
Secretary of National AIDS Commission

Table of Contents

List of Figures		
No.	Title	*Page*
3.1	Grouping of Women Based on Knowledge about Their Partners' Drug Consumption	*29*
4.1	*Map of Women in the Circle of Drugs*	*36*
5.1	*Female Partners of IDCs*	
5.2	*Female IDCs*	

List of Tables		
No.	Title	Page
2.1	Respondent Qualification	10
2.2	Service Provider Respondents	10
2.3	Issues and Aspects	12
3.1	Location and Number of Types of Respondents	
3.2	Age of Respondents	15
3.3	Education of Respondents	16
3.4	Occupation of Respondents	17
3.5	Relationship Status	17
3.6	Health Problems Reported by Female IDC Respondents	26
3.7	Health Problems Reported by Female Partner of IDC Respondents	33

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
Clean up day	A given day to discreetly exploit sellable goods in the house for drugs
Consumer	Widely known as user that in our product of documents we prefer use “consumer” describing indivIDCal who consume substance
Dealer	Somebody who sells illegal drugs
Dope	An illegal drug
Fix	To inject a drug
HIV	Human Immunodeficiency Virus
IDCs	Injecting Drug Consumer(s)
IHPCP	Indonesia HIV Prevention and Care Project
Methadone	A synthetic narcotic drug similar in its painkilling effect to morphine. Used as a substitute for heroin in the treatment of opiate dependence
MMT	Methadone Maintenance Therapy
Needle	A 1 ml hypodermic syringe used to inject heroin
Pack	Amount of drug preserved, usually consist of 0.1 gram of heroin or methamphetamine
Pill(s)	Antidepressant pills, sleeping pills, or sedatives
Pumping	To repeatedly pump the mixture of blood and drug with syringe before the entire liquid is injected into the vein
Putaw	Heroin
Shabu	Methamphetamine hydrochloride, known as “ice”
Sponsee	A person who is being sponsored
Sponsor	The term is from a recovery fellowship program for alcoholism and addiction, a recovering drug dependent who is willing to guide the new comer in the program, mutually
Stoned	Intoxicated, often with accompanying drowsiness
Stuff	A drug
Subutex	A medication for the treatment of opiate dependence. It contains the active ingredient, buprenorphine hydrochloride, which reduces the symptoms of opiate dependence. It is designed to be administered sublingually
User	Somebody who takes illegal drugs
Weed	Marijuana which is smoked as an intoxicant
Withdrawal Syndrome	A period which occurs when somebody who is addicted to a substance, stops taking it, causing them to experience painful or uncomfortable symptoms

1. BACKGROUND

UNAIDS reported in 2006, that Indonesia had the fastest growth rate of HIV amongst Asian countries. This rapid growth of the epidemic in Indonesia is of increasing concern to the general public.

The HIV epidemic in Indonesia is still concentrated in high risk population except in Papua where it has been described as a generalised HIV epidemic since 2007. The Ministry of Health (MoH) RI estimated that in 2006 there were 190,000 to 247,000 IDCs across the country with an estimated prevalence of 41.6 percent nationally. IDC comprised of 49.5 percent of the cumulative national AIDS cases.

The high rate of HIV infection among IDCs in the country is caused by the use of non sterile injecting equipment. Many IDCs still have a poor understanding of safe injecting practices. This high rate of HIV reflects a need to increase the response to the problem of HIV in IDCs by all sectors.

Although many studies on drugs and HIV/AIDS have been conducted, the focus of studies has generally been on male drug users. More than 90 percent of the IDC population are male. If most male drug users have female partners, a large number of women are also at risk of HIV. Other people are impacted from drug use and are often marginalised and have poor access to services.

Who are the women in the circle of drugs? What kind of life do they have? What are their problems and how do they survive? These are the questions that also need to be answered to address the issue of HIV/AIDS.

This study aims to gain a deeper understanding of women in the circle of drugs in order to respond more appropriately to their issues and the HIV epidemic in Indonesia.

2. OBJECTIVES AND METHODOLOGY

2.1 OBJECTIVES

The objectives of this study are to describe:

- Health, social and economic problems faced by female IDCs and female partners of IDCs
- Relationships between male and female IDCs
- Services needed by female IDCs and female partners of IDCs

In addition, this study aims to give recommendations to increase focus on the needs of female IDCs and female partner of IDCs.

2.2 LOCATIONS

The study was conducted in eight cities in Indonesia. Six of them are the working area of IHPCP's partners. The cities are:

1. Medan
2. DKI Jakarta
3. Bandung
4. DI Yogyakarta
5. Malang
6. Denpasar
7. Kupang
8. Makassar

2.3 PERIOD OF TIME

Preparation for the study started on July 2007. Data were collected during August and September 2007.

2.4. METHODOLOGY

a. Developing Study Design and Instrument

NGO field workers were involved in this study's preparation and data collection. The principal assessor presented and discussed

the draft assessment in a workshop with the field workers. Guidelines for in-depth interview and focus group discussion (FGD) as study methods were developed in the workshop by participants divided into three groups. In order to have optimal data collection, field workers were also trained to facilitate and generate transcripts of FGDs and in-depth interviews.

b. Respondent Recruitment

This study involved three categories of respondent: 1) female IDCs; 2) female partner of IDCs; 3) male IDCs. See Table 2.1 for the qualification of respondents.

Table 2.1: Respondent Qualification

	1	2	3
Category	Female IDC	Female partner of IDC	Male IDC
Age	15–45 years	15–45 years	15–45 years
Injecting drug use status	Actively inject drug/ MMT patient in the Last 6 months	Non drug user	Actively inject drug/ MMT patient in the last 6 months
Relation	-	Ongoing/ had been in an intimate relation with IDC in the last 6 months	Ongoing/ had been in an intimate relation with female in the last 6 months
Quantity	10 persons	10 persons	10 persons

Based on findings in FGDs and in-depth interviews of each main respondent category, at least two service providers in each city were selected for interview (Table 2.2) to confirm the findings.

Table 2.2: Service Provider Respondents*

▪ Doctor in primary health centre
▪ Head of rehab centre / doctor
▪ Head of prison / head of prison clinic
▪ Director / program manager of NGO
▪ Provincial / district AIDS commission
▪ Other potential service providers
* *To confirm findings in the FGD or in-depth interview, 2 service providers in each city were interviewed*

- *Informed Consent*

Consent was obtained from potential respondents after written and verbal explanations regarding objectives, procedures, respondent's rights, confidentiality, and usage of data/information of this study were given. If they understood these explanations and were willing to be involved in this study, qualifying candidates were asked to fill and sign an informed consent form.

- *Confidentiality*

Each respondent was given a specific ID number based on city, category of respondent, and order. This ID number was used for data management and analysis. All respondents identifying information is confidential.

c. Data Collecting

This study used a qualitative approach by conducting focus group discussion (FGD) with female IDCs, female partner of IDCs, and male IDCs. In-depth interviews were also conducted on 1-2 female IDCs and female partners of IDCs to further explore matters raised during FGD. The interviews were also conducted with health service providers, NGOs, and policy makers to confirm findings from interviews and discussions with respondents.

Collected data covered aspects and issues shown in the table below.

Table 2.3: Issues and Aspects

Issues	Aspects	Female IDC	Female Partner of IDC	Male IDC
History of drug use	• Beginning to use drugs • Problems that occurred during drug use • Recovery efforts	V		V
History of relation with partner	• Beginning of relationship • Experiences during relationship	V	V	V
Health status and related experiences	• Access to health services	V	V	V
	• Quality of services	V	V	V
	• Self care	V	V	V
Social condition	• Relationships with families, friends and community	V	V	V
	• Self-sufficiency	V	V	
	• Self-perception and perception of others	V	V	
Financial condition	• Financial sources	V	V	V
	• Expenditures	V	V	V
	• Savings/securities	V	V	V

NOTE: ■ *For male IDCs, these issues are about their female partners*

d. Data Management and Analysis

All group discussions and interviews were recorded digitally and processed into transcripts. The transcripts were then categorised by city and issues. Data were then analysed and mapped to identify problems needing further exploration.

e. Data Presentation

Qualitative data is described and directly quoted. A number of cases have been described in detail. These cases have been used for advocacy and educational purposes.

3. RESULTS – WOMEN IN THE CIRCLE OF DRUGS: A SNAPSHOT

This study attempted to capture the lives of women in the circle of illicit drugs. This portrait is formed from pieces of testimonies given not only by female respondents, but also from male respondents to show how they perceive female drug users (FDCs) and their female partners.

3.1 Characteristic of Respondents

In practice, not all working partners managed to recruit female respondents (FDCs or female partners of IDCs). Two out of eight cities did not manage to adequately recruit respondents in the three categories.

In Yogyakarta, only enough male IDCs were recruited to participate in the FGD although a small number of female IDCs participated in in-depth interviews. No female partners of IDCs were recruited in Yogyakarta as the male IDCs participating in the NGO's program tend to hide their drug use from their partners.

In Malang, only male IDCs and female partners of IDCs were recruited for FGDs. Only two female IDCs were recruited and performed in-depth interviews.

Overall, the total 193 respondents consisted of:

- 62 female partners of IDCs;
- 52 female IDCs
- 79 male IDCs

Table 3.1: Location and number of type of respondents

City	Male ID Consumers		Female Partners of ID Consumers		Female ID Consumers	
	FGD	Interview	FGD	Interview	FGD	Interview
Medan	10	-	8	1	9	1
DKI Jakarta	10	-	9	2	8	2
Bandung	10	-	8	1	5	1
Yogyakarta	8	-	-	2	-	2
Malang	10	-	7	1	-	2
Denpasar	11	-	9	2	10	2
Kupang	10	-	10	1	10	2
Makassar	10	-	11	-	10	-
Total	***79***	***0***	***62***	***10***	***52***	***12***

a. Age

Almost all female IDC respondents were in the 15-24 and 24-34 year-old ranges. In Kupang, the female IDC respondents were relatively younger than in other cities. Only one of nine female IDC involved in FGD was in 25-34 year-old range while the remaining eight women were in 15-24 year-old range.

60% of female partner of IDC respondents were in 15-24 year-old range, and about 40% of them were in 25-34 year-old range. In comparison, most male IDC respondents were in 25-34 year-old range. This reflects the fact that women tend to begin to have relationships with IDCs from a young age. In Kupang, all female partners of IDC respondents were in the 15-24 year-old range. In Indonesia, the 15-24 year-old range is categorised as adolescent.

Table 3.2: Age of Respondents

Age	Female IDC		Female Partner of IDC		Male IDC	
	N	%	N	%	N	%
15-24	25	48.1	36	59.0	16	21.1
25-34	23	44.2	24	39.3	58	76.3
35-44	3	5.8	1	1.6	2	2.6
> 45	1	1.9				
TOTAL	**52**	**100**	**61***	**100**	**76***	**100**

** Some respondents did not fill the information in the Basic Data Form*

b. Education

Almost all respondents, from all categories, had high school as their highest education level. One of the male IDC respondents had elementary school as his highest level of education reached. More male IDCs (33%) reached a higher than secondary school level of education compared to women IDCs (15%) and female partners (23%) interviewed.

Table 3.3: Education of Respondents

Education	Female IDC		Female Partner of IDC		Male IDC	
	N	%	N	%	N	%
No Academic Education	-		-		-	
Elementary School	-		-		1	1.3
Junior-High School	5	9.6	10	16.1	5	6.3
High School	39	75.0	38	61.3	47	59.5
Diploma III	6	11.5	9	14.5	15	19.0
Strata 1	1	1.9	5	8.1	10	12.7
Strata 2	1	1.9	-		1	1.3
TOTAL	**52**	**100**	**62**	**100**	**79**	**100**

c. Occupation

More than 50% of FDCs and female partners of IDCs respondents did not generate any income (unemployed, housewife, or student). None of the female partners of IDCs interviewed in Kupang generated any income.

Table 3.4: Occupation of Respondents

Occupation	Female IDC		Female Partner of IDC		Male IDC	
	N	%	N	%	N	%
Unemployed	13	25.0	11	17.7	22	27.8
Housewife	14	26.9	21	33.9	-	
Student	4	7.7	5	8.1	7	8.9
Civil Servant	1	1.9	1	1.6	-	
Private Sector's Employee	13	25.0	10	16.1	17	21.5
Labour/ Housemaid/ Migrant Labour/ Driver	-		3	4.8	2	2.5
Sex Worker	1	1.9	-		-	
Entrepreneur	5	9.6	7	11.3	28	35.4
Doctor/ Psychologist/ Teacher/ Journalist/ Researcher/ Other Professionals	-		1	1.6	-	
Others	1	1.9	3	4.8	3	3.8
TOTAL	**52**	**100**	**62**	**100**	**79**	**100**

d. Relationship Status

This study not only categorised respondents based on their marital status, but also used relationships such as dating or cohabitating. Most of the female and male IDC respondents were in a relationship, whilst 50% of female partners of IDC respondents are married.

Table 3.5: Relationship Status

No	Status	Female IDC		Female Partner of IDC		Male IDC	
		n	%	n	%	N	%
1.	Dating	24	47.1	19	30.6	34	43.6
2.	Cohabiting	6	11.8	4	6.5	9	11.5
3.	Married	12	23.5	31	50.0	28	35.8
4.	Divorced	5	9.8	1	1.6	4	5.2
5.	Widow by Death	3	5.9	6	9.7	1	1.3
6.	Separated	1	2.0	1	1.6	2	2.6
	TOTAL	**51***	**100**	**62**	**100**	**78***	**100**

** Some respondents did not fill the information in the Basic Data Form*

3.2 Female Drug Users

a. Beginning Phase of Drug Use

There were three types of people that tended to introduce FDC respondents to drugs:

- Friends (schoolmates, peers)
- Husband, spouse, partner
- Family members (parents, siblings, other relatives)

Friends were the main source of information about drugs since FDCs usually started using drugs at school age. Those who started after this age were usually introduced to drugs by their spouse.

It is important to note that a number of parents introduced FDCs to drugs. It was not necessarily a direct introduction, as claimed by some respondents in Jakarta and Denpasar, rather they witnessed their parents using drugs. Those who had been exposed to their family's drug use since early childhood will obviously have more difficulty avoiding drug use.

"My dad was smoking shabu in the front room with his friends. My sister was injecting drug with her boyfriend in her room, and so was my brother with his friends in his room…." (M, Jakarta)

"... I already know since I used to see my mom doing it. It's a genetic factor." (D, Denpasar)

Initiation into drug use did not always happen voluntarily. Some respondents were forced to try drugs. Respondents in Makassar and Denpasar claimed that they were forced to use drugs by their husbands or boyfriends.

"I was still in (high) school, having a boyfriend who liked taking pills, smoking weed, and getting drunk…, I was forced to take his pills and to get drunk…" (F, Denpasar)

There were many reasons given by FDCs for starting to use drugs. Other than being forced or living in drug using environment, reasons such as curiosity or 'just-trying-something-new' were given during the discussions in every city. Several respondents tried drugs because they believed that their spouses cared more about drugs than they did about them.

"...to satisfy my curiosity, whether it is really good that my husband couldn't stop using it…" (H, Denpasar)

Another reason for drug taking that often came up during the study was to escape from conflict with significant others, both family or spouse.

"I had a problem, I went to my friend to ease it up, but it was wrong place… my friend was a user and I caught it on from her - and then all the euphoria… the highs… then I was hooked…"

"I was breaking up with my beau. There was this fella who gave me stuff that he claimed could relieve stress. Because I was just so stressed out, I tried it… and not long afterwards it got really addictive…"

There were also respondents who continued to use drugs because of their affection towards their partners, and their fear

of losing their partners, which was the case experienced by this respondent in Makassar.

> *"Because I'm scared of him leaving me; because I love my partner; because of love, I have to accept the consequences."* (A, Makassar)

Using drugs was in fact also a form of rebellion against the shackles of law and prohibitions. Respondents in Makassar reported that they used drugs because drug use was illegal.

Respondents admitted that when they began to use drugs, they felt they did not receive complete information about the risks and effects. They did not know that heroin withdrawal could produce such a high level of discomfort. They also did not know that using non sterile needles or sharing with others, would increase the risk of being infected by HIV. Their knowledge of drug use was in fact very limited: that these drugs were illegal, but they gave pleasure.

> *"When I was in high school around 1992-1993, drugs had not yet been a trend, so there was no information available on them."*
>
> *"All I knew was that drugs were prohibited (for no reason)…"*
>
> *"… Before, there was no information that use of needles could spread HIV…"* (F, Denpasar)

One of the respondents in Makassar received a seminar at school about the dangers of drugs, after he had been using the drugs for the previous two years.

b. Pleasant Experiences in Drug Use

In the cities where Subutex is available as a treatment for dependence, the respondents reported injecting it despite the availability of heroin. Instead of being orally consumed, Subutex, as a substitution therapy of heroin, was crushed, dissolved, and injected. The pleasure of injecting became as important as the pharmacological effect of the drugs. The pleasurable memory of

"pumping" blood into a vein was reported to cause craving in some respondents.

It was common to respondents to use or inject in a group setting so as to enjoy a ritual of communal drug use. For particular respondents, using drugs was a way for making friends and boosting self-confident.

The use of drugs also affected sexual pleasure, although the effects were indivIDCalistic in nature. Male IDC respondents commonly claimed they experienced longer lasting erections when using drugs although they found it difficult to reach ejaculation. Initially, female IDCs and women with IDC partners thought that their partners were good sexual performers. However, the prolonged acts of intercourse tended to drain both sexual partners' energy and also caused irritation to the vagina. This irritation was painful and made female respondents unable to enjoy sexual intercourse. In contrast, other respondents believed that drug use increased sexual pleasure.

> *"...when we used it, and came to our husband or boyfriend, the sex got better."* (A, Jakarta)

Several respondents also claimed that they could only work and perform in their activities after injecting heroin. This became their rationalization for having heroin before doing daily activities, including being interviewed for this assessment.

c. Social and Economic Problems

Drug use was not always enjoyable for respondents. They had often had unpleasant experiences. IDC respondents feared withdrawal syndrome. All had experienced pain throughout their bodies during withdrawal and also found that their emotions became uncontrollable, triggering conflicts with people around them.

Respondents said that craving and fear of withdrawal led to habitual injecting of putaw, although their consumption of

putaw was often not matched by their financial income. In Malang, putaw or Subutex was consumed with other drugs (sleeping pills, sedatives) a combination which increases the risk of overdose.

Only one respondent reported that she had always been able to maintain her employment (in Malang) and earn a sufficient income to support her drug use.

- *Committing Crime for Drugs*

The majority of drug dependents had a very different experience with respect to employment than this solitary respondent from Malang. Almost 50% of respondents reported having no income from employment which compelled them to commit crimes such as stealing or robbery.

They started to steal in their own home, known as "clean up day", by selling items of value such as electronic devices, household goods or raw materials.

> *"That wire was peeled, and then I sold the bronze..."*

When there wasn't anything to exploit in their homes, respondents reported going out on the street for snatching or robbing. Some respondents reported doing these activities with the assistance of their spouse or friends.

> *"I once robbed with my friend using a motorcycle. My friend rode and I snatched. If there was someone nearby a window wearing a necklace, I had been previously taught how to hold and snatch it. That's how I got it…"* (S, Medan)

- *Sacrificing Children for Drugs*

Some respondents reported sacrificing their children's needs for drugs.

"I had kids; they got milk supply, and then I sold the milk..." (A, Denpasar)

A respondent in Jakarta reported injecting heroin in front of her child when they were an elementary student, this had remained as a powerful memory for this child. Other respondents reported that their children had found their syringes or putaw.

"...my kid was 6 years old. Sometimes he sees the stuff and keeps it..." (M, Jakarta)

Often at very young ages, children had to cope with their parents' drug use.

- *Becoming a "Slave" or Prostitute*

Drug dependency forced many respondents to commence work as sex workers. Respondents in Denpasar (mostly female IDCs) reported selling their body for sex when they had no money to buy heroin.

"... I even sold my body for drugs..." (L, Denpasar)

In Bandung, the respondents denied working as sex workers, but they admitted that they were willing to date or become a secret partner of their dealer in order to get heroin.

"It's better to date a dealer. No problem, even though it's not an ideal criterion of a partner." (B and E, Bandung)

Respondents who had had relationships with drug users also had to earn money to pay for drugs. If they failed to get money or drugs, they experienced violence from their partners.

"I sought guests, he stole their money. When I didn't earn money, I'll definitely be yelled at, 'You're a whore!'…" (B, Denpasar)

"... I'm often used by my partner to get drugs. It doesn't matter if I must find loans or even if it means dating the dealer while I'm still being his partner." (C, Denpasar)

"So he uses, I pay. That's because his wages are small, while I often get packages. When it comes to consuming drugs, he's so egotistical. The money comes from me; I earn it, while he just enjoys it" (B, Jakarta)

As well having to earn money to buy putaw, female IDC respondents had other problems. Many only received putaw that remained after their partners were satisfied. If they asked for more putaw, they risked their partners becoming violent.

"... So, if he wants a fix, I'm the one who find the money and the dope. If there is no dope, I get beaten. Even if there is dope, when I take too much, I can still get hit…" (C, Jakarta)

It was hard for female IDC respondents to avoid such situations. Some of them stated that they could not refuse their partners' requests because of love.

- *Experiencing Violence Because of Drugs*

Based on respondents' statements, violence was often part of their lives: either physically, psychologically, sexually and economically. It was repeatedly experienced by those with IDC partners and commonly triggered by drugs.

Violence was also experienced when they came into contact with law enforcement. They reported often being insulted and yelled at by police. A respondent in Medan had a shoe thrown at her by police and verbal abuse was also frequently experienced.

None of the respondents claimed that they ever received physical violence from their dealers, although sexual harassment was often experienced.

"...I only had 15,000. At that time, a pack was only worth 25,000… There was one dealer whom I thought was generous. He said, 'OK, you can hit it here.' When I was preparing to use it… he suddenly took off his pants!" (F, Jakarta)

A respondent claimed that she once received sexual harassment from her sponsor. Even though he was overseeing her recovery program and supposed to protect her.

"...All of a sudden he asked me to go to Ancol… There was a hotel with a parking lot below it… I was so appalled. He was supposed to be my sponsor who supported me..." (G, Jakarta)

d. Health Problems

Drug use impacted health condition of respondents, as shown in the table below:

Table 3.6: Health Problems Reported by Female IDC Respondents

General Health		Reproductive Health		Psychological Health	
Dizzy, Headache, Migraine	84.6	Menstrual Disorders	63.5	Depression	67.5
Digestive Disorders	75.0	Yeast Infection	63.5	Anxiety	75.0
Bone/ Muscle Pain	61.5	STI	15.4	Fears	51.9
Wounds/ Bruises	28.8	Abortion	11.5	Sleeping Disorders	75.0
Others	0.0	Pregnancy Complications	9.6	Eating Disorders	38.5
		Unwanted Pregnancy	30.8	Suicide Attempts	23.1
		Sexual Disorders	21.2	Hallucination (Aural / Visual)	26.9
N = 52					

Headaches, indigestion and muscle/bone pain were health problems commonly reported by respondents. Those who attended methadone substitution therapy reported drastic weight loss during the early months of therapy. They also

complained of dental problems. These conditions sometimes caused respondents to discontinue their therapy, especially when they failed to receive adequate information regarding side effects of the therapy.

Reproductive health problems such as irregular menstrual cycles and yeast infections were frequently reported. Unwanted pregnancy was reported by more than 30% of respondents. As active drug users, the pregnancy caused both physical and social problems. In general, they were pregnant to an IDC. Some respondents stated that due to pregnancy, they were forced to marry their drug using partners. As they were unemployed with no regular income the newborn children became a social, physical, and financial burden.

The reported rate of abortions was quite high and abortions were conducted unsafely and increased the risk of infectious disease transmission for both respondents and service providers, especially as many clients were HIV positive.

Respondents frequently reported suffering from depression, anxiety, irrational fear and sleeping disorders. A history of attempted suicide was commonly reported by respondents.

3.3 Female Relationships with Male IDCs

This sub chapter is about the experience of female respondents (IDCs and non-IDCs) in their relationships with male IDCs.

a. Beginning of Relationship

Their introductions to each other, which led to them becoming couples, were like most other couples. They met, were attracted to each other, and then agreed to start a relationship. In nearly all cities, the respondents claimed to have been introduced to their partners by friends. Although some of them met coincidently on public transport, on the street, or even, as

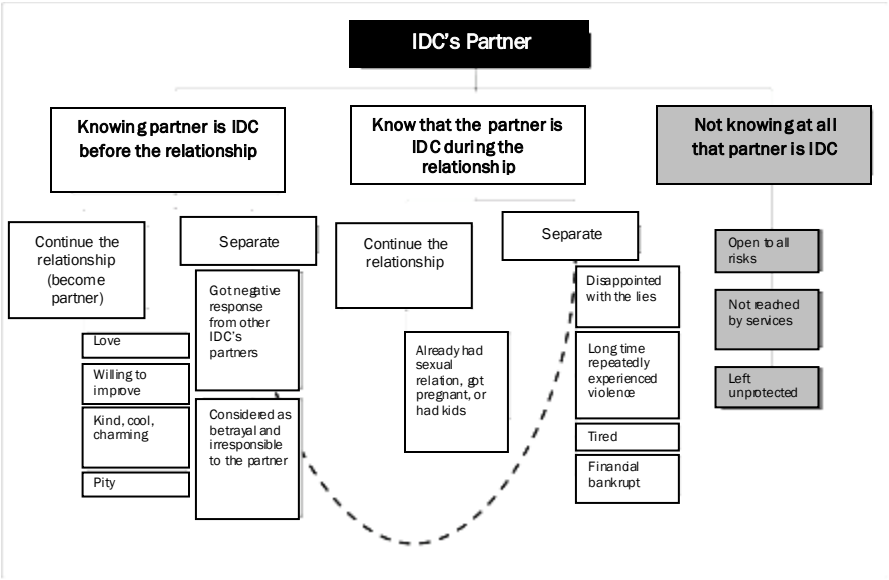
claimed by a respondent in Makassar, being matched up to marry their partner by family.

Not all respondents knew that their partners were IDCs when they first met them. Based on findings, female partners of IDC respondents were divided into three groups:

- Those that knew that their partner is an IDC before dating;
- Those that knew that their partner is an IDC after dating;
- Those that didn't ever know that the partner was an IDC.

The last group wasn't included in this assessment, however it was identified through analysis of data from male IDC respondents. This group appear to be the most vulnerable to all of the risks of having an IDC partner, unfortunately they could not protect themselves without realising the risks they were exposed to. In general, they were not well covered by health services and often only learned that their partners were IDCs when their partners became sick, or even they themselves or their children became sick. Stories about these belated realisations were often reported by female partners of IDC respondents.

Figure 3.1 Grouping of Women Based on Knowledge about Their Partners' Drug Use



Some of those who learned that their partner was an IDC before starting a relationship were able to end the relationship, while the others decided that it should continue. The decision to continue was usually based on reasons such as love, pity, consideration of the partners' kindness or their cool or charming demeanour. A similar situation arose in those who discovered that their partner was an IDC during the relationship or after married. In addition to reasons already mentioned, women said that they continued in the relationship because they already had commenced a sexual relationship, gotten pregnant, or had children.

On the other hand, some respondents decided to separate due to "physical or mental fatigue". They had too often been lied to, been hurt, or frequently experienced violence. After possessions

and money had been disposed of by their partners there was no good reason to continue their relationship.

In FGDs, those who chose to free themselves from their drug using partners reported that they had received negative responses from those who were still in relationships with IDCs. Women that chose to leave were considered cruel, irresponsible, uncaring or not prepared to sort out their relationship. They tend to be criticised for their actions by other respondents in the focus group.

b. Experiences Being Partners of IDCs

This study also explored women's experiences while being partners of IDCs. They are grouped and listed below.

- *Embarrassed in front of Family and Neighbours*

IDCs can sometimes place respondents in an embarrassing situation. IDCs were reported as stealing or selling things in their own home or even in the home of their parents' in law. These actions greatly embarrassed their wives/partners.

Respondents in Malang and Jakarta told stories about embarrassment toward their partners' behaviour during their wedding ceremonies. The IDCs had used putaw and in some cases became markedly intoxicated, despite being the centre of attention.

"...in our wedding party, he was on the stage taking everyone's attention. He clearly looked drowsy. His sibling whispered to me, 'An, hold his hand so he stops falling his head.'" (A, Malang)

"…when we were ready to snap a picture of our big family, he suddenly said that he needed to go to the bathroom. Everyone became annoyed." (R, Malang)

"When we were preparing to take a picture of the bride and groom with the family, the photographer asked my partner what

he was holding, and to put it down. 'Honey, hold this for a while.' I nearly passed out because it turned out that what he was holding was a syringe" (R, Malang)

Problems occurred for some respondents on the first day of their marriage. Thet were openly embarrassed in front of family and others, but this did not influence their willingness to continue their relationships.

Embarrassment was also felt by respondents when their partners were arrested by the police. One respondent only learned from the newspaper that her husband had been caught shoplifting.

- *Being Told a Lie*

Respondents were often lied to by their partners. Lies varied from small lies like about where they were or what they did, to big lies such as lying to cover their continuous consumption of drugs.

- *Suffering from Violence and Risky Behaviour*

Female partners of IDCs also experienced violence during their relationships. Violence ranged from physical, psychological to financial abuse. Physical abuse usually happened when their partners were experiencing withdrawal symptoms and involved striking the respondents. Mocking and insults were often directed at respondents. Conflicts were precipitated when respondents' requested that their partners stop using drugs.

Instead of peforming acts of violence towards the respondents, their partners often did other actions that harmed respondents and their children. One respondent reported once when she was in a vehicle driven by her stoned partner and they hit other vehicles or

Harmful activities were not only done together with respondents, but also with their children

sidewalks a total of seven times during the ride.

Children were often included in activities that were potentially harmful. A respondent in Jakarta told that their baby was brought along by the father to meet a drug dealer and his drug using friends.

- *Loss of Possessions and In Debt*

The majority of respondents involved in this assessment were the main breadwinner. The fruit of their hard work was often stolen or forcefully taken by their partners to fulfil their need of drugs. Even the money allocated for their children's needs was often stolen. Respondents often resorted to hiding money in unusual places. Due to financial pressures respondents reported that they had difficulty doing daily activities at home.

According to respondents' testimonies, to fulfil their need for drugs, their partners lent money but their respondents were the ones that had to pay it off. Some respondents just found out that their partner had been in debt only after their partner died. A respondent in Jakarta said that she was forced to borrow money, if she failed to get the money, her partner would act violently to her.

Only a few respondents claimed that their partners had stopped drugs. According to the respondents, it was only after many years of patient support. However, the majority of respondents still had to face the dilemma of maintaining a difficult marriage or fighting for a better future for themselves and their children on their own.

c. Health, Social, and Economic Impact

Living with an IDC was not easy. Experiences described above had a tremendous impact on all respondents. This study

captured impacts to female partners of IDCs on three sectors: health; social and economic.

- *Health Impact*

Impact on health was categorised as general health, reproductive health and psychological health. These data represents the subjective complaints by respondents and is not based on medical examination or diagnosis.

Table 3.7: Health Problems Reported by Female Partner of IDC Respondents (N = 62)

General Health		Reproductive Health		Psychological Health	
Dizzy, Headache, Migraine	83.9	Menstrual Disorders	54.8	Depression	64.5
Digestive Disorders	54.8	Yeast Infection	54.8	Anxiety	59.7
Bone/ Muscle Pain	48.4	STI	4.8	Fears	37.1
Wounds/ Bruises	14.5	Abortion	4.8	Sleeping Disorders	37.1
Others	9.7	Pregnancy Complications	4.8	Eating Disorders	25.8
		Unwanted Pregnancy	4.8	Suicide Attempts	14.5
		Sexual Disorders	8.1	Hallucination (Aural / Visual)	4.7

Although the respondents did not state their HIV status in their basic data form, some revealed it openly during discussions. They all reported being infected from their drug using partners. In the discussions, it was disclosed that most of them had been unaware of their HIV infections until their children were diagnosed after suffering from perpetual opportunistic

infections; some of them were only diagnosed after they had died. Or they only discovered that they were infected when their husband had fullblown AIDS, or had died.

Almost 15% of respondents had attempted suicide

Most of health problems reported by respondents were related to the psychological burden of their partners' drug use. Attempted suicide among partners of IDC respondents was quite common; with almost 15% having attempted suicide.

- *Social Impact*

IDCs, as well as their partners, were often forsaken by their families and community. The families of IDCs tend to wash their hands of their IDC member or felt that they were released from responsibility after their child was married. They believe that the wife was now responsible. On the other hand, respondents said that they could not always be honest about their partners' drug use to their families. This left respondents with no choice but to endure their partner's actions with resulting social, medical, and financial consequences. In addition, respondents still had to earn a living for their families and children.

- *Economic Impact*

The wives suffered the economic consequences while their partner continued to use drugs. They had to earn a living for their families and yet their incomes were raided to satisfy their husbands' drugs needs.

When their husbands were found to be HIV-positive, they also had to cover the expenses of the illness. Even by the time their husband died respondents said that usually hadn't fully understood what had happened because the husband concealed their status for so long.

The burden of being a breadwinner and their husband's "guardian" limiting partners of IDCs in taking care of her own finances. Their social lives were also usually limited. For example, few respondents said that they had had opportunity of participating in regular religious activities or traditional saving group meetings.

e. Services for Female Partner of IDC

There are no services that currently target the needs of female partners of IDCs. During this assessment process, many NGO realised that partners of IDCs need their attention.

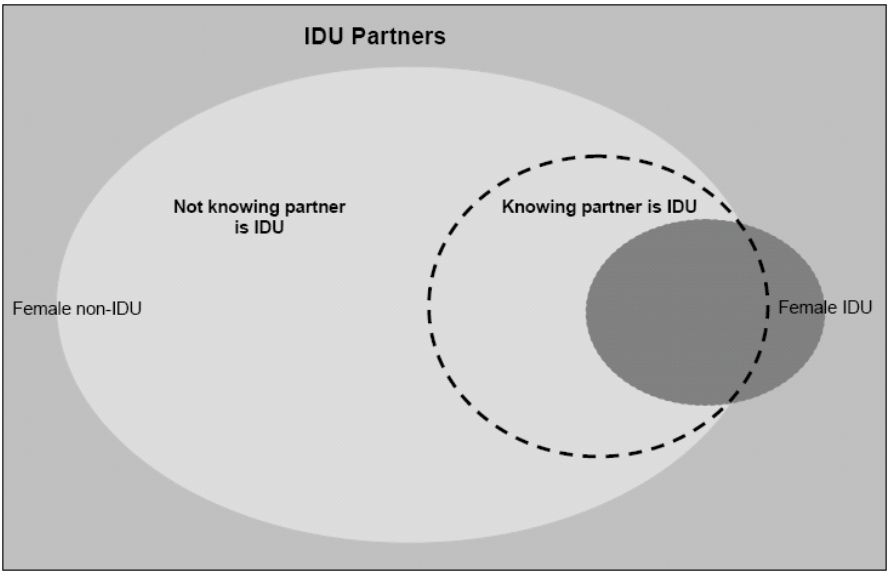
In rehabilitation centres visited during the course of this study, partners of IDCs were not involved in the rehabilitation process; moreover, the centres did not provide any services for them.

The only healthcare program directed to women is PMTCT (*prevention of mother-to-child transmission*) but this program only looks after these women when they are pregnant until the birth of the child in order to prevent HIV transmission from the mother to the newborn baby.

4. DISCUSSION – BREAKING THE CIRCLE OF DRUGS THAT BINDS WOMEN

From the gathered data, the women in the circle can be mapped in Figure 4.1 below. Male IDCs tend to seek non IDC women as partners. Whereas female IDCs do not have enough confidence to seek non IDC partners and most end up with male IDCs. Only a few of them are in relationship with non IDC men.

Figure 4.1 Map of Women in the Circle of Drugs



Not all female partners of IDCs know that their partner is an IDC or if their partners are HIV infected. These women are most at risk since they are ignorant of the need to protect themselves. They

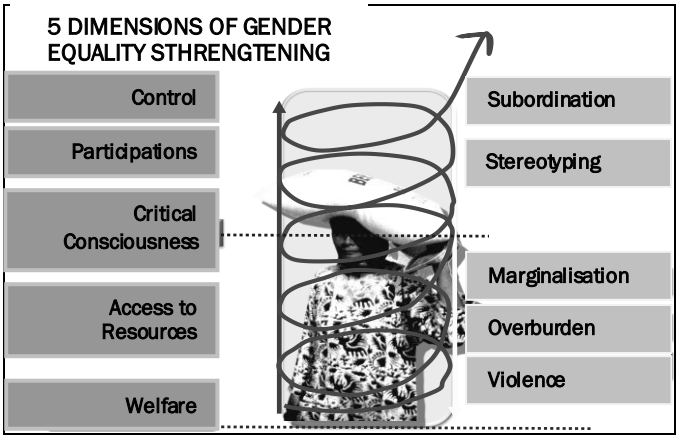
are also not currently targeted by any service or prevention program.

This chapter will describe how current HIV/AIDS program answers the challenging problems described in the previous chapters. The data were analysed by using Longwe's "Five Dimensions of Equality" which are welfare, access to resources, critical consciousness, participation and control. (See Figure 4.2).

Gender inequality occurs in many sectors. However, HIV prevention programs currently don't pay attention to these inequalities. Current HIV prevention programs only focus on the needs of IDCs, especially with respect to implementing transmission prevention programs, such as needle and syringe distribution. In fact, such programs are accessed more by male IDCs, since female IDCs are usually more isolated by their family responsibilities. These programs are also not paying attention to the different needs of female partners of IDCs who are burdened with the consequences of their partner's actions.

From the welfare perspective, HIV prevention programs have not yet reached these women to fulfil their welfare needs.

Figure 4.2. Longwe's Dimension of Gender Equality



Women do not have equal access to information. Female partners of IDCs do not receive drug and HIV/AIDS information. This study shows that women play a crucial part in the drug rehabilitation process of their partners. Considering that women are also impacted by drug dependency of their partners, they need to gain access to programs to be able to play their role of support.

The existing programs have not developed a critical consciousness among IDCs or amongst the program managers. There are strong stereotypes of IDCs held by the community, but even program officers hold their own stereotypes. One example, is that "IDCs are victims" "IDCs need to be continuously assisted to get clean needles" which creates an alternative dependency on needle syringe services. For FDCs, they have to deal with double stereotypes, i.e. typical stereotypes imposed on women that they should behave gently and politely - it is indecent for them to use drugs; as well as the usual stereotypes imposed on IDCs. In addition to this stereotyping women also tend to be blamed for being reclusive and uncooperative with services, even though this is a result of social, cultural and economic barriers.

Most services that offer support for women only note their grumbles without promoting the educational role of their experiences. What actions these women take in response to their situation is never explicitly discussed during the meetings. Most participating organizations do not have activities dedicated for the partners of IDCs.

Despite the heavy orientation of HIV/AIDS prevention programs towards IDCs, the opportunity for non-user partners of IDCs to participate is limited. Clearly, there is great potential in working with partners of IDCs as they do not have the constraints of drug dependency.

The HIV prevention programs have to make strong connections with NGOs and donors, in addition to policy-makers and policy-executors. Furthermore, most NGOs only role is to deliver the program. For this reason, there should be an effort made by the

NGO to reduce their financial dependence on any one donor and utilize a community-based approach as the community has an enormous capacity to support such programs.

Community organising is only one aspect of preventing HIV transmission. Interventions for IDCs should also be done hand in hand with community empowerment to introduce a pressure inside the community to look after all of its members and to actively participate in HIV/AIDS prevention and care.

The use of non sterile needles is the biggest contribution to the spread of HIV/AIDS in many places. This fact made HIV/AIDS programs focus more on IDCs. In reality, the programs are accessed more by male IDCs. This condition can act as a trigger in an analogy of an explosion.

In HIV/AIDS context, the fuses are as follows, 1) The isolated position of IDC and their partners due to social, cultural and economic barrier, and 2) There are more female IDCs or female partners of IDCs who are still unidentified. These situations can be compared to fuse that spreads the fire to explosives

The absence of services that cater to women's needs is a factor that accelerates the deterioration in the quality of their lives.

HIV/AIDS is explosive if no one directs cultural, economic and government policies towards the needs of women inside the drug circle. This will appear as a high infection rate of HIV/AIDS among women and children and be reflected in the national prevalence of HIV.

5. SUMMARY

Results of this study are demonstrated in Figures 5.1 & 5.2 below, which show the position of female partners of IDCs and female IDCs.

Figure 5.1: Female Partners of IDCs

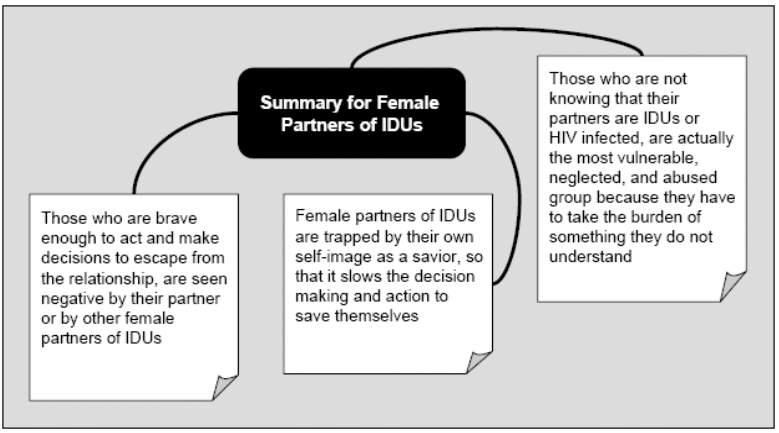
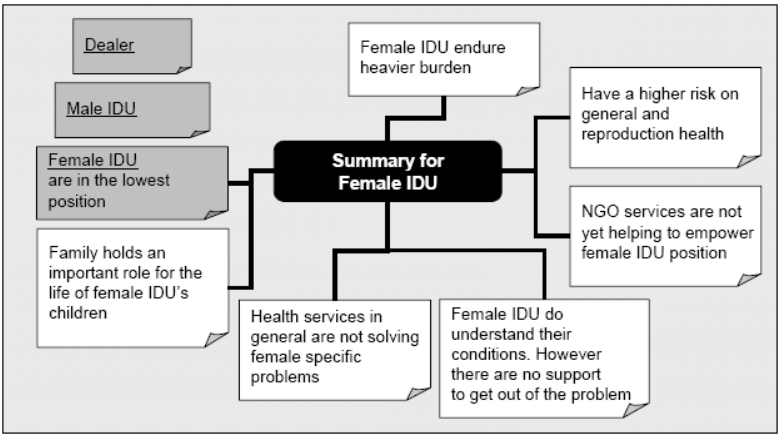


Figure 5.2: Female IDCs



There are many connections between HIV/AIDS and other social dimensions which remain hidden.

The problems and specific needs of women, including female IDC and female partners of IDCs, are neglected because the strategy of programs concerning HIV/AIDS are largely focused upon distribution of sterile needle to IDCs – male and female. As there are other groups also burdened by these IDCs, such as other women in this study, then it makes these strategies seem limited.

This study has identified groups of women who do not realise that their partners are drug users and/or do not know that their partners are HIV infected.

6. RECOMMENDATIONS

1. Develop a comprehensive strategic framework to address needs of women in harm reduction programs.
2. Clarify roles and responsibilities in harm reduction networks to develop of specific drug and HIV/AIDS interventions to address issues of women.
3. Issues of women must be included in program development to break social, cultural and economic barriers.
4. Develop strategies to inform women at risk who are not aware that their partners are IDC and/or infected with HIV.
5. Use the experiences of both IDCs and outreach workers in problem analysis to improve program implementation.
6. Recruit and train women as outreach workers to improve access of female IDCs and female partners of male IDCs.

Attachment 1: ASSESSMENT TEAM

Main Assessor: Amala Rahmah, Patri Handoyo, Ririn Habsari, Toto Rahardjo

Field Team:

Medan	
Field Coordinator:	Lely
Facilitator/Interviewer:	Lely, Patri
Transcript Maker:	Iwan
Respondents Recruiter:	Boy, Winner, Delvin, Agam, Eri, Rayi
DKI Jakarta	
Field Coordinator:	Laura Milette
Facilitator/Interviewer:	Muvitasari, Belinda, Ririn
Transcript Maker:	Muvitasari, Belinda, Wulan, Siti Nuraini
Respondents Recruiter:	Field Workers of Stigma and All HR PKBI DKI Program Staff Jakarta
Bandung	
Field Coordinator:	Priscillia Anastasia
Facilitator/Interviewer:	Agus Salim, Lili Herawati, Patri, Iie
Transcript Maker:	Agus, Lili
Respondents Recruiter:	Yosie, Kurniawan, Dwi, Anton, Arif Rahman

DI Yogyakarta	
Field Coordinator:	Rosi Angela
Facilitator/Interviewer:	Netty Sandra Dewi, Ririn
Transcript Maker:	Swasti Sempulur
Respondents Recruiter:	Dwi Kusumo, Agung Hajar
Malang	
Field Coordinator:	Roni
Facilitator/Interviewer:	Roni, Ririn
Transcript Maker:	Yunda Kamalia
Respondents Recruiter:	Rizano Irwanto, Edi Sasono, Ign. Joni Budiman, Jefri F, Sandi Irawan, Hermawan
Denpasar	
Field Coordinator:	Rosi Angela
Facilitator/Interviewer:	Dayu, Noldi, Rara
Transcript Maker:	Atik
Respondents Recruiter:	Field Workers of Yayasan Kesehatan Bali, Yayasan Matahati, dan Yayasan Hatihati
Kupang	
Field Coordinator:	Simplexius Asa
Facilitator/Interviewer:	Merlyn Mboeik, Rara
Transcript Maker:	Lenti
Respondents Recruiter:	PKBI NTT
Makassar	
Field Coordinator:	Andika Wirawan
Facilitator/Interviewer:	Iwan, Imam Ghozalie
Transcript Maker:	Siti Salmah, Hasan Husain
Respondents Recruiter:	PKM Kassikassi, Metamorfosa