Women who use drugs, harm reduction and HIV

The Global Coalition on Women and AIDS

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Introduction

This issue brief about HIV, harm reduction and the sexual and reproductive health and rights of women who use drugs is part of a series of briefing papers, commissioned by the Global Coalition on Women and AIDS (GCWA), and is designed to provide up-to-date information around key issues concerning HIV prevention, treatment and care related to women and girls. Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, including a focus on people who continue to use drugs.[1] The brief is unique in that it is the first to be generated by a global coalition working on issues specific to women who use drugs and HIV more broadly, and has been developed and written by members of the International Network of Women who Use Drugs (INWUD) with collaboration from the Women's Harm Reduction International Network (WHRIN), in line with GCWA's commitment to giving voice to vulnerable affected groups. To this end, members of INWUD have provided a series of perspectives from different parts of the world describing the issues faced by women who use drugs relating to harm reduction and HIV-related services. The brief is also timely, given that the political declaration which emerged from the 2011 High Level Meeting on AIDS includes, for the first time, a commitment to halve the prevalence of HIV among people who inject drugs.[2] This represents a historic commitment that recognizes the specific vulnerabilities to HIV of people who inject drugs, while also requiring scaled-up action to meet this target.

For many reasons, women who use drugs are more likely than their male counterparts to acquire HIV[3]. The stigma and discrimination that women who use drugs face increases the likelihood of engaging in behaviours that enhance their vulnerability to HIV and other blood-borne virus (BBV) transmission.[4] Furthermore, they face a range of gender-specific barriers to accessing HIV-related services, and in many regions continue to represent a hard-to-reach population even where harm reduction programs are in place.

This brief seeks to bring attention to policies, laws and practices that undermine the rights of women who use drugs, and to promote the realisation of their human rights in terms of an effective harm reduction response to HIV. The brief also outlines some of the challenges specific to protecting women who use drugs from HIV transmission that need to be considered when designing interventions, as well as the principles that must be upheld when striving to meet the goal set in the declaration, and lists recommended actions for moving forward from the programmatic level, through to national policy and global responses.

The Gendered Nature of Elevated Risk

Studies conducted in a number of countries have indicated a significantly higher prevalence of HIV among women who use drugs than their male peers, with some countries reporting incidences of HIV amongst women who use drugs to be as high as 85%, compared to rates of up to 65% among all people who use drugs in the worst affected countries.[5] [6] There are a number of reasons for this elevated risk. Many of the vulnerabilities experienced by women who use drugs illicitly are a compound of those that are experienced by women in general, in addition to those faced by all people who use illegal drugs. Culturally embedded power imbalances that exist between men and women around the world often leave women exposed to increased stigma, abuse, violence and coercion. Additionally, women are more biologically vulnerable to sexual transmission of HIV than men.[7] Such vulnerabilities, when combined with the particular risks experienced by women who use drugs, elevate their risk of infection even further. Also, structural and social determinants of gender inequality such as socio-economic conditions, gender norms, ethnicity, and religion can contribute to risk of HIV and viral hepatitis infection.[8] While it is clear that countries need to address these determinants for an effective HIV response, it is beyond the scope of this paper to deal with the determinants exhaustively.

STIGMA AND DISCRIMINATION

Women who use drugs are widely reported to experience disproportionate levels of stigma and discrimination, often compounded during pregnancy, and also as mothers.[9] [10] [11] [12] Health care providers have been reported to deny access to treatment and services to women who use drugs.[13] Women also risk suffering breaches of confidentiality relating to exposure of their drug use and their serostatus, which can lead to violence, harassment and family disconnection.[14] Such discriminatory practices, coupled with women's experiences of disadvantage and absence of support networks creates a significant barrier to accessing both HIV and harm reduction services.[15] In addition, the stigmatised nature of women's drug use can result in their being forcibly removed from their homes, ostracised by family, friends and the broader community and having their children removed from their custody, regardless of whether or not their parenting ability is impaired and often at great detriment to both mother and child.[16] [17] Pursuant to this, hostile attitudes can lead to violent and discriminatory acts perpetrated against women, including by those in positions of authority.[18] For example, a study conducted in Guangxi, China, found that guards at a 'rehabilitation' forced-work farm used HIV testing data to judge which women they could have sex with without using condoms.[19]

PUNITIVE POLICIES AND STATE VIOLENCE

In 2009, UN Secretary General Ban Ki Moon had the following to say with regard to policies concerning people at elevated risk of HIV infection:

'…Many countries impose criminal sanctions for same-sex sex, commercial sex and drug injection. Such laws constitute major barriers to reaching key populations with HIV services. Those behaviours should be decriminalized, and people addicted to drugs should receive health services for the treatment of their addiction...'[20]

Despite the clear and powerful edict from the Secretary General, policy across the UN system is still not unified. While the UN system promotes the health, welfare and human rights of people who use drugs, some of the programs supported by the United Nations Office on Drugs and Crime (UNODC) in overseeing implementation of the UN Drug Conventions are at odds with this principle. For example, the UNODC actively provides support to strengthen drug

As a woman who has experienced almost 30 years as an injecting drug user in Australia and then the UK, I feel as though I have lived through much of the evolution of harm reduction. HIV services were almost exclusively male domains throughout the 80's and 90's despite the welcoming rhetoric and HIV positive women were forced to create services for themselves because it became clear that services not created by women didn't cater for women. When I was diagnosed with HIV in the mid 90's, I already had Hepatisis C, and my repeated attempts to engage with both HIV and health services were consistently met with suspicion, distrust and a total disregard for the answers I was seeking. 'What does HIV mean for me as a woman? ("Sorry, there's no research on it") What impact will my Hep C status have on things? ("Umm, we don't know we haven't studied it") What treatment can I expect to get? ("Sorry, we don't think drug users are 'good adherer's to HIV drugs") What is the long term prognosis for a woman taking heroin with HIV? ("Maybe you better just go to your drug clinic").

We must address this unrealistic view we have of women who use drugs–vulnerable or deviant, or kicked to the curb or needing saving from themselves, the lives they can't control, or the children they shouldn't have had. HIV does not happen in isolation. It is strongly linked to violence against women, lack of knowledge and/or harm reduction, poverty, social and economic exclusion. We need sympathetic, knowledgeable women only services for women who use drugs, with the access bar set low. We must ensure rehab and respite include places for women's children.

Things are never black and white, and where it can seem we sit here with plenty, the reality is in Britain today, harm reduction's future is more fragile and uncertain than it's ever been.

INWUD Member, UK, 2011.

law enforcement in countries that retain the death penalty for drug crimes.[21] Countries will be less inclined to improve their national drug policy and harm reduction programming, as long as the policies of the UN system are not harmonised and directed towards prioritizing the human rights, health and wellbeing of women and girls injecting drugs. As a result, women and men who use drugs will continue to be at elevated risk of HIV infection.

In countries where drug possession is criminalised, responses to drug use are generally punitive in nature including beatings and torture, compulsory treatment programs or incarceration, the death penalty and summary executions, neglecting or overriding the need to address drug use as a public health issue. The overlap between drug use and sex work adds to women's increased risk, as sex work is frequently criminalised. Policies such as drug user registration, widely utilised in Eastern Europe and the Russian Federation, further discourage women from accessing services as their registration can lead to a loss of custody of their children, and lasting discrimination.[22]

Punitive prohibition policies are also commonly associated with police harassment and abuses, including violence and sexual violence against women who use drugs.[23] [24] Women have reported escaping police attention via the provision of sexual favours.[25] Where drug use is illegal, women are often deterred from reporting violence perpetrated against them to police.[26] Indeed, police crackdowns on drug use can inhibit women's willingness to access harm reduction programs due to a fear of being exposed, harrassed or arrested.[27]

Unfortunately, incarceration affects women disproportionately compared to men in prison: they are more likely to share injecting equipment, and they experience a higher rate of HIV infection[28], as well as viral hepatitis, particularly Hepatitis C Virus (HCV) infection.[29] Imprisonment also exposes women who use drugs to a variety of harms unrelated to drug use, including the loss of

Ayu started using heroin in 1994 when she met her husband who was drug dependent. At that time she was still in high school. Over the years she used more frequently until eventually she became dependent.

Many times Ayu became the target of police harassment and arrest, and also served prison sentences for being a drug user. Ayu had a job and could usually buy her drugs without having to steal, though occasionally she did have to resort to crime. However she was only ever arrested because of her drug use. Often when under arrest she was subject to rape, sexist insults and threats. Police would humiliate her and threaten to punish her spouse, who was at that time in detention, if she did not have sex with them or let them touch her. Ayu did not feel she could complain or report these actions because in Indonesia drug users consider it normal to experience police violence, because of the way they are criminalized by drug policy and stigmatized by society.

Ayu tried many times to stop using drugs with support from doctors but always relapsed. Life became even harder when her husband, who was HIV positive, died as a result of an opportunistic infection: In 2005 Ayu found out that she was HIV positive, when she accessed voluntary counselling and testing in one of the harm reduction services in Bandung that was supporting her efforts to stop using drugs. She felt very uncomfortable because she was afraid that her status would be known by others. She was also very shocked and regretful; she had not been made aware of the risks of HIV transmission nor how to protect herself from becoming infected. The community stigmatized and discriminated against her family: Ayu's brother had died of AIDS, and people knew that both he and Ayu had been drug dependent, so they turned away from the family entirely.

In 2009 she was refused access to methadone by doctors, because she was seen to disobey and to have failed the program previously. She was again arrested by police. After undergoing six months of detention and trial processes Ayu was finally diverted to rehabilitation by the judge. The family was ordered to pay transfer fees from prison to the rehabilitation facility as well as the cost of her rehabilitation treatment.

INWUD Member, Indonesia, 2011

custody of their children, inability to access education or welfare programs post-release, discrimination in the labour market, for example, and sexual violence perpetrated by prison guards.[30] In many parts of the world, harm reduction programs are not available to prisoners, and this is particularly true for women prisoners. In both Georgia and Kyrgyzstan, for example, some prisons for men provide methadone treatment, but women's prisons do not. [31] Furthermore, other closed settings such as 'rehabilitation' centres in countries including China, Vietnam, Burma and Laos that impose forced labour, without due legal process, place women at risk of violence perpetrated by those in authoritative positions.[32]

SEXUAL RISK

Women who use drugs are often unlikely or unable to negotiate safe sex practices with their primary partners. Sexual risk-taking may be related to feelings of trust in a relationship, or they may be culturally embedded in the gendered distribution of power.[33] Attempts to negotiate condom use with a primary partner can thus result in violence, isolation and exclusion if taken as an unwanted challenge to fidelity or privilege within the relationship.[34]

Studies have shown infrequent use of condoms by women who use drugs with long term and casual partners, and a correlation between inconsistent condom use and the sharing of injection equipment.[35] In both the United States and Europe it has been shown that high-risk sex is a more significant predictor of HIV infection than risky injecting practices in women who use drugs.[36] [37] Furthermore, women who inject drugs are more likely to have partners, clients and friends who also inject than women who do

not inject, contributing to their elevated vulnerability.[38] It has also been shown that many women rely upon their belief that their partners are free from disease.[39]

When sex is exchanged for drugs or other resources, women often exert little influence over their partner's condom use.[40] Women who use drugs and engage in sex work are less likely to gain employment in organised establishments and are often forced into street work, which in turn inhibits their ability to negotiate safe sex. They are also more likely to have to inject in a public space, where they will frequently hurry to avoid detection; this increases their risk of injection related-injury, and contributes to a reduced likelihood of using sterile equipment.[41] Other factors contributing to a higher prevalence of HIV among drug using sex workers include a larger number of sex partners and higher rates of sexually transmitted infection (STI).[42]

Women who use drugs often report a lack of knowledge around accessing sexual and reproductive health services and commodities. This should be no surprise as, in many parts of the world, such services are either not present, are poorly developed, or are not appropriate for drug users.[43] Moreover, when such services are available, women who use drugs face a range of barriers to accessing them, including cost, stigma and lack of confidentiality.[44]

INJECTION BEHAVIOURS AND INTIMATE PARTNER VIOLENCE

Women who inject drugs report a range of risky injecting practices which expose them to an increased risk of blood-borne virus (BBV) infection. They tend to share injecting equipment more frequently than men, particularly in the context of sexual relationships.[45] Further, when injecting with men, women are more likely to be 'last on the needle', which has obvious attendant implications concerning the risk of transmission of HIV and other BBVs from the use of contaminated equipment.[46] Women are also more likely to be injected by someone else, and to continue to be injected by a partner for long periods post-initiation, increasing the risk of BBV transmission.[47]

A refusal to use a partner's contaminated injecting equipment can place women at an increased risk of intimate partner violence, thus further increasing their risk of HIV infection.[48] Such violence is often supported by cultural constructs whereby the male partner is free to exert power and control. Sexual coercion is one of the forms of intimate partner violence most strongly associated with the risk of HIV transmission.[49] The risk of HIV among women who have experienced violence may be up to three times higher than those who have not.[50] Ultimately, the disempowering effects of intimate partner violence can result in greater difficulty for women in negotiating safer sex practices to lessen their risk of acquiring HIV.[51]

PREGNANCY

In many countries, pregnant drug users face criminal sanctions if they continue to use prohibited drugs. In the United States, cocaine users have been convicted on a number of charges including foetal abuse, delivering drugs to a minor, and even murder; this is despite a body of evidence showing cocaine to be no more harmful to a pregnancy than cannabis, and less harmful than alcohol.[52]

Pregnant drug users also face major barriers to accessing harm reduction and HIV-related services.[53] The criminalisation, where existing, and stigma and discrimination associated with drug use during pregnancy results in many women keeping their drug use

Eastern Europe and Central Asia (EECA) has the highest growth of HIV –infection in the world. From 2000 to 2009 there was almost a threefold increase in the number of people living with HIV. The epidemic is still concentrated among injecting drug users, commercial sex workers and sexual partners. The region has over 3.7 million drug users, and nearly one million of them are HIV -positive. In recent years, drug users in EECA have gained access to harm reduction programs. However, there has been a steady increase in the percentage of women among the newly infected, suggesting an inadequate amount of women-oriented services, as well as concerns about the accessibility and quality of those services.

"Kate was diagnosed with HIV in the 12th week of pregnancy. At that point, the doctors told her that it was necessary to terminate the pregnancy because she was still using drugs and the child would be born with deformities. Kate became frightened, and stopped going to the doctors before the birth. She never found out about the prevention of vertical transmission, and stopped communicating with family and friends. She had a difficult childbirth, and had to have a Caesarean section. Kate requested pain medication, but doctors refused because they believed she just wanted to get "high". After three days, Kate ran away from maternity hospital. We found her in a ruined house in serious condition, with great loss of blood. She requested just one thing from us: "Do not bring me to the hospital. They make fun of me." Kate died when she was 32. Her HIV - positive daughter is in an orphanage.

Drug user registration laws in the former Soviet Union unfairly restrict the civil rights of drug users and impede their access to drug treatment and violate human rights. These laws, legacies of Soviet-era legislation emphasizing control over cure, also create conditions conducive to police corruption and abuse.

Since the implementation of OST programs in some countries including Ukraine, Lithuania, Kyrgyzstan and Georgia, drug users began to live legally and women decided to declare and defend their rights. In Kyrgyzstan, pregnant women are given priority for admission to the OST program. Today Ukraine has opened specialized services in maternity hospitals, where women who use drugs can be directed to OST and receive material assistance in the form of medication, diapers, and baby food. We are trying to destroy stereotypes. In the women's clinics, doctors and gynecologists provide the scientifically-proven facts about the influence of legal drugs (tobacco, alcohol), that they may do more harm than illegal drugs-such as cocaine or heroin.

OST patients created the Association of Substitution Treatment Advocates in Ukraine, and defend their rights. Russian women who use drugs are currently trying for the removal of legislative barriers in Russia to the treatment of drug addiction with methadone and buprenorphine. And now women drug users are working to establish a European Union and Central Asia network of people who use drugs.

Most importantly, women who use drugs are involved in reforming drug policy and the direction of the country's humanitarian harm reduction approaches, based on its scientifically-proven effectiveness

INWUD Member, Ukraine, 2011.

concealed, preventing them from accessing HIV prevention and treatment programs, as well as the provision of interventions preventing vertical transmission of HIV.[54] Furthermore, health care providers in some regions are inadequately educated about the effects of drug use in pregnancy, which may lead them to deny services or provide care that increases distress and harm to the mother and child. Inadequate access to information, education and counselling can mean that women who use opiates or cocaine, (both of which can impact on the menstrual cycle), are unaware of the continued possibility of becoming pregnant, and can cause delays to accessing prenatal care where pregnancy occurs.[55] Misinformation and stigma and discrimination contribute to the promotion of ideas that any type of drug use during pregnancy will result in harm to the child. However, treatment with methadone or buprenorphine is known to be safe for use during pregnancy and recommended in international guidelines.[56] [57] In combination with appropriate prenatal care and necessary supports, such treatment protects both the woman and foetus from the very real harms caused by the perils of the unregulated market drug withdrawal and poor nutrition.[58]

In some countries, such as Russia and Ukraine, pregnant women who use drugs have been coerced by health providers to either terminate their pregnancies or relinquish their children to the state, and are denied information about and access to appropriate interventions.[59] Some nations make no provision for opioid substitution therapy (OST) at all, much less for pregnant women.

Where drug treatment is available, it may exclude women living with HIV, or may not provide separate facilities for women. Moreover, strict regulation or a lack of formalised systems may make it difficult for women to receive treatment in maternity hospitals or other health care settings.[60]

Women who continue to use drugs throughout pregnancy can be exposed to violence from their family or partners, and pressure from their communities to terminate their pregnancy. Such stigma and discrimination can force women into risky practices including injecting alone, and more marginalised forms of sex work.[61]

OTHER BARRIERS TO ACCESSING SERVICES

In addition to the barriers outlined above, there exist a range of other obstacles to women who use drugs accessing HIV testing, treatment, care and support, as well as drug treatment and harm reduction services. To begin, there are simply insufficient services available; Harm Reduction International estimates that only 5% of those that need harm reduction services have access to them worldwide.[62] Where evidence-informed treatments are available, there may be insufficient information regarding what services are provided, and they are likely to be geared toward men, rather than for women who use drugs.[63] Examples of this include the fact that most services fail to provide child-care facilities, discouraging access by women with children. Often services are located in places that are difficult to reach without access to transport, or where it is not safe for a woman to travel alone. They may have strict opening hours which make it difficult for women with work or domestic commitments to attend, and/or a lack of outreach services which could provide bridges to reach hidden populations of women. Other potential gender-specific barriers include: the cost associated with service utilisation; and a lack of female staff; staff being untrained in issues specific to their women service users; a lack of women-only spaces, and general gender insensitivity in program delivery.[64] [65]

Recommendations

1. DESIGNING HARM REDUCTION AND HIV-RELATED SERVICES FOR WOMEN WHO USE DRUGS

- **It is important that the meaningful involvement of women who use drugs in the HIV response be facilitated**. Their expertise and contribution to the design, implementation, monitoring and evaluation of services contributes to an informed approach to service provision, resulting in improved effectiveness and efficiency.
- **There are a number of ways that services can increase their gender-sensitivity and thereby increase access by women, even when resources are constrained.** It is essential that safe women-only spaces, or women only times at the very least, are available, in order for women to feel that they can attend services safely. Services must also recruit women who use drugs to provide peer support and enable women clients to feel more comfortable and less marginalised.
- Given that violence creates a significant obstacle to women accessing **harm reduction services, and correlates with an increased risk of acquiring HIV, harm reduction and HIV-related services should seek to connect with domestic violence and violence prevention programmes**, or offer such services onsite themselves, in order to improve relevance to and access for women who use drugs.
- Harm reduction and drug treatment services should also **provide opportunities for couples' counselling**, empowering women to negotiate safer injecting and sexual practices within their relationships, and ensuring that the responsibility for reducing the risk of HIV lies with both partners.
- **Women-specific** HIV and harm reduction information, education and communication materials developed in consultation with the target audience should be made available.
- More women can be reached by services that are **open at appropriate times to suit the needs of women** who are working or have child care responsibilities. Child care provision is also fundamental; particularly in the case of inpatient treatment facilities.
- A **variety of evidence-based drug treatments** should be available and made accessible. Where women are unable or unwilling to undergo inpatient drug treatment, outpatient treatments such as OST should be made as accessible as possible, and minimise interference with women's commitments. **Mobile dosing services and take-home dosing** are important features of such treatment and should be made widely available. Furthermore, in order to reduce the risk of exposure to HIV during pregnancy, **pregnant women who use drugs should have priority access to OST**. Obstetric services should provide non-punitive, evidence-informed education and care to pregnant women and nursing mothers to protect their health and that of their infants.
- The staff of harm reduction and HIV services, as well as mainstream services, should also be trained and supported to recognise the sexual and reproductive health needs of women who use drugs and to **improve service relevance and accessibility**. Sexual and reproductive health services that are appropriate and sensitive to the needs of women who use drugs should be incorporated into harm

reduction services and vice-versa; this is fundamental to assisting women to protect themselves against infection with HIV and other BBVs and STIs.

- Staff in harm reduction services should be supported to give appropriate **information on safer injection techniques**, to address some women's need to have partners or friends inject them.
- Increasing women's **access to sterile injecting equipment and condoms and lubricant**, in both community and closed settings is essential to effectively mitigating risk of exposure to HIV. broader reach can be achieved via the provision of mobile services and outreach to appropriate locations, including women's homes where appropriate; ensuring discreet over-the-counter availability in pharmacies; eliminating limits to the amount of equipment that can be procured per visit; and enabling and supporting secondary exchange and particularly peer delivery. Targeted outreach services should also provide HIV counselling and testing, testing and treatment for STI's, and referrals to non-judgmental doctors, accustomed to working with women who use drugs.
- Women who use drugs must have access to **free, confidential and voluntary HIV counselling and testing**, and accurate information about and treatment for the **prevention of vertical transmission**. Testing and counselling services should provide assistance with overcoming barriers to treatment (such as obtaining legal documents) and give appropriate referrals to HIV clinic doctors who are friendly and skilled in working with women who use drugs. Women receiving inpatient treatment in HIV clinics require **access on demand to OST**.

2. DESIGNING NATIONAL POLICIES TO PROTECT THE HEALTH AND WELLBEING OF WOMEN WHO USE DRUGS

Policies that punish, stigmatize and discriminate against women create a significant barrier to women accessing harm reduction and HIV-related services. In order to address the growing prevalence of HIV among women who use drugs, such policies must give way to evidence-informed frameworks that support health and human rights. To this end, national governments should:

- Develop **specific guidelines and targets** to address the needs of women who use drugs;
- **Support research endeavours** to improve understanding of the needs of women who use drugs and support evidence-informed service provision, as well as research into HIV, co-infection with hepatitis C and women's sexual and reproductive health, and drug interactions.
- **Refocus drug policies** away from attempting to reduce the size of the drug market to instead attempting to reduce associated harms, including violence and BBV transmission;
- Ensure that **laws relating to drug use and HIV are evidence-informed** and in harmony with human rights and population health frameworks;
- **Remove any legislative or policy barriers** to the provision of high quality, women friendly harm reduction services including evidence informed drug treatment and needle and syringe programs;
- Support the creation of accessible and integrated harm reduction/SRH/HIV/

violence prevention services, through the **engagement of women who use drugs** in the development of appropriate policy;

- Support the implementation of **accessible viral hepatitis testing and treatment** services;
- Ensure that **women's rights are protected under the law**, and that they can access support to prosecute police perpetrated and other human rights violations;
- Ensure that the curricula of law enforcement officers as well as mainstream healthcare workers include **credible and relevant training on women who use drugs**, their rights and their vulnerabilities, and the provision of appropriate referrals to relevant services;
- Enforce the **protection of women's confidentiality**, including the review and reform or removal of any existing compulsory drug registration systems;
- **Remove any legislation** that makes drug use an adequate justification for the removal of children from their parents' custody;
- Support the provision of harm reduction, HIV and drug treatment services in **women's prisons and other closed settings**;
- Include in relevant policies the promotion of and support for **income-generating interventions** for women who use drugs;

3. CREATING REGIONAL/GLOBAL SUPPORT FOR THE PREVENTION, TREATMENT AND CARE OF HIV AMONG WOMEN WHO USE DRUGS

In supporting member nations in the creation of a policy environment that protects the health and well-being of women who use drugs, UNAIDS and its global partners should:

- **Encourage governments to review drug policy** with a view to moving away from ineffective punitive policies and towards addressing drug use as a socio-health issue;
- Commit to **policy harmonisation across the United Nations system** to ensure that human rights and evidence inform future positions and actions (including across all UNODC programmes);
- Work together to **ensure that global drug control policies do not undermine HIV prevention** strategies by marginalising drug users and creating barriers to their accessing services;
- Work with member states to **scale up HIV and harm reduction services designed for women** who use drugs, including mobilising resources for the implementation and expansion of services and for research to inform the development of appropriate service models to suit local needs;
- Work with and the International Network of Women who use Drugs, the Women and Harm Reduction International Network, and other such networks at regional and national levels to advocate for, and share information pertaining to the **development of regionally appropriate models** of service delivery targeting women who use drugs.
- **Create compliance tools** to ensure that countries are expending harm reduction and HIV-related funding appropriately.

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