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IDPC Briefing Paper

Drug policy and women: Addressing the negative consequences of harmful drug control

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Introduction

A number of reports have documented the negative consequences of current prohibitionist drug control policies on health, human rights and development,[1] and these are the subject of growing international attention.[2] The past thirty years has also seen a growing number of studies on women's participation in all levels of the drug trade. However, limited research currently exists on the particular impact of drug control on women. This briefing paper focuses on this gap.

This briefing aims to highlight the effects of drug policy on women as producers, suppliers and consumers of drugs in order to inform and guide policy makers on practices that should be avoided, as well as highlight those policies which effectively incorporate and address women's needs. This briefing also features 'snapshots' from women and service providers working with women that are affected by drug policies. These snapshots explore the complex consequences that drug policies have on both individuals and services. Such snapshots also highlight examples of interventions that seek to address the negative consequences of drug control and provide positive support to women.

Box 1. A qualifying note about gendered language

This briefing paper focuses on how drug policies particularly affect women. Gender and sex are sometimes conflated in policy documents when discussing issues that relate differently to men and women. A person's sex is a biological construct, while a person's gender is a social construct. Gender is not a static, binary concept. Transgendered, two-spirited, transsexual, transitioning people, among others, may identify as the gender opposite of their sex, or may identify beyond the realm of either a 'man' or a 'woman'. For the conceptual purposes of this paper, 'women' refer to people who self-identify as such, regardless of their biological sex.

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The international framework

Security, development and human rights have been identified by the Charter of the United Nations (UN) as the key policy 'pillars' of global governance systems.[3] These pillars are enshrined in high level agreements as constituting the building blocks for international well-being and security.[4] Women's rights are specifically protected in a number of key international documents, including the Convention on the Elimination of Discrimination Against Women (CEDAW) and the 1995 Beijing Declaration, which aims to promote peace, development and equality for all women.[5]

However, despite the increasing amount of information available on women's involvement in drug production, traffic and consumption, UN bodies have not generally explored the various roles played by women in the drug trade.[6] The international drug control system is based upon the 1961 Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Substances and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances. For the past 50 years, the governments have pursued tough law enforcement and prohibition-based policies which have led to a number of negative impacts particularly on health and well-being. This is despite the recognition in the preamble to the 1961 Convention of the need to uphold the 'health and welfare of mankind'. The Commission on Narcotic Drugs (CND), the UN's drug control policy making body, describes drug dependence as an 'evil',[7] while the International Narcotics Control Board (INCB), the UN agency in charge of monitoring the implementation of the UN drug conventions, encourages governments to adopt a strict interpretation of the conventions that prioritises a strongly punitive approach. The INCB often offers guidance on the UN drug control conventions without due regard to other international health, development and human rights obligations.[8] Gender issues are no exception to this situation, and issues related to drugs and women have largely been ignored by UN drug control agencies and their policies.

The situation has started to evolve over the past few years, with the CND starting to acknowledge the importance of women's rights in drug policy. In Resolution 55/5 "Promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies"[9] for example, the CND recognises CEDAW and the Beijing Declaration, and calls on UN member states to adopt drug control measures that respond to the needs of women. CND Resolution 52/1 "Promoting international cooperation in addressing the involvement of women and girls in drug trafficking, especially as couriers"[10] also highlights key issues related to women's involvement in the international drug trade. The resolution mentions the need for more evidence-based research on women's involvement in the drug trade, and urges more education to reduce women's participation in drug-related crime.[11] However, although this resolution is a step towards incorporating gender issues into the drug policy agenda, the focus remains exclusively on the harms of women's involvement in the drug trade, while ignoring the harms that can also be caused by drug control strategies on women.[12]

The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), created in July 2010 by the UN General Assembly, stated explicitly that governments not only have the duty to pass laws that are aimed towards protecting women, but that the state should also take responsibility for laws that may have unintended consequences of harm.[13] It is therefore necessary to study women's involvement in the drug trade and analyse the effectiveness of drug control strategies and their consequences, both positive and negative. Such research will constitute the basis for a potential review of harmful policies to ensure that the rights of women are protected effectively by national policies.

Women's participation in the drug trade

Women are engaged at all levels of the global drug trade. This section intends to analyse the diverse roles that women play in the illicit production, trafficking and consumption of controlled drugs.

Women's involvement in drug production

Women play an important role in poppy cultivation in drug producing countries such as Afghanistan, Pakistan, Myanmar and Lao PDR,[14] and in coca production in the Andean region. Opium and coca cultivation can offer women the chance to earn money, and at times assume the role of the primary financial supplier for their family. However, while cultivation of crops destined for the illicit drug market may provide a degree of independence for some women, it can also lead to more demanding workloads. Women are often expected to continue performing their traditional duties; many are still expected to remain in charge of livestock, grain processing, dairy production and the management of fruit and poultry.[15] As a result, time spent working in the fields can prevent women from passing on skills, such as tailoring and embroidery, to their children, or look for less traditional types of work. Their involvement in this part of the drug economy can therefore have certain ramifications in terms of intergenerational development and skill transfer. In addition, while it has been acknowledged that involvement in drug production can lead to increased economic independence and greater power, the majority of the time no significant redistribution of power occurs with the involvement of women in the global drug economy.[16] Therefore, the power structures that tend to undermine women's social and economic role remain the same.

Women's involvement in drug trafficking

Resolution 52/1 of the CND estimates that 20 per cent of drug traffickers are women, based upon drug seizure reports,[17] although comprehensive statistics on the rates of female drug smugglers worldwide are unavailable.[18] However, available estimates show that women's participation in drug trafficking has increased significantly in recent years.[19] In Mexico, for example, the importance of women's roles in the trade continues to grow. The number of women imprisoned for federal crimes in the country has increased by 400 per cent since 2007, making the female prison population over 10,000. This spike has been partly attributed to the increased involvement of women in the drug trade.[20] Many of these women are young – for instance, the majority of the 160 women incarcerated at El Cereso, a Mexican prison located in Ciudad Juares, are between 18 and 26 years old.[21] The main drivers for increased involvement of women in trafficking include economic hardship, an absence of well-paid job opportunities and the desire to provide adequate housing and education for their children.[22]

Other possible reasons for the increase of women participating in drug trafficking include the reality that women sometimes play on traditional conceptions of femininity in order to avoid being suspected as participating in criminal activity.[23] Furthermore, women will often accept lower payment than men for similar work. An example is Kyrgyzstan, where there has recently been an increase from 5 per cent to 12 per cent of women involved in drug trafficking, partly because women are compelled to accept lower rates of pay than men.[24]

Based on the current research available, only a small number of women reach a level of socio-economic independence through their involvement in the drug trade. In his study of the US-Mexico border, Campbell argues that of all the women involved in drug trafficking, it is the women at the highest level of drug organisations who manage to achieve a level of 'empowerment'. Enedina Arellano Felix, believed to run the Tijuana cartel, is the highest-profile female cartel leader in Mexico.[25] Sandra Ávila Beltrán, dubbed the 'Queen of the Pacific', was another high-profile

cartel leader who was arrested in 2007 for money laundering and drug trafficking.[26] Campbell's study reviews female drug lords, women engaged at the middle level, low-level drug couriers and women who have little involvement but maintain a connection to the trade through their relationships with men. While this study is temporarily and contextually specific, Campbell argues that it is applicable to women involved in drug smuggling 'cross culturally, despite differences in specific political and social conditions'.[27] Female drug lords contradict the view of women in the drug world as that of 'passive, appendages of male *traficantes'.* [28] While very few women reach this level of 'queen pin', the fact that they exist at all may mean that they may serve as symbols of female power for other women in the drug trade.[29]

In this context, it is essential to distinguish between drug couriers (low-level individuals who usually transport drugs across the border out of poverty and economic necessity) and drug traffickers (individuals at the higher level of the trade chain, who have both organisational and economic power which allows them to make considerable profits out of the drug trade). Women are mostly involved as low-level drug couriers. They sometimes conceal drugs internally, 'in brassieres, in other clothing items, in faked pregnancies or surgically implanted in the buttocks'. [30] Single mothers sometimes become involved in transporting drugs across the border due to the feminisation of inequality and poverty. However, it is simultaneously a way for women involved in the drug trade to achieve a certain level of economic independence from a male partner.[31] In their analysis of fifteen different studies on women's involvement in the drug economy in various parts of the United States, researchers Maher and Hudson found that although the studies varied spatially, temporally and in terms of methods used, the majority demonstrated the hierarchical nature of the drug economy, with women holding subordinate or peripheral roles.[32]

It is also important to consider people involved in drug trafficking in order to finance their drug

Box 2. The linkages between drug dependence and drug dealing

The snapshot below was written by a British woman who explains her experience of drug dealing and drug dependence. Her testimony illustrates how people can get caught up in different aspects of the drug trade.

'I sold drugs from around the age of 20, via boyfriends who were selling at the time, until the age of about 25. At the age of 22, I was smoking weed heavily and was approached by a local dealer who asked if I wished to 'tick' (receive the drugs upfront and pay for them once they had been sold) a large amount of weed. I readily agreed as I knew a lot of people who regularly smoked and this also meant that I would end up smoking for free. My 'business' started off relatively small and I was selling mainly to my friends and family members. I felt that this was quite safe as these people would often come and visit me anyway, so this would not arouse suspicion from my neighbours. However, the business rapidly escalated and over the next few years my house became extremely busy.

However, being unemployed and socialising day in, day out with some of these people led me towards other drugs and I started to use cocaine. I was then approached by the dealer I was buying this from, who was impressed by the way in which I ran my weed business and offered to supply me with cocaine to sell. I quickly added this to my existing business. Unfortunately, my use of cocaine also quickly escalated due to there being a constant supply at my fingertips. [...] In the end I was just selling drugs (from a variety of different people by this point) in order to fund my habit'.

dependence. As is the case with poverty, drug dependence should also be considered as a mitigating factor in the imposition of penalties against drug traffickers, and include a health component, such as the possibility to attend evidence-based drug dependence treatment programmes. The snapshot below exemplifies the linkages between trafficking and drug dependence.

Women's involvement in drug consumption

While precise data on the number of women who use drugs is rarely available, it is estimated that women represent 40 per cent of people who use drugs in some parts of Europe and the United States, 20 per cent in Eastern Europe, Central Asia and Latin America, and between 17 and 40 per cent in certain provinces in China and 10 per cent in other parts of Asia.[33] Recent years have seen a rapid increase in the number of women who use drugs, particularly in Asia and Eastern Europe.[34]

It should be noted that most women who use drugs consume these substances occasionally, and/or without problems. Therefore, many women who use drugs do not experience some of the problems that will be discussed below. Those that are most affected by drug dependence, drug-related harms and the negative consequences of drug control (see next section of the briefing) are usually women who use drugs in difficult socio-economic

Box 3. The experience of a woman who uses drugs in Ukraine

In Ukraine, it is estimated that 290,000 people (that is, 0.9 per cent of the population) use drugs. Of these, approximately 87,000 (30 per cent) are women. Out of the 165,006 people who use drugs registered in police databases, only 47 per cent of them (77,840) are registered in hospitals. In October 2010, the criminal liability for possessing small amounts of drugs was restored, which led to a reduction in clients accessing needle and syringe programmes, and an increase of 15 per cent of arrests for drug possession in the first quarter of 2011.

'"Drugs saved me from suicide", said my female friend from Russia, as we sat in a cafe at the Vienna Conference on AIDS. I am also one of those women who began using drugs to get rid of the emotional pain of rape. Since then, 26 years have passed. During that time I endured more pain and humiliation following calls for help at the hospital.

I was always interested in the question: "When doctors offer a new method of treatment for drug addiction why is nobody watching what happens to a person afterwards?" It is harassment and humiliation, legitimised by one stereotype: she's a "drug addict".

In 1995, I did a "clean blood" procedure, so-called "Hemosorption". A three day programme costs the same as two months' average salaries in Ukraine. Three days later, I was discharged from the intensive care unit with clean blood and in abstinence from drugs. The pain ripped through my body, and a desire to inject drugs tore through my brain. I found drugs very quickly, and received the first result of 'treatment' – an overdose.

That night in the hospital ward; tied to a bed with sheets, coming off of the anaesthesia after an unplanned operation. I was in a lot of pain after surgery, and from withdrawal. My whole body was twisted. Waiting for my husband, he will bring heroin. The doctors and nurses, of course, immediately guessed that I was an addict. I asked them to give me pain medication, begging. They replied: "Be patient. You are to blame"'.

environments, living in situations of poverty and are at the margins of society.

Women experience more negative consequences from drug use than their male counterparts.[35] Although many women use drugs without experiencing any problems, many other women use drugs in environments of economic deprivation, and their use is often impacted by class and gender inequalities.[36]

In addition, although drug use is generally stigmatised, women's use carries a double stigma, as it is usually seen as contravening the natural roles of women in society as 'mothers, the anchors of their families, and caretakers'.[37] The stigma of drug use is also compounded with gender discrimination (see Box 3).

Women are also reportedly more likely to provide sex in exchange for housing, protection, drugs and/or sustenance. They also tend to experience violence from sexual partners and may have difficulty insisting that male sexual partners use condoms, making them more vulnerable to HIV and other sexually transmitted infections (STIs).[38] In addition, several studies have found connections between intimate partner violence or sexual violence and the illicit use of controlled drugs, in particular marijuana and crack use.[39] Researchers have underlined the need for further research in this area.[40] Often, drug prevention and law enforcement interventions that have been developed around the world do not take due account of all of these connections.[41]

Women tend to share injecting equipment more frequently than men. Further, when injecting with men, women are more likely to be 'last on the needle', which has attendant implications concerning the risk of transmission of HIV and other blood-borne viruses from the use

Box 4. Raising the voice, and promoting the rights, of women who use drugs

There are two main global networks that seek to represent women who use drugs and protect their basic human rights – the International Network of Women who Use Drugs (INWUD) and the Women and Harm Reduction International Network (WHRIN).

INWUD is a global network that represents women who use drugs in international agencies and with those that undertake international development work. It collaborates with other agencies to 'voice' the issues affecting women who use drugs. As well, INWUD provides women with a safe space (through a list serve) where they can share ideas and challenges they face when seeking support and promote women who use drugs as equal partners and contributors in all aspects of drugs theory and practice, including drug policy, drug law reform and harm reduction development. INWUD also conducts advocacy activities in order to impact on policy and practice.

WHRIN is a global platform that aims to reduce the harms associated with drug use by women and to develop an enabling environment for the implementation and expansion of harm reduction resources for women. It also seeks to facilitate access to high-quality resources, including educational materials, to assist women who use drugs and the people who work with them to improve access to gender-sensitive harm reduction services. Finally, WHRIN advocates for national, regional and international bodies to adopt and implement policies and programmes that promote and support harm reduction interventions that are adapted to the needs of women and girls.[46]

Because of their unique view and expertise, these two networks are a crucial source of information and should be involved in the review, design and implementation of drug policies that affect women who use drugs.[47]

of contaminated equipment. Women are also more likely to be injected by someone else, and to continue to be injected by a partner for long periods post-initiation, increasing the risk of transmission of blood-borne viruses.[42]

Studies across nine European countries found that HIV prevalence was over 50 per cent higher among women who inject drugs than their male counterparts. This figure is most likely much higher in countries where harm reduction programmes are not well developed. One study found that in Mombasa, Kenya, HIV infection was prevalent among 50 per cent of all people who inject drugs, but this figure reached 85 per cent among women who inject drugs.[43]

The recent report, 'HIV and the law: Risks, rights & health', by the Global Commission on HIV and the Law concludes that the criminalisation of drug use and sex work in many countries is a major driver of the HIV epidemic on a global scale.[44] There is a pressing challenge to develop ways to protect women who use drugs from HIV transmission.[45]

Recently, various international networks were created to promote the rights of women who use drugs and challenge the impact that some policies could have on them. These notably include the International Network of Women who Use Drugs and the Women and Harm Reduction International Network (see Box 4). These networks are instrumental to document, analyse and seek solutions to the numerous challenges faced by women who use drugs.

The Impact of drug policies on women

There is a general assumption in the literature reviewed that drug laws affect women predominantly as consumers of drugs. While this is indubitably true, there is a significant lack of exploration of the impact of drug control on women involved in other sectors of the international drug market.[48] Although a growing amount of studies consider women's roles as producers, consumers and traffickers,[49] much research focuses on women who use drugs, rather than on analyses of how drug policies impact women who are engaged in all aspects of the drug trade.[50] This section seeks to address this particular point.

Exacerbation of poverty

The involvement of people, and sometimes entire families, in drug production, trafficking and/or consumption often results from a variety of coercive forces '...often driven or even necessitated by poverty and social neglect'.[51] These drivers are usually overlooked and often worsened by contemporary drug policies that emphasise eradication and prohibition.[52] Our analysis shows that some aspects of drug control are particularly harmful to women.

Current policies have detrimental consequences for people who are dependent on drug crops for survival. Although drug crops generate an amount of household income in poppy production areas, there is scant evidence to suggest that drug production can lead to sustainable economic and social development.[53] In an illicit, unregulated market, appropriate mechanisms do not exist to ensure that growers receive a fair price for the goods they produce. A regulated market might be able to ensure that subsistence farmers are properly remunerated. In Vietnam, for example, areas that cultivate poppy have the lowest household income in the country. [54] In Pakistan, the average income for those households producing drugs was half of the national average.[55] Crop eradication campaigns often lead to the destruction of both crops destined for the drug market and food crops (and therefore of farmers' only means of subsistence), forcing entire groups to relocate to more isolated areas. Prohibition-led drug policies have specific negative impacts on women and girls. In conflict areas, when men are caught between war factions, women are often left with little choice other than to re-plant

drug crops for their and their children's survival. In Afghanistan, law enforcement-led approaches have put poppy-field eradication at the centre of counternarcotics policy.[56] Counternarcotics, counterterrorism and counter-insurgency policies have detrimental consequences on subsistence farmers. They can also have particularly negative effects on girls, child drug users and families. For example, some farmers had reportedly resorted to selling their daughters in order to pay off their opium debts.[57]

Similarly, women involved in drug trafficking mainly do so out of economic necessity. In many countries, laws regarding drug trafficking do not differentiate between the different levels of involvement and power, resulting in low-level drug couriers serving disproportionate penalties, sometimes involving years of imprisonment.[58] This leads to an exacerbation of poverty as those individuals with a criminal record may be denied access to educational or employment opportunities, leaving them with little choice but to engage again in criminal activities. Both men and women become drug couriers and may be affected by disproportionate penalties for their offence. However, women are often those in charge of the household and children. The incarceration of women for lengthy periods of time may result in children having no other choice but to accompany their mother to jail or end up in the streets, often selling or consuming drugs.[59] Poverty has now started to be considered in some laws and/or sentencing guidelines as a mitigating factor in courts. This is the case, for example, in the UK, where a review of the country's sentencing guidelines recommended a re-calibration of approaches to sentencing for drug offences.[60]

Drug dependence is also often related to situations of poverty. Evidence from around the world shows that drug dependence remains strongly concentrated among the most marginalised groups of society, and is associated with harsh living conditions and associated trauma.[61] However, it is necessary to point out that not all drug use is driven by poverty. Indeed, as mentioned previously, many people use drugs occasionally and/or without problems. Drug use is also driven by motivations of pleasure, and in many circumstances does not have any negative effect on the user's health and social well-being. Those most affected by the consequences of badly designed drug control policies are those who use drugs in situations of poverty and social deprivation that often have a strong connection with dependent use. As will be discussed below, many structural, cultural and ideological factors make women particularly vulnerable to health and social problems associated with drug use.

Inadequate provision of, and discrimination in accessing, health services

Social and biological factors often result in women's experiences with drugs different to that of their male counterparts.[62] Nevertheless, drug policies and programmes rarely take account of these differences. This can be illustrated, for example, by the lack of provision of gender-sensitive harm reduction services. Much improvement has taken place to provide harm reduction services to people who use drugs across the world, but many countries do not provide any services or only provide them on a small scale. In addition, although there is evidence to show that providing harm reduction services that specifically target women improves intervention outcomes, gender-sensitive interventions have not been integrated into harm reduction services on a global level.[63] This translates into a lack of provision of sexual and reproductive health resources in addition to HIV prevention, treatment and care specifically tailored to the needs of women who use drugs. There is also a chance that women will suffer from breaches of confidentiality in relation to their HIV status and drug use. This can result in harassment, violence and family conflicts or crises.[64] In addition, many services do not provide child-care facilities, or do not accept pregnant women or women with children.[65] For women who have children, this acts as a significant deterrent to accessing services.

Other services may be located in areas that are unsafe for women to travel alone or are located in hard to reach places. Inflexible opening hours can also mean that those women with domestic responsibilities have difficulty accessing the services, and there is often a lack of outreach services which could extend healthcare to potentially hidden populations of women.[66] These issues, coupled with the criminalisation of drug use, discourage many women from accessing health, harm reduction and drug dependence treatment services.[67]

Women who use drugs are sometimes characterised as 'the lowest of the low' by both men and women involved in the drug trade.[68] Stigma, abuse and violence towards women who use drugs may be compounded by ideas about what constitutes acceptable behaviour for women. This stigma often constitutes another barrier for women from accessing harm reduction services, HIV prevention, care and treatment, drug dependence treatment, sexual and reproductive health care, as well as other medical services.[69] Some countries have sought to address this issue by providing gender-sensitive services for women who use drugs (see Box 5).

Drug use and sex work are often intertwined,[77] and the harms associated with sex work and drug dependency can be mutually reinforcing. Research studies have found that sex workers

Box 5. Reducing stigma in Iran, Afghanistan and India with gender-sensitive programmes

Stigma and discrimination were important factors affecting the lives of women who use drugs in Iran.[70] The majority of women dependent on drugs have never received any help for their drug use.[71] In 2007, a methadone clinic specifically designed for women was established in Tehran. A review conducted by the clinic found that there was a significant uptake of services after it opened in 2007, with almost 100 women registered during the first year of operation. Clients started engaging in consultations with various healthcare professionals, including a psychologist, a doctor, a midwife and a social worker, and consider the clinic to be a supportive environment, offering essential services.[72]

Centres for women who use drugs have also been set up in Afghanistan, another country where women's drug use is rarely mentioned due to stigma. Laila Haidari, an Afghan woman, sought to break this stigma when she founded two centres for people who use drugs in Kabul;[73] one for men and one for women and children.[74] She also opened a restaurant, which she hopes will be staffed by those who went to the shelters – giving them a chance to learn new skills, rebuild their lives and reduce the stigma attached to drug use, whilst helping her operate a business.[75]

Chanura Kol in Manipur, India is another example of a service which was established to offer care and support services specifically for women who inject drugs. Many women who inject drugs in Manipur are HIV positive and require general and emergency care. The aim of Chanura Kol is to decrease the transmission of HIV and drug relapse amongst women who inject drugs. The project is set to run for three years (2010-2013) and seeks to reach 700 women who use drugs and provide them with care and support. A major element of the project is the provision of income generation support to prevent women relapsing after they have stopped using drugs. Chanura Kol has also filed cases on behalf of sex workers who have been the victims of violence perpetrated by clients, police officers or pimps. The services are offered in a non-discriminatory way free of stigma and moral judgement, based on the principles of harm reduction.[76]

who are believed to be using drugs can be prevented from working in safer environments, such as co-operative sex work establishments. This can mean that open, street-based and relatively dangerous markets become the only ones available to sex workers who use drugs.[78] Sex workers can also face restricted access to harm reduction services, and usually face stigma and discrimination with health care services.[79] Women who use drugs and engage in sex work therefore often face dual discrimination and vulnerability. As mentioned previously, women are often at a higher risk of contracting HIV, partly due to the criminalisation of sex work and drug use. It is estimated globally that sex workers are about eight times more likely to be infected with HIV than other women.[80] In developing countries, this rate is estimated to be fourteen times higher than women not engaged in sex work.[81] Such a high risk of infection has implications for the sex workers themselves, their sexual partners, their clients and the clients' partners.[82]

Incarcerated women who use drugs usually have even more difficulty accessing life-saving medical services. In the USA, imprisoned women have higher rates of HIV, hepatitis C and serious mental illnesses than among the general population, but may be denied basic medical care.[83] An EMCDDA report also found that because there are significantly less imprisoned women than men, there is a lack of specialised care services

Box 6. The impacts of drug policy on young women who use drugs[87]

In addition to gender-related vulnerabilities, young women who use drugs experience age-related vulnerabili-ties and barriers to services that put them at greater risk of experiencing drug-related harms. Most women who use drugs begin doing so at a young age where the risk of experiencing harms is greatest. As a young woman, initiation into injecting drug use often happens by an older, male partner, and dependence on a partner to inject them often continues until experience and skill is gained in self-injecting. HIV knowledge and skills for negotiat-ing safer injecting and/or sex practices are weaker among younger women. Young women also face age-related barriers to accessing harm reduction services – in many countries, women under the age of 18 are un-able to access harm reduction services due to arbitrary age restrictions.

Young women who use drugs may also find themselves trading sex for money or drugs. Research shows a greater occurrence of high-risk sexual behaviours among young female sex workers compared to older sex workers. If under the age of 18, however, most donors and programmers ignore young people who use drugs and sell sex as under international frameworks – sex workers under the age of 18 can only be considered as commercially sexually exploited.

The unique vulnerabilities that young women who use drugs experience are not well recognised by policy makers and service providers. An age and gender lens must be incorporated in programming and policy work. A number of steps can be taken to ensure that more young women who use drugs have access to healthcare and other essential services they need. This includes removing policies and laws that present barriers to young people accessing services such as age restrictions and parental consent requirements; introducing a holistic approach; providing flexible and low threshold services that are youth friendly; supporting community-based organisations of young women who use drugs; and starting having honest conversations about reaching under-18 young women who use drugs and sell sex that move away from a victimisation approach and instead assess how we can best ensure that the rights and needs of these young women are fulfilled.

for women.[84] As a result of the lack of evidence-based drug dependence treatment services, self-harm and depression are reported amongst women who are withdrawing from drugs.[85] In Europe, for example, it is estimated that up to 80 per cent of women in prison have a diagnosable mental health problem, often coupled with drug use. Although approximately 4 per cent of prisoners in Europe are women, around 50 per cent of all self-harm incidents in prison are carried out by women. Death rates on discharge are also substantially higher for women than for men.[86]

Ethnicity, discrimination and drug control

Those who suffer most from prohibition-led approaches are generally ethnic minorities, economically vulnerable people and other marginalised groups (see Box 7).[88] Female drug couriers in Ecuador, for example, are often motivated by poverty and constitute a large proportion of the prison population.[89] Similarly, in Canada and the USA, ethnic minorities are more likely to be incarcerated for drug related offenses than their Caucasian counterpart, especially amongst Native American, aboriginal and First Nations' people.[90] In the USA, African American women are seven times more likely to be incarcerated than Caucasian women and almost 70 per cent of those imprisoned were found to be single parents responsible for young children prior to being put in prison.[91] Policies are often detached from the socio-economic reality of women who are living in poverty.[92] Current drug policies and their implementation seem to exacerbate discrimination based on class and race.[93] In the USA, welfare acts such as the Temporary Assistance for Needy Families (TANF) prevent people convicted with state or federal offenses from being eligible for food stamps or any state form of cash assistance.[94] Such policies disproportionately affects the groups of women most criminalised for their drug-related activities (i.e. African American women), and impacts their ability to access health and social services, find and maintain adequate housing and employment, and break out of poverty-ridden situations.

There is a lack of knowledge about the ways in which interactions between gender and ethnicity shape experiences for men and women within specific drug markets and the broader drug economy.[95] The categories of gender, race and class are just as relevant to power relations and social stratification systems as are evident in the formal economy.[96] The complexity of such dynamics is glaringly absent from current drug policies.

Box 7. Racial discrimination in drug law enforcement in the UK

In the snapshot below, a black British woman discusses her experience of being regularly stopped and searched for drugs, highlighting how the current practice can facilitate a lack of confidence and trust towards the police.

'On some of the occasions when the police didn't make me feel too uncomfortable, it was like "okay its nothing, cool breeze". I could then go along on my daily route and it was nothing, but on most of the occasions I would just go home and stay in my house and be like "well I don't really wanna go out anymore" because I haven't done anything so what I am being stopped and searched for on so many occasions. Once or twice is fine, but on so many occasions it's a bit of a deterrent to go out [...].

To say I have a good relationship or a good eye view of the police, not really. My views are pretty negative. As far as I see it they are the police and I am me. They have got to do their job, so stop and search and do your job [...]. I think it would take a lot for me to go to the police. If I felt like I could handle it myself without committing a crime then I wouldn't approach them'.

Increased numbers of women incarcerated for drug offences

As a result of the increased involvement of women in all aspects of the drug trade and of the punitive nature of drug control in most regions of the world, women are more represented in criminal justice systems and prison populations worldwide than ever before.

In Mexico, the number of women in prison increased by 592 per cent between 1977 and 2001, mainly because of mandatory minimum sentencing laws in place since the early 1970s. This makes women the fastest-growing prison population across the nation for drug offences.[97] Across Europe and Central Asia, there are approximately 31,000 women in prison for drug offences – representing 28 per cent of the female prison population in this region.[98]

Women in penal institutions worldwide are generally young, have a low level of education and have dependent children.[99] A study undertaken by the European Commission found that many incarcerated women in Europe did not have financial security prior to incarceration, had never been employed or had held low-paid jobs with no job security, did not have secure accommodation, had a low level of education, were foreign or belonged to ethnic minorities and had been victims of physical and/or sexual violence.[100] In the USA, more women are convicted for non-violent drug-related crimes than for any other as a result of mandatory minimum sentencing laws. Although men still greatly outnumber women in arrests for drug-related crimes, women now comprise the fastest increasing prison population nationwide for drug offences.[101] It is estimated that between 1986 and 1999, punitive drug policies have resulted in an increase in the female prison population in the USA by up to 888 per cent.[102]

Incarcerated women who use drugs often face deteriorations in their general health and social ties during incarceration and as such face a very difficult period of reintegration into society following release.[103] In the USA, Russia and Georgia, for example, people who have been convicted for drug offenses or who are identified as drug users risk being denied public housing and other benefits, risk losing custody of their children and face discrimination from employers, courts, doctors and educational institutions.[104]

In 1999, the UN Special Rapporteur on Violence against Women stated that many women who are incarcerated for drug-related offences could be better served by community-based welfare and social support systems. However, this is yet to happen in many parts of the world.[105] There is a pressing need for a removal of harsh drug laws and the provision of appropriate services for children while their mothers, who are often their primary carers, are in prison. For instance, Argentina has recently reviewed the national regime of drug sanctions. In 2012, a draft piece of legislation was introduced in Parliament proposing to decriminalise drug possession for personal use and to lower the minimum penalty range for smuggling of drugs. This was justified by the fact that many people employed by criminal organisations to transport small amounts of drugs were women from disadvantaged backgrounds, who are often coerced into such activities.[106]

Law enforcement, imprisonment and parenting

Families and motherhood are dramatically reconfigured and disrupted by policies based on harsh punishment and imprisonment for women involved in the drug trade.[107] The majority of the time, women are incarcerated for non-violent offences and come from economically and socially marginalised backgrounds, with a main driver of crime being poverty. Many of these women are mothers. In Ecuador, for example, women (many of whom have children) are particularly vulnerable towards being engaged in micro-trafficking because of poverty and lack of any employment opportunity in the legal

economy. Once imprisoned, the chances for women to make positive changes in their lives and move away from the drug trade become even more unattainable.[108]

A recent study in the USA found that arresting, detaining, prosecuting and taking other legal actions against pregnant women who use drugs draws attention away from existing inadequacies in health care, the absence of policies to support pregnant women, the lack of social services for children and the failings of punitive drug policies. The study also found that current measures undertaken in the criminal justice system and family and drug courts that attempt to 'protect the foetus' in fact undermine foetal and maternal health and are not conducive to producing effective strategies for addressing the needs of pregnant women who use drugs and their families.[109] No state in the USA specifically criminalises drug use during pregnancy, but prosecutors have made attempts to draw upon criminal laws currently in existence in order to attack prenatal substance use. Currently, fifteen states regard drug use during pregnancy as child abuse, and in three states (Wisconsin, South Dakota and Minnesota) it is grounds for civil commitment.[110] Although there are programmes for pregnant women to receive drug dependence treatment, only four states prohibit publicly funded treatment programmes from discriminating against pregnant women.[111] All leading US medical organisations that have studied drug use during pregnancy have concluded that this is a health issue that should be addressed through education and community-based family treatment rather than through the criminal justice system.[112]

Box 8. Breaking the Cycle – Parenting and drug use in Canada

Amidst the austerity measures that have resulted in budget cuts from social and health services, a number of programmes are still thriving to assist pregnant and early parenting women who are dealing with drug and alcohol use issues. Breaking the Cycle is a Toronto-based initiative that aims to address the needs of their clients through a single access site, as well as providing a number of outreach services for pregnant and early parenting women with children up to six years old. Founded in 1995, Breaking the Cycle provides a range of services for their clients, including access to drug dependence treatment, pre- and post-natal care, parenting courses, nutrition and clothing programmes, and a wide range of counselling services. Breaking the Cycle aims to decrease isolation for women and to encourage them to access services by collaborating with other community-based programmes that can refer women to the various agencies and services, including assistance for clients who have unstable housing or are homeless.

Similar centres such as Sheway in Vancouver and Maxxine Wright Place Project in the Fraser Valley, British Colombia, and New Choices in Edmonton, Alberta, offer comprehensive, non-judgmental care for women in a safe and supportive environment. Such initiatives continue to slowly develop to a limited capacity throughout Canada. Such initiatives are continuing to slowly grow across the country, as is the case with the HerWay Home programme in Victoria, British Colombia. HerWay Home opened the first phase of their centre in late 2012, and offers basic health and social services, with the aim of expanding to respond to childcare and housing needs. These programmes are therefore moving beyond the traditional and narrow view of drug dependence treatment services, and embrace a holistic notion of caring for pregnant and early parenting women who use drugs through respect and empowerment.[127]

Pregnant women who use drugs also face considerable stigma and discrimination.[113] Sterilisation campaigns further compound this stigma and are a violation of human rights. Project Prevention, an organisation that offers a one-off payment to women who use drugs to be sterilised was started in the USA and has since branched out to the UK. This programme offers women who use drugs payment for long-term contraception (as the British Medical Association ethical requirements prevented the organisation from offering money for sterilisation).[114] Recently, the organisation began operations in Kenya, where the programme pays women living with HIV to accept long-term contraception.[115] The project has been strongly criticised as taking an extremely stigmatising and demeaning approach to women who use drugs and to women living with HIV, and for not allowing women to make informed decisions about their reproductive health.[116] Furthermore, providing monetary incentives for women to accept sterilisation or long-term contraception has been condemned as being coercive and a violation of reproductive choices and rights.[117] In Norway, pregnant women who use drugs may lose the right to personal freedom and remain under the control of ward staff until they give birth or decide to terminate the pregnancy.[118] Norway is the only country where social workers have the right to incarcerate pregnant women who are dependent on drugs.[119] A combination of stigma and pressure to have an abortion can mean that women who use drugs have limited access to prenatal care. One of the many negative effects of such a policy is the lack of access to services designed to prevent vertical transmission of HIV amongst pregnant women who inject drugs living with HIV, as well as general healthcare services to ensure that pregnancy and childbirth occur in healthy conditions.[120]

Many women are also disproportionately affected by the removal of their children from their custody in many countries.[121] It should be recognised that drug use does not by definition make a woman unfit to care for a child. Indeed, while in some cases parental drug use is associated with child mistreatment, drug use by parents does not necessarily equate with abuse or neglect of their children.[122] Research has shown that families in which drug or alcohol use is present are more likely to be reported and re-reported to child protection services, and are more likely to have children removed from their custody than those families with similar characteristics but no substance use. A recent study from the Australian Child Protection and Mothers in Substance Abuse Treatment found that the focus of policy and practice should be on interventions that address the mental health problems of mothers who use and improve their social support networks.[123] This is supported by research in Canada, a country where children can be removed from families on the basis of parental drug use.[124] Rather than channelling money into providing support for families where there is drug use (such as affordable child care, safe housing and health and social services), money is spent on foster and group homes. The lack of effort to provide supportive services where there is parental drug use is particularly evident in the case of aboriginal and First Nations' families. Nor are there services provided for women who are dealing with the aftermath of having had their children removed from their custody. Studies in Canada have recognised that women's drug use is often shaped by a variety of factors including poverty, physical abuse, punitive drug policies and inequalities in race, class, gender and sexuality.[125] In Kenya, there are no specific policies in place to remove children from the custody of women who use drugs, but as per culture and tradition there are many instances when family and relatives can remove children from their drug using mothers. Often these children are mistreated and put to early exploitative employment. This practice clearly overlooks the health and wellbeing of the mother and the child under the guise of saving the child.[126]

Some programmes have been developed in a few countries to remedy the harmful effects of

drug laws and their enforcement on parenting rights. This is the case, for instance, in Toronto, Canada, with the Breaking the Cycle programme (see Box 8).

Abuse and violence by law enforcement officials

Since drug use remains criminalised and governments have often adopted a zero-tolerance approach towards people involved in the drug trade, the latter often come in contact with law enforcement authorities, be it the police, prison employees or officials running labour camps for people who use drugs. As a result of the stigma specifically attached to women involved in the illicit drug market, practices of mistreatment, violence and sexual abuse are often reported. One study in Guanxi, China, found that guards at a forced labour camp used HIV testing data to determine which women they could have sex with without using a condom.[128]

In many countries, the criminalisation of drug possession has resulted in sexual exploitation of women by the police.[129] An assessment in Eurasia in 2009 found that 13 per cent of female respondents in Georgia had been asked for sexual favours during arrest. In Azerbaijan, 15 per cent of those participating in the assessment reported beatings by police, and 7 per cent reported coerced sex or rape by police officers and in Kyrgyzstan, 40 per cent of respondents reported violence perpetrated by police officers.[130] In Kazakhstan, it was reported that police arrive at locations where drugs are dealt and conduct body cavity searches. This often leads to demands for sexual favours in exchange for the return of drugs.[131]

In El Inca, the largest women's prison in Ecuador, male prison guards often demand that incarcerated women provide sexual favours in order to obtain access to services or other necessities. Until 2007, guards were able to call for a full body search at any time and such searches, which included a vaginal search, were used as a form of punishment.[132] While international documents such as the United Nations 2010 document Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders, known as the 'Bangkok Rules', call for fair and equitable treatment of imprisoned women and condemn violence, such rules are not always enforced in practice.[133]

Police interference in health service provision can also discourage women who use drugs from accessing harm reduction and other health services. A 2008 study in St. Petersburg, Russia found that women who had been subject to police violence at a needle and syringe exchange bus a decade earlier were still apprehensive about accessing harm services.[134]

Conclusion and recommendations

It is clear that current drug policies that emphasise punishments and incarceration are not only ineffective but also have serious negative implications for women's health, social and economic situations, and can result in violations of women's rights. Not only are women affected, but so are their children and families, particularly in cases of incarceration. In order to ensure that gender-sensitive policies and programmes are adequately designed and implemented, it is necessary that:

- Governments should conduct more research into the different ways women are involved in the drug trade and the potential harms that current drug policies can have on them.

- Governments should promote drug policies and programmes that are evidence-based, respectful of human rights principles, gender-sensitive, and that emphasize health and social inclusion.

- Governments should encourage the participation of those directly affected by drug policies in the design and implementation of drug policies.

- In the field of drug production, governments should promote alternative development programmes that integrate gender issues.

- In the field of drug trafficking, drug laws should make a clear distinction between high-level trafficking and minor level offences, such as couriering and low-level dealing, and impose proportionate penalties that take into account socio-economic factors.

- In the field of drug consumption, governments need to ensure that women who use drugs can access gender-sensitive harm reduction and drug dependence treatment services without fear of arrest or stigma and discrimination.

- At the international level, UN agencies should seek to promote better health, development and human rights practices that fully integrate gender issues as a key component of drug policy.

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