

Submission to the UN Working Group on discrimination against women and girls

Women's and girls' sexual and reproductive health and rights
in situations of crisis

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Reporting Organisations:



Harm Reduction International (HRI) is a leading NGO dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. HRI promotes the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

HRI is an NGO in Special Consultative Status with the Economic and Social Council of the United Nations.

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The **Women and Harm Reduction International Network** is a global platform to expand harm reduction approaches for women.

Introduction

It is estimated that 3.2 million women inject drugs worldwide, constituting around 20% of all people who inject drugs (notably, because of stigma, criminalisation, and lack of disaggregated data this is likely to be an underestimate). There are also indications that this number is increasing worldwide¹ while women who use drugs remain population inadequately served with sexual and reproductive health (SRH) services.

Harm Reduction International and the Women and Harm Reduction International Network welcome the opportunity to report on to the Working Group on discrimination against women and girls on the enjoyment of sexual and reproductive health and rights by women who use drugs, who are indeed “in situations of crisis”.

Women who use drugs: a human rights and public health crisis

The war on drugs is a war on people who use drugs. Women who use drugs are subject to daily crises as a result of drug prohibition, a policy clad in rhetoric around ‘well-being’ that in practice erodes public health, human rights and impacts women heavily. Under the banner of the war on drugs or drug prohibition, women who use drugs: face HIV and other health issues at a higher rate than their male counterparts,² experience the arbitrary removal of children; are subject to coerced serialisation and contraception; are subject to much higher rates of gender-based violence than women in the general population³; can be prosecuted and arrested for using drugs while pregnant; and, are incarcerated for non-violent crimes at alarmingly escalating rates.⁴ In some countries, women are disproportionately sentenced to death and executed for involvement with drugs.⁵ At the same time, there is an extreme lack of services designed to meet the SRH needs of women who use drugs.

Women who use drugs retain the full spectrum of health-related rights, including to harm reduction services and sexual and reproductive health rights (SRHR).⁶ Yet, they face multiple and intersecting obstacles in realising such rights, because of a combination of: lack of available, accessible and acceptable services; legal barriers; stigma and discrimination – both in healthcare settings and in society; and, the lack of meaningful involvement of women who use drugs in the design, implementation, and evaluation of harm reduction and SRH services.⁷

¹ Degenhardt L, Peacock A, Colledge S, Leung J, Grebely J, Vickerman P, et al, ‘Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review.’ *The Lancet Global Health* 2017;5:e1192–207.

² Among others, see International AIDS Society, ‘Women who inject drugs: Overlooked, yet visible’. Geneva: International AIDS Society, 2019.

³ Ibid. Also UNODC, UN Women, WHO and INPUD, ‘Women who inject drugs and HIV: Addressing specific needs’. Vienna: UNODC, 2015.

⁴ UNODC, ‘World Drug Report 2018, vol. 5: Women and Drugs. Drug use, drug supply and their consequences’. Vienna: UNODC, 2019.

⁵ Sander et al., ‘The Death Penalty for Drug Offences: Global Overview 2019’. London: Harm Reduction International, 2020.

https://www.hri.global/files/2020/02/28/HRI_DeathPenaltyReport2019.pdf

⁶ Among others, see: Paul Hunt, ‘Human rights, health, and harm reduction’, 8; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover(2010) A/65/255, para. 55; CESCR, Concluding Observations on the combined initial and second periodic reports of Thailand, UN Doc. E/C.12/THA/CO/1-2; CEDAW, Concluding Observations on the combined fourth and fifth periodic reports of Georgia (2014), UN Doc. CEDAW/C/GEO/CO/4-5, para. 31(e); Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, Mission to Poland (2010) A/HRC/14/20/Add.3, para. 86; CESCR, 2016, Concluding Observations on the sixth periodic report of Sweden. UN Doc. E/C.12/SWE/CO/6.

For more information, see: International Centre on Human Rights and Drug Policy/UNDP, International Guidelines on Human Rights and Drug Policy

⁷ WHRIN, ‘WHRIN members survey report on the status of harm reduction for women who use drugs, 2018’.

https://drive.google.com/file/d/1E_D5h-rXgIwY_HnKTGvNnmIsxRrXEIdv/view.

When women who use drugs are adolescents, sex workers, LGBTQI individuals, people living with HIV,⁸ or form part of other vulnerable groups, they experience intersecting forms of discrimination and heightened exclusion.

Availability, accessibility and acceptability of sexual and reproductive health services for women who use drugs: integrated services

Criminalisation constitutes an almost insurmountable legal barrier for women who use drugs to accessing health services, including sexual and reproductive health (SRH) services; it causes stigma and discrimination, including by healthcare providers; and it contributes to a lack of services focused on the specific needs of women who use drugs.

Harm reduction services, as HIV prevention services, are instrumental to women's enjoyment of their SRHR. Further, research shows that integrating SRH services in harm reduction services can be highly beneficial, enabling women who use drugs to access multiple services in one, non-judgmental setting where their specific needs are understood and addressed.⁹

However, where available, harm reduction services remain overwhelmingly gender-blind or male-focused, and do not integrate SRH services, leaving women underserved.¹⁰ For example, harm reduction services' opening hours may conflict with women's responsibilities as primary carers; many harm reduction services do not accommodate children nor provide childcare options, creating a barrier for mothers.¹¹ Pregnant women are excluded by some services, or may refrain from accessing for fear of stigmatisation or loss of custody.¹² Services may be located in areas difficult to reach or unsafe for women.¹³ A study conducted in Georgia concluded that "a lack of attention to childhood and current sexual, physical, and emotional abuse, the limited knowledge of medical personnel about substance use during pregnancy and very poor rates of referral to sexual and reproductive healthcare services constitute additional factors which negatively affect women's willingness to seek or remain engaged in substance use treatment."¹⁴

In addition, women who use drugs are reportedly reluctant to accessing services where the majority of clients (or staff) are male, because of stigma as well as experiences of gender-based violence. As such, lack of female-only services and safe spaces deter women from accessing these services.¹⁵

Conversely, there is a paucity of SRH services tailored to the needs of women who use drugs. In too many cases, services related to SRH and drug use are not integrated, forcing women who experience to move from one service to another to address different issues.¹⁶ This places a heavy burden on women with urgent needs, and acts as a deterrence for women accessing any services.

Requirements for identification documents can also constitute a barrier for women who use drugs to accessing SRH services, as in some regions many people who use drugs do not have such documents (in

⁸ On vulnerable categories, see Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. May 2018. <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>

⁹ Barlee D, 'Stigma and the Health of Vulnerable Women' MSFHR: *Women & Health Research Network* [Internet].

https://www.academia.edu/5994388/Stigma_and_the_Health_of_Vulnerable_Women; Stone, K and Shirley-Beavan, S, 'Global State of Harm Reduction 2018.' London: Harm Reduction International, 2018.

¹⁰ 'Women and Harm Reduction', London: Harm Reduction International, 2019. <https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf>. For an overview of gender-sensitive harm reduction service that integrates sexual and reproductive health rights, see 'Advancing the Sexual and Reproductive Health and Rights of Women who Use Drugs', WHRIN and Frontline Aids, 2020. <https://frontlineaids.org/wp-content/uploads/2020/02/Guide-for-harm-reduction-programmes-FINAL-24Feb-WEB.pdf>.

¹¹ El-Bassel N, Terlikbaeva A, Pinkham S, 'HIV and women who use drugs: double neglect, double risk.' *Lancet* 2010;376:312–4.

¹² International AIDS Society, 'Women who inject drugs: Overlooked, yet visible'. Geneva: International AIDS Society, 2019.

¹³ WHRIN, 'WHRIN members survey report on the status of harm reduction for women who use drugs, 2018'.

https://drive.google.com/file/d/1E_D5h-rXgijwY_HnKTGvNnmlsXrRXEidv/view.

¹⁴ Otiaishvili D, Kirtadze I, O'Grady KE, Zule W, Krupitsky E, Wechsberg WM, et al, 'Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers', *International Journal of Drug Policy* 2013;24:566–72 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797849/>

¹⁵ Kumar, S and Sharma, M, 'Women and Substance Use in India and Bangladesh' *Substance Use & Misuse* 2009; 1062-1077 <https://www.tandfonline.com/doi/abs/10.1080/10826080801918189?journalCode=isum20>

¹⁶ Mason R, Wolf M, O'Rinn S, and Ene G, 'Making connections across silos: intimate partner violence, mental health, and substance use' *BMC Women's Health* 2017;17:29.

some cases because of homelessness and/or poverty), or are reluctant to show them because they fear negative legal consequences.¹⁷ This is exacerbated in countries where laws require the registration of people who use drugs;¹⁸ in those contexts, drug use registration can translate in criminal sanctions, forced treatment, loss of social support, or removal of children.

Stigma and discrimination

Key barriers to the enjoyment of SRHR by women who use drugs are compounded discrimination and stigma, on account of both gender and drug use. Entrenched patriarchal social norms in many contexts lead to women, and especially women who use drugs, being reluctant to accessing health care; with pregnant women and women with children experiencing even greater stigma.¹⁹

Discrimination against women who use drugs in healthcare settings, including harm reduction and SRH services, is widespread, resulting in denial of services, provision of services of lesser quality, longer waiting periods, denigration, and abuse.²⁰ Further, women are reportedly more likely to be subjected to breaches of confidentiality when accessing harm reduction services.²¹ This issue is compounded by a lack of dedicated training of healthcare staff about drug use, HIV, and the circumstances and needs of women who use drugs.²² Because of stigma and fear of repercussions, women may decide not to communicate their drug use to healthcare professionals, leading to health interventions which are not tailored to their needs.²³

Gender-sensitive services in prison and other closed settings

In spite of the increase in the number of women incarcerated for drug offences worldwide, and the fact that women in prison tend to have a higher prevalence of blood-borne viruses and STIs and more health problems than male detainees, women in prison have more limited access to health services than men, including harm reduction services. HIV treatment and Needle and Syringe Programs, among others, are more widely available in male prisons than in female prisons.²⁴ In Mexico, for example, civil society reports that women “do not have access to [drug] treatment in prison, [and] the underlying factors of their dependent or problematic drug use – namely violence against children and gender-based violence against women and girls, sexual violence in most cases – are overlooked or further reinforced by their criminalization process and subsequent detention.”²⁵

¹⁷ Mouhebati, T ‘Sexual and Reproductive Health Services for People who Use Drugs’. Amsterdam: AFEW and Mainline.

https://mainline.blogbird.nl/uploads/mainline/Report_SRHR_Tatiana1.pdf

¹⁸ Ibid.

¹⁹ ‘Women and Harm Reduction’, London: Harm Reduction International, 2019. <https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf>. Otiashvili D, Kirtadze I, O’Grady KE, Zule W, Krupitsky E, Wechsberg WM, et al, ‘Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers’, *International Journal of Drug Policy* 2013;24:566–72 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797849/>

²⁰ Wechsberg WM, Deren S, Myers B, Kirtadze I, Zule WA, Howard B, et al. ‘Gender-specific HIV prevention interventions for women who use alcohol and other drugs: The evolution of the science and future directions.’ *J Acquir Immune Defic Syndr*. 2015;69:S128–39.

²¹ ‘Women and Harm Reduction’, London: Harm Reduction International, 2019. <https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf>.

²² Among others, see Otiashvili D, Kirtadze I, O’Grady KE, Zule W, Krupitsky E, Wechsberg WM, et al, ‘Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers’, *International Journal of Drug Policy* 2013;24:566; Otiashvili D, Kirtadze I, O’Grady KE, Zule W, Krupitsky E, Wechsberg WM, et al, ‘Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers’, *International Journal of Drug Policy* 2013;24:566–72; Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Lean RM, et al. ‘Stigma in health facilities: why it matters and how we can change it.’ *BMC Medicine* 2019;17:25.

²³ Mouhebati, T ‘Sexual and Reproductive Health Services for People who Use Drugs’. Amsterdam: AFEW and Mainline.

https://mainline.blogbird.nl/uploads/mainline/Report_SRHR_Tatiana1.pdf

²⁴ Among others see: Gilbert L, El-Bassel N, Rajah V, Foleno A, and Frye V, ‘Linking drug-related activities with experiences of partner violence: a focus group study of women in methadone treatment’ *Violence Vict*. 2001;16:517–36. El-Bassel; Stone, K and Shirley-Beavan, S, ‘Global State of Harm Reduction 2018’. London: Harm Reduction International, 2018.; Pinkham S, Stoicescu C, and Myers B, ‘Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy’ *Adv Prev Med*. 2012;2012:269123.

²⁵ Harm Reduction International, MUCD and Equis, ‘Submission to the UN Human Rights Committee ahead of Mexico’s sixth periodic review’ (16 September 2019). https://www.hri.global/files/2019/09/18/HRCtee_submission_Mexico_-_2019.pdf.

Because women tend to serve shorter sentences than men, incarceration also has a disproportionate impact on women's access to antiretroviral therapy compared with men.²⁶

One among many examples is that of Cambodia. As reported by Amnesty International, over 70% of all women prisoners in Cambodia are imprisoned on drug-related charges. Some of them are detained with their young children, in gravely overcrowded infrastructures and with no access to adequate food, water and sanitation, and essential healthcare – including harm reduction and pre- and post-natal care. In addition, thousands of persons are detained in compulsory drug detention and rehabilitation centres, in conditions reported as “even more inhumane than those found in the prison system.”²⁷ One witness detained multiple times at Prey Speu reported:

“My methadone levels are so high that if I skip it, I will pass out and I am at risk of dying. At Prey Speu it was so crowded. We could not sleep or move, so I had to fight people for space in there. Can you imagine living like that when there was no medicine for my methadone? I became so agitated. I wanted to pour water over myself to calm down, but it just made people around me so angry.”²⁸

Similar reports emerged on Indonesia. According to research by the International Drug Policy Consortium and LBH Masyarakat,

“Access to health services [in prison] remains a major challenge. Reproductive healthcare services are available in Semarang Women's Prison, but not in the other prisons. However, HIV testing is mandatory for all people upon entry into a pre-trial detention or prison facility (but not necessarily for those transferred to another facility), and the women therefore cannot refuse it. About 30% of the research respondents reported that mental health services were available, but only 9% said they have accessed it. However, sanitary pads for menstruation are not free and the women have to buy them in the prisons at a cost 2-3 times higher than outside. The women also need to buy their own soap, shampoo, detergent and other basic needs...There are no healthcare services whether physical or psychosocial and no rehabilitation treatment services for women who use drugs while they are incarcerated. This is despite the fact that 69% of the respondents reported having used drugs, mostly amphetamines.”²⁹

Obstacles to the enjoyment of specific sexual and reproductive health rights by women who use drugs:

- *SRH information for women who use drugs:* a widespread failure by health workers to provide accurate and evidence-based SRH information tailored to women who use drugs is reported, because of the interplay of criminalisation, stigma, and lack of capacity/training. In some cases, misleading information is provided to dissuade women who use drugs from using substances, or to push them into treatment; while in other cases it is driven by limited education on the interlinkages between drug use, social determinants, and health.
- *Services to address violence against women:* Women who use drugs are disproportionately exposed to gender-based violence. Despite that, harm reduction services often do not address gender-based violence, and are ill-equipped to adequately address the interaction between drug use and experiences of violence.³⁰ For example, women in Georgia report that the lack of services for people

²⁶ Strathdee SA, West BS, Reed E, Moazan B, Moazan B, Azim T et al, 'Substance Use and HIV Among Female Sex Workers and Female Prisoners: Risk Environments and Implications for Prevention, Treatment, and Policies' *J Acquir Immune Defic Syndr.* 2015;69 Suppl 2:S110-117.

²⁷ 'Substance Abuses: the Human Cost of Cambodia's Anti-Drug Campaign'. London: Amnesty International, 2020. <https://www.amnesty.org/en/documents/asa23/2220/2020/en/>.

²⁸ Ibid.

²⁹ Alvarez M.C, 'Women, Incarceration and Drug Policy in Indonesia: Promoting Humane and Effective Responses'. London: International Drug Policy Consortium, 2019. http://fileserver.idpc.net/library/Indonesia_Policy_Guide_Women.pdf.

³⁰ Malinowska-Sempruch K, 'What interventions are needed for women and girls who use drugs? A global perspective' *J Acquir Immune Defic Syndr.* 2015;69 Suppl 2:S96-97.

with experience of intimate partner violence is an unmet need in harm reduction services.³¹ On the other side, services to address gender-based violence or protect women at risk sometimes exclude women on account of their drug use.³²

- *Contraception and forced or coerced sterilisation:* Studies show a low uptake of contraception by women who use drugs.³³ Among the reasons are: a lack of financial resources; a lack of information concerning drug use, fertility and contraception; obstacles in negotiating condom use, because of engagement in sex work or intimate partner violence,³⁴ and reluctance by women who use drugs to access family planning.³⁵ This is due to fear of abuse, stigma, or pressure (when not coercion) to adopt potentially irreversible methods of contraception like sterilisation. Campaigns that pressure women who use drugs to undergo sterilisation are reported in the UK and the US, rooted in stigmatisation and prejudice about the ability of women who use drugs to care for their children.³⁶ Coerced sterilisation of women living with HIV also continues to be reported in South Africa.³⁷
- *Pregnancy, maternal and postnatal care.* Despite high rates of unplanned pregnancies among women who use drugs³⁸, many harm reduction services do not yet offer pregnancy tests, antenatal care, or other pregnancy-related services.³⁹ As a consequence, “some women do not realize they are pregnant until relatively late, making it more difficult for them to access appropriate prenatal care, drug treatment (if desired), and other support, or to terminate their pregnancies safely if they so choose.”⁴⁰

In addition, many women who use drugs do not have adequate access to antenatal care, or refrain from accessing those services.⁴¹ For example, injecting drug use was associated with insufficient antenatal antiretroviral treatment, which – in turn – can increase the risk of mother-to-child transmission of HIV.⁴² This is compounded by stigma, poverty, and in some countries punitive laws or attitudes whereby women who use drugs are either perceived as “bad mothers” and/or criminalised as using drugs during pregnancy – leading to the removal of children.⁴³ In some contexts drug use is in itself defined as a form of child abuse, while in others the stigmatisation surrounding it enables simplistic and prejudiced evaluation of women’s ability to care for their children.

Most notably, “fetal assault laws” in US states criminalise drug use during pregnancy, allowing for the arrest and prosecution of pregnant women who use drugs. As of 2015, 45 US states had

³¹ Otiazhvili D, Kirtadze I, O’Grady KE, Zule W, Krupitsky E, Wechsberg WM, et al, ‘Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers’, *International Journal of Drug Policy* 2013;24:566–72 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3797849/>

³² Pinkham S, Stoicescu C, and Myers B, ‘Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy’ *Adv Prev Med.* 2012;269123.

³³ Black, K.I and Day, C A, ‘Improving Access to Long-Acting Contraceptive Methods and Reducing Unplanned Pregnancy Among Women with Substance Use Disorders’ *Subst Abuse* 2016; 27-33; ‘Advancing the Sexual and Reproductive Health and Rights of Women who Use Drugs’, WHRIN and Frontline Aids, 2020. <https://frontlineaids.org/wp-content/uploads/2020/02/Guide-for-harm-reduction-programmes-FINAL-24Feb-WEB.pdf>.

³⁴ International AIDS Society, ‘Women who inject drugs: Overlooked, yet visible’. Geneva: International AIDS Society, 2019.

³⁵ Ayon, S, ‘Developing integrated community-based HIV prevention, harm reduction, and sexual and reproductive health services for women who inject drugs’ *Reprod Health* 2019; 59; Black, K I et al., ‘Unplanned pregnancy and contraceptive use in women attending drug treatment services’ *Aust N Z Obstet Gynaecol* 2012; 146-50.

³⁶ Olsen, A, Banwell, C and Madden, A ‘Contraception, punishment and women who use drugs’ *BMC Womens Health* 2014; <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3893510/>.

³⁷ Hu, S, ‘Forced Sterilizations Devastates Lives in South Africa’. <https://kenedyinstitute.georgetown.edu/showcase/wp-content/uploads/2020/04/Sonya-Hu-Bioethics-Forced-Sterilization.pdf>

³⁸ Black, K I et al., ‘Unplanned pregnancy and contraceptive use in women attending drug treatment services’ *Aust N Z Obstet Gynaecol* 2012; 146-50.

³⁹ Pinkham S, Stoicescu C, and Myers B, ‘Developing effective health interventions for women who inject drugs: key areas and recommendations for program development and policy’ *Adv Prev Med.* 2012;2012:269123.

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² European Collaborative Study in EuroCoord, Bailey, H, Townsend, C, Cortina-Boria, M, Thorne, C, ‘Insufficient antiretroviral therapy in pregnancy: missed opportunities for prevention of mother-to-child transmission of HIV in Europe’ *Antiviral Therapy* 2011; 895-903.

⁴³ International AIDS Society, ‘Women who inject drugs: Overlooked, yet visible’. Geneva: International AIDS Society, 2019.

prosecuted women for using drugs during pregnancy, 18 sanctioned drug use during pregnancy as child abuse, 15 required healthcare workers to report drug use during pregnancy, and three states forced pregnant women to undergo drug treatment.⁴⁴ This kind of laws and policies are neither necessary nor proportionate to achieve public health goals; on the contrary, they violate the rights of both women and children, and deter women who use drugs from seeking antenatal and postnatal care.

In Norway, women who use drugs during pregnancy can be incarcerated until they give birth or terminate their pregnancy.⁴⁵ Similarly, in countries such as Russia and Ukraine women who use drugs have been pressured to undergo abortions or relinquish their children after birth.⁴⁶

Expanded SRH framework and relevance for women who use drugs

In May 2018, the Guttmacher-Lancet Commission on SRHR⁴⁷ highlighted gaps in the global SRHR agenda, finding that challenges such as gender inequality, gender-based violence, restrictive laws and policies, and sexual norms still prevent many people's ability to enjoy the full extent of their sexual and reproductive health rights.

The Guttmacher Commission identified people who use drugs as having distinct SRHR needs yet being inadequately reached with appropriate SRH services. The Commission provided a new, comprehensive and integrated definition of SRHR which sets SRH standards and elements for our submission. Components of SRHR that should be universally available include: services to address gender-based violence, HIV/AIDS and other STIs, contraception, maternal and newborn health, safe abortion and post-abortion care and cervical cancer testing and treatment – emphasising that individuals should have autonomy in accessing these services. Priority SRH needs of women who use drugs in most settings are pre-conception support and/or access to contraception, PMTCT, STI services and cervical cancer screening. All of these SRH services can be incorporated into harm reduction services and vice versa. Women who use drugs may also benefit from ready and consistent availability of safe and discreet family planning services, including pregnancy tests, counselling support and termination services.⁴⁸

⁴⁴ Ibid. See also Propublica, 'How States Handle Drug Use During Pregnancy', accessible at <https://projects.propublica.org/graphics/maternity-drug-policies-by-state>.

⁴⁵ Soderstrom, K and Skolbekken, J A, 'Pregnancy and substance use – the Norwegian z 10-3 solution. Ethical and clinical reflections related to incarceration of pregnant women to protect the foetus from harmful substances' *Nordic Studies on Alcohol and Drugs* 2017; 155-171.

⁴⁶ 'Women who use drugs, harm reduction and HIV'. Geneva: The Global Coalition of Women and AIDS. <https://idhdp.com/media/1114/brief-women-drugs-hiv-harm-final.Pdf>

⁴⁷ Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. May 2018 <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>

⁴⁸ Addressing the specific needs of women who inject drugs. Practical guide for service providers on gender-responsive HIV services . UNODC 2016 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