UNODC
United Nations Office on Drugs and Crime

ADDRESSING THE SPECIFIC NEEDS
OF WOMEN WHO USE DRUGS

Prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis

TECHNICAL BRIEF

unicef for every child
INPUD International Network of People who Use Drugs
World Health Organization
UNFPA

UNITED NATIONS OFFICE ON DRUGS AND CRIME

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UNITED NATIONS
Vienna, 2021

Publishing production: English, Publishing and Library Section, United Nations Office at Vienna.

Contents

Acknowledgements

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The United Nations Office on Drugs and Crime (UNODC) gratefully acknowledges the contributions of the members of the technical working group established to assist with the preparation of this brief by providing their inputs and by commenting on the drafts: (in alphabetical order) Jane Batte (UNAIDS), Judy Chang (INPUD), Mauro Guarinieri (INPUD), Dr Niklas Luhmann (WHO), Ruslan Malyuta (UNICEF), Dorothy Mbori-Ngacha (UNICEF), Morkor Newman-Owiredu (WHO), Tim Sladden (UNFPA) and Annette Digna Verster (WHO).

This technical brief was edited by James Baer.

Abbreviations

EMTCT	Elimination of mother-to-child transmission
INPUD	International Network of People who Use Drugs
MNCAH	Maternal, neonatal, child and adolescent health
PTMCT	Prevention of mother-to-child transmission
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UNWOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

In 2016 the General Assembly, in its Political Declaration on HIV and AIDS, committed to the goal of ending AIDS as a public health threat by 2030. [1] This included an undertaking to "eliminate new HIV infections among children by reducing new infections by 95 per cent in every region by 2020". The same year, the World Health Assembly endorsed the World Health Organization (WHO) 2016-2021 global health sector strategies on HIV, [2] viral hepatitis, [3] and sexually transmitted infections. [4] These strategies mandate Member States to collaborate towards the goals of zero new HIV infections in infants by 2020, combating viral hepatitis as a public health threat by 2030, and the elimination of congenital syphilis.

Mother-to-child transmission of HIV remains a significant contributor to the HIV pandemic, accounting for 9 per cent of new infections globally. [5] The targets of the 2016 "Start Free, Stay Free, AIDS Free framework" were that by 2018, fewer than 40,000 children would become newly infected, and 95 per cent of pregnant women living with HIV would be receiving lifelong antiretroviral therapy. [6] However, in 2019 an estimated 150,000 children became newly infected with HIV (although this represented a decrease from 280,000 in 2010), and only 85 per cent of pregnant women living with HIV were on antiretroviral therapy. [7]

In 2019 people who inject drugs accounted for an estimated 10 per cent of new HIV infections globally. [8] International declarations and documents encourage and support countries to provide women and girls who use or inject drugs with access to comprehensive services for the prevention of mother-to-child transmission (PMTCT) of infectious diseases. [9] The sixty-first session of the Commission on Narcotic Drugs, held in Vienna in March 2018, adopted resolution 61/4 "Promoting measures for the prevention of mother-to-child transmission of HIV, hepatitis B and C and syphilis among women who use drugs". [10]

Targeted interventions and programmes are essential in order to reach women who use drugs who are otherwise unable to access services due to stigma and discrimination. Harm reduction services,[1] the entry point to health and social services for most people who use drugs, play a key role in PMTCT of HIV, viral hepatitis B and C and syphilis among women who use drugs. Without access to harm reduction services, and without strong linkages and integration with other relevant health services, women who use drugs and their children will continue to be disproportionally affected by these diseases.

If women who use drugs are left behind, the efforts of countries towards the triple elimination of mother-to-child transmission (EMTCT) of HIV, hepatitis B and syphilis, as well as of hepatitis C, are likely to experience significant delays.

[1] For the purposes of this technical brief, harm reduction services are defined by the interventions included in the Comprehensive Package detailed in the *WHO, UNODC, UNAIDS Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (2012).

The purpose of this technical brief is therefore to provide guidance for the provision of equitable, evidence-informed and human-rights-based services for PMTCT of HIV, hepatitis B and C and syphilis among women who use drugs, and to support countries in their efforts towards EMTCT.

The target audience includes policymakers, service providers and managers of programmes for HIV and hepatitis, drug treatment and harm reduction, sexual and reproductive health, and maternal, newborn, child and adolescent health (MNCAH); as well as non-governmental and community-based organizations, law enforcement agencies and development partners.

This technical brief builds on international guidance on HIV prevention, treatment and care for people who inject drugs, as well as guidance on women who use drugs, PMTCT, and hepatitis B and C, including the documents listed in the Resources section. The development of this brief was overseen by a working group led by the United Nations Office on Drugs and Crime (UNODC) and composed of the International Network of People who Use Drugs (INPUD), the International Network of Women Who Use Drugs (INWUD), World Health Organization (WHO), the Secretariat of the Joint United Nations Programme on HIV/AIDS (UNAIDS), UN Women, the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF).

A NOTE ON TERMINOLOGY

This brief is mainly concerned with women and girls who inject drugs, given the higher risks of HIV transmission through sharing injection equipment, but it is also relevant to some women and girls who use drugs such as stimulant drugs that they may not inject. Throughout this brief, "women who use drugs" is used for conciseness but should be understood to refer to all methods of administering drugs, including but not limited to injection.

Similarly, this brief recognizes that some girls under the age of 18 use drugs and may be in need of harm reduction services as well as PMTCT services. Therefore, throughout this brief, "women who use drugs" should be understood to refer both to women aged 18 and over, and to girls aged under 18.

RECOMMENDATIONS

As a general principle, all pregnant and breastfeeding women who use drugs should have at least the same access to evidence-based services for PMTCT as women in other populations. Women should not be excluded from health care because of their substance use. All interventions should be voluntary, with informed consent and maintenance of confidentiality, including about a person's drug use or HIV status. This technical brief recommends the following approaches to ensure PMTCT among women who use drugs.

1. **Make the four components of the WHO comprehensive PMTCT package – including harm reduction – available for women who use drugs and their children.**

2. **Remove barriers preventing women who use drugs from accessing the services for harm reduction, sexual and reproductive health and HIV that they or their children need, including for PMTCT.**

3. **Integrate services for sexual and reproductive health and PMTCT within women-friendly, supportive harm reduction and drug dependence treatment services, and establish strong linkages between these services.**

4. **Include representatives from the community of women who use drugs in strategic planning, implementation, monitoring and evaluation of PMTCT services.**

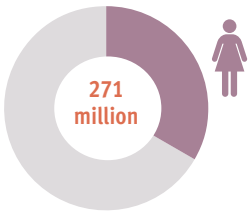
5. **Ensure that PMTCT for women who use drugs is included in countries' EMTCT plans and monitoring frameworks.**

1. Background

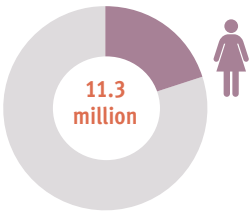
1.1 WOMEN WHO USE DRUGS

Women represent about one-third of the estimated 271 million people who use drugs globally, and 20 per cent of the estimated 11.3 million people who inject drugs. [11],[12] This proportion varies by region, from approximately 30 per cent in North America and 33 per cent in Australia and New Zealand to 3 per cent in South Asia. [13]

Unintended pregnancies among women who use drugs may be much more common than among women in the general population. For example, up to 86 per cent of women who use opioids who are in drug treatment report having been unintentionally pregnant, compared with about 40 per cent of women in the general population. [14]



people who use drugs globally



people who inject drugs globally

Unintended pregnancies

40%

women in the general population

86 %

women who use opioids, who are in drug treatment

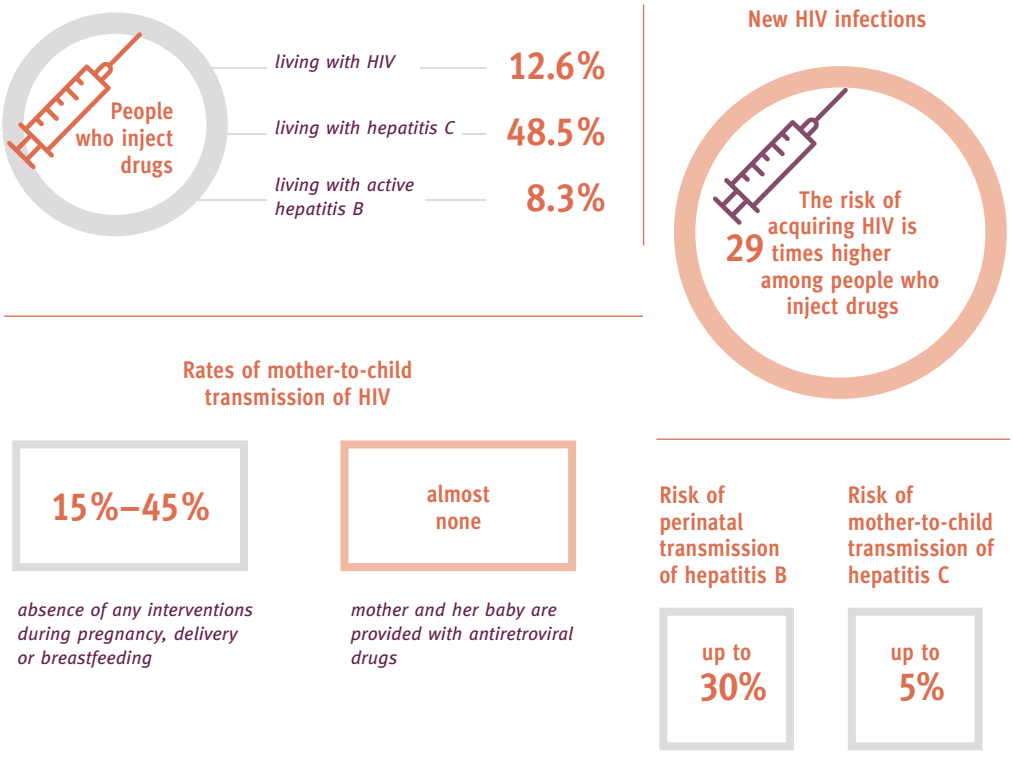
1.2 HIV, HEPATITIS B AND C AND SYPHILIS

Among people who inject drugs, an estimated 1.4 million (12.6 per cent) are living with HIV, 5.5 million (48.5 per cent) with hepatitis C and 0.9 million (8.3 per cent) with active hepatitis B (HBV). [12] The number of new HIV infections among people who inject drugs is estimated to be 22 times higher than in the general population. [15] People who inject drugs also account for 23 per cent to 39 per cent of new and 8 per cent of chronic hepatitis C infections, and 1 per cent of new and 0.5 per cent of chronic hepatitis B infections. [16]

There are no global estimates of HIV, hepatitis B and C or syphilis prevalence specifically in women who use drugs. However, in many countries, women who inject drugs have up to twice as great a risk of contracting HIV and hepatitis C as their male peers. [17],[18],[19] In some countries, HIV prevalence among women who use drugs but do not inject is comparable to that of women who inject drugs. [20]

In 2016 the estimated global maternal syphilis prevalence was 0.69 per cent, resulting in a global congenital syphilis rate of 473 per 100,000 live births, accounting for 200,000 stillbirths and neonatal deaths. [21] According to WHO estimates, in 2018 the median syphilis prevalence among female sex workers was 3.2 per cent. [22] In North America an increasing prevalence of syphilis among women who use methamphetamine and heroin is reported, related to unprotected sex. [23],[24]

In the absence of any interventions during pregnancy, delivery or breastfeeding, rates of mother-to-child transmission of HIV can be between 15 per cent and 45 per cent. This risk can be almost eliminated if both the mother and her baby are provided with antiretroviral drugs as early as possible in pregnancy and during the period of breastfeeding. [25] The risk of perinatal transmission of hepatitis B can be as high as 30 per cent. [26] The risk of mother-to-child transmission of hepatitis C during pregnancy or delivery is about 5 per cent, and much higher among women who are coinfected with HIV. [27],[28] There is no risk of transmission of hepatitis B or C through maternal breast milk.



1.3 DRUG USE, PREGNANCY AND BREASTFEEDING

The use of drugs such as methamphetamine, cocaine, benzodiazepines and opioids, as well as the use of alcohol and nicotine during pregnancy, can have negative effects on the development of the foetus.

There are few and sometimes contradictory data on the potential negative effects of exposure to methamphetamine or cocaine during pregnancy, such as low birth weight, preterm birth, reduced gestational age of the baby or miscarriage. [29] Opioid use in pregnancy is linked to risk of postnatal withdrawal syndrome for the newborn (neonatal abstinence syndrome). Opioid withdrawal during pregnancy can have serious negative impacts on the foetus that are reduced by opioid substitution therapy such as methadone treatment. [30] Heavy alcohol use during pregnancy is responsible for a range of disorders that can be severe (foetal alcohol syndrome). [31]

1.4 ACCESS AND BARRIERS TO HEALTH AND SOCIAL SERVICES

Women who use drugs encounter significant systemic, structural, social, cultural and personal barriers to accessing harm reduction, drug treatment, sexual and reproductive health and general health services. [32],[33]

Laws, policies and practices

Women who use drugs are hardly ever included in policy dialogue related to drug use or HIV responses, including for PMTCT.

Laws that criminalize the use of drugs, together with punitive approaches and practices, and the judgemental attitudes of police and of health and other social sector providers, constitute barriers for all people who use drugs who wish to access services for general health, HIV, harm reduction and drug treatment, or social services.

Drug use during pregnancy is criminalized in some countries, leading to incarceration for some women. [34] In some instances, laws criminalize exposure and/or transmission of HIV from mother to child during pregnancy or breastfeeding. Other countries allow coerced HIV testing, forced abortion and termination of the parental rights of women who use drugs or women living with HIV. [35] This causes some mothers living with HIV to avoid reproductive health services, including postnatal care for their newborn. In some instances, policies restrict access to welfare and social services for women who use drugs, exacerbating their vulnerability. Limitations on the age of consent for access to HIV and broader sexual and reproductive health services constitute an additional barrier for adolescent girls and young women who use drugs.

Stigma and self-stigma

Social attitudes severely stigmatize people who use drugs, and women who use drugs – especially mothers – suffer even more than men. [36] Health-care staff often have judgemental attitudes, and women who use drugs may experience mistreatment during pregnancy, labour and delivery. If they internalize this stigma, they may self-exclude from health, social and other support services.

Poor health-service response to the needs of women who use drugs

Because of stigma, discrimination and the fear of criminal sanctions, women who use drugs often conceal their drug use when receiving health-care services during pregnancy. [37] This limits their access

to services for HIV/sexually transmitted infection prevention, drug dependence and antenatal care. Health-care staff often lack knowledge and scientific information on drug use, drug dependence and the health effects of drug use, including during pregnancy. This creates an additional barrier to evidence-informed and rights-based treatment, care and support for women who use drugs. Sexual and reproductive health and MNCAH services often mandate abstinence instead of referring women who use drugs to harm reduction services and drug dependence treatment and support.

Harm reduction services, often tailored towards men who inject drugs, do not address the gender-specific needs of women and mothers who use drugs. [38],[39] Significant barriers preventing women from accessing harm reduction programmes include:

(a) Lack of a safe and confidential environment;

(b) Absence of child-friendly space;

(c) Inappropriate opening hours, long travel times and transport costs (in some regions, cultural norms may also prohibit women from leaving the house alone, making it difficult for them to access services);

(d) Lack of health, legal or social services addressing women's specific needs, and limited staff expertise in these areas; [37],[40]

(e) Lack of information on the effects of drugs on sexual and reproductive health, including during pregnancy or breastfeeding, or on the benefits of opioid substitution therapy and the risks of withdrawal during pregnancy or breastfeeding;

(f) Absence of services to support women who have experienced violence or sexual trauma, or for women who engage in sex work. [38]

Women who use drugs in prisons

Globally, 39 per cent of women in prison are incarcerated for drug-related offences, compared with 19 per cent of men. [41] Women who are incarcerated have even less access than their male counterparts to health-care services, and to preparation and support for their return to the community. 41],[42] Incarceration further decreases access to sexual and reproductive health and MNCAH health services. Upon release, women face the combined stigma of being a woman who uses drugs and an ex-prisoner (and sometimes also a sex worker), and they may face additional discrimination in health care, social services, labour markets and other settings. [43]

2. Comprehensive and integrated PMTCT services for women who use drugs

2.1 THE COMPREHENSIVE PMTCT PACKAGE

↘ ***RECOMMENDATION 1***: MAKE THE FOUR COMPONENTS OF THE WHO COMPREHENSIVE PMTCT PACKAGE – INCLUDING HARM REDUCTION – AVAILABLE FOR WOMEN WHO USE DRUGS AND THEIR CHILDREN

As the entry point for many women who use drugs in the health sector, harm reduction programmes play a key role in ensuring that women who use drugs access integrated, comprehensive services for HIV, hepatitis and syphilis, sexual and reproductive health, drug dependence treatment and antenatal care. It is critical to ensure the continuity of harm reduction services, including drug dependence treatment, throughout pregnancy and breastfeeding.

Based on the four-pronged approach recommended by WHO, [44] the comprehensive service package for PMTCT for women who use drugs includes the following components:

PRONG 1. Harm reduction to prevent new HIV, hepatitis B and C and syphilis infections among women of childbearing age who use drugs

HIV prevention in the context of harm reduction is described in the comprehensive package for HIV prevention and care among people who inject drugs. [45] The package includes the following 10 components:

1 **Needle and syringe programmes:** Women who use or inject drugs should access needle and syringe programmes. irrespective of whether they are pregnant or breastfeeding.

Needle and syringe programmes

2 **Opioid substitution therapy and other evidence-based drug treatments:** Women who are dependent on opioids and are pregnant or breastfeeding should be strongly encouraged to initiate or continue opioid substitution therapy. It is important for pregnant women dependent on opioids to start or continue opioid substitution therapy, preferably with methadone, rather than to attempt opioid detoxification, which could lead to spontaneous abortion or preterm birth. [46] Compared with heroin use, opioid substitution therapy has a positive impact on the development of the foetus and improves both antenatal care and the parenting of young children. Nursing women receiving opioid substitution therapy should be encouraged to breastfeed, which may reduce the incidence and/or severity of neonatal withdrawal syndrome in opioid-exposed infants. Other evidence-based psychological support can be offered to pregnant women who use stimulant drugs, such as motivational interviewing, brief interventions or cognitive behavioural therapy and contingency management. [46],[47],[48]

Opioid substitution therapy and other evidence-based drug treatments

3 **Testing services:** Voluntary and confidential testing for HIV and hepatitis B and C should be offered to all women who use drugs, with linkages to treatment in the case of positive tests.

Testing services

4 **Antiretroviral therapy:** All women who use drugs and live with HIV should receive lifelong antiretroviral therapy from the time of their diagnosis. Both the mother and her baby should be provided with antiretroviral drugs as early as possible in pregnancy and during the period of breastfeeding. For HIV prevention in the context of PMTCT, antiretroviral drugs also include pre-exposure prophylaxis, especially for women who use drugs who are at substantial risk of sexual infection, including those who engage in sex work. [49] Post-exposure prophylaxis is needed in the case of accidental blood, body-fluid or possible sexual exposure to HIV. In addition to post-exposure prophylaxis, women who experience violence should receive a package of essential services, including HIV and hepatitis testing, screening for sexually transmitted infections, emergency contraception, and psychological and legal support for addressing sexual violence, including intimate-partner and gender-based violence. [50]

Antiretroviral therapy

5 **Prevention, diagnosis and treatment of sexually transmitted infections:** Information, counselling, testing and screening for syphilis and other sexually transmitted infections should be offered to all women who use drugs. Treatment for all sexually transmitted infections should be based on symptoms (syndromic approach) in the absence of laboratory tests. [51]

Prevention, diagnosis and treatment of sexually transmitted infections

6 **Distribution of male and female condoms:** Male and female condoms, together with water-based lubricants, should be freely available and easily accessible to women who use drugs.

Distribution of male and female condoms

7 **Information, education and communication:** In addition to information on harm reduction, information, education and communication for women who use drugs should cover contraception, family planning, pregnancy, breastfeeding and drug use.

Information, education and communication

8 **Prevention, vaccination, diagnosis and treatment of hepatitis:** The hepatitis B vaccine should be offered to all women who inject drugs, including pregnant and breastfeeding women. Rapid hepatitis B vaccination regimen (1, 7 and 21 days) should be administered, where available. [52]

Prevention, vaccination, diagnosis and treatment of hepatitis

9 **Prevention, diagnosis and treatment of tuberculosis:** Women who use drugs should receive screening for tuberculosis and be referred with appropriate support to treatment services, where needed.

Prevention, diagnosis and treatment of tuberculosis

10 **Community distribution of naloxone for the prevention of overdose deaths.**

Community distribution of naloxone for the prevention of overdose deaths

PRONG 2. Prevention of unintended pregnancies among women living with HIV and women who use drugs through access to sexual and reproductive health services

Prevention of unintended pregnancy in women living with HIV and women who use drugs relies on ensuring that they have access to integrated, evidence-informed, human-rights-based [53] and affordable sexual and reproductive health care. This includes information, choice and access to voluntary contraception, hormonal contraception and oral emergency contraception, as well as voluntary safe abortion, to the full extent of the law, and post-abortion care. [54] In addition to hormonal contraceptive methods, women who are at high risk of HIV and other sexually transmitted infections should also be counselled to use condoms and lubricant. [55]

PRONG 3. Prevention of mother-to-child transmission of HIV, hepatitis B and syphilis by pregnant and breastfeeding women living with HIV, hepatitis or syphilis who use drugs

Screening

WHO recommends that all women be screened for HIV, hepatitis B and syphilis at their first antenatal clinic visit, and offered treatment as needed. [56] For women who inject drugs and women in high hepatitis C-prevalence areas, their first visit should also include hepatitis C screening. [57] Retesting for all four infections should be offered during the course of pregnancy, delivery and breastfeeding, on a regular basis according to national guidelines. WHO recommends HIV retesting during the third trimester and the breastfeeding period in higher-prevalence settings. [58],[59]

Treatment

All people living with HIV should receive lifelong antiretroviral therapy from the time of their diagnosis [59]. Some women who use drugs and live with HIV begin labour and reach obstetrics services for delivery without knowing their HIV status. In such cases they require an adapted antiretroviral drug emergency therapeutic protocol to prevent transmission during labour and delivery. [60],[61]

To prevent mother-to-child transmission of congenital syphilis, women with syphilis should be treated with at least one injection of 2.4 million units of intramuscular benzathine benzylpenicillin at least 30 days prior to delivery. [56]

To prevent mother-to-child transmission of hepatitis B, WHO recommends that pregnant women testing positive for hepatitis B infection (HBsAg positive) with a hepatitis B DNA ≥ 200,000 IU/mL (or HBeAg testing positive where hepatitis B DNA is not available) receive tenofovir prophylaxis from the 28th week of pregnancy at least until birth. In case of cirrhosis, the treatment should be lifelong. [62]

WHO recommends offering treatment with direct active antiviral drugs to all individuals diagnosed with chronic hepatitis C who are 18 years of age or older for a duration of 12–24 weeks. [63] However, women living with hepatitis C should be informed about the lack of available data on the safety and efficacy of direct active antiviral drugs during pregnancy.

Safe pregnancy monitoring and delivery

Elective caesarean section should not be routinely recommended to women living with HIV. [64] The same recommendations apply for hepatitis B and C infections. Health-care workers should follow universal precautions for all deliveries, including those involving mothers with HIV, or hepatitis B or C.

Breastfeeding

Women living with HIV, or hepatitis B or C, and women who use drugs, should be encouraged to breastfeed. They should be given accurate information and, if they wish, be supported for safe breastfeeding in the context of HIV, hepatitis and drug use. WHO recommends exclusive breastfeeding for the first 6 months of life, and that it be continued for at least 12 months of life, especially in low and middle-income countries. [64][65] When HIV viral load is undetectable, the risk of transmitting HIV through breastfeeding is low, [64] and the risk of hepatitis B transmission is negligible if the newborn receives the birth dose of monovalent vaccine within 24 hours of birth. Hepatitis C is not spread through breast milk and there is no risk of transmission as long as nipples are not bleeding. [66]

Women should receive information on potential risks related to drug or alcohol use and breastfeeding, and on risk reduction strategies. These include modifying the timing of taking drugs or breastfeeding, for example, ensuring at least a few hours in between, or using alternatives (stored breast milk or breast-milk substitutes) intermittently. [46]

PRONG 4. Provision of appropriate treatment, care and support to mothers living with HIV, hepatitis or syphilis who use drugs, and to their children and families

All HIV-exposed infants should receive antiretroviral drug prophylaxis from birth, and should be tested at birth for HIV infection using nucleic acid tests if at high risk, and within 2 months of birth for early-infant diagnosis. If tested positive for HIV, they should immediately be started on antiretroviral therapy. Women living with HIV should be counselled and supported for adherence to lifelong antiretroviral therapy.

Children exposed to syphilis, particularly when maternal treatment has not been adequate to prevent congenital syphilis,[2] should be assessed and provided with appropriate follow-up care, including treatment. [67] Other sexually transmitted infection-related neonatal morbidities should be assessed for and managed, including neonatal pneumonia and conjunctivitis.

Infants should receive their first dose of monovalent hepatitis B vaccination at birth, followed by two or three additional infant series according to the national infant vaccination protocol.

Women living with HIV, hepatitis B and C, syphilis or other sexually transmitted infections should be supported to inform their partner, with follow-up partner testing and management as needed.

The newborns of mothers who use opioids should be monitored for a few days for detection and treatment of possible symptoms of withdrawal. Neonatal abstinence syndrome should be managed with appropriate treatment, including opioid substitution therapy and care for the child. Mothers who are dependent on opioids should be encouraged to start or continue opioid substitution therapy and to breastfeed their infants, which may reduce the incidence and/or severity of neonatal withdrawal syndrome. [46]

Mothers should also receive access to comprehensive information and voluntary free contraception of their choice.

2.2 REMOVING OBSTACLES AND CREATING OPPORTUNITIES

> ↘ ***RECOMMENDATION 2***: REMOVE BARRIERS PREVENTING WOMEN WHO USE DRUGS FROM ACCESSING THE SERVICES FOR HARM REDUCTION, SEXUAL AND REPRODUCTIVE HEALTH AND HIV THAT THEY OR THEIR CHILDREN NEED, INCLUDING FOR PMTCT

A supportive environment that facilitates access for women who use drugs to harm reduction and other health services is crucial. An effective response requires a multisectoral approach to maximize service availability and access for women who use drugs, including those who are pregnant and those with children. The following recommendations incorporate the WHO-recommended critical enablers for key populations. [53]

- **Reform laws, policies and practices** that hinder access, for women who use drugs and their children, to health and social services for HIV and drug use prevention, treatment, care and support. Promote anti-discriminatory laws and establish alternatives to conviction and punishment, including the decriminalization of drug consumption and possession for personal use. [68] For pregnant women and women with dependent children especially, non-custodial measures should be prioritized for non-serious or violent crime or for women who do not represent a continuing danger, taking into account the best interests of the child or children (Bangkok Rule 63). [69]
- **Address stigma and discrimination** in the health, [70] social and law enforcement sectors through policies, sensitization and training, and by establishing accountability mechanisms.
- **Foster community empowerment** among women who use drugs by ensuring their engagement, ownership and leadership in the assessment, planning, implementation, and monitoring and evaluation of programmes for women who use drugs.

[2] According to WHO guidelines, adequate maternal treatment is defined as at least one injection of 2.4 million units of intramuscular benzathine benzylpenicillin at least 30 days prior to delivery.

- **Address physical, sexual and psychological violence** by law enforcement, health staff, family members and the community, especially against pregnant and breastfeeding women or mothers who use drugs.
- **Ensure access to tailored legal aid and legal literacy**, including for pregnant women and mothers who use drugs, and those who experience violence. This is critical for them to defend their rights, including in relation to child custody or access to social support. Legal services should be integrated within harm reduction services.
- **Provide social support**, including assistance for housing and financial support and safety. This is especially important for pregnant and breastfeeding women, mothers of children, and women who are released from prison, because of the additional barriers they face in accessing services.

3. Implementing comprehensive PMTCT services for women who use drugs

↘ ***RECOMMENDATION 3***: INTEGRATE SERVICES FOR SEXUAL AND REPRODUCTIVE HEALTH AND PMTCT WITHIN WOMEN-FRIENDLY, SUPPORTIVE HARM REDUCTION AND DRUG DEPENDENCE TREATMENT SERVICES, AND ESTABLISH STRONG LINKAGES BETWEEN THESE SERVICES

3.1. ESTABLISH WOMEN-, ADOLESCENT- AND MOTHER-FRIENDLY HARM REDUCTION AND DRUG TREATMENT SERVICES

In many countries, women remain a particularly hard-to-reach population, even where harm reduction programmes are in place. [38] Women-only harm reduction or drug dependence treatment services, including child-care services and other services tailored to their specific needs, have been shown to be effective in increasing women's access. [40],[71] Community-based and peer-led programmes are particularly effective for delivering services to women who use drugs. For more information on harm reduction services for women who use drugs see the UNODC and INPUD publication Addressing the specific needs of women who inject drugs: practical guide for service providers on gender-responsive HIV service. [72]

Some groups of pregnant women who use or inject drugs, such as those released from prison, are particularly vulnerable to HIV, hepatitis and sexually transmitted infections and often face additional barriers in accessing HIV services, including for PMTCT. It is critical to set up systems to ensure the continuity of PMTCT for women who use drugs upon entering or being released from prison. [41]

3.2 INTEGRATE SEXUAL AND REPRODUCTIVE HEALTH SERVICES FOR WOMEN WHO USE DRUGS WITHIN HARM REDUCTION SERVICES

Routine testing/screening for HIV, hepatitis B and C, syphilis and other sexually transmitted infections should be offered on the premises of harm reduction or drug treatment services, using rapid tests. [73] This should be complemented by other testing modalities, such as community-based testing and self-testing, to increase access to diagnosis for women and mothers who use drugs. Referral to care and clinical follow-up can be conducted by the clinical health staff (nurses, doctors) of harm reduction services. WHO recommends that HIV testing and initiation of antiretroviral therapy be managed at opioid substitution therapy sites. [53]

Ongoing antiretroviral therapy for people who use drugs living with HIV – including pregnant and breastfeeding women – whose HIV clinical status is stable can be dispensed by harm reduction services, or by trained peers or through secondary delivery. [74]

Sexual and reproductive health care: Sexually transmitted infections and family planning services can be integrated within HIV care settings. [64] Family planning services, including voluntary contraception, should be accessible through harm reduction services. Oral emergency contraception should be provided in a timely manner to any woman or girl of reproductive age who presents with concerns following unprotected sexual intercourse.

Sexual and reproductive health care should include comprehensive information on breast and cervical cancer, prevention of cervical cancer with human papilloma virus vaccination for adolescent girls and women who use drugs, as well as screening and treatment for cervical cancer in women.

3.3 ESTABLISH LINKAGES BETWEEN HARM REDUCTION AND OTHER RELEVANT SERVICES FOR PMTCT

When specific services such as antenatal clinics, gynaecology, obstetrics or child health services cannot be delivered on the premises of harm reduction or drug dependence treatment services, strong linkages should be established, ensuring that women are referred to these services with the direct support of harm reduction services. Staff can accompany women to access sexual and reproductive health care services, antenatal clinics or HIV, hepatitis and TB clinics. Onsite peer navigators are also helpful for providing guidance, reassurance and education to patients attending these clinics.

A referral/counter-referral management system between harm reduction and other clinical and social services relevant to women who use drugs strengthens the continuity of treatment, care and support and ultimately reduces the risk of mother-to-child transmission.

Harm reduction services can also be offered when women who use drugs are referred to antenatal clinics, HIV clinics and other primary health-care services.

3.4 PROVIDE INFORMATION, COUNSELLING AND SUPPORT

Pregnant and breastfeeding women who use drugs should be provided support by harm reduction services throughout pregnancy and post-partum. Special attention should be given to adolescents who use drugs and are pregnant, considering the specific risks of pregnancy at a young age. [75],[76] Pregnant women should be advised of the health risks to themselves and to their babies posed by alcohol and other drug use. [46]

Internet-based communication through social networks, online platforms or video calls can be effective for providing support and targeted information, especially for young people [77] or for women who cannot come to the services. Social networks can also be used to create groups for information exchange and support between peers, such as pregnant women or mothers who use drugs attending harm reduction programmes.

Pregnant women and mothers who use drugs should be offered information and support, including for developing parenting skills, breastfeeding guidance, adherence to treatments, and childcare skills responding to their needs. [78],[79]

4. Planning and monitoring

↘ *RECOMMENDATION 4*: INCLUDE REPRESENTATIVES FROM THE COMMUNITY OF WOMEN WHO USE DRUGS IN STRATEGIC PLANNING, IMPLEMENTATION, MONITORING AND EVALUATION OF PMTCT SERVICES

All countries developing national plans for EMTCT should ensure that these are established in consultation with community networks and groups of women who use drugs, including those in prison, sex workers and those living with HIV. Engagement of the community is critical in the development, implementation and monitoring of plans as well as in the validation process, to ensure that plans and strategy meet the needs and preferences of women who use drugs. [80]

↘ *RECOMMENDATION 5*: ENSURE THAT PMTCT FOR WOMEN WHO USE DRUGS IS INCLUDED IN COUNTRIES' EMTCT PLANS AND MONITORING FRAMEWORKS

The monitoring and evaluation plan for EMTCT, based on WHO guidance, [5] should include specific disaggregation of indicators and targets for women who use drugs. Indicators related to national EMTCT plans should be disaggregated by key population, including women who use drugs, with adjustment of indicators according to the context. Monitoring should be developed, implemented, and analysed with the community. Assessment of the comprehensive PMTCT cascade (prongs 1-4) specific to women who use drugs could be developed to analyse progress and identify possible bottlenecks.

5. Further considerations for the way forward

5.1 STRATEGIC AND POLICY DEVELOPMENTS

To reach the last 10–15 per cent of women who are not currently covered by PMTCT programmes and services, and achieve global EMTCT of HIV, hepatitis B and C and syphilis, targeted interventions should remain a priority to ensure equitable access to services for hard-to-reach women, including women who use drugs. Effective programmes and plans require a wide-ranging multisectoral approach that includes the community, the health sector (HIV/sexually transmitted infections, sexual and reproductive health, MNCAH, drug treatment and harm reduction services) and the justice, drug control, law enforcement, prison, social and welfare sectors.

In countries with a concentrated HIV epidemic and lower prevalence in the general population, the focus should be on addressing key populations affected by the epidemic, including women who use drugs, and those in prison settings. [5] Strategies and programmes must continue to be evidence-based and respect the human rights of women who use drugs.

5.2 CAPACITY-BUILDING

Capacity-building should be emphasized in several sectors:

- Health staff in primary health, laboratory, antenatal care, obstetrics and MNCAH services should be sensitized about the specific needs of women who use drugs, and trained on relevant components of harm reduction and drug use management, such as opioid substitution therapy. Training should have a strong focus on reducing stigma and discrimination.
- Staff working in harm reduction services and within community-based organizations should be trained on sexual and reproductive health, including family planning and comprehensive PMTCT approaches. Resources should be properly allocated to these harm reduction services to ensure good coverage and quality of support and services for women who use drugs.
- Law enforcement, especially police officers, should be sensitized to the specific needs of women who use drugs and on the negative impact of punitive approaches on women's access to PMTCT services.

5.3 QUALITY ASSURANCE

To ensure quality service provision for women who use drugs, national PMTCT programme staff should supervise and monitor services, and quality assurance criteria and indicators should reflect the needs of this population. Programmes should engage with community-based organizations of women who use drugs to partner in developing indicators.

6. Resources

The following resources are foundational for this technical brief:

- WHO, UNODC, UNAIDS (2012). *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision.* Geneva: WHO.
- WHO (2016). *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update*. Geneva: WHO.
- WHO (2017). *Consolidated guideline on sexual and reproductive health and rights of women living with HIV*. Geneva: WHO.
- WHO (2017). *WHO guideline on syphilis screening and treatment for pregnant women*. Geneva: WHO.
- WHO (2020). *Prevention of mother-to-child transmission of hepatitis B virus: guidelines on antiviral prophylaxis in pregnancy*. Geneva: WHO.
- UNODC, INPUD (2016). *Addressing the specific needs of women who inject drugs: practical guide for service providers on gender-responsive HIV services*. Vienna: UNODC.
- UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAID (2017). *Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions* (the IDUIT). Vienna: UNODC.
- UNODC, UNFPA, UN WOMEN, WHO (2019). *Prevention of mother-to-child transmission of HIV in prisons: technical guide*. Vienna: UNODC.

These resources will also be of use to policymakers, programme managers and health-care providers:

- UNFPA (2012). *Preventing HIV and unintended pregnancies: strategic framework 2011-2015*. New York: UNFPA.
- UNODC, UNWOMEN, WHO, INPUD (2015). *Policy brief: women who inject drugs and HIV: addressing specific needs*. Vienna: UNODC.
- WHO (2014). *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. Geneva: WHO.
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6. Start Free Stay Free AIDS Free framework. Joint United Nations Programme on HIV and AIDS, U.S. President's Emergency Plan for AIDS, et al., 2016 (*https://free.unaids.org/*, accessed 7 December 2020).
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V.21-01324