

A smiling Black woman with a baby on her back. The woman is wearing a vibrant pink and black patterned dress with a large orange shawl draped over her shoulders. The baby is wearing an orange shirt and is looking towards the camera. They are standing under a corrugated metal roof, possibly in a market or community setting. A white container with a green label is visible in the background on the left.

ADVANCING THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF WOMEN WHO USE DRUGS



**A GUIDE FOR
PROGRAMMES**

ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

As a result, 1.7 million people were infected with HIV in 2018 and 770,000 died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

ACKNOWLEDGEMENTS

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Cover photo: Mariam Yusuf, 22, with one of her two children. She participated in a project providing counselling and family planning support to people who use drugs in Malindi, Kenya. © Corrie Wingate for Frontline AIDS, 2017.

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FOREWORD

Access to sexual and reproductive health services for women who use drugs has long been restricted, chiefly as a result of criminalisation and the associated stigma and discrimination.

People who use drugs face significant barriers to accessing sexual and reproductive health services and realising their sexual and reproductive rights. Among this community, women who use drugs face additional barriers – including gender discrimination and gender-based violence – to accessing appropriate, stigma-free, rights-based services.

Access to sexual and reproductive health and rights services and interventions for women who use drugs must be a priority for everyone engaged in designing harm reduction programmes. They also need to provide evidence-based, accessible information for women who use drugs on their sexual and reproductive health needs and rights.

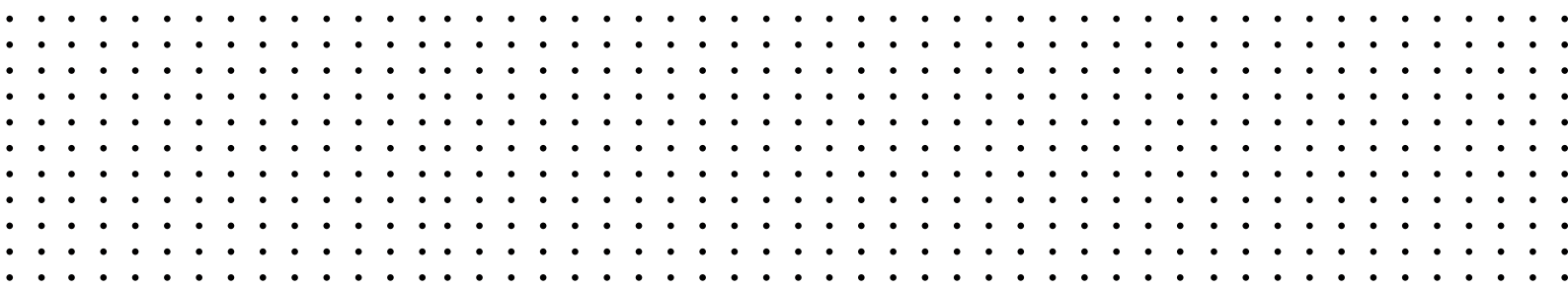
The Guttmacher Lancet Commission on Sexual and Reproductive Health and Rights, published in 2018, provides a welcome opportunity to focus on redressing this gap, with its emphasis on underserved populations, comprehensive definition and incremental approach. In keeping with this approach, we have used its recommendations to inform a framework that captures the realities of women who use drugs. We hope this guide will be a useful tool for harm reduction programmes and advocates to promote and advance sexual and reproductive health and rights for women who use drugs.



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INTRODUCTION

This guide is aimed at those who work with and advocate for women who use drugs in all their diversity. It equips them with practical, evidence-based interventions which will help advance the sexual and reproductive health and rights (SRHR) of women who use drugs.

It is based on the experiences of Frontline AIDS partners and others in implementing community-led harm reduction programmes in Kenya, India, Indonesia, Nigeria, Tanzania, Uganda and Ukraine from 2011 to 2020 through the Community Action on Harm Reduction (CAHR), PITCH, and Integrated Harm Reduction programmes, and others. It is informed by the recommendations of the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights 2018 report¹. The guide was developed in consultation with communities of women who inject drugs in select countries, and technical input was provided by the Women and Harm Reduction (WHRIN) Advisory Group.

Part 1 describes the current **context** for women who use drugs in relation to their SRHR. This part includes considerations of available data; the intersection of drug use with gender inequality, gender norms and stereotypes that create additional barriers to services for women who use drugs; and gender-based violence. It introduces the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights' 2018 definition of SRHR, and the **essential service package**, alongside the World Health Organization's package for comprehensive harm reduction services.

Part 2 elaborates seven **essential SRHR interventions** for women who use drugs, and an additional sub-section on the **sexual health and well-being** of women who use drugs. Short case studies from Frontline AIDS and partners' harm reduction programmes, as well as other NGOs, provide examples of successful interventions.

In conclusion, we draw on priority **recommendations** from the Guttmacher-Lancet Commission for achieving SRHR that are most relevant to the context of women who use drugs.



Participants in the female-focused harm reduction programme WINGS (Women Initiating New Goals for Safety), India.



This guide has been developed with meaningful involvement from women who use drugs - from diverse backgrounds and sexual identification/orientation. Their involvement included extensive consultation, input, review and testing of approaches. It draws on good practice both driven and endorsed by and for women who use drugs.

The meaningful involvement of women - including trans-women who use drugs - in the design, delivery, monitoring and evaluation of services and interventions should be the cornerstone of policy and practice to meet the SRHR needs of women who use drugs in their diversity. The values and preferences of women who use drugs should be gathered through a consultative process led by and for women who use drugs, to determine their needs and life priorities. The outcomes of this process can be used to both shape and monitor services and interventions.

Women who use drugs should also be involved in the delivery of services and interventions as managers, peer outreach workers, counsellors, researchers, etc, with appropriate training, remuneration, workforce development and support. The appointment of women who use drugs in the harm reduction workforce should not merely fulfil gender inclusive and gender equity quotas as an end in themselves. Meaningful involvement promotes and provides environments for women to advocate for the inclusion and needs of women. In advocacy, women who use drugs should be resourced and empowered to speak for themselves and represent their community at all levels.



CASE STUDY

FAMILY REUNIFICATION: MUSLIM EDUCATION WELFARE ASSOCIATION (MEWA), MOMBASA



Around 16,100 people in Kenya inject drugs and just over 18% of them are living with HIV². While there is little data on women who use drugs, 6.9% of Kenyan women are infected with HIV compared to 4.4% of men³. In 2016, the Muslim Education Welfare Association (MEWA) - as a partner of MAINline's 'Bridging the Gaps' programme - initiated a pilot to reach more women who use drugs with SRHR and harm reduction services, and research the service gaps. The findings confirmed that women who use drugs were not accessing MEWA's drop-in centre due to stigma, shame and police violence⁴.

In response, MEWA began providing women-only-hours with discreet access to their drop-in centre where they offered shelter, hygiene products such as sanitary pads, information on infection prevention, drug-related health knowledge, safe drug use, childcare and legal help, testing and treatment options, family planning and counselling.

One of the women using the drop-in centre described how this helped her:



I didn't know how to handle a child before and I was scared of the day I will give birth. This was really traumatic for me and I had to undergo several traditional abortions. Eventually, through female friendly hours, I overcame my fear and gave birth to a bouncing baby boy – I am now happy and feel complete as the sessions on parenting, maternal child health care and hygiene have built my confidence in caring for the child. – Zainab⁵





PART 1:

THE CONTEXT FOR WOMEN WHO USE DRUGS

Mariam Yusuf, 22, with one of her two children. She participated in a project providing counselling and family planning support to people who use drugs in Malindi, Kenya.

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While there is no data available on the larger community of people who use drugs, among the estimated 15.6 million people who inject drugs worldwide, nearly **one in five** lives with HIV.⁶ Women make up one third of people who use drugs globally and one fifth of the global estimated number of people who inject drugs. Drug use is often seen as contrary to the socially normative roles of women as mothers, partners and caretakers, leaving women who use drugs facing greater stigma and experiencing a range of specific harms⁷.

BACKGROUND

- **Globally, women are more likely than men to be imprisoned for drug-related offences**, with 35% of female prisoners compared to 19% of male prisoners sentenced for drug-related offences⁸. Women who are incarcerated have even less access than their male counterparts to harm reduction and other health-care services that are tailored to their needs, particularly SRHR needs. In addition, women who have been imprisoned face a combined stigma of their gender and status as an ex-offender and drug user⁹.
- **Women who use drugs, and particularly trans-women and those who exchange sex for money, food and/or drugs, are extremely vulnerable to gender-based violence**. Gender-based and intimate partner violence is estimated to be 2 to 5 times higher among women who use drugs than among women who do not^{10, 11}.
- **Women who use drugs face a range of SRHR barriers**. Among these are limited access to contraceptives (research shows that more than 69% of women who inject drugs do not use contraceptive services due to system barriers)¹² leading to high rates of unintended pregnancy and abortion¹³; limited access to appropriate ante- and post-natal care and related to this; poor access to antiretroviral therapy (ART) and prevention of vertical HIV transmission services.
- **Women who inject drugs generally have a greater vulnerability than men to HIV^{14, 15}**, hepatitis C (HCV) and other blood-borne and sexually transmitted infections (STIs), with young women and those who have recently initiated drug injection being most at risk. Women who inject drugs are also less enabled to access and adhere to ART than their male counterparts.
- **Women who use drugs also face higher levels of stigma and discrimination**, judgemental attitudes, and (often) misinformation from service providers – regarding their ability or suitability to have and raise children. Many women who use drugs have even experienced forced or coerced sterilisation or abortion, and/or had children taken from them and placed into care. Fear of this happening can deter them from accessing services¹⁶.

Margaret Gakii, 30, (right) participates in a project that provides harm reduction services to people who use drugs in Malindi, Kenya. Sauda Musa (left) is her counselor and also her friend.



Accurate data about women who use or inject drugs is generally missing. Criminalisation and stigma marginalises women who use or inject drugs, making them hard to reach, and women's involvement in drug use is often under-estimated, or simply not disaggregated. There is little disaggregated data on the prevalence of HCV and tuberculosis (TB), and gender-based violence experienced by women who use drugs.

The prevalence of drug use among sex workers is high¹⁷, and many women who use drugs may also sell or transact sex for drugs and other basic needs. In this context, due to criminalisation and stigma associated with both sex work and drug use, women may have little power to negotiate condom use and/or safer injecting. Women who sell or transact sex and who use drugs span two populations most affected by HIV, and may be stigmatised within both, as well as by the wider population. They are vulnerable to violence, including arbitrary arrest, surveillance and harassment, as well as numerous violations of their SRHR.¹⁸ This creates barriers to service access for sex workers who use drugs and increases risk of transmission of HIV and other blood borne viruses and STIs.

BOX 1:

SEX WORK AND DRUG USE

Sites providing services to sex workers don't always include harm reduction services, and harm reduction services may not be equipped to fully address the needs of women – including sex workers – who use drugs. So in addition to encouraging and supporting sex worker services to provide harm reduction commodities, it is also important to offer harm reduction services through referral by SRHR/HIV service providers or outreach services; harm reduction service sites (such as drop-in centres); or through outreach to brothels and street-based locations frequented by sex workers.¹⁹

The combined criminalisation of sex work and drug use also makes sex workers who use drugs extremely vulnerable to gender-based and other types of violence. Women who use drugs, whether or not they are involved in selling sex, are less likely to report violence to the police, at whose hands they may also experience abuse, harassment and extortion. In cases of domestic violence, for example, police in many countries will prioritise drug convictions over violence mitigation and prosecution.

Sex workers who use drugs should have access to holistic harm reduction services as well as comprehensive SRHR services. This means recruiting peers intersecting both communities to ensure access and build trust.

BOX 2:

TRANS-WOMEN WHO USE DRUGS

Trans-women experience among the highest concentrations of HIV, globally. UNAIDS estimates trans-women to be 12 times more susceptible to HIV acquisition than women from the general population²⁰. HIV prevalence among trans-women who do sex work is also much higher than among cis-male and female sex workers, globally²¹. Criminalisation, stigma, and violence, including in the context of sex work and/or drug use, and social and economic marginalisation contribute to trans-women's increased vulnerability to HIV.

BARRIERS TO ACCESSING SERVICES

Stigma and discrimination – underpinned by the criminalisation of drug use – are major barriers to accessing services. Thus, women face barriers in accessing health services – including harm reduction services – such as the threat of arrest, detention or forced rehabilitation, or that they will be forcibly separated from their children. Besides, women who use drugs often have limited access to harm reduction services, which tend to be designed by and for men. In its 2016 updated Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations²² WHO has included SRHR interventions in the package of essential health sector interventions (see Box 3 below). However, so far they are not typically integrated into harm reduction services – though limited components, such as condom distribution and HIV testing may be provided.

BOX 3:

COMPREHENSIVE PACKAGE FOR THE PREVENTION AND TREATMENT OF HIV AMONG PEOPLE WHO INJECT DRUGS

A) Health sector interventions

1. HIV prevention (including condoms)
2. Harm reductions interventions (incl. NSP, OST, Naloxone)
3. HIV testing and counselling
4. HIV treatment and care (including PrEP)
5. Prevention and management of viral hepatitis, TB and mental health issues
6. Sexual and reproductive health interventions

B) Critical enablers

1. Supportive legislation, policy & funding (including decriminalisation of drug use and possession)
2. Addressing stigma and discrimination
3. Available, accessible and acceptable health services for key populations
4. Enhanced community empowerment
5. Addressing violence against people from key populations

Source: WHO 2016²³



Preeti with her four-months-old baby, in India. Preeti, who lives with HIV and takes ARVs every day, gets support from the WINGS project.



THE GUTTMACHER-LANCET COMMISSION ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

In May 2018, the Guttmacher-Lancet Commission on SRHR launched a report highlighting the extent of unfinished business in the global SRHR agenda. The report *Accelerate progress – sexual and reproductive health and rights for all*, found that challenges such as gender inequality, gender-based violence, restrictive laws and policies, and sexual norms and taboos still prevent many people's ability to make decisions about their own sexual and reproductive lives.

The report offers a new, comprehensive and integrated definition of SRHR, and components of SRHR that should be universally available (**Box 4**). The report highlighted people who use drugs among other populations with distinct SRHR needs and who are typically underserved by SRHR programmes and services.

BOX 4:

COMPONENTS OF SRHR THAT SHOULD BE MADE UNIVERSALLY AVAILABLE²⁴

- Gender-based violence
- HIV/AIDS and other STIs
- Contraception
- Maternal and newborn health
- Safe abortion and post-abortion care
- Services for infertility
- Cervical cancer treatment

SRHR needs and issues around sexuality and sexual health are addressed through:

- Service
- Education
- Counselling
- Information

Individuals should have autonomy and choice in accessing these services.

Women who use drugs have the same rights, including equal rights to SRHR, as everyone else. Yet they face multiple barriers to realising these rights. Harm reduction and SRHR programmes need to integrate their services to meet the needs of women who use drugs.

As a step towards such integration this guide has used the essential package of sexual and reproductive health interventions in combination with the earlier presented WHO comprehensive package of interventions for prevention, treatment and care of HIV among people who inject drugs, to help identify the specific needs of women who use drugs.

In the following section we will highlight seven of the nine interventions of the Guttmacher-Lancet Commission report. Following its logic, services, education, counselling and information are the primary tools to implement these interventions. The first one (on sexuality education) and the last one (on information, counselling and services for sexual health and wellbeing) are tools to implement these interventions.



CASE STUDY

MAKING WOMEN WHO USE DRUGS VISIBLE IN UGANDA



Data from the Uganda Harm Reduction Network (UHRN) shows that HIV prevalence in women who use drugs is 45% - more than double men who use drugs (21%)²⁵. Yet drug use is still viewed as a male issue and women who use drugs are largely ignored - they are often hard to reach, isolated and excluded from national programming, policy development and gender-responsive programme development for HIV and SRHR.

In 2019, UHRN began working with adolescent girls and young women who use drugs to improve their access to health services. They gave community activists for women who use drugs the opportunity to share their experiences and viewpoints through photo voices²⁶.

The initiative inspired communities of women who use drugs to motivate and mobilise to demand SRHR, HIV and other harm reduction services tailored to the needs of women and girls who use drugs. This led to a recommendation for the meaningful engagement of women who use drugs, young people and gender minorities in programme design, advocacy and service delivery in the government's national guidelines for harm reduction.

UHRN has also worked to recruit women who use drugs as peer educators and paralegals. This has enabled the organisation to broaden its services to HIV, SRHR, and gender-based violence, and start holding clinical and outreach days for women who use drugs at the drop-in centre. As a result, the uptake of health and legal services among women who use drugs within Kampala has increased.





PART 2:

HOW TO INTEGRATE SRHR INTERVENTIONS FOR WOMEN WHO USE DRUGS INTO HARM REDUCTION PROGRAMMES

Anita (left) is a peer outreach worker with WINGS in Manipur, India. Pintoo (right) is the programme coordinator.

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This section looks at how each of the seven key interventions that are prioritised by the Guttmacher-Lancet Commission report relate to the needs of women who use drugs, and how to integrate them into harm reduction programmes. We also provide brief examples from the field to illustrate this. It offers a guide to gender sensitive, person-centred approaches to SRHR interventions for women who use drugs in their diversity, including trans-women.

01 GENDER-BASED VIOLENCE

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

Data indicates that women who use drugs experience a higher incidence of intimate partner violence and non-partner sexual violence than women who do not. Criminalisation and stigma compound the risks for women who use drugs – especially where compulsory rehabilitation exists.

WHAT CAN HARM REDUCTION SERVICES DO?

- Sensitise the police, service providers, prison and rehabilitation centre staff on gender and rights issues affecting women who use drugs.
- Make sure incidents of violence – including gender-based – are reported and acted on. Provide or refer women who have experienced violence to a comprehensive package of post violence care. In the case of rape or sexual violence, this should include:

- 
- Emergency contraception
 - Access/referral to safe abortion if needed
 - Post exposure prophylaxis (PEP) for HIV prevention
 - Screening and treatment for other STIs
 - Referral to legal services (including medical examination)
 - Referral to/or provision of psychosocial support and counselling.

- Provide women-only spaces and/or times within harm reduction sites.
- Work closely with women who have experienced or are experiencing violence to develop client-led mitigation strategies and develop a safety plan, which can include the use of evidence-based tools such as WINGS (Women Initiating New Goals for Safety, see case study on page 15 for more information) methodology²⁷.
- Offer women who use drugs, and their sexual partners, training and sensitisation around their rights, including gender-based violence.
- Provide support to women who have experienced partner violence with filing police reports.
- Establish links with legal aid facilities and support from human rights organisations.
- Provide links to women's shelters to provide a safe space for women who use drugs and their children, and provide training and support to shelters currently excluding women who use drugs to reform their policies towards greater inclusivity.
- Advocate for the closure of compulsory treatments and rehabilitation, in accordance with the joint UN statement on compulsory drug detention and rehabilitation²⁸.



IMPORTANT THINGS TO REMEMBER

- Gender-based violence services must respond to the needs, priorities and lived experience of the woman who has experienced violence. Interventions that go beyond or without her consent could risk exposing her to further violence or trauma.
- Ensure that reporting/redress mechanisms respect the confidentiality of the client, and prioritise her safety, and that they provide realistic options for survivors of violence. Where these essential gender-based services do not exist, it is critical to advocate for them.



USEFUL READING:

- WHRIN/Talking Drugs position statement on the violence of law enforcement
<https://www.talkingdrugs.org/position-statement-women-who-use-drugs-and-the-violence-of-law-enforcement>

CASE STUDY

GENDER BASED VIOLENCE: INDIA'S WOMEN INITIATING NEW GOALS FOR SAFETY



Gender-based violence is one of the greatest public health threats facing women who use drugs in India. In a risk assessment study among 1,865 women who use drugs in Northern India, 75% of participants had sustained physical injuries from violence perpetrated by their partners, neighbours, friends and pimps²⁹.

India HIV/AIDS Alliance implements the programme Women Initiating New Goals for Safety (WINGS), that aims to reduce gender-based violence and the risk of contracting HIV among women who use drugs in India. WINGS supports women who use drugs to assess their lives and develop personal safety plans in three steps:

Screening:

Women are recruited to the programme through a snowball referral method, whereby a small number of service beneficiaries already known to the CSO referred their peers to participate. Screening involves assessing their age, drug use patterns, HIV risk behaviours, healthcare uptake and experiences of gender-based violence.

Brief intervention:

Women develop individual safety plans to address the gender-based violence they are experiencing.

Service and treatment referrals:

They are then referred to a wide range of services based on the above.

Women who participated in the WINGS report increased empowerment and ability to identify potentially threatening situations and negotiate safer behaviours. They also display an increased capacity to share their experience of violence in order to seek help.³⁰

02 HIV AND OTHER STIs

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

According to UNAIDS, people who inject drugs are approximately 22 times more likely to be living with HIV than people who don't.³¹ HIV prevalence among women who use drugs is higher than among their male counterparts. The high prevalence of HIV among people who inject drugs is underpinned by the criminalisation of illicit drug use and marginalisation of people who use drugs, as well as other structural barriers including stigma, discrimination, gender-based violence, and poverty.

Women using stimulant drugs may experience dehydration and over-drying of the vaginal mucose bringing increased risk of cracks, tears and infection, which in turn increases the risk of HIV and other STIs. To address this, harm reduction services should add lubricants and bottles of drinking water to home kits for women who use stimulants.

WHAT CAN HARM REDUCTION SERVICES DO?

- Advocate for the full implementation of the WHO package for the prevention and treatment of HIV among people who use drugs at sufficient coverage.
- Meaningfully involve women, including trans-women, who use drugs in the design, delivery and monitoring of harm reduction services and programmes.
- Provide information on transmission of HIV and other STIs; symptoms of STIs and promotion of safer sex and safer drug use (including couples counselling and empowerment strategies to negotiate safer sex and safer drug use). There needs to be a sensitive approach to HIV and STI testing, diagnosis and treatment along with access to care and support services.
- Supply free external and internal (male and female) condoms, as well as lubricant, and equip peers and other field workers with accurate knowledge, messaging and practical skills training around condom use. This should include addressing stigma, gender-related and socio-cultural attitudes that can act as barriers to accessing and consistently using condoms.
- Harm reduction workers need to understand the connection (where there is one) between drug use and sex practices so they can give clear and accurate information to people who use drugs. For example, the use of certain psychoactive drugs such as methamphetamine, to accompany, enhance and/or facilitate sex ('chemsex')³², is increasingly popular.
- Provide counselling to women who use drugs on dual protection strategies to prevent both the transmission of HIV, STIs and HCV, and unintended pregnancy. Dual protection strategies can include:

- 
- condoms plus another contraceptive method
 - condoms plus emergency contraception if condom fails
 - selectively using condoms and another method (for example, using the pill with main partner, but the pill plus condoms with others).

- Ensure women who use drugs are linked to comprehensive prevention of mother-to-child transmission (PMTCT) programmes (see Box 5).
- Provide training to referral network partners to ensure client centred, non-judgemental service provision through the referral chain.
- Provide optional couples counselling where partners are encouraged to take equal responsibility for SRHR and safer drug use.
- Consult with women who use drugs to discuss the potential for free hygiene packs (for example, soap, toothbrush, toothpaste, hair and skin products, panties and sanitary napkins).
- Disaggregate data (testing results, service uptake) by gender.
- Provide accurate, non-judgemental guidance on how to prevent sexual and drug use-related transmission of HIV, including safe injection, Needle Syringe Programmes (NSP) Opioid Substitution Therapy (OST) and the option of post exposure prophylaxis (PEP); and provide access to male and female condoms and lubricant, with information on their correct use and on condom negotiation skills³³.
- Provide information about secondary infection and other co-infections such as HCV, Hepatitis B along with other STIs.
- Link women who use drugs who are living with HIV to ART programmes and make sure they get support to access services to diagnose and treat TB. Psychosocial support is a vital care component for all women living with HIV – especially women who use drugs as they are likely to face even greater stigma and discrimination.
- Establish, host or link women who use drugs and are living with HIV to peer support groups (see case study on page 18).

BOX 5:

COMPREHENSIVE PMTCT STRATEGY

WHO recommends four dimensions of a comprehensive PMTCT strategy:

1. Primary prevention of HIV infection among women of childbearing age;
2. Preventing unintended pregnancies among women living with HIV;
3. Preventing HIV transmission from women living with HIV to their infants (including HTC, ART, safe delivery, safer infant feeding, post-partum interventions in the context of ongoing ART);
4. Providing appropriate treatment, care and support to mothers living with HIV, their children and families.³⁴



IMPORTANT THINGS TO REMEMBER



- To ensure that women who use drugs use (specialist) health services, harm reduction workers need to provide assisted referrals to drug user-friendly service providers.
- For trans-women living with HIV who are receiving hormone treatment, ART may need to be tailored – and hormone levels monitored – to avoid negative interactions³⁵.
- It is vital to ensure that STIs are diagnosed accurately, early and are treated properly. The presence of STIs can be masked by the use of antibiotics to treat other health issues, for example, abscesses resulting from injecting drug use. Genital ulcers that occur from injecting drugs into the groin can be misdiagnosed as STIs.³⁶



CASE STUDY

HIV & STIs: 'WOMEN SPEAKOUT' IN INDONESIA



It is not always easy for harm reduction projects in Indonesia to reach women who inject drugs. There is also a lack of gender-and age-disaggregated data which has led to women being under-represented in population and HIV prevalence estimates.

To address these disparities, the Indonesian Drug User Network implemented 'Women Speak Out', a peer-driven, participatory study. The study explored the HIV-related vulnerabilities and barriers faced by women who inject drugs, and their access to health.

As part of the research, 731 women who inject drugs from six cities³⁷ which have some of the highest rates of HIV and injecting drug use in the country, shared their experiences. As the first large-scale, community-led study with this group in Indonesia, the research established a baseline on health status and health care access among women who inject drugs and helped identify priority areas for subsequent gender-specific advocacy and programmatic efforts.

The study findings confirmed that women who inject drugs have many unmet needs that had largely been ignored by existing harm reduction programmes.³⁸ Many women face economic insecurity, high levels of gender-based violence, mental health challenges, and are frequent targets of punitive law enforcement – all factors that exacerbate HIV and HCV risks.

By engaging in the participatory research, women gained skills in developing grant proposals, data collection, and project management, leading to employment opportunities. It also gave them a platform and visibility through participation in national and international high-level events and conferences.

”

As a fieldworker for the [Women Speak Out] research, I felt valued, I felt my perspective was taken into account.
– Indah

03 CONTRACEPTION

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

Unplanned pregnancy or late detection of pregnancy can easily occur among women who use drugs. For example, women who are dependent on opioids may experience irregular menstruation and assume they cannot become pregnant, sometimes leading to late awareness of pregnancy and late or lack of antenatal care.

Fear of stigma, hostility and violence may put off women who use drugs from accessing family planning services. This could include coercion to adopt long-acting or potentially irreversible methods of contraception like implants and sterilisation, with the intention of preventing women who use drugs from having children.

WHAT CAN HARM REDUCTION SERVICES DO?

- Train and support harm reduction and other staff to discuss with clients their hopes and desires around having children (or not) and avoid making assumptions or judgements – or decisions – on their behalf.
- Provide accurate, evidence-based and non-judgemental information and guidance covering the full range of contraceptives, discussing the advantages and disadvantages of each method, either directly through the harm reduction service, or by referral to safe, trusted, and trained providers.
- Ensure the availability of lubricants and condoms (male and female), and provide training in how to use and negotiate use of these.
- Advise women seeking contraception on the benefits of condom dual protection – for prevention of both pregnancy and HIV/STIs including HPV and viral hepatitis B & C (see above section 2 on prevention of HIV and STIs).
- Provide emergency contraception on request to a woman who has had unprotected vaginal sex, is not currently using a contraceptive method and does not want to be pregnant.
- Provide emergency contraception as part of a comprehensive post violence/post-rape care package (see section 1 on gender-based violence).
- Advocate for choice and method mix, and for research and development of new women-controlled technologies which respond to the priorities and needs of women who use drugs.
- Encourage communication and engagement between women who use drugs and their partners to promote shared responsibility around SRHR (provide optional couples counselling).



IMPORTANT THINGS TO REMEMBER



- Use of opioids, as well as a lifestyle of irregular eating and sleeping, can affect a woman's menstrual cycle, causing menstruation to become irregular or to stop. Women should be informed that this does not prevent them from becoming pregnant and that both contraception and regular pregnancy testing are advised.
- Women who inject drugs may need information about the effect of hormonal methods of contraception on veins, the risks of varicose veins and blood clots in women.³⁹
- Where sex work is criminalised, women may be arrested for carrying condoms under the pretext that this is evidence of sex work. Harm reduction services, together with women who use drugs and sex workers, need to sensitise police on the importance of carrying condoms and advocate for the decriminalisation of sex work and drug use.



CASE STUDY

REACHING OUT TO WOMEN WHO USE DRUGS IN TANZANIA



Women in Tanzania are disproportionately affected by HIV: of the 1.5 million adults living with HIV, over 58% are women⁴⁰. With the support of MAINline International, Mukikute, the patient-led TB and harm reduction organisation, has adopted gender-responsive strategies during outreach work and at community sites in Dar es Salaam.

Women who use drugs are given information and essential harm reduction services at their homes and brothels, and they are encouraged to access services at the community centre. The centre is a welcoming space for women who use drugs, and staff encourage women to spend time there and get to know each other.

The centre provides services for women who use drugs including regular psychosocial sessions and others on SRHR. They also offer the women education, self-help groups, vocational training, legal support, childcare support, and hygiene kits.

04 MATERNAL AND NEW-BORN CARE

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

Women who use drugs and are hoping to become pregnant and raise children generally experience stigma, discrimination, coercion and violence, including in health settings. They may be coerced into having abortions against their wishes as a result of misrepresentation about the negative effects of drugs during pregnancy or media-sensationalised misinformation. While women should be advised about the potential harmful effects of drugs during pregnancy, they should also be prepared that they may be given misinformation about this by health professionals.

The effects of illicit drug use on women during pregnancy, the foetus or new-born child has been over-emphasised and sensationalised in the media and among health workers.⁴¹ On balance, other potentially harmful factors such as use of legal drugs (particularly alcohol and tobacco), homelessness, violence and poor nutrition may not receive the attention they deserve. Without ignoring the risks of substance use during pregnancy, it is essential that women are told that drug use per se does not mean that their foetus' health will necessarily be compromised. Women who use drugs must have accurate information provided in a non-judgemental manner to help them make informed decisions about whether to continue or stop drug use; start substitution therapy; and whether they wish to continue with the pregnancy. Health workers need to create a comfortable environment where women will feel able to mention their drug use so they can discuss and prepare for any potential complications.

It is important to note that hidden substance impurities common in the black market can present additional risks – particularly of overdose. In the context of opioid overdose in pregnant women, the use of naloxone has been noted as a potential miscarriage risk. However, it is important that peers, significant others, health workers and other potential first responders do not hesitate to administer naloxone to pregnant women in an overdose scenario, as this will still save her life.



Preeti and husband Manoj (not their real names) with their new baby during a home visit by WINGS support workers, in India.

If available, and where relevant to the woman concerned, opioid substitution therapy (OST) programmes can aid stabilisation, promote healthier behaviour and improve access to other health care services, including antenatal care. This is usually a much safer option than trying to stop opioid use, since sudden abstinence and withdrawal can cause miscarriage, and relapse brings overdose risks.

For women who use drugs and are living with HIV, pre- and postnatal care are important to prevent transmission of HIV to the foetus or infants during pregnancy, delivery or breastfeeding. And babies born to women who use opioids may require supportive treatment for management of neonatal abstinence syndrome (NAS) (see Box 6). Breastfeeding practices should not change with maternal drug use. Both methadone and buprenorphine are safe for breastfeeding as only small amounts of the drugs are transferred through breast milk.

Finally, it is well-established that drug use alone does not equate with bad parenting. Nevertheless, women who use drugs report fears and actual experiences of having their children taken away from them by family members or by social services because they are considered 'irresponsible' or 'incompetent' parents. It is essential to link parents to support systems for the care and safety of their children, as well as access to legal recourse for custody as required.

WHAT CAN HARM REDUCTION SERVICES DO?

- Provide free pregnancy testing for women who use drugs.
- Educate and sensitise harm reduction staff and other health service providers on stigma reduction and provide accurate, evidence-based information about drug use in relation to pregnancy and foetal health.
- Provide accurate, evidence-based and unbiased information for women who use drugs and who are pregnant or considering pregnancy on: the effects of different drugs in pregnancy; how negative effects can be minimised; support/referral networks available; and provide links to appropriate, client centred services.
- Ensure pregnant women who use drugs have access to peer support. Where such support does not yet exist, harm reduction providers should consult with peers on establishing this.
- Provide referrals (and accompaniment if desired) to antenatal care with a trusted provider who can support women to manage drug use during pregnancy, monitor for complications, improve pregnancy outcomes and ensure her general health and well-being and that of the foetus/child.
- Where non-judgemental services for assisting pregnant women who use drugs do not exist, provide training and support for relevant services to build capacity. Ensure that training addresses common misinformation and misconceptions about the risks related to drug use during pregnancy.
- Provide non-judgemental support and evidence-based guidance on the best options in relation to continued drug use, substitution therapy or cessation of drug use during or after pregnancy. This guidance should be offered to help women make a voluntary and informed decision on the best course of action for themselves and their foetus.
- Methadone programmes should offer dosing flexibility for pregnant women. Methadone should be available at the clinic where women who use drugs will be giving birth.
- Offer pregnant women who use drugs or women whose partners use drugs HIV counselling and testing, and if found to be living with HIV, refer them for appropriate treatment. Delivery should be provided in a health clinic or hospital so that HIV transmission to the baby can be prevented with the administration of medication to the mother and baby. Post-natal care is also essential to support the mother with infant feeding (see Box 5 on page 17).

BOX 6:**NEONATAL ABSTINENCE SYNDROME (NAS)****What causes NAS?**

Newborns whose mothers took opioids during pregnancy — including prescribed painkillers, addiction treatment medications, and illicit opiates — may experience NAS. But prenatal exposure to opioids does not always result in NAS. Research has not yet determined why some babies develop NAS and others do not.

How is NAS treated?

Research shows that skin-to-skin contact, breastfeeding, and caring for mother/baby in the same room ("rooming in") can significantly reduce a newborn's hospital stay and need for medication. Some NAS-diagnosed newborns may need medication.

NAS is a treatable and temporary condition. It is not life threatening, and studies show that newborns with NAS do not develop any differently from other children.^{42, 43}

**IMPORTANT THINGS TO REMEMBER**

- Stigma around drug use – from health workers and others – relates to gender norms about motherhood with the result that pregnant women who use drugs are subject to stigma, discrimination, violence and other human rights violations.
- As with other SRHR services for women who use drugs, the emphasis should always be on client-led approaches through which client confidentiality and autonomy are safeguarded.
- Kits – such as pregnancy and HIV self-testing – should be provided discretely and with no requirements from the recipient, to encourage uptake by women who use drugs.

**USEFUL READING:**

- The Women's Information on Drugs and Policy
<https://www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-drugs-alcohol/drugs>



A Convictus Ukraine mobile clinic bringing STI testing closer to those who live remotely.

© Convictus, Ukraine



CASE STUDY

MATERNAL AND NEW-BORN CARE: A PERSON-CENTRED APPROACH IN UKRAINE



Ukraine has the second largest HIV-epidemic in Eastern Europe and Central Asia. In 2017 there were 13,000 new HIV infections in Ukraine; 25% of these among people who inject drugs⁴⁴.

The NGO Convictus Ukraine offers services specifically tailored to the needs of women who use drugs using a person-centred approach. They have a community centre offering free needles, syringes, condoms, counselling and other services to people who use drugs.

Women visiting the centre are marginalised by society and used to living on the street, a particularly harsh existence in winter. Many visitors to the centre are mothers who used drugs during their pregnancy. Most had challenging pregnancies and were concerned about their babies' welfare. With guidance from staff at the centre, they can access a range of support - from counselling to free infant formula, - often via referral to the Kyiv AIDS Centre.

In a study conducted by Frontline AIDS and Alliance for Public Health on Convictus' work, participants said they found the community centre a much-valued 'safe place' to get together⁴⁵. They spoke about the support groups there, which they said offered them a chance to meet with their peers and discuss their problems, free from judgement.

”

My friend was pregnant. She was using drugs... and got pregnant at the same time... I brought her here... they directed her, put her on OST, helped to deliver. Did all the things before the baby was born. The baby was born dependent on drugs and had to go through withdrawal... They gave her food rations, and other things... They cared for her to the fullest.

—Natalia

05 SAFE ABORTION AND POST-ABORTION CARE

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

Women who use drugs may be demonised as unsuitable mothers, vectors of disease and/or unable to bear healthy children, or care for them. These factors bring additional pressures for women who use drugs who have often reported being forced or coerced into having abortions on the basis of inaccurate information from service providers. It is crucial that women who use drugs are given the chance to make their own decisions about whether to continue with a pregnancy free from judgement or coercion, and on the basis of sound evidence-based advice.

WHAT CAN HARM REDUCTION SERVICES DO?

- Have clear, up-to-date, accurate information on the circumstances in which women can get a safe, legal abortion, and know where to refer women for safe abortion, and post-abortion care.
- Provide confidential, accurate advice to pregnant women who use drugs about all their options including safe abortion.
- Ensure that women who use drugs know their rights in relation to abortion.
- Provide referrals (and accompaniment if needed) for women who use drugs who wish to terminate their pregnancy to trusted safe abortion providers.
- Provide or refer women to post-abortion counselling and relevant services (could include family planning, post violence care, other psychosocial support services).
- Offer links to relevant peer support groups.
- Identify gaps in care/service provision and join with other rights-based organisations to lobby for safe abortion services where they currently do not exist, and access to post-abortion care.



© Gemma Taylor for Frontline AIDS, 2018



Participants in the WINGS project, India.



IMPORTANT THINGS TO REMEMBER



- Women who use drugs must be well informed and supported in whatever choice they take.
- Abortion is a topic which elicits emotive and often value-laden reactions. When talking about abortion, be accurate and use non-judgemental language. For example, avoid referring to the pregnant woman as the 'mother', or her partner as the 'father'; don't ask whether she intends to 'have the baby', but rather whether she intends to 'continue with the pregnancy', etc.
- In most countries, abortion is legal under some circumstances. However, community and even health worker perceptions can be that it is illegal. It is important to know the law, and know how it is interpreted in practice.
- Even in countries with more liberal laws around abortion, stigma can remain very high, and some women therefore opt for 'backstreet' abortions. Explain the risks of unsafe abortions and support women to navigate the safest options available.
- Post abortion care is not subject to the same restrictions as abortion but is often confused (by health staff and community members) as being part of the same process. Post-abortion care is an essential, sometimes life-saving process that must be available to any woman who has experienced a miscarriage ('spontaneous abortion') or who has chosen to terminate the pregnancy, whatever the circumstances.

BOX 7:

'GLOBAL GAG RULE'

The Mexico City Policy (also called 'global gag rule') is a U.S. foreign aid policy, implemented under Republican administrations since 1989, and greatly expanded under the Trump administration in 2017. The current policy prevents foreign organisations receiving U.S. government health funding from providing, counselling, or referring women for abortions, even when abortion is legal in the country where they work. Exceptions may be made for cases of rape, incest, or if the woman's life is in danger, and referrals to or provision of post-abortion care. The policy also bans U.S. funding recipients from advocating for more liberal abortion laws, even if they are using their own or another donor's funds to support the activities. Similarly, if an organisation does not receive U.S. government health funding, but members of their referrals network do, the same conditions may apply.



USEFUL READING:



- Do you really know the Global Gag Rule?
<https://pai.org/advocacy-guides/really-know-global-gag-rule/>
- Ungagging abortion: Safe abortion in the context of HIV
<https://frontlineaids.org/resources/ungagging-abortion-safe-abortion-in-the-context-of-hiv/>

06 SERVICES FOR INFERTILITY

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

Women who use drugs may be infertile as a result of a range of issues including STIs; infections following unsafe abortion or post-partum infection; exposure to certain drugs (including long term use of alcohol and tobacco) and chemicals; menstrual irregularities; some reproductive cancers and other abnormalities of the reproductive tract including blocked fallopian tubes, fibroids or long term exogenous hormone use in trans-women. Although long term hormone usage may affect fertility, trans-women can and do conceive, and they can choose to come off hormones to become fertile.

Infertility among women who use opioids can be caused by factors including hormonal suppression leading to the disruption of ovulation, or may be due to reduced sperm count and motility in male partners which may also be attributed to the use of certain types of drugs such as opioids.⁴⁶

There are various assisted reproductive technologies, including assisted or intrauterine insemination, surgery to address reproductive tract issues, or drugs to encourage ovulation. However, access to these is extremely inequitable and can be very expensive. Adoption or surrogacy may be alternative routes for individuals or couples who are unable to conceive. These options are circumscribed by varying degrees of regulation which may exclude some people. Specific populations, such as people in same sex unions, trans-women, and women who don't have a partner, may benefit from assisted fertility, adoption or surrogacy (where legal).

WHAT CAN HARM REDUCTION SERVICES DO?

- Ensure that information, education and counselling on SRHR includes accurate information on safe conception and reproductive health – including the potential risk of infertility caused by undiagnosed STIs or reproductive tract infections (RTIs).
- Discuss fertility desires with female clients and couples, and support individuals and couples who wish to become pregnant with pre-conception support, information on safer use of drugs during pregnancy, and birth delivery options for women who use drugs.



Olivia (not her real name), with a family member. Olivia participates in the WINGS programme in India.

07 CERVICAL CANCER TREATMENT

WHY IS THIS RELEVANT TO WOMEN WHO USE DRUGS?

There is no evidence that the use of illicit drugs in women causes reproductive cancers. However, all sexually active women, including trans-women who have had vaginoplasty⁴⁷, should be encouraged to undergo regular screening for cervical cancer, especially if they are living with HIV. Due to higher prevalence of cervical cancer in women living with HIV, WHO recommends they should be screened for cervical cancer on diagnosis, and every 12 months for the first three years following diagnosis, regardless of age.⁴⁸

WHAT CAN HARM REDUCTION SERVICES DO?

- Ensure that sexually active women who use drugs – especially those living with HIV – are aware of the need to screen regularly for cervical cancer and integrate cervical cancer screening services. Where screening can't be provided on site, or where visual inspection tests reveal abnormalities, link women to trusted and reliable service providers
- Advocate for regular cervical cancer screening for women who are living with HIV, in line with WHO guidelines.

CASE STUDY

HARM REDUCTION SERVICES FOR YOUNG PEOPLE

In Nigeria, women who use drugs face a lack of tailored SRHR services; there is criminalisation of drug use and persistent gender-based violence perpetrated by both their male partners and law enforcement agents.

To help address these challenges, the NGO YouthRISE runs a drop-in centre for women who use drugs which provides social and health care. They offer a range of services including information on SRHR in a locally produced manual; as well as condoms, hygiene kits, family planning, HIV tests, STI screening and legal support for gender-based violence cases.

One woman had her life transformed by the programme:

“ I am 19 years old. I never used condoms when engaging in sex and I had many sexual partners to keep up with my drug demands. I got pregnant a couple of times and had a series of abortions. I did not have access to information on HIV, safe sex and SRHR. I came in contact with one of the community outreach workers from YouthRISE Nigeria who invited me to a 5-day 'Peer Educators Training' on Sexual Reproductive Health organised at the YouthRISE Centre. I got information there on drug use, HIV, human rights, sexual and reproductive health. This training also built my capacity in being a community peer educator. I now provide information on SRHR and HIV to young women in my community.⁴⁹

Winnie Nyawira is a sex worker in Kenya. She used to inject drugs but is now enrolled on a methadone programme since over a year, and says she is "doing well".

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PROMOTING SEXUAL HEALTH AND WELLBEING OF WOMEN WHO USE DRUGS

In addition to the seven service areas described above, the Guttmacher-Lancet Commission report emphasises the importance of holistic sexual health and wellbeing. This implies more than the absence of problems like those discussed above, but also the ability to: enjoy a safe and pleasurable sex life with a partner (or partners) of one's choosing and/or avoid unwanted sexual contact (e.g. sexual harassment or violence); make and enact decisions related to how, where, when and with whom to have sex, relationships, and children; and access reliable, appropriate, and respectful information and services about matters related to sex and sexuality. A reduction in healthy, fulfilling sexual relationships can increase depression and anxiety - both for men and women. When working with women over 45 years it is also important to address issues around menopause in the context of sexual health.

Some drug use can have physiological effects on sexual and reproductive processes. For instance, long-term opioid use is known to decrease sexual desire and libido (and may cause erectile dysfunction), while amphetamine type substances can temporarily increase sex drive and reduce sexual inhibitions leading to possible increase in sexual risk-taking and injury.

Counselling and treatment of sexual dysfunctions needs to be included in SRHR programmes. They can include strategies such as establishing support groups for people who use drugs as well as their sexual partners; couples counselling and training on communication skills and how to talk about this issue with a partner.



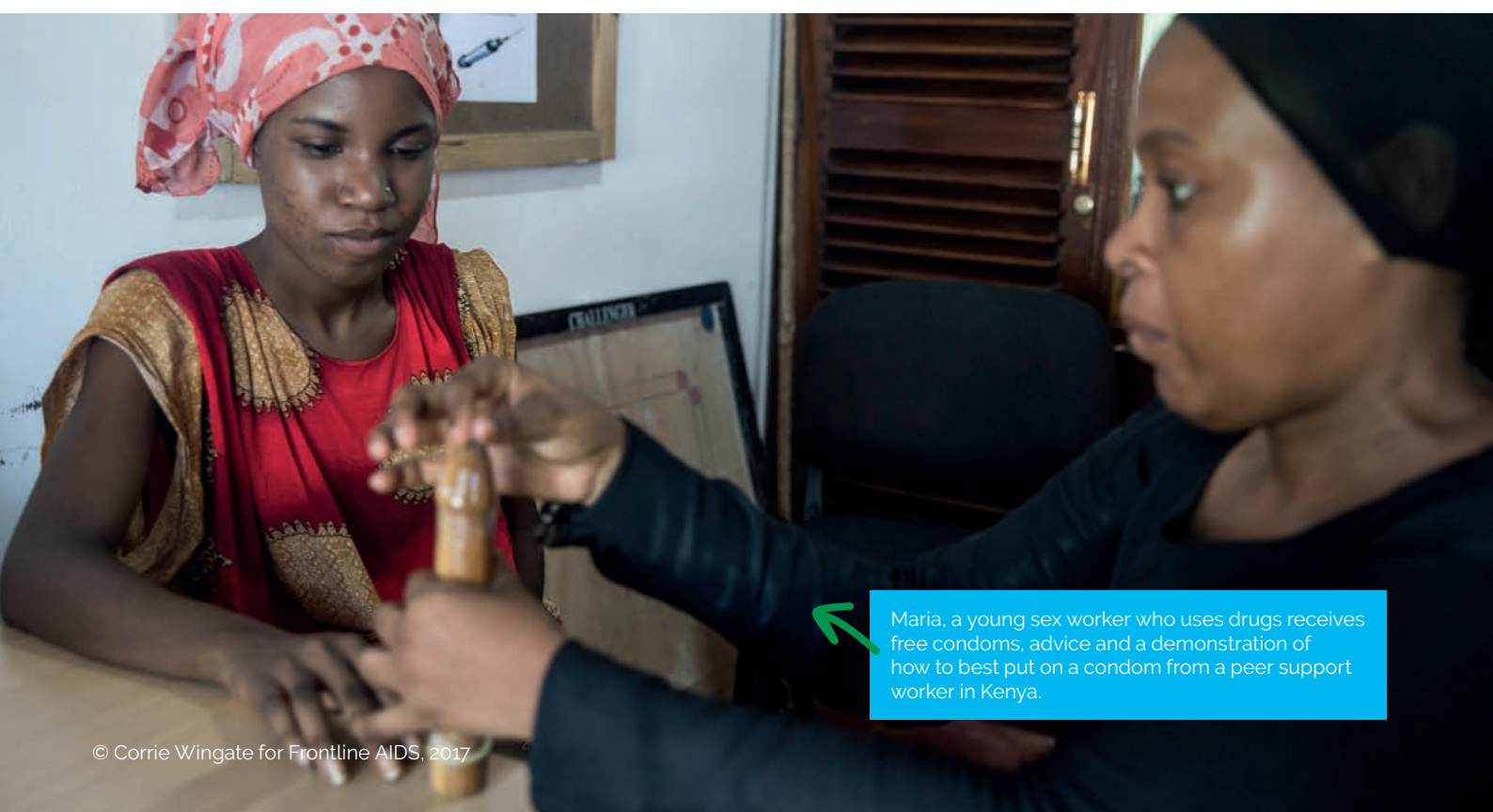
IMPORTANT THINGS TO REMEMBER



In most cultures, it is difficult for people to talk about issues related to sex and sexuality. Staff must be equipped with the knowledge and skills to balance sensitivity to cultural practices with the need to promote health and wellbeing, including discussion of the full range of LGBTQ+ sexuality issues in a non-judgemental way.

WHAT CAN HARM REDUCTION SERVICES DO?

- Work with, train and resource women who use drugs as peer outreach workers to act as a bridge between services and other women in the community. Peers can include sex workers who use drugs, and LGBTQ+ (lesbian, gay, bisexual, and transgender+) women who use drugs.
- Create space for discussion of related issues (such as drug use among sex workers) without making assumptions – such as that all sex workers use drugs, or that all women who use drugs sell sex.
- Provide accurate, accessible, non-judgemental information about sex and sexuality.
- Ensure services are welcoming and responsive to women in all their diversity.
- Make sure that all harm reduction staff are properly trained to engage respectfully with trans-women (for example, through gender affirmation and proper pronoun use), and to understand and respond to the health needs and rights of trans-women.
- If requested by a woman who uses drugs, help engage spouses or sexual partners in couples counselling.
- Provide safe spaces for family members and children to access clinical services, nutritional support and counselling, and/or for women who use drugs to come together to share experiences and collectively mobilise for action.
- Hold group discussions, 'sister-to-sister' talks and one-on-one sessions to help address concerns around the SRHR needs of women who use drugs and their spouses or sexual partners.
- Document the benefits of peer-led community empowerment service models, networking and advocacy by and for the most marginalised women who use drugs, such as LGBTQ+ women and sex workers.
- Build sensitised and safe referral networks for sex workers who use drugs and LGBTQ+ women who use drugs.



Maria, a young sex worker who uses drugs receives free condoms, advice and a demonstration of how to best put on a condom from a peer support worker in Kenya.



Winnie Nyawira, Kenya, with the daughter of a friend.

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CONCLUSION AND RECOMMENDATIONS



Throughout this guide we have highlighted what harm reduction organisations can do to ensure access to SRHR for women who use drugs in their diversity. Probably the most important is to invest in organisations and networks of women who use drugs, not only with funding, but also with capacity building and by offering them a safe space. This is crucial to build their voice, visibility and advocacy, and to develop cross-movement partnerships with other women's rights advocates and activists.

Women who use drugs have the same right to sexual and reproductive health and wellbeing as other women. Yet, they face specific hurdles to realising these rights and are often overlooked in policy and practice. The Guttmacher-Lancet Commission on SRHR offers a comprehensive definition and service package for advancing the SRHR of all, and highlights the need to address socio-structural barriers such as gender inequality, stigma and discrimination, as fundamental to achieving these.

The Commission's report draws particular attention to underserved populations, including people who use drugs, as well as neglected issues like gender-based violence and reproductive rights - two areas of particular concern to women who use drugs. To advance this agenda, the Commission has identified a number of key priorities.



PRIORITIES PARTICULARLY RELEVANT FOR ADDRESSING CRITICAL BARRIERS FACED BY WOMEN WHO USE DRUGS INCLUDE:



Advocate for laws, policies, and social norms and structures that enable women who use drugs to understand, protect, and fulfil their SRHR. The criminalisation of drug use is a critical barrier stopping women who use drugs from claiming and realising their SRHR. Punitive drugs policies underpin stigma, discrimination and violence faced by this group, and make reporting violence, or seeking tailored services almost impossible.



Progressively expand access to an essential, integrated package of SRHR interventions, ensuring that the needs of women who use drugs in all their diversity are addressed. Harm reduction services can serve as an entry point to integrated SRHR services tailored for women who use drugs, provided by known, trusted providers, and to expanding referral systems.



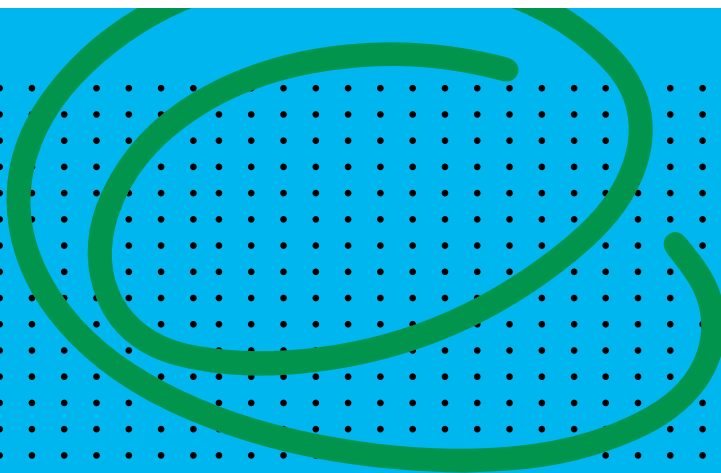
Provide additional support. As described above, women who use drugs experience multiple stigma, discrimination and violence. Peer support and tailored counselling services, by sensitised providers with specialist knowledge, should be part of the intervention design.



Prioritise SRHR research needed for policy and programme decision-making. Evidence around the SRHR of women who use drugs is inadequate. Gender disaggregation is missing in virtually all estimates related to people who use drugs, as are intersectional identities and issues, such as the overlap between drug use and sex work and drug use among trans-women. Research priorities should be identified in consultation with women who use drugs, who should also be meaningfully involved in data gathering, analysis and validation of the research.



Use accountability processes at all levels to ensure that SRHR goals and commitments are realised. Women who use drugs should meaningfully participate in the development, implementation, monitoring and evaluation of national and international frameworks, guidelines and policies related to drug use. The needs and rights of women who use drugs should be integrated in national plans and strategies on topics such as HIV, SRHR, and gender-based violence.





OTHER IMPORTANT THINGS WE CAN DO ARE:



PUT WOMEN WHO USE DRUGS AT THE CENTRE OF YOUR ACTIVITIES

To ensure that women access a broad range of SRHR services and can enjoy satisfying sexual health and wellbeing, they need to be at the centre of what we do. This means:

- Meaningfully involving women who use drugs in all their diversity in the design, implementation and monitoring of all services, so that their needs are at the centre of each response and so that services are welcoming and responsive.
- Offer women who use drugs training and sensitisation around their rights and other issues related to their (sexual) health for them to take informed decisions.
- Facilitate peer support, peer networks, peer outreach and other types of peer-led initiatives.
- Provide safe space for women who use drug, their family members and children. Consider women-only spaces or women-only hours.
- Involve (sexual) partners of women who use drugs and other members of their support networks, such as relatives and friends.

ENSURE STAFF ARE EQUIPPED TO WORK WITH WOMEN WHO USE DRUGS IN THEIR DIVERSITY

For services and spaces to be safe for women who use drugs in all their diversity it is vital that people working in those spaces respect them and are able to at least empathise with their realities. Teams should incorporate women who use drugs as full members of the team, rather than tokens. All team members should be trained on cross-cutting issues that relate to women who use drugs, such as transsexuality, gender norms, sexual practices and fertility. This is a first step to engaging respectfully with women who use drugs in their diversity; team members also need to be non-judgemental, not make assumptions, and be open to discussing anything that is of importance to the women they are serving. This way can they provide accurate and unbiased information.

Harm reduction service providers should also sensitise and train other professionals who women who use drugs encounter, such as health workers and other staff of health centres (reception, administration, guards), social workers, police officers, prison staff, prosecutors and other law enforcement officials. Only then can they start to establish referral systems with health, social and legal facilities.

DOCUMENT AND ADVOCATE

Harm reduction implementers can and should also contribute to creating an enabling environment. Together with (networks of) women who use drugs in their diversity they need to challenge the narrative on drugs: denouncing both the war on drugs with its criminalisation of drug use and drug possession as well as the disease model that turns people who use drugs into passive victims. But they also need to advocate against the laws that criminalise same sex, sex work and abortion, and the social, cultural, medical and legal practices that limit the freedom of women to make their own informed choices. Finally, it is important to contest (sensationalised) misinformation.

Harm reduction implementers, alongside women who use drugs, need to document their work and use this information to show what works and what is needed, so this can feed into national guidelines and frameworks.

FINALLY

We should always remember that holistic sexual health and wellbeing means much more than the absence of problems. Everyone has a right to enjoy a safe and pleasurable sex life; avoid unwanted sexual contact; decide on whether or not, when and how to have children; and access reliable, appropriate, and respectful information and services related to sex and sexuality.



REFERENCES

1. The Lancet Commission, 2018. *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*. The Lancet, 391(10140), pp.2642–2692. [Accessed 12 Feb 2020] at: <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>
2. UNAIDS, 2018. *Kenya*. [online] Available at: <https://www.unaids.org/en/regionscountries/countries/kenya> [Accessed 19 Feb. 2020].
3. Kimanga, D.O., Ogola, S. and Umuro, M., 2014. Prevalence and incidence of HIV infection, trends, and risk factors among persons aged 15–64 years in Kenya: results from a nationally representative study. *Journal of acquired immune deficiency syndromes* (1999), 66(Suppl 1), p.S13.
4. MAINline. *Change Story MAINline-MEWA*.
5. MAINline. *Change Story MAINline-MEWA*.
6. HRI, 2018. *The Global State of Harm Reduction 2018*. 6th Edition. [online] Harm Reduction International. Available at: <https://www.hri.global/files/2019/02/05/global-state-harm-reduction-2018.pdf> [Accessed 19 Feb. 2020].
7. HRI, 2018. *Women and Harm Reduction: Global State of Harm Reduction 2018 Briefing*. [online] Available at: <https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf> [Accessed 19 Feb. 2020].
8. IAS, 2019. *Women Who Inject Drugs: Overlooked, yet invisible*. [online] Available at: https://www.iasociety.org/Web/WebContent/File/2019_IAS_Brief_Women_who_inject_drugs.pdf [Accessed 19 Feb. 2020].
9. UNODC, 2018. *Women and Drugs: Drug use, supply and their consequences*. [online] Available at: https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_5_WOMEN.pdf [Accessed 19 Feb. 2020].
10. Gilbert L et.al, 2015. *Targeting the SAVA (substance abuse, violence and AIDS) syndemic among women and girls: a global review of epidemiology and integrated interventions*. *Journal of acquired immune deficiency syndromes* (1999), 69(0 2), p.S118.
11. Roberts, A., Mathers, B. and Degenhardt, L., 2010. *Women who Inject Drugs: A review of their risks, experiences and needs*. [online] Available at: https://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf [Accessed 19 Feb. 2020].
12. Black, K.I. and Day, C.A., 2016. *Improving access to long-acting contraceptive methods and reducing unplanned pregnancy among women with substance use disorders*. *Substance abuse: research and treatment*, 10, pp.SART-S34555.
13. UNODC, 2014. *Women who inject drugs and HIV: Addressing specific needs*. [online] Available at: https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf [Accessed 19 Feb. 2020].
14. Leung, J. et al, 2019. *A Global Meta-analysis of the Prevalence of HIV, Hepatitis C Virus, and Hepatitis B Virus Among People Who Inject Drugs—Do Gender-Based Differences Vary by Country-Level Indicators?*. *The Journal of infectious diseases*, 220(1), pp.78–90.
15. Des Jarlais, et al, 2012. *Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas*. *Drug and alcohol dependence*, 124(1-2), pp.95–107.
16. IAS, 2019. *Women Who Inject Drugs: Overlooked, yet Visible*. [online] Available at: https://www.iasociety.org/Web/WebContent/File/2019_IAS_Brief_Women_who_inject_drugs.pdf [Accessed 19 Feb. 2020].
17. Hope Ditmore, M. 2013. *When Sex Work and Drug Use Overlap: Considerations for advocacy and practice*. [online] Harm Reduction International. Available at: https://www.hri.global/files/2014/08/06/Sex_work_report_%C6%924_WEB.pdf [Accessed 19 Feb. 2020].
18. NSWP & INPUD, 2015. *Briefing Paper: Sex workers who use drugs, experiences perspectives, needs and rights: ensuring a joint approach*. [online] Available at: https://www.inpud.net/sex_workers_who_use_drugs_nswp_inpud_oct_2015.pdf [Accessed 19 Feb. 2020].
19. INPUD, 2016. *Addressing the specific needs of women who inject drugs: Practical guide for service providers on gender-responsive HIV services*. [online] Available at: https://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf [Accessed 19 Feb. 2020].
20. UNAIDS, 2019. *UNAIDS Data 2019*. [online] Available at: <https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data> [Accessed 19 Feb. 2020].
21. UNAIDS, 2016. *Prevention Gap Report*. [online] Available at: https://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf [Accessed 19 Feb. 2020].
22. WHO, 2016. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: 2016 update*. [online] Available at: <https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/> [Accessed 19 Feb. 2020].
23. WHO, 2016. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations: 2016 update*. [online] Available at: <https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/> [Accessed 19 Feb. 2020].
24. The Lancet Commission, 2018. *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*. *The Lancet*, 391(10140), pp.2642–2692. [Accessed 12 Feb 2020] at: <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>

25. Uganda Harm Reduction Network (2019). *UHRN programme data*.
26. See for the photo voices: <https://twitter.com/uhruganda/status/1158678097480290306/https://twitter.com/uhruganda/status/1108721814220521473>
27. Columbia CTL., 2020. *WINGS*. [online] Available at: <https://ctl.columbia.edu/project/wings/> [Accessed 19 Feb. 2020].
28. UN, 2012. *Joint Statement: Compulsory drug detention and rehabilitation centres* [Press release]. March. Available at: http://files.server.idpc.net/alerts/Joint-Statement_Compulsory-drug-detention-and-rehabilitation-centres.pdf (Accessed: 19 February 2020).
29. Murphy P, 2008. *Women and drug use in India: substance, women and high-risk assessment study*. [online] Available at: <http://nimhans.ac.in/cam/sites/default/files/Publications/41.pdf> [Accessed 19 Feb. 2020].
30. The India HIV/AIDS Alliance, August 2019. *WINGS Intervention Midterm Report*.
31. UNAIDS, 2018. *Miles to Go: Closing Gaps, Breaking Barriers, Righting Injustices*. [Online] Available at: https://www.unaids.org/sites/default/files/media_asset/miles-to-go_en.pdf [Accessed 20 Feb. 2020]
32. INPUD, 2019. *Chemsex: A Case Study of Drug-Userphobia*. [online] Available at: https://www.inpud.net/sites/default/files/000441_INP_Chemsex_online_0.pdf [Accessed 19 Feb. 2020].
33. Note that pre-exposure prophylaxis (PrEP) for people who inject drugs is a complex matter; WHO does recommend it, based on individual assessment (WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, 2016 update: <https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>), but the International Network of People who Use Drugs (INPUD) advocates for scaling up other harm reduction services first (Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs: Community Voices on Pros, Cons, and Concerns <https://www.inpud.net/sites/default/files/INPUD%20PrEP%20-%20Community%20Voices.pdf>).
34. WHO, 2010. *PMTCT Strategic Vision, 2010-2015*. [Online] Available at: https://www.who.int/hiv/pub/mtct/strategic_vision.pdf [Accessed 19 Feb. 2020].
35. Terrence Higgins Trust, 2018. *Sex as a trans woman*. [Online]. [19 February 2020]. Available from: <https://www.tht.org.uk/hiv-and-sexual-health/sexual-health/improving-your-sexual-health/sex-trans-woman>
36. UNODC, 2012. *Standard Operating Procedure for Intervention among Female Inject Drug Users*. Regional Office for South Asia. [online] Available at: https://www.unodc.org/documents/southasia/publications/sops/FIDU_SOP.pdf [Accessed 19 Feb. 2020].
37. Study cities included Jakarta and adjacent suburbs Bogor, Tangerang, Depok, Bekasi, and Bandung, the provincial capital of West Java province. The study was led by PKNI (Indonesian Drug Users Network) and was a collaborative piece of work with researchers from Oxford University working together with local CBOs: Kios Atma Jaya, Karisma Foundation, Stigma Foundation, Rumah Cemara, Grapiks Foundation, Rumah Singga Peka, and Rumah Sebaya which implemented the research. To read more, see: <https://ora.ox.ac.uk/objects/uuid:8e331673-d5dd-4ecb-8085-3a00cf3c4f0f>
38. Indonesian Drug User Network. Women speak out: Understanding women who inject drugs in Indonesia. [Online] Available from: http://korbannapza.org/files/pdf/WomenSpeakOut_English_Web.pdf [Accessed 19 Feb. 2020]
39. For more information see: <https://www.centerforvein.com/blog/relationship-birth-control-varicose-veins>
40. UNAIDS, 2018. *United Republic of Tanzania*. [online] Available at: <https://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania> [Accessed 19 Feb. 2020].
41. The Global Coalition on Women and AIDS. *Women who use drugs, harm reduction and HIV*. [online] Available at: <https://idhdp.com/media/1114/brief-women-drugs-hiv-harm-final.Pdf> [Accessed 19 Feb 2020].
42. National Advocates for Pregnant Women, 2016. *Understanding Opioid Use During Pregnancy*. [online] Available at: <http://advocatesforpregnantwomen.org/Opioid%20Use%20Pregnancy%202016.pdf> [Accessed 19 Feb. 2020]
43. Kraft, W.K. and van den Anker, J.N., 2012. *Pharmacologic management of the opioid neonatal abstinence syndrome*. *Pediatric Clinics*, 59(5), pp.1147-1165.
44. UNAIDS, 2018. *Global AIDS Monitoring 2018: Ukraine Summary*. [online] Available at: https://www.unaids.org/sites/default/files/country/documents/UKR_2018_countryreport.pdf
45. Frontline AIDS, 2019. *Responding to the needs of women who use drugs in Ukraine*. [online] Available at: <https://frontlineaids.org/wp-content/uploads/2019/04/FrontlineAIDS-Ukraine-Report-Web-002.pdf> [Accessed 19 Feb 2020].
46. Safarinejad M.R. et al, 2013. *The effects of opiate consumption on serum reproductive hormone levels, sperm parameters, seminal plasma antioxidant capacity and sperm DNA integrity*. *Reproductive Toxicology*, 36, pp.18-23.
47. Canadian Cancer Society, 2020. *Prevention and Screening*. [online] <https://www.cancer.ca/en/prevention-and-screening/reduce-cancer-risk/find-cancer-early/screening-in-lgbtq-communities/trans-women-and-cervical-cancer-screening/?region=on> [Accessed 19 Feb 2020]
48. AIDS Info, 2020. *Guidelines for the Prevention and Treatment of Opportunistic Infections in Adults and Adolescents with HIV*. [online] Available at: https://aidsinfo.nih.gov/contentfiles/lvguidelines/glcchunk/glcchunk_343.pdf [Accessed 19 Feb 2020]
49. YouthRISE, 2020. *Programme data*.



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