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Commentary

Women, drugs and HIV

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ABSTRACT

Background: Women who use drugs, irrespective of whether these are injected or not, are faced with multiple issues which enhance their vulnerability to HIV.
Methods: In this commentary, we explore the HIV risks and vulnerabilities of women who use drugs as well as the interventions that have been shown to reduce their susceptibility to HIV infection.
Results: Women who inject drugs are among the most vulnerable to HIV through both unsafe injections and unprotected sex. They are also among the most hidden affected populations, as they are more stigmatized than their male counterparts. Many sell sex to finance their own and their partner's drug habit and often their partner exerts a significant amount of control over their sex work, condom use and injection practices. Women who use drugs all over the world face many different barriers to HIV service access including police harassment, judgmental health personnel and a fear of losing their children.
Conclusion: In order to enable these women to access life-saving services including needle-syringe and condom programs, opioid substitution therapy and HIV testing and treatment, it is essential to create a conducive environment and provide tailor-made services that are adapted to their specific needs.

Introduction

Globally, the number of people who inject drugs (PWID) is approximately 16 million, of whom 3 million are estimated to be HIV-infected (Mathers et al., 2008). Statistics for females who inject drugs (FWID) are scarce, but a recently published meta-analysis (Des Jarlais, Feelemyer, Modi, Arasteh, & Hagan, 2012; Des Jarlais, Feelemyer, Modi, Arasteh, Mathers, et al., 2012) of 135 studies with data collected between 1982 and 2009, including over 125,000 PWID from four continents (excluding Africa and Oceania) had an overall proportion of 21.5% women, which would correspond to approximately 3.5 million FWID globally. The analysis revealed variation in the female:male odds ratios for HIV prevalence but overall there was a modest but significantly higher HIV prevalence among females with an overall odds ratio of 1.18. FWID had higher rates of infection than MWID in Eastern Europe (33.0% vs. 27.9%), Western Europe (42.8% vs. 40.3%), Latin America (38.5% vs. 34.6%) and North America (34.5% vs. 31.3%). A similar review from Central Asia, on data collected between 2002 and 2012, showed that FWID in Russia, Kazakhstan, Uzbekistan and Tajikistan also had higher HIV prevalence; 10.1% compared to 9.5% among MWID.

Non-injection drug use e.g. cocaine/crack, heroin, amphetamine-type stimulants (ATS), that are administered by snorting, smoking, inhaling, ingesting, and rectal insertion, are more common worldwide than injection drug use (Shoptaw et al., 2013). Available global estimates on the numbers of ATS and cocaine users show high burden (Degenhardt & Hall, 2012) and ATS use appears to be rising in many countries including some in South America, East and South East Asia (Dargan & Wood, 2012). HIV prevalence is also high among persons who use non-injection drugs (Strathdee & Stockman, 2010) and studies in New York City have shown that HIV prevalence among injecting and non-injecting heroin and cocaine users were similar (Des Jarlais et al., 2007). The principal risk for HIV transmission among non-injection substance users is from high risk sexual behaviours and both cocaine and ATS can increase sexual arousal and promote risky sex (El-Bassel, Shaw, Dasgupta, & Strathdee, 2014a; Shoptaw et al., 2013; Strathdee & Stockman, 2010). In women, non-injection drug use has been associated with high risk sexual behaviours including multiple concurrent partners (Adimora, Schoenbach, Taylor, Khan, & Schwartz, 2011) and not using condoms (Wechsberg et al., 2010).

Women who use drugs, irrespective of whether these are injected or not, are faced with multiple issues which enhance their vulnerability to HIV; these include concomitant sex work, sexually transmitted infections (STIs), viral hepatitis, mental health problems, reproductive health issues, child care, stigma, violence and

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lack of access to health services including for HIV prevention, care and treatment. In this commentary, we will provide an overview on some of these issues particularly those related to sex work, relationships with intimate partners, STIs, Hepatitis C, stigma and violence, reproductive health and child care, and availability and access to HIV prevention, care and treatment services.

Women, drug use and sex work

Many women are driven to sell sex to support their own or their partner's drug use, which can put them at dual risk of HIV infection: through unsafe sex as well as unsafe injections. Overlap between sex work and injecting drug use is especially high in parts of Eastern Europe and Central Asia and is a growing concern in some Latin American countries, such as Mexico (El-Bassel et al., 2014a; Morris et al., 2013). Women engaging in both the sex trade and use of illicit drugs are more likely to share needles/syringes and other injection paraphernalia among themselves and their clients, have unprotected sex with their clients as well as their intimate partners, have higher rates of STIs and they are also more likely to experience sexual violence and incarceration (Azim et al., 2006; Des Jarlais, Feelemyer, Modi, Arasteh, & Hagan, 2012; Des Jarlais, Feelemyer, Modi, Arasteh, Mathers, et al., 2012; El-Bassel, Shaw, Dasgupta, & Strathdee, 2014b). FWID-sex workers (FWID-SW) are more likely than sex workers who do not use drugs to engage in street-level sex work, which is associated with higher levels of violence and high-risk sex due to a different type of clientele and lack of safe places to take clients (Deering et al., 2013). However, sex work can also provide economic freedom for women. A study in Tanzania revealed that females using drugs who also sold sex were more likely to purchase and use drugs alone than males (Asher, Hahn, Couture, Maher, & Page, 2013; Williams et al., 2007). In general however, the combination of multiple high-risk behaviours, vulnerabilities and discrimination associated with FWID-SW has led to high HIV prevalence among this sub-population. Examples include:

- In Central Asia FWID-SW are up to 20 times more likely to acquire the infection compared to FSW who do not inject drugs (Baral et al., 2013).
- Along the US-Mexican border, HIV prevalence among FWID-SW is 12.3%, nearly 3 times higher compared to other FSW (Strathdee et al., 2008).
- In Tanzania, 85% of FWID are sex workers and their HIV prevalence is 62%, compared to 28% among MWID (Lambdin et al., 2013).
- In Nepal, over 50% of FWID sell sex and their HIV prevalence is 33%, compared to 6.3% among MWID (Ghimire, Suguimoto, Zamani, Ono-Kihara, & Kihara, 2013).

Since FWID-SW are at high risk of becoming infected with HIV through unprotected sexual intercourse and sharing injection equipment with intimate partners, clients and peers, this subgroup meets the criteria for a 'bridge' population that is associated with the transition from concentrated to generalized HIV epidemics (Des Jarlais, Feelemyer, Modi, Arasteh, Mathers, et al., 2012).

Women with intimate partners who inject drugs

FWID are more likely to have MWID as sex partners (El-Bassel et al., 2014a). Women's relationships with their intimate male partners who also use drugs are complicated and dynamic. Generally these women work to sustain their own as well as their partner's drug habits. A study on women using drugs and selling sex in Canada (Shannon et al., 2008) found that men take control of women's lives through a process of building trust, supplying and controlling the supply of drugs, gaining control of their sex work environment and transactions with their clients. Violence – both physical and sexual – is common and the experience of and the threat of violence serves to marginalize women further. Moreover, the intimate partner often controls decisions on condom use (Des Jarlais, Feelemyer, Modi, Arasteh, Mathers, et al., 2012), and lower rates of condom use have been reported by women who use drugs with both clients and their intimate partners (El-Bassel et al., 2014a).

On the other hand, these relationships are also emotional and women rely on their intimate partners for companionship as well as for support to negotiate with clients and law enforcement. A qualitative study conducted among drug using couples revealed the complex relationships and the role that emotional considerations play such that in one case the woman was initiated into injecting drugs by her intimate partner on her insistence as she wanted to be able to better share and understand his life (Simmons, Rajan, & McMahon, 2012).

Non-drug using women who are partners of MWID are also vulnerable to HIV as unprotected sex with intimate partners is common. Transmission of HIV to non-injecting wives of MWID has been documented in Manipur (Panda et al., 2000). In many cases, the female partner cannot change risky practices with her partner by herself, but harm reduction interventions aimed at couples can successfully decrease drug use and needle sharing and increase the use of condoms among drug-using couples (El-Bassel et al., 2014b). In addition, couple-based approaches often have positive effects on sexual communication skills and balancing power within the relationship (Roberts, Mathers, & Degenhardt, 2010). Evidence from a harm reduction program in Vietnam shows that reaching out to female partners of MWID is possible and may be effective in promoting condom use by the couple (Hammett et al., 2012).

Stigma, discrimination and violence

FWID are more stigmatized and discriminated against than their male counterparts as reported from several countries (El-Bassel et al., 2014a). Stigma is prevalent through all strata of society starting with their own families, friends and neighbours to service providers and law enforcement. In Bangladesh, a woman who uses drugs said "*when I visit any house they assume I am a thief*" (*UNODC, icddrb, & 2010)* and a similar opinion was expressed in a study conducted in Georgia – "*they (women who use drugs) are liars, big liars . . .and they are ready to go as far as possible. . . they are ready to sell themselves. . .*" (Otiashvili et al., 2013). In the same study from Georgia, the attitude of law enforcement was reflected in the statement "*Generally the attitude of police towards a drug user is similar to their attitude towards criminals and not sick people. . . their attitude towards women is even worse than to men. . .*" The views held by society cause women who use drugs to suffer from extremely low esteem, feelings of guilt and self-blame.

Violence is commonly experienced by FWID (Braitstein et al., 2003) from their intimate partners and in the case of FWID-SW from their clients as well (Morris et al., 2013). There is a direct correlation between violence and increased HIV vulnerability as data show that women who have experienced intimate partner violence are less likely to use condoms and more likely to share needles, to have multiple sexual partners and to trade sex (Braitstein et al., 2003; Gilchrist, Blazquez, & Torrens, 2011). Women also report high rates of sexual violence from police and law enforcement agencies and experience high rates of incarceration. In some countries, the police confiscate condoms, sterile injection equipment and other paraphernalia thus compromising adoption of safe behaviours (El-Bassel et al., 2014a; UNODC & icddrb, 2010). A sequelae of sexual violence is post-traumatic stress disorder which is common among women who use drugs (Braitstein et al., 2003).