Mapping harm reduction services for women who use drugs, Asia region.

WHRIN survey results. 2020

Key findings

- Only two countries across the region report any specific service designed for women who use drugs (India, Myanmar), and these are not nationwide programmes.
- The top 3 barriers to service access across the region are *gender based violence* (GBV), criminalization of drug use and a general lack of harm reduction services.
- Lack of meaningful involvement for female staff/peer workers.

Background

In their Global State of Harm Reduction: 2019 updates, HRI note that the spread of harm reduction services is still stalling globally in continuation of a trend observed since 2012. The 2018 Global State of Harm Reduction 2018 briefing, highlights that although women are estimated to account for one third people who use drugs globally and are consistently reported to have less access to harm reduction services and to be at higher risk of HIV and hepatitis C infection, robust data on this subject is scarce, and research on drug use and related health issues rarely produces information about women. While tools exist to enable harm reduction services to institute a gender lens and gender mainstreaming in their programmimg in order to improve relevance and reach to women who use drugs, services that have introduced such approaches are thin on the ground. Where they do exist, there is not necessarily scope to document and promote experience. In order to leverage greater accountability from governments that have endorsed UN guidelines and resolutions around the provision of services for women who use drugs, it is important to document and promote such services where they do exist. With this, models can be replicated, resourced and established at other harm reduction programmes, while pressure builds to reverse the stalling of actions that improve respectful access to health for women who use drugs. With this in mind, WHRIN undertook a survey, in order to attempt a 'mapping' of women friendly services around the world.

Method

Regional focal points identified among WHRIN membership worked with a WHRIN coordinator to create survey participant lists targeting two well networked women who use drugs and two additional key informants (KI) with a good understanding of harm reduction services in their country. *Per country* (or state/province in Canada, US and Australia). Separate short survey monkeys were created per region. These applied the same 7 questions aimed to identify key barriers to service access and to 'map' harm reduction services designed for women who use drugs. Data was processed into short reports, to share back with all original survey participants in draft form for feedback before finalisation and dissemination.

Region	Month 2020
Asia	April
W Europe	May
EECA	June
MENA	July

Region	Month 2020
Oceania	Aug
N America/Canada	Sept
Africa (E,W,S)	Oct
Latin America	Nov

WHRIN acknowledge some limitations to the approach of relying primarily on participation from membership and other recommendation contacts where available. In some cases, a country or state participant could not be identified, or there was not a full complement of 4 participants for every state/country. The survey was short and simple and may not have delivered on required specificity in all cases. For these reasons, the survey reports cannot be said to be exhaustive, but they do serve a role in beginning to map and promote services for women who use drugs around the world.

Results:

Participants

There were survey participants from India, Vietnam, Pakistan, Malaysia, Japan, Indonesia, Philippines, Myanmar, Nepal (amounting to 22 women who use drugs and other key informant responses from 9 countries; 50% of all participants are women who use drugs).

Harm reduction services for women

Survey participants in Nepal, Malaysia, Myanmar, (both women who use drugs and other informants) reported harm reduction services designed for WUD. Further definition from Nepal was not provided although NSP was mentioned, there was nothing to demonstrate particular design for women who use drugs. Similarly, Malaysia reported that services do not exclude women but nor are the harm reduction services designed with a gender lens.[1]

Survey Participants from Vietnam, Pakistan, Japan, Indonesia, Philippines reported the absence of services for women who use drugs, with the Philippines highlighting current overarching criminalization of drug use and security concerns.

The survey identified the following harm reduction services designed for women who use drugs in Asia:

- ***India:*** National AIDS Control Organization has 5 'targeted interventions' for women who use drugs. There is a demonstration site for women who use drugs funded under the Harm Reduction Advocacy in Asia grant (Global Fund). The project provides the WHO recommended comprehensive packages of HR services specific to women who use drugs. Another program is in Punjab supported by HIV Alliance. SPYM also has had a programme addressing the basic needs of women who use drugs in a shelter home in Delhi.
- ***Myanmar:*** In Kachin State, MdM support a women's advisory group made up of women who use drugs from surrounding townships. In response to their feedback, women drug users days are held every Saturday in 3 DICs in Kachin state.
  AHRN reaches out, through their drop in centres, to 76878 sex workers, of whom 5394 also inject drugs. These clients are reached through the clinics, or through mobile medical teams and outreach (accessing 'shooting galleries' and brothels). Increasingly more women have been involved through female-focused interventions. Women outreach workers were recruited and trained for women-focused activities (which also include SRH and GBV) along with the full harm reduction cascade service delivery.

Key barriers to access

56.25% of respondents across the region listed GBV at a critical barrier, with criminalization of drug use and a general lack of harm reduction services also noted among the top 3 barriers to service access. Also noted as key barriers were domination of male clients in service centres, lack of childcare facilities, gender inequality, lack of relevant services (eg sexual and reproductive health care) and a lack of women and peer staff.

WUD and key informant responses were not divergent on the top three barriers.

Other barriers were mentioned as follows:

- There is a need for shelter and a proper follow up system. Sometimes the women are forced to leave a rented place and it becomes difficult to track them. Gender inequality increases stigma among families and community. There is a lack of sensitization to the specific needs of women who use drugs (India).
- The punitive law against people who use drugs is a barrier for them to access to services in community because 1) people who use drugs are sent to compulsory detention centres, 2) the punitive law increases stigma and discrimination of the community toward people who use drugs (Vietnam)
- Anti-harm reduction drug policy, stigmatization against women who use drugs (Japan)
- Lack of mainstreaming issues of WUD within the women movement itself (Indonesia)
- Security (Philippines)
- Lack of political will to address women and drug use, limited involvement of women who use drugs in national programmes including at the strategic level, legal barriers, stigma and discrimination. Political will is not strong enough and misconceptions of woman who used drugs as criminal dominate; enabling environment is also a challenge (Malaysia)
- Remote and conflict areas - difficult to reach people who use drugs and for them to access services (need to imagine performing harm reduction in war zone) (Myanmar)

Key service gaps

The following additional reported gaps are not exhaustive nor confined in relevance to respondent country alone:

- Gender based violence against women who use drugs is not addressed in any services (Vietnam)
- No proper facilitation to women (Pakistan)
- Gender mainstreaming harm reduction. Current programmes do not adequately address cross-cutting issues, such as sex workers who use drugs, SRH, shelter and rehabilitation for women who use drugs. Lack of strategic information on women who use drugs. Lack of representation of women who use drugs in national programmes, CCM, management of HR programmes etc (Malaysia)
- Lack of appropriate services available to women who use drugs to address their specific needs; lack of privacy: there is a lack of women specific harm reduction services; lack of services to address violence, and for those with mental health problems. Severe lack of women centric treatment centres and women centric policies, and a profound lack of awareness regarding the needs of women who use drugs (India)

[1] *Harm reduction in Malaysia is implemented mostly by CSOs. Whilst the programme is not yet fully gender sensitive, outreach and services do no not preclude women and transgender women. Full info on Malaysian HR programme https://www.mac.org.my/v3/programmes/prevention-strategies . The Harm Reduction Program from Malaysian Ministry of Health did include woman who used drugs in their programme but it is not specifically designed to their needs and often gender bias happening where more programs are predominantly for men.*

- Referral to services for women is missing (Indonesia)
- A low number of people who have good understanding of gender issues (Japan)
- Lacking harm reduction services including SRH (Nepal)
- Needing reliable legal protection services for women who use drugs (Myanmar)

Discussion

This brief discussion reflects on the three key findings drawn the survey responses.

Only two countries across the region report any specific service designed for women who use drugs (India, Myanmar), and these are not nationwide programmes. Gender specific harm reduction services are needed to attract and actively engage women who use drugs across the region.

A key barrier to service access is gender based violence (GBV) This reflects the confluence of various forms of gender based structural violence and their impacts in the lives of women who use drugs. For example, the high incidence of GBV experienced by women who use drugs and the scarcity of harm reduction services to respond effectively to the needs of women who are experiencing GBV reflects not only the criminalisation of drug use but its discriminately gendered nature. There is an acute lack of resources and services responding to both the immediate and longer term impacts of GBV on women who use drugs.

Another key barrier reflected in several countries is the lack of meaningful involvement for women staff/peer workers. This reflects harm reduction as a 'masculinized space'. The lack of female staff/peers as the critical interface between women who use drugs and their effective engagement with harm reduction services is noteable.

These findings highlight the need for both a multi-level approach to improving the provision of harm reduction services for women who use drugs. Political will at all levels is crucial in order to ensure the systematic roll out of adequate support for women who use drugs across the Asian region. At the same time, it is clear that communities of women who use drugs must be resourced and supported to develop stronger peer networks, to organise and build partnerships.