

# Women, Harm Reduction, and HIV



Key Findings from Azerbaijan,  
Georgia, Kyrgyzstan, Russia, and Ukraine





ASSESSMENT IN ACTION SERIES

Women, Harm  
Reduction, and HIV:  
Key Findings from Azerbaijan, Georgia,  
Kyrgyzstan, Russia, and Ukraine

October 2009

International Harm Reduction Development Program



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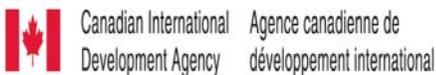
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### **International Harm Reduction Development Program**

The International Harm Reduction Development Program (IHRD), part of the Open Society Institute's Public Health Program, works to reduce HIV and other harms related to injecting drug use and to press for policies that reduce stigmatization of illicit drug users and protect their human rights. Since 1995 IHRD has supported more than 200 programs in Central and Eastern Europe and Asia, and bases its activities on the philosophy that people unable or unwilling to abstain from drug use can make positive changes to protect their health and the health of others. Since 2001, IHRD has prioritized advocacy to expand availability and quality of needle exchange, drug dependence treatment, and treatment for HIV; to reform discriminatory policies and practices; and to increase the participation of people who use drugs and those living with HIV in shaping policies that affect their lives.



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This work is based on assessments conducted in five countries:

- ▶ **Azerbaijan:** *Assessment of HIV Infection Risks among Women Who Use Drugs and Work in the Sex Industry* (2009). Baku: The Social Union to Help Women “Chisty Mir”
- ▶ **Georgia:** *Drugs, Women and Harm Reduction in Georgia* (2008). Tbilisi: Georgian Harm Reduction Network.
- ▶ **Kyrgyzstan:** Dzhalbieva I.D., Ermolaeva I.V., and Tokombaeva M.M. *Limited Access to Services and Socio-psychological Factors Influencing the Spread of HIV Among Women IDUs in the Southern Region of Kyrgyzstan. Report on Research Results* (2009).
- ▶ **Russia:** Oleynik S and Fedoseyeva N. *An Evaluation of the Services, Policies and Social Factors Affecting Female Drug Users in Seven Russian Regions* (2008). Penza: Penza Anti-AIDS Foundation.

- ▶ **Russia, St. Petersburg:** Meylakhs N and Meylakhs P (2008). *Women, Drug Use and Harm Reduction: A Study of the Case of Russia Based on the Example of St. Petersburg*. St. Petersburg: Center for Independent Sociological Research and Charitable Foundation Humanitarian Action
- ▶ **Ukraine:** Tishchenko S.P., Goncharova I.O., Monakhova N., and Strel'tzov O.M. *A Report Based on the Results of the Study on the Accessibility of Harm Reduction Services and Services for the Protection of the Sexual and Reproductive Health of Women Who Use Drugs in Ukraine* (2008). Kyiv: Social Agency "The Center for Psychosocial Rehabilitation of Chemically Dependent Youth 'Step by Step'"

# Executive Summary

Women who use drugs face a dual challenge: They are more vulnerable to both sexually and injection-transmitted HIV infection than male drug users, and they encounter greater obstacles to accessing the services they need. This paper summarizes the results of field assessments of women's access to harm reduction, antiretroviral, and reproductive health services in five countries: Azerbaijan, Georgia, Kyrgyzstan, Russia (St. Petersburg and seven regions), and Ukraine. These assessments, supported by the Open Society Institute's International Harm Reduction Development Program, local Soros Foundations, and the Canadian International Development Agency (in Russia, Georgia, and Ukraine), provide new data on gender-specific vulnerability and access issues for women who use drugs, and suggest directions for future research and programming. The assessments found that women who use drugs have gender-specific injection-related vulnerabilities to HIV infection and encountered gender-specific barriers to accessing harm reduction and drug treatment services.

## **Increased HIV Risk**

Women were more likely to be “second on the needle” and share injection equipment; many did not perform injections themselves, but relied on a male partner to perform injections. The assessments also found that women were vulnerable to sexual transmission of HIV and documented a significant overlap between drug use and sex work, as well as low levels of condom use and limited access to sexual health services. Nearly

43 percent of women interviewed in the Russian regions exchanged sex for drugs or money; 62 percent of women interviewed in Kyrgyzstan identified themselves as sex workers, and 84 percent of women interviewed in Azerbaijan engaged in transactional sex for drugs or money. Women reported challenges negotiating condom use with clients during sex work. In Ukraine, women reported that they were themselves unwilling to use condoms with their regular partners either because they felt condoms were uncomfortable or because they felt that the condoms available were low quality and likely to break. In Georgia, despite the high percentage of women drug users whose sexual partners were themselves using drugs, more than four in five women had not been tested for HIV.

### **Limited Access to HIV Prevention and Drug Dependence Treatment**

Women were also less likely to attend harm reduction services than men—citing housework, child care responsibilities, or gender norms as reasons not to access services directly—and tended to rely on male partners for obtaining clean needles and syringes. Women also encountered obstacles to attending drug treatment, including lack of childcare at inpatient treatment facilities, the high cost of anonymous treatment, and requirements that their names be added to government registries, which could jeopardize child custody. Most detoxification and rehabilitation services required that family members be separated during treatment, posing a significant obstacle to women who feared losing their partner during a prolonged separation. Some inpatient drug treatment facilities lack rooms or beds to provide privacy for women patients or expertise in women-specific needs. The assessment in St. Petersburg noted a number of further gender-specific obstacles to treatment, including restrictions on admitting homeless women, women who had experienced domestic violence, and women with family members who still used drugs. Drug treatment facilities generally had poor or nonexistent referral to sexual and reproductive health services.

### **No Harm Reduction While Incarcerated**

Access to sterile injection equipment or methadone treatment is extremely limited for male and female prisoners in all countries surveyed. Nonetheless, while Kyrgyzstan offers needle exchange in prisons, and Georgia and Kyrgyzstan both offer some methadone treatment in penal institutions, these are not available to women prisoners. Post-release services are inadequate to women's needs, especially women with small children, since shelter is provided for less time than is required for them to gather the requisite documents for obtaining more permanent housing or other benefits.

## Limited Access to Appropriate Prenatal Care

Few women accessed prenatal care and those who did often did so only in the third trimester. Some women only accessed care when they went into labor. Access to obstetricians and gynecologists familiar with the issues of drug use during pregnancy was practically nonexistent, and many women reported judgmental or stigmatizing attitudes by providers, as well as prohibitive fees.

## No Substitution Treatment During Pregnancy or in Maternity Hospitals, and Loss of Custody of Newborns

Only the study in Kyrgyzstan reported that pregnant women had access to methadone. Lack of methadone or buprenorphine in maternity wards forces women out of the hospital immediately after giving birth in search of drugs to relieve withdrawal; some maternity wards release babies for adoption without the mother's consent.

## Removal of Older Children from Custody and Violations of Confidentiality

Women also lose custody of older children as a result of being registered as drug users. Others report difficulties accessing medical care and providing education for their children if schools and medical services become aware of the mother's history of drug use.

## HIV Testing without Counseling or Consent

Women report that providers test them for HIV without counseling, consent, or knowledge that they are being tested, particularly during pregnancy or labor.

## Barriers to HIV and STI Treatment

Lack of childcare, as well as judgmental attitudes by treatment providers toward drug users and fear that antiretroviral treatment would make them infertile were among the reasons cited by women for reluctance to seek treatment for HIV infection.

## Lack of Protections for Victims of Domestic Violence, and Experiences of Police Abuse

Women who use drugs reported high levels of domestic violence—particularly in Azerbaijan—but were uncomfortable accessing medical or social and legal services after being beaten or raped. Some medical facilities report cases of domestic violence to the police; women who use drugs distrust the police and many also have experienced physical and sexual violence at the hands of police officers. Legal and social services intended to support women in the event of domestic or police violence were either inaccessible due to financial constraints, unsupportive, or ineffective.

## Recommendations

Concrete steps by service providers and policymakers can sharply increase access to and effectiveness of services for women who use drugs. For a fuller description, please see the “Recommendations” section on page 55.

### To Providers of Needle Exchange and Outreach Education

- ▶ Make harm reduction services user-friendly for mothers by providing childcare, child-friendly goods and services, and parenting classes.
- ▶ Provide structured opportunities for women to support each other such as women-specific support groups.
- ▶ Offer education about contraception, pregnancy, and legal rights to women drug users.
- ▶ Create couples-counseling at harm reduction, drug treatment, and HIV services.
- ▶ Provide instruction on safe injection in women-only training sessions.
- ▶ Link to or provide low-threshold sexual and reproductive health services, including provision of condoms and instruction on how to use them, as well as take-home pregnancy test kits or access to pregnancy testing.
- ▶ Improve NGO capacity through ongoing training of staff and outreach workers on working with women drug users.
- ▶ Document the difficulties caused by lack of integrated services, and advocate with national officials, government medical institutions, and regional and local authorities to improve coherence and accessibility of services for women who use drugs.

### To Providers of Drug Dependence Treatment

- ▶ Ensure that drug treatment facilities provide rooms for women, and childcare facilities for mothers with children.
- ▶ Revoke restrictions on treating women who are homeless, victims of domestic violence, or women whose family members are still using drugs.
- ▶ Offer drug treatment for couples and family members to improve treatment attendance and adherence.

- ▶ Offer or establish strong linkages to HIV treatment and reproductive health services, including gynecological and prenatal care.
- ▶ Train providers of HIV and reproductive health services on appropriate conduct with drug-using patients, and strategies to increase treatment adherence.
- ▶ Ensure access to methadone treatment for pregnant women, including inside maternity wards.
- ▶ Provide or enable provision of methadone or buprenorphine in tuberculosis clinics and AIDS centers.

### To Providers of HIV and STI Testing, Treatment, and Care

- ▶ Improve provision of reproductive health services, integration of HIV, STI, and drug treatment, and referrals between drug treatment and sexual health services.
- ▶ Train providers on work with active drug users, and on appropriate supports to increase treatment adherence.
- ▶ Establish linkages with domestic violence and crisis centers.
- ▶ End mandatory inpatient treatment of sexually transmitted infections; instead offer syndromic treatment that does not require expensive, time-consuming laboratory confirmation.
- ▶ Offer anonymous STI treatment, and ensure confidentiality of all medical information, including drug use history, HIV status, or history of STIs and hepatitis.

### To National, Provincial, and Local Policymakers

- ▶ Eliminate registration as a drug user as grounds for loss of child custody.
- ▶ End mandatory notification of police in domestic violence incidents, and strengthen supportive services for victims of violence.
- ▶ Guarantee that women are not tested for HIV without their knowledge or consent, and ensure that testing is voluntary and confidential.
- ▶ Issue instructions to police officers on appropriate conduct with sex workers and drug users, and enforce their observance.
- ▶ Train social service bureaus, legal aid providers, and medical personnel on the needs of drug users and non-discriminatory practices.



# Methodology

This report synthesizes six assessments, conducted with the support of the Open Society Institute, Soros foundations, and the Canadian International Development Agency in 2007 and 2008, in Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine. While each of the six assessments was independently developed by a local nongovernmental organization, all shared an overarching goal: to identify gender-specific needs and vulnerabilities of women who use drugs, assess the availability and accessibility of services for women who use drugs, and provide recommendations for improving service quality and access to services. The assessments focused particularly on women's access to harm reduction, drug treatment, and sexual and reproductive health services.

While the methodologies and research instruments of the six assessments were not uniform, all research teams conducted in-depth interviews with women who use drugs. Specifics on research teams and methodologies for each assessment are as follows:

## Azerbaijan

Research in Azerbaijan took place in 2007 and 2008. The project was carried out under the direction of the Civil Society Organization to Help Women Chisty Mir ("Clean World") and was undertaken by a research team led by a sociologist; the team included representatives from NGOs Chisty Mir, Spasatel, and "Struggle against AIDS," as well as the chief narcologist from the Lenkoran Narcological Dispensary. Research was

carried out in five cities: Baku, Mingechaur, Ganja, Khachmaz, and Astara. The team interviewed 150 women drug users.

## **Georgia**

The assessment in Georgia was carried out by the Georgian Harm Reduction Network in 2008. The Network conducted interviews with both women and men who use drugs, and reported that the project interviewed 39 female respondents, as well as a number of male drug users.

## **Kyrgyzstan**

The assessment in Kyrgyzstan was carried out by a team that included the director of NGO “Asteria,” the president of the Kyrgyz Harm Reduction Network, and a sociologist. The team carried out research in December 2007 in the cities of Osh and Jalal-Abad, where it conducted interviews with 73 women who were using drugs.

## **Russia, Seven Regions (Penza assessment)**

This assessment was developed by the Penza Anti-AIDS Foundation and was undertaken in Volgograd, Voronezh, Kaliningrad, Murmansk, Omsk, Orenburg, and Ufa. The assessment included a survey of 376 women IDUs, in-depth one-on-one interviews with 63 women (IDUs, IDUs engaged in sex work, and HIV-positive IDUs), and interviews with more than 40 project administrators from organizations providing medical, social, and legal services. In five of the regions, interview subjects were recruited with the help of harm reduction programs; in the other two, subjects were recruited through drug user support groups, people living with HIV, and their relatives. Regional data were collected by project coordinators, harm reduction program staff, and regional support groups.

## **Russia, St. Petersburg**

The assessment in St. Petersburg was carried out by the Center for Independent Sociological Research with the participation of the Charitable Foundation Humanitarian Action. The assessment included analysis of local regulatory and legislative frameworks impacting women who use drugs, an assessment of the local harm reduction program run by Humanitarian Action, assessments of the city narcological dispensary and the St. Petersburg AIDS Center, and an analysis of the barriers women who use drugs encounter when accessing or attempting to access services. Researchers mapped the services available to women drug users at six facilities: a clinic for sexually transmitted infections (STIs), a women’s clinic, a general hospital, a drug treatment center, the AIDS center and a maternity clinic. In 2007, researchers conducted participant observation at two

syringe exchange units run by the charitable organization Humanitarian Action: one exchange located at the organization’s headquarters, and another by a mobile unit that visited the St. Petersburg AIDS Center and the Municipal Drug Addiction Treatment Center. Researchers conducted key informant interviews at all locations, held two focus group discussions with women drug users—one with women who were sex workers and one with women who were attending detoxification—and conducted 13 in-depth, one-on-one interviews with women who use drugs.

## Ukraine

The assessment in Ukraine, conducted by Kiev-based NGO Krok za Krok (KzK), focused on four cities—Kiev, Odessa, Chernovtsy, and Pavlograd. KzK held seven focus group discussions with women who use drugs; seven focus group discussion with the staff of harm reduction services; 20 in-depth interviews with service providers at youth social services, medical facilities, HIV/AIDS centers, women’s health clinics, and maternity clinics; and 20 in-depth interviews with women who use drugs. The assessment applied a number of criteria for selecting interview subjects among women who use drugs. All women in the assessment had used drugs for at least three years; they were either currently using drugs or had stopped using not more than one year prior to the assessment. In addition to these two criteria, interview subjects had to meet at least one of the following four criteria: 1) experience with sexually transmitted infection (STI) treatment; 2) experience with HIV testing; 3) previous participation in harm reduction programs; 4) pregnancy within the last three years.



# Gender-Specific Risks and Barriers to Harm Reduction Access

## Heightened Injection Risk for Women

The assessments in Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine found that women who use drugs were particularly vulnerable to HIV infection via injection for three reasons. First, women tend to inject with a shared needle after someone else has used it, and they tend to be injected by another party—often a husband or partner. Second, women are less likely than men to have direct access to harm reduction services, which they often access indirectly via their male partner, and therefore have weaker access to information about safe injection behaviors or other support services. Third, women encounter a number of gender-specific barriers to accessing detoxification, rehabilitation, and methadone or buprenorphine treatment.

## Gender Dynamics of Needle Sharing and Harm Reduction Access

For the women surveyed, the experience of injection was often *relational*: begun with, and at times governed by, a male partner who procured drugs and/or syringes, performed the injections, and injected himself first. In all the assessments, the majority of women reported sharing injection equipment. For many women, gender roles deeply

shaped their experience of injection, the likelihood of needle sharing, and their inclination or ability to practice safer injection or visit harm reduction programs. The gendered nature of this relation, including the dominant role of men in getting drugs and needles, setting the order of injection, or even telling women how the drug's effects should be experienced, was a common theme. The following excerpts from Ukraine, where 100 percent of women surveyed began using drugs with men who obtained the drugs for them and performed their first injections, offers an illustration:

*“The first time, my friend—a man—injected me. The guys were the ones who decided on the dose I had and told me what I should feel and everyone was standing over me and watching the state I was in. I really liked it.”*

*“I started using drugs with my first husband. He was the initiator and he convinced me. I married him and only later found out that he had started using. At first, we had a lot of fights, then I thought that I was going to freak out. So I shot up for the first time. He injected me so that I wouldn't bug him anymore and we wouldn't get into fights, and I liked it.”*

One Ukrainian respondent noted that her reliance on her partner to procure and inject drugs was so complete that she found herself uncertain of how to do either after his arrest:

*“I was always home and he would go buy it himself, until he got busted. When I was waiting for him, I saw where he went and went there the first time I got drugs for myself. I didn't know whether it was on the 3rd or 4th floor, but it was obvious when I saw the door. I knocked and this older woman who was a drug addict opened the door. I told her that Andrey had gotten busted and I didn't know anyone. I went in, she took pity on me, injected me. I don't even think she made me pay. She was the one who injected me. Even now, I rarely inject myself. Whoever is near me injects me. Right now, it's my boyfriend.”*

Respondents in Kyrgyzstan and Azerbaijan similarly reported initiation by a husband or boyfriend, sharing of injection equipment, and being second on the needle. In the Azerbaijan assessment, 76 percent of women reported sharing injection equipment.

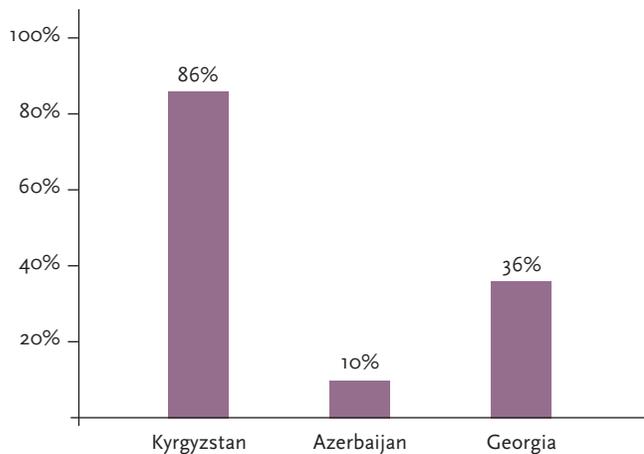
Of these, nearly two thirds reported using a needle after someone else had used it—35 percent after their husband or male partner.

### Gender and Harm Reduction Knowledge

The assessments revealed wide variations in women’s awareness about harm reduction services. In countries with more developed harm reduction service networks, women drug users were more likely to know about the existence of these services. In Kyrgyzstan, for example, where harm reduction programs have operated since 1999 and have been widely publicized, 86 percent of women knew about the existence of these services. In Azerbaijan, only 10 percent of respondents had heard about harm reduction programs, and those who had heard were exclusively in Baku. Though harm reduction programs were operating in Ganja and Astara at the time of the assessment, none of the respondents knew about them. In Georgia, 64 percent of female respondents did not know about the existence of harm reduction projects in their area.

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**FIGURE 1**  
**Women Drug Users Reporting Knowledge of Existing Harm Reduction Programs (Select Countries)**





# The Gender Gap in Harm Reduction Access

Even where women knew of the existence of harm reduction services, this knowledge did not always translate into equitable access. Ukrainian women cited housework and child care responsibilities among the reasons for not visiting harm reduction services; according to harm reduction staff, resistance from a male partner is another common obstacle. Men are often the ones to visit the harm reduction service and bring supplies such as needles and syringes back home for their female partners. Whether in the name of protection or control, this dynamic prevents women from accessing the full range of services available through harm reduction projects, including referral to drug treatment or information about HIV, and restricts access to other support and medical information. One Ukrainian service provider reported:

*“Often, husbands don’t want women to go with them to NEPs (needle exchange points). They understand that their way of life is not normal and will cover for her. They keep it a family secret.”*

In St. Petersburg, staff of the mobile unit similarly reported that women tended to give their registration card to a boyfriend or friend who would then pick up supplies

such as needles and syringes. Here too, staff noted that this dynamic deprived women of the opportunity to receive counseling, instruction on risk reduction, and other services.

Interviews in Georgia provided some of the clearest examples of ways in which male drug users felt that female attendance at public services for drug users was inappropriate. While they saw nothing wrong with attending harm reduction services themselves, male drug users explained that female drug use is socially unacceptable, incompatible with motherhood and family values, and that they would report any woman whom they saw attending harm reduction services to friends and relatives. As one man explained:

*“A woman is a woman. A woman should know what a family is and had better get married, have a child, and do what is worth being a pure Georgian lady. Instead she goes and destroys herself. We also destroy ourselves, but she destroys her future as well.”*

The Georgian assessment also found that relationships between women who use drugs and men who do not tended to break down.

## **Weak Links between Women’s Medical Care and Harm Reduction Services**

While women are less likely to go to harm reduction services, they are also unlikely to find such services in clinics that serve them specifically. In St. Petersburg, for example, staff at maternity wards and women’s health clinics report that fear of being charged with promotion of illegal drug use leads them to refrain from offering sterile injection equipment, or from broaching the subject. Clinic staff members are unwilling to even discuss or refer to harm reduction services unless the women themselves ask.

Mobile harm reduction units run by the NGO in St. Petersburg have worked to improve access to medical professionals by developing a network of “trusted doctors” and referring clients to them. Because women who use drugs are less likely than men to attend even mobile harm reduction services, however, they are less likely to benefit from this trusted doctor network.

While the assessments focused primarily on identifying barriers to access for women drug users, researchers in Ukraine and St. Petersburg also identified factors that improved access. The assessment in Ukraine found that harm reduction services that provided products for children, such as food and diapers, were likely to attract women; respondents reported satisfaction with these services in part because they offered them something, even if unrelated to drug use, that helped them fulfill a role expected of them as a mother or family member. One harm reduction client in Ukraine explained:

*“What would make me come here? I come here anyway. I always come here for treatment. Because I know that they’ll either give me something, or I’ll pick up some cereal for my child, or Pampers, and I’ll take those syringes, and there’s something else. I get a sense of pleasure from this, the way people get a sense of pleasure from shopping. I leave here and my mood is elevated and I’m happy. I come home and show it all to grandma. I have enough happiness for the entire day.”*

While previous assessments on harm reduction services have noted that having female staff and outreach workers improves attendance and adherence to services among women drug users, this finding should not be generalized without attention to context. Staff at the mobile harm reduction program in St. Petersburg, for example, noted that employing male staff made the service more attractive to women clients. One employee said:

*“They really like interacting with men. I did an experiment, I tried to get a lot of men and see how this will affect their [women drug users’] motivation. It turned out to be a very good influence.”*

### Gender-Specific Barriers to Accessing Drug Treatment

Both women and men who use drugs have difficulty accessing services such as detoxification, rehabilitation, and opiate substitution therapy in the countries surveyed. This is particularly the case in Russia, where methadone and buprenorphine are illegal, and in Georgia where demand for affordable drug treatment has for years vastly outstripped supply.

The assessments suggest that drug treatment services, however, are particularly ill-equipped to meet the range of women’s needs. Issues related to childcare are a particular impediment for mothers, who risk loss of child custody in some countries if they are registered as drug addicts, and who cannot take their children with them to government-run inpatient drug treatment facilities in any country surveyed. In Russia, concerns about anonymity and loss of child custody are sometimes compounded by regulations that exclude especially vulnerable women—for example, victims of domestic violence are excluded from the St. Petersburg Municipal Drug Addiction Treatment Center, as are homeless women and women whose partners or close relatives are active drug users. Lack of privacy is also a barrier—while some drug treatment facilities have separate rooms or spaces for women, others have dormitory-style beds without dividers. The St. Petersburg center offers no sexual or reproductive health services for women, does not provide referral to such services, and will not accept pregnant women.

Worry about separation from a male partner was cited as an obstacle to inpatient drug treatment by women in Russia and Ukraine, yet no country surveyed offered the opportunity for couples to remain together during treatment. In the words of one woman in Ukraine:

*“And where will my husband go? In a year, he will go astray. And none of the rehabilitation centers want families to remain together.”*

Anxiety about drug users leaving the house or relationship was not restricted to women alone. In couples where the male partner did not use drugs, a Russian respondent reported that women were subjected to so-called “home treatments,” where the men locked them in rooms and refused to allow them to go out. When locked into prisons, too, women find their options for medication-assisted drug treatment restricted: methadone is available to some male prisoners in Georgia and Kyrgyzstan, but is unavailable in any women’s prison in the five countries surveyed.

Concerns regarding childcare and child custody are particularly powerful disincentives for women contemplating treatment. Registration as a drug user, required of all those receiving free drug treatment at government facilities in Ukraine and Russia, can be used by relatives or in court to remove children from a mother’s custody. While registration is not imposed on those who can afford to pay for treatment, respondents in both Ukraine and Russia reported that the fees for anonymous detoxification and rehabilitation are prohibitive.

Government detoxification and rehabilitation services in Ukraine do not provide childcare, although there are two rehabilitation centers in Ukraine run by religious organizations that do provide childcare. Similarly, women in St. Petersburg reported that they were unable to attend detoxification or rehabilitation because they had nowhere to leave their children. In the Russian regions, one woman explained her dilemma:

*“Admitting myself and getting treatment inpatient means I have to leave everything behind; I have children, I can’t go in for inpatient treatment. They say to me, ‘You come for a prescription every month, why don’t you just admit yourself?’ But I don’t want to. That is to say the services are only partially accessible.”*

Women drug users also noted a number of barriers to drug treatment that also affect men, including long waiting periods for entry (up to six months’ wait was reported in the Russian regions), a limit of one admission to inpatient detoxification per six-month period, and the requirement that clients be “sober” (i.e. in a state of withdrawal) when registering for the waiting list.



# Sexual Risk: Sex Work, Unsafe Sex, and Poor Access to Sexual Health Services

## Sex Work

The assessments in Kyrgyzstan, Georgia, Azerbaijan, and the Russian regions documented a significant overlap between drug use and sex work among women who use drugs. In the Russian regions, 43 percent of respondents indicated that they exchanged sex for money or drugs; in Kyrgyzstan, 62 percent identified themselves as sex workers;<sup>1</sup> in Georgia, the majority of female assessment participants engaged in sex work; and in Azerbaijan, approximately 69 percent of assessment participants reported engaging in some form of sex work,<sup>2</sup> while 84 percent of respondents reported having exchanged sex for drugs.

The primary reason given for engaging in sex work was lack of money, including insufficient funds to buy drugs. One woman in Kyrgyzstan explained: “No work, I need money for drugs and to pay the rent.”

Women reported a variety of reasons for entering sex work, including the demise or departure of a male bread winner. An 18-year-old in Jalal-Abad, Kyrgyzstan, reported:

*“I have been injecting for three years, my younger sister injects—she started with me. We are six sisters, we live together and rent a small house. We had a brother who helped us, but he died not long ago from an overdose and we had to somehow find a way to live and eat. So we work on the street. I am already too old to sell my body, but my sisters have an opportunity [to work].”*

Conversely, evidence from Georgia suggests that women drug users may enter into relationships with men who encourage or force them to engage in sex work in order to generate the income necessary to buy drugs for both of them. Male drug users in Georgia may encourage their wives to generate money for drugs, or may initiate relations with women who are able to generate income through sex work or other means. In some cases, the woman generates the income, while the man obtains drugs and needles through his connections. Direct contact between women drug users and drug dealers appears fairly limited in the Georgian context. The assessment noted that “a woman without a man may come across serious problems in getting drugs.”

The dynamic by which women drug users generate income for their male partners was also evident in the Kyrgyzstan assessment, in which one 22-year-old from Jalal-Abad reported:

*“I have worked in the sauna since I was 16—as a prostitute. My husband stole me in Uzbekistan when I was 14 years old. I gave birth to a son and ran away. I do not want to see my husband or his son to whom I gave birth. I came here, met a guy, he initiated me [into drug use], and after two months sold me to the sauna, so that I would make money for him. Then he died of an overdose.”*

## **Unprotected Sex: Power Dynamics and Lack of Information**

Respondents in Kyrgyzstan, Azerbaijan, and Ukraine reported infrequent condom use. This was not the result of lack of knowledge: in Kyrgyzstan, although 96 percent of respondents knew condom use is important for safer sex, 67 percent reported that they did not use a condom regularly with their partners. Those who were sex workers reported that they did not use condoms during work because the clients refused (particularly in cases where clients were drunk), or else offered more money for sex without a condom. Similarly, in Azerbaijan, 84 percent of women reported exchanging sex for drugs or money, but only 29 percent used a condom in every encounter. Some 74

percent of respondents reported that in cases where a condom was not used during sex, this was the partner's decision. In Ukraine, where fewer sex workers were interviewed, women also reported irregular condom use, but said that this was their own or a shared decision. The most common reasons given by the Ukrainian respondents for unprotected sex were having a regular sexual partner, trusting their sexual partner, and the perception that sex with a condom is unnatural and unpleasant. Illustrative responses from Ukraine include:

*“My husband and I never used condoms. Once we tried it as a joke, but we didn't like it, nothing happened and then we never did it again.”*

*“I don't use condoms. Very rarely. I don't like it, it doesn't feel the same. It didn't even come up in conversation. When I lived with my husband, we decided to try it a couple of times, but we didn't like it.”*

*“I live with my husband. I'm certain that he doesn't have anything.”*

*“There's no sensation. It's like kissing through a handkerchief.”*

*“I've had 16 abortions and four of them [the pregnancies] occurred with condoms. They tore. I don't trust them. I trust myself and my partner.”*

*“I don't use condoms on principle. I don't like it.”*

The assessment in Georgia did not report on condom use, but interviews with male drug users in Georgia emphasized that while male promiscuity was condoned, female fidelity was expected. One male drug user explained: “I am a man. I may even be absolved of infidelity but I won't absolve my wife of infidelity.”

## **Poor Access to Sexual Health Services**

Barriers identified in the assessments to sexual health services included limited knowledge of sexually transmitted infections (STIs), lack of anonymity for those who could not pay medical fees and were registered as infected with sexually transmitted diseases, and discriminatory attitudes from medical practitioners. The assessment in St. Petersburg found that linkages between women's health services and other services for women drug users were weak or nonexistent: the STI clinic had established a referral mechanism to the local women's shelter, but never used it.

Although women who use drugs are a population particularly vulnerable to STIs and sexual transmission of HIV, the Ukraine assessment suggested that they had limited knowledge of the fact that infections could be asymptomatic. As one interview respondent who did not use condoms put it: “I’ve never had any venereal diseases. I would have known. I would have seen it.”

Seeking an examination or treatment for an STI from gynecologists can be difficult for all women, who are often required to purchase speculums or pay fees, and who may feel discomfort at the way in which they are treated. While this is an experience common to drug-using women and those not using drugs, respondents’ experience of stigmatization make them particularly sensitive to slights experienced in medical settings. One woman in Ukraine reported:

*“I’m afraid of gynecologists. Once, I went to a gynecologist. I didn’t like the way she behaved with me. And I won’t go back. Not to mention that the examination table was facing a window. I’m in this position, she’s looking and talking, saying, ‘yes, young woman you have this kind of milk-thrush.’ I got embarrassed. This person had a look of disgust on her face. After that, I won’t go again. In principle, nothing is bothering me, and because of this, I don’t go. Maybe, if I want to have a child I’ll go to the gynecologist and find out why I haven’t had children yet.”*

The assessment in Azerbaijan found that fear of stigma often precluded attendance or frank communication at sexual or reproductive health services: women drug users who had attended STI services reported that when they went to the clinic, they tended to hide their drug use and were more comfortable presenting themselves as sex workers.

Respondents in Ukraine and Russia who had experienced symptoms of STIs preferred to treat on their own, or noted that they feared discrimination as a result of their drug use. As one Ukrainian noted: “I have tracks in my groin, and I’ll get attitude for it.”

A woman from the Russian regions noted:

*“In a medical institution, the doors to many kinds of services will be closed to drug users. Especially the women’s health center: they don’t admit drug users. I’ve had bad experiences personally when there were gynecological problems.”*

## Unsafe Abortion

As is common in countries of the former Soviet Union more generally, a significant share of women reported a history of abortions. The assessment in Kyrgyzstan found that 40 percent of respondents reported having an abortion, a figure higher than the national average (11 percent<sup>3</sup>). In Azerbaijan, 34 percent of women reported having an abortion.

While abortions are ostensibly available for free, women receiving abortions are often asked to pay for anesthesia and other related services. Drug users often lack this money, increasing their difficulties in accessing services and negative attitudes by providers. As with STI treatment, women drug users in Ukraine and Russia reported poor treatment when seeking abortions:

*“The price was higher than usual for the abortion because the dosage of anesthesia had to be doubled. And even though I paid, their attitude toward me was very bad.” (Ukraine)*

*“They consider drug addicts inferior, like they’re animals.... I was getting an abortion at Sevryba (a Murmansk hospital). I waited for a really long time. Then they told me I had to pay for anesthesia.... Then when I was in the ward, there were two beds there and the nurse said you’re lying on this side [of the ward], don’t go to the other side. ‘Here’s a basin, whatever you touch, you wipe down.’” (Russia)*

Because women who inject opiates regularly often experience irregular menstruation, many women drug users do not detect their pregnancies for some time. The need for later term abortions and the lack of ability to pay fees drive disproportionate numbers of women drug users to seek alternate, self-administered means of terminating their pregnancies. Two women from Ukraine reported the following incidents:

*“I lived in a women’s group home for a long time and there was a practice there, among the women, of aborting pregnancies themselves... I shot up 2.5 ccs of some chemical and I intentionally lifted heavy objects, and the blood began to flow. I knew what I had to do from hearing rumors. I was in my second month of pregnancy. I sat in a little tub, the fetus came out. I took painkillers.”*

*“In 2003, I also had an abortion. It was late in the term, almost five months. My partner insisted on an abortion. I wasn’t showing and my menstrual cycle was irregular. That’s why I didn’t realize what was happening. He noticed and he said, could so much time have passed and you haven’t had your period? So we bought a test and the test showed right away. He had an uncle in Poland. We turned to an acquaintance there to do it unofficially but something went wrong [during the procedure] and she returned the money. Then I started bleeding pus and blood. I was in a bad way.”*

# Barriers to Appropriate HIV Testing and Treatment

The assessments found that women faced a series of obstacles to HIV testing and treatment. On the one hand, access to HIV testing and awareness of risk, particularly in Azerbaijan and Kyrgyzstan, was low. On the other, routine or mandatory HIV testing during pregnancy or police raids (in the case of women involved in sex work) with little or no counseling, and reports of discriminatory attitudes by providers seeking additional fees or expressing harsh judgments toward drug use, meant that those who did know their status had little information or incentives to seek treatment.

## **Improving Access**

The assessment in St. Petersburg found that the regional AIDS center has worked to improve access to HIV services for drug users in general and women in particular. Women seeking services at STI clinics, tuberculosis clinics, or drug treatment facilities were referred to the AIDS center for testing as appropriate. More importantly, the AIDS center sent doctors to the various services for on-site consultation, breaking down the traditional silos between services and diminishing the burden on patients to access multiple sites with different requirements and protocols for entry.

## Low Rates of Voluntary HIV Counseling and Testing

Respondents reported relatively low rates of voluntary HIV counseling and testing (VCT). Mandatory testing, or HIV tests performed without women's knowledge, in contrast, was high, particularly for those women deemed likely to pass infection along to others either through sex work or through pregnancy.

In Azerbaijan, 82 percent of women who participated in the assessment had never tested for HIV. Those who had not taken an HIV test reported lack of information about testing services and a belief that there was no reason to take the test: 94 percent reported that their sexual partners were HIV-negative (and the remainder did not answer this question). Respondents asserted this despite the fact that more than nine in ten (93 percent) reported that their sexual partners were drug users, and despite limited access to HIV testing generally in Azerbaijan.

Among the minority of respondents in Azerbaijan who reported that they had taken an HIV test, more than one in five (23 percent) reported they were obligated to do so. While not discussed explicitly in the assessments, women's organizations in Azerbaijan report that police conduct "medico-police" raids in which sex workers are forcibly tested for HIV and charged US\$45 as a violation fee for engaging in sex work. In December 2008, 56 women were tested in these raids without access to pre- or post-test counseling; five were found to be HIV-positive. Women who have recent HIV and STI medical certificates can avoid forced testing, and NGOs advise sex workers to test for HIV and STIs on a regular basis. Groups in Kyrgyzstan, too, report "medico-police" raids and forced HIV testing of sex workers, though it is not clear whether these practices have been halted.

In Kyrgyzstan, only 6 percent of assessment participants had accessed VCT in the past year. Those women who did access VCT reported poor to nonexistent counseling services: One quarter received no pre- or post-test counseling whatsoever. This was clearly not because of low risk for HIV: 23 percent of those who took the test said that they were HIV positive, which is considerably higher than the average among IDUs in Osh which stands at 14 percent.<sup>4</sup>

## Routine or Involuntary Testing of Pregnant Women

In Ukraine and St. Petersburg, the assessments found that most women drug users who were HIV-positive learned about their status during pregnancy. Testing during pregnancy was performed in a routine manner, women were often told the test was mandatory, and in some cases, the test was performed without the woman's knowledge. In Azerbaijan, testing of pregnant women is mandatory.

In St. Petersburg, HIV tests at the women's health clinic were routinely performed on pregnant women without their consent. Hospitals and maternity clinics simi-

larly performed HIV tests on pregnant women without informing the woman that the test was being performed. Explanations given for this practice included concerns that staff would be at risk of infection and “legal obligations” to test high-risk groups.<sup>5</sup>

Evidence from Ukraine suggests that HIV testing during pregnancy is *de facto* mandatory and does not include counseling:

*“During my gynecological appointment, they told me that I have to get tested for HIV, that it cost 86 UAH.<sup>6</sup> My gynecologist gave me the results over the telephone. There was nothing else pre-test and nothing post-test. This was a year ago.”*

*“During the gynecological appointment they said that taking an HIV test was as mandatory as the regular tests. No kind of consultation either before or after the test was made available.”*

Proper counseling is available only at specialized medical facilities—HIV/AIDS centers—which pregnant women who do not already know their status do not attend.

## **Discrimination and Gender-Specific Barriers to Access to HIV Treatment**

Drug users who test positive for HIV often face barriers to treatment access. Discriminatory attitudes, in particular, pose important obstacles for male and female drug users seeking to access ARVs. Fear of stigma associated with taking an HIV test was reported by respondents in Kyrgyzstan as a reason for not seeking VCT. Research in St. Petersburg found that the old practice of denying active IDUs antiretroviral treatment had been discontinued in favor of prescription of ARVs to those who a committee deemed to have “an adaptive and relatively normal way of life.” Many doctors, however, continue to believe that individuals actively using drugs can not be seriously interested in the state of their health or capable of absorbing health information. The assessment in St. Petersburg also found that doctors at the AIDS center treated clients poorly when clients returned to treatment after a period of absence.

Assessments in St. Petersburg and Ukraine highlighted a number of gender-specific issues impacting women drug users’ access to HIV services and the quality of the services they receive. As with drug treatment, lack of childcare facilities made women reluctant to visit AIDS centers. In St. Petersburg, some women reported they

were reluctant to access ARV treatment because they believed that ARVs would render them infertile. Further, anxiety by male partners about women drug users leaving the home impeded HIV treatment: in one case in St. Petersburg, a man refused to allow his female partner to visit the AIDS center.

# Pregnancy and Motherhood: Poor Access to Prenatal Care, Threats to Child Custody, and Obstacles to Parenting

## Poor Prenatal Care

Because regular opiate use can disrupt menstruation or alter experience of morning sickness, women who use drugs frequently do not realize they are pregnant until the pregnancy is far advanced. In addition, many drug-using women fear discrimination by health providers both because of their status as drug users and the potential that a routine test will reveal them to be HIV positive. In the words of one woman from Ukraine:

*“This is the kind of medical care we have. [Friends] told me that if you’re HIV positive, then don’t tell the doctor, because our medical system looks down on people who are HIV positive just as it does on drug addicts. That if you’re a drug addict, that’s it. You’re finished there, that’s the end of the conversation.”*

As a result, access to prenatal care is often limited to the third trimester, and some women drug users access medical services only when they go into labor. The assessments in Ukraine and Azerbaijan found that the majority of women surveyed had no access to prenatal care. In Ukraine, most of the women who had given birth first accessed medical care when they were already in labor.

Even for those women who do seek prenatal care, evidence from the assessments suggests that women encounter a variety of structural systemic impediments to accessing quality services. In Russia, primary among these impediments is a lack of substitution treatment for pregnant women, despite international guidelines recommending methadone maintenance for pregnant opiate users. Even well-meaning providers who seek to detoxify pregnant women rather than treating them with appropriate medication endanger their health and the health of their fetuses. The St. Petersburg assessment relates the story of a woman who, with the support of a psychologist, decided to go through withdrawal in her fifth month of pregnancy. When the maternity hospital refused to admit the young woman because she was only 22 weeks pregnant (regulations required 25 weeks of pregnancy to admit), the woman used personal connections to gain entry. Generally, the St. Petersburg maternity clinic refers pregnant drug-using women to detoxification services; improper detoxification during pregnancy puts the fetus at risk.

Unsurprisingly, the St. Petersburg assessment found that women drug users who attended the maternity clinic rarely gave birth to healthy babies. An employee of the maternity clinic reported:

*“The children are rarely born healthy. We immediately hospitalize such children in the newborn pathology ward where 50 percent of the children are the children of drug addicts.”*

The assessment in Kyrgyzstan documented two cases in Osh in which pregnant women accessed methadone maintenance and reported that both pregnancies were successful and that the two mothers continued to access methadone after giving birth. A more recent report from August 2008 noted that four pregnant women had received methadone, and that all had healthy babies.<sup>7</sup>

In Azerbaijan, 20 percent of women reported that doctors at maternity wards treated them badly when aware of their drug use. Common issues cited by those women who encountered difficulties with doctors in maternity wards included demands for money, and threats by doctors that they would inform acquaintances or the police about the women’s drug use.

## Implications for Prevention of Mother-to-Child Transmission (PMTCT)

While not a focus of these assessments, poor access to prenatal services has implications for measures to prevent mother-to-child transmission of HIV. Data from the European Collaborative Study shows that women in Ukraine with a history of injecting drug use have a 50 percent increased risk of not receiving any ARV prophylaxis compared with other women, that non-receipt of ARV prophylaxis is significantly higher among women diagnosed with HIV during labor or delivery than among women diagnosed earlier in their pregnancies, and that women with an IDU history are four times more likely to be diagnosed with HIV at labor or delivery than other women.<sup>8</sup>

Data from Russia similarly suggest that pregnant drug users have considerably weaker access to PMTCT than non-drug users: in Russia, the estimated percentage of HIV-positive pregnant women receiving PMTCT in 2007 was between 59 percent (low estimate) and over 95 percent (high estimate).<sup>9</sup> An assessment of female IDUs conducted in St. Petersburg, however, found that only 51 percent of pregnant women drug users received PMTCT—and it is not clear what percentage accessed treatment only during delivery. Disturbingly, the same assessment found that female IDUs' access to PMTCT in St. Petersburg has decreased since 2005—when 63 percent had access.<sup>10</sup>

Data from the region shows that MTCT rates among HIV-positive IDUs are higher than among other HIV-positive women. Ukraine data from the European Collaborative Assessment show that transmission rates are 31 percent higher among HIV-positive women who inject drugs<sup>11</sup> than non-drug-using women.<sup>12</sup>

## Threats to Child Custody

Women who use drugs face a series of challenges to retaining custody of their babies. Laws that make registration as a drug addict grounds for loss of child custody, doctors who believe drug users cannot or should not raise children, clinics that offer the babies of drug users for adoption without the mother's consent, and a lack of substitution treatment in maternity wards, which forces women out of the hospital in search of a fix after birthing, all conspire to make it difficult for drug-using women to keep their newborns.

In Russia, official registration as a “drug addict” is legal grounds for losing parental rights; the assessment in St. Petersburg found that this law is a strong deterrent to a woman accessing government drug treatment or other medical services, including prenatal services, where she risks exposure as a drug user. The assessment in Georgia also reported that registration as a “drug addict” is legal grounds for loss of custody; according to this assessment, 13 percent of respondents had lost custody of a child due to drug use. In Azerbaijan, 22 percent of women reported facing threats of losing custody of a child due to drug use (and 41 percent of assessment participants declined

to answer this question). Among those in Azerbaijan threatened with removal of their children, 23 percent reported that they “solved the problem” by paying money, and 12 percent faced actual legal action (62 percent did not report on the outcome of custody threats).

Maternity clinics in the St. Petersburg assessment reported that women drug users experienced withdrawal after giving birth, and generally left the hospital in search of heroin soon after delivering their babies; few returned. Their precipitous departure meant that they left without completing the paperwork necessary to initiate an adoption process, and most of the children were placed in orphanages. Harm reduction providers and women who use drugs, however, reported that maternity clinics discouraged drug-using women from keeping their babies, at times subjecting them to great psychological pressure to give up their babies, and offered newborns for adoption without the requisite papers from the mother. According to one woman who gave birth in a clinic:

*“When I got there, after a while, when I had come down a little bit and came to my senses the nurse went up to me and asked, ‘So are you going to take the child with you?’ It just sounded so crazy to me.”*

An employee of a harm reduction program in St. Petersburg added:

*“These girls give birth and [clinic staff] don’t give them their children. We pursue [the institutions] and they say that they’ve already promised someone this baby, they won’t arrange to give them to us. There’s a demand for very young children because there are many people who want to adopt babies. Even when the woman hasn’t signed a release.”*

## Obstacles to Parenting

Evidence from the Russian regional assessment suggests that women drug users continue to face threats to child custody once they do succeed in bringing their babies home, and that they have little or no support from the social service bureaus charged with supporting them. Women drug users in Russia made the following statements:

*“Those social services people—they go around and just ruin your life, they’re not capable of doing anything but complicating matters. They can’t actually help, they can only cause all kinds of problems: termination of parental custody, you’re like this, you’re like that...I ask them, ‘Can you actually help me?’ they say, ‘No, we can only file documents for them to be taken away.’ If I wanted to give my children to the government, I would do it myself. Aren’t there enough orphans in this country? Are my children hungry or barefoot? They start pulling in the police...Only trouble from those people. They’re just a headache, it’s hard enough without them. They don’t answer to the needs of women drug users. They only make life difficult.”*

*“In principle, the services are accessible, but will they deal with these issues? And deal with them right? Or will it come out all wrong? Let’s say you go there and somehow they find out that the mother is registered as a drug user. Then they can, if there are kids, take them out of her custody. Everything will be turned around on her—against what she’d wanted in coming there. Otherwise, the services are accessible. Accessible on paper—in action, probably not, because knowing how they’ll be treated, nobody is likely to go there.”*

In St. Petersburg, the assessment also found that the medical staff of polyclinics wrote the mother’s status as a drug addict on the child’s medical record, even when the child was completely healthy.

In Kyrgyzstan, the assessment found that only 14 percent of respondents with children aged one-to-three years old were caring for their children themselves. Most left their children in the care of relatives or gave them up to government services. Reasons given for relinquishing care of children were: “I was in prison, and when I injected I did not pay attention to the children;” “I have to earn money to live;” “At first we lived together but when I started to inject, my parents took them;” and “I cannot raise a child in a normal way.” None of the Kyrgyzstan assessment participants had custody of their children legally removed.

The Kyrgyz assessment also found evidence that a mother’s drug use can adversely impact children’s access to education: nine percent of school-age children of drug-using women did not attend school. Reasons included lack of funds (11 percent), illness (7 percent), and discrimination (13 percent), such as kindergartens and schools refusing to admit a child due to the mother’s drug use.



## Incarceration

In 2008, at the time of the assessments, Kyrgyzstan was the only country surveyed where needle and syringe exchange or methadone was available in prison, but these programs did not operate in prisons for women. Some 45 percent of respondents had been imprisoned at some point in their lives, the majority in connection with drug use. The need for gender-sensitive services geared toward facilitating the transition to freedom became particularly evident in 2008, when changes to Kyrgyz drug law reduced penalties for minor drug possession to an administrative rather than criminal infraction. Because the change was retroactive, large numbers of women were released: according to a source at the Ministry of Justice interviewed by researchers, the population of women's prison No. 2 decreased from 500 inmates in 2007 to 265 in 2008. Most NGO-supported housing options for released prisoners in Kyrgyzstan allow people to stay for one month; obtaining more permanent housing requires certain documents, and many former inmates do not have the proper documents. The average time required to obtain these documents is six months. This leaves released inmates facing several months without a place to live, a situation that is especially challenging for women caring for children. One woman explained:

*“I was released with my small child. I myself am from Kochkor-Aty in Jalal-Abad oblast, and I lived there with my husband. While I was in prison, he sold the house and went off somewhere. I don’t have my parents, and had nowhere to go. They wanted to put my child in a state home until I found work, a place to live, got my documents in order. But I heard that it is difficult to get a child back once you give it up. Now I am afraid to give him up, and I don’t know where to go.”*

# Health Insurance and Medical Costs

Obtaining the documentation necessary to get medical insurance, paying for services in the absence of medical insurance, and surcharges levied by medical professionals all pose barriers to all those seeking health care in the countries surveyed. Attendance at public medical services in post-Soviet countries involves a formal registration process that requires clients to produce a passport, residential registration papers (*propiska*), and proof of health insurance. Producing these documents can be challenging for drug users due to loss of identity papers in the process of arrest or incarceration, or inability to obtain residential registration papers due to migration—especially common in Central Asia and the Caucasus where migrant labor is a key component of economic survival. In parts of Central Asia, “wife stealing”—a process by which a man steals a young woman from her village to be his bride—can make it difficult for young wives to obtain the documents necessary to obtain medical insurance. Further, women drug users surveyed reported that these obstacles restricted access to reproductive health services as well as other types of medical services. While not gender-specific, barriers to health care thus carry particular implications for women drug users.

Some post-Soviet countries have established a system to support access to health insurance for people who are unemployed, but the evidence suggests that few women drug users access this system. In Russia, the mechanism for obtaining health insurance outside the workplace varies by region, but generally requires unemployed individuals

to apply at their regional or district social services office. The assessment in the Russian regions found that few women drug users were aware of this service and those who did know about the services were reluctant to attend, citing bureaucratic procedures, long lines, and discriminatory attitudes as principal barriers to access. In Kyrgyzstan, researchers found that drug users had difficulty obtaining health insurance because they did not have residential registration papers or passports, and that some doctors believed that drug users should pay more for health services than they spent on drugs. In addition, some social services offices inform the police when a drug user accesses their services.

Evidence from the Russian regions shows that the demand for access to free medical services is widespread among women who use drugs: 66 percent of women surveyed in the Russian regional assessment reported a need for free medical services; this was especially the case for those who were HIV positive, of whom 73 percent expressed a need for access to free medical care. Lack of health insurance posed a significant obstacle to obtaining service. Two young women in the Russian regions explained:

*“Yes, it’s happened to me. The paramedics refuse, if they see you’re a drug addict, they don’t want to treat you, they don’t even want to examine you. At the dentist’s, too, I didn’t have insurance and they refused to treat me, they didn’t want to see me. There have been many times, it happens a lot. If you don’t have insurance—I’m sorry, but no treatment.”*

*“A couple times my insurance policy was expired and they wouldn’t treat me under any circumstances.”*

For those who do have health insurance, surcharges for services render access difficult or impossible for many women who use drugs. One woman said:

*“The gynecologist himself is accessible, but an extensive examination costs money. They look at you, but the examination costs money. If you get a yeast infection and you don’t have money, you have to live with it.”*

In other cases, health insurance will cover the cost of an examination, but clinics require payment for attendant aspects of the examination. In St. Petersburg, for example, women attending STI clinics and women's health services must pay for the gynecological kit, including the speculum, and all polyclinics in St. Petersburg require payment for shoe covers.

Even when doctors do not levy formal surcharges and clinics do not require extra payments, women drug users report that accessing quality care, notably care that respects doctor-patient confidentiality, costs. A woman in Russia said:

*“I think that if you have a passport and registration, then treatment is basically accessible. But if you want confidentiality, then that costs money. If you pay, you don't need any kind of documents. If you have the money to pay for it, it's accessible. If you don't have the money, then everyone will know what's wrong with you and there will be no way to remain anonymous.”*

In some cases, accessing care, regardless of quality, requires payment, even when clients do have medical insurance. According to one woman:

*“Accessibility is, again, a matter of money. Everything is based on cost. I don't know of a facility here where you can get examined for venereal diseases for free.”*

This problem similarly impacts women drug users in Azerbaijan where 26 percent of women surveyed reported that the doctors at STI clinics asked for “a lot of money.” In Kyrgyzstan, 21 percent of assessment participants indicated that they had not attended medical services in the past year, and 82 percent of those said they did not see the doctor due to lack of money. In Ukraine, only pregnant women can access STI services free of charge; most local clinics refer women who are not pregnant to specialized laboratories for STI tests, where high fees place these services beyond the reach of most women drug users.



# Domestic Violence, Police Abuse, and Lack of Legal Recourse

## Domestic Violence

Evidence from the assessments in Azerbaijan, Kyrgyzstan, and Russia suggests that women who use drugs experience high levels of domestic violence and are unlikely to report incidents to the police or to access medical or legal services after they have been beaten or raped. Women drug users attribute their reluctance to access medical services to the practice—documented in the assessments in Azerbaijan and St. Petersburg—by which medical staff inform the police in cases where they suspect a woman has experienced domestic violence.<sup>13</sup> Many women drug users have also experienced violence and forced sex at the hands of police officers, and believe the law enforcement and legal systems to be corrupt and ineffective.

The assessment in Azerbaijan found that 76 percent of women drug users experienced violence from family members, mostly from husbands and fathers. Women in the Azerbaijan assessment who worked and brought money home were especially likely to have experienced domestic violence. In the Kyrgyzstan assessment, 38 percent of respondents indicated that they had experienced physical and/or sexual violence. The women reported battery and rape from partners, acquaintances, and from clients during sex work.<sup>14</sup> One woman drug user who did sex work explained: “On the street, I was hit on the head with a bottle, beaten, raped.”

Women drug users are unlikely to report domestic violence to the police. In Azerbaijan, 85 percent of those who had experienced violence did not file a police report; the most common reasons given for not reporting to the police were that the police would blame the women themselves for the violence and that the police would demand a bribe.

Women drug users were unlikely to attend medical services in the event of violence: less than 10 percent of those who experienced domestic violence in the Azerbaijan assessment sought medical care after being beaten. In part, this is due to the requirement that medical facilities report domestic violence cases to the police who then formally register the incident. Evidence from the St. Petersburg assessment suggests that hospitals in Russia also inform the police in cases of domestic violence. The hospital at which the St. Petersburg assessment was carried out routinely calls the police in cases where hospital staff suspects a woman may have experienced domestic violence.

Evidence from the Russian regional assessment suggests that crisis centers do not meet the needs of women experiencing domestic violence. A report from a Penza newspaper in December 2007 reproduced in the Russian regional assessment, describes the situation:

*“For a long time, I’ve been hearing about the women’s crisis center in our city. The directory assistance operator doesn’t know about it—but fine, I have the number at home and my friends read in the paper about a trust hotline I could call. I called and they gave me the crisis center number. And only then did I find out that if I don’t feel well, my husband is beating me or I want to kill myself, it should all happen before 5p.m. After 5, they won’t admit me to the center or even listen to me on the phone—it’s the end of the workday. If I get lucky and call them during business hours, then perhaps I will be admitted, but I have to have a passport.”*

## Police Abuse

Police violence is a problem for all drug users, but the assessments from Georgia, Kyrgyzstan, and Azerbaijan show that women are likely to experience sexual abuse by police and suggest that police may treat women drug users more harshly than they treat men who use drugs. Evidence from Russia and Azerbaijan suggests that police abuse deters women from seeking help from police when they experience violence at the hands of clients in the course of sex work. Evidence from the St. Petersburg assessment

suggests that fear of police abuse also contributes to women’s unwillingness to attend harm reduction services.

In Georgia, 13 percent of female assessment respondents had been propositioned for sex by police officers during arrest. Respondents also reported that police “treat women more cruelly than men users,” and were “stricter” with women drug users than with men. Women in Kyrgyzstan reported high rates of police violence: 40 percent of assessment participants had experienced violence at the hands of police officers; these women reported that they “addressed their problems” with the police by paying money, providing information, and providing sexual services. Violence was most likely to occur when the women could not pay or resisted providing sex for free. Describing their interactions with the police during arrest, women in Kyrgyzstan said, “They tried to use my services for free;” and “They said, that if I don’t work for them, I could not work on the street.” In Azerbaijan 15 percent of assessment participants reported they had been beaten by the police and 7 percent reported rape or coerced sex with police officers.

In the Russian regions, women drug users who did sex work reported an inability to report abuse to the police. According to two sex workers:

*“There are bad clients, naturally. Even if the clients are bad, you can’t report them, no one wants to get involved in that. Even the police—since I’m a prostitute, the customer is always right. No one would help me in any case, even if I’m right.”*

*“A client reported me and they took me down to the station. I wanted to write a report on him, that he had kept me in his apartment by force, didn’t let me out, and forced me to perform sexual acts. They just laughed in my face. They said that coming from someone in your line of work, we won’t even accept that report. And that was that.”*

Fear of arrest and police abuse posed serious barriers for some women drug users in St. Petersburg who reported they would not attend mobile harm reduction services because they feared arrest. The St. Petersburg assessment found the effects of police abuse were lasting:

*“It turned out that such a thing happened to them in 1998. This case illustrates how easily punitive measures from police can destroy the trust in a service provider. Ten years have gone by, but the client is still afraid of returning to the service.”*

## **Lack of Knowledge about Rights and Poor Access to Legal Services**

Women in Kyrgyzstan, Azerbaijan, Russia, and Ukraine have low levels of awareness about their legal rights, little faith in the legal system, and poor access to legal aid and the social services that provide legal advice. Although women expressed a need for legal support, most felt the system was corrupt, ineffectual, or overly expensive. As a result, women who use drugs were vulnerable to violations of their rights and unable to access services to which they had a right. This is not particular to women drug users, though difficulties in obtaining legal support may be particularly acute for those who are less likely than men to leave home to access services generally.

The assessment in Kyrgyzstan found that most women were unaware of their legal rights and 82 percent did not know it was possible to obtain free legal aid. Only five percent of assessment participants in Kyrgyzstan had accessed free legal support. Women in Azerbaijan reported low knowledge of their legal rights and did not know that personal use of narcotics is not a criminal offense according to Azerbaijani law. Most had little faith in the legal system: 45 percent reported that the legal system was corrupt, 12 percent reported that the legal system did not fulfill its obligations, and 22 percent reported that the police violated the law. Most believed they could not access legal recourse and preferred to solve problems with the law by paying bribes.

Nearly two-thirds (60 percent) of women respondents in the Russian regions expressed a need for free legal consultations, but very few actually accessed these services. Nearly one third of those who did attend services encountered negative attitudes and demands for extra payment. Two women said:

*“I had to go in for legal assistance. Nothing. I went to the justice of the peace with a case against the building management administration and, in the end, they wanted me to pay a lawyer 1,000 rubles to write a complaint. I didn’t have the money and didn’t file anything. I didn’t get to go to court.”*

*“I had to go in because of a criminal case. The services were accessible and free. But without money, they won’t say anything useful. The lawyer wouldn’t even go with me to the interrogation until I paid her.”*

The assessment in Ukraine found that the majority of women drug users could not access social services when they required legal aid, and did not know what these services were or how to access them. One woman said:

*“I didn’t turn to the social services centers. I didn’t have much information, I don’t even know what they do and how they could help me.”*

Poor access to social services and legal aid leaves women who use drugs without the services to which they are entitled. The following quote from a woman with HIV, published in a Penza newspaper and included in the Russian regional assessment, offers an illustration of the problem:

*“From December 14th to the 21st of 2007, I was in the hospital, in the infectious disease unit. I was put in a division exclusively with other HIV-positive women. There were three of us. One of the women, Maria [Masha], was seriously ill and had been in the division since November 3rd. Her diagnosis was ‘third stage HIV infection with cirrhosis of the liver with portal hypertension, liver decompensation. Hepatic failure. Abdominal swelling.’ Her mother was taking care of her. I could clearly see that Masha was in a bad state. But the saddest and scariest part was that Masha has the right to receive disability payments that no one will give her because she doesn’t have a passport or registration.”*



# Recommendations

Certain recommendations, while not gender-specific, are critical to improving access to HIV prevention and treatment for women drug users as well as for men who use drugs:

- ▶ Eliminate registration requirement for drug users seeking treatment.
- ▶ Implement evidence-based drug dependence treatment, including methadone and buprenorphine prescription.
- ▶ Include discussion of sexual risk, condom provision, and safer sex counseling in all harm reduction, drug treatment, HIV, and STI services.

In addition, a number of concrete steps by service providers and policymakers can sharply increase access to and effectiveness of services for women who use drugs.

## To Providers of Needle Exchange and Outreach Services

- ▶ **Ensure childcare and other services attractive for mothers.** In each assessment reviewed here, women reported that lack of childcare made it difficult to access HIV services and drug dependence treatment. Childcare at harm reduction services would also improve attendance and adherence, as would child-friendly goods and services such as baby food, diapers, and parenting classes.

- ▶ **Create support groups and other opportunities for women drug users to learn from and help each other.** With many women entering into drug use in the context of their sexual relationships and less likely than men to go to harm reduction centers, women drug users have relatively limited opportunities to build supportive networks.
- ▶ **Offer couples' services.** Specific services for couples can provide incentives for women to make contact with a harm reduction service provider.
- ▶ **Offer safer injection instruction for women.** Given that men frequently buy and administer drugs and secure injection equipment, special efforts to ensure that women have the information and means to protect themselves from HIV, abscesses, and overdose, are needed.
- ▶ **Include condoms and education about sexually transmitted infections, pregnancy testing, prenatal treatment, and prevention of mother-to-child transmission** in work with women and men.
- ▶ **Offer ongoing training to improve provider and NGO capacity to address needs of women drug users.** At the time of publication, WHO Euro and the Eurasian Harm Reduction Network were in the process of developing an online training course on women drug users in Russian and English.
- ▶ **Document the difficulties caused by lack of integrated services, and advocate with national officials, government medical institutions, and regional and local authorities** to improve coherence and accessibility of services for women who use drugs.

## To Providers of Drug Dependence Treatment

- ▶ **Relax restrictions on women's access to treatment.** Ensure that drug treatment centers have separate spaces and beds for women, create treatment that allows women to bring children, and remove prohibitions on treating women who have experienced domestic violence, women who are homeless, and women whose sexual partners are still using drugs.
- ▶ **Offer drug treatment for couples and family members to improve treatment attendance and adherence.** Anxiety about leaving a male partner, or concerns by male partners about separation, pose a major barrier to service access for women drug users.
- ▶ **Offer or establish strong linkages to HIV treatment and reproductive health services,** including voluntary counseling and testing for HIV and STIs, and gynecological and prenatal care.

- ▶ **Ensure access to methadone treatment for pregnant women and in maternity wards.** Failure to provide this effective and safe medicine forces women to avoid prenatal care or leave children behind in maternity wards, and exposes women and their fetuses to risks associated with withdrawal during pregnancy.
- ▶ **Provide or enable provision of methadone or buprenorphine in tuberculosis clinics and AIDS centers.** Integrated treatment reduces barriers, improves adherence to complicated medical regimens, and can improve patient and provider satisfaction.

### To Providers of HIV, STI, and Reproductive Testing, Treatment, and Care

- ▶ **Improve provision of reproductive health services, and referrals between drug treatment, HIV, and sexual health services.** Late detection of pregnancy and lack of prenatal care are major obstacles to the health of women drug users. Integrated gynecological services, safe abortion, maternity services, and testing and treatment for HIV and sexually transmitted infections are all required.
- ▶ **Train providers on how to work with active drug users, including methods to increase patient comfort, communication, and treatment adherence.** With proper supports, active drug users can achieve the same clinical benefits from HIV treatment, for example, as other patients.
- ▶ **Establish linkages with domestic violence and crisis centers,** and ensure that they are trained on work with active drug users. Protection from domestic abuse may be among the most critical health needs of women drug users.
- ▶ **End mandatory laboratory confirmation of and inpatient treatment for sexually transmitted infections.** Anonymous, syndromic treatment is important to sex workers and drug users who fear drug user registration, police action, and stigma.
- ▶ **Offer anonymous STI treatment, and ensure confidentiality of all medical information,** including drug use history, HIV status, or history of STIs and hepatitis.

### To Local and National Health, Justice, and Law Enforcement Authorities

- ▶ **Eliminate registration as a drug user as grounds for loss of child custody.** Mothers should be gauged on fitness to parent, not on a history of past illegal drug use.
- ▶ **End mandatory notification of police in domestic violence incidents, and strengthen supportive services for victims of violence.** Requirements that all cases

of domestic violence be reported to police discourages women drug users from seeking medical attention. Instead, hospitals should support women in finding refuge from abusive partners.

- ▶ **Guarantee that women are not tested for HIV without their knowledge or consent, and ensure that testing is voluntary and confidential,** and accompanied by accurate information on PMTCT, sterile injection, and referrals to appropriate services.
- ▶ **Issue instructions to police officers on appropriate conduct with sex workers and drug users, and enforce their observance.** Kyrgyzstan issued such an instruction to police officers in 2009—given the high levels of police abuse reported by all respondents, this is a high priority in all countries surveyed.
- ▶ **Train social service bureaus, legal aid providers, and medical personnel on the needs of drug users and non-discriminatory practices.** Building the capacity of social service bureaus to address the needs of women who use drugs, and improving responsiveness of legal aid services, will help protect women from domestic and police violence, strengthen families, and facilitate access to medical insurance and disability benefits.
- ▶ **Remove restrictions at domestic violence shelters that forbid shelter for active drug users.** Training for domestic violence workers on how to work appropriately with drug users is needed.

# Notes

1. This is the percentage of women who formally declared themselves sex workers. The Kyrgyzstan assessment did not ask women if they exchanged sex for money or drugs in an informal manner. As the results from Azerbaijan suggest, the numbers of women exchanging sex for money or drugs tend to be considerably higher than the numbers for women who consider themselves to be sex workers.

2. In the Azerbaijan assessment (n=150), 119 participants (79 percent) responded to the question as to the nature of their occupation. Out of these 119, 92 women (61 percent of the total group) considered themselves to be sex workers. Additionally, the assessment found that 12 women (10 percent) out of those reporting on their occupation worked at beauty salons, and also that beauty salons were unofficial sex work venues. If all the women who reported working at beauty salons were also unofficial sex workers, then 69 percent of the total number of assessment participants reported engaging in some form of sex work.

3. <http://www.johnstonsarchive.net/policy/abortion/ab-kyrgyzstan.html>. Accessed 18 June 2009.

4. Kazakhstan CDC. 2006. *Epidemiya VICH v Tsentral'noy Azii, Baurzhan Zhusupov*. Power-Point presentation. On file with Katya Burns.

5. The assessment in St. Petersburg found that mandatory HIV testing is routinely practiced at hospitals with both men and women who use drugs if they are admitted for emergency services. Those who test positive are segregated in a separate ward that is “thoroughly cleaned” after the patient is released. A hospital worker explained that: “Even though by general municipal decree, it [the HIV test] is only to be performed with the patient’s consent, we prioritize the safety of our staff. Secondly, such carriers of the virus need to be identified one way or another. Everyone who is admitted is required to give a blood sample to be tested for HIV, all forms of hepatitis, and syphilis.”

6. 86 Ukrainian Hryvnia (UAH) is approximately US\$11.
7. See Burkhanov, S. *Methadone Substitution Therapy in the City of Osh, Kyrgyz Republic*. International Conference on AIDS. Mexico City, 2008. Available at [http://www.pgaf.org/news/pangaea\\_satellites\\_mexicocity](http://www.pgaf.org/news/pangaea_satellites_mexicocity). Accessed on 19 June 2009.
8. See 1) Malyuta, Ruslan and Claire Thorne. *Eastern Europe and Central Asia: IDU, HIV and PMTCT in the Context of Drug Use*, Presentation at the XVII International AIDS Conference, Mexico City, August 3, 2008. [http://www.pgaf.org/files/site2/asset/Malyuta\\_ENG.pdf](http://www.pgaf.org/files/site2/asset/Malyuta_ENG.pdf); 2) Burns, Katya. *Opioid Substitution Therapy for Pregnant Drug-Users: A Critical Component to Supporting Maternal, Newborn and Child Health*. UNICEF CEE/CIS 2009.
9. UNICEF. 2008. *Children and AIDS: Third Stocktaking Report*.
10. Kissin et al. 2008. Abstracts, 2nd EE/CA AIDS conference, Moscow.
11. This data adjusted for ARV prophylaxis, mode of delivery and prematurity. Unadjusted data show an even greater disparity at 80 percent.
12. Malyuta and Thorne. 2008.
13. The assessments from Azerbaijan, Kyrgyzstan, and Russia do not compare levels of domestic violence among women who use drugs and those who do not, and it is therefore not possible to conclude that women who use drugs experience higher levels of domestic violence. However, the assessments presented here do provide evidence that women who use drugs are particularly reluctant to interact with police officers. Thus, the practice of hospitals to inform police in domestic violence cases, while it likely constitutes a deterrent to all women, carries additional implications for women who use drugs; many women drug users have experienced violence at the hands of police officers, and also fear identification as a drug user by law enforcement agencies. For a discussion of women drug users' access to legal services, see the section on legal services.
14. Data on violence against women in Kyrgyzstan did not differentiate domestic violence from violence from clients in the course of sex work. For this reason, the figure cited, 38 percent, includes both domestic and sex work-related violence.



Women who use drugs are more vulnerable to HIV infection than male drug users. They share injection equipment and are often “second on the needle.” Engagement in sex work and low levels of condom use add to their risk of infection. At the same time, women face greater obstacles to accessing the services they need to protect their health. This report examines women’s access to harm reduction, reproductive health, and HIV and AIDS services in five countries: Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine.

