

# **Women, Harm Reduction, and HIV**

September 2007

**International Harm Reduction Development Program**

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Cite as: Pinkham S, Malinowska-Sempruch K (2007). Women, Harm Reduction, and HIV. New York: International Harm Reduction Development Program of the Open Society Institute.

Published by  
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New York, New York 10019 USA  
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## **Acknowledgments**

This paper was written by Sophie Pinkham and Kasia Malinowska-Sempruch of the Open Society Institute's International Harm Reduction Development Program.

Katya Burns, Hannah Byrnes-Enoch, Nancy Goldstein, Lesia Lozowy, Nandini Pillai, and Cecile Kazatchkine helped research the paper.

Special thanks to Matt Curtis, Daniel Wolfe, Camille Abrahams, Wyndi Anderson, Mary Barr, Anna Benyo, Faranak Chamanyzadeh, Françoise Girard, Daliah Heller, Tiloma Jayasinghe, Lynn Paltrow, Karen Plafker, Penelope Saunders, Phoebe Schreiner, Anna Shakarishvili, Susan Sherman, Sue Simon, Rona Taylor, Christina Voight, and Wendee Wechsberg for their comments on drafts of this paper.

## **Executive Summary**

For women who inject drugs, the stigma of injection drug use is added to gendered discrimination; these factors combined can push women into behaviors that increase their risk of HIV. There is a higher likelihood that women drug users will provide sex in exchange for housing, sustenance, and protection; suffer violence from sexual partners; and have difficulty insisting that their sexual partners use condoms. Women drug users may also rely on men to inject them with drugs and acquire drugs and injection equipment, a behavior shown to increase the likelihood of injection with contaminated equipment.

Factors that reduce women drug users' access to health care include punitive policies, discrimination by police and health care providers, the intense social stigma attached to drug use by women, a preponderance of harm reduction and drug treatment programs directed primarily toward men, an absence of sexual and reproductive health services for drug users, and poor access to effective outpatient drug treatment, in which methadone or buprenorphine are prescribed to reduce cravings for illicit opiates.

Pregnant drug users are particularly vulnerable. In too many instances, they receive little or no accurate information about drug use during pregnancy or prevention of mother-to-child transmission of HIV. In some countries pregnant drug users are rejected by health care providers, threatened with criminal penalties or loss of parental rights, or coerced into having an abortion or abandoning their newborns to the state. Poor access to medication-assisted treatment jeopardizes the pregnancies of opiate-dependent drug users.

Increasing women drug users' access to needed services, including drug treatment, harm reduction, and sexual and reproductive health care services, is crucial. Achieving this goal requires policies that encourage women to seek drug treatment and harm reduction rather than punishing or stigmatizing them for drug use during pregnancy or motherhood; increased availability of medication-assisted treatment; incorporation of sexual and reproductive health and other women's services into harm reduction programs; flexible, low-threshold services that are more convenient for women with children; and links between harm reduction, drug treatment, women's shelters, and violence prevention services.

## Challenges Facing Women Who Use Drugs

Gender shapes the experience of drug use and its associated risks. In most parts of the world, however, harm reduction and drug treatment programs that tailor their services to meet women's needs are rare or nonexistent.<sup>1</sup> Policies toward drug users tend to ignore the needs of women, or, worse, inflict ill-conceived penalties on women who use drugs. More research on women drug users is needed. There is, however, abundant evidence that many existing services inadvertently exclude women, and that discriminatory policies and social stigma drive women drug users from care and expose them to human rights abuses.

This paper, drawing upon evidence from existing studies, examines ways in which gender-related factors can increase women drug users' vulnerability and decrease their access to harm reduction, drug treatment, and sexual and reproductive health services. The paper makes recommendations to assist researchers, policymakers, and service providers in investigating the circumstances women drug users face in their own countries and in formulating policies and programs to better serve these women.<sup>2</sup>

While it reviews research and evidence from around the world, this paper places special emphasis on the areas in which the International Harm Reduction Development Program (IHRD) of the Open Society Institute works. For more than a decade, IHRD has worked as a donor and advocate to reduce HIV and other harms related to injecting drug use—particularly opiate injection—and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. IHRD has supported more than 200 harm reduction service programs in Central and Eastern Europe and in Asia, focusing on countries in which the greatest part of HIV infections are among IDUs. IHRD advocates to expand the availability of needle exchange, high quality drug treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the political participation of people who use drugs and those living with HIV.

This paper limits its scope to HIV and focuses on injecting drug use. It should be noted that sharing injecting equipment also increases the risk of other illnesses, such as hepatitis B and C, and that in some contexts non-injecting drug use is associated with high risk sexual behaviors.<sup>3</sup>

### *Growing numbers of women drug users worldwide*

According to the United Nations Office on Drugs and Crime (UNODC), about 25 million people worldwide are “drug addicts or problem drug users.”<sup>4</sup> One percent of the world's

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<sup>1</sup> UN Office on Drugs and Crime (UNODC) (2006). HIV/AIDS prevention and care for female injecting drug users. Vienna: United Nations.

<sup>2</sup> Much of the information on women drug users comes from small studies or anecdotal evidence, and circumstances vary from country to country and among different cultural, ethnic, and socioeconomic groups. The often fragmentary information discussed is not meant to describe the situations of all women drug users.

<sup>3</sup> Winstanley EL, Gust SW, Strathdee SA (2006). Drug abuse and HIV/AIDS: International research lessons and imperatives. *Drug Alcohol Depend*, 2006, 82 Suppl 1:S1-5.

<sup>4</sup> UNODC (2006). World drug report. Vienna: UN.

population aged 15-64 use opiates, cocaine, or amphetamine-type stimulants, and about 13 million users inject.<sup>5</sup> Though precise data on women drug users is rarely available, women have been estimated to represent about 40 percent of drug users in the United States and some parts of Europe, 20 percent in Eastern Europe, Central Asia, and Latin America, between 17 and 40 percent in various provinces of China, and 10 percent in some other Asian countries.<sup>6</sup> In some countries, including China, India, and Russia, which are home to a combined 4.6 million of the world's injecting drug users (IDUs),<sup>7</sup> drug use among women appears to be on the rise, and in many regions more women are seeking harm reduction services and drug treatment.<sup>8</sup> In recent years, there has been a rapid increase in the portion of IDUs who are women, especially in Asia and Eastern Europe.<sup>9</sup> In China, researchers have documented a rapid increase in the number of women IDUs who share injection equipment.<sup>10</sup> In Central Asia, drug use is increasing rapidly among women.<sup>11</sup> Large numbers of women are in need of services to reduce drug-related harm, including HIV spread through contaminated injection equipment and high risk sexual behavior associated with drug use.

### *Inattention to women drug users*

Research into drug use outside high-income countries has largely neglected women drug users. Many studies have included so few women that analyses of the effects of gender are unreliable, while others do not mention gender at all. National and international statistics often do not disaggregate by gender. For instance, the UNODC's 2006 World Drug Report, which relies in large part on national self-reporting, makes more references to the female cannabis plant (14) than to women drug users (5), despite assertions in its 2005 report that the number of women drug users was increasing and that injection-driven HIV epidemics were feminizing.

Existing research is in many ways culturally specific and bound by its context. The vast majority of research has been done in North America, Western Europe, and Australia.<sup>12</sup> In developing and transitional countries, women drug users have been overshadowed by their male counterparts, who comprise the majority of drug users and clients of harm reduction and drug treatment services. With little information even on the number of women drug users in these countries—including those countries experiencing explosive

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<sup>5</sup> UNODC (2006). World drug report.

<sup>6</sup> UNODC (2004). Substance abuse treatment and care for women: case studies and lessons learned. New York; UN. Xinhua News Agency. (June 25, 2004) Female IDUs, key population for fighting AIDS in China: experts. In UNODC (2005), World drug report. Vienna, UN.

<sup>7</sup> Aceijas, C., Friedman, S. R., Cooper, H. L. F., Wiessing, L., Stimson, G. V., Hickman, M. on behalf of the Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries (2006). Estimates of injecting drug users at the national and local level in developing and transitional countries, and gender and age distribution. *Sexually Transmitted Infections*, 82 (suppl\_3), iii10-iii17.

<sup>8</sup> UNODC (2004). Substance abuse treatment and care for women.

<sup>9</sup> World Health Organization (WHO). Where sex work, drug injecting, and HIV overlap. Forthcoming.

<sup>10</sup> Choi, S.Y.P., Cheung, Y.W., Chen, K. (2006). Gender and HIV risk behavior among intravenous drug users in Sichuan Province, China. *Social Science and Medicine*, 62, 1672-1684.

<sup>11</sup> Godinho, J., Renton, A., Vinogradov, V., Novotny T, Gotsadze, G, Rivers, MJ, Bravo, M (2005). Reversing the tide: Priorities for HIV/AIDS prevention in Central Asia. Washington, DC: World Bank.

<sup>12</sup> See Reinerman, C. and Levine, H. (eds.) (1997). *Crack in America: Demon drugs and social justice*. Berkeley, California: University of California Press.

injection-driven HIV epidemics—we can only surmise the complex needs of women who use drugs in countries as diverse as Ukraine, China, Malaysia, and Tajikistan. The one exception is IDU sex workers, who have received attention because of their elevated HIV risk and potential to act as a so-called “bridge” by which HIV can be transmitted to sex worker clients and then to their non-sex worker partners. Such research is often narrowly focused, concentrating on the containment of IDU sex workers as a “vector of disease” rather than on the health, safety, and human rights of drug users and sex workers themselves. Moreover, such research may not reflect the needs of the many IDUs who are not sex workers.

*Women who inject drugs are especially vulnerable*

The treatment of women who use drugs reflects society’s expectations and beliefs about all women and all drug users, and the problems faced by women who use drugs are often amplifications of those faced by other women or by male drug users. Power imbalances related to gender, which are present to varying degrees in virtually all societies, increase the vulnerability of women in similar ways, exposing women to abuse, and particularly coercion and abuse by male partners.<sup>13</sup> On the biological level, women are estimated to be twice as likely as men to be infected with HIV during unprotected vaginal intercourse.<sup>14</sup> This vulnerability combines with stigma against women drug users to leave women with reduced access to harm reduction services, drug treatment, and sexual and reproductive health care.<sup>15</sup>

Biological and social factors conspire to increase women drug users’ risk of HIV. Studies in nine EU countries showed that the average HIV prevalence was more than 50 percent higher among women IDUs than it was among their male counterparts.<sup>16</sup> It is likely that this disparity is even greater in countries without the EU’s relatively well-developed harm reduction programs. Studies in Yunnan Province, in China, found that HIV prevalence was significantly higher among women IDUs than among male IDUs.<sup>17</sup> In Mombasa, Kenya, a study found that the prevalence of HIV infection was 50 percent among all IDUs, but 85 percent among women IDUs.<sup>18</sup>

The stigma attached to women’s drug and alcohol use, particularly during pregnancy, has been documented throughout the world. In the United States, “crack whore” is a nasty insult heard on television and in schoolyards. In rural Uganda, women who drink alcohol in bars are menaced by stories of drunken women who “fall by the roadside” and are

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<sup>13</sup> Human Rights Watch. (June 2006). UN: AIDS Fight Depends on Respect for Rights. Retrieved May 31, 2007 from <http://hrw.org/english/docs/2006/06/01/global13496.htm>. Epele, ME (2002). Gender, violence, and HIV: Women’s survival in the streets. *Culture, Medicine and Psychiatry* 26: 33–54.

<sup>14</sup> Joint United Nations Program on HIV/AIDS (UNAIDS). Women and girls. [http://www.unaids.org/en/Policies/Affected\\_communities/women.asp](http://www.unaids.org/en/Policies/Affected_communities/women.asp). Accessed June 26, 2007.

<sup>15</sup> UNODC (2005). World drug report.

<sup>16</sup> European Monitoring Centre for Drugs and Drug Addiction. (2006). Annual report 2006: the state of the drugs problem in Europe. Retrieved May 31, 2007 from <http://ar2006.emcdda.europa.eu/en/home-en.html>

<sup>17</sup> Choi, S.Y.P., Cheung, Y.W., Chen, K. (2006). Gender and HIV risk behavior among intravenous drug users in Sichuan Province, China. *Social Science and Medicine*, 62, 1672-1684.

<sup>18</sup> Ndeti, D. (2004). UNODC study on the linkages between drug use, injecting drug use and HIV/AIDS in Kenya. University of Nairobi, 2004. In UNODC (2005) World drug report.

attacked by men compelled to rape by alcohol.<sup>19</sup> Such hostile attitudes promote sexual and physical abuse of women drug users, suggesting that those who use drugs do not deserve respect. In a survey across seven regions of Russia, 21 percent of respondents said that a wife's drug or alcohol addiction was a valid reason for her husband to beat her.<sup>20</sup> It is not uncommon for women drug users to be reluctant to seek care and to report crimes committed against them. Admission of drug use exposes women to harsh judgment from health care providers, law enforcement agents, and social networks, and after long experience of discrimination many women are justifiably skeptical of any positive outcome from a complaint.<sup>21</sup> Social stigma and physical and sexual violence even lead some women to believe that they deserve abuse, making them even less likely to report crimes.<sup>22</sup>

### *Women drug users' disproportionate sexual risk*

A growing body of evidence has shown the intimate relationship between sexual and injection-related HIV risk among IDUs. Most IDUs are sexually active, and many engage in a range of sexual behaviors that increase their risk of HIV.<sup>23</sup> Studies in many countries have observed infrequent condom use by IDUs during encounters with sex workers, casual partners, and other drug users at risk of HIV through injection.<sup>24</sup> Some studies have found an association between condom use and avoidance of syringe sharing, or between syringe sharing and inconsistent condom use, suggesting that sexual and injection-related risk factors are associated.<sup>25</sup> The joint United Nations Programme on

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<sup>19</sup> Wolff, B., Busza, J., Bufumbo, L., Whitworth, J. (2006). Women who fall by the roadside: gender, sexual risk and alcohol in rural Uganda. *Addiction*, 101, 1277-1284.

<sup>20</sup> Gorshkova, ID and Shurigina, II (2003). Violence against women in Russian families. Paper prepared for a conference on May 15-16, 2003. Moscow State University, Lomonosov, Women's Soviet. Retrieved May 31, 2007, from [www.womenmsu.msu.ru/appendix/bookall.pdf](http://www.womenmsu.msu.ru/appendix/bookall.pdf)

<sup>21</sup> Murphy, S and Sales, P (2001). Let's get real looking at the lives of pregnant drug users. Harm Reduction Communication, Harm Reduction Coalition. [http://www.harmreduction.org/pubs/news/spring01/sp01murphy\\_salesp2.html](http://www.harmreduction.org/pubs/news/spring01/sp01murphy_salesp2.html), retrieved February 2007.

<sup>22</sup> *Ibid.*

<sup>23</sup> For example, see: National Aids Center, Belarus (2002). *Findings of rapid assessment of HIV and STI among key risk groups*. Unpublished manuscript. Initiative for Health Foundation (2004). *Injecting drug users in Bulgaria: Profile and risks*. Central and Eastern European Harm Reduction Network (CEEHRN) (2005). *Sex Work, HIV/AIDS and Human Rights in Central and Eastern Europe and Central Asia*. [www.ceehrn.org](http://www.ceehrn.org). Monitoring the Aids Pandemic (MAP) (2001). *Status and trends of HIV/AIDS/STI epidemics in Asia and the Pacific*. Provisional Report. Pisani, E, Dadun Suchaya, PK Kamil, O and Jazan, S (2003). Sexual behavior among injection drug users in 3 Indonesian cities carries a high potential for HIV spread to non-injectors. *Journal of Acquired Immune Deficiency Syndrome*. 34(4):403-406. Choi, SYP et al (2006). *Op cit.* MAP (2005). Drug injection and HIV/AIDS in Asia—MAP Report 2005. Geneva: MAP. Lau, TF, Feng, T, Lin, X, Wang, QH, Tsui, Y (2005). Needle sharing and sex-related risk behaviours among drug users in Shenzhen, a city in Guangdong, southern China. *AIDS Care*, 17: 2,166-181.

<sup>24</sup> Winstanley, EL, Gust, SW, Strathdee, SA (2006). Drug abuse and HIV/AIDS: International research lessons and imperatives. *Drug Alcohol Depend*, 2006, 82 Suppl 1:S1-5. UNAIDS (2006), Report on the global AIDS epidemic. *Op cit.* Rhodes, T, Stimson, GV, Crofts, N, Ball, A, Dehne, K, Khodakevich, L. (1999). Drug injecting, rapid HIV spread, and the "risk environment" implications for assessment and response. *AIDS* 13, S259-269. Lau et al (2005). *Op cit.* UNODC (2005). *Op cit.* Dewing, S, Pluddemann, A, Myers, B, Parry, CDH (2006). Review of injecting drug use in six African countries: Egypt, Kenya, Mauritius, Nigeria, South Africa and Tanzania. *Drugs: education, prevention, and policy*, 13(2), 121-137.

<sup>25</sup> Booth, RE (1995). Gender differences in high risk sex behaviours among heterosexual drug injectors and crack smokers. *Am J Drug Alcohol Abuse* ;21:419-32. In UNODC (2005). *Op cit.* Myers, T, Millson, M, Rigby, J et al (1995). A comparison of the determinants of safe injecting and condom use among injecting drug users. *Addiction* 90.

HIV/AIDS (UNAIDS) has called for increased provision of sexual health services to prevent the spread of HIV to the sexual partners of IDUs.<sup>26</sup>

A number of studies in the United States have found that sexual practices have a greater effect on HIV risk for women IDUs than for males. In a study in Baltimore, high risk sexual activity surpassed risky drug use practices as the main predictor of HIV infection among IDU women during the period observed. HIV incidence more than doubled among women IDUs who had an IDU sex partner.<sup>27</sup> In a San Francisco study of young IDUs, women were more likely than men to have had a recent sexual partner, to have a steady partner, and to report that they did not always use a condom during vaginal or anal sex.<sup>28</sup> This variance is likely due to a greater correlation between women's drug use and high risk sexual practices,<sup>29</sup> and to the fact that women are more easily infected through vaginal sex.<sup>30</sup> In a number of countries, women drug users are more likely to have IDU partners and inject with them, at times injecting after a partner who may be HIV-positive.<sup>31</sup> Some studies have shown that women IDUs' social networks contain more IDUs than do those of male injectors and that there is greater overlap between women's sexual and injection networks, perhaps because women's drug use is more stigmatized and thus more isolating than men's.<sup>32</sup> A study of young Los Angeles injectors showed that women were more likely to have sexual partners and friends who were also IDUs, putting them at greater risk of HIV.<sup>33</sup>

### *Obstacles to condom use*

A number of factors make it difficult for women to insist that their partners use condoms.<sup>34</sup> These factors include sexual and domestic abuse,<sup>35</sup> fear of abandonment,

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<sup>26</sup> UNAIDS (2006). Report on the global AIDS epidemic. *Op cit.*

<sup>27</sup> Strathdee, S, Galai, N, Safaiean, M *et al.* (2001). Sex differences in risk factors for HIV seroconversion among injecting drug users: A 10-year perspective. *Arch Intern Med*, 161.

<sup>28</sup> Evans, JL, Hahn, JA, Page-Shafer, K, Lum, PJ, Stein, ES, Davidson, PJ, & Moss, AR (2003). Gender differences in sexual and injection risk behavior among active young injection drug users in San Francisco (the UFO Study). *J Urban Health*, 80(1), 137-146.

<sup>29</sup> Freeman, RC, Rodriguez, GM, and French, JF (1994). A comparison of male and female intravenous drug users' risk behaviors for HIV infection. *Am J Drug Alcohol Abuse*, 20(2), 129-157. Evans *et al.* (2003). *Op cit.* Riehm, KS, Kral, AH, Anderson, R, Flynn, N, & Bluthenthal, RN (2004). Sexual relationships, secondary syringe exchange, and gender differences in HIV risk among drug injectors. *J Urban Health*, 81(2), 249-259. Gossop, M, Griffiths, P, Strang, J (1994). Sex differences in patterns of drug taking behaviour. A study at a London community drug team. *Br J Psychiatry*, 164(1), 101-104. Breen *et al* (2005). *Op cit.*

<sup>30</sup> UNAIDS. Women and girls. *Op cit.*

<sup>31</sup> Rhodes, T, Platt, L, Filatova, K, Sarang, A, Davis, M, & Renton, A (2002). *Behaviour factors in HIV transmission in Eastern Europe and Central Asia*. Geneva: UNAIDS. Berezhnova, I *et al.* (2006). HIV/AIDS behavioral risk among women using drugs. XVII International conference on the reduction of drug related harm. Vancouver, Canada. Gore-Felton, C, Somlai, AM, Benotsch, E, Kelly, JA, Ostovski, D, Kozlov, A (2003). The influence of gender factors associated with HIV transmission risk among young Russian injection drug users. *The American Journal of Drug and Alcohol Abuse*, vol. 29, No. 4, pp. 881-894. UNAIDS Program Coordinating Board (2007). *Assessing Gender Equality and Equity as Critical Elements in National Responses to HIV: Cambodia, Honduras and Ukraine*. Geneva.

<sup>32</sup> Doherty, MC, Garfein, RS, Monterosso, ER *et al.* (2000). Correlates of HIV infection among young adult short-term injection drug users. *AIDS*, 14, 717-726. Latkin, CA, Mandell, W, Knowlton, AR *et al.* (1998). Gender differences in injection-related behaviors among injection drug users in Baltimore, Maryland. *AIDS Educ Prev*, 10, 257-263.

<sup>33</sup> Montgomery, SB, Hyde, J, Johnson De Rosa, C *et al.* (2002) Gender differences in HIV risk behaviors among young injectors and their social network members. *Am J Drug Alcohol Abuse*, 28(3), 453-475.

<sup>34</sup> UNAIDS (2006). Report on the global AIDS epidemic. *Op cit.*



cultural expectations about male desire and female acquiescence, and poverty. The latter is particularly true in instances that involve the exchange of sex for food, housing, or drugs (see discussion of transactional sex below). For some women IDUs, as for many women who are not IDUs, requesting that a partner use a condom can result in accusations of infidelity or in violence. For some married women, a request that a husband use a condom is out of the question. In the words of one Vietnamese woman married to an IDU who shared injection equipment and did not use condoms: “He is a man and the husband of the family; I am the wife, so I must obey him and let him do what he wants...husband and wife should share life and death.”<sup>36</sup> Women drug users are disproportionately likely to experience sexual and physical violence, including childhood sexual abuse.<sup>37</sup> This can include sexual violence and exploitation by police.<sup>38</sup> The experience of violence influences not only drug use, which is often a way of coping with trauma, but HIV risk, since women in abusive relationships and women experiencing sexual violence often do not have the option of insisting on condoms, and because the trauma, disempowerment, and loss of self-esteem associated with such violence can make it more difficult for women to avoid high risk sex.<sup>39</sup> Other IDUs, like many non-IDUs, are in steady sexual relationships in which condoms do not seem necessary or desirable. Across a wide range of countries, women IDUs are more likely than male IDUs to have a steady partner who is an IDU,<sup>40</sup> which puts women at disproportionate risk of sexual transmission of HIV when condoms are not used.

### *Transactional sex and commercial sex work*<sup>41</sup>

Poverty and an absence of employment opportunities make transactional sex a survival strategy for some women who use drugs.<sup>42</sup> Women may have sex with someone who gives them a place to stay, food, drugs, or protection. Compared to commercial sex

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<sup>35</sup> Miller, M (1999). A model to explain the relationship between sexual abuse and HIV risk among women. *AIDS Care*, 11(1). El-Bassel, N, Gilbert, L, Wu, E, Chang, M, Gomes, C, Vinocur, D, Spevack, T (2007). Intimate partner violence prevalence and HIV risks among women receiving care in emergency departments: implications for IPV and HIV screening. *Emergency Medicine Journal*. Apr;24(4):255-9. Braitstein, P, Li, K, Tyndall, M, *et al* (2003). Sexual violence among a cohort of injection drug users. *Social Science & Medicine*; 57(3):561-9.

<sup>36</sup> Go, V, Quan, VM, Voytek, C, Celentano, D, Nam, LV (2006). Intra-couple communication dynamics of HIV risk behavior among injecting drug users and their sexual partners in northern Vietnam. *Drug and Alcohol Dependence*, 84, 69-76.

<sup>37</sup> Braitstein, P (2003). *Op cit*. UNODC (2004). Substance abuse treatment and care for women. *Op cit*.

<sup>38</sup> Charitable Foundation "Kolodets" (2006). *Narkopolitika v Rossii*. Moscow: International Harm Reduction Development Program of the Open Society Institute. Human Rights Watch (2003). Fanning the flames: How human rights abuses are fueling the AIDS epidemic in Kazakhstan. New York, www.hrw.org.

<sup>39</sup> Miller, M. (1999). *Op cit*.

<sup>40</sup> Among the many studies documenting this: Bronzan, RN, Zhussupov, B, Favorov, M, Kryukova, V, Muratbayeva, G, Kuznetsov, N, Shakarishvili, A & Ryan, CA (2004). Risk factors for HIV infection among injection drug users in Kazakhstan: implications for prevention intervention. XV International AIDS Conference. Bangkok, 2004. Gore-Felton *et al* (2003). *Op cit*. Rhodes, T *et al* (2002). *Op cit*. Davies, AG, Dominy, NJ, Peters, AD, Richardson, AM (1996). Gender differences in HIV risk behaviour of injecting drug users in Edinburgh, *AIDS CARE*, 8(5). Personal communication, Faranak Chamanyzadeh, Rangin Kaman, Persepolis, 2007; Evans *et al* (2003) *Op cit*.

<sup>41</sup> This paper considers sex work only in the context of drug use, and will not delve into the health and human rights issues around sex work unrelated to drug use. For publications and links to organizations that address the health and human rights of sex workers, please visit the website of OSI's Sexual Health and Rights Project at <http://www.soros.org/initiatives/health/focus/sharp/>

<sup>42</sup> Maher, L (1997). *Sexed work: Gender, race, and resistance in a Brooklyn drug market*. New York: Oxford University Press. Taylor A (1993). *Women drug users: An ethnography of a female injecting community*. Oxford: Clarendon Press.

work, transactional sex is less likely to take the form of an explicit exchange of goods for services, and is more likely to be framed in terms of gratitude, indebtedness, trust, and dependence, which can leave little space for women to insist that their partners use condoms. Moreover, the choice between food or shelter and safer sex is not a free one, since almost all people will choose daily survival over protection from HIV, a comparatively abstract risk.<sup>43</sup>

In some parts of the world, there is also a substantial overlap between commercial sex work and injecting drug use. It is estimated that between 20 and 50 percent of women IDUs in Eastern Europe and between 10 and 25 percent of women IDUs in Central Asia are involved in sex work.<sup>44</sup> In a study of 82 women IDUs in Sichuan, China, 47 were sex workers,<sup>45</sup> and 21 percent of women IDU participants in a study in Yunnan were sex workers.<sup>46</sup> Research suggests that drug-using sex workers, like drug users involved in transactional sex, have less freedom to practice safe sex than their non—drug-using peers. For those who become sex workers primarily to support their drug addiction, commercial sex work has much in common with transactional sex, with the same absence of genuine choice in the face of urgent need.<sup>47</sup> This absence of options translates into higher levels of HIV: in many places, HIV prevalence among IDU sex workers is higher than it is among either non—sex worker IDUs or non-IDU sex workers.<sup>48</sup> Finally, if sex workers are identified as IDUs it can reduce their earning power and make it more difficult for them to attract clients. This can make them reluctant to be seen at harm reduction sites, and thus reduce their access to services.

Drug-using sex workers often engage in higher risk forms of sex work. This is largely because of the financial pressures imposed by poverty and the need to support their own and sometimes their partners' habits, and because IDUs are seen as undesirable and at high risk of HIV, and are therefore often excluded from brothels.<sup>49</sup> In Asia, Russia, and Ukraine, studies have found that IDU sex workers are more likely than non-IDUs to work on the street<sup>50</sup> and to experience violence from their clients.<sup>51</sup> Drug-using sex workers may also engage in riskier drug use practices than sex workers who are not IDUs; for example, studies in Russia and Bangladesh, among other places, have shown that IDU

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<sup>43</sup> Epele, ME (2002). *Op cit.*

<sup>44</sup> Rhodes, T *et al* (2002). *Op cit.*

<sup>45</sup> Choi, SYP *et al* (2006). *Op cit.*

<sup>46</sup> MAP (2005). Drug injection and HIV/AIDS in Asia. Geneva: MAP.

<sup>47</sup> Epele, ME (2002). *Op. cit.*

<sup>48</sup> See citations in “Transactional sex and commercial sex work.”

<sup>49</sup> Tran, TN, Detels, R, Hien, NT, Long, HT, Ngad, PTH (2004). Drug use, sexual behaviours and practices among female sex workers in Hanoi, Viet Nam—a qualitative study. *International Journal of Drug Policy* 15. 189–195.

Burrows, D, Sarankov, Y, Sarang, A (1999). *HIV/AIDS prevention, treatment, care and support in the Ukraine*. Kiev: Medecins Sans Frontieres. Rhodes, T, Mikhailova, LA, Lowndes, C, *et al* (2002). *Preventing HIV infection among injecting drug users in Togliatti City, Samara Oblast Russia: Key findings from rapid assessment*. London: Imperial College of Science, Technology and Medicine.

<sup>50</sup> Tran *et al* (2004). *Op.cit.*; Jenkins C (2002). Injecting sex workers or sex working injectors: crossing risk zones. In *National Institute on Drug Use*. Global Research Network. Meeting on HIV Prevention in Drug-Using Populations: Fourth Annual Meeting Report October 11-12 2001 (2002). Melbourne, Australia/ Bethesda.

<sup>51</sup> WHO. Where sex work, drug injecting, and HIV overlap. *Op cit.*

sex workers are more likely than non-sex worker IDUs to engage in risky injecting practices.<sup>52</sup>

One result of these differences is dramatically increased HIV rates among IDU sex workers. In Ukraine, sentinel surveillance data found that HIV prevalence among IDU sex workers varied from 8.3 percent to 100 percent depending on the study site, as compared to 0 to 21.1 percent among non-IDU sex workers.<sup>53</sup> In Hanoi, a study found that 33 percent of IDU sex workers were HIV-positive, as opposed to 1.6 percent of non-IDU sex workers,<sup>54</sup> and a study in Ho Chi Minh City found that HIV rates among IDU sex workers were more than twice those among non-IDU sex workers.<sup>55</sup> In China, compared to non-IDU sex workers, IDU sex workers have more clients, use condoms less often, and are more likely to share syringes.<sup>56</sup> According to a 2002 study in St. Petersburg, 30 percent of women IDU sex workers were HIV positive, as opposed to 20 percent of women IDUs who were not sex workers.<sup>57</sup>

The greater likelihood that IDU sex workers will be street-based may also increase the likelihood that they will have IDU clients, and evidence from many regions of IDUs' inconsistent condom use<sup>58</sup> suggests that this is a particularly high risk activity. This is illustrated by a study in Hanoi, which showed that street-based sex workers' poverty forced them to accept drug user clients who were rejected by higher status sex workers. The street-based sex workers were more likely to have sex without a condom if offered more money, though they made an effort to use condoms with drug users. Male IDUs reported frequent visits to sex workers and low condom use, explaining that they did not use condoms in part because they felt that the risk of HIV infection through sex without condoms was irrelevant compared to the much greater risk of contracting HIV through drug injection<sup>59</sup>. A sex worker's injecting drug use may be linked with a higher

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<sup>52</sup> Platt, L, Rhodes, T, Lowndes, CM, *et al* (2005). Impact of gender and sex work on sexual and injecting risk behaviors and their association with HIV positivity among injecting drug users in an HIV epidemic in Togliatti City, Russian Federation. *J Sex Transmitted Diseases*, 32(10), 605-12. Azim, T, Chowdhury, EI, Reza, M, *et al* (2006). Vulnerability to HIV infection among sex worker and non-sex worker female injecting drug users in Dhaka, Bangladesh: Evidence from the baseline survey of a cohort study. *Harm Reduct J*, 17(3), 33.

<sup>53</sup> UNAIDS Program Coordinating Board (2007). *Op cit*.

<sup>54</sup> Tran *et al*. (2005). HIV infections and risk characteristics among female sex workers in Hanoi, Vietnam. *J AIDS*, 39(5), 581-586. (from UNAIDS (2006), Report on the AIDS epidemic. *Op cit*).

<sup>55</sup> MAP (2005), Drug injection and HIV/AIDS in Asia. *Op cit*.

<sup>56</sup> Ibid. MAP (2005). Sex work and HIV/AIDS in Asia. Geneva, MAP.

<sup>57</sup> Aral, SO (2005). Commercial sex work, drug use and sexually transmitted infections in St Petersburg, Russia, *Social Science and Medicine*, 60, 2181-2190.

<sup>58</sup> Rhodes *et al* (1999). *Op cit*. Tran, TN, Detels, R, Hien, NT, Long, HT, Nga, PTH (2005). Drug use, sexual behaviors and practices among male drug users in Hanoi, Vietnam—a qualitative study. *Int J Drug Policy*, 15, 182-188.

<sup>59</sup> Lau *et al* (2005). *Op cit*. El Shimi, T (2003). UNODC Global Assessment Programme in Egypt, Cairo. In UNODC (2005), World drug report. *Op cit*. UNAIDS (2006). Report on the global AIDS epidemic. *Op cit*. Dewing *et al* (2006). *Op cit*. Lowndes *et al*. (2002) *Female injection drug users who practice sex work in Togliatti City, Russian Federation: HIV prevalence and risk behaviour*. XIV International Aids Conference. Abstract MoPeC501. Barcelona, Spain. Filatov, A and Suharsky, D (2002) *Peculiarities of HIV infection among intravenous drug users in Mirminsk district, Yakut area*. 4<sup>th</sup> European AIDS Conference, Vilnius. Rhodes, T, Judd, A, Mikhailova, L *et al*. (2004). *Op cit*. Rhodes, T, Sarang, A, Bobrik, A, Bobkov, E, Platt, L (2004). HIV transmission and HIV prevention associated with injecting drug use in the Russian Federation. *International Journal of Drug Policy*, 15, 1-16. UNAIDS/WHO (2005). *AIDS epidemic update: Eastern Europe and Central Asia*. Geneva. Central Asian HIV/AIDS Program (2006). *Rapid assessment final report*.

<sup>59</sup> Tran *et al* (2004). *Op cit*.

proportion of IDU clients: in Iran, a service provider reports that women sex workers who are IDUs usually have only IDU clients..<sup>60</sup>

### *Poor sexual and reproductive health services for IDUs*

Despite evidence of the link between sexual and injection risk behaviors, integrated interventions are relatively unusual in many parts of the world. Even in San Francisco, a city with a well-developed harm reduction movement, a study found that high-coverage syringe exchange programs had achieved drastic reductions in injection-related HIV risk behavior, but that IDUs continued to be infected with HIV because they did not have access to sexual health services that addressed their needs. While IDUs were receiving strong messages about preventing HIV through unsafe injection, and were given the means to do so, sexual health messages and services were aimed largely at gay men or the general population, and were not reaching drug users.<sup>61</sup>

In Eastern Europe and Central Asia, sexual and reproductive health services for drug users are rare, and often operate on a very small scale. Even sexual health services for the general population are poorly developed, and it is safe to assume that IDU women have drastically reduced access to these services. High STI rates in some countries of the region—particularly Russia—suggest widespread HIV risk behavior.<sup>62</sup> A lack of high quality, affordable STI services likely increases STI prevalence and allows STIs to go untreated.<sup>63</sup> This, too, disproportionately affects women, who are biologically more vulnerable to STIs, and for whom untreated STIs increase the risk of HIV.<sup>64</sup>

In some countries of Eastern Europe and Central Asia, those who test positive for STIs are registered as STI “carriers,” and hospitalized for STIs that most countries treat on an outpatient basis. In some Central Asian countries, those who test positive for STIs are subject to compulsory treatment for up to 28 days and required to provide the names of their sexual partners for notification. The police are involved in the notification process, which can extend to employers and community members.<sup>65</sup> The prospect of registration and hospitalization may deter many patients, whether or not they are women or drug users, from seeking treatment. Stigma, the absence of drug treatment, and the need to seek drugs daily to prevent withdrawal can create overwhelming obstacles to hospitalization for drug users.

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<sup>60</sup> Personal communication, Faranak Chamanyzadeh, Rangin Kaman/Persepolis NGO, 2007.

<sup>61</sup> Kral, AH, Bluthenthal, RN, Lorvick, J, Gee, L, Bacchetti, P, Edlin, BR (2001). Sexual transmission of HIV among injection drug users in San Francisco, USA: risk-factor analysis. *Lancet*, Vol. 357.

<sup>62</sup> WHO Regional Office for Europe. Centralized information system for infectious diseases (CISID). <http://data.euro.who.int/cisid/?TabID=131338>. Retrieved May 27, 2007.

<sup>63</sup> Dehne, KL, Riedner, G, Neckermann, C, Mykyev, O, Ndowa, FJ, Laukamm-Josten, U (2002). A survey of STI policies and programmes in Europe: preliminary results. *Sex Transm Inf*, 78, 380-384.

<sup>64</sup> Nusbaum, MR, Wallace, RR, Slatt, LM, Kondrad, EC (2004). Sexually transmitted infections and increased risk of co-infection with human immunodeficiency virus. *J Am Osteopath Assoc*, 104(12), 527-35.

<sup>65</sup> Wolfe, D, Elovich, R, Boltaev, A, Pulatov, D. HIV in Central Asia: Tajikistan, Uzbekistan, and Kyrgyzstan. In *Public Health Aspects of HIV/AIDS in Developing Countries: Epidemiology, Prevention and Care*. In press.

## *Injection risk*

Women drug users' heightened sexual risk is intertwined with an increased risk of contracting HIV through shared injection equipment. Research indicates that a significant number of women begin injecting drugs in the context of a sexual relationship<sup>66</sup> and that women are more likely than men to borrow or share injection equipment,<sup>67</sup> particularly with their sexual partners.<sup>68</sup> According to a cross-sectional study in Russia, 24 percent of women IDUs reported sharing injection equipment with their IDU sexual partner, compared to 11 percent of male IDUs.<sup>69</sup> Some studies have found that women are more likely to report that someone else injected them with drugs, which has been found to be an independent predictor of HIV incident infection, and, in cases in which the injecting partner is male, women often inject last using shared equipment.<sup>70</sup> One study showed that women in San Francisco were more likely to pool money to buy drugs,<sup>71</sup> which suggests financial restraints and group injecting that may increase HIV risk behavior. According to the study, women's more frequent risky injecting practices were linked to their sexual partnerships with IDUs, though they were more likely to be injected by another IDU regardless of their sexual partnerships.<sup>72</sup> Some women IDUs stay at home to inject<sup>73</sup> and rely on their male partners for drugs and injection equipment, which can make it especially difficult for them to avoid used injection equipment and unprotected sex,<sup>74</sup> or to access other services.

For women IDUs who share equipment with their partners, questions of intimacy and trust that inhibit condom use between steady sexual partners can also increase the likelihood of syringe sharing. A study of women IDUs and IDU couples in Scotland showed that love, trust, and intimacy were the most frequently cited reasons for the women to share needles and not use condoms with their male partners.<sup>75</sup> The power imbalances that make it difficult for women to enforce condom use can also make it difficult to avoid sharing injection equipment; if a woman is economically dependent on a man or being abused by him, for instance, it may be too dangerous for her to refuse to

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<sup>66</sup> Doherty, MC, Garfein, RS, Monterroso, E, Latkin, C, Vlahov, D (2000). Gender difference in the initiation of injecting drug use among young adults, *Journal of Urban Health*, 77(3), 397. Sherman, S, Latkin, C, Gielen, A (2001). Social factors related to syringe sharing among injecting partners: a focus on gender. *Substance Use Misuse*, 36(21), 13-36.

<sup>67</sup> Evans et al. (2003). *Op cit.* Vidal-Trécan, G, Coste, J, Coeuret, M, Delamare, N, Varescon-Pousson, I, Boissonnas, A (1998). Risk behaviors of intravenous drug users: are females taking more risks of HIV and HCV transmission? *Rev Epidemiolo Sante Publique*; 46(3):193-204. UNAIDS Program Coordinating Board (2007). *Op cit.*

<sup>68</sup> Gore-Felton et al. (2003), *Op. cit.* Davies et al (1997). *Op cit.*

<sup>69</sup> Berezhnova, I et al. (2006), *Op. cit.*

<sup>70</sup> Gore-Felton et al (2003). *Op cit.*; Kral et al (1999). *Op cit.*; MacRae, R and Aalto, E (2000). Gendered power dynamics and HIV risk in drug-using sexual relationships. *AIDS Care*, 12(4), 505-15. O'Connell, JM, Spittal, P, Li, K, Tyndall, MW, Hogg, RS, Schechter, MT and Wood, E (2004). *Requiring help injecting independently predicts incident HIV infection in a prospective cohort study of injection drug users* in XV International AIDS Conference, Bangkok. Bourgois, P, Prince, B, Moss, A (2004). The everyday violence of Hepatitis C among young women who inject drugs in San Francisco. *Human Organization* 63(3). Latkin, C, Mandell, W, Vlahov, D et al. (1996). People and places: behavioural settings and personal network characteristics as correlates of needles sharing. *J AIDS and human retrovirology*, 13, 273-80.

<sup>71</sup> Evans (2003). *Op cit.*

<sup>72</sup> *Ibid.*

<sup>73</sup> Wevers A (2001) Quietly different: Women drug users. *Harm Reduction News*, vol. 2 issue 3.

<sup>74</sup> MacRae, R., Aalto, E. (2000). *Op. cit*

<sup>75</sup> *Ibid.*

use his syringe after he does. On the physiological level, women's smaller surface veins make them more likely to need help injecting<sup>76</sup> and thus to share injection equipment. Finally, a history of sexual violence is associated with a variety of risks, including those that are drug-related. In a Vancouver study of 932 male and 505 female IDUs, 68 percent of women and 19 percent of men reported a history of sexual violence. Study participants with a history of sexual violence were more likely to have been in the sex trade, to knowingly share injecting equipment with HIV-positive people, to have attempted suicide, to have accidentally overdosed, and to have been diagnosed with a mental disorder/disability.<sup>77</sup>

Bourgois, Prince, and Moss' ethnographic investigation into the increased risk of hepatitis C infection among homeless IDU women in San Francisco provides insight into some of the factors that increase women's injection-related risk. Bourgois *et al.* suggest that "patriarchal cultural scripts" increase women's risk by causing them to be injected by their partners and to allow their partners to purchase their drugs (though the women often pay for them). Young women new to a drug scene at first have easy access to resources, as older men compete to partner with them. Women's vulnerability to violence makes it preferable for them to partner with a man: though violence from partners is commonplace, it is a single, familiar threat that replaces attacks from many sides. In exchange for a measure of protection, men receive financial support through women's sex work, shoplifting, or drug dealing. Control of a woman's drug use becomes a way for a man to control her financial resources. Men get the drugs, prepare them, and inject them. The men sometimes inject first and then inject their partner with the used needle, or they prepare the drugs out of sight so that their partners cannot tell whether they are using a clean syringe.<sup>78</sup>

### *Transgender women and women who have sex with women*

The disfavored and often illegal status of transgender women and women who have sex with women (WSW) reduces their access to health care from nondiscriminatory providers who will give them care and information appropriate to their needs,<sup>79</sup> and reduces their leverage when bargaining for safer sex and clean injecting equipment.<sup>80</sup> There is very limited research on WSW and transgendered women who use drugs, but existing evidence suggests this discrimination puts them at heightened risk of HIV.

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<sup>76</sup> Kral, AH, Bluthenthal, RN, Erringer, EA, Lorvick, J, Edlin, BR (1999). Risk factors among IDUs who give injections to or receive injections from other drug users. *Addiction*, 94, 675-683.

<sup>77</sup> Braitstein, P *et al* (2003). *Op cit.*

<sup>78</sup> Bourgois, P (2004). *Op cit.*

<sup>79</sup> Dean L *et al* (2000). Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns. *Journal of the Gay and Lesbian Medical Association* 4(3) 102-151. Schleifer, R (2004). *Hated to Death: Homophobia, Violence, and Jamaica's HIV/AIDS Epidemic*. Human Rights Watch, New York. Vol. 16, No. 6(B). For a list of countries with enforceable laws against sex between consenting same-sex partners, see International Gay and Lesbian Human Rights Commission, "Where having sex is a crime." <http://www.iglhrc.org/site/iglhrc/content.php?type=1&id=77>. Accessed July 16, 2007.

<sup>80</sup> Young, R, Friedman, S, Case, P (2005). Exploring an HIV paradox: An ethnography of sexual minority women injectors. *Journal of Lesbian Studies* 9(3).

Research from the United States confirms a fairly high prevalence of same-sex sexual behavior among women IDUs<sup>81</sup> and a high prevalence of risky sexual and drug use practices among drug-using WSW.<sup>82</sup> A study in New York and Boston investigated markedly higher HIV rates among WSWs<sup>83</sup> than among other injectors, and attributed the elevated rates to multiple forms of marginalization that promoted unsafe sexual and injection practices.<sup>84</sup> Another study in the United States found that over 50 percent of 231 women who had reported female sex partners in the last month had also had sex with men. Of these, 70 percent had not used condoms for vaginal sex and 74 percent had not for anal sex. Over 66 percent had shared injection equipment, and 53 percent had shared needles.<sup>85</sup>

Similarly, studies in the United States have shown that the risk factors driving HIV transmission in transgender people include social stigma, transactional sex for survival needs, and lack of regular, informed, confidential, and nonstigmatizing medical care. One 1991 study found higher seroprevalence rates among transgender people than among nontransgender groups, including IDUs.<sup>86</sup> Studies have also found evidence of risky behavior during illicit drug, hormone, and silicone use. In a 2002 study of 81 transgender participants, 8 of the 12 respondents who reported a history of injecting drug use said they had used a needle that was not new or clean.<sup>87</sup> For a variety of reasons, notably lack of access to affordable, legal hormone therapy and plastic surgery, some transgender women use contaminated needles for illicit hormone or silicone injections, putting them at risk of HIV and other blood-borne illnesses.<sup>88</sup>

### *Drug use, pregnancy, and motherhood*

Ill-informed and punitive policies, ferocious stigma, and lack of access to accurate information jeopardize the health of women drug users and their children. Media rhetoric, popular belief, and some health care providers promote the idea that any drug use, including drugs used in medication-assisted treatment, precludes the possibility of a healthy pregnancy, despite evidence that it is not the fact of drug use but rather withdrawal and the degree, type, and timing of drug use, as well as other secondary factors that have a profound effect on the outcome of a pregnancy.<sup>89</sup> Researchers have

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<sup>81</sup> Warren, N (1993). Out of the question: Obstacles to research on HIV and women who engage in sexual behaviors with women. *SIECUS Report*, 22(1), 14.

<sup>82</sup> Kral, A, Lorvick, J, Bluthenthal, R., *et al.* (1997). HIV risk profile of drug-using women who have sex with women in 19 United States cities. *J Acquired Immune Deficiency Syndromes and Human Retrovirals*, 16, 21.

<sup>83</sup> Absalon, J, Fuller, CM, Ompad, DC, Blaney, S, Koblin, B, Galea, S, Vlahov, D (2006). Gender differences in sexual behaviors, sexual partnerships, and HIV among drug users in New York City. *AIDS Behavior*. 10:707–715.

<sup>84</sup> Young *et al* (2005). *Op cit.*

<sup>85</sup> Young, RM, Weissman, G, Cohen, J (1992). Assessing risk in the absence of information: HIV risk among women injection drug users who have sex with women. *AIDS & Public Policy Journal*, 7(3), 175-183. A study of health behaviors among lesbian and bisexual women. A community-based women's health survey conducted by the San Francisco Department of Public Health AIDS Office, Prevention Services Branch, October 1993. Young, RM, Friedman, SR, Case, P, *et al.* (2000). Women injection drug users who have sex with women exhibit increased HIV infection and risk behaviors. *J Drug Issues*, 30, 499.

<sup>86</sup> Gattari, P, Rezza, G, Zaccarelli, M *et al.* (1991). HIV infection in drug using transvestites and transsexuals [letter to the editor]. *European Journal of Epidemiology*, 7, 711–712.

<sup>87</sup> Kenagy, GP (2002). HIV among transgendered people. *AIDS Care*, 14(1), 127-134(8).

<sup>88</sup> Dean *et al* (2000). *Op cit.*

<sup>89</sup> Reinerman, C and Levine, H (1997). *Op cit.*

found that many of the health problems and behaviors once attributed to prenatal exposure to cocaine are in fact the result of malnutrition, lack of sleep, lack of medical care, tobacco and alcohol use, and lack of early mother-child bonding due to isolation of babies in specialized units.<sup>90</sup> Good prenatal care, a healthy diet, drug treatment, and other forms of support allow women drug users to give birth to healthy babies. Medication-assisted treatment with methadone or buprenorphine, which are safe for use during pregnancy, is essential in helping opiate users to avoid withdrawal, overdose, HIV transmitted through unsafe injection, and other drug-related risks that endanger the health of a woman and her fetus. (See section on designing drug treatment services for women.)

Because regular opiate use and the poor nutrition and stress associated with many types of habitual illicit drug use can cause amenorrhea, the cessation of monthly menstrual flow, women drug users may not know they are pregnant for several months. Vomiting, nausea, and other signs of pregnancy may seem unremarkable for a drug user, and some assume that drug use prevents conception and obviates the use of contraception. As a consequence, women may not attempt to enter drug treatment, safely reduce drug use, or improve nutrition and sleep habits until the third trimester, when such risk-reduction strategies are least effective and most potential injury to the fetus has already been done. In many countries, the third trimester is also too late for women to choose to have an abortion, should they wish to do so. The stigma of drug use during pregnancy also encourages women to conceal their drug use from providers, similarly limiting their access to harm reduction information and specialized care.<sup>91</sup>

Myths and half-truths about drug use during pregnancy can spur pregnant drug users to try to cease all drug use abruptly and without medical support, inadvertently causing injury to their fetus through withdrawal. If a woman relapses or is unable to abstain, she may assume that all is lost and that nothing more can be done to protect her fetus.<sup>92</sup> Some women respond to this artificially imposed dilemma by remaining in denial about their pregnancy until the last moment, giving them little opportunity even to consider services to prevent mother-to-child transmission of HIV (PMTCT), drug treatment, or risk reduction strategies.<sup>93</sup> Failure to provide pregnant women drug users with harm reduction, drug treatment services, and other medical and social support is particularly regrettable since pregnancy is often a powerful motivator to reduce problematic drug use and related harms,<sup>94</sup> and is an excellent opportunity for providers to offer care that can lead to long-term changes in drug use and lifestyle that can protect women's health long after their baby is born.

Pregnant drug users face stigma and vilification from every side. Hostility in the media and in the popular imagination is compounded by hostility from health care providers,

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<sup>90</sup> Frank, D, Augustyn, M, Knight, WG, Pell, T, Zuckerman, B (2001). Growth, development, and behavior in early childhood following prenatal cocaine exposure: A systematic review. *JAMA*, 285(12). Reinerman, C and Levine, H (1997). *Op cit*. Klee, H, Jackson, M, Lewis, S (2002). *Drug Misuse and Motherhood*. London: Routledge.

<sup>91</sup>Entire paragraph: Murphy, S & Rosenbaum, M (1999). *Pregnant Women on Drugs: Combating Stereotypes and Stigma*. New Brunswick: Rutgers University Press.

<sup>92</sup> Murphy, S and Rosenbaum, M (1999). *Pregnant Women on Drugs*. *Op cit*.

<sup>93</sup> *Ibid*.

<sup>94</sup> *Ibid*., Taylor A (1993), *Women drug users*, *Op cit*.



family members, and even other drug users. Accounts of pregnant drug users in San Francisco and in Glasgow found that partners became abusive or violent when women continued using drugs during pregnancy, that drug dealers sometimes refused to sell to women who were visibly pregnant, and that partners, family, and friends pressured women to abort.<sup>95</sup> The stigma attached to a pregnant drug user can force women into riskier practices such as injecting alone, paying someone else to buy them drugs, concealing their pregnancy, and engaging in the most marginal, high risk forms of sex work.<sup>96</sup>

In the United States, drug-using women have been shackled immediately after childbirth, arrested, and tried in court for endangering their unborn children.<sup>97</sup> In 2004, a woman from South Carolina was charged with murder after cocaine was found in her stillborn baby's system. She was convicted and is now serving a 12-year sentence.<sup>98</sup> In the United States, Canada, and some Western European countries, detection of a mother's drug use is often a central factor in her loss of custody. As a consequence, some women avoid contact with health care providers, giving birth outside hospitals or not seeing a doctor until they go into labor.<sup>99</sup>

In other countries, including Russia and Ukraine, drug-using or HIV-positive women are pressured or coerced to abort or to give up their children to the care of the state, and are denied accurate information about PMTCT or drug use and treatment during pregnancy.<sup>100</sup> This, along with drug user registration, reduces women drug users' access to drug treatment and PMTCT. In Russia, pregnant women with HIV who do not seek prenatal care before delivery are often active drug users or sex workers.<sup>101</sup> In Irkutsk, Russia, Kiev, Ukraine, and in other places, it has been reported that IDU women do not seek prenatal care, arriving at birthing centers (*roddom*) only when they are already in labor.<sup>102</sup> In 1996–2001, most HIV-infected infants in Ukraine and the Russian Federation were born to mothers who were either injecting drug users or sexual partners of injecting drug users.<sup>103</sup> And in Poland, only 50 percent of pregnant drug-using women receive prenatal care; a six-month study in obstetric clinics found that of those who identified themselves as drug users during delivery, 54 percent were HIV positive.<sup>104</sup> It has been argued that the encouragement and coercion to abandon children is the product of a

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<sup>95</sup> *Ibid.*

<sup>96</sup> *Ibid.*, Murphy, S and Sales, P. *Op cit.*

<sup>97</sup> Paltrow, LA (1999). "Punishment and prejudice: Judging drug-using pregnant women," in Julia E. Hanigsberg and Sara Riddick, eds., *Mother Troubles*. Beacon Press.

<sup>98</sup> Lester, BM, Andreozzi, L, and Appiah, L (2004). Substance use during pregnancy: Time for policy to catch up with research. *Harm Reduction Journal*, 1(5), 6. South Carolina is the only state to have upheld this approach.

<sup>99</sup> Murphy, S & Rosenbaum, M. (1999). *Op cit.*

<sup>100</sup> Babakian, G (2005). *Positively Abandoned. Stigma and Discrimination against HIV-positive Mothers and Their Children in Russia*. Human Rights Watch, New York, 2005. Personal communication, Olga Belyaeva, Charitable Foundation Virtus, Ukraine, 2007.

<sup>101</sup> Babakian, G (2005). *Op cit.*

<sup>102</sup> *Nezavisimaya Gazeta*. (2006). Vich obosnovalsya vblizi baikal'skikh voln. Retrieved from [http://www.ng.ru/health/2006-12-01/9\\_vich.html](http://www.ng.ru/health/2006-12-01/9_vich.html). Personal communication, Dr. Svetlana Tishenko, Krok za Krok, Kiev, May 2007.

<sup>103</sup> Hamers, FF and Downs, AM (2003). "HIV in Central and Eastern Europe," *Lancet*, 361: 1036.

<sup>104</sup> Niemiec, T (2006). *Sprawozdanie z realizacji programu badawczego „Model opieki perinatalnej nad ciężarną uzależnioną od środków psychoaktywnych, otrzymującą metadon.”* Warsaw: Mother and Child Institute.

Soviet ideology that values institutionalization over individual care and promotes the replacement of the family by the state.<sup>105</sup>

The story of one Thai drug user, interviewed in 2002 by human rights researchers, illustrates some of the anguish, desperation, and violent stigma faced by so many pregnant drug users:

She lived under a rickety bamboo and corrugated tin shack in Bangkok's biggest and most drug-plagued slum.... She was seven months pregnant and had never been to a doctor out of fear of being seen as a bad woman. When she walked down the street, she got derogatory looks and catcalls for being a junkie. She tried to avoid going anywhere, and lived among garbage, rusty nails, animals, and brackish water underneath a house, where her boyfriend injected her with heroin. She was desperately afraid for her unborn children (in the end, she had twins), and didn't know anything about methadone, thinking it might harm her fetus. [Researchers] provided her with the information that methadone is not harmful in pregnancy, but that reducing her cigarette smoking would be enormously beneficial, which made her glad to know that she could do something immediately and on her own.<sup>106</sup>

Punitive policies and stigma toward pregnant drug users have tragic and at times lethal effects on women and their children, driving women away from the services that will allow them to have healthy babies and make positive changes that will help them be healthy mothers.

#### *Punitive drug policies, incarceration, and police abuse*

In many countries with injection-driven HIV epidemics, stigmatizing, punitive public policies discourage drug users from seeking services.<sup>107</sup> Harsh drug policies have a disproportionate impact on women: according to UNODC, the proportion of drug users among female prisoners is higher than among male prisoners, injecting drugs with shared equipment is particularly common among female prisoners, and the HIV rate among female prisoners is higher than it is among male prisoners.<sup>108</sup> In the United States, the country with the world's highest rate of incarceration, harsh drug policies have increased the number of women in prison by as much as 888 percent between 1986 and 1999.<sup>109</sup> Drug possession and complicity in drug transactions often carry heavy penalties,<sup>110</sup> and

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<sup>105</sup> Personal communication, Anna Shakarishvili, UNAIDS Ukraine, April 2007.

<sup>106</sup> Personal communication, Karyn Kaplan, Thai Treatment Action Group, May 2007.

<sup>107</sup> For more information, see Malinowska-Sempruch, K, Gallagher, S (eds). (2004). *War on drugs, HIV/AIDS and human rights*. New York: International Debate Education Association. Human Rights Watch (2004). Not enough graves: The war on drugs, HIV/AIDS, and human rights (2004); Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation (2004); Rhetoric and risk: Human rights abuses impeding Ukraine's fight against HIV/AIDS (2006), New York.

<sup>108</sup> UNODC (2006). HIV/AIDS prevention and care for female injecting drug users. Retrieved from [http://www.unodc.org/pdf/HIV-AIDS\\_femaleIDUs\\_Aug06.pdf](http://www.unodc.org/pdf/HIV-AIDS_femaleIDUs_Aug06.pdf).

<sup>109</sup> American Civil Liberties Union, the Brennan Center, and Break the Chains. *Caught in the Net: The Impact of Drug Policies on Women and Families*. Retrieved from <http://www.fairlaws4families.org/final-caught-in-the-net-report.pdf>.

<sup>110</sup> For example: "Brenda Prather was sentenced to forty years to life imprisonment upon conviction of criminal sale of a controlled substance. Brenda was charged with this offense after her husband sold drugs to an undercover New York State police investigator on two occasions. The charge was based in part on the fact that Brenda handed her husband a roll of foil from their kitchen that he subsequently used in drug related activity. Although her husband testified that Brenda was unaware of the drug transactions for which she was charged, the state imputed knowledge of the drug transactions to her." American Civil Liberties Union *et al*, *Caught in the Net*. *Op cit*.

women who are carrying drugs only for personal use or are in the vicinity of a partner or family member's drug dealing receive substantial prison sentences that separate them from their families, expose them to an array of physical and psychological harms, and reverberate through the rest of their lives.<sup>111</sup> In some countries, including the United States, Russia, and Georgia, those convicted of drug offenses or identified as drug users can suffer consequences that include denial of public housing and other benefits, increased risk of losing custody of their children, and discrimination from employers, doctors, courts, and educational institutions.<sup>112</sup> Imprisonment further increases the HIV risk of a group that is already many times more likely than women in the general population to experience addiction, have a history of sexual and physical abuse, and suffer from mental illness.<sup>113</sup> Female prisoners have reported widespread sexual abuse by guards, another potential HIV risk and a clear human rights abuse.<sup>114</sup> Women in prison may also face reduced access to life-saving medical care. Compared to men, incarcerated women in the United States have higher rates of HIV, hepatitis C, and serious mental illnesses, yet can be denied even basic medical services, including prenatal care.<sup>115</sup>

Criminalization of possession of drugs for personal use also exposes drug users to police abuse, and can make it difficult or impossible for users to report crimes. Women drug users are especially vulnerable to such abuse, which can take the form of sexual exploitation. In Kazakhstan, police come to drug-dealing points to conduct body cavity searches, which women IDUs report lead to sex in exchange for the return of seized drugs.<sup>116</sup> In Russia, Ukraine, and other countries, reported abuses of drug users include extortion by the police, denial of access to legal counsel, drug withdrawal used as torture, and involuntary HIV testing.<sup>117</sup> These all constitute serious human rights violations<sup>118</sup>

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<sup>111</sup> The health risks of incarceration are by no means limited to women. Prisoners in most parts of the world have little or no access to harm reduction or drug treatment in prisons, though drug use and unsafe sex, including rape, continue. Availability of other forms of health care, including HIV and TB treatment and mental health care, is usually poor, as well. See, for example, Canadian HIV/AIDS Legal Network (2004). *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience*. [www.aidslaw.ca](http://www.aidslaw.ca). Belenko S, Peugh J (2005). Estimating drug treatment needs among state prison inmates. *Drug and Alcohol Dependence* 77. Stern V (2001). Problems in prisons worldwide, with a particular focus on Russia. *Annals of The New York Academy of Sciences*, Vol. 953. Sarang, A, Rhodes, T, Platt, L *et al* (2006). Drug injecting and syringe use in the HIV risk environment of Russian penitentiary institutions: Qualitative study. *Addiction*, 101. UNAIDS (1997). *Prison and AIDS*. Geneva. Bollini, P, Laporte, JD, Harding, TW (2002). HIV prevention in prisons: Do international guidelines matter? *Eur J Public Health*, 12(2), 83-9.

<sup>112</sup> American Civil Liberties Union *et al. Caught in the Net*. Op cit. Personal communications, Lev Levinson, International Center on Human Rights; Yuri Ivanov, narcologist, Tver'; David Otiashvili, Union Alternative Georgia, 2006-2007.

<sup>113</sup> Henderson, DJ (1998). Drug abuse and incarcerated women: a research review. *J Substance Abuse Treatment*, 15(6), 579-587.

<sup>114</sup> Amnesty International (1999). "Not part of my sentence: Violations of the human rights of women in custody." Retrieved from <http://web.amnesty.org/library/index/ENGAMR510011999>

<sup>115</sup> Barr, M (2007). Some facts and anecdotes of women arrested and imprisoned in the United States. In Nagel, M and Asumah, S (eds). *Prisons and Punishment: Reconsidering Global Penalty*. Trenton, NJ: Africa World Press.

<sup>116</sup> Human Rights Watch (2003). *Fanning the flames: How human rights abuses are fueling the AIDS epidemic in Kazakhstan*. *Op cit*.

<sup>117</sup> Yale Center for Interdisciplinary Research on Aids (CIRA) (2005). *Drug policy and HIV prevention in Russia. The case of HIV/AIDS prevention*. Conference report. Human Rights Watch, *Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation, Rhetoric and risk: Human rights abuses impeding Ukraine's fight against HIV/AIDS*. Op cit. Csete, J, Cohen, J. Lethal violations: Human rights abuses faced by injecting drug users in the era of HIV/AIDS, in *War on drugs, HIV/AIDS and human rights*. Op cit.

that inhibit IDUs' ability to use harm reduction services and practice safer drug use.<sup>119</sup> Even when the police are not the perpetrators, drug users often do not report crimes out of a reluctance to attract potentially damaging attention, or out of the often justified belief that law enforcement officials do not take crimes against drug users and sex workers seriously. This further increases women drug users' vulnerability to physical and sexual violence and exploitation that can increase their risk of HIV.

#### *Lack of confidentiality from service providers and police*

In many countries of Eastern Europe and Central Asia, court- or police-ordered drug treatment, arrest on a drug-related charge, or even admission of drug use to a doctor can lead to registration as a drug user, which can have a range of detrimental consequences, including ineligibility for free ARV treatment and public housing, loss of drivers' licenses, and police harassment.<sup>120</sup> Registration can be especially threatening to women, whose custody of their children can be jeopardized and who, as discussed earlier in this paper, face particularly severe stigma and discrimination when their drug use is exposed. It can lead women to avoid many types of services, from drug treatment to harm reduction to prenatal care. In Russia, a diagnosis of drug addiction is legal grounds for loss of parental rights,<sup>121</sup> providing women with a clear reason to avoid drug treatment. Research in Ukraine found that women had difficulty using harm reduction services because of registration requirements that raised concern about stigma and loss of custody.<sup>122</sup>

A lack of safeguards to protect women drug users' privacy discourages contact with institutions and disclosure of drug use. Whether out of carelessness, poor planning, or the assumption that women drug users do not have a right to confidentiality, caregivers often reveal women's drug use and HIV status, whether intentionally or inadvertently, to family members and others. Some health care providers intentionally disclose a patient's status to others, including the police or government agencies. Sometimes information about drug use and HIV are not kept confidential—for instance, the outside of a patient's medical file states that she is a drug user, or the beds of HIV-positive patients are marked.<sup>123</sup> The organization of hospital wards can also reveal a patient's drug use—for example, if babies born to active drug users are kept in a separate ward, visitors know immediately that mothers used drugs during pregnancy.<sup>124</sup> This can be deeply upsetting to women who have gone to great lengths to conceal their drug use from parents, partners, or friends, let alone the police or other authorities, and can compromise their relationships with their families, their custody of their children, and their physical safety.

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<sup>118</sup> Csete J., Cohen, J. *Op. cit.*

<sup>119</sup> Human Rights Watch, *Lessons not learned: Human rights abuses and HIV/AIDS in the Russian Federation. Op cit.*

<sup>120</sup> Personal communication, Yury Ivanov, 2006. Rhodes, T, Platt, L, Sarang, A, Vlasov, A, Mikhailova, L, Monaghan, G (2006). Street policing, injecting drug use and harm reduction in a Russian city: A qualitative study of police perspectives. *J of Urban Health: Bulletin of the New York Academy of Medicine*, 83(5).

<sup>121</sup> Lev Levinson. Personal communication, 2007.

<sup>122</sup> Centre for Social Expertise of the Institute of Sociology at the National Academy of Science of Ukraine (2005). A review of work with injecting drug users in Ukraine in the context of the HIV/AIDS epidemic. Kiev.

<sup>123</sup> Klee *et al* (2002). *Op cit.* Personal communication, Milena Naydenova, Hope-Sofia, 2006. Human Rights Watch, Rhetoric and Risk. *Op cit.*

<sup>124</sup> Klee *et al* (2002). *Op cit.*

### *Marginalization within services*

In many parts of the world, harm reduction and drug treatment programs have mostly male clients and do not provide services specific to women's needs, offer spaces or times for women, or have safeguards to ensure that women are not threatened by men in the program.<sup>125</sup> This can create an intimidating, alienating, and unsupportive environment for women, particularly since women drug users are more likely than other women or male drug users to have experienced physical or sexual violence, and are in particular need of a safe, non-threatening environment.<sup>126</sup> Many programs have few, if any, women outreach workers,<sup>127</sup> which can impede their ability to attract women to their services. At the largest harm reduction program in Iran, only 2-5 percent of clients are women, and the director reports that scarce resources and high demand force programs to focus on men, while patriarchal social structure and powerful stigma against women drug users make them last in line to receive services.<sup>128</sup> In Sichuan, China, substantially fewer women IDUs than men reported having access to methadone maintenance, in part because many of them were migrant sex workers and therefore ineligible for programs<sup>129</sup> (China has since eliminated residency registration requirements for methadone treatment).

Worldwide, women appear to be underrepresented in drug treatment, and many inpatient drug treatment services have no special sleeping areas, bathrooms, or other spaces for women.<sup>130</sup> Failure to provide specialized services or to create a space in which women feel comfortable may deter women from accessing services, further reducing the number of women clients, making women drug users even less visible to service providers, and making it even less likely that programs will develop gender-sensitive services.

### *Barriers to access to drug treatment*

Though the desire to give birth to healthy babies, be good mothers, and retain custody of children is one of the most powerful motivators to enter drug treatment, lack of child care is the most significant obstacle to women wishing to enter drug treatment.<sup>131</sup> Many women do not want to leave their children for weeks or months while they undergo inpatient treatment, and studies show that women are more likely to remain and succeed in treatment when they retain custody of their children.<sup>132</sup> Even if they are willing to be

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<sup>125</sup> Personal communication, Grzegorz Wodowski, Monar (Poland), 2006; Ingrid Irawati Atmosukarto, Laura Nevendorff, Sekar Wulan Sari (Indonesia), 2007; Karyn Kaplan (Thailand), 2007. Khodakevich, L, Andrushchak, L, Gailevich, R, Adamian, R, Bivol, S (2004). The extent of use of maternity and child health services by pregnant women injecting illicit drugs. *International Journal of Drug Policy*, 15(3), 209.

<sup>126</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

<sup>127</sup> Burrows, D. High coverage sites: HIV prevention among injecting drug users in transitional and developing countries: Case studies. UNAIDS Best Practice Collection. Geneva, 2006.

<sup>128</sup> Personal communication, Bijan Nassirimanesh, Persepolis, 2006.

<sup>129</sup> Choi (2006). *Op. cit.*

<sup>130</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

<sup>131</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.* McMurtrie, C, Rosenberg, K, Kerker, B, Kan, J, Graham, E (1999). A unique drug treatment program for pregnant and postpartum substance-using women in New York City: Results of a pilot project, 1990–1995. *Am J of Drug and Alcohol Abuse*, 25(4), 701–713.

<sup>132</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

separated from their children during treatment, many women do not have the option to do so. Women are children's primary caregivers in all sectors of society, and women drug users are less likely to have the financial resources and social support networks to allow them to leave their children for a prolonged period.<sup>133</sup> Yet few drug treatment or harm reduction programs have the child care services, flexible hours and regulations, short waiting periods, and mobile delivery of medications that would make it easier for women to fit visits into their schedules. In Eastern Europe, Central Asia, South and Southeast Asia, China, and Africa, effective outpatient drug treatment—notably medication-assisted treatment—is available to only a tiny proportion of those in need.<sup>134</sup> In Russia, home to two million IDUs, methadone and buprenorphine are unavailable. Worldwide, only a handful of drug treatment programs have child care facilities or a child-friendly environment that would allow women to bring their children with them on visits.<sup>135</sup> Inpatient treatment with child care would help some women, but even given the opportunity, some women do not want their children to spend long periods in a treatment center, and others do not wish to undergo treatment in the presence of their children.<sup>136</sup> Lack of child care can also limit women's access to harm reduction services, since women may not be able to leave their children for trips to a service site. In general, women require programs that take into account domestic responsibilities. In an Australian survey, women were less likely to drop out of drug treatment programs that were flexible, had few rules, and offered individualized care.<sup>137</sup>

Drug treatment in many countries is prohibitively expensive for many people of both sexes, but because women are more likely to be financially dependent on others and to earn less, they may have even greater difficulty than men do in paying for drug treatment. Especially in resource-poor settings, families tend to invest less in female family members than in males,<sup>138</sup> and this can translate into a reduced willingness to pay for drug treatment.

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<sup>133</sup> *Ibid.*

<sup>134</sup> IHRD (2006). *Harm reduction developments 2005: Countries with injection-driven HIV epidemics*. New York: International Harm Reduction Development Program (IHRD) of the Open Society Institute.

<sup>135</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

<sup>136</sup> Taylor A (1993). . *Op cit.*

<sup>137</sup> Swift, W, Copeland, J, Hall, W (1995). *Characteristics and treatment needs of women with alcohol and other drug problems: Results of an Australian National Survey*. Canberra, Australia: National Drug Strategy Research Report Series, No. 7.

<sup>138</sup> Lin, N. (2000). Inequality in Social Capital. *Contemporary Sociology*, 29(6), 785-795. UNFPA (2000). *Counting the Cost of Gender Inequality*. The State of World Population 2000. New York.

## Designing Services for Women Who Use Drugs

The needs outlined in the previous sections show clearly that gender-sensitive services for women drug users are necessary. For example, well-trained, qualified women staff and outreach workers will help create a woman-friendly environment. Special times, places, and services for women will serve their needs better and give them a safe space in which they feel comfortable. Fulfillment of basic needs will give women the time, space, and safety needed to make positive changes to their drug use and sexual practices. The following section outlines gender-sensitive harm reduction, drug treatment, and sexual and reproductive health services for women who use drugs.

### *Involve women drug users in services and policymaking*

Meaningful involvement of women who use drugs in service design and delivery can improve the effectiveness and efficiency of health and social services. The presence of other women drug users as staff members and volunteers will make women drug users feel more comfortable, less stigmatized and marginalized, and better understood by a program. People who use drugs have “inside knowledge”<sup>139</sup> that is essential to an informed approach to service provision and policymaking. For both ethical and practical reasons, the involvement of women who use drugs must be the basis of any response to this population’s needs.

Greater involvement of women who use drugs can be accomplished in a number of ways.<sup>140</sup> The overarching goal should be to empower women to contribute ideas and to hold real decision-making authority. Agencies serving women who use drugs should, for example, be required to establish service-user advisory committees and elect women who use drugs to their boards of directors. In the hiring and promotion of staff, including for management positions, direct experience of injecting drug use should be considered a positive credential in evaluating a candidate. Similarly, research projects that include drug users as subjects have a responsibility to involve drug user representatives on ethical review boards, to seek consultation with drug users throughout all phases of research, and to share results. There is also a growing body of expertise and experience in conducting community-based participatory research.<sup>141</sup> Researchers should pursue participatory research as a means of both enhancing quality and supporting social justice, particularly when focusing on marginalized or otherwise “hard to reach” populations such as women who use drugs. Finally, government and other policymaking bodies should strive to include women drug users on relevant committees, involve them in hearings, and otherwise support substantive participation. This includes support to overcome the barriers to effective participation that are caused by stigma, discrimination, and health concerns.

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<sup>139</sup> Balian, R and White, C (1998). “Defining the Drug User.” *Harm Reduction Communication*. Harm Reduction Coalition, New York. <http://harmreduction.org/pubs/news/fall98/f98toc.html>.

<sup>140</sup> For a comprehensive, practical overview of this subject, see *Nothing About Us Without Us: Greater, Meaningful Involvement of People Who Use Illegal Drugs*. Canadian HIV/AIDS Legal Network. Toronto: 2005. Available online at [www.aidslaw.ca](http://www.aidslaw.ca).

<sup>141</sup> See, for example, Minkler, M and Wallerstein, N (2003). *Community Based Participatory Research for Health*. San Francisco: John Wiley & Sons.

### *Create a woman-friendly environment*

Since women drug users are inordinately likely to have experienced violence and often feel marginalized and stigmatized even by other drug users, services must strive to create a woman-friendly environment. Trained women staff members and volunteers may make women feel more at ease, and are essential for women who are not comfortable receiving care or treatment from men. Women's support groups provide a forum for women to discuss their concerns and experiences in a space in which they do not feel marginalized or vulnerable to sexual harassment or assault. Separate space used only by women can create a sense of safety and ownership.<sup>142</sup> Because so many women drug users have experienced sexual violence, it is imperative that programs work to ensure that male harm reduction clients are not aggressive or threatening to women clients. Staff members need clear policies, training, and supervision to prevent sexual harassment or sexual relationships between staff and clients/patients,<sup>143</sup> and to ensure that women can receive care in an atmosphere free of any perceived threat.

### *Help women become more independent*

A growing body of evidence suggests that in order to be effective, HIV prevention interventions must address risk factors beyond the level of the individual.<sup>144</sup> Such interventions are especially important for women, for whom sexual and familial relationships, experiences of sexual and physical violence, and social and structural power imbalances play a greater role in drug use and HIV risk. Couples counseling can help women to negotiate a reduction in sexual and injection-related risk behavior with their partners, and address the power dynamics that underlie these risks. Women's support groups, specialized counseling, and women outreach workers can help women drug users to negotiate safer injecting, while gender-sensitive syringe exchange and outreach can provide women with injection supplies and reduce their reliance on men. Safer injection education can help women learn to inject themselves safely without assistance. Strong connections between harm reduction programs and women's shelters, services for survivors of domestic violence, and rape and domestic violence prevention programs can reduce women's vulnerability to their partners. Job training and placement assistance can help women become financially independent and avoid damaging economic dependence on abusive partners. Legal aid programs can help women access legal remedies for abuse, exploitation, unjust incarceration, and loss of custody of their children, while sending the message that women drug users cannot be abused with impunity. Self-defense classes can help women protect themselves from assault.

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<sup>142</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

<sup>143</sup> For an insightful discussion about the need to prevent sexual relationships between staff and clients, and about the complexities of sexual relationships between volunteers and clients, see Balian, R & White, C (1998). User Friendly Policies for Harm Reduction Organizations. Retrieved from <http://209.249.52.94/research/policy/userfriendly.htm>

<sup>144</sup> See, for example, Miller, M & Neaigus, A, *op cit*; Rhodes, T, Singer, M, Bourgois, P, Friedman, SR, Strathdee, SA (2005). The social structural production of HIV risk among injecting drug users. *Social Science and Medicine*, 61, 1026-1044.



For many women drug users, poverty lies at the heart of risk. Many successful harm reduction programs help fulfill basic needs, showing women that they care about their immediate well-being by providing food, shelter, transitional housing, clothing, and showers. Tampons, sanitary pads, and other useful women's products can be provided along with standard safe injecting kits to attract and retain women and show them that programs are aware of their needs and recognize that women use drugs, too. For pregnant and parenting women, some programs have provided prenatal vitamins and nutritional counseling, children's clothing and other items, childhood immunizations, infant formula and food, pediatric consultations, parenting support, and help dealing with social services.<sup>145</sup>

Race, ethnicity, and lack of resident status are often crucial factors in whether a woman is poor, homeless, in prison, or without access to health services.<sup>146</sup> Long experience of discrimination and disenfranchisement can have a negative impact on the self-esteem and mental health of racial, ethnic, and sexual minority women, increasing the risk of problematic substance use and high risk behaviors. Service providers need to ensure that they are creating an inclusive space by employing staff members who reflect their clients' background and providing services that respond to their needs as they are shaped by racial, ethnic, national, or sexual identity.

Many successful services for women drug users provide case management to help women make and keep appointments with doctors and social workers and to navigate the often labyrinthine landscape of health and social services. This can include long-term, individual counseling and assistance in navigating health and social services, accompaniment to appointments, and patient advocacy.

#### *Make programs available for mothers*

Since lack of child care is the greatest obstacle to women's access to drug treatment,<sup>147</sup> providing child care and allowing children to stay with their mothers in inpatient drug treatment facilities can increase women's willingness and ability to enter treatment. The many women who do not need or want inpatient treatment, or who cannot or will not bring children with them to treatment, need access to effective outpatient treatment that interferes as little as possible with their child care, work, and household responsibilities. If possible, drug treatment and harm reduction programs should create safe, clean, age-appropriate spaces where children can stay while their mothers receive care. However, it should be noted that this may be difficult for programs with limited resources; the presence of children may be unwelcome to other clients or to the mothers themselves; the presence of children at some service sites may pose a prohibitive safety risk; and mothers may not want their children to know that they are drug users. These limitations make it especially important that programs work with women to provide services that do not interfere with their family responsibilities (see below).

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<sup>145</sup> For an example of such a program, see the website of Sheway, a program for pregnant and parenting drug users in Vancouver. <http://www.vch.ca/women/sheway.htm>

<sup>146</sup> See *Caught in the Nets, op cit.*, for an in-depth examination of race, gender, and drug policy in the United States.

<sup>147</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

*Provide low-threshold syringe access, mobile services, and secondary exchange*

Some women may be unable to visit harm reduction sites because of child care and other domestic responsibilities, because their partners oppose it, because they cannot afford the cost of transportation to a site, because they are unwilling to be identified as a drug user, or for other reasons. There are a number of changes that harm reduction sites, with the support of policymakers, can use to overcome these obstacles.

The frequency of syringe exchange visits can be reduced by elimination of limits to the number of syringes that can be exchanged at one time. Visits of all types can be made more convenient by extending working hours or making them more appropriate to client schedules, providing mobile services and outreach to locations easily accessible to women drug users, and minimizing waiting times. Making syringes available over the counter in pharmacies, without the threat of police harassment or a pharmacist's breach of confidentiality, can also make syringes more accessible to women by providing a discreet source in women's neighborhoods, though stigma may still deter some women. Providing harm reduction and drug user-oriented sexual and reproductive health services through other women-centered services (for instance, women's shelters or domestic violence prevention services) can provide access to those unwilling or unable to visit a harm reduction or drug treatment site. Particularly in small communities, services should be positioned in such a way that entry is not tantamount to disclosure that one uses drugs.

Secondary syringe exchange, when a woman obtains and returns syringes through another person who visits a syringe exchange site, can increase access for women unable to use syringe exchanges directly.<sup>148</sup> For example, a woman who is unwilling to be seen at a syringe exchange because of stigma, or who is unable to visit the exchange because she has no one to take care of her children while she is gone, can get clean syringes from a partner or friend. While secondary exchange can improve women's access to syringes, it does not in itself improve access to other harm reduction services, and, particularly if women are receiving syringes from a sexual partner, can perpetuate patterns of dependence. If a harm reduction program chooses to promote secondary exchange, it should also maintain services such as outreach programs, home visits, and hotlines to ensure that women do not remain invisible to providers, and that they have access to services beyond sterile syringes.

Certain services have the same benefits as secondary exchange while allowing providers to make contact with women drug users. For example, home delivery of clean injection equipment can help programs reach women and give outreach workers an opportunity to assess a woman's circumstances in person, and offer her additional services and support. Mobile harm reduction and drug treatment services can improve access for those unable to leave their own neighborhoods. Hotlines can provide anonymous, convenient information to women reluctant to visit harm reduction sites or disclose their identity.

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<sup>148</sup> Miller M, Neaigus A (2001). Networks, resources and risk among women who use drugs. *Social Science and Medicine*, 52, 967-978.

### *Incorporate sexual and reproductive health into harm reduction services*

Incorporation of sexual health services into harm reduction programs can attract women to services and help them protect themselves from HIV, STIs, and unwanted pregnancy. Integrated services can provide compassionate, non-stigmatizing counseling and access to drug treatment and prenatal care for pregnant women. Programs can educate women and their partners about the continued importance of using contraception even while using drugs, and of using both condoms and sterile injection equipment with sexual partners. They can provide high-quality male and female condoms and other forms of contraception. Rather than viewing sexual and injection-related HIV transmission as separate risks in need of individual interventions, services should recognize the synergistic relationship between the two and support women as they work to reduce such risks.

Gynecological consultations at harm reduction sites can provide women with low-threshold access to care from a doctor who is accustomed to working with drug users, is accustomed to their needs and concerns, and will not stigmatize or reject them. If this is not possible, programs can provide clients with referrals to obstetrician-gynecologists who work with drug users and can be trusted to provide appropriate care. Many programs provide staff to accompany women to their doctor's appointments. This can be helpful for women who are deterred by experienced or anticipated stigma from providers, and for women whose lives are chaotic or who have mental health issues and have trouble remembering and keeping appointments.

### *Provide gender-sensitive drug treatment*

Effective drug treatment can help women manage, reduce, or cease drug use, injection, and equipment sharing, and can reduce sexual risk by making women less likely to be high or in withdrawal when making sexual choices. But in order to be effective, entry to treatment must be available without long waiting periods, daunting paperwork, or residency requirements. Treatment cannot have inflexible rules that promote dropout by punishing relapse or refusing to work around responsibilities or concerns, such as dependent family members or abusive partners, which may interfere with a patient's adherence to a program. Low-threshold medication-assisted treatment without onerous admission requirements and with mobile delivery units or take-home doses is more accessible for all drug users, but it is particularly valuable for opiate-dependent women whose child care and household responsibilities may make it difficult for them to visit a clinic every day at a fixed time or to undergo inpatient treatment, and whose attendance at a methadone or buprenorphine clinic may be especially stigmatizing.

By helping women to avoid withdrawal and overdose, reduce or cease injection and illicit drug use, stabilize their lives, and improve their health, methadone maintenance treatment (MMT), which is safe for use during pregnancy, is an essential tool in helping opiate users to have healthy babies. It is widely recognized as the treatment of choice for opiate-dependent pregnant women.<sup>149</sup> After birth, medication-assisted treatment's

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<sup>149</sup> UNODC (2004). Substance abuse treatment and care for women. *Op cit.*

stabilizing effects can make it easier to mother. In order to minimize HIV risk and drug-related harm during pregnancy, women need access to MMT on demand. Drug treatment providers and obstetrician-gynecologists should be trained in methadone maintenance for pregnant and parenting women, including the possibility of adjusted doses during pregnancy, management of neonatal abstinence syndrome, and breastfeeding during methadone treatment.<sup>150</sup> When women are hospitalized during pregnancy, they should be given their methadone discreetly and according to their usual schedule. All obstetric clinics should have non-punitive, non-threatening, evidence-based policies and procedures concerning drug use and treatment during pregnancy.

Though there have not yet been large-scale trials, it appears that buprenorphine is also safe for use during pregnancy.<sup>151</sup> Buprenorphine providers and obstetrician-gynecologists should be educated on its use during pregnancy. Oral slow-release morphine has also been used safely and successfully during pregnancy.<sup>152</sup> Where no form of maintenance treatment is available, advocates should press to introduce its use during pregnancy. Because it is clearly vital to the survival and health of the fetus, countries may be willing to make a special exception for methadone or buprenorphine use during pregnancy. For instance, until the early 1990s, Germany only permitted the use of methadone for drug users who met very narrow criteria, but one of the exceptions was for pregnant women.<sup>153</sup>

Finally, measures by governments and international donors to make evidence-based drug treatment affordable for all who need it will improve women's access.

#### *Provide integrated harm reduction programs for sex workers who use drugs*

IDU sex workers need services that do not treat sexual and injection-related risk in isolation, but address the ways in which they interact. Programs should provide sterile injection equipment, safe injecting information, condoms, and other harm reduction and sexual health interventions, but must also work to alleviate the underlying causes of risk behavior. Services to reduce drug-related risk can also reduce sexual risk. For example, effective drug treatment to help sex workers avoid being high or in withdrawal during a transaction, or to reduce their need to generate income to support an illicit drug addiction, will help them avoid sexual risk-taking.

In areas where there is an overlap between injection drug use and sex work, injection-related prevention must be integrated into services for sex workers. Being known as an IDU may make it more difficult for sex workers to attract clients, so services for sex workers should include discreet syringe exchange and other harm reduction services.

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<sup>150</sup> UNODC (2004) Substance abuse treatment and care for women. *Op cit.*

<sup>151</sup> Lacroix, I, Berrebi, A, Chaumerliac, T, Lapeyre-Mestre, M, Montastruc, JL, Damase-Michel, C (2004). Buprenorphine in pregnant opioid-dependent women. *Addiction*, 99, 209-214.; Comer, V & Annito, W (2004). Buprenorphine: A Safe Method for Detoxifying Pregnant Heroin Addicts and Their Unborn. *Am J on Addictions*, 13, 317-318.

<sup>152</sup> Fischer, G, Jagsch, R, Eder, H *et al* (1999). Comparison of methadone and slow-release morphine maintenance in pregnant addicts. *Addiction* 94(2).

<sup>153</sup> Michels, II, Stover, H, Gerlach, R (2007). Substitution treatment for opioid addicts in Germany. *Harm Reduction Journal*, 4:5.

Likewise, harm reduction programs should include services for sex workers where applicable. In both cases, programs should employ staff members and outreach workers who are familiar with the community of sex workers who use drugs, and who are comfortable addressing the intersection of sex work and drug use.<sup>154</sup>

#### *Connect with domestic violence and rape prevention services*

In order to be truly accessible, services (as well as policies and advocacy) must address the prevalence of violence in women drug users' lives. Women may not be able to practice safer sex or injection, visit a syringe exchange site, enter drug treatment, or make their own decisions about childbearing because of violence or threats of violence from their partners.

At the moment, few drug-related services are linked with women's shelters and services for battered women and rape survivors, if either type of service exists at all. In some Russian cities, for example, women's shelters refuse to accept drug users.<sup>155</sup> Given the disproportionate number of women drug users in need of such services, and given that violence is a principal obstacle to their access to life-saving harm reduction, drug treatment, and sexual and reproductive health services, the integration of these two types of services is direly needed. Existing programs should collaborate to develop strong links to one another, and to ensure that each has staff with the skills, resources, and experience needed to work with women drug users who have experienced violence. Harm reduction programs should train all staff members to recognize and respond to signs that a woman is experiencing violence or suffering from post-traumatic stress. Women's shelters should welcome drug users and offer strong connections to harm reduction and drug treatment services and education, or provide them on-site.

#### *Educate mainstream providers*

Mainstream medical services are generally uninformed and unaccommodating where drug use is concerned, and as long as drug users remain stigmatized and marginalized, specialized services will be necessary. Specialized programs serving women drug users should make an effort to provide as many services as possible on-site. But there is a limit to how many medical services can be provided at a specialized program, and some women will make contact first with mainstream providers. It is essential, therefore, that curriculums for primary care providers, adolescent care providers, obstetrician-gynecologists, psychiatrists and psychologists, and social workers include training in the signs and risks of problem drug use and how to offer effective drug treatment, accurate information, and referrals to harm reduction services.

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<sup>154</sup> For comprehensive discussions of service design and policies for sex workers, please refer to the resources cited at the beginning of this paper.

<sup>155</sup> Personal communication, Nadezhda Fedoseeva, Anti-AIDS Foundation Penza, 2007.

### *Adapt programs based on available resources*

No harm reduction, drug treatment, or women's programs have unlimited resources, and many face a chronic shortage of funds, staff, and materials which may make gender-sensitive services seem an unattainable luxury. Fortunately, many of the changes needed cost little or nothing. For example, services can make an effort to ensure gender balance among staff, to hire staff members with experience in women's issues, and to be vigilant in preventing sexual harassment or gendered intimidation in services. It costs little or nothing to have a designated "ladies' night" when women can come to a service center with the confidence that they will be, for once, in the majority. Distributing literature or harm reduction kits targeted to women is inexpensive, disseminates valuable information, and sends the message that services are aware of women drug users and care about their needs. Provided that governments make it accessible, outpatient MMT is the most cost-effective option for those dependent on opiates and is also an excellent option for women, particularly if it is provided at convenient times and locations, and if take-home doses are allowed. Inpatient treatment of STIs is a costly and most often unnecessary measure that discourages treatment; its elimination should be a priority.

Added services are meaningless if women are not using them. Access should be the first consideration in weighing the benefit of new programs given financial constraints. If there is a choice of extending service hours or offering new services during hours when women cannot come, extending hours is a better use of funds. Likewise, if a key barrier to women's access is that they cannot leave home long enough to come to a syringe exchange point, it may be better to provide mobile exchange than to have a gynecologist available at the site. Involving women drug users in the design and implementation of new services will help ensure that programs are practical and accessible.

Policy changes that benefit women drug users are more cost-effective than existing punitive policies that depend on incarceration and discourage preventive care. Analysis in the United States has concluded that both outpatient and long-term residential drug treatment services cost only a fraction of the price of incarceration, and an even smaller fraction when the costs of foster care, often necessary when mothers are imprisoned, are included in the cost of incarceration. Incarceration often adds to the trauma and physical and mental health problems that contributed to women's drug use in the first place, increasing women's vulnerability, need for future assistance, and likelihood of repeat incarceration. Moreover, it damages families and communities and increases children's vulnerability, generating further costs to the state.<sup>156</sup> Policy changes to reduce incarceration and increase access to drug treatment are not only compassionate, but pragmatic and cost-effective.

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<sup>156</sup> ACLU *et al. Caught in the Nets. Op cit.*

## **Shaping Policy to Protect Women’s Health**

For policymakers and health care systems:

- **Develop policies that encourage women to seek care**

For many women drug users, fear of punishment or loss of custody of children is a central reason to avoid drug treatment, harm reduction services, and prenatal care. Shape policy to encourage women drug users to seek care. Rather than punishing women who use drugs, give them access to high-quality, gender-sensitive drug treatment services, including methadone or buprenorphine maintenance. (See recommendations for service design, above.) Protect the health of women and their children by supporting accessible harm reduction services, sexual and reproductive health care, and violence prevention services. Ensure that residency status, drug use, drug user registration, or financial means are not obstacles to women’s access to life-saving care. When developing regulations for syringe exchange and drug treatment, be sure that they permit services such as mobile or secondary exchange and take-home doses, which can be beneficial for women drug users. Involving women who use drugs in policymaking will help ensure that policy responds intelligently to women drug users’ needs.

- **Protect women drug users’ rights**

Ensure that women drug users can benefit from the full protection of the law. Fear of the police or the courts should not deter women from accessing services or reporting crimes committed against them. Train police on the rights of drug users and sex workers, hold law enforcement agents accountable for abuses, and provide safe mechanisms for drug users and sex workers to protest abuse.

- **Protect women drug users’ confidentiality**

Women drug users are often concerned about confidentiality, as they face special stigma and potential loss of their children if their drug use is revealed. Develop and enforce legal protections of patient confidentiality, so that women can go to the doctor without fear that their drug use will be disclosed to police, family, employers, or others. Encourage women to seek HIV and STI testing by ending mandatory testing and routine testing without counseling or consent. Make confidential, voluntary counseling, testing, and treatment for HIV and STIs available to all women. Allow women to enter drug treatment without fear that they will lose custody of their children.

- **Make harm reduction and drug treatment available in women’s prisons**

Women are disproportionately likely to be imprisoned on drug-related charges, and incarceration can increase the HIV risk of women drug users, many of whom continue to use drugs in prisons. Women also need services to help them protect themselves after

release. Provide syringe exchange, evidence-based drug treatment, including methadone or buprenorphine, and sexual and reproductive health services in women's prisons, and provide links to services for those who have just been released.

- **Incorporate women drug users' needs into guidelines and targets**

Ensure that women drug users' needs are included in national strategies to respond to HIV and drug use. In national guidelines on HIV and drug use, acknowledge and address the needs of women, and set specific targets for the provision of gender-sensitive harm reduction, drug treatment, and sexual and reproductive health services for drug users. Include specific targets for women drug users' services in plans to achieve Universal Access to HIV/AIDS Prevention, Treatment, Care and Support.

- **Structure health care systems to provide integrated care**

Women drug users often have multiple health needs and few resources with which to pursue care. Support gender-sensitive harm reduction services that provide or connect to sexual and reproductive health care. Ensure that pregnant drug users who test positive for HIV have immediate, easy access to PMTCT services and counseling. Ensure that all pregnant drug users have immediate access to drug treatment. Strengthen connections between women's services, such as domestic violence prevention, and harm reduction projects, and coordinate drug-related services with social services. Whenever possible, provide outpatient treatment for STIs so that women will not avoid treatment because they do not wish to be hospitalized.

- **Educate providers**

Educate health care professionals, especially obstetrician/gynecologists, on care and treatment for women drug users, including risk reduction strategies during pregnancy, PMTCT, medication-assisted treatment during pregnancy, and nonjudgmental support of women drug users. Cultivate a tolerant attitude toward injecting drug users, particularly women, among health care providers and health care managers.

For researchers:

- **Research the needs of women drug users**

Research on women drug users is still inadequate in many countries, and more quantitative and qualitative research on drug use, HIV, and sexual and reproductive health among women drug users is needed. Data collection from pilot programs can show which harm reduction, drug treatment, and sexual and reproductive health interventions serve women drug users best (e.g., attract them to services, retain them in contact with services, and improve health outcomes). When doing research that involves women drug users, involve women drug users on ethical review boards and in consultations, and share results with women drug users.



For donors:

- **Support services for women drug users**

Fund and advocate for the services described above. Urge countries to respect women drug users' right to sexual and reproductive freedom, and to health care and mainstream social services. Include women drug users in service and research design and advocacy, and include requirements for the participation of women drug users in funded activities