BRIEFING

INVISIBLE AND IGNORED

How can women who use drugs demand their sexual and reproductive health and rights?

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

Universal access to sexual and reproductive health services is critical to the achievement of SDGs 3 (health) and 5 (gender equality), and to realising the sexual and reproductive rights of women who use drugs. Yet, in May 2018, the Guttmacher Lancet Commission on Sexual and Reproductive Health and Rights (SRHR) launched a report highlighting the scope of unfinished business in the global SRHR agenda. The report found that issues such as gender inequality, gender based violence, restrictive laws and policies, and sexual norms and taboos still stand in the way of many people's ability to make decisions about their own sexual and reproductive lives.

The Commission's report, *Accelerate progress – sexual and reproductive health and rights for all*, offers a new, comprehensive and integrated definition of SRHR, and an essential package of SRHR services that should be universally available (Fig 1).

The report brings particular attention to some of the populations who have distinct SRHR needs and who are typically underserved by SRHR programmes and services. These include people who inject drugs.

FIG 1: ESSENTIAL PACKAGE OF SEXUAL AND REPRODUCTIVE HEALTH INTERVENTIONS[1]

1. Comprehensive sexuality education
2. Contraceptive method choice
3. Antenatal, childbirth and postnatal care
4. Safe abortion and post abortion care
5. Prevention and treatment of HIV and other sexually transmitted infections
6. Comprehensive sexual and gender-based violence services
7. Prevention, detection and management of reproductive cancers
8. Infertility services
9. Sexual health and wellbeing services

The Commission's essential package of interventions is an important resource to help identify the specific SRHR needs of women who use drugs, when used in combination with the WHO-UNODC-UNAIDS comprehensive package of interventions for prevention, treatment and care of HIV among people who inject drugs (Fig 2).

In addition, the Commission's emphasis on rights as both intrinsic to, and a condition for, realising sexual and reproductive health, has particular relevance for this community.

Below, we draw out three of the key challenge areas that have particular relevance for meeting the SRHR needs and priorities of women who use drugs.

Accurate data about women who use or inject drugs are missing. Criminalisation and stigma marginalise women who inject drugs, making them hard to reach, and women's involvement in drug use is often under-estimated, or simply not disaggregated. Existing data suggest that women make up between three and 33% of all people who use drugs globally, have higher rates of HIV than men who inject drugs, and are more likely to die from HIV-related illness than men who inject drugs.[3]

However, data on many areas, including demographic information, prevalence of Hepatitis C and TB, and gender based violence among women who inject drugs are unavailable.

Gender inequality is greatly magnified among women who inject drugs, who are routinely excluded from decision-making spaces at all levels. For women (including trans women) who use drugs, their gender intersects with other factors including criminalisation, stigma and discrimination, HIV and other health issues, poverty and motherhood. Many women who use drugs sell or transact sex for drugs and other basic needs, and under these circumstances may have little power to negotiate condom use.

FIG 2: COMPREHENSIVE PACKAGE FOR THE PREVENTION, TREATMENT AND CARE OF HIV AMONG INJECTING DRUG USERS (IDU)[2]

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other drug dependence treatment
3. HIV testing and counselling (T&C)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for IDUs and their sexual partners
7. Targeted information, education and communication (IEC) for IDUs and their sexual partners
8. Vaccination, diagnosis and treatment of viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB)

Uganda Harm Reduction Network collected data among a project cohort of 311 people who inject drugs. HIV prevalence was 45% among women compared to 21% among men, with women

Gender based and intimate partner violence is estimated to be two to five times higher among women who inject drugs than among women who do not. Many women enter drug use within the context of a personal relationship and can be dependent on their partner for accessing drugs and help with injection. Sharing needles can be an expression of trust and refusal to do so may trigger partner violence[3]. Women who inject drugs may also be exposed to sexual or gender based violence by clients if they are also sex workers, and other power holders – including the police.

Stigma and discrimination is one of the largest barriers to women who use drugs accessing services. Women who inject drugs often have limited access to harm reduction services, which tend to be designed by and for men[3]. Women may fear that accessing services will lead to arrest, detention or forced rehabilitation, or that they will be forcibly separated from their children.

When it comes to SRHR services, women who use drugs face higher levels of stigma and discrimination, judgemental attitudes, and (often) misinformation from service providers. This can act as a compounding factor preventing access to services, in addition to barriers women already face (which can include pervasive social norms and gender inequality, existing stigma, gender-based violence, and punitive and ineffective laws[1]).

Women Speak Out research in Indonesia reveals a high rate of unsafe abortions among women who use drugs. Unintended pregnancies are common due to lack of access to a full range of contraceptive methods, and difficulty in negotiating condom use, especially while under the influence of drugs or in transactional settings. Service providers often encourage women who use drugs to seek abortions, often based on misinformation about the possibility of a safe pregnancy.

Hope and Trust research in Ukraine led by and for women who use drugs has revealed lack of access to antenatal and maternal health services for women who use drugs; de-linkage between harm reduction and maternal health services, and high rates of abortion among women who use drugs.

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RECOMMENDATIONS OF THE GUTTMACHER LANCET COMMISSION ON SRHR MOST RELEVANT FOR WOMEN WHO USE DRUGS[1]

- **Support changes in laws, policies, and social norms and structures that enable all people to understand, protect, and fulfil their SRHR, and respect the rights of others.** *"Laws and policies must support the right of all individuals to access services that protect reproductive choice."*

- *Progressively* **expand access to an essential, integrated package of SRH interventions, ensuring that the needs of vulnerable and marginalised populations are addressed.** *"Programmes must give special attention to individuals who are most vulnerable to discrimination and social exclusion, so that no one is left behind in efforts to improve health. … Health ministries and service providers should consider the points of entry for health care and how best to integrate sexual and reproductive health interventions with other health care services...to avoid missed opportunities"*

- **Provide additional support to groups often marginalised, disadvantaged, and subject to discrimination.** *"Community outreach is also essential because stigma, discrimination, and violence in these settings can inhibit the use of sexual and reproductive health services."*

- **Address evidence gaps and prioritise SRHR research needed for policy and programme decision-making.** . *"More representative survey data is needed on people who inject drugs."*

- **Strengthen and use accountability processes at all levels to ensure that SRHR goals and commitments are realised.** *"National policy makers should … expand the agenda to include a broader set of services, covering people's SRHR needs over the life course and including people often missed in traditional service settings."*

REFERENCES

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