Women who use drugs: intersecting injustice and opportunity

Advocacy Brief

Women and Harm Reduction International Network

At least one third of all people who use drugs are women: An estimated 88 million women use drugs worldwide including millions who inject drugs[1]

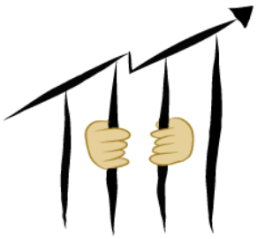
Higher disease burden

Women who use drugs were more likely to be living with HIV and have higher mortality rates than their male peers[3]

Women who inject drugs have significantly higher Hepatitis C Virus associated risk exposures than men[4]

Bangkok Rules undermined

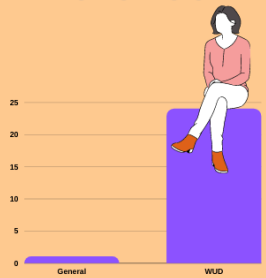
The number of women in prison increased by 50% between the year 2000 and the year 2015.[1]



- 714000 women are prisoners globally, with 35% serving drug related sentences (much higher than the 19% among men[2])
- 76 out of the 83 women on death row in Thailand are sentenced for drug offences[2]
- Imprisoned women have less access to opiate agonist treatment than male prisoners[6]

Gender-Based Violence

Women who use drugs subject to rates of violence 24 times that experienced by women who do not[5]



Gender impact of prohibition

- Higher levels of social disapproval, stigma and discrimination
- Worse access to harm reduction and treatment services
- Less control over access to drugs and injecting equipment
- Victimised and punished in gendered ways[1]

Gender inequality

Harm reduction services are generally designed for men or gender blind.

Approaches used are rarely relevant to the needs of women[1]

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Introduction

Gender inequality and punitive drug policy have combined to create intersecting injustices where women who use drugs (WUD) face daily barriers to realising basic rights including the attainment of health and safety. WUD experience high rates of imprisonment, stigma, discrimination, sexual and gender-based violence (SGBV) and inadequate access to clinical and social services.

While more men than women use drugs, globally the gap is narrowing.[7] Even today, the numbers of WUD are substantial, making inaction around gender-sensitive harm reduction provision inexcusable. Prevalence of HIV among WUD is higher than among men who use drugs.[8] In 30 countries reporting data on women who inject drugs, the pooled HIV prevalence among women was 13% compared to 9% among men.[9] Drug prohibition, disproportionate rates of incarceration, stigma and discrimination, gender inequality and SGBV,[10] combine to greatly disadvantage WUD. These factors that increase the risk of HIV transmission for WUD are compounded by biological and structural factors and further exacerbated by limited access to HIV and sexual and reproductive health (SRH) services.[11] Women are being incarcerated for drug offences at accelerated rates while prisons, particularly women's prisons, lack harm reduction services.[12] Meanwhile, service providers and governments remain largely 'gender blind' to factors that increase health risks for WUD and service adjustments that would address those risks.

WUD are too often unrepresented at the table in discussions about women's rights and must be meaningfully involved in the creation of policies and programmes impacting their community. To align with the principle of Greater Involvement of People with AIDS (GIPA) as endorsed by the United Nations in 2001,[13] women living with HIV and WUD (including trans women, gender non-binary women and sex workers) must be meaningfully involved in the design, delivery, monitoring and evaluation of services. This should be the cornerstone of policy and practice to meet the health and other needs of WUD, in all their diversity.[14]

This advocacy brief highlights areas of public health and social concern regarding WUD and their access to HIV prevention, testing and treatment and other harm reduction services. The paper underscores a shared recognition that it is time to hear the voices of WUD in order to truly put substance behind intention to 'leave no woman behind'.[15] This advocacy paper, while not attempting an exhaustive overview, provides specific guidance as well as broader recommendations as part of an effort to further facilitate momentum for change.

The gendered impact of prohibition

In 2018, the United Nations Chief Executive Board unanimously supported the United Nations system common position reaffirming the importance of a human-centred and rights-based approach firmly anchored by the 2030 Agenda. The common position also stressed the special needs and circumstances of women and the need to integrate a gender perspective when addressing drug related issues. Directions for action include: " *…to promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use, and to promote the principle of proportionality, to address prison overcrowding and overincarceration by people accused of drug crimes, to support implementation of effective criminal justice responses that ensure legal guarantees and due process safeguards pertaining to criminal justice proceedings and ensure timely access to legal aid and the right to a fair trial, and to support practical measures to prohibit arbitrary arrest and detention and torture".*[16]

Thereafter, the Global AIDS Strategy 2021-2026[17] noted that failure to reach the targets for reducing stigma and discrimination, decriminalization and gender equality will prevent the world from achieving essential milestones in the global AIDS response. Similarly, in their Joint United Nations Statement on Ending Discrimination in Health Care Settings, United Nations agencies called for reviewing and repealing punitive laws that have been proven to have negative health outcomes and that counter established public health evidence. They particularly note the devastating impact for women of punitive laws that criminalize or otherwise prohibit drug use or possession of drugs for personal use; prevent access to sexual and reproductive health care services, including information; and broadly criminalize HIV non-disclosure, exposure or transmission.[18]

The criminalization of drug use is a disproportionate cause of imprisonment of women. Over a third of women who are incarcerated are incarcerated for drug offenses (the rate for men is one in five).[19] In 2010, 193 countries signed the United Nations Rules for the Treatment of Women Prisoners and Non-custodial

Measures for Women Offenders ('The Bangkok Rules') as a minimum set of standards to protect women in prison and promote appropriate non-custodial measures for women involved with criminal justice systems. The Bangkok Rules urge countries to seek alternatives to incarceration for petty, non-violent offences. To date, however, punitive drug policy has undermined implementation of the Bangkok Rules by providing a platform for accelerated incarceration of women while inhibiting access to harm reduction and evidence-based treatment.[20]

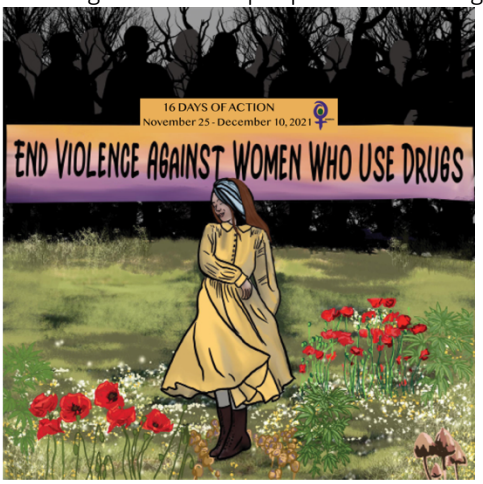
The number of women in prison increased by 50% between the years 2000 to 2015.[21] Pre-trial detention and mandatory minimum prison sentences contribute to this dynamic,[22] with some women held in pre-trial detention for years – sometimes for longer than their potential sentences.[23] Only ten countries in the world have harm reduction services that are available in at least one prison setting,[24] and where such rare services do exist they tend to be in prisons for men.[25] In addition to imprisonment with inadequate services, drug prohibition also subjects women to high levels of violence and harassment at the hands of law enforcement[26] as well as arbitrary detention, compulsory drug 'treatment' and/or registration (associated with a host of human rights violations and other counter-productive restrictions[27]), discontinuity of essential medical treatments, denial of legal aid and lack of due process.[28]

Punitive drug policy perpetuates stigma, criminalization and violence and has a differential impact on women and gender non-conforming people who use drugs, heightening their risk of HIV, STIs and other blood-borne virus transmission and inhibiting access to health and social services. Decriminalization and drug law reform will mitigate rights violations and violence while enabling access to essential health and social services, bringing clear benefits for women, families, communities and the society at large.

Violence towards women who use drugs

Sexual and gender-based violence are widely recognized as increasing the risk of HIV transmission.[29] WUD have a much higher risk of SGBV than women who do not use drugs, with a concurrent increase in their risk of HIV as well. WUD are at risk of many types of violence including intimate partner violence, SGBV, violence from family and community members, obstetric violence and if involved in sex work, violence from clients, as well as structural violence (perpetrated by police, prison guards, doctors and from staff in other closed settings). Due to the criminalised status of their drug use, they lack recourse to report abuse and access justice.[30] Violence is also linked to elevated rates of needle and syringe sharing, inconsistent condom use, fatal overdose and barriers to care.[31] Women and gender non-binary people who use drugs and engage in sex work are subject to particularly high rates of violence and have very limited access to harm reduction and HIV and STI prevention services.[32] COVID-19 lockdown conditions have resulted in increased rates of SGBV, homelessness, poverty and dislocation among WUD even as the access to harm reduction services is reduced.[33]

WUD groups and networks are responding with efforts to address gender-based violence through advocacy and information campaigns around the world. For example, the Elimination of Violence Against Women who Use Drugs (EVAWUD) campaign coincides with the international 16 Days of Activism against Gender-Based Violence to draw much-needed attention to the extreme prevalence of violence against WUD. Over the last three years, WUD from over twenty countries have rallied through the EVAWUD campaign.[34] For example, a Nigerian WUD-led effort successfully organized a social media campaign and soccer match with female police officers to highlight the need to reform police practice. In Spain, the NGO Metzineres launched radio discussions and art activities with a focus on homeless women, trans women and sex workers who use drugs, leading to positive reactions among members of society. Other EVAWUD activities resulted in: the establishment of resource packs for WUD; expanded referral networks; on-going efforts of WUD to design and implement advocacy actions; the founding of new networks of WUD; and the strengthening of women's roles in existing networks of people who use drugs.[35]



EVAWUD21 Global Poster

Services to address SGBV against women and gender non-conforming people who use drugs should: include support and information about where and how to report on police misconduct; offer survivors of sexual assault clinical care, access to post-exposure prophylaxis and emergency contraception; offer STI services along with psychosocial support; and support the development of individualised safety strategies (including access to safe housing) and violence prevention sessions. Anti-violence strategies that are implemented by the WUD community themselves can be very effective. For example, the Women Initiating New Goals of Safety (WINGS) initiative has helped keep WUD safer in Georgia, Kyrgyzstan, Kazakhstan and Ukraine.[36] In addition, harm reduction programmes can assist in the development of community-based online instruments to document and report cases of police violence; support the use of human rights mechanisms to advocate against police violence; and organize dialogue with stakeholders, media and decision makers to present data and negotiate improved protection and accountability systems.[37]

Making harm reduction relevant for women who use drugs

Harm reduction programmes minimise the negative health, social and legal impacts associated with punitive drug policies and drug use. Grounded in social justice and human rights, harm reduction assists people who use drugs without judgement, coercion, discrimination, or requiring abstinence as a precondition for support. Harm reduction is well-evidenced and cost effective in preventing transmission of HIV, viral hepatitis and tuberculosis.[38] In Estonia, for example, the expansion of comprehensive harm reduction services was followed by a 61% countrywide reduction in HIV infections and a 97% reduction in infections among people who inject drugs between 2007 and 2016. Epidemiological estimates derived from programme data suggest that HIV incidence decreased by more than half among women in the general population, including women who may be partners of people who inject drugs.[39]

Despite the demonstrated efficacy of harm reduction approaches, they are not available in all countries and, where services do exist, they rarely function with a gender lens which means that women may find them irrelevant or otherwise difficult to access.[40] To improve access for women, harm reduction services should be comprehensive, linking to HIV, SRH and SGBV services as well as other related services needed by clients.

Harm reduction services for WUD must be gender responsive, non-judgmental, equitable, accessible, affordable, unrationed, voluntary and confidential with integration of quality SRHR and SGBV services and linkages with other social protection services including shelter and legal aid. Services should never be restricted by criteria such as sex or gender, employment status, criminal justice history, age, drug use status, marital or pregnancy status.

Strong and sustainable harm reduction programmes for WUD feature meaningful participation of WUD in all aspects of planning, delivery and monitoring of harm reduction services—including involvement as decision makers, experts, and implementers. Médecins du Monde in Kachin State, Myanmar, for example, greatly values guidance from a peer women's advisory group that informs services for WUD. They use approaches such as special women's days, peer counsellors, and safe spaces to build women's trust and improve access.[41] Where couples counselling can be provided, it should be aimed at ensuring that the responsibility for preventing HIV and health risks is shared equally between both partners. Priority service additions or adjustments vary by location but may include provision for perinatal healthcare; and services tailored for women and gender non-conforming people who use drugs who are also engaged in sex work.

In almost all contexts, there remains a lack of information, education, and communication materials that are specifically relevant to WUD – including safer injecting and safer sex techniques. This is again a gap best filled with meaningful involvement from WUD. The provision of psychosocial and ancillary services and commodities has been an important element in improving service relevance for WUD in a range of settings. For example, when the first drop-in centre for people who use drugs was opened in Tanzania, most of the attendees were male drug users. Recognizing that WUD have different needs than men, the programme added various commodities and utilities such as showers, nutritional support and laundry facilities, in addition to sterile injecting equipment and condoms. Women reported that such ancillary services are critical to improving access to harm reduction services.[42]

The Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights (SRHR) highlights the extent of unfinished business in the global SRHR agenda. The Commission has redefined SRHR components to be inclusive of: services for gender-based violence; HIV/AIDS; STIs; contraception; perinatal health services;

safe abortion and post-abortion care; infertility and other reproductive health services. The Commissioners stress that these rights are universal and must also be available to people who use drugs.[43] The Commission further recommendeds that SRH services be integrated with harm reduction programmes for people who use drugs.

To date, however, sexual and reproductive health (SRH) services tailored to the needs of WUD are largely absent.[44] This despite the fact that WUD have particular SRH needs while also facing a heightened risk of acquiring HIV and viral hepatitis, and other sexually transmitted infections.[45] Due to limited SRH access, WUD often experience a delay in pre-natal care and are sometimes diagnosed with HIV late in pregnancy or when already in labour. Additionally, vertical transmission rates for WUD living with HIV are significantly higher than for other women living with HIV. Harm reduction services should integrate SRH to bridge this essential service gap together with options of assisted referrals for any specialist, clinical or surgical needs. To ensure that the resulting services are relevant to WUD, meaningful involvement of WUD is critical. For additional information, please see the Frontline AIDS/WHRIN guide on advancing the sexual and reproductive health and rights of WUD.

There remains a lack of accurate information about the effects of different drugs on women's SRH, particularly on menstruation regularity and pregnancy. Compounding this problem, medical professionals often perpetuate myths and overinflate risks associated with drug use which make it difficult for women to make informed decisions about their own reproductive health and family planning.[46] WUD are the subject of sensationalist disinformation from governments and the media (for example, 'crack babies' and 'neo-natal abstinence syndrome,' with WUD portrayed as 'bad mothers') serving only, in practice, as a barrier to reliable information and medical support.[47] Drug use alone does not equate with bad parenting, while evidence suggests that issues such as homelessness, smoking tobacco, poor nutrition and socio-economic factors generally have more significant impacts on foetal outcomes than illicit drug use.[48] Any legislation or practice that makes drug use alone the rationale for extracting children from their parents' custody or that seeks to punish women for using drugs during pregnancy must be dismantled and removed.

Gender mainstreaming, based on the recognition that gender equality and equity are linked to human rights and social justice, should be an ongoing characteristic of harm reduction services where all staff, including service managers, are accountable for the achievement of gender-related goals and objectives.[49] In the process of integrating services, expanding referral networks and addressing stigma and discrimination, harm reduction programming can also include tailored capacity building on gender sensitive and human rights-based approaches for other duty bearers including healthcare and social workers and law enforcement personnel.

There is now sufficient evidence, endorsement, guidance, case examples and training material to pave the way for harm reduction services optimized for women without delay. UNODC and INPUD's guidance on addressing the needs of WUD further details pathways to design and implement gender sensitive harm reduction services.

Women who use drugs in women's spaces

The disproportionate impacts of prohibition on WUD discussed above are rooted in patriarchal gender norms. WUD, particularly those living with HIV, face harsher stigma within families and communities and are often perceived as unfit mothers or as ill-equipped to manage their household.[50] In spite of the clearly gendered impact of drug policy, in many feminist spaces there is limited will to engage with WUD and the issues they face.

While use of intersectionality frameworks has strengthened the response of the women's movement

to a myriad of issues, 'drug use status' has not yet been properly incorporated as an intersection axis.[51] Although narrative around intersectionality enables discussion of synergies between systems of injustice,[52] we have yet to see the intersecting influence of patriarchy and drug prohibition discussed except within drug user networks and some harm reduction organizations, and in some limited segments of the feminist movement.

Some key tenets of feminist narrative around bodily autonomy also directly apply to harm reduction. Forced abortions, sterilizations, misinformation and harmful misconceptions about drugs during pregnancy disproportionately affect WUD and contradict feminist ideas on consent and freedom from infringement on bodily integrity.[53] Several civil society organizations acknowledge that the right to use drugs is also in line with the concept of bodily autonomy. The feminist critique of the medical establishment, highlighting humiliating and/or sexist treatment in medical settings and inadequate access to needed medical services are likewise very relevant to the experience of women who use drugs.

Beliefs that WUD lack agency or threaten feminist goals around empowerment persist. Even in women's spaces, WUD are blamed for their disadvantage and marginalisation rather than empowered to challenge and counter the policies that cause negative impact on their lives. This contrasts strongly with feminist narrative around the imperative to stop 'victim blaming'. These contradictions have long been highlighted by the Women Harm Reduction International Network (WHRIN), the International Network of People who Use Drugs (INPUD), other allied organizations and, only recently, by some feminist organizations. For example, according to the Association for Women's Rights in Development (AWID), the feminist movement *"...must continue to confront racism, classism, sexism, heterosexism, transphobia and able-bodyism, as well as whore phobia and drug user phobia."*[54]

WUD have collaborated to challenge prevalent feminist positioning on issues around women and drug use by creating spaces for dialogue and learning between WUD and other women within the feminist movement. In 2019, WUD from Europe and EECA together with those working at the global level developed the Barcelona Declaration, which was endorsed by 119 organizations and promoted during the 2019 meeting of the Commission on Narcotic Drugs, declaring *"The War On Drugs is racist, sexist, classist and heterosexist, and disproportionately affects womxn of colour, youth and womxn in poor communities."*[55] Similarly, the organization, Creating Resources for Empowerment in Action (CREA), as well as Latin American feminist NGOs have begun engaging in drug policy advocacy.[56] In 2021, WHRIN in collaboration with International Women's Rights Action Watch (IWRAW) supported internships for two Indonesian WHRIN members to engage with the Committee on the Elimination of Discrimination against Women (CEDAW) national review processes. The resulting landmark Indonesian shadow report on the situation of WUD was the first of its kind having been developed by WUD.[57] Following submission of the 2021 Indonesian shadow report, concrete recommendations were included in the CEDAW Concluding Observations on its 8th report on Indonesia, to address stigma, discrimination violence and inadequate access to social and health including SRH services by WUD.[58] Just as spaces must be supported for the meaningful involvement of WUD in consultations on healthcare, social service or justice sector reforms, it is also important have WUD voice their needs and priorities when planning and implementing national Gender Equality Women's Empowerment action strategies.

UN Women, with its strong track record in addressing the needs of and meaningfully involving women living with or affected by HIV, is joining WHRIN and other WUD, harm reduction and drug policy organisations and groups in taking positive steps to highlight the needs and agency of WUD. This advocacy brief has outlined some key gap areas that must be addressed to ensure WUD are no longer left behind.

Opportunities:

- Governments are urged to actively and systematically dismantle punitive responses towards WUD in order to eliminate stigma, discrimination, violence and other associated human rights violations.
- UN agencies and relevant stakeholders should ensure meaningful involvement of WUD, including those living with HIV, at all levels of policy and programmatic responses, including HIV/AIDS responses, for ethical, optimal and cost-effective outcomes.
- UN agencies, donors and relevant stakeholders should support the development of partnerships between communities of WUD, women living with HIV, the women's movement and the HIV sector to build a shared vision to address the convergence of punitive drug policy and gender inequality.
- To improve access for WUD, HIV prevention, testing, treatment and care and harm reduction services must become more responsive to the needs of women in all their diversity, including women living with HIV. Government and donor attention is required to support the adoption of gender-responsive approaches in design and implementation of harm reduction programmes and in the overall HIV/AIDS response.

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