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Access to treatment for substance-using women in the Republic of Georgia: Socio-cultural and structural barriers

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Abstract

Background—In the Republic of Georgia, women comprise under 2% of patients in substance use treatment and to date there has been no empirical research to investigate what factors may facilitate or hinder their help-seeking behavior or access to treatment services.

Methods—This study included secondary analysis of in-depth interviews with 55 substance-using women and 34 providers of health-related services.

Results—The roles and norms of women in Georgian society were identified as major factors influencing their help-seeking behavior. Factors that had a negative impact on use of drug treatment services included an absence of gender-specific services, judgmental attitudes of service providers, the cost of treatment and a punitive legal position in regard to substance use. Having a substance-using partner served as an additional factor inhibiting a woman's willingness to seek assistance.

Conclusions—Within the context of orthodox Georgian society, low self-esteem, combined with severe family and social stigma play a critical role in creating barriers to the use of both general health and substance-use-treatment services for women. Education of the public, including policy makers and health care providers is urgently needed to focus on addiction as a treatable medical illness. The need for more women-centered services is also critical to the provision of effective treatment for substance-using women.

Keywords

treatment policies; women; substance abuse; barriers; Republic of Georgia

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Author Disclosures

Conflict of interest

All authors declare that they have no conflicts of interest related to this article.

Background

An international review of substance use reveals that women constitute approximately 10% of the substance-using adult population in several Asian countries, 20% in post-Soviet countries and Latin America, and up to 40% in North America and in several European countries (UNODC, 2004). The past decade has seen an overall decrease in the traditional gender gap in alcohol and substance use, with increasing numbers of young women reporting such use (Center for Substance Abuse Treatment, 2009; EMCDDA, 2005; Grant et al., 2006). Research has shown that, although women are likely to consume less alcohol and illicit substances than men, they tend to develop substance-use-related psychosocial problems more rapidly and with greater severity than men (Center for Substance Abuse Treatment, 2009; Cormier, Dell, & Poole, 2004; Hernandez-Avila, Rounsaville, & Kranzler, 2004; Piazza, Vrbka, & Yeager, 1989; Ridenour, Maldonado-Molina, Compton, Spitznagel, & Cottler, 2005).

Examination of prevalence rates of substance use disorders and treatment enrollment in the US population suggests that compared to men, women underuse substance use treatment, including specialized gender-focused services (Greenfield et al., 2007). In the European Union (EU), the percentage of women in substance use treatment services varies between approximately 20% and 40% (EMCDDA, 2005), and slightly more than 30% in the US (Grella, 2007). In some post-Soviet countries, the proportion of women in treatment constitutes 8% of the total substance-using population (CADAP, 2012). In contrast, women constitute less than 2% of the treatment-seeking population in the Republic of Georgia (Javakhishvili, Sturua, Otiashvili, Kirtadze, & Zabransky, 2011), suggesting traditional treatment engagement strategies have failed to attract women to substance use treatment programmes and low threshold services. Even advanced recruitment strategies, such as respondent-driven sampling (RDS) employed for a bio-behavioral surveillance survey among injection-drug-using adults, yielded a sample composed of 97% men (Curatio International Foundation & Public Union Bemoni, 2009). Thus, women who use substances, either in or out of treatment, represent a seriously understudied and underserved section of the substance-using population in Georgia.

Research has suggested higher vulnerability to HIV for women who use substances compared to men. Women are more likely to inject drugs with multiple injection partners, use injecting paraphernalia after use by their substance-using partner, engage in sexual relations for drugs or money, and have difficulties in negotiating use of condoms with sexual partners (Ashley, Marsden, & Brady, 2003; Brook, Brook, Richter, Masci, & Roberto, 2000; Bryant & Treloar, 2007). This mirrors the findings of Georgian and regional reports (Pinkham & Malinowska-Sempruch, 2007; Shulga, Tokar, Smirnov, & Dvinskykh, 2011; The Global Coalition on Women and AIDS, 2012). Results from the only available research focusing of substance-using females in Georgia show that 80% of the women interviewed had never been tested for HIV, and 64% had no information on harm reduction services in their area (International Harm Reduction Development Program, 2009).

Few studies have attempted to examine the complex environmental factors that surround substance use by women in Eastern Europe and likewise shape access to HIV prevention and substance use treatment. Ukrainian researchers have noted that women are less likely to seek treatment due to social stigma and the opposition of their male partners (Shulga, et al., 2011). Childcare responsibilities, gender norms and judgmental attitudes of health care providers were identified as important barriers to women seeking treatment (Pinkham & Malinowska-Sempruch, 2007; The Global Coalition on Women and AIDS, 2012). In addition, research conducted in Georgia, Azerbaijan, Ukraine, Russia, and Kyrgyzstan has pointed to a range of factors that preclude women from entering substance use treatment and

seeking substance-use-related services. These include the risk of breaches of confidentiality, poor or nonexistent referrals to sexual and reproductive health services, and the preponderant focus of services toward substance-using males (International Harm Reduction Development Program, 2009).

There is a lack of incidence and prevalence estimates about substance-using women in Georgia. In addition there is scant empirical research about their substance use practices and the social context in which their substance use occurs. The failure to collect systematically data on women substance users means that little is known about what might constitute women-sensitive treatment engagement strategies and models of treatment. Furthermore, no empirical research has examined factors that may facilitate or hinder their access to and use of treatment services.

Methods

The aim here was to better understand the barriers, socio-cultural context, and programme and policy factors which might have an impact on women's access to substance-related treatment services in the Republic of Georgia. To that end, the qualitative databases of two separate studies were examined for their public policy implications. The first study (Kirtadze et al., 2013) examined the attitudes and perspectives expressed in depth interviews with 34 health service providers in Georgia who had provided services to an injection-drug-using (IDU) woman at least once in the past two months. The second study (Kirtadze et al., in preparation) investigated the beliefs and self-reported behaviours of 55 IDU women in Georgia. Both studies were implemented at the formative stage of a clinical trial that aimed to assess treatment needs and develop and test a comprehensive treatment approach for substance-using women. The Addiction Research Center (ARC) *Alternative Georgia*, a non-profit research institution, located in Tbilisi implemented the clinical trial.

A Community Advisory Board (CAB), composed of 11 health care providers for women, and a Beneficial Advisory Board (BAB) composed of four substance-using women, was used to develop recruitment procedures and assist in the construction of interview questions and eligibility criteria for participants for both studies.

IDU Women Study Procedures

An IDU woman had to: be conversant in Georgian; be able to provide informed consent; be 18 years of age or older; have injected illicit substances in the past 30 days; and have been sexually active at least once in the past 30 days.

Recruitment of IDU women occurred through local low threshold service providers and peer-to-peer or peer-to-professional word of mouth in Tbilisi, Gori, and Zugdidi. These cities were selected to provide diversity in population sizes and geographic representation: Tbilisi (estimated 1,152,500 inhabitants), Zugdidi (75,900), and Gori (49,500), respectively.

Interviews were conducted in offices of low threshold programmes in Gori and Zugdidi, or at the ARC research site in Tbilisi. The interview guide was developed from discussions regarding the issues that women may face in their life and the research literature about women and substance use from other countries. The final schedule was composed of open-ended questions and structured probes that covered four main topics: women in Georgian culture; substance use practices and patterns; effects of alcohol and/or substance use; and substance abuse treatment needs and experiences. Interviews lasted approximately 60-90 minutes and all were audio-recorded following the written consent of the participants.

Initially, 67 women volunteered to participate in the study, however, eight failed to meet study criteria and four later refused to participate, yielding a final sample of 55 women with whom individual in-depth interviews were conducted between April 2011 and September 2011. The participants were all Georgian with a mean age of 35.7 years (range 18 to 55 years). Fifty-five per cent were less than college educated, 13% were employed, and 62% were living with partners. Complete details regarding this sample are presented in Table 1.

Health Service Provider Study Procedures

A purposive sampling strategy was employed to recruit health care providers. First a comprehensive listing of treatment settings and locations that might provide services to IDU women in Tbilisi, Gori, and Zugdidi was developed. Several providers in each treatment setting were contacted by research staff and invited to participate.

Health service providers included nurses, physicians, psychologists, social workers, addiction specialists, methadone maintenance providers, and other substance use treatment-related professionals. A health care provider was eligible if she/he had treated an IDU woman at least once in the past two months.

Individual in-depth interviews were conducted in a private location at the respondents' office setting, office of the partner low threshold programme (in case of Gori and Zugdidi), or at the research site of ARC (in case of Tbilisi), and lasted approximately 60 minutes. The guide for the service providers differed slightly from the one for substance-using women in its focus on systemic issues as opposed to personal experience. The schedule included open-ended questions and thematic probes and focused on four main topic areas: respondent's clinical practice; respondent's perspectives on the roles of women and men in Georgian society; respondents' perceptions of substance use and addiction treatment; and respondent's thoughts about the current substance use treatment system in Georgia. All interviews were digitally audio-recorded with the consent of the participants.

An initial recruitment pool consisting of 44 health service providers was contacted. One failed to show for the interview, and nine did not fit recruitment criteria, yielding a final sample of 34 health service providers. Interviews were conducted between April and October 2011. Participants were all Georgian with a mean age of 42.6 years (range 23–62 years), more than two-thirds were female, and they were generally highly educated (M=17.0; range 14–20 years of education completed). Basic socio-demographic characteristics of this sample can be found in Table 1.

The Institutional Review Boards of RTI International and the Georgian Maternal and Child Care Union approved the protocols of both studies. In addition, given the sensitive nature of this topic and the relatively small population of Georgia, no personal information was attributed to interview quotations in order to maintain confidentiality of all participants.

Qualitative analysis

Interviews were conducted in Georgian, transcribed in full and imported into NVivo 9 qualitative data analysis software. Parallel content and thematic analysis was conducted on all transcripts. Three authors served as raters and analyzed the transcripts. Regular discussions were held to achieve consensus on emerging themes. These were independently coded, collated, and cross-referenced. In other words, each rater compared themes in all transcripts in both databases simultaneously, identified similarities and differences (if any), and then regularly met to review the overall themes that best described the viewpoints and experiences of respondents. Themes were based on a number of *a priori* agreed-upon categories and sub-categories that had emerged in our previous research as well as our

knowledge of substance use activities and their context in Georgia (for example, socio-cultural context, stigma, program barriers). Similarly, themes inductively emerged through the raters' analyses (for example skills and knowledge of health care providers, substance-using partner's role, myths and prejudice towards treatment). There was consensus among the raters regarding both the *a priori* and emergent categories based on strong consistencies found in the responses and virtually no response outliers that did not fit into the emergent categories. Importantly, this methodological approach allowed us to use data triangulation (perspectives of two major stakeholder groups) and researcher triangulation (multiple researchers participated in data analysis and interpretation). Further, all transcripts were translated into English to allow US research team members to review content and data analyses.

Results

The original questions posed to the two groups of respondents were not identical but rather reflected our perception of the respective knowledge and experience possessed by these groups. However, based on a qualitative analysis of these interview data, a policy-relevant breakdown of the topics common to both groups emerged. These included: internal/interpersonal factors; socio-cultural context; structural/programme barriers; and policy environment.

Internal/interpersonal factors and socio-cultural context

Societal and family expectations and norms were identified as a major factor influencing help-seeking behavior of women with substance use problems. A woman's role in Georgian society is often idealized and she is perceived as the main resource for family norms and values – her "destiny" is to be a caring wife and mother. As indicated by the respondents in the service providers' group, substance use is viewed as a serious deviation from these traditional societal norms. This often results in substance-using women being characterized as morally weak, irresponsible, and negligent (see, for example, Box 1: SP11, SP13). Respondents in the substance users' group shared personal experiences, indicating that these stereotypes, societal, and family norms and expectations influence a substance-using woman's perception of herself and lead to extreme self-stigmatization and low self-esteem. A woman can feel guilty and ashamed of her behavior and in turn can be reluctant to disclose substance use to family members, friends, and even more so to individuals outside the family, including health care providers.

A number of accounts from the women detailed how when family members were informed about their substance-use problem, they often resisted asking for assistance from outside the family, making the family an additional barrier for women seeking treatment for their substance use problems (see Box 1: WHUD07). Interestingly, in many cases, the family was identified as the only hope when a decision about substance use treatment was being made as it is they who will cover the cost of treatment, take care of any children and provide the additional support needed. On the other hand, family members might expect recovery and complete abstinence when such support is provided.

Analysis shows that prejudices and beliefs held by substance-using women could negatively influence their decision to seek treatment. For example, respondents from the group of IDU women perceived medical personnel in treatment services, and elsewhere in healthcare, as holding traditional hostile and judgmental attitudes towards "deviant" women (Box 1: WHUD22, WHUD04). This perception was held even among women who had not personally experienced a negative attitude from a health care professional. Interestingly, respondents saw negative attitudes of medical staff as a major problem preventing women from seeking or engaging with services. The service providers noted that many physicians

lacked the qualifications to effectively treat substance-using patients (see for example Box 2: SP01). Another prejudice was related to medication-assisted-treatment programmes. We found that potential patients often viewed them as a "last resort" option, for the most disadvantaged and failed substance-abusing individuals. Many women viewed entering medication-assisted treatment as equal to admitting ultimate failure and belonging to "those on the bottom".

Participants in both groups acknowledged that in the majority of cases a woman's substance use was initiated and supported by a substance-using male partner (see Box 1: SP13, WHUD09). Having such a partner was said to be an additional factor inhibiting a woman's willingness to seek assistance – the partner can resist her treatment-seeking and, in addition, she might fear losing him if she becomes drug-free. Women IDU further suggested that if women are pregnant or have children, they are more afraid to admit substance use problems and get in contact with relevant services because of the fear of losing custody of their children.

Finally, a lack of knowledge about available (though scarce) treatment options was mentioned by a number of Women IDU respondents as yet another impediment to treatment entry. This factor was considered to be equally relevant for men with substance use problems.

Structural and policy barriers

Respondents indicated that agencies offering women-specific interventions are virtually nonexistent in Georgia. Service provider respondents pointed out that the vast majority of substance use treatment and low-threshold programmes were designed to serve men and were not equipped with the knowledge and skills to address the unique needs of women (Box 2: SP01). The interviews with the IDU women strongly indicated that absence of childcare, a lack of attention to childhood and current sexual, physical, and emotional abuse, the limited knowledge of medical personnel about substance use during pregnancy and very poor rates of referral to sexual and reproductive healthcare services constitute additional factors which negatively affect women's willingness to seek or remain engaged in substance use treatment.

The vast majority of health service providers were unaware of specific types of substance-use-treatment opportunities in their city, and did not seek connections with other service providers, indicating a lack of links between substance-use and other services. Treatment providers did not fully understand the needs of women, nor have sufficient knowledge of gender-specific characteristics of disease progression, and only vague ideas about women-specific interventions. Interviews suggest that myths and prejudices influenced their attitudes and behaviors. For example, a commonly shared belief was that women with substance use problems have a more severe clinical profile, are less responsive to treatment, and have poorer treatment outcomes, when compared to men (see quote from SP23 in Box 2). Not surprisingly, respondents in the substance-using group pointed to a lack of support and tolerance in treatment environments, coupled with judgmental attitudes of service providers toward substance-using women as factors that impeded women's entry to treatment.

The vast majority of participants in both groups agreed that harsh substance use legislation and policy regulations compromise the ability to provide or receive treatment for substance use disorders. Service providers indicated that low threshold intervention programmes are the only facilities that offer anonymous services. No other treatment can be delivered without a patient's personal information. In an environment of societal hostility and stigmatization women do not trust treatment services and fear disclosure. As SP01 suggests,

there is little, if any, understanding of the needs of substance-using women on the part of police, and those who use substances are in general treated as criminals (see Box 2). A number of women's' accounts describe their personal negative experience of punitive legislation and the hostile attitude of police (Box 2: WHUD04, WHUD05).

Both groups noted the cost of treatment as an important barrier (see for example Box 2: SP02, WHUD11). The majority of programmes are for-profit, and require payments, ranging between 1250-2000 GEL (US$750-1200) for two-weeks of medication-assisted withdrawal. Therefore, even when a substance-use problem is acknowledged and a decision to enter treatment is made, the prohibitively high cost of treatment stands as an insurmountable barrier for women.

Discussion

The majority of research focusing on women with substance use problems has been conducted in North America, Western Europe, and Australia. In Georgia, similar to other developing and transitional countries, women who use substances are in the shadow of their male counterparts, who comprise the vast majority of low threshold and substance use treatment clients (Pinkham & Malinowska-Sempruch, 2007). This qualitative study included perspectives of health service providers and substance-using women and identified a variety of complicating factors that can influence help-seeking behavior of women with substance use problems. Many of these factors are universal and have been reported in different geographical regions and diverse economic and political settings.

In the context of Georgia, many factors affecting access to treatment are not specific to gender, however, there are barriers that more adversely affect substance-using women than men. In a previous article we argued that cost-related barriers primarily affected women, as most are unable to pay for their treatment due to financial dependency, typically on their male partner (Kirtadze, et al., 2013). We also suggested that while stigma plays an important part in influencing all treatment-seeking behavior, the most serious stigmatization (from the perspective of larger Georgian society, substance-using men, and service-providers) is experienced by women and can be identified as one of the most powerful gender-specific socio-cultural barriers adversely affecting demand for, and accessibility to, treatment.

The negative impact of socio-cultural and personal factors on treatment-seeking behavior of Georgian women represents a unique finding of this study. Substance use by women occurs in an environment of severe societal hostility, extreme stigmatization, and intolerance on the part of family and broader society, and is perceived as the worst possible deviation from social and cultural norms and expectations. These factors, combined with low self-esteem and strong feelings of guilt and self-blame among women, create conditions in which admitting substance use and openly seeking help are extremely difficult, even if a comprehensive treatment programme was available. Changing societal attitudes, creating a tolerant treatment environment, and most importantly educating and empowering women, are critical to any endeavor to engage and treat women with substance use problems.

The vast majority of substance-using women in Georgia are introduced to substance use by male partners. Compared to those women who do not have substance-using partners, they experience less support and even resistance, to entering abstinence-based treatment and they remain in treatment for a shorter period of time (Dorte & Morten, 2009; Lex, 1991). Our previous research suggests that in the Georgian cultural context, a partner's involvement and a couple-focused approach has significant potential to facilitate treatment entry, and improve both treatment retention and treatment outcome (Jones, Tuten, & O'Grady, 2011; Kirtadze, Otiashvili, O'Grady, & Jones, 2012; Otiashvili, Kirtadze, O'Grady, & Jones, 2012).

The service delivery environment is an important factor influencing the desire for treatment and therefore requires critical assessment. To a large extent the current state of addiction treatment in Georgia has been shaped by Soviet "narcology". This operated within a highly centralized and closely regulated vertical health care system. There was a focus on heavy medicalization and an emphasis on administrative duties, rather than caregiving, with few incentives to seek any major changes in the field. These historical characteristics of Soviet narcology can be found in contemporary narcology in Georgia and in other post-Soviet countries (Elovich & Drucker, 2008; Latypov, 2011). Respondents in the service-providers' group were able to identify a range of factors hindering access to treatment for substance-using women, but appeared unable to propose any meaningful solutions. For example, while there was consensus on the need for developing women-specific services, respondents fell short of suggesting what these services should look like. In our previous publication we pointed to the absence of national treatment guidelines and a lack of agreement among clinicians on how to measure effectiveness of treatment for substance use disorders (Kirtadze, et al., 2013). This lack of effort continues and can be viewed as an additional sign of the generally passive and static position of treatment institutions towards developing and introducing novel approaches for substance use treatment. Yet service providers would benefit from gaining new knowledge and skills. They also need to be motivated to create a physically and emotionally safe treatment environment and to introduce structural and procedural changes to make treatment attractive and accessible to women.

Strengths and limitations of the study

A major strength of this study was its qualitative approach, providing an in-depth understanding of complex environmental factors in which the treatment-seeking behavior of women is formed and maintained. To our knowledge this is the first comprehensive attempt to examine policy-relevant problems experienced by substance-using women in Georgia from the perspective of both service providers and potential service beneficiaries. Importantly, interviews were conducted with a diverse group of substance-using women, including those in treatment, out-of treatment and those in contact with low threshold harm reduction programmes. Another strength of the study was the triangulation of results. Both sets of transcripts were analyzed simultaneously and this enabled us to extract themes common to both sets of respondents.

The study involved secondary analysis and interviews that focused primarily on policy-relevant issues related to substance abuse and its treatment in Georgia may have yielded richer data. Performing parallel analysis of two datasets and examining themes and categories and their relationship within as well as across samples was a challenge. However, analyses resulted in high inter-rater reliability, the absence of response outliers and the emergence of common themes across the datasets, which all contributed to the validity of our findings.

Another potential limitation is that we did not assess the perceived need or desire for substance abuse treatment. Evidence from studies in other countries suggests that even when appropriate treatment is available at low or no cost, some substance-using individuals do not take advantage of it (Appel, Ellison, Jansky, & Oldak, 2004; McCoy, Metsch, Chitwood, & Miles, 2001; Zule & Desmond, 2000). Moreover, findings suggest that a significant number of individuals use substances without developing dependence and/or without visible interference to their social or professional functioning (Decorte, 2001; Notley, 2005; Warburton, Turnbull, & Hough, 2005). It has been acknowledged that how the wider society perceives and labels "problematic" use of substances can adversely impact on an individual's social integration or substance use rehabilitation (Buchanan, 2006). One of the primary purposes of the parent clinical trial was to advance our understanding of the treatment needs of women, to determine the barriers to providing treatment for women, and

to use these findings to develop an appropriate intervention for women. Examining women's substance use problems from a broader socio-economic perspective or elaborating on the needs of those who are able to self-regulate their substance use was beyond the scope of this research.

Within the context of orthodox Georgian society, low self-esteem and self-blame, combined with severe social stigma, labeling on the part of family, friends, and society, and an often hostile and judgmental attitude of health service providers plays a critical role in creating barriers to both general health and substance-use-related services for women with substance use problems.

There is an urgent need to develop comprehensive women-specific substance use treatment services with a focus on long-term sustainability. Significant efforts should be directed towards educating staff of such programmes in order to ensure a non-judgmental and supportive environment that would serve to attract women and retain them in treatment. Health professionals in primary care and mental health settings should be trained to identify and refer women to specialized substance abuse services. Similarly, public health campaigns to educate the population regarding the need for substance use treatment for women should be undertaken. Finally, there is an opportunity for policy reform to eliminate legal barriers for substance-using women to seek assistance.

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Box 1. Internal/interpersonal factors and socio-cultural context

Societal expectations, stigma and hostility towards women who use drugs

Woman can't be a drug user, a woman should first of all be a mother, a wife, and she must do her business… (SP11)

They (women who use drugs) are liars, big liars… and they are ready to go as far as possible … they are ready to sell themselves…(SP13)

There are some things that men are forgiven while the same things might not be forgiven to women, they are required more from the society and they are punished more from the society. (WHUD02)

I would describe her as weak-willed or weak person, who does not care about other people, about anything…(SP01)

They are hated both, by men and women who do not use drugs. The society does not consider them as humans or a member of the society… (WHUD03)

If family finds out that woman is injecting they will cast her away…(WHUD07)

Prejudice towards drug treatment

When we were brining women to X….. [organization, providing services to drug-using women] they were saying that they were ashamed and at the same time scared of the cameras they thought would be installed in that organization…(WHUD22)

I imagine those dumb doctors have this perception about drug users, that they are evil and it's unacceptable…(WHUD04)

Drug-using male partner

She was trying to make him (husband) give up drugs, but as a result of this struggle she herself started to use drugs…(SP13)

Her partner was beating her and forcing her to use drugs… (SP13)

Well, I am a user myself but I never have drugs if someone does not provide me with it… If I don't have a man by my side that can get drugs… (WHUD05)

It is getting easier for a man because a woman becomes absolutely dependent on her husband…(WHUD09)

Drug use and parenting

There is a doubt about her perspectives as a parent, and her possibilities to adequately look after children….(SP06)

Well, if this problem is revealed by women and if gynecologists can, they will always advise it (abortion)…(SP06)

I also had similar situation when police told me that I was not worth being a mother and that they should take away my baby..(WHUD04)

Box 2. Structural and policy barriers

Availability of comprehensive treatment

There was a talk to create a separate substitution program for women, as long as they are embarrassed to visit these programs together with boys… I think it is far more practical and comfortable to have them separately for women… (SP01)

Once and for good drug addiction should be acknowledged as a disease in Georgia like in other countries and instead of casting us away and arresting us, government should assist us, provide treatment and ensure that we somehow re-socialize…(WHUD04)

Knowledge and skills of service providers

Level of training is very low… it is a new thing for them, … he (doctor) does not know what kind of medication to prescribe, what would be reaction if it is combined with other medicine… he needs to consult us…(SP01)

They (service providers) have some kind of a feeling of disgust towards such patients… and they want to terminate these relations as soon as possible…(SP10)

This disease is very complicated among women and it is very difficult to cure them.. (SP23)

Drug policy and practice

Generally, attitude of a police towards a drug user is similar to their attitude towards the criminals and not sick people… their attitude towards women is even worse than to men…(SP01)

I once took my friend to a doctor and he noticed that she was real bad and he also noticed that I was not feeling well as well. Finally he told us to get away; otherwise he threatened to call the police. It seems that he is obliged to call a police when drug user refers to him but I think he did not want us to be caught so he just got rid of us…(WHUD05)

There was my friend she had high fever for days and almost developed gangrene, she was feeling very bad and when we called ambulance they called police and she was arrested for 2 days…(WHUD04)

Cost of treatment

I do not think the treatment is easily available as it is very expensive, if it were free, I am sure the demand would be much higher, in fact very few people have the finances to take a course of treatment…(SP02)

There were some cases when somatic condition of a patient is severe, but they do not go to a doctor because of a lack of money…(SP13)

Well I want to enter a substitution program but I don't have 500GEL to get into paid program and I can't also enter the free program…(WHUD11)

First of all that's government's fault that they are not visiting doctors and also you need a lot of money and most don't have that amount but I'm sure they have desire to go to a doctor…(WHUD04)

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Table 1

Socio-demographic characteristics of health service providers (n=34) and females who use drugs (**n**=55)

		Health service providers *n* = 34		**Females who use drugs *n* = 55**	
		***f* (%)**	***M* (*SD*)**	***f* (%)**	***M* (*SD*)**
Gender					
	Female	24 (71%)		55 (100%)	
	Male	10 (29%)			
Ethnicity					
	Georgian	34 (100%)		52 (94.6%)	
	Ukrainian			2 (3.6 %)	
	Abkhazian			1 (1.8%)	
Age			42.6 (9.9)		35.7 (9.5)
Education (years)			17.0 (1.4)		8.6 (3.3)
Employment					
	Employed	34 (100%)		7 (12.7%)	
	Unemployed			48 (87.3%)	