# DEVELOPING EFFECTIVE HARM REDUCTION SERVICES FOR WOMEN WHO INJECT DRUGS

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Information for the case studies was contributed by Anna Ivanova and Ian Bromage. The authors would also like to thank Ruth Birgin, Jude Byrne and Eka Iakobishvili for their valuable input, and acknowledge Claudia Ahumada and Dr Wendee Wechsberg for reviewing the chapter.

## Introduction

Despite evidence of important differences in drug use experiences and access to harm reduction services for women and men, gender-sensitive interventions have not yet been fully integrated into these services around the world. However, research and experience suggest that the provision of enhanced harm reduction services for women can increase uptake and improve the outcomes of these interventions.

This chapter provides an overview of the risks and harms experienced by women who inject drugs, and of women's access to harm reduction and related health services.[a] Drawing on programmes from around the world, the chapter proposes a 'menu' of gender-sensitive services for women who inject drugs.[b] These services aim to provide more accessible, comprehensive and effective care for women by addressing their needs in an holistic way and respecting their human rights and freedom of choice. The chapter concludes with recommendations for policies that support gender-sensitive harm reduction.

## Risks and harms experienced by women who inject drugs

Due to a mix of social and biological factors, women and men have different experiences of injecting drug use (IDU) and its accompanying risks and harms.[1-2] A recent systematic review of international research on the risks, experiences and needs of women who inject drugs found the following major themes:

» Compared to their male counterparts, women who inject drugs experience significantly higher mortality rates; an increased likelihood of injecting-related problems; faster progression from first drug use to dependence; higher rates of HIV; and higher levels of risky injecting and/or sexual risk behaviours.[1]

» For women who inject drugs, there is greater overlap between sexual and injecting social networks than there is for men who inject drugs. This may increase women's risk of acquiring HIV through sexual transmission as well as through unsafe injecting. Women who inject drugs are more likely than their male counterparts to have a sexual partner who injects drugs, and to be dependent on them for help acquiring drugs and injecting. Relationship dynamics can make it difficult for women to access harm reduction services, enter and complete drug treatment (if desired) or practise safer drug use and safer sex.[1]

» Intimate partner violence (IPV) is more commonly reported among women who inject drugs than among women in the general population.[1] Violence has an immediate effect on a woman's ability to practise safer sex and safer drug injecting, and can contribute to continued drug use.

» There is significant overlap between women's engagement in IDU and in sex work, especially street-level sex work. Participation in sex work has been associated with syringe sharing and inconsistent condom use, as well as other risks posed by the dangerous circumstances in which sex work often takes place.[1]

» There are a number of differences between men's and women's motivations to enter and complete opioid substitution therapy (OST) and other drug treatment modalities, and in the personal dynamics that play a part in treatment success. Many women cite pregnancy as a central reason for entering treatment, although punitive policies that separate women who use drugs from their children can deter pregnant women and mothers from entering drug treatment. A partner's entry into treatment is another key factor that can facilitate treatment entry for women. OST and certain other types of drug treatment have been found to be especially effective in helping women to reduce their drug use, while detoxification alone is significantly less successful for women who inject drugs than for men.[1]

A systematic review of studies from 14 countries found a significantly higher prevalence of HIV among women who inject drugs than among their male counterparts in settings with high HIV prevalence.[3] Studies in nine EU countries found that the average HIV prevalence was more than 50% higher among women who injected drugs than among their male counterparts.[4]

## Access to services

The intense social stigma attached to women's IDU and HIV infection can pose a formidable barrier to their access to harm reduction services, drug treatment, HIV treatment, sexual and reproductive health care, and other medical services, especially in culturally conservative societies.[5-6] As a minority of people who inject drugs (PWID), women are not always included in medical or social programmes for drug users. For example, anti-retroviral treatment (ART) and OST are sometimes available in men's penal institutions, but not in women's.[5,7,8] Many programmes for drug users do not respond to the specific needs of women.

a The scope of this article is limited to women who inject drugs, rather than all women who use drugs. It should be noted that there is also a significant amount of research on women who use drugs without injecting. For a discussion of the general literature on women who use drugs and the implications for future HIV prevention efforts, see El Bassel N, Wechsberg W and Shaw S (2012) Dual HIV risk and vulnerabilities among women who use or inject drugs: no single prevention strategy is the answer, *Current Opinion on HIV/AIDS* (7):326–331.

b For reasons of space, the scope of this article does not address the specific needs of transgender people who use drugs.

## Limited data on injecting drug use among women

Women have been estimated to represent roughly 40% of people who *use* drugs in the USA and some parts of Europe, and 20% in Eastern Europe, Central Asia and Latin America.[9, 10] However, data on women as a percentage of people who *inject* drugs are sparse, due in part to the difficulties of estimating the size of a hidden population engaged in an illicit activity. There has been no systematic analysis of the prevalence of IDU among women internationally. While data on the prevalence of IDU and HIV among PWID are available for more than 148 countries, for the most part these data are not disaggregated by gender. In the global data holdings on IDU and HIV maintained by the Reference Group to the UN on HIV and Injecting Drug Use, none of the countries that report IDU have data disaggregated by gender. This failure to collect gender-disaggregated country-level data on IDU makes it difficult to evaluate the precise scope and nature of needs among women who inject drugs, and should be remedied.

Similarly, the Reference Group's global data holdings show that countries that provide HIV prevention, treatment, care and support services for PWID generally fail to report on the number of women served by OST, ART and needle and syringe programmes (NSPs). This lack of data is disquieting, as it makes it difficult to assess whether at a country level there are gendered disparities in access to these essential services, or the degree to which available services are responsive to women's needs. This may have a negative impact on efforts to improve harm reduction service coverage and, consequently, on efforts to curtail the HIV epidemic within this population.

Despite these significant data gaps, evidence suggests that there is indeed a substantial population of women who inject drugs worldwide. In Europe, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) reported that, while precise data on women as a proportion of out-of-treatment PWID were not available, women comprised 22% of new patients for OST and 33% of new patients for amphetamine dependence treatment.[11] This suggests that women are a sizable minority of PWID in the region as a whole. Estimates of the gender balance among PWID in various countries (see Table 3.1.1) show that women are a very sizable minority of PWID in Russia, home to at least 1.8 million PWID, of whom more than 37% are living with HIV;[12] China, where 6.4% of the country's 2.35 million PWID are living with HIV;[12] and Ukraine, which has the highest HIV prevalence in Europe and an epidemic largely concentrated among PWID.[13] This points to the importance of addressing the needs of the large populations of women who inject drugs in these areas. The wide variation among and within countries also points to the importance of geographical difference, and the need for services that are adjusted accordingly.

**Table 3.1.1:** Women as percentage of all people who inject drugs in selected countries

| Country/territory | Women as an estimated (%) of all PWID[14] |
|---|---|
| Cambodia | 10 |
| Canada | 33[15] |
| China | 20 |
| Estonia | 9[11c] |
| Georgia | 10 |
| Indonesia | 11 |
| Kenya | 11 |
| Kyrgyzstan | 10 |
| Malaysia | 10 |
| Russian Federation | 30 |
| South Africa | 27 |
| Ukraine | 26 |
| Vietnam | 18 |

## Sexual and reproductive health and pregnancy

While harm reduction programmes usually include condom distribution, information on sexual health and sexually transmitted infections (STI) testing and sometimes treatment, many do not address other aspects of sexual and reproductive health, even though many women who inject drugs experience unplanned pregnancies.[5, 6, 8, 16] Some women do not realise they are pregnant until relatively late, making it more difficult for them to access appropriate prenatal care, harm reduction services, drug treatment (if desired) or other support, or to terminate their pregnancies safely if they so choose.[6, 8, 17]

Faced with pressure to have abortions and high levels of stigma, women who inject drugs sometimes have reduced access to prenatal care.[5, 6, 8] This can lead to reduced levels of prevention of mother-to-child transmission (PMTCT) services among women living with HIV who inject drugs, among other negative effects. A 10-year study in Western and Central Europe of ART during pregnancy found that a history of IDU was associated with the risk of not receiving ART, and with being diagnosed with HIV late in pregnancy.[18]

The comprehensive package for the prevention, treatment and care of HIV among people who use drugs, produced by the World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), does not include contraceptive methods other than condoms; pregnancy tests; pre- and post-natal care; or links between harm reduction, drug treatment and prevention of vertical transmission of HIV.[19] Adding these services to the comprehensive package

c Based on estimated 10:1 ratio of male to female drug users, based on IDU estimates from HIV reference laboratory, police arrests, overdoses and drug treatment.

could help women who inject drugs to better manage their sexual and reproductive health, thus preventing unplanned pregnancies and improving pregnancy outcomes, including through improved access to prevention of vertical transmission of HIV.

Pregnant women who inject drugs may wish to begin OST or other forms of drug treatment, and prompt, easy access to these services is essential in improving outcomes for these women and their children. While there has been some scale-up of OST worldwide, information and protocols on OST provision during pregnancy and post-partum (including during stays in maternity hospitals) are not always in place.[5, 6, 8, 20] This risks treatment interruptions and makes it difficult for women to access the 'treatment of choice' during pregnancy.[9] Long waits to enter OST and other drug treatment programmes in some countries, and the complete lack of OST in others (notably Russia), threaten the health of all PWID, but are especially troubling in the case of pregnant women.[9]

### *Sexual and intimate partner violence*

Problematic drug use among women is often associated with a history of sexual abuse,[6, 9] and women who inject drugs experience elevated rates of IPV.[1] Violence has an immediate effect on a woman's ability to practise safer sex and safer drug use, and contributes to continued drug use. A history of violence can make women feel uncomfortable in certain situations – for example, in a support group where the majority of participants are men, or when receiving pelvic examinations.[23] Where a history of trauma contributes to problem drug use or risky behaviours, it is important that harm reduction and drug treatment programmes take this into account and that staff are aware of how to deal appropriately with these issues.[9]

### *Women, injecting drug use and prisons*

Just as women's experience of drug use often differs from that of men, women occupy a different stratum of the drug economy. A meta-synthesis of qualitative literature found that the drug economy is gender-stratified and hierarchical, with women mainly confined to the lower levels.[24] Low-level dealers and drug 'mules' are easier to arrest than higher-level traffickers. In addition, they often have fewer resources for legal defence. This, combined with the low thresholds for criminal responsibility for drug possession in many countries, means that low-level players (many of them women) receive long prison sentences.

An increasing number of women are being incarcerated for drug-related offences worldwide.[25-30] A recent study found that more than one in four female prisoners in Europe and Central Asia had been convicted of a drug offence, and that the number of women incarcerated for drug-related offences in Russia is more than double the total number of female prisoners in all EU countries combined.[31] In Tajikistan, up to 70% of all female prisoners have been incarcerated for drug-

## Comprehensive care for women and their children

Vancouver, Canada

Recognising that women's social and economic environment has the greatest impact on maternal and foetal health, Sheway brings together representatives from the government and the community to provide comprehensive, non-judgemental health and social services to pregnant and parenting women with current or past issues with substance use. Sheway provides education, referrals and support to help women access prenatal care and reduce risk behaviours – in particular, reducing or ceasing the use of alcohol and other drugs during pregnancy. It also supports the health, nutrition and development of participants' children for up to 18 months after their birth. The programme is absolutely voluntary, and based on the choices women make for themselves.

Sheway's services include:

- Outreach and drop-in services
- Hot lunch, food bags and coupons, formula, clothing, infant items
- Accompaniment to appointments, transportation assistance (taxi vouchers, bus tickets)
- Assistance with securing housing, day care, emergency funds
- 12 transitional housing units
- Pre- and post-natal health care
- Advocacy and counselling
- Needle and syringe exchange (NSP)
- Methadone maintenance therapy (MMT)

Sheway works in partnership with the combined care unit at the Fir Square British Columbia Women's Hospital, which provides flexible, non-judgemental services for pregnant women with a history of drug use. It offers continuous care for mother and child before, during and after birth, including help stabilising and withdrawing from substances if necessary. The multidisciplinary team includes physicians, a senior practice leader, nurses, a social worker, an addictions counsellor, a nutritionist and a life skills/parenting counsellor. Fir Square aims to improve perinatal outcomes, increase the percentage of mothers able to safely retain custody of their babies, increase the number of women seeking drug treatment and their readiness to enter treatment, and increase access to medical services for substance-using women.[21, 22]

related crimes.[31] The dual criminalisation of sex work and drug possession puts sex workers who use drugs at exceptionally high risk of police harassment, extortion and arrest.[26]

In multiple settings, rates of IDU and problematic drug use[d] have been found to be higher among incarcerated women than among their male counterparts.[32, 33] In some settings, HIV prevalence among women prisoners is higher than among men.[34] However, health programmes for male prisoners sometimes do not extend to women's facilities. Because of financial constraints and logistical or bureaucratic obstacles, programmes sometimes prioritise male prisoners, operating only in men's prisons and leaving women without essential care.[5, 7, 8] For example, a 2008 survey of women's access to OST in prisons found that in Georgia, methadone was available in some men's prisons but not in women's prisons.[8] In Kyrgyzstan, though methadone programmes were planned for women's prisons, funding cuts have meant that they are still unavailable, and as a result OST is available only in men's prisons.[5]

Increased advocacy is urgently needed to ensure that all prisoners, regardless of gender, have access to necessary interventions (including NSP, OST, and ART) while incarcerated, including during pre-trial detention, and that no interruptions of ART and OST occur in these settings.[27]

Other needs of incarcerated women who inject drugs include general medical care, mental health care and vocational preparation.[35] Decriminalisation of personal possession of drugs would substantially reduce the number of women who are incarcerated unnecessarily, thus eliminating harms associated with incarceration for women as well as for their children and other family members.

### *Designing harm reduction services for women who inject drugs*

To date, there has been limited research on the efficacy of interventions specific to women who inject drugs. This is partly because gender-sensitive services often mix multiple approaches, are tailored to the individual and are relatively long-term. Services that combine structural, biomedical and behavioural interventions can be more difficult to evaluate through randomised controlled trials (RCTs) measuring HIV incidence, the current 'gold standard' of research on the efficacy of HIV prevention interventions, especially given large data gaps on the epidemiology of drug use and HIV among women. Limited research funding poses another obstacle. Finally, even simpler services, such as NSP, need to achieve considerable coverage before they can have a substantial impact on HIV incidence or prevalence.[36] In some cases, lack

## Reaching out to women who inject drugs

St. Petersburg, Russia

Humanitarian Action provides preventive health services to PWID in St. Petersburg. Of 5,000 annual clients, about 2,000 are women, 51% of whom are living with HIV and 30% are supporting their drug use through sex work. (In 2011, there were an estimated 15,000 women who inject drugs in the city.) Russia's extremely punitive drug policies drive drug users underground, incarcerate them en masse, and pose major obstacles to harm reduction services. OST has never been legal in Russia, and NSP faces mounting opposition. Most donors no longer fund NSP in Russia, compromising the crucial first point of contact between drug users and medical services.

In 2008 Humanitarian Action developed a project promoting equal access to prevention, treatment, care and support for women who inject drugs. Mobile street outreach in a special bus provides safer injection and safer sex supplies, including sanitary napkins and women-specific information materials; consultations with doctors, psychologists and social workers; express HIV and pregnancy tests; STI tests; and referrals.

Legal aid helps respond to the frequent loss of parental rights, physical and sexual violence and discrimination in medical settings experienced by clients. Project staff members accompany women to appointments and help them navigate medical and social services. A network of trusted doctors provides women with low-threshold care in a non-judgemental atmosphere. In the past five years, 11,346 women have received services from the project, with in-depth case management for 372 women.

There are no rehabilitation centres in St. Petersburg for women with children, and the city's shelters do not accept women living with HIV or those who actively inject drugs. Because this group of women often faces unstable housing and domestic violence, Humanitarian Action opened a 'Crisis Apartment' where women can live for up to three months. Pregnant women and mothers of small children have priority, since they are most vulnerable and have the most difficulty finding work. Women receive structured assistance with medical, legal, bureaucratic and family problems and in seeking employment and permanent housing.[e]

d The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) defines 'problem' drug use as "injecting drug use or long duration or regular use of opioids, cocaine and/or amphetamines." Definitions of 'problem', 'hard' or 'heavy' drug use can vary, but generally fit this basic description.

e Case study information provided by Anna Ivanova, Programme Coordinator, Humanitarian Action.

of evidence of impact may reflect external limitations, such as a cap on the number of syringes provided daily, rather than a problem with the intervention design.[37]

These limitations have led some experts to push for new methodologies to assess the impact of health promotion programmes, arguing that a lack of data on HIV incidence should not deter programmes that have positive results in practice and could be essential to reducing HIV risk and other harms.[38] Alternative measures of effectiveness could include baseline-to-follow-up reductions in reported risk behaviours and incarceration rates; improvement in health status, family relations, housing, self-efficacy and well-being as reported by clients; and increased uptake of medical and social services. Such indicators are easier to measure, though they cannot be used as proxies for reduced HIV transmission. Community randomised trials that compare a basic intervention to an enhanced intervention pose fewer ethical problems than standard RCTs, and help reduce the biases of observational studies by randomising by group.[37] Some of these methods and indicators were used in evaluating the programmes described below.

To date, HIV risk-reduction interventions among women who inject drugs have been more successful in reducing drug-related risks than unsafe sexual behaviours, likely because of structural factors that shape sexual relationships and limit condom use among vulnerable women.[39-41] This points to a need for interventions that address these broader, structural factors, increasing self-efficacy and autonomy as well as awareness of the importance of safer sex.

The following interventions[f] have documented success among women who inject drugs:[g]

» A woman-focused intervention in an inpatient detoxification programme in St. Petersburg, Russia, found that in comparison with the control group (which received nutritional counselling), women receiving the HIV-focused intervention reported a lower frequency of partner intoxication during their last sexual act and a lower average number of unprotected vaginal sex acts with their main sexual partner who injects drugs. Both groups reported lower levels of injection frequency. The two-session intervention consisted of educational activities, skills-building demonstrations, guided practice and roleplaying, covering topics including drug use and relationships; physical and sexual abuse; rape and violence prevention; ways of discussing and negotiating safer sex; and developing a personalised action plan to help women reduce alcohol and drug use and HIV risk and avoid sexual and physical violence.[42]

» In Baltimore, USA, the JEWEL intervention combined HIV prevention education and skills building with economic enhancement to reduce HIV risk among women who use drugs (injecting and non-injecting) who traded sex for drugs or money. The HIV component aimed to increase women's knowledge about HIV, STIs and drugs, improve their risk reduction knowledge and skills, and enhance self-efficacy and negotiation and communication skills to support safer sex. The economic component taught women how to make and sell jewellery, giving them practical skills while aiming to increase their self-efficacy in relation to licit employment. Self-reports three months after the intervention showed significant reductions in the exchange of drugs or money for sex, the median number of sex trade partners per month, daily drug use and daily crack use, the amount of money spent on drugs daily, and IDU. There was also a small increase in the percentage of women reporting that they never shared needles (from 86.7% to 93.7%). Income from jewellery sales was associated with a reduction in the number of sex trade partners at follow-up. The study suggested that exposing women to the possibility of gaining legal employment could support positive behaviour change, and that sustainability of these positive behaviours would likely require women's access to job training programmes and job opportunities.[43]

» In Miami, USA, a study with female sex workers who traded sex for drugs and used heroin or cocaine regularly compared a standard HIV prevention intervention for drug users with a new sex-worker focused (SWF) intervention. The standard intervention provided pretest counselling on HIV, Hepatitis B and C (HBV/HCV), transmission routes, risky drug use, unsafe sex practices, male and female condom use, disinfection of injection equipment, and the benefits of drug treatment. The SWF intervention was developed through a collaborative process with sex workers, including focus groups and engaging sex workers as outreach workers. It covered many of the topics in the standard intervention but discussed them in language recommended by sex workers themselves, addressing specific misconceptions and needs identified during the focus groups – notably, the need to avoid violence. Both study groups reported significant decreases in the number of days using alcohol and other drugs between baseline and three- and six-month follow-ups. Mean occasions of sex work while drunk or high declined significantly for both groups at six-month follow-up. Group averages for unprotected vaginal and unprotected oral sexual contact decreased significantly at both follow-up time points for both intervention protocols. Both physical and sexual

f A review of the evidence for harm reduction interventions in general is outside the scope of this article. For information on harm reduction interventions in general, see, for example: WHO (2004) *Effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. Evidence for action technical papers*. Geneva: WHO; WHO/UNODC/UNAIDS (2004) *Joint Position Statement: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*. Geneva: WHO; International Harm Reduction Development Program (2007) Delivering HIV Treatment and Care to People Who Use Drugs. New York: Open Society Institute; Hunt N (2003) *A review of the evidence-base for harm reduction approaches to drug use*, http://www.forward -thinking-on-drugs.org/review2-print.html.

g For other examples, see Gay J, Hardee K, Croce-Galis M et al. (2010) What Works for Women and Girls: Evidence for HIV/AIDS Interventions. New York: Open Society Institute. www.whatworksforwomen.org.

victimisation were reduced significantly at three and six months among participants in both intervention protocols. The SWF intervention was significantly more effective in reducing sexual violence at the six-month contact, with participants nearly twice as likely as those in the standard intervention to report a decrease in sexual abuse/victimisation.[44]

» In 2005, Family Health International Bangladesh established drug treatment services especially for women, leading to increasing numbers of women accessing treatment. Because OST was not available, treatment consisted of clonidine-assisted detoxification followed by three months of in- or outpatient care and follow-up. Women received HIV risk-reduction counselling and VCT; screening and treatment of STIs; overdose prevention education; and information on HBV and HCV. Counselling services were based on cognitive behavioural therapy and client-centred approaches. The services were free of charge, targeting homeless women with a history of drug-related harms. They were provided by specially trained female staff members and included childcare, prenatal care and vocational rehabilitation. Treatment for male drug-using partners was offered to reduce barriers to treatment and poor treatment outcomes. A study of the programme found that participation was significantly associated with correct use of condoms, use of condoms during the last sexual act, HIV testing, and correct assessment of risk. A possible association was found between programme participation and reduced borrowing or lending of injecting equipment during the last injection, correct knowledge about where to receive STI treatment, and correct knowledge about where to get VCT for HIV.[45]

» One review analysed studies of alcohol and drug treatment programmes for women that included childcare, prenatal care, women-only programmes, supplemental services and workshops that addressed women-focused topics, mental health programming and comprehensive programming. These components were positively associated with better treatment outcomes, reduced mental health symptoms, improved birth outcomes, employment, improved self-reported health status, and HIV risk reduction. One randomised study of pregnant methadone clinic patients who received prenatal care, therapeutic childcare during visits and relapse prevention support found improved outcomes at delivery and a threefold increase in the number of prenatal visits.[46]

» A qualitative meta-synthesis of studies of US and Canadian integrated drug treatment programmes for pregnant or parenting women and their children found that these programmes, which combined medical and social support, increased women's sense of self and personal agency, engagement with the programme staff and sense of giving and receiving support, openness about feelings, recognition of patterns of destructive behaviours and goal setting. These psychosocial processes were reported to play a role in women's recovery and contribute to favourable outcomes. The motivating presence of children during treatment was also found to support women in their recovery. Perceived outcomes of programmes included improved maternal and child well-being and enhanced parenting capacity.[47]

## Women supporting women

Hanoi, Vietnam

In Vietnam, PWID are highly stigmatised. Many are forced into rehabilitation centres that violate international human rights law, and where relapse rates are very high. Women who inject drugs are even more marginalised than men, since drug use runs counter to cultural ideals of motherhood and femininity. Women are also a minority of PWID. They are often neglected by interventions, have less access to harm reduction services and are at greater risk of HIV.

In 2005 the Medical Committee Netherlands-Vietnam (MCNV), in partnership with the Red Cross and others, established a support group for women who inject drugs. Called the 'Cactus Blossoms', the group originally consisted of 10 women with a history of IDU, and aimed to provide mutual support, help give women access to the services they required, and raise public awareness of this issue. Today the group has over 200 members who conduct outreach work with other women who use drugs and sex workers, meet with women in compulsory rehabilitation centres and work with providers to ensure that health services are delivered in a non-discriminatory manner. The Cactus Blossoms provide information within the rehabilitation centres and a mutually supportive environment after release, helping to reduce relapse rates. The group has organised high-profile media events to fight stigma and discrimination within society.

Since the group began, 130 women have received help in finding employment. Women have reported increased self-esteem and confidence. One member said, "After coming back from a rehabilitation centre and going home, I had no rope to cling to. But joining the group provided me with support. Now I feel reborn."[h]

h Case study information provided by Ian Bromage, HIV Programme Manager, MCNV.

## Greater involvement of women who use drugs

In recognition of the need for more active involvement of women who use drugs in the international harm reduction and drug policy reform community, two international networks are now in operation.

The International Network of Women Who Use Drugs (INWUD) represents the interests of women who use drugs in the International Network of People Who Use Drugs (INPUD). INWUD actively seeks to collaborate with relevant UN and other international groups and bodies to give greater voice to issues affecting women who use drugs. INWUD helps channel the views and experiences of women who use drugs into advocacy efforts.

The Women and Harm Reduction International Network (WHRIN)[i] is a global platform that seeks to reduce harms for women who use drugs and to develop an enabling environment for the implementation and expansion of harm reduction resources for women. WHRIN provides a forum to discuss the needs of and challenges faced by women who use drugs. It advocates for national, regional and international bodies to adopt and implement policies and programmes that promote and support harm reduction interventions for women and girls. It also aims to provide access to high-quality resources (including educational material) to help women who use drugs and/or the people who work with them to improve access to gender-sensitive harm reduction services.

i To register, visit www.talkingdrugs.org/user/register.

## Developing a 'menu' of services for women who inject drugs

The following table draws on examples of existing gender-sensitive harm reduction services to provide a 'menu' of options to improve and expand care for women who inject drugs. Ideally, services should be targeted according to the documented needs of women in a given context. Women who use drugs should always be involved in the design and implementation of these programmes, to ensure that programmes are effective, appropriate, and respectful of the human rights of women who use drugs.[j]

It should be noted that the establishment of gender-sensitive harm reduction services depends on the pre-existence of standard harm reduction services, which remain unavailable in many settings. Basic harm reduction services should be provided on a scale adequate to need and based on internationally endorsed WHO, UNODC and UNAIDS coverage targets necessary for an impact on HIV transmission rates.[36] Gender-sensitive services should then be added as required.

Because the resources available in different settings vary widely, the services are sorted into three groups based on the rough magnitude of cost, time and effort required for implementation.[k] It should be noted that some of the proposed services do not require any additional expenditure – for example, establishing staff gender balance, designating a time when only women visit the drop-in centre, or organising self-help groups specifically for women.

j Recommendations on service provision and advocacy goals are also provided in Pinkham (2007) op cit.; EHRN (2011) op cit.; Global Coalition on Women and AIDS (2011) *Women who use drugs, harm reduction and HIV*. Geneva: GCWA http://www.womenandaids.net/news-and-media-centre/latest-news/women-who-use-drugs--harm-reduction-and-hiv.aspx Accessed 27 June 2012; and International Harm Reduction Development Program (2011) *By Women, For Women*. New York: Open Society Institute.

k These are very rough estimates; real costs would vary widely depending on location.

| | SERVICE |
|---|---|
| **Adjustments and small additions to existing services:**<br><br>Added commodities distributed, additional staff training, designation of special activities for women clients | » Addition of women-specific items to basic harm reduction kits (women's hygiene materials and female condoms along with syringes, male condoms, wipes, lubricant)[6, 48, 49]<br>» Additional basic services/material assistance for women at harm reduction sites (pregnancy tests; diapers and other supplies for children; short-term babysitting while women get counselling/participate in support groups; informational materials specific to women; help learning to inject oneself and thereby eliminate dependence on partners) [6, 48, 49]<br>» Staff training on gender issues (counselling techniques for women, needs of women who use drugs etc.)[9, 48, 49]<br>» Gender balance in harm reduction staff, including active involvement of women drug users in service provision and design[48, 49]<br>» Special time for women only ('Ladies' Night')[k]<br>» Women-only support groups, women-specific counselling programmes (including structured HIV prevention counselling interventions)[42]<br>» Relationships with trusted gynaecologists, obstetricians and other specialists for client referrals[49]<br>» Secondary-syringe exchange programme focusing on expanding coverage of women[26]<br>» Training OST providers and OB-GYNs on drug use and drug treatment in pregnancy[9]<br>» (For OST programmes/policymakers): take-home doses, flexible clinic hours[5, 9]<br>» Basic training on drug use for primary care and women's healthcare providers, to enable effective and prompt referrals to harm reduction and related services when needed[50]<br>» Links between services for people who use drugs and for sex workers, including discreet provision of harm reduction for sex workers unable to openly visit a harm reduction site[26, 35] |
| **New services added by existing organisations:**<br><br>Hiring a new staff member, adding new types of services to an existing programme, designating permanent space or significant equipment to women | » Specialist to work with women's children and give counselling on parenting skills[9, 21, 35]<br>» Counselling services to respond to sexual violence, IPV, other trauma, and to address the links between trauma and risky behaviours[9, 35, 48]<br>» Women-only drop-in centre or space in the harm reduction centre devoted specially to women[9, 51]<br>» Appointments with a gynaecologist, other medical specialists at the harm reduction site[6, 51]<br>» Multidisciplinary case management for women and their children, including pregnant women[6, 52]<br>» Mobile harm reduction, OST, basic medical services for women unable to visit service-sites[6, 53]<br>» Legal aid to help women resolve problems with documents, access to social support, legal problems etc.[6, 49]<br>» Free, low-threshold sexual and reproductive healthcare, including PMTCT<br>» Job training, job placement assistance and economic empowerment programmes to increase women's economic independence[35, 43]<br>» Social support for women released from prison, including support related to parenting[35] |
| **New stand-alone services:**<br><br>Creation of an entirely new centre/service site | » Open separate rehabilitation centres for women (if possible, where children can also stay)[9]<br>» Establish comprehensive maternity and post-natal services for pregnant women who use drugs[52]<br>» Provide short-term/transitional housing for homeless women and their children[21, 35] |

## Building a supportive policy environment

Access to services depends on a supportive policy environment. The following actions are recommended to support effective health and social services for women who inject drugs:

- Whenever feasible, collect gender-disaggregated data on the epidemiology of drug use and HIV; coverage and uptake of essential HIV and harm reduction services such as NSP, OST and ART; health service provision in prisons and incarceration for drug-related crimes; and other relevant subjects.
- Continuously and meaningfully engage women who use drugs in policy and programme design, monitoring and evaluation.
- Establish a system that guarantees free or low-cost, non-judgemental sexual and reproductive health services, including PMTCT, for vulnerable women, including women who use drugs.
- Provide NSP, OST, psychosocial support and ART in women's prisons and pre-trial detention centres, as well as sexual and reproductive healthcare and other forms of gender-sensitive care.
- Eliminate punitive approaches toward pregnant women who use drugs; introduce policies that improve access to voluntary, evidence-based drug treatment on demand and to perinatal care and other supports.
- Establish clinical protocols on OST and other care for pregnant women who use drugs, and provide OST in maternity hospitals.
- Eliminate laws that make drug use, a history of drug use or participation in an OST programme (as opposed to negligence or abuse) grounds for the removal of parental rights, as this is a strong deterrent to mothers in need of care.
- Support links between harm reduction programmes and primary and women's healthcare systems.
- Establish stronger protections for patient confidentiality.

It has become clear that the HIV epidemic demands an approach that addresses multiple health and social factors, on the structural as well as individual level. This lesson should be applied to harm reduction for women who inject drugs. A gender-sensitive approach to harm reduction will benefit not only women but their children, families and communities.

I See Magee C & Huriaux E (2008) Ladies' night: Evaluating a drop-in programme for homeless and marginally housed women in San Francisco's Mission district. International Journal of Drug Policy 19, 113–121.

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