What Interventions Are Needed for Women and Girls Who Use Drugs? A Global Perspective

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Abstract: Women and girls who inject drugs are more likely than their male counterparts to acquire HIV. In addition to criminalization, punitive laws, and social stigma that puts all injecting drug users at increased risk, women are made even more vulnerable by social, economic, and culturally embedded power imbalances. Women and girls are also less likely to seek treatment and healthcare, even when they are pregnant. This is in part due to underfunded harm reduction and drug treatment programs limited in their ability to surmount the unique barriers women face. This does not have to be the reality. There are steps–some simple, some more complex–that can reduce infection rates and provide women and girls with health care and harm reduction services that are designed with their needs and concerns in mind.

Key Words: injecting drug use, HIV, AIDS, adolescents, women, girls, policy, programming, care, treatment, harm reduction, sex work

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According to UNAIDS, criminalization and punitive laws and widespread societal stigma are among the leading causes of HIV prevalence among injecting drug users (IDUs).[1] Women are uniquely vulnerable to the harms related to drug use because they also face gender-based discrimination. In many counties, there is actually a higher prevalence of HIV among female IDUs. Studies in 9 European Union countries showed that the average HIV prevalence was more than 50% higher among female IDUs than their male counterparts.[2] Women who inject drugs also experience significantly higher mortality rates, an increased likelihood of injection-related problems, faster progression from first drug use to dependence, and higher levels of risky injecting and/or sexual risk behaviors.[3]

Culturally embedded power imbalances that exist between men and women leave women exposed to increased stigma, abuse, violence, and coercion. These make female IDUs more vulnerable to infection, as when gender norms deter women from controlling their own injection process and women find themselves "second on the needle."[4] These factors also make female IDUs less likely to use harm reduction services, even when they are available.

Although it is widely accepted that harm reduction effectively reduces HIV transmission among people who inject drugs, there remains a significant gap between what we know works and what is actually being done.[5] Consistently underfunded, harm reduction and drug treatment programs are rarely able to make accommodations for the unique barriers to healthcare and treatment that women face when they self-identify as drug users, thus reducing the likelihood that they will use the services.[6]

Intense social stigma against female IDUs is often incorporated into social welfare policy. As a consequence, comparatively few visit needle exchange programs. In a sample of needle exchange projects from Bulgaria, Romania, Slovenia, and Kyrgyzstan, 5%–37% of the clients were women, with an average of 19%.[7] This is due, in part, to an environment that is counterproductive for women who have children. Mothers who use drugs are too readily separated from their children, temporarily or permanently, by unjust loss of custody. In some cases, they are barred from treatment programs and homeless shelters. Drug users are demonized, but female drug users are especially so, and their ability to be mothers is routinely questioned.

Women who are pregnant face an additional layer of hostility in the popular imagination that is compounded by hostility from healthcare providers, family members, and even other drug users. In Ukraine, a billboard with the image of a child's 6-fingered handprint reads, "Mommy, Why am I a Monster?"[8] Stigmatization like this can force pregnant drug users into riskier practices, such as injecting alone, paying someone else to buy their drugs, concealing their pregnancy, avoiding wellness visits, and engaging in the most marginal high risk forms of sex work.[6]

When a woman IDU who is living with HIV becomes pregnant, she also faces greater barriers to preventing her child from acquiring HIV—even more so than other women who are living with HIV. The availability of HIV services is not always enough for women to access treatment successfully.[1]

Harm reduction, specifically for women, can close the gap between the mere availability of services and their actual use and effectiveness. Here is what we know works:

- Centers only for women or that have women-only hours that are open according to the needs of their clients and are located in neighborhoods that are convenient and safe for women as well as particular minorities and migrants.
- Programs that offer safe, clean, age-appropriate spaces where children can stay while their mothers receive care.

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- Centers that support rather than interfere with their clients' other commitments by offering mobile dosing services and take-home dosing.[9] Services and policies that allow women flexibility in the frequency of their visits, such as increasing the number of needles/syringes that can be exchanged per visit.
- Integrated services that incorporate sexual and reproductive health education and services and that network with women's shelters, domestic violence and rape prevention, and drug treatment.[6]
- Programs that address the unique needs of specific subpopulations such as drug-using sex workers, women in prison, transgender women, and women who have sex with women.
- Legal literacy and services that empower people who inject drugs to challenge discrimination and abuse. Sensitization of law enforcement and healthcare personnel to reduce institutionalized stigma, discrimination, and abuse.[1]

Efficient and effectively delivered services depend on the availability and analysis of gender- and age-disaggregated data, specifically on addiction, drug use, and service access among women and girls. They also depend on drug laws that facilitate rather than deter provision of and access to services for women.

In every country, women experience discrimination through laws and policies, gender-based stereotypes, and social norms and practices. These vulnerabilities are compounded by the exclusion and stigmatization of drug use. As a result, women's ability to exercise choice and claim their rights to support and protection are significantly challenged.[10] In effect, the social stigma, shame, and discrimination that accompany drug use function as tools of women's further oppression. Harm reduction programs cannot change how society views women who use drugs, but they can positively influence how they view themselves, help them to regain their independence, and in so doing, save their lives.

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