IMPACT OF HARM REDUCTION SERVICES DISRUPTION ON WOMEN, ETHNIC MINORITY GROUPS AND INDIGENOUS PEOPLE WHO USE DRUGS

NOVEMBER 2022

HARM REDUCTION INTERNATIONAL

Harm reduction is fundamentally grounded in principles that aim to protect human rights and improve public health.

Acknowledgements

This briefing has been developed using data from surveys, interviews, and academic and grey literature. The analysis and writing was led by Temitope Salami and supported by Shenae Jonas on behalf of Harm Reduction International (HRI), with data and inputs from Sam Shirley-Beavan, Robert Csak, Colleen Daniels and Naomi Burke-Shyne. HRI acknowledges the contributions of Ruth Birgin and Wangari Kimemia, WHRIN; Rhiannon Thomas, COUNTERfit; Becky Fleming, SJSOWC; Catherine Mwangi, Women Nest; Stacey Doorly-Jones, STAND; Bernice Apondi, VOKAL Kenya; Hamimu Masudi, Health Poverty Action; Murdo E. Bijl, AHRN, Myanmar; Esther Alenge Myambano, Indigenous Women for Health and Equality; Happy Assan TaNPUD; Shawn McGregor, RISE Jamaica; Uki Atkinson, NCDA Jamaica; and Tom Muyunga-Mukasa, Advocacy Network Africa. Ann Noon edited this paper.

Special thanks are due to Robert Carr Fund for their strategic partnership and providing the grant that led this research.

Introduction

Women, ethnic minority groups and Indigenous people who use drugs have been adversely affected by the spread of COVID-19. The introduction of swift executive orders and restrictions on movement by national governments may have contributed significantly to multiple challenges women have faced.[1] In Indonesia, Kenya and South Africa, women experienced victimisation[1] and violent treatment from family, intimate partners and law enforcement.[3–6] Indigenous people suffered stigma from the community and, together with women who use drugs, experienced discrimination, harassment and exploitation by the police and healthcare workers.[4–10] Other challenges affecting the health and rights of women, ethnic minority groups and Indigenous people who use drugs include limited access to quality health and social services, experiences of homelessness and the loss of social bonds and food security.[1,6,10–13]

Availability and accessibility of harm reduction services for women, ethnic minority groups and Indigenous people are hindered notably by structural violence and stigma that result from patriarchal social norms and attitudes compounded by other identities such as poverty, class, race, ethnicity, and sexuality as well as a lack of harm reduction services attuned to their needs. This is apparent in the greater stigma faced by women who use drugs compared with men.[14]

Many women, LGBTQI+ people and ethnic minority communities were isolated during the pandemic and did not access HIV and harm reduction services due to lockdown restrictions and transport difficulties.[5–7,10,15,16] During lockdown, many outreach services were paused and activities that kept women connected were significantly halted.[1,17] Worse still, paucity of harm reduction funding limited opportunities for service adaptations to meet the needs of women.[13]

Generally, people who use drugs had minimal access to health services owing to healthcare worker shortages and limited contact with clients during the pandemic. This was particularly true for women, ethnic minority groups and Indigenous people as specific services for these demographics are limited and they are often not prioritised in harm reduction programming.[4] Moreover, a lack of trust in healthcare workers and experiences of structural stigma and racism increased during COVID-19.[1] These factors were compounded by changes in the drug supply, with the proliferation of toxic, illicit drugs together with limited access to drug checking, supervised consumption, in-person treatment and longer periods of isolation which have led to higher incidences of drug overdose and overdose-related deaths.[4,11,17]

Nevertheless, the pandemic provided a window of opportunity for positive change as many services initiated rapid adaptations[17] such as increased peer-led

[1] Victimisation is the process of being victimised, either from a physical or a psychological or a moral or a sexual point of view.[2] In this instance, women experienced physical abuse, sexual abuse, assault in domestic and community settings and, in some cases, from law enforcement.

outreach, provision of food, temporary shelters, personal protective equipment (PPE), information sharing and peer support.[4,6,13] Community and civil society demonstrated strong leadership and a duty of care through advocacy which mitigated the negative outcomes for women, ethnic minority groups and Indigenous people.

Women, Ethnic Minority Groups and Indigenous people who use drugs faced multiple barriers to services

Women, ethnic minority groups and Indigenous people who use drugs are faced with many barriers to accessing harm reduction services such as stigma, gender-based and structural violence, criminalisation, incarceration and limited gender-responsive and gender-affirming services.[14,18] The latest global systematic review of the epidemiology of people who inject drugs shows that there are approximately 2.8 million women who inject drugs globally,[19,20] and research indicates that more women than men are at greater infection risk from both HIV and viral hepatitis, with the highest burden seen in Africa, Eastern Europe, Latin America and Southeast Asia.[18,21–23]

COVID-19 created conditions which increased existing barriers. Notably, lockdown expanded health, political and socioeconomic disparities. Women who use drugs are particularly vulnerable due to criminalisation and stigma.[24] A global survey by the International Network of People Who Use Drugs (INPUD) reported women who use drugs faced multiple challenges to health and support services with only 15% having access to women-specific programmes such as sexual and reproductive health services and childcare.[25] Further studies indicate that emergency powers[2] were disproportionately used by governments and law enforcement meting out violence towards Indigenous, Black and Brown people, women who use drugs, sex workers, people experiencing mental health issues, and trans people.[26] Women and Indigenous people who use drugs endured violent treatment in particular from intimate partners and law enforcement mostly due to homelessness and the need to obtain drugs.[27]

In the United Kingdom and the United States, Black and Brown people were not prioritised for care during the pandemic and were 8-10 times more at risk of being affected by COVID-19 than the white majority.[28,29] The syndemic of COVID-19 and the opioid crises in these countries has also increased the harms experienced by women, ethnic minority groups and Indigenous people who use drugs, with limited access to pre-exposure prophylaxis (PrEP), naloxone, drug checking, supervised consumption, sterile syringes, methadone and psychosocial support, further demonstrating the effect of COVID-19 on expanding health disparities.[29,30]

The impact on women, Indigenous people and migrants in the Middle East and North Africa has been disparate. In Aden (Yemen) for example, the government and civil society did not provide access to COVID-19 prevention and treatment for people who use drugs.[31]

[2] Emergency powers can be defined as executive orders given to law enforcement to implement laws and regulations during a state of emergency. Harm Reduction International advocates for such laws and regulations to be proportionate, legal and justified to the crisis at hand. Special protections for inalienable rights of vulnerable communities must be safeguarded and mainstreamed in such measures.[26]

The crisis further exacerbated the vulnerabilities of Indigenous women and ethnic minorities, particularly those living in remote hard-to-reach locations, limiting access to harm reduction services. Low coverage heightened the difficulties in accessing safe and regular treatment. These factors reinforced the harms already faced, further driving many women underground.[29,32–34] Furthermore, the global lockdown shifted the treatment landscape considerably. Low-threshold services, including services led by peers, reported staff absences due to illness and burnout, and increased homelessness and isolation among clients.[7,17,30,35]

SPOTLIGHT: CANADA

"COUNTERfit attributes its success during COVID-19 to the fact that most staff are peers with salaries and benefits."

COUNTERfit in Ontario found that, during lockdown, services that kept women connected were stopped. Government restrictions, together with staff shortages, contributed to increased feelings of isolation and an increase in overdose cases among service users. Community-based satellites, mobile services, needle and syringe programmes and drug consumption rooms (safer consumption sites) continued at limited capacity, while routine community outreach and drop-ins, and group sessions were suspended. However, since July 2022, full-scale services have been restored on site and 'at-the-door' screening for COVID-19 has been stopped."[1,17]

During lockdown, Indigenous women and those from Afro-Caribbean and Latin American communities reported being more unwilling to access services due to risk of undue scrutiny by social workers, health clinicians and child welfare authorities – based on knowledge of cases where the state removed children from their families. For example, in Toronto, some services for Indigenous people such as HIV organisations that have some cultural awareness require abstinence from women accessing their services.[1]

COUNTERfit provided resources for women with experience of homelessness who use drugs, had COVID-19 and were largely excluded from already overcrowded shelters. By using drivers from its suspended service for senior citizens, COUNTERfit organised mobile outreach and home visits. A few women who had appointments were permitted to use the service centre once a week. They received training to make harm reduction and COVID-19 prevention kits and were provided with food, transit tokens and stipends to support themselves. This initiative created opportunities to meet with peers and programme staff, reducing the possibility of harmful drug use heightened by isolation.

To reduce stigma and discrimination, and to encourage service uptake, some programmes were integrated to include supervised drug consumption, hepatitis C diagnosis and treatment and safer supply of drugs. Midwives were also available to assist pregnant and parenting women with antenatal services and childcare needs. Referral links to other service providers such as housing and social services created opportunities. However, a lack of formal partnerships with housing, health and legal services created suspicion among clients owing to past instances of unfair treatment.

COUNTERfit attributes its success during COVID-19 to the fact that most staff are peers with salaries and benefits. Currently the programme has 16 staff members (nine women and seven men), and COVID-19 provided a window to access funding for safer drug supply programmes while budgets from suspended programmes where repurposed to provide essential items such as food and sanitary products to women and other service users.

Stay-at-home orders and physical distancing rules negatively impacted harm reduction service accessibility and coverage

Government orders to stay at home presented a particular risk for women, ethnic minority groups and Indigenous people who use drugs.[36] Recent studies report increased drug use and opioid overdoses among people who use drugs during the pandemic, specifically with women and rural communities disproportionately affected.[37–40] In three US states (Illinois, Indiana and Kentucky) for example, potential factors underlying this trend include risky opioid use behaviours such as using alone, changing dealers, more intense use, greater adulteration of illicit drug supply, disrupted treatment and service access leading to increased relapse risk.[41] Furthermore, lockdown exacerbated structural barriers to accessing harm reduction services such as lack of public transport, insufficient supplies of syringes and overdose prevention materials.[42] Reports from Asia indicate that measures introduced impeded upon rights, raising concerns about legality, proportionality and effectiveness of lockdown measures.[43]

Despite the generally negative effect of COVID-19 restrictions on movement for access to services, some jurisdictions have taken proactive steps to address the problem. In Dublin (Ireland), the government, in partnership with non-

governmental organisations (NGOs) and harm reduction services, developed a framework for the management and provision of housing and lower threshold provision of naloxone, methadone, and benzodiazepine – emphasising the benefits of adopting a harm reduction approach to drugs in order to prevent avoidable deaths and overdose.[45]

In Eastern Canada, the St. John's Status of Women Council (SJSOWC) reported that lockdown restrictions negatively impacted harm reduction service delivery in Newfoundland and Labrador due to less contact between providers and clients. Higher incidences of overdose, changes in the drug supply, limited access to clean drugs, community isolation due to transportation and communication challenges (many people could not afford a mobile phone) all impacted accessibility and coverage of services.

After the onset of COVID-19, SJSOWC introduced a SWAP satellite site providing commodities for drug use and safer sex (condoms, PrEP, sterile syringes). SJSOWC became the only SWAP satellite site provider in the province without a requirement for in-person meetings in order to receive commodities. It introduced a mailbox with instructions outside the building; the mailbox was restocked several times a day and was accessible to clients and non-clients without identity checks. It became the busiest satellite in the city, leading the way for other services.

To ensure that clients remained connected to care and community services, counselling at the SJSOWC women's centre switched to a virtual and phone service which continued even after lockdown restrictions ended, thus providing all three service options: virtual, phone, and in-person. The SJSOWC housing programme Marguerite's Place, which provides supportive housing, suspended group programming during the first wave of the pandemic but, by the second wave, adapted by providing virtual peer support sessions (and the technology to access these) with other residents. Another COVID-19 shift involved advocating for the provincial government to provide COVID-19 rapid test kits, which resulted in SJSOWC gaining access to several thousand test kits that were distributed to women at no cost. In addition, the service engaged in community-wide advocacy for other organisations and community residents to have access to COVID-19 rapid tests.[11]

"SJSOWC employs and pays women and non-binary individuals to work as peer leaders. Peer leaders facilitate groups, offer individual support, and provide additional assistance to the organisation's administrative functions."

SJSOWC serves all women, including women from ethnic minorities and Indigenous communities, and non-binary and transwomen. The service employs and pays women and non-binary individuals to work as peer leaders. Peer leaders facilitate groups, offer individual support, and provide additional assistance to the

organisation's administrative functions. SJSOWC prioritises individuals with lived experience in all hiring including its volunteer programme.

Services are well integrated to multiple programmes although no services are a one-stop shop. SJSOWC is well linked to other organisations, including the regional health authority for nursing services. Differences in approaches between SJSOWC and referral organisations create challenges; for example, SJSOWC reports some healthcare workers appear hostile and use stigmatising language towards people who use drugs. Some organisations do not accept clients who use drugs.

Prisons

In closed and custodial settings, Harm Reduction International (HRI) reported in 2020 that people detained for drug offences were excluded from decongestion measures adopted by prisons, including for women, in 12 countries (Afghanistan, Belarus, Chile, Colombia, Costa Rica, Kyrgyzstan, Nigeria, Peru, Rwanda, Turkey, Uganda, and the United Kingdom [England and Wales]) with confirmed cases of COVID-19 infection and death in custody.[43] Incarceration (and exclusion from decongestion measures) further increases the risk of HIV, tuberculosis, hepatitis C, and poor mental health.[43] Women have made up a higher percentage of prison entrants - 33% over the past 20 years compared to 25% of men in the same period; and people from ethnic minority and Indigenous communities are overrepresented in the criminal justice system.[44] Prisons have been accorded low priority in many COVID-19 vaccination plans; *Global Prison Trends 2022* reports only 43% of 131 countries included people in prison in their vaccination plans.[44,45]

Community-led harm reduction service providers adapted quickly in response to the needs of women, ethnic minority groups and Indigenous people

In Myanmar, the political instability and civil unrest brought on by the Tatmadaw military coup that began in February 2021 added further complexity to service delivery during lockdown. Nevertheless, the Asian Harm Reduction Network (AHRN) exemplified resilient and dynamic integrated women-centred harm reduction service provision in this period through a project with support from the USAID HIV/AIDS Flagship Project. The programme focuses on provision of safe spaces for women who use drugs and other at-risk women to access peer support and harm reduction services. A comprehensive package of harm reduction services that includes women-specific health service provision such as counselling on safer sex and safer drug use behaviours, psychosocial support, outreach services, and employment support was initiated during lockdown.

Information and awareness raising focused on social media campaigning, covering topics such as harm reduction principles, stigma and discrimination towards women who use drugs and drug use from the point of view of community members. Staff and service providers were trained on the health and social needs of women who use drugs to improve service delivery for women in their communities. Despite COVID-19 and the political crisis in Myanmar, more than 500 women have benefited from outreach and gender-sensitive harm reduction services.[46]

A study of street outreach programmes across five continents during the pandemic reports on innovative service modifications to adapt to COVID-19 circumstances, including expanded use of telehealth services. For example, telemedicine visits for buprenorphine; virtual individual or group therapy sessions, and provision of mobile phones; increased take-home medication allowances for methadone and buprenorphine; expanded uptake of long-acting opioid medications (such as extended-release buprenorphine and naltrexone); home delivery services together with the provision of naloxone and safer supply opioids.[35]

Although challenges with service adaptions persist (such as low funding, nascent research and guidelines etc.), accelerated innovations through knowledge sharing and technology use by low-threshold peer-led services provide lifesaving treatment options and programme accessibility has developed as a useful alternative to in-person treatment, especially to women, ethnic minority groups and Indigenous people who use drugs in remote locations.[34,47]

“STAND has a network of Indigenous women’s groups in rural communities that provides assistance and psychosocial support to peers.”

In South Africa, the decision by the government to initiate a national lockdown on 23 March 2020 disproportionately affected key populations. There was an

increased demand for homeless shelters and harm reduction services for people who use drugs, specifically women in rural communities and sex workers.

Together with partners in the Western Cape province, STAND Action (STAND) – a community-based organisation – commissioned special projects to advocate for women through women-centred education, gender-based violence treatment and support, training for community responders and capacity building for service providers within community shelters on harm reduction principles and practices. In partnership with other local civil society groups, STAND provided COVID-19 rapid tests, masks, hand sanitisers, clothing, menstrual products, shelter, and gender-based violence services in the Western Cape province to support Indigenous women (specifically the San and Khoekhoe previously known as the Griqua) who use drugs and alcohol.

In a positive development in June 2022, law enforcement in the Western Cape agreed for the first time to engage in harm reduction training.

Work with Indigenous women in rural communities

During the COVID-19 pandemic, violence against Indigenous women and women who use drugs increased considerably. STAND understood that Indigenous women in rural communities have very limited access to shelters and community care in South Africa. For example, in the Langeberg region of the rural Northern and Western Cape there are no treatment services available to people who use drugs, with women mostly at the receiving end. STAND, in collaboration with the South African Network of People Who Use Drugs (SANPUD) and the United Nations Office on Drugs and Crime (UNODC), trained over 200 community members (mostly women) on effective ways to work with rural communities through a harm reduction lens to provide care and support for women who use drugs and women dealing with trauma associated with gender-based violence. Now, STAND has a network of Indigenous women's groups in rural communities that provides assistance and psychosocial support to peers. Although the women are not directly employed, they receive stipends and some form of employment support (such as practical, easy-to-implement onsite training as critical community role players or peer supporters).

Spain experienced a notable decrease in harm reduction services during lockdown - an average of twenty-two percent across the country.[36] Community and civil society organisations responded swiftly,

including by increasing operating hours. Services reported a decline in needle and syringe distribution and testing rates for HIV, hepatitis C and tuberculosis. This meant that fewer clients accessed services, putting them at higher risk of unsafe practices like sharing syringes, polydrug use and overdosing.[36]

Women experienced increased harmful patterns of drug use and violent treatment

According to the World Drug Report 2022, women who use drugs may have been negatively affected by COVID-19 due to increased domestic, sexual and physical violence. Unhealthy patterns of drug use increased during the pandemic and although women account for over forty percent of people using pharmaceutical drugs for non-medical purposes and nearly 50% of people using amphetamine-type stimulants (ATS), only 1 in 5 in treatment for ATS is a woman.[49] An INPUD survey on COVID-19 and people who use drugs found that in Zambia, government shelters and social welfare schemes initiated during the pandemic excluded women actively using drugs, many of whom were already victims of stigma and gender-based violence.[27] In Malaysia, service provision was so inadequate due to lockdown rules and supply chain delays that women who use drugs resorted to lowering drug use (leading to withdrawals) as a consequence of shortages in the drug supply. A survey respondent in Malaysia noted that female sex workers who use drugs experienced increased threats of violence including *"demands of quick sex"* and being *"forced to beg for money by partners due to less sex work or face beatings."*[27]

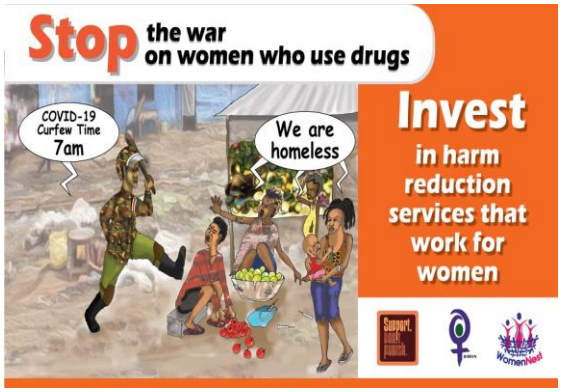
In some countries, governments issued executive orders to restrict movement and relied heavily on law enforcement to carry out public health guidelines. In 2021, HRI's analysis of five Asian countries (Indonesia, Malaysia, the Philippines, Singapore, and Sri Lanka) revealed an over-militarisation of the interministerial 'national task force' set up to address the crises. In Indonesia, the Philippines and Sri Lanka, the COVID-19 response was dominated by military or former military personnel with limited (if any) public health training. Hence, COVID-19 health protocols (social distancing, mask wearing, temperature checks and quarantine management) were enforced by the police and military. People found in violation of these rules (often communities of people who use drugs, homeless people and women in sex work, and migrants) were targeted for punishment ranging from physical threats and beatings to public humiliation and detention.[43]

Women Nest in Nairobi (Kenya) found that women experienced high levels of gender-based violence and homelessness while harm reduction services were not fully operational during COVID-19 lockdown. Increased police raids to enforce lockdown measures meant that many women, including sex workers, dropped out of, or were unable to access harm reduction programmes. Access to COVID-19 information, testing and treatment was limited and, due to self-stigma, many women avoided the services that were available.

In response to this, Women Nest used three shelters in informal settlements in Nairobi to enable women to escape violence and abuse from intimate partners, police, and others. These shelters remain operational although the overwhelming

number of women who need these services means that women are only allowed to stay between four to six weeks at a time. However, special provisions are available for pregnant women and mothers to remain for longer periods of time. Women Nest partners with peer educators (many of whom are receiving methadone) to provide peer support and a sense of community around women in shelters.

Furthermore, Women Nest works to establish a strong link to empower women



"Women Nest used three shelters in informal settlements in Nairobi to enable women to escape violence and abuse from intimate partners, police, and others."

through 'sustainable livelihoods'[3] to help reduce the risks of acquiring HIV and provide services that positively impact the lives of women. As stated by the convener: *"Women need to have a voice and be empowered beyond being peer educators…"* The organisation also provides capacity building and training workshops for women to become decision makers and role models in their communities. Unfortunately, funding remains a challenge for expanding programming in these areas.

In Canada during the pandemic, six provinces and territories recorded increased fatal overdoses and related harms among people who use drugs due to a rapidly changing drug supply. A high proportion of these fatalities involved both stimulants and opioids.[48] Regrettably, most of the data reported were among males as services are better suited to the needs of men, underscoring the point on limited availability of data to inform service provision and coverage for women.

[3] DFID defines a sustainable livelihood based on capabilities, assets (both material and social resources) and activities required for living. A livelihood is sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining natural resource bases.[50]

In Uganda, women experienced violent treatment and increased levels of domestic abuse during the pandemic. Some of the major drivers of abuse from intimate partners and family members were reported to be fear of falling ill, facing economic pressure and being confined indoors under stay-at-home orders.[51]

Conclusion

COVID-19 impacted negatively on harm reduction services for women, ethnic minority groups and Indigenous people who use drugs. Community and civil society, particularly low-threshold services and peers, responded to the needs of women despite the shortage of supplies and limited funding for harm reduction. Key to this was understanding the barriers faced by women, ethnic minority and Indigenous groups, recognising their specific vulnerability to violence, and prioritising lived experience and peer-led services in programme design and implementation. There are strong examples of innovation and adaptation in Africa, Asia, Europe and North America; these examples demonstrate the important work that community and civil society continue to do to improve availability, accessibility, acceptability and quality of services.

Women, ethnic minority groups and Indigenous people who use drugs are stigmatised and pathologised; these experiences curtail and disrupt their access to essential harm reduction services. Women-centred and culturally appropriate services that are integrated to address multiple needs are imperative.

“There are strong examples of innovation and adaptation in Africa, Asia, Europe and North America; these examples demonstrate the important work that community and civil society continue to do to improve availability, accessibility, acceptability and quality of services.”

Recommendations

- Maintain harm reduction services in the community and in prisons throughout public health emergencies. COVID-19 has revealed the importance of harm reduction services, including in prison. Harm reduction services (including for women, ethnic minority groups and Indigenous people) must therefore be recognised as essential and included in basic healthcare packages and future pandemic responses.
- Peer-led low threshold and community-based responses have been vital in sustaining access to services during the pandemic, and can help limit the structural violence and the harms experienced by women, by providing adequate support from a lived experience lens.
- Governments must commit to consistent training for healthcare workers on harm reduction and on addressing stigma and discrimination, and to supporting tailored services for women, ethnic minority groups and Indigenous people who use drugs.
- Services for women, ethnic minority groups and Indigenous people should be expanded, integrated, need-based, person-centred and life-enhancing. People should not be required to stop drug use to access services. Integrated harm reduction services understand the challenges women, ethnic minority groups and Indigenous people face when accessing external services and can ensure that clients are referred to the most appropriate options.
- Invest in harm reduction programming that supports women, ethnic minority groups and Indigenous people who use drugs. It is essential to safeguard funding and support for community-led initiatives and civil society organisations to ensure person-centred services are available and drug use trends are consistently monitored and adequately reported.

References

1. Thomas R. Impact of harm reduction services on women who use drugs and Indigenous people interview response (Canada). 2022.

2. Muratore MG. Victimiation [Internet]. In: Michalos AC, editor. Encyclopedia of Quality of Life and Well-Being Research. Dordrecht: Springer Netherlands; 2014 [cited 2022 Oct 5]. page 6917–21. Available from: https://doi.org/10.1007/978-94-007-0753-5_3156

3. HRI, UNODC. Tailoring Vccination Campaigns and COVID-19 Services for People Who Use Drugs - Technical Guidance. Capacity building package, video testimonials. ahead-of-publication. [Internet]. Harm Reduct. Int.2022 [cited 2022 Oct 5]. Available from: https://www.hri.global/contents/2219

4. Mwangi C. Impact of harm reduction services on women who use drugs and Indigenous people interview response (Kenya). 2022.

5. Apondi B. Impact of harm reduction services on women who use drugs and Indigenous people survey response (Kenya). 2022.

6. Doorly-Jones S. Impctof harm reduction services on women who use drugs and Indigenous people interview response (South Africa). 2022.

7. Mwangi C. Impact of harm reduction services on women who use drugs and Indigenous people survey response (Kenya). 2022.

8. Doorly-Jones S. Impact of harm reduction services on women who use drugs and Indigenous people survey response (South Africa). 2022.

9. AHRN. AHRN-Myanmar/USAID HIV&AIDS Flagship Fund Women Who Use Drugs Project Assessment April 2022. 2022.

10. Alenge Myambano E. Impact of harm reduction services on women who use drugs and Indigenous people survey response (DR Congo). 2022.

11. Fleming B. Impact of harm reduction services on women who use drugs and Indigenous people email response (Canada). 2022.

12. Fleming B. Impact of harm reduction services on women who use drugs and Indigenous people survey response (Canada). 2022.

13. Country examples of COVID HR responses for WUD [Internet]. WHRIN [cited 2022 Oct 26]. Available from: https://whrin.site/ourpublication/country-examples-of-covid-hr-responses-for-wud/

14. HRI. Barriers to Harm Reduction for Women Who Use Drugs [Internet]. Harm Reduct. Int.2020 [cited 2022 Jun 29]. Available from: https://www.hri.global/contents/2041

15. Muyunga-Mukasa T. Impact of harm reduction services on women who use drugs and Indigenous people survey response (United States). 2022.

16. Happy E. Impact of harm reduction services on women who use drugs and Indigenous people survey response (Tanzania). 2022.

17. Thomas R. Impact of harm reduction services on women who use drugs and Indigenous people survey response (Canada). 2022.

18. Shirley-Beavan S, Roig A, Burke-Shyne N, Daniels C, Csak R. Women and barriers to harm reduction services: a literature review and initial findings from a qualitative study in Barcelona, Spain. Harm Reduct J 2020;17(1):78.

19. Degenhardt L, Webb P, Colledge-Frisby S, Ireland J, Wheeler A, Ottaviano S, et

al. Prevalence, sociodemographic characteristics, risk environments and injecting-related harm. The Lancet Global Health. Lancet Glob Health 2022.

20. Colledge-Frisby S, Ottaviano S, Webb P, Wheeler A, Grebely J, Cunningham E, et al. The global coverage of interventions to prevent and manage drug-related harms among people who inject drugs: A multi-stage systematic review of the evidence. Lancet Glob Health 2022.

21. Des Jarlais DC, Feelemyer JP, Modi SN, Arasteh K, Hagan H. Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas. Drug Alcohol Depend 2012;124(1–2):95–107.

22. WHO. Hepatitis C [Internet]. 2022 [cited 2022 Sep 19]. Available from: https://www.who.int/news-room/fact-sheets/detail/hepatitis-c

23. UNODC and UNAIDS. Facts about Drug Use and the Spread of HIV [Internet]. 2010. Available from: https://www.unodc.org/documents/frontpage/Facts_about_drug_use_and_the_spread_of_HIV.pdf

24. Chang J, Agliata J, Guarinieri M. COVID-19 - Enacting a 'new normal' for people who use drugs. Int J Drug Policy 2020; 83:102832.

25. INPUD online survey on COVID-19 and people who use drugs data report [Internet]. [cited 2022 Sep 1]. Available from: https://idpc.net/publications/2020/07/inpud-online-survey-on-covid-19-and-people-who-use-drugs-data-report

26. The Securitisation of COVID-19 Health Protocols: Policing the Vulnerable, Infringing Their Rights [Internet]. Harm Reduct. Int. [cited 2022 Sep 20]. Available from: https://www.hri.global/contents/2163

27. INPUD. INPUD ONLINE SURVEY ON COVID-19 & PEOPLE WHO USE DRUGS (PWUD) DATA REPORT 2 (August 2020) [Internet]. 2020. Available from: https://inpud.net/wp-content/uploads/2022/01/COVID-19-Survey-Data-Report-2_0.pdf

28. Smith K, Bhui K, Cipriani A. COVID-19, mental health and ethnic minorities. Evid Based Ment Health 2020;23(3):89–90.

29. Rosales R, Janssen T, Yermash J, Yap KR, Ball EL, Hartzler B, et al. Persons from racial and ethnic minority groups receiving medication for opioid use disorder experienced increased difficulty accessing harm reduction services during COVID-19. J Subst Abuse Treat 2022; 132:108648.

30. Mistler CB, Curley CM, Rosen AO, El-Krab R, Wickersham JA, Copenhaver MM, et al. The Impact of COVID-19 on Access to HIV Prevention Services Among Opioid-Dependent Individuals. J Community Health 2021;46(5):960–6.

31. Van Hout MC, Haddad P, Aaraj E. The Impact of COVID-19 on Drug Use and Harm Reduction Programming in the Middle East and North Africa (MENA) Region: A Regional Consultation of Stakeholders and People Who Use Drugs. Int J Ment Health Addict 2021;1–14.

32. Thakarar K, Kohut M, Hutchinson R, Bell R, Loeb HE, Burris D, et al. The impact of the COVID-19 pandemic on people who inject drugs accessing harm reduction services in a rural American state. Harm Reduct J 2022;19(1):80.

33. Nutter KJ. Substance Use in Rural Areas: A Narrative Concerning the Care, Treatment, and Stigma of Rural Substance Users. 2022; 3:16.

34. Jacka BP, Janssen T, Garner BR, Yermash J, Yap KR, Ball EL, et al. Impacts of the COVID-19 pandemic on healthcare access among patients receiving medication for

opioid use disorder. Drug Alcohol Depend 2021; 221:108617.

35. Krawczyk N, Fawole A, Yang J, Tofighi B. Early innovations in opioid use disorder treatment and harm reduction during the COVID-19 pandemic: a scoping review. Addict Sci Clin Pract 2021;16(1):68.

36. Picchio CA, Valencia J, Doran J, Swan T, Pastor M, Martró E, et al. The impact of the COVID-19 pandemic on harm reduction services in Spain. Harm Reduct J 2020;17(1):87.

37. Nguyen TT, Hoang GT, Nguyen DQ, Nguyen AH, Luong NA, Laureillard D, et al. How has the COVID-19 epidemic affected the risk behaviors of people who inject drugs in a city with high harm reduction service coverage in Vietnam? A qualitative investigation. Harm Reduct J 2022;19(1):6.

38. Nguyen T, Buxton JA. Pathways between COVID-19 public health responses and increasing overdose risks: A rapid review and conceptual framework. Int J Drug Policy 2021; 93:103236.

39. Bolinski RS, Walters S, Salisbury-Afshar E, Ouellet LJ, Jenkins WD, Almirol E, et al. The Impact of the COVID-19 Pandemic on Drug Use Behaviors, Fentanyl Exposure, and Harm Reduction Service Support among People Who Use Drugs in Rural Settings. Int J Environ Res Public Health 2022;19(4):2230.

40. Rosenbaum J, Lucas N, Zandrow G, Satz WA, Isenberg D, D'Orazio J, et al. Impact of a shelter-in-place order during the COVID-19 pandemic on the incidence of opioid overdoses. Am J Emerg Med 2021; 41:51–4.

41. Dir AL, Tillson M, Aalsma MC, Staton M, Staton M, Watson D. Impacts of COVID-19 at the intersection of substance use disorder treatment and criminal justice systems: findings from three states. Health Justice 2022;10(1):25.

42. Seaman A, Leichtling G, Stack E, Gray M, Pope J, Larsen JE, et al. Harm Reduction and Adaptations Among PWUD in Rural Oregon During COVID-19. AIDS Behav 2021;25(5):1331–9.

43. Harm Reduction International, Asia Centre. WAGING WAR AGAINST COVID-19: The Securitisation of Health Responses in Five Asian Countries. 2021;6.

44. HRI. COVID-19, Prisons and Drug Policy [Internet]. Harm Reduct. Int.2020 [cited 2022 Aug 4]. Available from: https://www.hri.global/covid-19-prison-diversion-measures

45. O'Carroll A, Duffin T, Collins J. Harm reduction in the time of COVID-19: Case study of homelessness and drug use in Dublin, Ireland. Int J Drug Policy 2021; 87:102966.

46. UNODC and HRI. Tailoring Vaccination Campaigns and COVID-19 Services for People Who Use Drugs Technical Guidance (pending publication). 2022.

47. Mark TL, Treiman K, Padwa H, Henretty K, Tzeng J, Gilbert M. Addiction Treatment and Telehealth: Review of Efficacy and Provider Insights During the COVID-19 Pandemic. Psychiatr Serv 2022;73(5):484–91.

48. Opioid- and Stimulant-related Harms in Canada [Internet]. [cited 2022 Aug 6]. Available from: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

49. World Drug Report 2022 [Internet]. U. N. Off. Drugs Crime [cited 2022 Jul 21]. Available from: //www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2022.html

50. Sustainable livelihoods | Guide for Monitoring and Evaluating Land Administration Programs | Food and Agriculture Organization of the United Nations [Internet]. [cited 2022 Sep 19]. Available from: https://www.fao.org/in-

action/herramienta-administracion-tierras/module-1/proposed-methodology/sustainable-livelihoods/en/

51. Miller AP, Mugamba S, Bulamba RM, Kyasanku E, Nkale J, Nalugoda F, et al. Exploring the impact of COVID-19 on women's alcohol use, mental health, and experiences of intimate partner violence in Wakiso, Uganda. PLOS ONE 2022;17(2): e0263827.

"Women, ethnic minority groups and Indigenous people who use drugs are stigmatised and pathologised; these experiences curtail and disrupt their access to essential harm reduction services. Women-centred and culturally appropriate services that are integrated to address multiple needs are imperative."