WOMEN WHO INJECT DRUGS: *OVERLOOKED, YET VISIBLE*

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BACKGROUND

"Society has chosen to criminalise, condemn and discriminate against women who use drugs; to incarcerate us, force us into treatment, subject us to state removal of children, and leave us vulnerable to violence, abuse and neglect. Drug use should not be viewed as something negative in and of itself – it is often a rational response to life's experiences. For some people, including myself, these experiences included childhood and adolescent trauma and societal pressure. In many instances, drug use helps us to cope – and it is a source of relief and pleasure."

Judy Chang, Executive Director, International Network of People Who Use Drugs – Milan, Italy

Gender inequality is greatly magnified among women who inject drugs. Women who inject drugs are uniquely vulnerable to medical, legal, economic and social consequences, gender-based violence and loss of custody of their children, and experience high levels of stigma, both within the general society and among the community of people who use drugs [1]. Women who inject drugs are often described in terms of their risk for HIV, viral hepatitis and other sexually transmitted infections – with scant emphasis on their human rights and dignity.

Globally, of an estimated 15.6 million people who inject drugs, 3.2 million are women. In different regions of the world, women who inject drugs make up 3-33% of all people who inject drugs, with overall population prevalence ranging from 0.01% to 0.64% (see Table 1) [2]. These may be significant underestimates, though, since criminalization and stigma keep women who inject drugs hidden and data are often not disaggregated by gender.

The Global Commission on HIV and the Law notes: "For women, the intersection of poverty, criminalization, motherhood, and illicit drugs can be deadly... The first step to alleviating these miseries is to decriminalize the possession or cultivation of drugs for personal use and to correct the imbalance in global drug policy that skews the governing policy towards law enforcement at the expense of human rights and public health [3]."

Table 1. Global regional prevalence of injecting drug use, disaggregated for women who inject drugs (as of 2017) [2]

Region	Estimated number of people who inject drugs [i]	Estimated number of women who inject drugs	Proportion of women among all people who inject drugs
Eastern Europe	3,020,000	768,000	25.4%
Western Europe	1,009,500	288,000	28.6%
East and Southeast Asia	3,989,000	828,000	20.8%
South Asia	1,023,500	32,000	3.1%
Central Asia	281,500	35,500	12.6%
Caribbean	79,500	14,500	18.2%
Latin America	1,823,000	236,500	13.0%
North America	2,557,000	766,000	30.0%
Pacific Island States and Territories	22,500	5,000	22.1%
Australasia	115,500	38,500	33.4%
Sub-Saharan Africa	1,378,000	160,000	11.6%
Middle East and North Africa	349,500	12,500	3.5%
Globally	15,648,000	3,185,000	20.4%

[i] Although people who inject drugs primarily inject opioids (>80%), injection of amphetamine-type stimulants is increasing in many countries [2].

The criminalization of drug use has had severe repercussions for women who inject drugs. Drug criminalization endangers women who inject drugs. It heightens their vulnerability to trauma, rape and gender-based violence and rips their families apart. It also increases women who inject drugs' risk for HIV, viral hepatitis and overdose. Harsh drug laws have led to ever-increasing incarceration rates among women; once imprisoned, female detainees are more likely to inject drugs and have less access to opiate agonist treatment than male detainees [4].

Although funding for harm reduction programmes is limited and shrinking – especially in low- and middle-income countries – the needs of women who inject drugs are often neglected regardless of the amount of available resources.

Women who inject drugs are underserved by harm reduction programmes, most of which are designed by and for men. In some countries, women who inject drugs are excluded from essential medical and social services, or cannot access services without fear of losing their children, undergoing compulsory drug treatment or being imprisoned.

Rates of gender-based and intimate partner violence are two to five times higher among women who inject drugs than women who do not inject drugs; yet women who inject drugs are often prohibited from women's shelters [5,6,7]. Up to a third of women who inject drugs also participate in sex work. Female sex workers who inject drugs are often highly stigmatized for their drug use and forced to work on the street (rather than premises based), where female sex workers who inject drugs face high levels of violence, including sexual assault [4,8,9].

BOX 1. THE TABLE OF MISSING DATA

In 30 countries, HIV prevalence is 13% among women who inject drugs versus 9% among men who inject drugs [13]. Besides this information, there are substantial gaps in the available data about women who inject drugs despite the fact that this information is essential for planning and allocating resources for integrated services tailored appropriately to meet their needs. This lack of information is particularly prominent in low- and middle-income countries. Further, a recent global review of the prevalence of injection drug use and socio-demographic characteristics of people who inject drugs noted a lack of gender-specific data to draw from [8]. Transgender women who inject drugs are even more overlooked.

Table 2. Availability of regularly updated national level data about women who inject drugs [13,14,15]

Available data	Needle and syringe programme coverage among women who inject drugs
Unavailable data	Opiate agonist treatment coverage among women who inject drugs
	Opioid overdose deaths among women who inject drugs
	Access to overdose prevention and management interventions among women who inject drugs
	Injection drug use among women living with HIV
	AIDS-related deaths among women who inject drugs
	HIV treatment coverage among women who inject drugs living with HIV
	Hepatitis C virus (HCV) prevalence among women who inject drugs [ii]
	Injection drug use among women living with HCV
	HCV treatment coverage among women who inject drugs living with HCV
	Tuberculosis (TB) prevalence among women who inject drugs [iii]
	Injection drug use among women living with TB
	TB treatment coverage among women who inject drugs living with TB
	HIV/HCV co-infection prevalence among women who inject drugs
	HIV/TB co-infection prevalence among women who inject drugs
	Proportion of transgender women among women who inject drugs
	Injection drug use and HIV prevalence among transgender women
	Sex work by women who inject drugs
	Injection drug use and HIV prevalence among female sex workers
	Rates of imprisonment for drug-related offences among women who inject drugs
	Injection drug use and HIV prevalence among women in prisons
	Experiences of intimate partner and/or other violence among women who inject drugs

[i] HIV data show higher HIV prevalence among women who inject drugs compared with men who inject drugs globally.
[ii] Women who inject drugs have been shown to be at higher risk of acquiring HCV compared with men who inject drugs [16]. No gender-disaggregated data was reported in the WHO 2017 Global Hepatitis Report [17].
[iii] TB data are disaggregated by gender and HIV status, not for both and not for people who inject drugs [18].

"If we want better outcomes, then we need better policies and services – and to do this, we have to start collecting better data."
Lisa Maher, Viral Hepatitis Epidemiology and Prevention Program Head, Kirby Institute; Honorary Senior Principal Research Fellow, Burnet Institute; NHMRC Senior Research Fellow – Sydney, Australia

Women who inject drugs have higher mortality rates and HIV prevalence compared with their male counterparts. There is a lack of key information available about their access to harm reduction programmes and antiretroviral therapy [10]. Data on people who inject drugs are rarely gender disaggregated despite numerous calls and policies for collecting and publishing such information (see Table 2) [11,12]. This renders women, including transgender women who inject drugs, and their needs invisible.

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INJECTION DRUG USE AND GENDER

"Women get into intimate relationships with other drug users as a form of protection. They may find they are in an abusive relationship, but won't leave, because he will protect her from other consequences. HIV prevalence and risk are so high among these women, because many of them did not have their own syringes and other commodities until the [needle and syringe programme] was initiated. But we still aren't sure if they are sharing with their intimate partner."
Angela McBride, Peer Manager for Community Oriented Substance Use Programme – Pretoria, South Africa

Women are more likely than men to begin injecting drugs in the context of social and/or sexual relationships [19]. Women who inject drugs are also more likely to have another person inject them – and to be "second on the needle" – sometimes because some women who inject drugs do not know how to self-inject, have difficulty doing so, or rely on someone else to avert withdrawal [20]. Women may share needles with intimate male partners; this may either reflect trust and intimacy or gendered power imbalances and dependency – since men are often in control of acquiring and preparing drugs for intimate female partners [20, 21]. Refusal to share injection equipment with an intimate partner may trigger gender-based violence [6, 22]. Women who inject drugs experience high rates of gender-based and intimate partner violence, which also can undermine their power to use condoms [5,6,10].

"If physicians are not open about the true risks for women who inject drugs, they miss the entire opportunity to keep women who inject drugs alive and safe. Too often physicians can be dismissive of true healthcare concerns, and only focus on getting these women off drugs. This leads to women not feeling safe or respected in the healthcare system, and they do not seek the care they need."
Brianna Norton, Montefiore Medical Center; Assistant Professor, Department of Medicine, Albert Einstein College of Medicine – New York, USA

HIV prevalence is higher among women who inject drugs than their male counterparts in Eastern and Western Europe, Latin America, North America, Central Asia and South Africa [23,24,25,26,27]. Women who inject drugs need access to comprehensive healthcare, including mental healthcare where it exists, and HIV services.

In countries where HIV pre-exposure prophylaxis (PrEP) is available, awareness of and access to PrEP is low among women who inject drugs; medical providers may be reluctant to prescribe it and discussions around PrEP may in fact detract from other HIV prevention methods that are more accessible and acceptable to women who inject drugs [28,29].

Sexual- and injection-related risks for HIV are often intertwined among cisgender and transgender women who inject drugs. Almost a third of women who inject drugs participate in sex work, often to pay for drugs for themselves and their partners [8,10]. Poverty, gender-based power differences and cultural contexts often increase vulnerability among cisgender and transgender female sex workers who inject drugs. Female sex workers who inject drugs may have difficulty negotiating condom use with intimate and commercial partners, or may lack access to free or affordable condoms (sometimes due to policies that obstruct access to and consistent use of condoms) and are often forced to work on the street, where they face abuse, rape and violence from clients and police. In Dar es Salaam, Tanzania, an estimated 34% of people who inject drugs are female and over 80% of them participate in sex work; these women who inject drugs are often beaten, raped and robbed [30].

The high level of stigma directed towards female sex workers who inject drugs can complicate, delay or prevent access to and engagement in healthcare and drug treatment services [31]. Female sex workers who inject drugs may be reluctant to disclose sex work and/or injection drug use to healthcare providers for fear of judgement; female sex workers who inject drugs may have difficulty attending appointments when they interfere with working hours or if the services are inconveniently located.

BOX 2. GENDER AND OVERDOSE – SPOTLIGHT ON UNITED STATES AND CANADA

Injection drug use among women in the USA has been increasing, especially in rural and urban-deprived areas where opioid use, poverty, low employment levels and distress are widespread. Inadequate access to needle and syringe programmes and opiate agonist treatment has led to increases in HCV and HIV among women who inject drugs. From 2010 to 2014, new HCV infections among women in the USA increased by 260%. The United States Centers for Disease Control and Prevention projects that one in 23 women who inject drugs in the USA will acquire HIV [32,33].

Women who inject drugs in the USA face high levels of stigma, harsh drug laws, increasing rates of drug-related incarceration and limited access to harm reduction services, especially gender-sensitive services. They also fear that they will lose custody of their children. These barriers prevent women who inject drugs from accessing necessary services where they exist. In 2016, women made up 13,751 of 42,249 fatal opioid overdoses in the USA, a 20% increase over 2015. Yet women are three times less likely than men to receive emergency treatment with naloxone, possibly because responders are not aware that these women have overdosed [34,35].

In Canada, British Columbia's rise in overdoses has increased violence against women who inject drugs, particularly among poor, homeless, transgender and indigenous women. Rapid and severe intoxication or overdose from fentanyl-laced opioids leaves them vulnerable to robbery and physical and/or sexual assault, often from the same men who offered the drugs. Women who inject drugs describe overdose prevention sites as "masculine spaces", where they are harassed by men who have assaulted them and are expected to assume gendered roles, such as cleaning up and acting as caretakers for men [36]. In response to this situation, British Columbia now has an overdose prevention site exclusively for cisgender and transgender women, the first of its kind in Canada [36].

HARM REDUCTION FOR WOMEN WHO INJECT DRUGS

"Since they face higher stigma for using drugs, women use in hiding and do not access basic harm reduction services."
Abigael Lukhwaro, Programme Coordinator, Kenya Harm Reduction Programme, Médecins du Monde – Nairobi, Kenya

In 2018, the Women and Harm Reduction International Network conducted a 13-country survey to update the status of harm reduction for women who use drugs. Since 2016, few new gender-sensitive harm reduction programmes have been launched, and existing programmes are threatened by funding cuts and lack of meaningful involvement of women who inject drugs. The survey reported that common access barriers experienced by women who use or inject drugs, such as stigma, violence, loss of child custody and criminalization, have either remained stable or increased since 2016 [37].

Research to inform the design and delivery of essential harm reduction, healthcare and other social services often neglects women who inject drugs. It rarely considers intersectionality, the overlapping and combined effects of age, class, gender, race/ethnicity and nationality with other identities (such as motherhood, drug use, homelessness, poverty, mental health challenges and sex work) [38]. As a consequence, women who inject drugs are generally underserved by harm reduction programmes since most do not provide a "gender lens" or safe spaces for women and/or cater for the needs of women with multiple and diverse identities [37,39,40,41,42]. Services especially for women who inject amphetamine-type stimulants remain limited [2].

SERVICES FOR WOMEN WHO INJECT DRUGS

"If a woman wants [opioid substitution therapy], she must give her name to the government, and be registered as a drug user. But if government social workers know that a woman is using drugs, they can take her children away, so women do not use government social services because they are afraid of losing their children."
Vielta Parkhomenko, Manager, Trainer at Club Eney; Coordinator, Division for Organizational Development for People Who Use Drugs, Ukraine; Country Key Populations Platform, Ukraine; Vice-Chair, Women and Harm Reduction International Network Interim Governing Board – Kyiv, Ukraine

In order to ensure that safe, appropriate and comprehensive services are available to women who inject drugs, it is important to acknowledge that trauma, violence, sexual abuse, depression and anxiety can lead women to inject drugs even though these experiences are not always causally related [10]. This information, however, is often inappropriately used to pathologize women who inject drugs. It is therefore important to recognize societal stigma and processes of marginalization that exclude women who inject drugs.

In many countries, fragmented healthcare systems and siloed harm reduction programmes prevent a holistic approach to the needs of women who inject drugs. An integrated approach would co-locate needle and syringe programmes, opiate agonist treatment and sexual and reproductive health and rights with HIV and viral hepatitis services, in addition to offering programmes that address intimate partner violence and provide childcare, counselling, legal aid, housing and food [43,44]. Some best practices do exist (see Table 3).

Table 3. Best-practice examples of services for women who inject drugs [37,45]

Region	Estimated number of people who inject drugs
Canada [i]	In Vancouver, SHEWAY provides specialized services to pregnant women who use drugs, focusing on the elimination of violence for women who use drugs and ensuring the best birth outcomes for their babies. The services offered include education, nutrition and substitution therapies. Pregnant women who use drugs are supported in their choice to continue or stop using drugs during their pregnancy, with differentiated approaches for both scenarios: focusing on the quality of drugs used if continuing or initiating substitution therapy if stopping drug use.
India [ii]	As part of providing HIV and harm reduction services to people living with HIV and people who use drugs (including their partners and families), the Social Awareness Service Organisation runs a programme dedicated to women who inject drugs. This programme includes a drop-in centre and provides harm reduction services. It also serves as a night shelter for homeless women who inject drugs and there are plans to develop other services, such as vocational training and microcredit programmes.
Mauritius [ii]	The Harm Reduction Community Container project, developed by Collectif Urgence Toxida, works to identify and support women who inject drugs, young people who inject drugs and others. It blends community-based healthcare services (including HIV and viral hepatitis counselling, information on safe injecting practices and provision of sterile injecting equipment and condoms) with mobile units (that include a large proportion of women, many of whom have a history of injecting drug use) for people unwilling to attend the static site.
Spain [iii]	In Catalonia, Metzineres, Environments of Shelter for Women who Use Drugs Surviving Violence is a grassroots, client-led and holistic harm reduction programme exclusively for women, offering health, support, vocational and housing services. It is the first integrated harm reduction programme dedicated to women who use drugs in Catalonia and offers direct and flexible access to flexible services respectful of women's particular situations and lived experiences.
Tanzania [i]	There is growing interest in the development of harm reduction services for women who inject drugs in Tanzania following efforts by Médecins du Monde to offer a gender-sensitive approach. The services include a weekly women-only evening with gender-based violence support, sexual healthcare services covering sexually transmitted infections, peer-education activities, nutritional support, the provision of various commodities (injecting equipment, condoms, hygiene materials) and hair, make-up and washing.
Ukraine [i]	Initiated by the United Nations Office on Drugs and Crime (UNODC) and handed to municipal services across Ukraine since 2013, the Women for Women initiative has expanded availability of gender-sensitive HIV and harm reduction services. Services offered to women who inject drugs include prevention of gender-based violence (including counselling for male sexual partners), legal assistance, child care, hygiene and food supplies, shelter, self-esteem skills building and employment support. Women who inject drugs are involved in delivering these services.

[i] Example taken from the IDUIT [45]
[ii] Example taken from UNODC [46]
[iii] Example taken from WHRIN [37]

"I had three children and had been an injecting drug user and/or methadone maintained for all of their childhood. My memories of that time are filled with pain, guilt and fear. The uniform belief of every drug and alcohol worker, family member and other interested busybodies – that my drug using would ruin my children's possibility of a happy, fulfilled life – has not happened."
Jude Byrne, Senior Project Officer, Australian Injecting and Illicit Drug Users League – Canberra, Australia

The stigma that women who inject drugs face from gendered social norms is particularly harsh when it comes to pregnancy and parenting. Pregnant women may be excluded from or avoid harm reduction services since they are subject to stigma from staff and other users – and these programmes do not provide childcare.

When women who inject drugs receive supportive, evidence-based and non-judgemental healthcare, negative health outcomes are avoided for both mothers and their babies [47]. Instead of prenatal and postnatal care and support, pregnant women who inject drugs are often subject to punishment, violations of human rights and legal consequences, such as loss of custody of their children.

Many women cite pregnancy as an important motivation for initiating opiate agonist treatment. Methadone and buprenorphine improve outcomes for opioid-dependent mothers and their infants. These treatments are the standard of care during and after pregnancy, as recommended by the World Health Organization, the Joint United Nations Programme on HIV and AIDS (UNAIDS) and other international and national organizations [48,49].

However, pregnant women who inject drugs may be pressured into abstinence instead of being offered opiate agonist treatment. Inadequately trained healthcare providers may withhold pain medication during labour and delivery. This and other common non-evidence-based practices, such as separating babies from their mothers immediately after birth, can worsen health outcomes among mothers who inject drugs and their babies [50].

In some countries, women who inject drugs are vulnerable to coerced or forced sterilization, especially if they are living with HIV [51]. As an example, in the USA and the UK, Project Prevention pays $300 (£200) to women who use and inject drugs to either initiate long-term contraception or undergo sterilization [52]. This is a human rights violation.

In the USA and many other countries, criminalization of drug use, involuntary drug testing, lack of confidentiality and fear of losing custody of their children often delay or prevent pregnant women from getting necessary medical care and other services [53]. In the USA, at least 45 states have prosecuted women for prenatal drug use; in 15 states, healthcare workers are required to report prenatal drug use; 18 states prosecute for child abuse; and three states force pregnant women into drug treatment [54].

BOX 3. INCARCERATION AND WOMEN WHO INJECT DRUGS

Harsh drug laws have led to the mass incarceration of women who inject drugs. In Europe and Central Asia, women are more likely to be incarcerated for drug-related offences than men [55]. Thailand has also adopted similar anti-drug tactics; it now has the world's second highest rate of female incarceration. In 2018, 82% of Thailand's 48,136 female prisoners were incarcerated in overcrowded facilities for drug-related offences, usually for possession of small amounts [41,56]. Globally, the majority of incarcerated women have children. These children experience devastating consequences, including stigma, fear and depression, and may be forced into foster or state care, live in prison with their mother or become homeless [57].

MOVING FORWARD: GENDER-DISAGGREGATED DATA INFORMING ADAPTED SERVICES FOR WOMEN WHO INJECT DRUGS

"We need special programmes and shelters for women. We need to see women users at the decision-making table, and on technical working groups that develop and review national guidelines."
Happy Assan, Coordinator, Tanzania Network of People Who Use Drugs – Dar es Salaam, Tanzania

The persistent lack of gender-disaggregated data keeps women who inject drugs invisible, making informed policy development impossible. To address this, women who inject drugs, medical societies, researchers, scientific journals, advocates and key UN agencies recommend gender-disaggregated data collection for women who inject drugs on harm reduction coverage, as well as on HIV, HCV and TB epidemiology and access to services across the cascade of care.

In addition, women who inject drugs must be meaningfully involved in the design, implementation and oversight of relevant research, policies and services. Sufficient resources are needed for developing policies and providing services that are effective, comprehensive, gender sensitive and adapted to the realities of women who inject drugs.

"There is a huge population that has been poisoned by the idea that people who use drugs are criminals and monsters – we need a 10- or 20-year recovery plan to get rid of these ideas."
Dasha Ocheret, Policy Reform Advisor, Eurasian Harm Reduction Association – Vilnius, Lithuania

The effects of drug criminalization are particularly devastating for women who inject drugs. Decriminalization of drug use and possession of drugs for personal consumption has been recommended by the Global Commission on Drug Policy, the Global Commission on HIV and the Law, Médecins du Monde, UNAIDS, UNODC and the World Health Organization, among others [3,45,58,59,60,61,62]. It is an important first step towards addressing the needs of women and other people who inject drugs.

Moving forward, there is a wealth of existing recommendations from women who inject drugs, researchers, advocates and key UN agencies to draw from (see Table 4 and selected resources). These are tangible opportunities to make women who inject drugs visible and provided for.

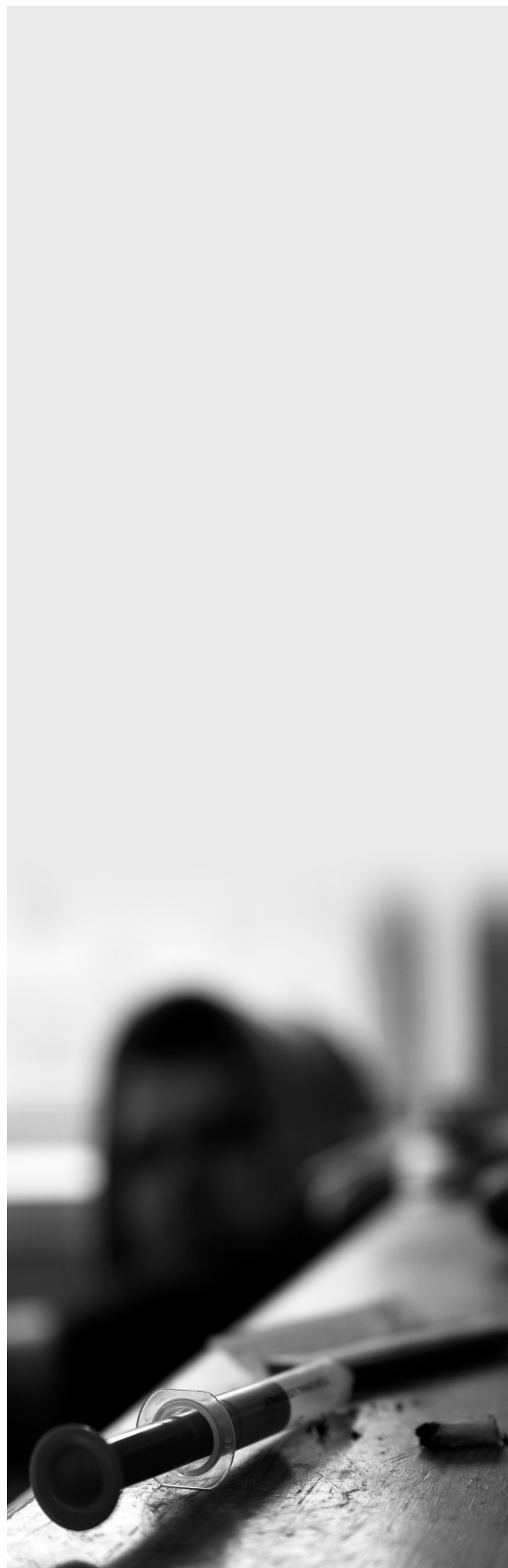

Table 4. Matrix of recommended services and policies for women who inject drugs

<table>
<tr><th colspan="5">Underlying principle</th></tr>
<tr><td colspan="5">A human rights perspective, based on social and gender equity, should guide the development, implementation and oversight of evidence-informed services and policies. Meaningful involvement of women who inject drugs should be standard throughout these processes.</td></tr>
<tr><th colspan="4">Services</th><th>Policies</th></tr>
<tr><td colspan="4">All services must provide safe spaces for women. Programmes that are unable to provide gender-specific services should offer referrals, including for sexual and reproductive health and rights and gender-based violence.</td><td rowspan="5">Ensure meaningful participation and involvement of women who inject drugs in programmes and policies, and ensure that gender-disaggregated data is produced, made available and informs policy development and implementation of services.
· Eliminate legal and structural barriers; work to end stigma
· Provide funding for gender-specific research
· Support programming involving community-based organizations that provide services to cisgender and transgender women who inject drugs, including those who participate in sex work
· Create an enabling environment for advocacy around decriminalization, harm reduction and gender equality
· Focus on ending mass incarceration of women for low-level, non-violent drug-related offences, especially among indigenous women and women of colour
· End criminalization of drug use during pregnancy
· End removal of children from maternal custody solely based on drug use
· Conduct research on amphetamine-type stimulants use among women who inject drugs, including on adapted harm reduction services
· Decriminalize sex work
· Decriminalize drugs and move towards legal regulation</td></tr>
<tr><th colspan="3">Integrated service delivery</th><th>Social and support services</th></tr>
<tr><td colspan="3">Provide integrated services with facilitated referral, adapted opening hours, easily accessible walk-in facilities, with no user fees, including women-specific spaces, schedules that foster peer support and providing information designed specifically for and with women who inject drugs.</td><td rowspan="3">Provide training for health and social workers on gender-specific service delivery and for police and law enforcement officials.
Provide gender-specific outreach, programming and services, including for young and transgender women and sex workers; and ensure that these services reach indigenous women and women of colour.
Services should include:
· Childcare
· Parenting support
· Housing and shelter, including for children
· Showers
· Clothing
· Food and meals
· Job training and skills development
· Legal aid
· Services for gender-based violence
· Post-release services for female detainees</td></tr>
<tr><th>Harm reduction</th><th>Medical care</th><th>Mental healthcare</th></tr>
<tr><td>· Fixed and mobile needle and syringe programme and opiate agonist treatment
· Women-specific overdose prevention, including access to naloxone and overdose prevention sites
· Services for women who inject amphetamine-type stimulants
· On-request referral to voluntary, evidence-based drug treatment
· Condoms (male and female) and lubricants</td><td>· Comprehensive sexual and reproductive services, including prenatal and postnatal support for pregnant women who inject drugs
· Gender-affirming healthcare for transgender women who inject drugs
· Neonatal and paediatric healthcare
· HIV prevention, testing, care and treatment, including PrEP
· Prevention, testing, care and treatment for sexually transmitted infections, TB and viral hepatitis</td><td>· Trauma-informed care, including cognitive therapy supporting coping mechanisms
· Counselling (individual and for heterosexual and same-sex couples)
· On-request psychiatric care</td></tr>
</table>

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SELECTED RESOURCES

Expecting Better: Improving Health and Rights for Pregnant Women Who Use Drugs
Medley, Rychkova & Thumath (2018). Open Society Foundations – https://osf.to/2FjRx6G [47]

Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical guidance for collaborative interventions
UNODC, INPUD, UNAIDS, UNDP, UNFPA, WHO, USAID, PEPFAR (2017) – http://bit.ly/2Y1unt8 [45]

Bringing State Commitments to Gender Equality into Action: Addressing the Needs of Women Who Use Drugs
INPUD, INWUD (2016) – http://bit.ly/2Ta3Fel [63]

Addressing the specific needs of women who inject drugs: Practical guide for service providers on gender-responsive HIV services
UNODC, INPUD (2016) – http://bit.ly/2HHyRzl [46]

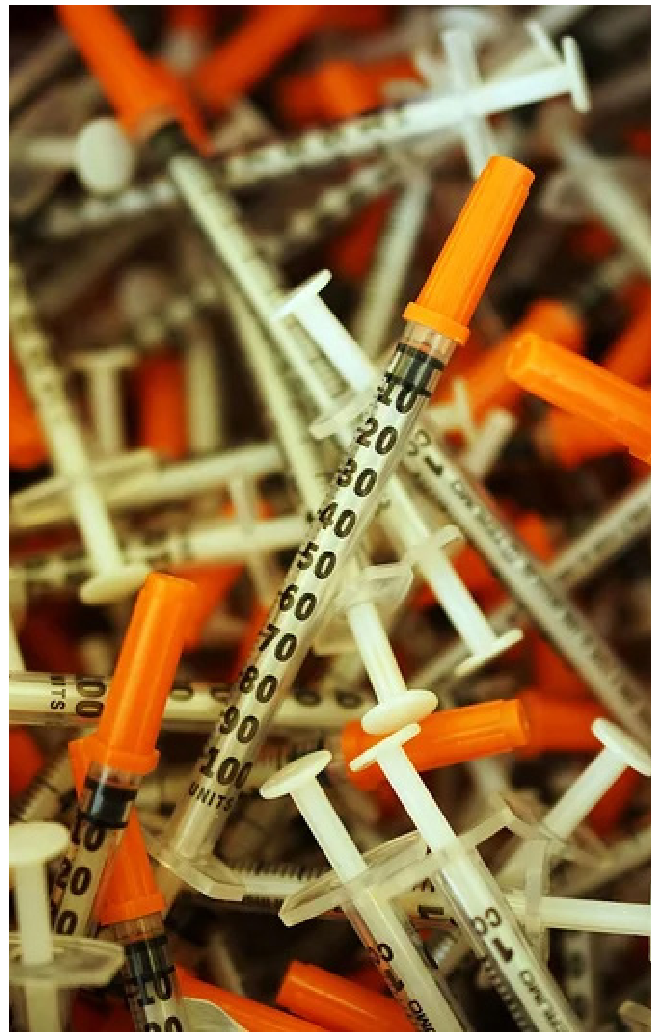
Women Who Use Drugs and HIV: Position Statement 2015
ICW, INPUD, INWUD (2015) – http://bit.ly/2Y6XOtJ [64]

Women Who Use or Inject Drugs: An Action Agenda for Women-Specific, Multilevel and Combination HIV Prevention and Research
El-Bassel & Strathdee (2015). JAIDS, 69: S182-S190 – http://bit.ly/2Tjl2cM [65]

Biomedical HIV Prevention Including Pre-exposure Prophylaxis and Opiate Agonist Therapy for Women Who Inject Drugs: State of Research and Future Directions
Page, Tsui, Maher, et al. (2015). JAIDS, 69: S169-S175 – http://bit.ly/2Tl2wj8 [66]

Women who inject drugs and HIV: Addressing specific needs
UNODC, UNWOMEN, WHO, INPUD (2014) – http://bit.ly/2UMUhyZ [1]

Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations
WHO (2014) – http://bit.ly/2THdxRT [60]



ABOUT THE IAS HIV CO-INFECTIONS AND CO-MORBIDITIES INITIATIVE

The International AIDS Society (IAS) HIV Co-Infections and Co-Morbidities initiative aims to remove structural barriers and address human rights violations that inhibit access to and uptake of comprehensive HIV and other health services for vulnerable populations and communities. In particular, people who inject drugs are disproportionately affected by HIV and HCV because of limited investments in and hugely restricted access to proven interventions. Even when effective care is available, the combination of punitive laws and experiences of stigma – both within healthcare settings and in the broader community – create barriers to their use. There is a need to support the rationale for inclusive HIV and HCV care policies that use an evidence- and human rights-based approach to drug policies and harm-reduction interventions.

For World Hepatitis Day 2018, the IAS released a policy brief shining a spotlight on people who inject drugs in global HCV elimination efforts, titled Ending an epidemic: Prioritizing people who inject drugs in HCV elimination efforts. It was the first of a series of IAS policy briefs in this area. This brief, Women who inject drugs: Overlooked, yet visible, is the second in this series.

Find more information at
http://www.iasociety.org/HIV-Programmes/Programmes/Co-Infections.

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FOOTNOTES

1. UNODC, UNWOMEN, WHO, INPUD. Women who inject drugs and HIV: Addressing specific needs. Vienna, 2014 [cited 20 February 2019]. Available from: http://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf
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