PROGRAMME ON

SUBSTANCE

ABUSE

WOMEN
AND
SUBSTANCE
ABUSE:

1993 country assessment report

WORLD HEALTH ORGANIZATION
ABSTRACT

This 1993 country assessment report on women and substance abuse is the second in a series of country studies on the sociocultural, health and policy impact on women who are affected by substance use, whether they are themselves substance users or not. The earlier provisional findings, entitled Women and substance abuse, 1992 interim report (WHO/PSA/92.9), comprised country reports from Africa, Central America and Eastern Europe.

This report consists of country studies from all WHO Regions: Cameroon and Kenya in the African Region; the Bahamas, Bolivia, Brazil and Honduras in the Region of the Americas; Egypt and Lebanon in the Eastern Mediterranean Region; Estonia, Greece, Kazakhstan and Turkmenistan in the European Region; India and Sri Lanka in the South East Asian Region and China, Japan and the Philippines in the Western Pacific Region.

These two compilations of country studies are part of a global assessment being carried out for the women and substance abuse project supported by the United Nations International Drug Control Programme (UNDCP). The financial contribution of UNDCP is gratefully acknowledged.

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INTRODUCTION

This document is the second compilation of country reports on women and substance abuse prepared under the auspices of the World Health Organization Programme on Substance Abuse (WHO/PSA). It includes reports from all WHO Regions; the African Region, the Region of the Americas, the Eastern Mediterranean Region, the European Region, the South East Asian Region and the Western Pacific Region. The document forms part of the 1993 Women and Drug Abuse, HIV/AIDS project funded by the United Nations International Drug Control Programme (UNDCP). It expands and updates an earlier compilation of reports from Africa, Central America and Eastern Europe entitled Women and Substance Abuse, 1992 interim report (WHO/PSA/92.9).

Two additional reports have been prepared from the 1993 project: Women and Drug Abuse; United Nations System Position Paper, which is a collaborative report prepared by WHO/PSA, UNDCP and the UN Department of Policy Coordination and Sustainable Development, Division for the Advancement of Women (UN/DPCSD/DAW), and Women and Drug Abuse; a gender analysis and review of health and policy implications (WHO/PSA/93.12).

All country reports in the present document are the result of assessments carried out in 1993. The countries included are the Bahamas, Bolivia, Brazil, Cameroon, China, Egypt, Estonia, Greece, Honduras, India, Japan, Kazakhstan, Kenya, Lebanon, the Philippines, Sri Lanka and Turkmenistan. All reports were prepared by specialists active in the areas of drug abuse research, prevention or treatment in the countries concerned. The term "drug" refers to alcohol, tobacco, illicit or licit drugs and other psychoactive substances.

The country assessments presented here are based on several sources of information: a comprehensive review of published literature on women and substance abuse and dependence in each country, admission statistics from treatment facilities, and police and prison records. In addition, interviews were conducted with persons providing a variety of services to drug abusers and drug dependents, with women substance users themselves, and with women affected by the substance abuse problems of relatives or friends.

The country assessments have three objectives:

(1) to identify drug use related issues faced by women, whether they are drug users or not;
(2) to assess the trends, regional variations or unique aspects of the issue of women and substance abuse;
(3) to document women’s resources in countries that have potential for providing interventions to reduce drug abuse demand.

This compilation of country report is the first international assessment of women and drug abuse and should serve as a useful reference work on the topic. While the country reports differ considerably in the quantity and range of information they are able to provide, each is presented in accordance with a common overall structure. With minor variations, therefore, each country report includes the following five elements:

(1) introductory section covering the historical, sociocultural and gender perspectives of substance abuse in the country concerned;
(2) report on literature review;
(3) summary of treatment statistics by gender and type of substance used;
(4) assessment of the role of women in demand reduction interventions;
(5) conclusions
The purpose of this series of reports is not to provide a comparison between countries. Rather it is to place on record what is known regarding women and substance abuse, what is not known, and what may be considered possible steps for future research or action.

Common factors

With such a wide variety of cultural backgrounds and social attitudes, and with such variation in availability of data, national priorities in one country may often differ from those in another. This is only to be expected, but while similarities between women or between substances used in different national situations may not always be easy to visualize, it is clear that a number of factors are common to the issue of women and substance abuse in more than one country.

One obvious common factor is that, in most countries, substance abuse has traditionally been seen as a man's problem. Substance abuse was felt to be incompatible with women's role in society. Consequently, while men's abuse of substances could be excused, or even condoned, as an acceptable part of manhood, women's abuse of substances attracted a negative stigma. While this latter fact may be claimed to have prevented many women from abusing drugs, it has also made it extremely difficult for substance-dependent women to seek assistance for their dependence in many societies.

Negative attitudes to women's substance abuse coupled with the reluctance of women to admit their abuse and dependence have resulted in scanty data being available specifically on women. Even in countries with considerable research information about drug abuse and dependence it is often hard to find data relating directly to women. In cases where studies have examined women's role in substance abuse the approach has by no means always been gender-specific, so that conclusions may have been clouded by viewing women's involvement from a male perspective.

A third factor related to the concept of substance abuse as a male problem is the lack of services for women substance users. The country reports in this document bear witness to this lack of services and to the need to provide such services as a priority. Where services, such as treatment and rehabilitation services, do exist, they may frequently have an approach based on male role models of drug dependence. Where services are provided for women it is clear that they must be accessible. This is not always easy when women's drug dependence is stigmatized and when cost of treatment is beyond the means of the majority of women.

Varied situations

Differing country situations make for a set of reports that vary in a number of respects. Wherever possible, for instance, drug abuse by women has been assessed by age group - from adolescence through adulthood to old age - but there are cases where the data was simply not available to allow this. Similarly, information about the relationship of HIV/AIDS to women and substance abuse has been included wherever reliable data could be found.

In the document, the country reports are organized according to the WHO Regions to which the country belongs.

African Region

The most common drugs used in Cameroon are licit, including tobacco, palm wine and other alcoholic drinks. Women are involved in the production of and sale of alcohol, especially harki. Palm wine is also used for medicinal purposes and by children. Traditionally, the use of tobacco by women was common only among old women, who chewed or sniffed a powder made of the ground leaves and other spices. With the adoption of western practices, there is an increased number of women smoking cigarettes today. Among the illicit drugs, cannabis is the most commonly used. Women often use cannabis pessaries
in the vagina to increase the sexual desire of their partners, as "dry" sex is a common practice and it is believed that men prefer a woman with a dry vagina. This practice can contribute to alteration of the vaginal mucosa and increase in exposure to HIV.

Kenya has seen increases in the use of a number of substances by women, with changing social attitudes leading to acceptability of alcohol and tobacco use by young women. Women's alcohol abuse is especially linked to the distilling of illicit liquor, often in situations of low socioeconomic status where selling liquor may be seen as the only way of producing income. Studies have indicated alcohol dependence among women slum-dwellers and female students. The lifestyle of a typical alcohol-abusing female slum-dweller is described and a link is made to the problem of substance abuse among street children. Women are also noted to be frequent users of tranquillizers and barbiturates. In view of the lack of services for treatment of drug dependence, the report suggests the provision of home-based care for dependent persons.

American Region

Alcohol is the most commonly used drug for all groups, and alcohol abuse has long been a problem in the Bahamas. Rapid social changes have contributed to an increase in alcohol dependence and alcohol related problems, and the differences between men and women have narrowed. In the last 20 years, poly-drug use has become common, including the combined use of alcohol and methaqualone. Cocaine use and abuse has also increased, especially among women. Not only do women substance abusers seem less willing than their male counterparts to enter treatment, but they also seem less likely to complete inpatient treatment. The HIV infection has become the focus of much concern in the Bahamas due to the rapid increase in the number of infected people and AIDS cases. Unsafe heterosexual practices and intravenous drug use are the most important modes of transmission. Women do not perceive themselves as at risk and lack knowledge of HIV transmission. A high percent of HIV infected women are cocaine dependent, keeping their habit by trading sex for drugs.

The abuse of alcohol, cocaine, cannabis and psychoactive drugs by women is reported to be growing in Bolivia, but in each case the amount of abuse is said to be less than that among men. Bolivia is a coca-producing country and the use of coca paste, one of the by-products of cocaine production, is considered to be a growing problem. While women are reported to abuse substances less than men do, women are shown to become dependent after a shorter period of use. The report indicates that treatment programmes specifically for women are needed as a priority, that prevention programmes should include a component specifically aimed at women, and that greater effort should be made to reach rural women with such programmes. Although the extent of women's alcohol abuse is less than men's, rural women in Bolivia are found to be more likely to use alcohol than their urban counterparts.

In Brazil the main drugs of abuse are said to be licit ones. Self-medication with benzodiazepines and anorectic drugs is a major concern among women that is compounded by easy availability of drugs without prescription. While studies indicate that HIV infection and use of alcohol and drugs are increasing among Brazilian women, little is known about the impact they are having. Violence against women by alcohol-abusing males is a problem that is often unrecognized and the role of alcohol in traffic accidents needs further evaluation. Studies indicate a rise in the incidence of AIDS among injecting drug users. Treatment services for women are reported scarce and there is a call for more training of health professionals in the treatment of substance dependence and related problems.

Honduras lists substance abuse as one of the country's top 10 health priorities. Alcohol is the most abused substance but women also show relatively high rates of benzodiazepine use. Again the easy availability of drugs without the need for a prescription is mentioned as a major obstacle to prevention. More services for women are needed and the role of women's groups in drug abuse prevention is highlighted.
Each of the Latin American reports mentions the particular problem of substance abuse among street children, many of whom use solvents. This group is likely to be undernourished and high rates of sexually transmitted diseases were found among female street children in Bolivia. Brazilian street children are reported to use a range of drugs in order to escape from reality.

**Eastern Mediterranean Region**

Information on women’s abuse of substances is particularly sparse in Egypt, though some studies have focused on abuse among students. Very few women are known to seek treatment for drug-related problems and it is suggested that there needs to be a conscious effort to find out why this is so. Egypt has seen a rise in use of hashish, and of amphetamines which are manufactured in the country. Opium use has declined but heroin use has increased. Psychotropics are the main drugs used by women. The report stresses the need for women to be trained to treat women, for women’s NGOs to take an active role in sensitizing people to the issue of women and substance abuse, and for more consideration of how to overcome cultural and traditional barriers to prevention.

An overall low level of substance abuse is reported in Lebanon, with women using drugs far less than men. The extent of tranquilizer use is not known but medicines are reported easy to obtain without prescription.

**European Region**

In Estonia, alcohol has been traditionally consumed in the society, and the existence of alcohol related problems is recognized. Little data are available on the patterns of other drug use and related problems in Estonia, although there is evidence that both consumption and drug-related problems are increasing, particularly from cannabis, amphetamines, barbiturates and other sedatives. However, these problems have not yet been fully appreciated by authorities in the society. It is foreseen that rapid social and economical changes, including increasing unemployment, will make drug abuse more likely.

Greece notes an increase in the abuse of substances among young people in the past two decades and the country has carried out a number of surveys of abuse among school students. Women are found to use licit drugs such as pain relievers and tranquilizers without prescription, and licit drug abuse is noted among school students. A need for more services for women is indicated and steps are under way to provide a range of more targeted services that include more focused counselling for drug abusers. A pilot health education programme to prevent drug abuse was carried out in the late 1980s and a more extensive one is under way on the basis of this. There are indications that the rise in substance abuse among students who were part of the project was less than among other students.

Kazakhstan has also experienced a rise in substance abuse among women and contributing factors are thought to be a rise in women’s disposable income and the ready availability of the substances of abuse, such as alcohol. Women conceal their dependence longer than men do because of the social stigma and the social consequences of dependence are greater in women than in men. Women dependent on alcohol are, for instance, more likely to lose their job than male dependents. The report describes traditional use of koknar, which is still a part of social life in rural areas. Because Kazakhstan has a number of women’s organizations at governmental and regional level, it is proposed that these organizations could play an important role in planning and implementing prevention programmes among women and among the general population.

Cannabis is often the first drug of abuse tried by both men and women in Turkmenistan. Alcohol was not a traditional substance in this population until the country was annexed by Russia. Since then, availability increased significantly, and drinking problems are more prevalent. However, the society remains fairly intolerant towards the consumption of alcohol, especially by women. Crude opium (known locally as teryak) has been used for centuries by Turkmenis as a broad-spectrum medicine and as an
euphoriant. Traditionally, it is smoked or taken by mouth. A clear shift from traditional use of opiates towards the Western model of drug taking has occurred, especially in urban areas. An increased number of intravenous opiate injectors has been noted, among town dwellers, both men and women between 20-40 years old, unemployed or underemployed, often having a criminal record. New drugs to Turkmenistan have also entered the market, including ephedron (methyl catinone), for intravenous use, especially among young women, followed by medical and social adverse consequences.

**South East Asian Region**

Changes in the social roles of women are seen both as part of the problem of women’s substance abuse and as part of the solution. While a loosening of traditional social roles is seen as contributing to the rise of substance abuse by women in India and Sri Lanka, the India report sees a change in women’s social status as a prerequisite for effectively combating drug problems in women and for providing better access to medical and social services.

While in India most of those who abstain from substance use are women, there has been a noted rise in the extent of substance dependence among women. Tribal women and female plantation workers are observed to have a relatively high rate of alcohol use, while many urban women of low socioeconomic status use bhang and ganja. Tobacco use is a major health problem with an estimated 10 million women smokers. Studies in both India and Sri Lanka indicate that substance abuse is generally a problem of the less educated woman rather than of her educated counterpart. Treatment services are said to be often inconvenient or inappropriate for women, and some treatment staff are said to display negative attitudes to women dependents. While most women appear to have little knowledge of the effects of drug use and abuse, young women were found to have very little knowledge of sexually transmitted diseases and AIDS. The report urges more education and information on these issues, more social and medical services for women generally and for women substance abusers in particular, more training of social/medical personnel and more focus on the counselling of family members so that they support rather than reject the female drug abuser.

The report from Sri Lanka indicates a fairly stable situation there with regard to women and substance abuse at present. Alcohol problems are seen among women involved in the production of illicit liquor but abuse is said to be limited to small numbers in specific social groups. In view of rapid socioeconomic change, however, periodical review of the situation is recommended. Injecting drug use is reported to be a minor problem, but it is recommended that monitoring of this be implemented because of the link between drug injecting and the spread of AIDS. The report expresses some concern for women working in manufacturing industries, away from their families and free of the traditional constraints that may help prevent substance abuse. The major substance-related effects on women in Sri Lanka are identified as indirect ones that stem from the substance abuse of male partners. Many families in Sri Lanka have low incomes but the situation is exacerbated by substance abuse or dependence of the traditional head of the family. The impact on women of poverty and violence related to male substance abuse appears to have been underestimated, and can be reduced only by changing the positive masculine image that the use of alcohol and drugs may have.

Each of these reports stress the value of women’s organizations in combating substance abuse, educating women about substance-related issues and giving assistance to women substance abusers.

**Western Pacific Region**

As China has a large population and clear cultural and economic variations within the country, this report investigated substance abuse in three regions, i.e., Hunan, Heilongjiang and Jiangsu. The study showed that both licit and illicit drugs are used more frequently by males than females. Women use more minor tranquillizers and analgesics than men. Alcohol and tobacco became an increasing concern in the 1980s. Since then China has become the world’s major cigarette manufacturer. Alcohol consumption
increased 20-fold between 1952 and 1990. With increasing industrialization and modernization, smoking and drinking in China are likely to increase further if preventive strategies are not rapidly implemented.

Japan reports a rise in the amount of alcohol use by women over the past few decades as women have taken on more independent and less family-oriented roles. Women are found to be heavy users of anti-anxiety drugs, and to a lesser extent of sleeping pills and analgesics. Again, education about the issue of substance abuse is mentioned as a necessary future step, as an increase of community-based care for drug dependent women and their families.

In the Philippines the involvement of women in substance abuse, and particularly in drug-related crimes like possession, trafficking, sale and distribution is today a very disturbing social reality. Since 1960, a variety of drugs have become available and abused, including heroin, cannabis, barbiturates, LSD, methaqualone, and stimulants. Substance abuse is closely associated with prostitution and sex workers in the Philippines, and HIV/AIDS cases have been concentrated in these high risk groups. The tourism industry had indirectly encouraged prostitution as a dollar earner despite the strong social stigma it carries. This social stigma creates feelings of guilt, shame and low self-esteem and is further exacerbated by substance abuse. Drinking alcohol is an indigenous practice among Filipinos, and problems related to its abuse are relatively low among women.

It is clear that there is a growing concern for the issue of women and substance abuse in many countries. The existing data are scarce - on an issue that can have major consequences not only for the individuals concerned but also for their families and society in general. The series of country reports of which this document forms a part is a first attempt to survey a relatively unknown area of substance abuse. It is hoped that these reports, despite their gaps in knowledge and tentative conclusions, will alert countries and the international community to the seriousness of substance abuse for women’s physical, social and mental health.

This global assessment of women and substance abuse has been supported by the United Nations International Drug Control Programme (UNDCP). The financial contribution of UNDCP is gratefully acknowledged.
COUNTRY REPORTS: WHO AFRICAN REGION

- CAMEROON
- KENYA
WOMEN AND SUBSTANCE ABUSE IN CAMEROON

INTRODUCTION

Substance abuse in Cameroon is a problem that has not been looked at in depth. The extent of substance abuse is immense, involving children, women and men. The most common drugs used are licit drugs. These include tobacco, which is grown as a cash crop and used in the cigarette industry of the country, palm wine, (commonly called white wine, matango, or palm tree mimbo), alcoholic drinks distilled from white wine, cocoa, corn, cassava on ripe plantain, beers made by licensed breweries, and imported wines and other alcoholic drinks. Illicit drugs are not uncommon. The most common type available all over the country is cannabis. This plant is grown in most of the provinces of Cameroon. Officials are trying to put an end to its cultivation but this has not been successful. The market for cannabis is large. Persons with leprosy, who are not checked or questioned by the authorities, often sell cannabis. Psychotropic substances and solvents are also used as drugs.

METHODOLOGY

A literature review was carried out on the few publications available on abuse of drugs, alcoholism and tobacco. Passive observation was carried out by some field-workers, usually by counting persons present in bars at different times of the day. The numbers of females and males present were counted, as were the numbers of those taking alcoholic and soft drinks. At the same time those smoking were counted, as well as the number of children.

All this information was analysed using EPI-INFO.

LITERATURE REVIEW

Very few articles have been written about substance abuse in Cameroon, but some reports have been presented at a seminar in 1990 for persons involved in combating substance abuse. According to J. Escomba (1), drug trafficking and production in Cameroon before 1986 was mainly of cannabis. The actual amount produced during this period could not be evaluated, but Escomba pointed out that people apprehended with the drug hardly ever had more than 2.5 kg of it. In 1983, 1962 persons were arrested for possessing cannabis, while in the period of 1987-1988, 3605 were arrested. Regardless of the large number of persons arrested only 10 and 14 persons were imprisoned in 1986 and 1987-1988 respectively. In 1986, 800 kg of Indian hemp destined for export to Europe was seized in Douala.

The trafficking of amphetamines and barbiturates has also been observed, some 800 kg of secobarbital capsules were seized in Kousseri. In 1989, two persons were arrested in possession of 4500 tablets of binocital while, in 1990, one person was imprisoned for possessing 10 kg of cannabis and another for having 500 capsules of oui-oui (psychotropic substance).

Since 1986 heroin and cocaine has passed through Cameroon from Bombay and Addis Ababa to Nigeria. Between 1988 and 1990, more than 100 drug dealers trafficking in heroin were arrested in Douala, 84% of them foreigners. Escomba indicated that Cameroon had ratified all the international conventions regarding drug use, and drug abuse. Though Cameroon has no specific laws regarding drug use, trafficking of illicit drugs and other psychotropic substances is a punishable offence.

Another paper presented at the same seminar was that of Leon P. Seudie (2). He described types of drugs and the means of trafficking used. According to Seudie, the problem of drugs is a nationwide problem. Both iboga and cannabis, commonly called bangia, have been used traditionally in Cameroon. Amphetamines and barbiturates circulate freely and are sold by street vendors. The paper by N.D. Lantum
(3) brought out the need for multi-disciplinary studies on substance abuse to determine the correlation between the consumption of drugs and the socioeconomic and health consequences.

Most other articles are about licit drugs. Studies by Ndax (4) and Mvondo Abane (5) indicated that there is a relationship between cigarette smoking and cardiovascular diseases, especially cardiac failure due to hypertension. Kouegoua (6) found that a good number of university students were moderate smokers and that this habit was copied either from parents or from friends. Medou (7) found that 12% of secondary school children smoked, drank alcohol or did both. Smoking and drinking was much more common among boys than girls. Poor children were also found to consume illicit drugs. In a survey of alcohol dependence in a rural population, Atchou (8) found that 87% of the study population drank alcoholic beverages but that 62% of them did not know this was detrimental to health. Women made up 33% of those taking alcohol. Studies by Andoseh (9) and Irombe (10) have demonstrated a correlation between alcohol in take and hypertension.

ALCOHOL

The consumption and purchase of alcoholic beverages is not prohibited in Cameroon. Even children freely purchase alcoholic drinks. Consumption is common among both sexes. In the villages the sap of the palm tree serves as a drink for everybody. This fermented drink is given even to children during weaning. It is available in all the southern areas of Cameroon where palms trees are found. It is produced from the oil palm tree as well as the raffia palm tree.

Palm wine is also used to prepare a highly alcoholic drink through distillation, called harki, aforfor, African gin, illicit gin or ha’a. Palm wine is mostly made by men, while women are the specialists in preparing harki. This distilled alcoholic drink can also be prepared from maize, ripe plantains, sugar cane or cocoa. The drinks is sold mainly by women in drinking places or in bars. This trade serves as a source of income for the women and their families. Though women serve as bartenders in a good number of bars, that does not make them drunkards. Nor do all these bartenders drink alcoholic drinks.

Palm wine may be used for medicinal purposes. A child that appears to be developing measles is given medicine that has palm wine as its base.

Observations showed that the proportion of women in bars around the markets in the morning period was high. These women come to shop in the markets and to sell things there. It is very common to find women selling with a bottle of beer beside them. As the day goes on, the proportion of women to men in these bars reduces.

In general, as observed in Table 1, there are more men than women in bars and the proportion taking alcoholic drinks is also greater among men than women. When salaries are paid the number of people in the bars increases and it reduces as the month advances.
Table 1. Number and percentage of persons in bars at different hours of the day, by sex

<table>
<thead>
<tr>
<th>Time</th>
<th>Bars</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>Mean No. per bar</td>
<td>%</td>
</tr>
<tr>
<td>10.00hrs</td>
<td>12</td>
<td>566</td>
<td>47.17</td>
<td>66.4</td>
</tr>
<tr>
<td>12.00hrs</td>
<td>4</td>
<td>230</td>
<td>57.5</td>
<td>64.1</td>
</tr>
<tr>
<td>14.00hrs</td>
<td>7</td>
<td>346</td>
<td>49.4</td>
<td>59.8</td>
</tr>
<tr>
<td>16.00hrs</td>
<td>4</td>
<td>234</td>
<td>58.5</td>
<td>66.5</td>
</tr>
<tr>
<td>18.00hrs</td>
<td>9</td>
<td>782</td>
<td>86.89</td>
<td>57.7</td>
</tr>
<tr>
<td>20.00hrs</td>
<td>3</td>
<td>578</td>
<td>192.67</td>
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</tr>
<tr>
<td>22.00hrs</td>
<td>8</td>
<td>1213</td>
<td>151.63</td>
<td>61.8</td>
</tr>
<tr>
<td>24.00hrs</td>
<td>2</td>
<td>191</td>
<td>95.5</td>
<td>42.2</td>
</tr>
</tbody>
</table>

Table 1 shows the mean number of women and men in bars at different hours of the day. These figures do not reflect the real situation since the bars visited at different hours were not the same. The proportion of women in the bars is lower than that of men all day long except at midnight. Couples go to drinking place for distraction, but late at night there are more single ladies looking for clients.

Table 2. Percentage of persons in bars taking or not taking alcoholic drinks by sex

<table>
<thead>
<tr>
<th>Time</th>
<th>Bars</th>
<th>Male</th>
<th>Alcohol</th>
<th>No Alcohol</th>
<th>Female</th>
<th>Alcohol</th>
<th>No Alcohol</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>10.00hrs</td>
<td>12</td>
<td>442</td>
<td>78.1</td>
<td>123</td>
<td>21.9</td>
<td>225</td>
<td>78.7</td>
</tr>
<tr>
<td>12.00hrs</td>
<td>4</td>
<td>129</td>
<td>56.1</td>
<td>101</td>
<td>43.9</td>
<td>60</td>
<td>46.5</td>
</tr>
<tr>
<td>14.00hrs</td>
<td>7</td>
<td>287</td>
<td>82.9</td>
<td>59</td>
<td>17.1</td>
<td>187</td>
<td>80.3</td>
</tr>
<tr>
<td>16.00hrs</td>
<td>4</td>
<td>1817</td>
<td>77.4</td>
<td>53</td>
<td>22.6</td>
<td>80</td>
<td>67.8</td>
</tr>
<tr>
<td>18.00hrs</td>
<td>9</td>
<td>647</td>
<td>82.7</td>
<td>135</td>
<td>17.3</td>
<td>498</td>
<td>86.9</td>
</tr>
<tr>
<td>20.00hrs</td>
<td>3</td>
<td>446</td>
<td>77.2</td>
<td>132</td>
<td>22.8</td>
<td>313</td>
<td>81.3</td>
</tr>
<tr>
<td>22.00hrs</td>
<td>8</td>
<td>1020</td>
<td>84.1</td>
<td>193</td>
<td>15.9</td>
<td>601</td>
<td>80.2</td>
</tr>
<tr>
<td>24.00hrs</td>
<td>2</td>
<td>168</td>
<td>88.0</td>
<td>23</td>
<td>12.0</td>
<td>252</td>
<td>96.2</td>
</tr>
</tbody>
</table>

Table 2 shows that most women going into bars or drinking places consume alcoholic drinks. This does not mean that there are more women drinking alcoholic beverages than those who do not; it simply describes those visiting bars. In Cameroonian culture women in bars are looked on as not respectable. Most of the women found in drinking places late at night are sex workers. We find that in Table 2 at 24 hours there are more women in the bars than there are men and 96.2% of them are consuming alcoholic beverages.
TOBACCO

Traditionally, the use of tobacco by women was common only among old women. They chewed the leaves or sniffed a powder made of the ground leaves and other spices. With the adoption of western practices, there are more and more women smoking cigarettes today. Women who smoked used to be looked upon as loose women.

This practice, which is copied from western culture, is thought to be elegant by some women. Though some respectable women smoke, most women who smoke are sex workers who believe smoking makes them more appealing to men. Sex workers are also known to smoke cannabis.

Table 3. Percentage of persons in the bars smoking versus not smoking by sex

<table>
<thead>
<tr>
<th>Time</th>
<th>Bars</th>
<th>Male</th>
<th></th>
<th>Female</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Smoking</td>
<td>Not Smoking</td>
<td></td>
<td>Smoking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
</tr>
<tr>
<td>10.00hrs</td>
<td>12</td>
<td>245</td>
<td>43.3</td>
<td>321</td>
<td>56.7</td>
</tr>
<tr>
<td>12.00hrs</td>
<td>4</td>
<td>45</td>
<td>19.6</td>
<td>185</td>
<td>80.4</td>
</tr>
<tr>
<td>14.00hrs</td>
<td>7</td>
<td>139</td>
<td>40.2</td>
<td>207</td>
<td>59.8</td>
</tr>
<tr>
<td>16.00hrs</td>
<td>4</td>
<td>87</td>
<td>37.2</td>
<td>147</td>
<td>62.8</td>
</tr>
<tr>
<td>18.00hrs</td>
<td>9</td>
<td>300</td>
<td>38.4</td>
<td>482</td>
<td>61.6</td>
</tr>
<tr>
<td>20.00hrs</td>
<td>3</td>
<td>341</td>
<td>59.0</td>
<td>237</td>
<td>41.0</td>
</tr>
<tr>
<td>22.00hrs</td>
<td>8</td>
<td>587</td>
<td>48.4</td>
<td>626</td>
<td>51.6</td>
</tr>
<tr>
<td>24.00hrs</td>
<td>2</td>
<td>120</td>
<td>62.8</td>
<td>71</td>
<td>37.2</td>
</tr>
</tbody>
</table>

Table 3 shows that the percentage of women smoking among those present in the bars increases as the day advances. Half of those women present in bars in the late hours of the night are smoking.

The practice of sniffing tobacco and chewing tobacco leaves is still common among old women in the villages.

ILLEGIT DRUGS

Among the illicit drugs encountered in Cameroon, cannabis stands out as the most frequently used. It is known by names such as Indian hemp, marijuana, hashish, or bang. Cannabis grows wild throughout Cameroon though some people now cultivate it. People with leprosy who are usually not questioned by the police, sell this drug. The leaves are wrapped up in the form of small cigars for sale. Other substances used in Cameroon are binoctal, oui-oui, and solvents. We encountered one lady who used cocaine that was provided by her European boyfriend.

The number of persons who use these substances cannot be easily estimated. They include entertainers, bandits, police, soldiers, students, street children and sex-workers.

Our study put us in contact with 21 women who included sex workers, dancers and military women. Fourteen of these women used cannabis only, four used binoctal only, two used binoctal, oui-oui and cannabis, while one used binoctal and cocaine.
SOURCE OF DRUGS

Cannabis is obtained from persons with leprosy, traditional doctors, farms in the villages where it is grown, or from other consumers. Cannabis is presented as leaves or grains. It can be obtained very easily and it is cheap. This makes it the most commonly used drug.

Unlike cannabis which is grown in Cameroon, binocatal and oui-oui enter the country from neighbouring Nigeria. Solvents and glue are commonly found in repair shops. These drugs can be obtained in large quantities in the northern part of Cameroon, the northwest and southwest provinces, all of which share borders with Nigeria. In the big town, the drugs can easily be obtained in Muslim neighbourhoods as well as in areas where foreigners live.

Though cocaine has been discovered at Douala airport, it is not very common in Cameroon. The only lady we encountered who used cocaine could not inform us how it was obtained since her European boyfriend provided her with the drug.

REASONS FOR USING HARD DRUGS

From our conversations with women we learned that they started using hard drugs either to lose inhibitions, to imitate friends or because drugs were a part of the environment in which they were living in. The reasons women gave for using drugs included:

- gaining courage or strength and losing inhibitions for sexual acts.

The women also indicated the use of cannabis pessaries. All the women we talked to had used cannabis pessaries in the vagina to increase the sexual desire of their partners. The exact effect of the pessary in the vagina is not known but we were told that it was used as a spermicide, to cause abortion and to dry up the vagina. Dry sex is a common practice in some cultures and it is believed that men prefer a woman with a dry vagina since this gives them the feeling of making love to a virgin. The cannabis pessaries are inserted in the vagina when:

- the women go looking for sex partners;
- after a sexual act in preparation for having sex with the next partner;
- after menstruation so as to dry up the vagina;
- if there is a delay in the onset of the menses.

The women also use cannabis mixed with their body lotion as a charm to attract men.

Other than the narcotic effect of this plant and its use by sex workers, it has other uses. Traditional doctors use cannabis mixed with herbs, tree barks, palm oil, and albinos hair as treatment against bad luck. Traditional doctors also smoke cannabis to get into a trance before dispensing treatment or invoking spirits.

Cannabis is used for treating filariasis and against fungal diseases. The leaves and grains can also be ground and mixed in the soil as a fertilizer.

PRESCRIBED DRUGS

A survey was carried out of 74 persons buying psychotropic drugs from four pharmacies of the city. Among these persons, 51.4% were male and 48.6% were female. Adults made up 78.4% (58) of the study population (see Table 4).
Table 4. Sex and maturity distribution of respondents

<table>
<thead>
<tr>
<th>Sex</th>
<th>Adult</th>
<th>Adolescent</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>33</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Female</td>
<td>25</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>16</td>
<td>74</td>
</tr>
</tbody>
</table>

Although these drugs should not be sold over the counter and although there are laws regulating their sale, 28.4% of the study group did buy their drugs without a prescription. More adolescents bought drugs without prescriptions. (see Table 5).

Table 5. Distribution based on maturity and medical prescription

<table>
<thead>
<tr>
<th>Maturity</th>
<th>Medical Prescription</th>
<th>No Medical Prescription</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>44</td>
<td>5</td>
<td>38</td>
</tr>
<tr>
<td>Adolescent</td>
<td>9</td>
<td>11</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>53 (71.4%)</td>
<td>16</td>
<td>74</td>
</tr>
</tbody>
</table>

A large variety of substances were used. Table 6 shows those used most frequently, those grouped under ‘others’ being used by either one or two persons only. Chlorpromazine (largactil) and phenobarbital (gardenal), the two drugs most frequently used are among the essential drugs (psychotropes) for mentally ill patients.

Drugs bought without a prescription were optalidon, mogadon, gardenal, anafranil 25, artane 15, donormyl, haldol, lexomil, orap, rivotril, rohypnol, tegretol, temesta, urbanyl and valium (in order of frequency).

The mean duration of use of these drugs without prescription was 13.6 months. This was not significantly different from those with a prescription (12.2) months. In like manner there was no significant difference in the duration of drug consumption between the two sexes (females 16.02 months, males 9.3 months), or between adults (11.5 months) and adolescents (16.4 months). The observations of this study indicate that pharmacists should emphasize the need to present a prescription before buying psychotropic drugs.

The fact that the average user of psychotropic drugs has used them for more than a year is very alarming and calls for immediate remedial action.

Table 6. Types of psychotropes consumed

<table>
<thead>
<tr>
<th>Substance</th>
<th>Frequency</th>
<th>Relative Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>largactil</td>
<td>7</td>
<td>9.5</td>
</tr>
<tr>
<td>gardenal</td>
<td>7</td>
<td>9.5</td>
</tr>
<tr>
<td>optalidon</td>
<td>6</td>
<td>8.1</td>
</tr>
<tr>
<td>tegretol</td>
<td>5</td>
<td>6.8</td>
</tr>
<tr>
<td>rohypnol</td>
<td>4</td>
<td>5.4</td>
</tr>
<tr>
<td>temesta</td>
<td>4</td>
<td>5.4</td>
</tr>
<tr>
<td>anafranil</td>
<td>4</td>
<td>5.4</td>
</tr>
<tr>
<td>mogadon</td>
<td>3</td>
<td>4.1</td>
</tr>
<tr>
<td>others</td>
<td>34</td>
<td>46.1</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Essential health education on psychotropic drug abuse is highly indicated. As many as 33.8% of users, are still getting into the habit, and at this stage, at least, dependency is more easily reversible.

Among those surveyed, 43 (58.1%) did not know the possible side-effects of the drugs they were taking (see Table 7). This could be due to insufficient education of consumers by service providers. Nevertheless, 16 (21.6%) of the users cited the sedative effect of the drugs.

When asked about the possible effects of the drugs procured, 15 out of 16 of those who mentioned sedation as an effect had a medical prescription. Four out of seven of those who mentioned somnolence had no medical prescription. It can thus be assumed that psychotropic drugs are mainly prescribed for their sedative effect while many who consume the drugs without prescription do so mostly for their somnolent effect.

Table 7. Frequency of knowledge of effect of psychotropes in relationship to state medical prescription

<table>
<thead>
<tr>
<th>Effects</th>
<th>Prescription</th>
<th>No Prescription</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedation</td>
<td>15</td>
<td>1</td>
<td>16 (21.6%)</td>
</tr>
<tr>
<td>Addiction</td>
<td>1</td>
<td>2</td>
<td>3 (4.1%)</td>
</tr>
<tr>
<td>Euphoria</td>
<td></td>
<td>-</td>
<td>0 (%)</td>
</tr>
<tr>
<td>Somnolence</td>
<td>3</td>
<td>4</td>
<td>7 (9.5%)</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>0</td>
<td>5 (6.8%)</td>
</tr>
<tr>
<td>No response</td>
<td>29</td>
<td>14</td>
<td>43 (58.1%)</td>
</tr>
<tr>
<td>Total</td>
<td>53 (71.4%)</td>
<td>21 (28.6%)</td>
<td>74 (100%)</td>
</tr>
</tbody>
</table>

Seventy-one patients (95.9%) were aware of the reasons why they consumed the prescribed drugs though a few persons could not mention any reason what so ever. Generally, epilepsy, followed by insomnia, depression and psychoses, were among the most common reasons stated.

For those who had a medical prescription, reasons for use were found to include a much more precise diagnosis such as epilepsy, depression, neurosis schizophrenia or migraine. On the other hand, the reasons for drug consumption by those without medical prescription were vague (asthenia, anxiety, insomnia) or even not known (see Table 8).

Table 8. Reasons for consumption of psychotropes

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Relative Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epilepsy</td>
<td>13</td>
<td>17.6</td>
</tr>
<tr>
<td>Insomnia</td>
<td>9</td>
<td>12.2</td>
</tr>
<tr>
<td>Depression</td>
<td>8</td>
<td>10.8</td>
</tr>
<tr>
<td>Psychosis</td>
<td>8</td>
<td>10.8</td>
</tr>
<tr>
<td>Asthenia</td>
<td>5</td>
<td>6.8</td>
</tr>
<tr>
<td>Headache</td>
<td>5</td>
<td>6.8</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>4.1</td>
</tr>
<tr>
<td>Anti parkinsonian</td>
<td>4</td>
<td>5.4</td>
</tr>
<tr>
<td>Others</td>
<td>19</td>
<td>25.5</td>
</tr>
<tr>
<td>Total</td>
<td>74</td>
<td>100.0</td>
</tr>
</tbody>
</table>
CONCLUSIONS / RECOMMENDATIONS

Substance abuse exists among women in Cameroon but very few studies have been carried out so far for us to be able to understand the extent of the problem.

On the basis of the small-scale pilot studies carried out we found that, among persons drinking alcoholic drinks, women made up 40% while 33.4% of those smoking were also women. This indicates that among those found in bars drinking alcoholic drinks or smoking, one in three is a woman.

The pilot study on the use of illicit drugs was geared towards women in particular, so no comparison with men can be made. The use of cannabis as pessaries has been identified. This can contribute to alteration of the vaginal mucosa and increase in exposure to the AIDS virus.

The purchase and probably the use of prescribed drugs is not a gender issue. The difference between the number of men buying these drugs compared to women was not significant. However, there were proportionally more adolescents than adults buying drugs without prescriptions. Among those purchasing drugs without prescription, 67% are not aware of the side-effects of the drugs.

Community based studies are required to:

- determine the real impact of smoking and drinking in the different populations;
- evaluate the extent of the use of cannabis;
- make clear the effect of cannabis as regards its use as pessaries, treatment of filariasis, treatment against fungal infections in farms and its use as fertilizer.

The law regarding the sales of psychotropic drugs must be enforced. Prescribers should make it a duty to inform their patients about the effects and side-effects of the drugs they are to consume.
REFERENCES


WOMEN AND SUBSTANCE ABUSE IN KENYA

INTRODUCTION

Women and development in Kenya

Kenya continues to emphasize and appreciate the role that women play in development activities. Women play a dominant role in food and cash crop production. They provide much of the initiative and drive behind the remarkable growth in small scale business and "jua kalik" (informal sector) activities. Above all, directly or indirectly, women are responsible for much of the improvement in the quality of life of Kenyans.

In 1985, the Government of Kenya adopted the "forward looking strategies for the advancement of women" which aim at complete integration of women into the mainstream of national development, advancing equity and social justice for women. The strategies provide the working framework for greater sex equality in all spheres (1). These efforts will be intensified in collaboration with nongovernmental organizations (NGOs), United Nations agencies and other bodies.

Over 50% of Kenya’s population of over 24 million are women and the number of female heads of households is increasing. Despite this, according to the 1992 situation analysis of children and women in Kenya (2), the status of women in Kenya is yet to improve. The role that women play in our society is certainly not fully recognized. Rampant substance abuse that is threatening to tear the very fabric of our nation is yet another factor that will mitigate against the efficiency with which women can fulfill their role in society, especially in view of the fact that over 70% of household income among the poor rural and urban dwellers is generated by women.

The nature and extent of substance abuse in Kenya

Formerly, the substances that were commonly abused in Kenya were alcohol and khat, but over the years - and particularly in the last two decades - there has been an upsurge in use and abuse of a variety of other substances such as tobacco, cannabis sativa, tranquillizers, and volatile solvents (petrol, glue and plastics) (3). Studies have concentrated mainly on youth and have shown that, among this group, 50% to 60% drink alcohol regularly. The problem is more widespread in the urban and peri-urban areas than in rural areas. These young frequent drinkers have also been observed to take other substances such as cannabis sativa, tobacco, tranquillizers and khat, as well as petrol. More boys than girls are involved in this behaviour. (3). Among adults in one study in a rural area, up to 24% of female heads of households were alcohol dependents who had developed various health and socioeconomic problems, as compared to 27% of males. In a slum area in the city of Nairobi the problem was bigger and affected 46% of males and 23% of female adults.

Among youth, there is a recognized and growing drug problem (3, 4-18, 21-27, 24-27). Whereas such substances as cannabis and khat (miraa) have been used for centuries in Kenya by certain communities, they were originally used with care, mainly by middle-aged and elderly individuals, and therefore caused minimal problems. Now, however, they are being used and abused by the young people and are definitely associated with mental illness and other health problems.

To compound the problem of substance abuse, there are many cases of drug trafficking by people of all nationalities, including women. Kenya has become a transit point for narcotics like heroin and cocaine. The extent to which the use of heroin and other "hard" drugs has infiltrated the country is yet to be established, but the evidence is already visible. Substance abuse is slowly but surely becoming a problem for everybody - including women. Substance abuse has direct impact on education, vocational training and family life, and it is linked to child battering and lack of safety in general (3, 5, 6, 15, 16, 21).
It also has an impact on health - particularly mental health (17, 24, 25, 26). The extent to which substance abuse affects women must be addressed urgently because of its far-reaching implications.

WOMEN AND SUBSTANCE ABUSE

While studies of substance abuse have clearly demonstrated its effect on the family - mainly women and children - few studies have actually focused on women as the users of substances. The omission can be explained by the fact that traditional cultural practices in Africa did not permit women and children to take alcohol and drugs openly. Taking alcohol, and above all abusing it, was considered an activity for men. Women took alcohol in moderation and only on social occasions. In fact, situations were prescribed under which women could take alcohol. In modern society one can see women drinking alcohol, excessively at times. Many smoke tobacco, cigarettes included, without society really getting concerned. Public concern tends to be directed to men, youth and schoolchildren. It is therefore important that the issue of women and substance abuse should be addressed.

Extent and types of substance abuse among women in Kenya

Two studies have attempted to show the extent of women's involvement in alcohol and drug use in Kenya. Although these studies were confined to specific communities and their samples were rather small to warrant generalizations, both point to the fact that more and more women are now taking alcohol in Kenya. Both studies demonstrate the need to conduct more comprehensive studies on women and substance use in Kenya.

The first study to show that women were using alcohol was done in Mathare Valley, one of the oldest slum communities in Nairobi, in 1970 (5). In this study, Wanjiru demonstrated that 23% of her sample of 30 men and 26 women were drinking excessively and could fit the WHO criteria of alcohol abuse.

The second study to report women taking alcohol in Kenya was done by the Departments of Psychiatry and Community Health of the University of Nairobi. The study of medical students in Kisii district showed that 24% of women respondents could be classified as alcohol-dependent according to WHO criteria (3).

Subsequent studies on drug use show that women are also drug users. A pilot study with 100 respondents revealed that 10% of drug users were women aged 18-21 who use cannabis, khat, heroin and alcohol (6). A study by Onyango et al. among street children in Nairobi revealed that the few female children interviewed were either taking alcohol or sniffing glue or gum (7). Similarly, a case study on female child prostitutes aged 12-16 in Nairobi in 1985 (8) revealed high intake of beer, cigarettes, cannabis, khat and heroin among these children. All these studies clearly indicate that alcohol and drug use among different groups of women and female children may be significantly high although little attention has been given to this problem.

Women and alcohol

Alcohol is readily available in Kenya. The cheapest brand is changaa, a local liquor that is actually made by women. The majority of women in Kenya who have never been to school or who drop out of school at lower primary level have this as their major occupation. Studies carried out in Kenyan slums confirm this (9). According to available literature, the slum dwellers are often young, and many of them are single mothers who have few skills because most of them dropped out of school before completing primary education. Making illicit liquor is the major occupation from which they can earn their living.

The most common crime that leads to imprisonment of women in Kenya is the illicit production of liquor (10, 11). Information from the Riziki Women's Rehabilitation Programme, which caters for women
who have been to prison, reveals that the majority of the women in this programme have a drinking problem and were taken to prison because of alcohol-related criminal activities. Some women, for instance, were arrested for fighting and being disorderly in public places while under the influence of alcohol (12).

The use of alcohol is not restricted to women in the slums of urban centres. The use of changaa is widespread in rural Kenya. Changaa and another type of alcohol known as "Busaa", which is opaque beer, offer viable economic activity to both urban and rural women. It is quite common to find women in the rural areas not only selling both but drinking them as well. It is difficult to believe that some women who brew and trade in illicit alcohol do not become dependent according to WHO criteria.

The illicit sale of alcohol seems high in schools near slum communities. Drinks sold include names like "Toivol" and "Texas Tornado" which are types of changaa of different quality. Both types are popular among university students, according to information obtained for this study (13). Changaa seems to be popular in general because it intoxicates drinkers faster and is cheap. Students and those from low-income groups can easily afford it. Since women are the makers of this product and since it is cheap and readily available, it is not surprising that women are likely to abuse it, although hard data is not available to support this observation. Changaa production may indeed be a risk occupation for women.

**Women and drugs**

The commonest and most readily available drug in Kenya is cannabis sativa (bhang). Bhang is grown in some parts of Kenya illicitly and some people derive their livelihood from it. In some situations it is a lucrative business for those looking for quick money. A significant number of women in prison are there because they were caught trading bhang.

Cannabis is used sparingly by prostitutes and students, according to reports, because the drug is expensive. Prostitutes use it to face their difficult occupation. One prostitute said during an interview: "I cannot afford to be drunk as the people we meet are total strangers, but I need to be high to face the situation. We meet people of all kinds - ugly, old, young, some maybe with AIDS or diseases. You need courage to face them. "Pot" gives you courage." Reports indicate that individuals who take cannabis also go on to use changaa.

The other drugs commonly used in Kenya include mandrax and miraa (commonly known as khat). Kenya is a major route for those trafficking in drugs like mandrax from Asia. There have been many reports in local newspapers of men and women arrested and jailed for long periods, sometimes up to six years, for trafficking in drugs. The harsh sentences have not deterred those determined to smuggle mandrax into or through Kenya and the business seems to be very lucrative, according to newspaper reports. Mandrax is easily obtainable in some residential areas, especially in Nairobi and Mombasa. Although no data exist regarding its use among women, the drug is observed to be widely used by prostitutes as well as by university students, women included, although the numbers are reported to be few (13).

Mira is grown in the eastern part of Kenya (Meru) and chewing miraa is a common practice in Nairobi schools. Its popularity among students in particular is due to the fact that teachers and parents can hardly detect its use. The consumer simply appears alert and active, precisely the qualities teachers and parents like to see in students. Miraa is also widely chewed by adult males because of its psychostimulant effects, particularly among Muslims who do not take alcohol for religious reasons. Miraa (khat) is one of the three or four leading drugs of abuse in East Africa (14). In its traditional use, miraa is chewed to allay hunger and fatigue. The leaves, buds and stalks of the plant are chewed while fresh and the juice is swallowed.
In Kenya, miraa (khat) is a cash crop that is grown for domestic use and also for export to places such as Yemen and the Middle East. It is not considered a dangerous drug to be prohibited. For a long time miraa has been a male concern but recently it has reached women too. Observations from slum communities in Nairobi clearly show that women, especially those of Somali origin, chew miraa openly as well as trading in it. Nevertheless, its use among Kenyan women in general has still to be established.

The use of hard drugs such as cocaine, heroin and opium is on the increase among the Kenyan population, especially in urban areas. Trafficking of these drugs through Kenya seems to be rather common and some of the drugs find their way onto the streets of the major towns in the country. Newspaper reports indicate that youth out of school, street children and prostitutes are users of hard drugs. In a study of street children and children in especially difficult circumstances in Nairobi, the findings clearly indicate that some street children use heroin and cocaine (7). Similarly, a case study of some prostitutes indicates that they also use these drugs (8).

**Women and psychotropic drugs use**

The most common psychotropic drugs are tranquillizers and barbiturates. These are easily available in Kenya since they are used to treat mental illness. However, because they are available, people can obtain them either legitimately with a doctor’s prescription or through illicit means. The use of valium (diazepam) is very common, especially among female students. In some residential estates in Kenya, tranquillizers and barbiturates are used by young people and are simply known as "Roche". Junior medical staff can make lucrative business out of these drugs since they have access to them. Reports from universities, and especially the University of Nairobi, indicate that the use of Roche is widespread among both male and female students. Those using Roche do so to get to sleep and allay fears and depression. The few young women interviewed for this review who admitted taking this drug did not think it was really harmful. They saw the drug as enhancing their performance at the university. For example, "After taking Roche I sleep better and wake up the following day to face the world" (personal interview). Valium can easily be obtained from most pharmacies in Kenya without a doctor’s prescription.

**Women, tobacco and volatile substances**

Many women in Kenya smoke cigarettes. All types of cigarettes are available and many people hardly bother about the dangers of smoking cigarettes. Tobacco is grown and cigarettes are manufactured in Kenya. Smoking cigarettes seems to be an accepted part of the culture.

However, the sniffing of gum, glue and even petrol among street children has created a lot of concern, as reported by newspapers. Female children on the streets also sniff these substances. The substances are cheap, apart from the petrol, and are peddled on the streets by adults.

It is apparent that substance abuse is not limited to men. Kenyan women can easily have access to alcohol and drugs if they so wish. The few studies that have been done and the observations made clearly show that the use of substances by women is on the increase and that this demands urgent attention.

**THE IMPACT OF SUBSTANCE ABUSE ON WOMEN**

The effect of substance abuse on its users and their families has been well documented. Alcohol dependence has been observed to create havoc with the health of users and their families. Alcohol, according to Acuda (14), makes it difficult for the dependent user to judge what is right or wrong, what is good or bad and what is moral or immoral. At its worst, alcohol abuse can lead to accidents and death.

Prolonged alcohol abuse may lead to family disintegration and financial hardship. The emotional development of children and their education may be compromised if parents abuse alcohol. Children may also be subjected to violence in families where one or both parents abuse alcohol (15, 16, 17).
The misappropriation of family resources is quite common among alcohol abusers. The productivity of such persons diminishes, leading either to loss of employment or a fall in income if the person is self-employed. Cases of theft, fraud, assault, murder and sexual offenses due to alcohol dependence have been found to be common. The incidence of domestic violence, child abuse, divorce, neglect and cruelty to a partner has been associated with alcohol dependence.

Recently the effect that alcohol may have on the unborn fetus has been reported. Mothers who use alcohol during pregnancy stand a chance of producing children with mental retardation because alcohol retards intrauterine growth of the brain. This may also lead to a child being born with other defects and some children may develop alcohol-related problems before they are born (14).

According to literature, it is not just the abuse of alcohol that leads to social and family problems. In Kenya, for example, excessive use of khat was found to be associated with marked socioeconomic problems such as family instability, economic drain, prolonged absence of fathers from their families, malnutrition and poor educational performance leading to delinquency in some children. One study in Nairobi's Mathare Valley showed that alcohol abuse is also characterized by cannabis smoking and prostitution. It is not surprising, therefore that separation and divorce was found to be common among alcohol abusers (5).

The above findings refer to both men and women who are regular users of substances. In the absence of data specifically on the impact of substance abuse on women, we have to look at cases that contain reference to women's abuse of alcohol and other drugs.

Two studies on street children and those termed "children in especially difficult circumstances" provide a clear picture of what happens to children when their parents - especially their mother - abuse either alcohol or drugs. While a significant number of the mothers of street children claimed to make illicit liquor (changaa) in order to raise money to take care of their children, this was not the case. In some situations children dropped out of school and went onto the streets even after their mothers had paid their school fees. These mothers appeared to have been too involved in the liquor business to have time for the children. Some of the children interviewed reported being locked out of the house when changaa was being sold. Some children reported being tired because they were expected to be on the look-out for the police when the liquor was being sold, while others complained of having no place to study since the changaa drinkers occupied all the space. In some cases the changaa customers sexually molested the children, especially if the children were girls.

In some situations, the mothers, most of whom were single, admitted not knowing the fathers of their children since they conceived while under the influence of alcohol. During the data collection process, the research team met mothers who were totally drunk when they went to interview them. In other cases, some mothers were under the influence of alcohol while and jovially selling their brew. The state of general disorder in the houses of these families supported the statements of some of the children interviewed that they go on the streets to get a "breathing space". Some of the houses were full of disorderly male customers, while others had no sign of food being provided to the children since the mothers were sleeping or nursing their hangover. Others were disorderly and at times abusive. While visiting the communities where the parents of street children live, the researchers met drunken men and women who greeted them with abusive language. These persons under the influence of alcohol appeared uninhibited and it is not surprising that rape and abuse of children is quite common in the slums of Kenya, as often reported by the newspapers.

It was apparent that excessive use of alcohol and drugs in the communities that the street children come from may have direct influence in driving the children onto the streets. Their mothers sold alcohol and showed little concern for them. The children suffered hunger, physical abuse and extreme neglect while their mothers were busy making and drinking changaa. While on the streets the children were found smoking cigarettes, or sniffing gum and glue. Some reported they had drunk changaa while at home. The
girls on the streets were found to have sexually transmitted diseases, while some girls of 10 or 11 years had already had babies themselves. The state of the street children made the researchers conclude that children are more likely to suffer when their mothers abuse alcohol.

**The type of women likely to abuse substances in Kenya**

In the studies on street children and children in especially difficult circumstances a total of 137 mothers were interviewed. Most were either selling changaa or drinking it. In addition, six women with alcohol and drug problems attending the Riziki Women’s Programme provided their histories and two prostitutes were interviewed for this study.

The picture that emerges shows some commonalities of experience among these women. Most of the women reported abandonment by their fathers so that they had to be raised by their single mothers. In most cases they dropped out of school having become pregnant and most reported having their first babies rather early (ages 13-15). The family sizes were large which is consistent with family sizes in Kenya, but they were overwhelmingly large for a deserted mother. Some mothers continued having babies with different boyfriends after the initial abandonment.

Many teenagers have babies and leave them with their parents, usually mothers. In order to get money to support their families, some move to towns. While in town, some are introduced to changaa manufacture as a way of making money. As they live in town they may associate with women and men who have more babies. Many women have relationships with customers who come to buy alcohol from them.

While in town they may send money home to support their children but this depends on the level of their alcohol or drug abuse. If the money is not enough, they may add prostitution to changaa manufacture. Some women go to prison several times for petty crimes such as selling changaa, loitering with intent to prostitution, selling goods without a proper license, being disorderly and fighting in public, stealing, and causing bodily harm. Their drinking habits always expose them to criminal activities.

Most of these women are quarrelsome and easily provoked. They are likely to have children who have been sexually assaulted. If they live with their children, the children are often left at the mercy of the neighbours or relatives. The women are poor users of services provided in such communities. Having dropped out of school at lower primary level, most of these women have no steady means of earning a living. Those who manage to get jobs have difficulty keeping them. Those who marry do so very early and tend to have partners who also drink excessively. Such is the plight of some of the women who find themselves dependent on alcohol and drugs.

**SERVICES AVAILABLE TO SUBSTANCE ABUSERS**

Problems associated with substance abuse are dealt with in Kenya within the existing infrastructure of health and social services and therefore there are no specialized services available. A substance abuser who develops mental illness is treated at the established psychiatric institutions. The same happens when substance abusers develop other health problems. They are treated by the various departments of the existing health services. There is adequate evidence in available literature that substance abuse problems are both medical and social.

The medical problems experienced are not only severe but also require long-term management, usually in institutions. Mental illness is difficult to cure and often requires hospitalization. The other medical problems also require treatment either with expensive procedures (such as surgery) or drugs which must be taken over a long period of time. Staff with special skills are also required, which makes the management of complications arising from substance abuse expensive.
Social problems have perhaps not been adequately addressed because they are much more complex than a straightforward medical case. In Kenya, a few NGOs like ANPPCAN, the Udada Society and Edelvalle homes are addressing the problem. ANPPCAN has a project for the rehabilitation of women who have been in jail. Udada rehabilitates street girls and Edelvalle homes rehabilitates unmarried mothers.

The penal system has been used without much success in Kenya. The main reason for failure in our view is lack of sensitivity to the reasons behind the law-breaking practices. When street children are arrested, they are put into government-run approved schools for corrective purposes. After evaluation, they are released into their former environment and circumstances. Illicit brewers, substance peddlers and users are charged, jailed and also released to the same environment. Hospitalized cases also meet the same fate eventually. Consequently prisoners keep going back to jail and approved schools and the sick persons keep going back to hospital. The saga of abuse, punishment and treatment becomes a vicious circle.

Kenya is served by a government health service network that is very widespread. This is complemented by private institutions (profit and non-profit) that provide health care. Most of the private institutions are located in rural areas and are difficult to reach. Psychiatric services are available only at provincial hospitals, major private hospitals in urban areas, private clinics and at specialized government-run psychiatric hospitals which are few. Counselling and other social/psychological services are also available in some urban areas of Kenya and these are provided mainly by private clinics, nongovernmental organizations and religious bodies.

In addition to these services, the Government of Kenya runs approved schools for convicted minors. Some religious organizations also provide vocational training to unmarried mothers, street children and other disadvantaged persons who may include substance abusers. Most of the services are not free and charges are quite high, rendering them inaccessible to the poor women and children who may need them most.

It is inadequate for interest groups to continue addressing the problem of substance abuse from the "consequence" point of view. It is time now to address the "whys" or "causes" with a view to assisting the sufferers to work out a strategy that will lead to long-term solutions.

Social amenities that catered for recreational needs and were previously provided for by our traditional societies no longer exist. This leaves an unfilled need that has been wrongly substituted by modern entertainment which is devoid of the necessary values and moral principles. It is at these modern entertainment venues that some children and adults are introduced to the use of alcohol, tobacco and later other substances. The authors were not able to identify any preventive programme and it can be assumed that none exists.

**Services for women substance abusers**

Women are disadvantaged in many ways because of society’s expectations of them. They are usually only seen as providers rather than as beneficiaries. Above all, they are not expected to use - let alone abuse - substances. Their personal problems, needs and limitations are therefore inconsequential. This situation does not facilitate adequate consideration of the type of services that women in general and women substance abusers in particular may require.

Women continue to be "needed" by their dependents even when they are incapacitated by their own personal problems, including those related to substance abuse. It is not unusual to find a woman who has been convicted of making an illicit drink like changaa in prison together with her youngest baby. She worries about the other children that she left at home unattended and who most likely have gone onto the streets. In cases like this the penal system does not promote rehabilitation but rather adds to the woman’s existing problems. When men are jailed, they find their families intact on release. When this happens to women, their families disintegrate.
The case for home-based care for women substance abusers

Home-based care has been successfully used in Zambia, Uganda and to a lesser extent in Kenya for the care of AIDS patients. This approach has gone a long way towards helping both the patients and their families to cope with the consequences of AIDS. Home-based care would be ideal for dealing with problems related to substance abuse, and the primary health care approach using community health workers, traditional healers and traditional birth attendants provides a good model that could be adopted. Traditional healers and traditional birth attendants provide health services to the majority of Kenyans.

These services offer many advantages in terms of convenience, familiarity and payment. The patients are attended to in their own environment where they are also able to take care of their other responsibilities. They are attended to by people from the same sociocultural background. Friends and relatives participate in the whole process which is good for ensuring sustainability. Normally the mode of payment is negotiable and can be in the form that best suits the client. A goat, chicken or bag of beans are as suitable as cash. The period of payment is also negotiable.

A programme fashioned in a flexible and familiar manner would be best for the provision of curative, rehabilitative and even preventive services for substance abusing women. The three elements must be interrelated and supportive of each other. All involved need to plan together. Substance abusers require a holistic approach to their problems which has far-reaching effects on themselves and the community as a whole.

POLICY ISSUES REGARDING SUBSTANCE ABUSE

Efforts to curb the use of substances in Kenya seem to concentrate on controlling availability, accessibility, utilization and prescription practices, especially for therapeutic drugs. Hence the Anti-Narcotic Squad operates mainly at the points of entry into the country. The manufacture and sale of some brands of alcohol are banned or restricted by Act of Parliament. For example, the production and sale of busaa (opaque beer) is restricted, while the production and sale of changaa is prohibited. Times of sale for other types of alcohol such as beer and spirits in pubs are restricted. Sale of alcohol outside specified times requires a license or special permission.

It is an offence to use hard drugs in Kenya, as stipulated in the Dangerous Drugs Act. This also includes growing substances such as cannabis. Currently a national drugs policy for prescribed and non-prescribed drugs is being drafted. Also to be drafted is the National Drug Control Strategy which will include narcotics. This is being spearheaded by the Law Reform Commission in collaboration with the Attorney General’s Office. Although there is a law that controls the use of therapeutic drugs under the Pharmacy and Poisons Act, the enforcement of this law is highly ineffective. Kenya still has to develop and implement consistent policies regarding substance use and abuse.

CONCLUSIONS / RECOMMENDATIONS

According to the literature reviewed and accounts of people interviewed for this purpose, it is apparent that substance abuse is widespread in Kenya, especially among young people in and out of school. There is also evidence that substance use and abuse may be prevalent among women although no specific study has addressed this subject.

The information available reveals the absence of programmes addressing the issue of substance abuse. Policies are just in the process of being examined. As a whole, research on substance use and abuse in Kenya’s adult population in general and in women in particular is very scanty. In the absence of adequate data for the development of policies and programmes, it is important that research on substance use and abuse among women be undertaken in Kenya as a first step.
Given the role that women play in African societies, Kenya included, one would expect that the impact of substance abuse on the family will have great consequences if women are the abusers. Hence the need for research to verify the salient factors for the ultimate goal of prevention.

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COUNTRY REPORTS: WHO REGION OF THE AMERICAS

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WOMEN AND SUBSTANCE ABUSE IN THE BAHAMAS

INTRODUCTION

The Bahamas, independent since 1973, has a population of 250,000, of whom more than half live on the island of New Providence where the capital city of Nassau is situated. The rest of the population live on islands spread over an area of some 100,000 square miles between Florida and Haiti.

Thirty years ago the Bahamas was a simple island economy. Now it has the highest Gross National Product in the region. The economy is dependent on tourism and banking, but there are some efforts to expand local fisheries and agriculture. The Bahamas has experienced an economic recession over the last few years and many persons are experiencing difficulties as a result.

Substance abuse in the form of alcohol has long been a problem in the Bahamas. In the 1970s alcohol abuse was identified as its foremost social and health problem and a major constraint to social development. In 1974 the Minister of Health referred to the extent to which Bahamian society had been eroded by alcohol dependence: "In our everyday life one sees only too often many instances in which the family unit is destroyed as a result of either the father or mother or, in some cases, both parents falling prey to alcoholism. The unfortunate children left on their own without maternal or emotional security in most cases become the juvenile delinquents and social dropouts that later inhabit our prisons and our mental institutions."

Twenty years later the same comment might be made about a new substance which has been abused widely (1) and has facilitated the upsurge of AIDS and the HIV virus. The way in which alcohol was used (2) and abused over the previous 40 years laid very fertile soil for the entrance of cocaine to Bahamian society in the 1980s.

The Bahamas has experienced rapid social change which has been observed to provide the best seedbed for alcohol dependence (3) and other substance abuse. Parsons (4) suggests that frustration is endemic in today's industrialized world, that it accompanies the modernization process and is most manifest in the family and occupational systems. In the Bahamas we can readily observe the undermining of the extended family. The absentee father, a feature in many families (2,5) was not a problem so long as the extended family could be relied upon. Today responsibility falls more and more on women who are also increasingly drawn into the labour force. The rise of female alcohol dependence and cocaine abuse is indicative of this new situation and the resulting pressures on modern women.

Cocaine is recognized as a sexual drug. Women describe the highly sexual sensations they are able to achieve after cocaine. After intravenous use of central nervous stimulants such as cocaine, both men and women tell of engaging in sexual acts which they view in retrospect as humiliating and guilt producing. In the Bahamas this is more common with freebasing. Women in particular are made to perform a wide range of sexual acts in order to obtain cocaine. It is in fact the prostituting of their bodies that enables female drug users to keep out of the criminal system, unlike male cocaine users who frequently steal and perform other criminal acts to sustain their habits. This kind of sexual activity with different partners has an obvious impact on the increase of sexually transmitted diseases.

This paper is an attempt to pull together all the data available on substance abuse by Bahamian females and the serious implications of this.

BAHAMIAN WOMEN

The 1970s saw tremendous development in the education and employment of Bahamian women. Today women enrolled and graduating at the top of their class in the College of the Bahamas and other
institutions of higher education outnumber men. Between the ages of 25 and 54, more females than males attend school on a part-time basis as well. Women occupy leading positions in education as principals, deities and teachers at the College and in public and private schools.

The rise of women on the educational ladder affects their impact on the national economy. In 1990 women comprised 48% of the labour force. Women hold top civil service and government positions. While many women make significant advances in such areas as law, medicine, accounting and engineering, many others still hold positions as domestics and clerical workers.

Bahamian women perform multiple roles - as mothers, wives, employees, community workers - and are often stretched to the limit. Well over 40% of the nation’s households are headed by women. Many are alone with children, without adequate support and services, and often unemployed. Many others are ill-housed, uneducated and under-employed. The cost of fulfilling multiple roles shows up in the increasing number of women who find themselves in our mental health facilities and Family Court.

THE BAHAMIAN FAMILY

Bahamian family structures, as in the rest of the Caribbean, are of several types: marital union, common law union, extra-residential sexual or visiting union and the extended family.

Dr Gail Saunders (6) gives an interesting historical sketch of family life in the Bahamas. She finds that for the black working class in the late 19th and early 20th centuries, monogamy was the norm but more often than not children were born before the couple married and marriage later gave the couple "an established position in the community". Little stigma was attached to separation. Women might leave their families and emigrate to the USA; men would frequently go to work in the capital or overseas. The mother-headed home and the lack of a father image in "Bain Town" were not uncommon. The power of women was "the cementing agent that held families together".

Families were large. Children were viewed as economic assets and proof of the fertility of women. Illegitimacy was not considered to be a problem, as it was in other parts of the Caribbean. The earliest census which mentioned the illegitimacy rate was taken in 1963 and recorded 35% of Bahamian births as illegitimate. The rate has steadily risen in the last 20 years: by 1981 the figure had risen to 59.3%.

Though having children when unwed was previously considered a phenomenon of lower socioeconomic groups and a disgrace for middle and upper class women, the working woman of today does not allow lack of marital status to stand in the way of having a child.

There has been a drastic rise in the numbers of female-headed households and working mothers, with all the stress that accompanies these. Two important aspects of society traditionally absorbed stress by sustaining single parents and poor families - the extended family and the church. However, inflation and the current economic recession have made the task more difficult in the 1990s.

When common-law and marital or visiting relationships break up, a number of men renego on their parenting and their obligations to support their families. Men may end up playing peripheral roles in the socialization of their children and in their partner’s life. The picture is one of mother-centered, single parent homes, often with multiple, absent and/or delinquent fathers. The numerous women who come to family courts in search of financial assistance for their children reflect the stress of such situations and the feminization of poverty in the Bahamas.

HISTORY OF SUBSTANCE ABUSE IN THE BAHAMAS

Drinking is culturally and socially acceptable behaviour in the Bahamas. Alcohol has been said to have four types of function: religious, ceremonial, hedonistic and utilitarian. From Africa, Bahamas have
a legacy of the ceremonial and hedonistic; the colonizers introduced drinking practices that were utilitarian, associated with ceremonial rites of passage for young men.

An instrumental dimension was added in the face of oppressive and dehumanizing experiences, first of slavery and then of colonialism, with obvious psychological consequences for self-esteem. Migration to the city, from the unstructured, easy-going life in a sharing community to wage-earning Nassau and greater isolation is the result of institutionalized inequality of economic opportunity. This is the social change that provides fertile ground for substance abuse. During such periods of change, traditional coping mechanisms may not be available or effective, and alternative mechanisms are sought. Since the Bahamian cultural definition of alcohol is that of a mood alterer, it is seen to provide an accessible and immediate way to alter one’s consciousness and to cope with rapid change.

The cultural heritage which associates the use of alcohol with celebrations and having a good time has provided fertile ground for the growth of other mood changers such as cannabis and cocaine.

A survey of admissions to Sandilands, the only psychiatric hospital in the Bahamas, in 1961 revealed that only 2.8% of admissions that year were alcohol-related. Schizophrenia accounted for the largest number of admissions (56%). By the late 1960s and early 1970s, the picture had changed dramatically: in 1969, 64% of the males admitted and 25% of the females came for alcohol-related problems. For the next 10 years alcohol accounted for 25-30% of female admissions to the hospital. Other drug-related admissions in the 1970s were predominantly for cannabis and the numbers of females admitted was small but steady.

LITERATURE REVIEW

The use of cannabis was first reported to be on the increase in the 1970s. In 1971 it was reported that a dozen young men treated at Sandilands for symptoms of aggressive behaviour, gross psychomotor over-activity, bizarre grandiose delusions, passivity and amnesia had been smoking cannabis.

In the 1970s alcohol abuse was recognized as a major constraint on the social development of the newly independent Bahamas (2). Per capita consumption of alcohol was estimated at 9 litres in 1957 and 11.3 litres by 1967. This placed the Bahamas third internationally after France and Italy. First admission rates to mental hospitals, one index of morbidity, were calculated at 125 per 100,000.

Admissions to Sandilands give a startling indication of the severity of the problem. In 1969, 41% of all admissions were alcohol-related, while among admissions to a typical mental hospital in the United Kingdom 2-3% were alcohol-related. In the USA the corresponding proportion was 20%.

A survey of 119 patients in the general hospital in Nassau revealed 30% of all cases (25 males, 10 females) to be either totally or partially a result of chronic alcohol poisoning. In a 1968 post-mortem survey of 466 deaths, 48 cases (10%) showed microscopic evidence of alcohol liver damage and 13 were "unnatural deaths" with blood levels at more than 0.10 mg%, with the result that 13% of all deaths were found to be alcohol-related.

In a paper on "Drug Abuse in the Bahamas in 1974", Podlewski (7) reiterated the fact that alcohol was the most popular and frequently abused substance of all age groups, yet noted a "small but increasing number of individuals" snorting cocaine.

Using the Jellinek formula, Archer (8) estimated a figure of 6,300 alcoholics in the Bahamas. He pointed to autopsy figures for 1977, of which 10% indicated alcoholic cirrhosis or alcoholic fatty degeneration of the liver. He described the Bahamian problem of alcohol dependence as "easily twice as bad as our closest neighbor the USA".

McCartney (5) drew attention to three psychosocial tenets of Bahamian society which have been an underlying cause of drinking and are still significant today:

1. The matriarchal orientation of society and the male's dependence almost exclusively on the mother for satisfaction of all his physical, social and psychological childhood needs. "He goes to school and is taught by female teachers. His mother is sometimes replaced by an older sister, aunt, grandmother etc. to take care of him - another female dependent relationship." This preponderance of female images leads to psychological emasculation, making the male doubt his masculinity, and is undoubtedly a factor in the high incidence of alcohol dependence among men in the Bahamas.

2. Bahamian family structure with a high rate of illegitimacy and the father often not living at home. Even if he lives at home he may often take little interest in the children and their welfare. He is more interested in proving that he is a man and that "no woman gon push me around". McCartney claims that this attitude lays a foundation in early childhood for alcohol dependence.

3. Socioeconomic factors such as poor housing conditions. Overcrowding and lack of privacy create stress, territorial assertiveness and domination, heightened aggressiveness, and magnification of trivial situations. Individuals seek escape from reality and a release of tension - an ideal foundation for potential alcohol dependence. The bar-room is readily accessible while other leisure pursuits are lacking.

Patterson's longitudinal study of alcohol use and abuse in the Bahamas (2) documented the blurring of sex differences in the area of substance abuse. While drinking was normative behaviour for many Bahamian women in 1969, there were still significant differences between the sexes, with more men than women not only drinking but drinking to excess. In the higher intake groups, males outnumbered females substantially. In 1969, 43% of females were found to be abstinent, compared with 17% of males. These respondents reported similar habits for their parents: 19% of fathers and 47% of mothers had been abstinent.

When the same women were questioned again in 1977, more said that they drank and female drinking patterns could be better described as light drinking rather than non-drinking. In 1977, only 28% of the women said they did not drink. Nor were the drinking patterns of the heavy drinking females very different from those of their heavy drinking male counterparts, except that for women the heavier drinking was concentrated in the 30-39 age group whereas for men it was in the 50-59 age group. Similar proportions of men and women drank on weekends (19% and 20%) and even on a daily basis (8% and 7%).

Robins and Smith (9) suggested that while men have more drinking and drug problems than women, the differences are narrowing and may be disappearing. They noted that similarities in frequency and cause of drug use are greater than the differences in substance abuse between the sexes; this factor seems to be associated with early deviance, origin in deviant families and peer influence.

TRENDS IN SUBSTANCE ABUSE

Prior to 1980 alcohol abuse was the major substance abuse problem in terms of health and social impact for both men and women in the Bahamas. In the mid-1970s, however, poly-drug use became common. Methaqualude, known locally as Mx Quaaludes or disco bisquit, was popular on the streets. It potentiated the action of alcohol so that a person could get high almost immediately for the price of one drink and a pill. Apparently about the same time cocaine hydrochloride began to appear on the market in increasing quantities. The major problems that arose were drug-induced psychosis, acute intoxication and episodes of violent and bizarre behaviour (10).

Prior to 1978 cocaine was chiefly snorted. Freebase cocaine was introduced to the Bahamas around 1979 (11). Information from persons undergoing treatment suggested some reasons for the shift from
snorting to freebase cocaine: the high is perceived as being more intense, dealers began selling cocaine "rocks" and cocaine powder was more difficult to obtain.

While the typical cocaine user at this time was a male aged 18-35, it is clear that women were also used the drug. In 1979, nine women were admitted to treatment for drug dependence, and the number had risen to 45 by 1984. By 1985 substance abuse had become the most common cause of female admission to the psychiatric hospital.

Today there are few users who exclusively take cocaine. Most persons entering treatment give a history of cocaine, cannabis, and alcohol use as well. The National Drug Council, together with other governmental and nongovernmental agencies, has led an influential anti-drug campaign and there is some evidence that there are fewer new users of cocaine among young people. Alcohol is becoming more popular and there seem to be some who still see cannabis as harmless.

A cause for concern is the increasing number of persons who have chronic cocaine dependence (more than eight years' use), who are estranged from their families, unemployed, have problems with the law, and yet are disinclined to enter treatment. A number of this group are women. Treatment specialists are puzzled by the difficulty of attracting women to treatment programmes. Bed utilization at the only inpatient treatment programme for women, the Lignum Vitae Unit at the Sandilands Rehabilitation Centre, was 44% in 1990 but had dropped to 13% by 1992. Bed utilization by males was 71% in 1990 and 66% in 1992.

Not only do women substance abusers seem less willing than their male counterparts to enter treatment, but they also seem less likely to complete inpatient treatment. While 50-60% of the men who enter inpatient treatment complete the expected period, for women the completion rate is 25-30%. This is probably to be expected. Women in treatment are separated from their children and feel an ambivalence which often results in premature departure from inpatient treatment and a consequent return to drug abuse.

STUDIES OF SUBSTANCE ABUSE

Studies of subpopulations

Several studies of substance abuse in the Bahamas were carried out among sub-populations between 1986 and 1988 with funds from UNFDAC, now UNDCP.

The first study was done on children of school age (above 11 years), in a representative sample of 4,767 students in 32 schools, with a 71% response rate. The survey looked at the use of alcohol and drugs by the respondents, their friends and relatives, problems of alcohol, cocaine and cannabis use, the availability of these drugs, reasons for trying or not trying them, attitudes about drugs and drug sellers and attitudes to the questionnaire itself.

The second study was done on students at the College of the Bahamas, the only government funded tertiary level educational establishment. Sample students represented 71% of the total student population. The questionnaire included questions on demographic characteristics, alcohol and drug use, age at first use, drug use among parents, closeness to relatives, and attitude to drug use and trafficking. Participation was voluntary and the students were assured confidentiality.

The third study involved 55 boys and 19 girls in government homes for difficult children, who either had problems with the law or were placed there because their parents found them uncontrollable at home. The confidential questionnaire was similar to that used in the school and college surveys.

The fourth study included 90 male and 24 female prisoners. Interviews were done without prison officers present. This questionnaire included items on demography, age, sex, prior employment, marital
status, criminal offence and year of incarceration, as well as the use of alcohol, cocaine, cannabis and prescription drugs. The results concentrated on reported drug use and the question of recidivism.

Although the studies were somewhat different in methodology, some comparisons can be made. The studies of young persons showed the greatest similarities but the prison study and its results are difficult to compare with the others.

In summary, the studies showed that alcohol is the most commonly used drug for all groups except the prisoners, for whom cannabis is just as popular as alcohol. Cannabis is the most common illicit drug for all groups except the prisoners, for whom cocaine is just as popular as cannabis, especially among recidivist males.

A small group of students reported having tried cannabis and/or cocaine. Among delinquent young and prisoners, a majority had tried cannabis and cocaine. Some 66% of school students reported having used alcohol, as did 76% of college students, 74% of delinquent youth, 54% of female prisoners, 57% of first-offender male prisoners and 68% of male recidivists. The regular use of cannabis was reported by 8.2% of school students, 11% of college students, 57% of delinquent youth, 37% of juvenile prisoners, 55% of male first-offenders and 68% of male recidivists.

Among school students, 1.7% reported having used cocaine at least once, along with 3.7% of college students, 11% of delinquent youth, 62% of female prisoners, 51% of male first-offenders and 80% of male recidivists. For prisoners, use of the drug concerned use in the month before incarceration.

Analysis of the studies shows that:

- Drug use is most common among delinquent youths and prisoners.
- There is some drug use among school and college students.
- Alcohol is still the most commonly used substance of abuse across all groups.
- There is a link between drug use and law-breaking beyond simple possession, especially for male recidivist prisoners and specifically with the use of cocaine. The connection is also evident in the case of female prisoners.

These findings are not unlike those in other Caribbean territories such as Trinidad where similar problems exist.

Community survey  (Tables 1 and 2)

While the findings of the studies of subpopulations are important, they do not reflect the picture of the general population. A community survey completed in 1991 attempted to estimate the prevalence and nature of drug use in the overall Bahamian community.

This survey studied a representative sample of individuals from the household population of adults (16-59 years of age) of New Providence (the capital island) and Grand Bahama (the second most developed island). It examined their experiences of substances such as cocaine, cannabis, pills, alcohol and tobacco and assessed their knowledge and attitudes about drug abuse.

The survey showed, as expected, that alcohol is the most popular substance used by the general population. The study found that the prevalence of substance use is significantly higher among males than females and that the rate of illicit drug use among males is even higher when men aged 18-29 years are considered as a separate group. For cocaine and cannabis, the male:female user ratio was significantly higher than for alcohol. Overall, the results indicated that the use of substances on New Providence was higher than on Grand Bahama.
### Table 1. Community survey prevalence of substance use among adults 16-59 years - New Providence

<table>
<thead>
<tr>
<th>Substance</th>
<th>Time of Use</th>
<th>Population Groups</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Overall</td>
<td>Male</td>
<td>Female</td>
<td>Young Males 18-29 yrs</td>
</tr>
<tr>
<td>cocaine</td>
<td>Ever used</td>
<td>5.7</td>
<td>9.7</td>
<td>3.0</td>
<td>15.9</td>
</tr>
<tr>
<td></td>
<td>Past year</td>
<td>2.4</td>
<td>5.1</td>
<td>0.6</td>
<td>8.9</td>
</tr>
<tr>
<td></td>
<td>Past 30 days</td>
<td>1.6</td>
<td>3.6</td>
<td>0.3</td>
<td>5.5</td>
</tr>
<tr>
<td>cannabis</td>
<td>Ever used</td>
<td>13.9</td>
<td>25.1</td>
<td>6.7</td>
<td>38.3</td>
</tr>
<tr>
<td></td>
<td>Past year</td>
<td>4.7</td>
<td>9.0</td>
<td>1.8</td>
<td>15.6</td>
</tr>
<tr>
<td></td>
<td>Past 30 days</td>
<td>3.2</td>
<td>6.7</td>
<td>0.8</td>
<td>11.3</td>
</tr>
<tr>
<td>alcohol</td>
<td>Ever used</td>
<td>73.5</td>
<td>84.6</td>
<td>66.1</td>
<td>86.3</td>
</tr>
<tr>
<td></td>
<td>Past year</td>
<td>56.6</td>
<td>69.8</td>
<td>47.8</td>
<td>74.8</td>
</tr>
<tr>
<td></td>
<td>Past 30 days</td>
<td>44.3</td>
<td>63.8</td>
<td>31.3</td>
<td>67.6</td>
</tr>
<tr>
<td>pills</td>
<td>Ever used</td>
<td>3.2</td>
<td>6.2</td>
<td>1.2</td>
<td>9.2</td>
</tr>
<tr>
<td>sedatives</td>
<td>Past year</td>
<td>0.7</td>
<td>1.3</td>
<td>0.4</td>
<td>2.8</td>
</tr>
<tr>
<td>tranquillizers</td>
<td>Past 30 days</td>
<td>0.2</td>
<td>0.3</td>
<td>0.2</td>
<td>0.7</td>
</tr>
<tr>
<td>stimulants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Analysis of the community survey shows that:

- Drug use usually begins in the teens or early twenties.
- In the heaviest user group (males aged 18-29 years) a significant number (5.7% on New Providence, 4.2% on Grand Bahama) report chronic cocaine use.
- Drug use is not clearly related to income, employment or general health status.
- Substantial alcohol problems exist. Problems needing intervention were reported by 5-10%.
- Relatively few persons reporting what appeared to be problem drinking had received treatment.
Table 2. Prevalence of substance use among adults 16-59 years - Grand Bahama

<table>
<thead>
<tr>
<th>Substance</th>
<th>Time of Use</th>
<th>Population Groups</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Overall</td>
<td>Male</td>
<td>Female</td>
<td>Young Males 18-29 yrs</td>
<td></td>
</tr>
<tr>
<td>cocaine</td>
<td>Ever used</td>
<td>5.4</td>
<td>8.9</td>
<td>3.2</td>
<td>13.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past year</td>
<td>0.9</td>
<td>2.3</td>
<td>0.2</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past 30 days</td>
<td>0.9</td>
<td>2.3</td>
<td>0.2</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>cannabis</td>
<td>Ever used</td>
<td>13.6</td>
<td>22.1</td>
<td>8.5</td>
<td>29.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past year</td>
<td>3.4</td>
<td>7.8</td>
<td>0.6</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past 30 days</td>
<td>2.1</td>
<td>5.2</td>
<td>0.2</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>alcohol</td>
<td>Ever used</td>
<td>70.0</td>
<td>77.0</td>
<td>65.7</td>
<td>76.3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past year</td>
<td>52.5</td>
<td>64.4</td>
<td>45.3</td>
<td>61.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Past 30 days</td>
<td>40.3</td>
<td>55.9</td>
<td>30.7</td>
<td>52.6</td>
<td></td>
</tr>
<tr>
<td>pills, sedatives,</td>
<td>Ever used</td>
<td>2.3</td>
<td>4.5</td>
<td>0.9</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>tranquilizers,</td>
<td>Past year</td>
<td>0.5</td>
<td>1.2</td>
<td>0.2</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>stimulants</td>
<td>Past 30 days</td>
<td>0.1</td>
<td>0.4</td>
<td>-</td>
<td>1.0</td>
<td></td>
</tr>
</tbody>
</table>

AGENCIES ENGAGED IN REHABILITATION

Government-sponsored programmes

1. The Community Mental Health Centre of the Princess Margaret Hospital, Nassau, provides acute and follow-up care in an outpatient setting. The entire programme lasts one year and seems to meet the needs of highly motivated, intelligent individuals with relatively strong egos.

For most chronic cocaine users and poly-substance abusers with poor motivation, problems of impulse control and poor family support, this programme may be unsuitable. It is attractive for women who need to be available for their children and those persons still employed who can attend in the mornings and work in the evenings.

2. The Lignum Vitae Unit is housed at the country’s only inpatient psychiatric facility. It came into existence at the height of the cocaine freebase epidemic. While the programme certainly meets a need for some persons, mainly young men, it is less than attractive for women responsible for young children since admission to this programme implies separation from their children. While there are 20 beds for men and 10 for women, in recent years the female beds have been markedly underused.

Other treatment programmes

1. The Haven is an inpatient church-sponsored rehabilitation programme that provides services exclusively for young men.
2. The Dean Granger Memorial Centre is another church-sponsored programme that provides sheltered accommodation in a camp-like setting. It is not a rehabilitation programme in the truest sense. Again it caters exclusively for young men.

3. The Bahamas Association for Social Health (BASH) is another programme exclusively for young males.

There are no agencies at this time that provide services especially for female substance abusers or that address the specific problems and special needs of females.

SUBSTANCE ABUSE PREVENTION

The cocaine freebase epidemic which began in 1984-1985 led to a major public education campaign against drug abuse in general and against cocaine in particular. A variety of approaches included radio and television anti-drug messages, rallies for young people focusing on drug-free living, posters and bumper sticker competitions for young people and, most recently, the introduction of the Family Life Education programme in schools (with a major anti-drug component).

While prevention efforts have had an impact on illegal drug use, it is becoming increasingly evident that alcohol use among young people may be escalating.

There have been no specific prevention and education efforts made towards women of childbearing age. Although the use of drugs may not be as great a problem for this group as it is for young men, there is growing evidence that women of this group who use alcohol and drugs risk becoming dependent on them and may develop related health problems, notably sexually transmitted diseases including AIDS.

HISTORY OF AIDS IN THE BAHAMAS

According to Orlander et al (12), the rise in the number of reported cases of genital ulcer disease in the Bahamas from 1983 to 1985 was unprecedented with 124 cases in 1983, 473 in 1984 and 1492 in 1985. The increase in gonorrhea was substantial but less dramatic. However, both genital ulcer disease and gonorrhea have declined since 1987 (Table 3).

**Table 3. Reported cases of selected sexually transmitted diseases - Nassau 1982 - 1992**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chancroid</td>
<td>7</td>
<td>7</td>
<td>17</td>
<td>476</td>
<td>321</td>
<td>298</td>
<td>251</td>
<td>146</td>
<td>113</td>
</tr>
<tr>
<td>LGV</td>
<td>14</td>
<td>18</td>
<td>127</td>
<td>475</td>
<td>375</td>
<td>472</td>
<td>254</td>
<td>155</td>
<td>159</td>
</tr>
<tr>
<td>Primary syphilis</td>
<td>70</td>
<td>42</td>
<td>134</td>
<td>251</td>
<td>8</td>
<td>337</td>
<td>304</td>
<td>192</td>
<td>133</td>
</tr>
<tr>
<td>Grand total</td>
<td>91</td>
<td>67</td>
<td>278</td>
<td>1,202</td>
<td>779</td>
<td>1,107</td>
<td>809</td>
<td>493</td>
<td>405</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>642</td>
<td>857</td>
<td>1,068</td>
<td>1,109</td>
<td>1,001</td>
<td>1,035</td>
<td>798</td>
<td>606</td>
<td>529</td>
</tr>
<tr>
<td>HIV infection</td>
<td>3</td>
<td>9</td>
<td>109</td>
<td>218</td>
<td>294</td>
<td>217</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total visits</td>
<td>3,658</td>
<td>4,885</td>
<td>5,048</td>
<td>7,940</td>
<td>NA</td>
<td>8,006</td>
<td>8,019</td>
<td>8,623</td>
<td>6,164</td>
</tr>
</tbody>
</table>

The HIV infection has become the focus of much concern in the Bahamas. The first AIDS patient was identified in 1985 and the Ministry of Health began testing for the virus in August of that same year in New Providence and in September in the second largest city, Freeport, Grand Bahama. The same year a very effective voluntary tracing programme was established. In a 1990 study, over 89% of HIV infections transmitted in the Bahamas were found to be directly or indirectly related to sexual behaviour
Sexual practices of individuals were described as 83% heterosexual, 2% homosexual, 5% bisexual and 11% as unknown.

Female cocaine abusers accounted for the birth of 22 HIV-positive babies between August 1985 and November 1988. According to Bain (14), these mothers frequently sold their bodies to support their drug habits. Between August 1985 and March 1989, 217 adults and 52 children were diagnosed as HIV positive; 51 of the children had been born to HIV-positive mothers.

A recent study of knowledge, attitudes, beliefs and practices of HIV-infected females in the Bahamas, which compared them with a control group of HIV-negative females, has revealed significant data (15). Of the HIV-infected group, 67% did not believe to be at risk of HIV infection; 11% of the HIV-positive group compared with 47% of the control group knew that AIDS was transmitted by a virus, while as many as 67% of the HIV positive group and 70% of the control group were unaware that sexual intercourse with someone who has the HIV virus was a method of spreading the disease. Significantly, 80% of the HIV positive group and 48% of the control group had multiple partners. A large number of both HIV-positive women (67%) and the control group (45%) had no perception of risk.

The belief that the HIV infection affects only homosexuals and prostitutes was held by many women in the survey. A large number of those with HIV infection said they had never requested their partner to wear a condom during sexual intercourse, even after they were diagnosed and informed about the risk of infecting others.

Since March 1993, 3284 HIV-positive cases, 1161 cases of AIDS and 699 deaths from AIDS have been identified.

Orlander et al (12) surveyed patients leaving STD clinics in 1989 and noted two striking findings. Firstly, reported cocaine use was almost twice as common in female patients as in male patients. Secondly, the rate of reported cocaine use was highest among HIV patients of both genders, (including 78% of HIV females) and lowest for men and women with chlamydial infections (Table 4). The researchers noted that rates of reported cocaine use fell dramatically in 1990 for both sexes, to 12.4% in men and 20.8% in women, but continued to remain higher for females than males. Cocaine use was also found to be significantly correlated to genital ulcer disease.
Table 4. Relationship of reported cocaine use and STD diagnosis by gender - 1989

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Male</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Cocaine Users</td>
<td>Total</td>
</tr>
<tr>
<td>Primary syphilis</td>
<td>21</td>
<td>157</td>
</tr>
<tr>
<td>Secondary syphilis</td>
<td>10</td>
<td>38</td>
</tr>
<tr>
<td>Latent syphilis</td>
<td>19</td>
<td>118</td>
</tr>
<tr>
<td>Chancroid</td>
<td>36</td>
<td>112</td>
</tr>
<tr>
<td>LGV</td>
<td>40</td>
<td>133</td>
</tr>
<tr>
<td>Herpes</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>All GUD (primary syphilis, chancroid, LGV, herpes)</td>
<td>105</td>
<td>431</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>44</td>
<td>5,707</td>
</tr>
<tr>
<td>NGU</td>
<td>4</td>
<td>120</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td>Warts</td>
<td>11</td>
<td>33</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>37</td>
<td>95</td>
</tr>
<tr>
<td>HIV</td>
<td>85</td>
<td>189</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>327</strong></td>
<td><strong>1,631</strong></td>
</tr>
</tbody>
</table>

In 1992 a study of the prevalence of seropositivity was conducted with the aim of preventing HIV infection among selected population groups. The prevalence among female prison inmates was 19.6% and among female cocaine dependents it was 44%. Three out of every 100 antenatal patients in community clinics were HIV positive (16).

**COCAINE AND AIDS**

**Case study**

Ellen was 17 on first admission to Sandilands in 1984. She was the product of a teenage pregnancy and had been given up to an adopted family but had been allowed to maintain a relationship with her biological mother. Her biological father died when she was six.

Ellen became involved with a "steady boyfriend" in the 4th grade and was sexually active with him at 15. She claims she was an average student who was very popular for "being rude". After a confrontation with an adopted sister and because of difficulties with her adopted mother, she was asked to leave her home at age 15. She went to live with her biological mother.

Ellen’s mother had a man friend who not only ill-treated the mother but also raped Ellen. She dropped out of school at 16 and moved out of her mother’s house to live with a friend. Four months before her admission to Sandilands she took cocaine for the first time following a fight with her boyfriend. She said it gave her a feeling of "wonderment", helping her to forget her problems for a while. Since then she had been "hitting coke" every day, first using her own money to buy it and then selling her body to support her habit.
Admitted to Sandilands, Ellen remained in the adolescent unit for two months and then signed out against medical advice after having severe cravings. She was readmitted six years later with alcohol dependence and early cirrhosis of the liver. She had stopped cocaine three years earlier, after involvement with a much older man who was himself a problem drinker. Diagnosed with HIV and syphilis, she remained in the alcohol dependence unit for two months and then discharged herself following a weekend leave when she had consumed alcohol. She died aged 23 as a result of AIDS.

A study of female patients admitted to the psychiatric hospital between January 1989 and July 1990 revealed an HIV seropositive rate of 12%, far higher than expected for the general population (17). Seven HIV seropositive patients were diagnosed with schizophrenia, 28 with substance abuse, and eight with substance misuse and other mental illness. The authors of this study were concerned by the number of schizophrenics with HIV infection. They pointed to cross-transmission of the virus between mentally ill patients and substance misusers as a likely result of the downward drift, personality deterioration and a probable limited choice of sexual partners.

A review of treatment charts of female substance abusers admitted to the psychiatric hospital between 1990 and 1992 substantiates the rate of HIV-positive females among the drug abusing population. Of 63 female substance abusers admitted in 1990, 28 were diagnosed with the HIV virus; in 1991, 19 out of 64; in 1992, 13 out of 55.

In 1990, 50% of the HIV-infected women had first taken drugs before the age of 18 and the majority were dependent on cocaine, with a smaller number of poly-drug abusers and one known alcohol dependent. Six were schizophrenics. In 1991, most of those with AIDS had first used drugs before 18, and most of those had done so before they were 12 years old. Most were dependent on cocaine but were poly-drug users. In both 1990 and 1991 all reported selling their body for their drug of choice.

The woman who freebases is in a particularly difficult situation, since cocaine and sexuality are so intertwined. There are social and cultural expectations of how girls are supposed to behave. Treatment for women is complicated by the fact that they have violated social taboos and stereotypes of expected feminine behaviour. They recognize that society defines women like them as "promiscuous," "cheap", "babbitts" (bad women).

Many female drug abusers sustain their habits through sexual activities and by selling their one commodity, their body. What Allen (18) terms ethical fragmentation is classically manifest in the female cocaine user's utilization of her body. This is the key factor behind poor prognoses of female cocaine users.

Women are not permitted the double standard which enables men to boast of their sexual exploits and still be able to leave them behind. When a woman undergoing treatment recalls the level to which she was forced to sink, she is unable to disengage herself and ends up returning to self-destructive behaviour, putting herself at continued risk of HIV infection.

Recent years have seen a decrease in drug dependent women admitted to the psychiatric hospital. This reflects both the problems of treating drug dependent females and the failure of the present male-oriented programmes to reach women. The freebasing epidemic in the Bahamas calls for an additional component to treatment services for women. The power that sex stereotypes and sexual taboos have in our culture must be recognized and strategies built to enable women to work through them and find ways to feel good about themselves.

Self-esteem is also influenced by reinforcement from one's environment. Consciousness-raising and sensitization to this problem is necessary among those who have contact with the woman after treatment when she returns to the community. Negative responses by peers and associates batter a woman's newly
acquired sense of being, refusing to allow her to be the new person she wants to become. These negative reactions facilitate the self-fulfilling prophecy which forces her back into drug dependence, the sale of her body and vulnerability to HIV infection.

GOVERNMENT AND COMMUNITY ACTION ON AIDS

A standing committee for the prevention and control of AIDS was established in 1986, chaired by the Chief Medical Officer with members from a wide cross-section of the Ministry. In 1991 this committee was reconstituted with members drawn from among senior officials in other government and private agencies to ensure a multidisciplinary approach. The AIDS Secretariat, as it is now known, has embarked on a series of prevention activities in schools and places of work. A team has begun to visit the Family Islands to raise awareness there.

Facilities to treat and combat AIDS include a comprehensive clinic for inpatients and outpatients, where community nurses provide education, counselling and support. As the number of AIDS cases increased, a Pediatric Aids Unit was opened in 1991 to improve and facilitate the care of children affected by AIDS and HIV. Several voluntary groups - including church bodies, the National AIDS Hotline and the Samaritans - offer services to AIDS sufferers.

CONCLUSIONS

- Basic data regarding women, substance abuse and AIDS in the Bahamas point to a dire need to obtain more accurate information about these grave problems.

- There are women who do not avail themselves of the existing opportunities to receive help for their substance abuse problems, for reasons which are complex.

- Treatment opportunities available for persons with substance abuse problems in the Bahamas are for the most part male-oriented and do not attract women; some categorically restrict their services to young men.

- Attention has focused on abuse of cocaine, alcohol and cannabis. It is known, however, that a growing number of persons, a significant number of them women, abuse prescription medications (benzodiazepines, valium, [lorazepam] ativan, [alprazolam] xanax).

- Women who abuse drugs are theoretically more likely to be the victims of violence and in some instances the perpetrators of acts of violence. This is another area requiring further study.

RECOMMENDATIONS

- A study should be made specifically on women, substance abuse and AIDS. Such a study should produce reliable information on women who have the problem but do not avail themselves of opportunities for treatment.

- Rational and innovative treatments for women suffering from substance abuse and HIV infection should be developed, taking into consideration the very special needs of single parents. These mothers might have to be provided with ways to address their problems which do not imply separation from their children.

- Public information and educational efforts to disseminate gender-sensitive information on the risks of sexual activity must be increased. Educational programmes on sexuality in general need to be refined and made more available to the community. Educational strategies must be developed to combat present sex stereotypes and taboos which encourage double standards with regard to men and women. Information and education programmes must be urgently produced for the electronic media.
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WOMEN AND SUBSTANCE ABUSE IN BOLIVIA

INTRODUCTION

In recent years there has been growing concern in Bolivia for a gender-specific approach to a number of issues, especially in the social sciences. There is considerable scope for this new approach in the future, especially in relation to issues such as the abuse of psychoactive substances.

Bolivian women are known to abuse alcohol, cocaine, cannabis and other substances, though to a lesser extent than men do. Cultural restrictions on alcohol consumption have prevailed since pre-Columbian times, when drinking spirits was forbidden.

The pre-Columbian Andean societies were aware of several substances with hallucinogenic properties. There are descriptions of the use of "chamico" (Daturas) and "willca" (Piptadenia perugrinned). Substances with psychodysleptic properties derived from cactus are also described (mezcalina), as well as "ayahuasca" (Banisteri caapi) in the forest area. The use of "coca" leaves (Erythroxilium coca) was restricted to a religious context, and was used almost exclusively by the nobility. Like other substances, it was part of religious, prophetic, curative and festive ceremonies. Abuse, especially of alcohol, was subject to severe punishment.

The story told by the chroniclers about alcohol abuse among the Incas belongs to a time well after the Spanish conquest when sociocultural restraints were eliminated.

The Aymara people of the Andes believed that man and woman were indispensable to each other. Women's contribution to production was considered equal to that of men, and their participation in society was culturally recognized as essential for success. The traditional partnership was also dramatically altered by the colonizers who distorted this man-woman relationship to fit their own model, legitimizing discrimination and violence against women.

That is how the idea of women playing socially inferior roles to those of men was born. Women were assigned the duty of biological reproduction, care and education of children, and home chores aimed at satisfying the needs of other family members. However, the current economic crisis in Bolivia has forced women, especially from lower socioeconomic levels, to work outside the home.

The psychosocial stress generated by these circumstances has led to a high consumption of alcohol and other psychoactive substances by Bolivian women.

PROFILE OF THE FEMALE POPULATION

Half the Bolivian population (50.6%) is female. Of these, 58.5% live in urban areas and 48% in rural settings. In recent years migration from the country to the city has been constant and growing.

There is a tendency for women to marry young and have a large number of children. Almost half Bolivia's women are of childbearing age and there is an average of five children per woman. A large amount of mortality in women is linked to complications of pregnancy and delivery. One of every four Bolivian women is illiterate and many rural women have no access to school education.

Women's involvement in economic activities rose from 22.5% in 1976 to 56.6% in 1992. Most of these economic activities are in the informal sector. According to the Integrated Household Survey, 36% of working women in an urban area work in small businesses, 13% in temporary personal services, 15.5% in manufacturing and 12% as technicians or professionals.
In recent decades, diluted alcohol has been introduced in the country and is being made available as chicha. Women, traditionally in charge of preparing meals and alcoholic beverages, have started marketing alcohol with good profits. This has led to a change in the pattern of alcohol intake in these communities, with a consequent increase in the number of cases of violence, behavioural problems, intoxication, and accidents while inebriated. Dependence and other complications due to the chronic abuse of alcohol are seen more frequently than in the past.

Many peasants have also migrated to tropical areas of the country because the land is good for growing vegetables. The largest migration has occurred towards the south, to the region of Chapare where the coca bush is cultivated. Coca leaves have become the main income source for many families.

The young men migrate first but, once they have established themselves, they fetch their families to join them. Some have begun establishing families with the original inhabitants of these tropical areas.

Most of these people live in deprived conditions. Although coca is grown, its cultivation is illegal in that area. Some settlers are established in small communities, but others live in isolated dwellings. Settlers’ “unions” have a strong influence in the area.

As is traditional in their home community, women help to do the work and join in social activities. These settlers consume chicha, as well as beer and distilled spirits which are a sign of greater status. Their consumption patterns are the same as those of their home communities of the valley and altiplano.

Also in the tropical area are casual workers who form a fluctuating and unstable group. They survive because of their involvement in growing coca and manufacturing cocaine. Women work as small business owners and many also work as prostitutes. They suffer from loss of their cultural values and from anonymity. They consume beer, distilled spirits and pure alcohol excessively and frequently. Many of these people are alcoholic dependents who also smoke the cocaine-based paste that results from the first stage of the chemical process of cocaine production.

Many settlers from rural areas have established themselves on the periphery of the cities, particularly La Paz, Cochabamba and Santa Cruz. They live mostly from the informal economy. In general, women and children can easily start working in minor business activities such as selling and reselling products or providing services. Men usually remain unemployed or underemployed in casual jobs so many families do not have stable incomes.

Living conditions are neither healthy nor well maintained. The people have no access to education, health or other services. Their cultural traditions are weakened. Psychosocial frustrations are frequently expressed through violence, delinquency and alcohol abuse.

These urban fringe dwellers consume chicha, beer, distilled spirits and pure alcohol. Complications associated with drunkenness are frequent, and there are also problems of alcohol dependence and chronic consumption of alcohol.

Studies conducted in La Paz (5) and Cochabamba (6) on the mental health of urban fringe dwellers show that the abuse of alcoholic beverages is the most important problem found in men, with associated findings of depressive and anxiety disorders in almost half the women. Anxiety disorders ranked as the major problem among children.

Middle and upper socioeconomic classes of the urban population have ready access to a variety of services, including education, health and recreation. Their family model is the nuclear family.

This group consumes large amounts of beer and distilled spirits recreationally, particularly at weekends. The age of starting to drink is gradually getting lower (13-14 years). Adolescent and young
adult women have started drinking heavily in the last five years, even designating a particular day for the social consumption of alcohol.

TOBACCO

Studies on tobacco prevalence rates among students show a life prevalence of 27.31% and 15.81% during their final year in school, out of which 11.92% relates to men and 3.89% to women. Prevalence in the previous month was 8.32%, of which 6.27% relates to men and 1.75% to women.

A 46.8% life prevalence rate was found in the household survey (64.5% for men and 32.7% for women). The past year prevalence rate was 50% in men and 21.4% in women, with past month prevalence rates being 38.2% for men and 14.3% for women. Data showed that women smoke less than men do.

OTHER PSYCHOACTIVE SUBSTANCES

Prevalence studies

The first study of the extent of use of psychoactive substances in Bolivia was conducted in 1979 by the Bureau for the Control of Dangerous Substances. The survey was carried out among students aged 14-22 years in nine cities. The results showed a life prevalence rate of psychoactive substance use of 11.3%. Cannabis abuse ranked first, followed by tranquillizers and cocaine-based paste.

A 1986 survey in the main cities of all departments concluded that 8.85% of the population aged 8-25 years had consumed a psychoactive substance at least once in their life.

Also in 1986, the Bolivian Red Cross conducted a survey in La Paz that reported that 10.42% of the population had consumed a psychoactive substance at least once, and that 0.78% admitted using them consistently. The highest consumption was among those aged 16-25 years.

In 1990 the Red Cross conducted a new survey among persons aged 10-45 years in five Bolivian cities (7). This study reported a life prevalence rate of illegal substance abuse of 9.3%. The data were stratified by gender and socioeconomic status. Thus in the highest socioeconomic group, 3% of women had tried psychoactive substances compared with 5.6% of men; in the middle socioeconomic group, the percentages were 2.2% of women and 4.5% of men; and in the lower socioeconomic group, 1.7% of women had used a psychoactive substance, as against 3.7% of men. The male to female ratio was 2.1 in each group.

In its student survey, DINAPRE (2) found a life prevalence rate of 12.88% for the abuse of psychoactive substances, excluding alcohol and tobacco, and a consistent use of 2.65%. The most frequently used substances were amphetamines, sedatives, cannabis, inhalants and cocaine, in that order.

Table 5. Prevalence of psychoactive substances abuse by gender in a Bolivian student population

<table>
<thead>
<tr>
<th>Substance</th>
<th>Consistent use</th>
<th>Life prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Amphetamines/Sedatives</td>
<td>0.13</td>
<td>0.06</td>
</tr>
<tr>
<td>Cannabis</td>
<td>0.65</td>
<td>0.19</td>
</tr>
<tr>
<td>Sulphate base</td>
<td>0.42</td>
<td>0.24</td>
</tr>
<tr>
<td>Inhalants</td>
<td>0.13</td>
<td>0.02</td>
</tr>
<tr>
<td>Hallucinogens</td>
<td>0.05</td>
<td>0.05</td>
</tr>
</tbody>
</table>

In 1992, DINAPRE published the results of its household survey (3). The life prevalence rate of substance abuse in men reached 13.6%, as against 8% in women. The consumption prevalence rate in the previous year was 4.2% in men and 4.1% in women. Finally, the consumption prevalence rate for the last month was 1.9% in men and 1.8% in women. The extent of consistent use of substances was almost identical for both sexes. This is completely different from alcohol abuse, where there are marked differences between the sexes. This may indicate a higher tendency in women towards the abuse of illegal substances.

COCAINE

Prevalence studies

Prevalence studies consider both the use of cocaine-based paste and cocaine hydrochloride. In its 1990 five-city study, the Red Cross (7) reported a cocaine life prevalence rate of 2.1%. DINAPRE reported a 2.08% life prevalence rate for cocaine use in its student survey (2).

Table 6. Prevalence distribution of cocaine consumption (sulfate & hydrochloride) by gender in the student population

<table>
<thead>
<tr>
<th>School level</th>
<th>Consistent abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>High school</td>
<td>0.20</td>
</tr>
<tr>
<td>University</td>
<td>0.99</td>
</tr>
</tbody>
</table>

Source: DINAPRE, Illegal Substances Abuse by the Student Population of Bolivia.

DINAPRE’s household survey in 1992 (3) reported a cocaine life prevalence rate of 1.1%, a year prevalence rate of 0.2%, and a month prevalence rate of 0.1%.

Profiles of cocaine users

Cocaine paste is the product of the first stage of the chemical process in the production of cocaine. The paste results from the addition of sulfuric acid, kerosene and gasoline to the macerated coca leaves. This paste contains about 40-90% of cocaine sulfate, other coca-derived alkaloids and a variety of residual chemicals. The paste may be smoked alone or with tobacco.

There are three types of cocaine paste users: street children, adolescents of middle and upper socioeconomic levels, and casual workers in the coca production zone.

Estimates of the number of street children in Bolivia range from 600 to 10,000. The cities with the most street children are Cochabamba, La Paz, El Alto and Santa Cruz. Approximately 30% of these homeless children and youngsters who live on the streets are girls or female teenagers.

Predominant age groups of street children are 7-18 years for males and 13-18 years for females. Undoubtedly girls take longer to leave their homes because they endure for longer periods the family aggression, which frequently includes sexual abuse.

About 70% of girls on the street migrate to other cities to get away from their home city. Close to 20% of the girls between 17 and 18 years of age have a stable sex partner which is usually a younger
child. These girls’ affection for their partner is usually very strong and the struggle to keep him often leads to fights with other females.

Almost one-third of these older teenage girls living on the streets admit to having had children, 80% of them have been pregnant and 26.6% have had an abortion. Infant mortality in this environment is considered to range from 50% to 80%. For these young women, having a child means that their partner will give them support. Even though pregnancies are not wanted, these young women do not use contraceptives, and sterilization is not an accepted option.

Many street children begin using psychoactive substances by inhaling organic solvents. After two to three years on the streets, 30% of them become members of adolescent gangs and subsequently begin consuming cocaine-based paste. In their sub-culture, this gives them higher status.

Among female youngsters living on the streets, 22.7% abuse psychoactive substances. They use these substances, especially inhalants, consistently in a pattern of dependence. About 6.3% smoke cocaine-based paste. The reasons for starting the habit are linked to the need for acceptance by their peers, identification with the group and the benefits of solidarity, affection and protection from the group. Substance consumption is on a daily basis, with subsequent increase in the amount needed to produce an effect. The youngsters stop this pattern only when physical waste is extreme and they are rescued by a rehabilitation programme or arrested by the police.

Secondary effects arising from constant substance abuse include malnutrition, growth retardation, vitamin deficiency, tooth decay, bronchitis, various infections and sequelae to wrongly treated trauma. Substance dependence is almost always present.

Adolescents and young adults from the middle and upper socioeconomic classes tend to start abusing substances for recreation, often mixing alcohol with cocaine hydrochloride. Some of them feel the need for something stronger and go on to cocaine-based paste.

An unknown number of women between 17 and 35 years of age fit this profile. They consume large amounts of cocaine-based paste, even more than men do, and even consume it in public places. Prostitution is usually used as a means of obtaining the substance. There are many pregnancies and abortions among this group. Partners of these women are also usually abusers of the same substance and they tend to have very stable relationships that are respected by the other members of the group.

Secondary effects of substance abuse in this group are the same as in those on the streets, although the evolution of problems may be slower. The deterioration of physical health and social functioning is often delayed until they break their family ties.

Casual workers in the coca production zone are the group about which the least is known because they rarely attend a health facility. Most are migrant peasants who have become involved in coca growing or cocaine production. Often their work is trampling the coca leaves to facilitate their maceration. For this reason they are called "coca stompers". Many are given cocaine-based paste to increase their output during work, and even as payment for their work. Severe intoxications are common and in extreme cases have prompted them to seek medical attention.

Another form of cocaine abuse is the consumption of cocaine hydrochloride which is obtained after further mixing of the cocaine-based paste with hydrochloric acid. When the mixture is refined, purity may be 98% or even more.

Cocaine hydrochloride (known as "crystal") consumption is seen in city youngsters and adults from both middle and upper socioeconomic levels. Consumption for recreational purposes is usually related to drinking alcoholic beverages at weekends. Groups get together and drink alcohol until they are drunk, then
inhal cocaine hydrochloride to recover their "normal" state so that they can start consuming alcohol again. Following this pattern they can consume large quantities of alcohol and cocaine which frequently lead to severe overdose. It is well known that a significant number of women have this behaviour pattern, although the precise number has not been determined. To control the symptoms of withdrawal, they usually use benzodiazepines in relatively high doses.

The number of users of cocaine hydrochloride is not as high as of those who smoke cocaine-based paste. Direct consequence of cocaine hydrochloride use are necrosis and rupture of the nasal veli.

INHALANTS

Inhalants are mostly used in Bolivia by street children. Among the most commonly used are plastic cement, gasoline, paint thinner and acetone.

Prevalence studies

In 1992 a national level survey of consumption levels of inhalants among working children still attending school (8) was carried out in three cities (El Alto, Cochabamba and Santa Cruz) where the problem of street children is especially acute. It was found that 7.7% of the children had consumed psychoactive substances at least once, particularly inhalants (4.73%) and cocaine (1.47%). There was regular use among 0.3%.

Profile of inhalant users

Working in the streets predisposes children to inhalant abuse. Nevertheless, even in these circumstances they might be merely experimenting. It is considered that in this context girls are more prone than boys to consume psychoactive substances.

The working children are a sign of the survival strategies of poor families. They have developed these working family networks in order to take advantage of opportunities in the informal sector of the economy. Girls help their mothers or other relatives in exchange for clothing or food, often by selling things. Boys take jobs that require giving a service on the streets, such as selling newspapers, carrying packages, taking care of or washing cars.

Once the children have left their homes and established themselves in the streets, the consumption of inhalants becomes a part of the street codes that have to be followed in order to be accepted by the group. Consumption is associated with overcoming fear and anxiety. This "courage" helps them survive on the streets. Under these circumstances substance abuse becomes more frequent and can reach levels of dependence.

Observed consequences of the chronic use of inhalants include bronchitis, asphyxiation, burns, malnutrition, seizures and hallucinations. The users' lifestyle puts them at risk of malnutrition-related deficiencies, infections and accidents.

CANNABIS

DINAPRE's surveys of student populations (2) indicate a life prevalence rate of 2.67% for cannabis use, a prevalence in the last year of 1.82%, and 0.99% for use in the last month. Use among females is less frequent than among males, with a male:female ratio of 4:1.

DINAPRE's household survey (3) found a life prevalence rate of cannabis use of 3.1%, a prevalence of 0.4% in the last year, and 0.2% for the last month.
There are only a few published studies on the use of cannabis in Bolivia. It seems to be preferred by adolescents and young adults from the middle and upper socioeconomic levels. Most use it occasionally. Cases of severe dependence are rare, possibly due to a rapid switch to cocaine.

SEDATIVES AND STIMULANTS

The life prevalence rate for the consumption of sedatives and stimulants among the student population of Bolivia is 1.73%. Broken down by sex, the prevalence rate of use in the last year is 0.25% for males and 0.07% for females. The prevalence rate of use in the last month is 0.13% for males and 0.06% for females.

In the household survey, a life prevalence rate of 0.5% was given for cannabis use. The last year prevalence rate was 2.2% and 0.5% for the last month (3).

It is known that cocaine users from the urban middle and upper socioeconomic classes also frequently use benzodiazepines. University students tend to use more stimulants. There are no significant differences between the sexes in these groups.

In the case of other drugs that may be abused (hypnotics, pain killers, syrups and others), DINAPRE’s household survey (3) reports a life prevalence rate of 8.3% for males and 11.1% for females, a year prevalence rate of 3.4% for males and 4.8% for females, and a last month prevalence rate of 1.1% for males and 1.5% for females. This use is all related to self-medication.

AIDS AND OTHER SEXUALLY TRANSMITTED DISEASES

There was no practice of intravenous injection of psychoactive drugs in Bolivia until early 1993. It became known only recently that groups of young university students have started injecting cocaine in a recreational context.

No AIDS cases have been reported in relation to the use of psychoactive substances. National AIDS Control Program statistical data report a total of 66 diagnosed cases of AIDS since 1985 (62 male and 4 female). Most of these are members of middle or upper socioeconomic population groups and acquired the disease abroad.

Surveys conducted on street girls and young women report that 78.28% of them have suffered from at least one sexually transmitted disease. In order of frequency these are syphilis, diverse vaginal infections, gonorrhea, condylomata and trichomoniasis. It is important to remember that these young girls do not have access to any health service so they do not receive adequate treatment. The disease either follows its natural course or they treat it themselves.

THERAPEUTIC APPROACHES

In Bolivia there are a few therapeutic programmes for abusers of psychoactive substances, but none is exclusively for women.

General hospitals and primary health care facilities provide emergency treatment in cases of overdose and intoxication. They also take care of direct somatic effects, especially those due to alcohol (such as neuritis, hepatitis, pellagra and cirrhosis), as well as trauma, burns and other lesions related to the consumption of alcohol and other substances. The diagnosis of alcohol intoxication is not registered, however, when it is simultaneous with a treated lesion. Psychiatric hospitals handle the mental complications of substance dependence.


70. Hochgraf PB et al. Female alcoholism: consumption level, demographic factors and other characteristics related to alcohol consumption compared to males in Brazil (unpublished manuscript).


72. Zilberman ML et al. Female alcoholic outpatients: a comparative follow-up study (3 and 6 months) (unpublished manuscript).

73. Zilberman ML, Zoppe EHCC, Hochgraf PB. Características socio-demográficas de mulheres alcoolistas que abandonaram tratamento ambulatorial (unpublished manuscript)


WOMEN AND SUBSTANCE ABUSE IN HONDURAS
(Translated from Spanish)

INTRODUCTION

Honduras is a country of 5 million inhabitants with an area of 112,000 square kilometres. It is divided into 18 administrative departments, and for health purposes Honduras has eight health regions.

In recent years, the use and abuse of substances has increased and has become a priority health concern for the country’s Ministry of Health because of its economic, social, human and political implications.

Substance abuse was first included as one of the 10 priorities of the Ministry of Health in 1987. That same year, a law was enacted to establish the Honduran Institute for the Prevention of Alcoholism, Drug Addiction and Substance Dependency (Instituto Hondureño para la Prevención del Alcoholismo, Drogadicción y Farmacodependencia or IHADFA). In 1989 the National Council Against Drug Traffic was also created.

One phenomenon we have witnessed in Honduras is that of single women as heads of households. Many of these cases are caused by alcohol or drug dependence. Concurrent studies by the Mental Health Division of the Ministry of Health have addressed family problems, especially the relationship between parents and children, as one of the factors contributing to substance abuse. When one of the parents is absent or there is not enough time for dialogue between parents and children, this contributes to drug use among young people.

Alcohol is the substance most abused by the Honduran population, especially young people. Initiation into alcohol abuse takes place between the ages of 10 and 15 years, according to studies done in this area. There seems to be no difference between the sexes, with males and females using and abusing alcohol equally. It is only at the stage of alcohol dependence that one finds a sex differential in that more men suffer from alcohol and drug dependence problems than do women. Although some housewives drink alcohol heavily, treatment institutions for alcohol and drug dependence that admit both women and men have 20 male admissions for every woman admitted.

EPIDEMIOLOGY OF SUBSTANCE ABUSE

For the present study, information was collected from a review of literature published by Honduran professionals, from personal interviews and from a review of undergraduate theses of the Honduras School of Medicine. Social acceptance of alcohol consumption makes the data highly reliable, which is not always the case in studies of drug use.

Drug-related admissions to the Dr Mario Mendoza National Psychiatric Hospital have increased in recent years. In 1987 the ratio of alcohol:drug abuse diagnosis at discharge was 8:1, but by 1992 it was 3:1.

Review of patients’ medical records revealed that, among those admitted, the most commonly abused substances were cannabis, plastic cement and cocaine. Prior to 1985 there was no evidence of cocaine abuse among patients so the increase is a warning of the need for preventive measures.

According to the vice-president of the National Council Against Drug Traffic, cocaine is becoming an important substance of abuse, especially in the administrative departments of Atlántida, Islas de la Bahía, Cortes, Francisco Morazán, Choluteca and Olancho. Consignments of drugs have recently been confiscated in these areas and there is a rise in violence related to drugs.
Nongovernmental organizations (NGOs) and privately owned centres such as Proyecto Victoria, Amor Viviente, Clinica San Juan, Hospital el Carmen and Ciudad Blanca deal with alcohol dependence as the commonest form of dependence, although their managers claim a significant rise in cases related to cannabis and cocaine in the last eight years.

It is hard to establish the extent of damage from substance abuse according to sex because over 90% of these institutions admit only male patients. Admission of female patients is most often at the discretion of the attending physician, which means that hospitalization is not a standard service offered to women. In some cases, especially in religious institutions, the refusal to admit female dependents has to do with difficulties in dealing with the sex drive of these patients once inside the institution. There have been proposals for the development of special units for the treatment of women with alcohol dependence at existing treatment facilities, but so far none of these plans has been implemented.

Women have recently started showing evidence of problems with alcohol, cannabis and cocaine abuse. According to private institutions providing outpatient and hospitalization services, alcohol and benzodiazepines (Diazepam) are the substances most frequently abused.

Laws have been passed to restrict the sale of psychotropic drugs, including anxiolytics, to those obtainable with a physician's prescription only. Some pharmacies do not comply with this regulation, however. There is a strong market for drugs of this type smuggled from neighbouring countries, and for that reason psychotropic drugs can be purchased illegally in the streets. We believe that non-psychiatric medical practitioners may sometimes prescribe these drugs without considering the possibility of a future problem of dependence.

There are many signs of an increased tendency towards substance abuse. Its damaging effects on the family, society, the economy and morals are directly or indirectly contributing to the instability of our country. Regretfully we have not yet been able to make a better diagnosis that includes all population groups at national level. Since this would allow us to develop educational interventions to prevent substance use and abuse, we consider it most necessary to conduct a national survey of substance use and abuse.

HEALTH PROBLEMS DUE TO SUBSTANCE ABUSE

Adolescents of both sexes say that their reasons for first using alcohol and drugs were mostly to discover new sensations, to imitate others, to satisfy their curiosity or because they were introduced to these substances by strangers.

Alcohol use problems in Honduran adult women are related to conditions such as abortion, death of a relative, failure, and desertion by the father of her children leaving her with little or no economic support. These factors are seen especially in the middle and lower socioeconomic levels of society.

There is anecdotal evidence that it is harder to provide treatment to women than to men. This could be because women face stronger social disapproval of their alcohol abuse, which makes them delay seeking medical attention until they have abused alcohol for a longer period.

The social consequences of substance abuse in women are more severe than among men. Such consequences include family disintegration, loss of employment and rejection by friends. This situation lowers motivation for eventual rehabilitation.

Smoking is still a severe problem for women because of heart disease and low-weight births. However, both government and NGO sources agree that the amount of smoking has decreased in both sexes.
IMPACT OF SOCIOECONOMIC CHANGE AND SUBSTANCE ABUSE

Alcohol intake in large amounts has traditionally been a part of the Honduran lifestyle. The "chicha del maiz" (spirits distilled from corn) culture dates from ancient times. Alcohol has been used as a stimulant at religious ceremonies, funeral services, parties and celebrations, and at local religious festivities. Nevertheless, rural and urban areas show significant differences with regard to the substances abused - chiefly because in the urban areas, besides alcohol, there is high use of benzodiazepines, cocaine and cannabis.

Those who abuse inhalants frequently do so in the open without any intervention from passers-by. Members of the public perhaps do not realize the significance of what is happening in front of their eyes. Regrettfully, control measures implemented by plastic cement producers to reduce the misuse of their product have not accomplished the desired effect because substances are being smuggled from other Central American countries. Therefore the prevention of the use of neurotoxic and deteriorating substances by children is not being achieved.

The illegal sale of psychoactive drugs is not punished. It is well known that these drugs can cause dependence, but the real dimensions and consequences of the problem are not recognized. Honduras has two laws on the abuse of substances: the Law Against the Illegal Traffic of Tranquillizers, Psychotropic and other Dangerous Drugs, and the Law of the Honduran Institute for the Prevention of Alcoholism, Drug Addiction and Substance Dependence (IHADFA).

In 1987, the National Committee for Mental Health (CONASAM) was created, with members from several ministries and private institutions. Its main objectives are the creation of laws, the implementation of national planning and the coordination of related activities. More recently the Honduran Inter-institutional Coordinator on Addictions (CIHSA) was created.

The taxes on alcoholic beverages and cigarettes are strong sources of income for the government. Paradoxically, these funds sometimes provide financial support to activities sponsored by the Ministries of Education, Sports, Health and other institutions. Tax income from these products is estimated to be more than 20 million US dollars a year. These tax revenues were generated from the production of more than 100 million packets of cigarettes, 150 million bottles of beer, 5 million litres of rum and 2 million litres of "aguardiente" (grain alcohol). Faced with a difficult economic recession, the Honduran Government finds itself unable to protest strongly against the mass media campaigns that invite the population to use alcohol and tobacco.

Despite economic adjustments, currency devaluation and reduction of people's purchasing capacity, no reduction in alcohol use has been noticed. It is also more troubling to note that psychotropic drugs, benzodiazepines and cocaine, which have mostly been used in urban environments by persons of higher socioeconomic levels in the past, have now started to be commonly used by the middle and lower socioeconomic levels. This could be explained by a greater availability and lower price of drugs. In 1988 the street cost of one gram of cocaine was US$ 220, in 1990 it was US$ 100 and in 1992 it was US$ 20.

THE ROLE OF HONDURAN WOMEN IN MEASURES TO PREVENT SUBSTANCE ABUSE

Although there have been specific interventions regarding legislation and drug-related violence in women, there is no group or organization of women concerned exclusively with the problem of alcohol and drug abuse in Honduras. Some groups of Alcoholics Anonymous have been involving alcohol-dependent women in their activities for the past six years. Some women's organizations - such as the Federation of Honduran Women, the Centre for Studies in Women, and the "Visitación Padilla" group - have developed educational activities about the problem of alcohol and drugs within the context of problems that women face.
The lack of information about the size and severity of the problem has not helped anyone to find a solution. There is a need to create new NGOs devoted to fight against alcohol and drug use problems in women, especially in relation to prevention, diagnosis, treatment, rehabilitation and social reintegration. It is also considered important to train physicians in appropriate prescription practices for psychopharmacologic drugs. At present, in the public hospitals, the Honduran Social Security hospitals and private centres large amounts of benzodiazepines (Diazepam) are being prescribed daily.

GOVERNMENTAL AND NONGOVERNMENTAL INTERVENTIONS AGAINST SUBSTANCE ABUSE

Hospital services for dependents are almost exclusively detoxification. This is carried out at the two national psychiatric hospitals, Dr Mario Mendoza Hospital and Santa Rosita Hospital. The first one handles the acute phase and has 85 beds that are also used for psychotic patients of both sexes. The average length of stay is 15 days. Patients are given psychological evaluations and they are encouraged to join an Alcoholics Anonymous group. Follow-up is provided at the hospital outpatient clinic. Table 1 illustrates the nature of the diagnoses of substance-dependent patients at the Dr Mario Mendoza Hospital.

Table 1. Discharges from Dr Mario Mendoza Hospital, 1987 and 1992

<table>
<thead>
<tr>
<th>Diagnosis at discharge</th>
<th>1987 Men's ward</th>
<th>1987 Women's ward</th>
<th>1992 Men's ward</th>
<th>1992 Women's ward</th>
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<tbody>
<tr>
<td>Drug dependency</td>
<td>48</td>
<td>6</td>
<td>80</td>
<td>16</td>
</tr>
<tr>
<td>Psychosis due to drugs</td>
<td>8</td>
<td>0</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Psychosis due to alcohol</td>
<td>10</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Alcohol dependency</td>
<td>367</td>
<td>14</td>
<td>204</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>433</td>
<td>20</td>
<td>296</td>
<td>29</td>
</tr>
</tbody>
</table>

Table 2. Outpatient Clinic Visits at Dr Mario Mendoza Hospital, January-December 1992

<table>
<thead>
<tr>
<th>Visits</th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>First time visit</td>
<td>31</td>
<td>249</td>
</tr>
<tr>
<td>Repeat visits</td>
<td>33</td>
<td>253</td>
</tr>
</tbody>
</table>

Table 2 shows that women attend the outpatient clinic at Dr Mario Mendoza Hospital eight times less frequently than men. Both sexes usually have only one follow-up visit. At Santa Rosita Hospital there is an alcohol and drug dependence ward with 60 beds for men only. Women are hospitalized in the same ward as chronic psychotic patients. There were 15 female and 564 male admissions reported to the Division of Mental Health of the Ministry of Health for the period January-October 1992. Most cases at the Honduran Institute of Social Security Hospital are managed through contracts with the public psychiatric hospitals. In 1990, 320 alcohol-dependent patients were treated at Santa Rosita Hospital and 16 at Dr Mario Mendoza Hospital.

General hospitals also provide detoxification services for patients of both sexes, with the exception of the hospital in the Choluteca health region which has an alcohol and drug detoxification unit for men only. Admissions in 1990 were 250 patients with an average stay of nine days. Services at some of the health regions, as reported to the Mental Health Division of the Ministry of Health during January to October 1992 are shown in Table 3.
Table 3. Detoxification services provided from January to October 1992 by health regions

<table>
<thead>
<tr>
<th>Health Region Number</th>
<th>Incidence</th>
<th></th>
<th>Prevalence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>88</td>
<td>9</td>
<td>269</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
<td>47</td>
<td>4</td>
<td>59</td>
</tr>
<tr>
<td>6</td>
<td>0</td>
<td>13</td>
<td>1</td>
<td>29</td>
</tr>
<tr>
<td>7</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

Some of the private clinics providing detoxification services are the San Juan Medical Clinics and El Carmen Hospital, as well as religion-oriented rehabilitation centres such as Cerepa in Olancho, Casa Nazareth (Nazareth House) and Amor Viviente (Living Love). Victoria Project is an alcohol and drug dependence treatment project for men. Admission requirements include a psychiatric evaluation with recommendations for management, issued by Dr Mario Mendoza Hospital. Ciudad Blanca (White City) is a rehabilitation centre for sick adults but also treats alcohol dependence. This centre has a religious orientation and practices ergotherapy which encourages patients to take care of each other. There are no alcohol or drug dependence rehabilitation centres for women.

Institutions conducting prevention activities in Honduras are IHADFA, the Ministry of Health through its Mental Health Division, the Ministry of Education, PRIDE in Honduras, the National Board of Social Well-being, the Army Health Department and organizations like Casa Alianza (Alliance House), Compartir Project (Project Share), as well as Proyecto Alternativas (Project Choices) that works with children. Most institutions for prevention, service and rehabilitation were created by the Honduran Inter-institutional Coordinating Group on Addictions which is an effort to collaborate among institutions, share financial resources and avoid duplication of services.

One of the institutions with the most success among dependent persons in Honduras is Alcoholics Anonymous. It was founded in 1960 and has groups throughout the country. They have a group for alcohol-dependent women in Tegucigalpa. They are also on good terms with both psychiatric hospitals and with IHADFA.

CONCLUSIONS

Alcohol undermines the basic social group, the family, and has even affected the country’s economy. Alcohol encourages machismo behaviour that leads to irresponsible parenthood. Some men - and even women - abandon their homes or children without legal penalty. This increases the number of street children, who in the past decade have been increasingly abusing inhalants.

Recently Honduras changed from being a drug transit country to being a drug consumer country, too. Social pressures and everyday stress in Latin America (currency devaluation, inflation, unemployment, disease, loss of moral values and increased emphasis on materialism) account for alcohol and drug use, especially among women, as a means to escape from reality.

RECOMMENDATIONS

The following recommendations are made in view of the current situation regarding drug and alcohol abuse in Honduras. There is a need to consider:

- conducting a national diagnostic study on drugs and alcohol with emphasis on youth;
- setting up inpatient services that would favour admission of women with alcohol and drug problems;
- passing laws and decrees to punish irresponsible parenthood;
passing and enforcing regulations emphasizing appropriate prescription practices among general practitioners;
supporting the creation of NGOs working in the prevention and management of alcohol and drug problems in women and providing them with financial support.

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- EGYPT
- LEBANON
WOMEN AND SUBSTANCE ABUSE IN EGYPT

INTRODUCTION

Egypt lies at the junction of the Asian and African continents. It has an area of 1 million square kilometers but 99% of the population live in the Nile valley or Nile delta area. In 1991 the population of Egypt was estimated at 57 million.

Around 56% of the population live in rural areas though there is a continuing migration to urban areas, particularly to greater Cairo, Alexandria and other big cities. One-fifth of the total population lives in Cairo. The crude birth rate is 37 per thousand and the crude mortality rate is nine per thousand. The population growth rate is 28 per thousand, with urban population growth reaching 31 per thousand. People under 15 years of age are estimated to make up 39% of the total population.

The number of females in Egypt is smaller than the number of males (96 females to 100 males). Life expectancy for Egyptian females is higher than for males (63.3 years at birth for females compared to 58.7 years for males).

Women's status in Egypt

Women occupied a unique status in ancient Egypt which was often ruled by women, such as the celebrated Hathshepsut and Cleopatra. There was a restrictive view of women during the Ottoman Empire but the movement for political rights spread during this century and in 1956 Egypt became the first country in the Arab world to give political rights to women.

Women now have the right to participate in political life and stand for public election, though many women do not seem keen to use their rights and the number standing for election has fallen. This may be due to general political passivity, but one cannot ignore the effect of fundamentalism on women's roles and work.

Women have made remarkable achievements in the field of education with females accounting for one-third of all Egyptian university students in 1986. The ratio of illiteracy among women fell from 84% in 1960 to 62% in 1986 and there has been a rise in the number of women completing primary education.

Many men have migrated to big cities and to oil-producing Arab countries to earn money for their families, often leaving their wives to do the agricultural labour at home. Women have to perform the roles of both father and mother. At the same time, the women receive money from their husbands and become able to purchase drugs that they believe can calm them down and give them relief from biological, psychological and social pressures.

Women occupy about 15% of the total number of jobs in the public and private sectors, most of them in urban areas. The number of female employees increases by 20,000 each year. Many women work in the fields of insurance, tourism and aviation, cultural affairs and media, trade, finance and administration. Moreover, women account for 97% of all teachers in elementary schools. About 50% of doctors are female, as are 95% of nursing staff in health services in urban centres.

Some women's groups complain that women face injustice in finding jobs, yet at the same time other more conservative groups are encouraging Egyptian women to stay at home. These latter groups also condemn government employment of women. Since 25% to 30% of families depend on the income of the mother, a ban on work for women would cause a great deal of harm.
research also indicated that alcohol abuse is increasing [2% of those seeking treatment in the first five-year period, 11% in the second period, 15% in the third period and 10% in the last five years]. The study further showed that hashish abuse is rising [2%, then 7%, then 8% and then 10%]. With psychotropic drugs the rates were 5%, then 10%, then 20%, then 22% for the four successive five-year periods. For amphetamine by injection the percentages were 5%, then 3%, then 8%, and then 12%. Heroin use at the El-Ataba outpatient clinic reached its peak in 1987 when heroin users accounted for 68% of all patients coming to the drug dependence clinic. These findings match reports of seized narcotic substances and the rates recorded by other treatment facilities.

The Behman private hospital recorded an increase in heroin abusers treated there from 10 only in 1987 to 400 in 1989, none of whom were women. The state hospital of El-Maamoura stated that heroin abusers were the main group of drug abusers seeking treatment in the dependence treatment centre there in the years 1987, 1988 and 1989. Since 1990, heroin abusers have taken second place to the abusers of psychotropic drugs. Again, El-Maamoura hospital mentions no request from a female for treatment. Statistics from seven state centres for treatment of substance dependence do not include any female coming for treatment, although the centres received 8,086 abusers between 1987 and 1992. During 1993, however, the number of heroin dependents has increased once again both in number and in percentage in persons seeking treatment at treatment facilities. This happened because of an increase in the amount of heroin available this year as a result of smuggling into Upper Egypt via the Red Sea (9).

Although some studies have ignored women’s role in drug dependencies, others have pointed to the negative role of some women in making their sons and daughters become abusers. In the countryside, the mother may offer her son a drug in the context of practising traditional medicine. In a study that included 503 students who use psychotropic drugs, it was found that mothers were first to give the abused drug in 8.75% of cases. They gave their sons the drug to help them overcome pain or insomnia, to help them to study, or for various other reasons. The women do not realize the possible dangers in their behaviour. Another study on 292 students investigated the relationship between the student who abuses substances and the person who provided the abused substance on the first occasion. The relationship is shown in Table 5.

Table 5. Use among students by original provider of substance

<table>
<thead>
<tr>
<th>Provider</th>
<th>Urban Users</th>
<th>Rural Users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
</tr>
<tr>
<td>Father</td>
<td>19</td>
<td>14.39</td>
</tr>
<tr>
<td>Mother</td>
<td>15</td>
<td>11.36</td>
</tr>
<tr>
<td>Relative</td>
<td>8</td>
<td>6.06</td>
</tr>
<tr>
<td>Friend</td>
<td>18</td>
<td>13.64</td>
</tr>
<tr>
<td>Colleague</td>
<td>41</td>
<td>31.06</td>
</tr>
<tr>
<td>Other person</td>
<td>15</td>
<td>11.36</td>
</tr>
<tr>
<td>Two sources</td>
<td>16</td>
<td>12.12</td>
</tr>
<tr>
<td>Not indicated</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>132</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Source: Soueif, 1991

The practice of traditional medicine and giving drugs without consultation is not confined to the countryside. Mothers in urban societies offer drugs to their sons even more than rural mothers do.
Research has not ignored the distorted attitude of the mother towards her drug-dependent son. She is submissive, tolerant of her son’s faults and markedly emotionally involved with him (10). There are some factors that justify the absence of women from treatment facilities, despite the fact that researchers agree that there is a considerable number of drug-dependent women. The first factor is the keen desire to avoid social condemnation and the feeling of shame. The social stigma for drug-dependent women is much greater than that for drug-dependent men. Another factor can be seen in the link between treatment facilities and mental hospitals. Also, there are no treatment facilities for women, except for one that is being prepared. Women do not accept mixed treatment. They may avoid existing services because they perceive them to be expensive or unsuitable. Lack of awareness of the possible hazards of psychotropic drug abuse or the properties of these drugs may help to explain the absence of women from treatment services. Women’s drug dependence is more related to traditional medicine or self-medication, rather than to enjoyment and fun as in the case of men.

State facilities for the treatment of drug-dependent persons have been increased to 639 beds. In order to encourage women to seek treatment, a new section for the treatment of drug-dependent women is being prepared. This facility will be an independent one with 75 beds, following the model of the hospital for treatment of dependence in El-Kalibio. The majority of the therapists working in this hospital are female. They run the hospital as a therapeutic community. They carry out individual psychotherapy (about 200 sessions a month), group psychotherapy (about 148 sessions a month), and they also carry out psychodrama in a special theatre prepared for that purpose (8 sessions a month). There is also family and marital psychotherapy (140 sessions a month). In addition, the staff organize entertainment, occupational therapy, art therapy and activity therapy, as well as rehabilitation programmes, follow-up and relapse prevention programmes. Female therapists showed good results in this difficult field and they will treat patients in the independent department for women.

Success is anticipated firstly because of the efficiency of the female therapeutic staff, and secondly because of the social preference in Egypt and Islamic countries for women to be treated by women.

WOMEN’S NONGOVERNMENTAL ORGANIZATIONS

Many Egyptian women’s organizations are interested in removing social injustice against women and defending their rights. Such organizations include the Birth Control Society, the Egyptian Ladies Society, the Cairo Ladies Society, the Health Promotion Society, the Hoda Sharaawy Society and many others. Such organizations have not yet played a preventive role in protecting women from drug dependence or treating them. These organizations can be encouraged to play this role by making information about the size of the problem available to them. In order for these groups to play an integral role, they must realize how dangerous drug abuse is for the Egyptian woman. They should understand that drug dependence may occur because of the psychological suffering of a woman as a result of pressures and social injustice.

CONCLUSIONS

It is quite clear that drug-related problems in Egypt are growing. Significant increases in the consumption of alcohol, hashish, heroin, amphetamine and psychotropic drugs have been recorded. Women’s abuse of drugs, especially psychotropic drugs, has begun to become apparent but we see only the tip of the iceberg. Information about women’s drug related-problems is definitely lacking. Research data on this important subject is insufficient and fragmented.

We must make a determined effort to find out why Egyptian women do not make use of treatment facilities.

A multisectoral effort should be made to put into action collaborative programmes that allow Egyptian women who are drug-dependent to seek help without feeling stigmatized or socially rejected. We may also need specific treatment and rehabilitation programmes specially tailored to deal effectively
with Egyptian women. Such programmes might integrate a variety of approaches, including promotion of healthy lifestyles and prevention of social injustice, alongside prevention, treatment and rehabilitation.

It is clear that the problem of women infected with AIDS is only beginning to become evident. It is not the number of infected cases that is important but the fact that many women have no knowledge about how to protect themselves from becoming infected. Hence they are at increased risk.

The main difficulty in planning for preventive programmes is finding the right formula to introduce awareness and information across the cultural and traditional barriers. A multisectoral approach and a great deal of voluntary effort is needed to achieve this goal.

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WOMEN AND SUBSTANCE ABUSE IN LEBANON

INTRODUCTION

Lebanon is a republic of 10,452 square kilometres bordered by the Mediterranean Sea to the west, by Syria to the east and north, and by Israel to the south. Lebanon has been ravaged by wars since 1975 but, except for the south of the country, has been relatively stable since 1990. The population is estimated at 3.5 million, with 17 recognized forms of Christianity, Islam and Judaism.

The family network is very strong and extended families remain the foundation of the social structure. Lebanon has six universities and 20% of the adult population has a university education. The country has for several thousand years been a crossroads between East and West and remains an important financial and educational centre for the Middle East.

There has been reorganization of Lebanon’s social welfare, health, financial and education infrastructure since the country regained its stability in 1990. National commissions, drawn from both the private and public sectors, have been formed and have begun rebuilding the country.

The Lebanese Government partially covers medical expenses (inpatient) for needy individuals and about half the population has private or corporate insurance. A national health insurance system is being reviewed.

Studies conducted in 1989 and 1990 (1,2) seem to confirm that there is some misuse of alcohol and tobacco, both of which are sold freely in Lebanon. Alcohol is most frequently used by middle-aged single males. However, this finding (3) has to be confirmed by larger studies.

The general impression of most Lebanese professions is that illicit substance abuse has remained remarkably low in spite of the ready availability of cannabis (grown traditionally on Lebanese soil) and heroin. Since it regained authority after the end of the Lebanon war, the government has been active in curbing the traffic in drugs, as shown in Table 1.

Tranquillizer misuse, if defined as taking more than a prescribed dose or taking the tranquillizer to reach an altered state of consciousness, is difficult to ascertain in Lebanon since it is still relatively easy to purchase medicine without a prescription. It is our understanding that the Ministry of Health will soon change this situation.

Lebanon has not been immune to HIV infection. The National AIDS Control Programme reported a total of 205 HIV-infected individuals as of September 1993.

Table 1. Substances seized: Internal security report (1990-1993)

<table>
<thead>
<tr>
<th>Substances</th>
<th>1990 (kg)</th>
<th>1991 (kg)</th>
<th>1992 (kg)</th>
<th>1-5/1993 (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hashish</td>
<td>785</td>
<td>1,385</td>
<td>4,218</td>
<td>7,900</td>
</tr>
<tr>
<td>Hashish Paste</td>
<td>-</td>
<td>1,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Heroin</td>
<td>32</td>
<td>100</td>
<td>734</td>
<td>29</td>
</tr>
<tr>
<td>Cocaine</td>
<td>16</td>
<td>13</td>
<td>142</td>
<td>289</td>
</tr>
</tbody>
</table>
Epidemiological studies (1) carried out among the university population (Table 4) confirm the trend noted in the population under treatment. Females use illicit drugs less often than do males and even abuse them more rarely in the context of an already low general prevalence. Licit substances are abused more readily by the university population but at lower levels than those reported in the international literature.

Table 4. University study: Prevalence and sex distribution

<table>
<thead>
<tr>
<th>Name of the substance</th>
<th>Lifetime Prevalence - (used at least once)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total (N=1,851)</td>
</tr>
<tr>
<td>Tranquillizer</td>
<td>9.3%</td>
</tr>
<tr>
<td>Barbiturate</td>
<td>7.3%</td>
</tr>
<tr>
<td>Morphine</td>
<td>0.7%</td>
</tr>
<tr>
<td>Stimulant</td>
<td>1.6%</td>
</tr>
<tr>
<td>Codeine</td>
<td>2.8%</td>
</tr>
<tr>
<td>Hashish</td>
<td>2.2%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.5%</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.3%</td>
</tr>
<tr>
<td>Any licit</td>
<td>14.9%</td>
</tr>
<tr>
<td>Any illicit</td>
<td>2.9%</td>
</tr>
</tbody>
</table>

NB: Illicit: Hashish/Cocaine/Heroin

It is to be noted that the universities surveyed cater to the more affluent and westernized sections of the Lebanese population. Cigarettes are smoked regularly by about 20% of the university population. Some of the predictors of later ethanol abuse (getting intoxicated more than once before age 15) held true in the Lebanese university population.

A small community pilot study (9) corroborates the findings of the university study. The male:female ratio drops when illicit drugs are compared to licit ones, again in the context of a very low prevalence of abuse in general.

The issue of comorbidity (of mental illness) and substance abuse was the subject of major study undertaken by the St Georges Group (8). The data showed clearly that women with a history of substance abuse were twice as likely to have mental illness when compared to pure substance abusers. The comorbidity in females was not as evident in strictly psychiatric institutions. This could be due to the stigma attached to admission to psychiatric hospitals and is probably due to the different populations that general hospitals serve.

As shown in Table 2, less than 3% of substance abusers admitted for long residential treatment are female. This population is, however, not representative of Lebanese substance abusers in general, since 95% of residents (4) are heroin abusers (though in the context of polyabuse).
For the sake of completeness, it should be noted that the estimates of the Jeunesse Anti-Drogue action group in Lebanon, although not based on strict epidemiological data, in fact seem to corroborate the findings of others. Less than 3% of the total Lebanese population (all ages) have ever tried drugs (11).

HIV IN WOMEN

Of the 205 HIV-infected individuals reported in Lebanon from 1988 to 1993, approximately 30 are female (16%) (Table 5). These women seem to have been infected primarily though heterosexual contact. Injecting drug use is responsible for less than 10% of the cases (10).

Table 5. HIV reported cases in Lebanon

<table>
<thead>
<tr>
<th>Age of Females</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>30-39</td>
</tr>
<tr>
<td>43%</td>
<td>33%</td>
</tr>
</tbody>
</table>

*10% not specified

Several large groups (National AIDS Program, SOS SIDA, Lebanese AIDS Society), with very active female professional members, have participated in highly visible AIDS prevention campaigns (on television, radio, road posters and through public meetings).

Data on safe sex practices are now available in Lebanon. It is to be noted that unmarried mothers are almost unheard of. Prostitution is expected to rise, especially if Lebanon regains its pre-war level of prosperity and tourism.

GENERAL CONCLUSIONS

On the basis of the data gathered for this expert report, illicit substance abuse and HIV infection remain rather limited among Lebanese females when compared to males. It is to be noted, however, that licit substance abuse may not be as rare in the female population. It should also be remembered that ethanol consumption is much less frequent in Muslims in general, and especially so in Muslim females.

Lebanon does not have a high proportion of AIDS cases and substance abuse does not seem to be a major contribution to HIV infection in Lebanon (whether in males or females) because of the low prevalence of injecting drug use.

Some factors seem to indicate that the future regarding women in substance abuse and HIV infection may not be so bleak because of the very active concern of the Ministry of Health and the national associations, and the direct expertise the United Nations, the WHO and its professionals. One factor that, unfortunately, might undermine all these efforts is the lack of adequate financial resources to research and deal with the issues at hand.
Table 6. Substance abuse in Lebanon - University study: Prevalence and sex distribution (RDC criteria)

<table>
<thead>
<tr>
<th>Name of substance</th>
<th>Total (N=1,851) %</th>
<th>Males (N=924) %</th>
<th>Females (N=871) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tranquillizer</td>
<td>9.2</td>
<td>6.6</td>
<td>12.9</td>
</tr>
<tr>
<td>Barbiturate</td>
<td>7.4</td>
<td>4.2</td>
<td>10.8</td>
</tr>
<tr>
<td>Morphine</td>
<td>0.7</td>
<td>0.8</td>
<td>0.6</td>
</tr>
<tr>
<td>Stimulant</td>
<td>1.5</td>
<td>1.2</td>
<td>1.8</td>
</tr>
<tr>
<td>Codeine</td>
<td>2.7</td>
<td>3.6</td>
<td>1.7</td>
</tr>
<tr>
<td>Hashish</td>
<td>2.1</td>
<td>3.7</td>
<td>0.3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>0.3</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.2</td>
<td>0.3</td>
<td>0.1</td>
</tr>
<tr>
<td>Any illicit</td>
<td>14.8</td>
<td>10.9</td>
<td>18.8</td>
</tr>
<tr>
<td>Any illicit</td>
<td>2.7</td>
<td>4.3</td>
<td>1.0</td>
</tr>
</tbody>
</table>

NB: Illicit: Hashish/Cocaine/Heroin - Beirut, Lebanon

REFERENCES


