Commentary on McFall et al. (2017): The need for harm reduction interventions that are effective for women who use drugs

Women injectors are more likely than male injectors to acquire HIV, with a double vulnerability stemming from sexual and injection-related transmission, and they are less likely to access harm reduction and mainstream services. There is a need for tailored harm reduction services that are attractive and effective for women.

There are significant differences in the epidemiology of HIV and other blood-borne viruses between men and women who inject drugs. In their recent paper, McFall et al. [1] report that women who inject opioids in Northeast India have a higher HIV prevalence (53 versus 17%) and a lower hepatitis C virus (HCV) prevalence (22 versus 32%) compared to their male counterparts, indicating critical differences in the risks experienced by men and women injectors. This is not a newly discovered phenomenon. Women injectors are a particularly vulnerable and isolated subpopulation, typically carrying a higher risk of HIV infection, with a double vulnerability stemming from transmission pathways through both unsafe injecting and unprotected sex [2,3]. This dynamic is underscored by a number of important contextual factors. For example, women injectors are more likely than men to have sex partners who are also injectors [4], not only creating complications when trying to cease injecting, but also placing them at a higher risk of sexual transmission of HIV due to unsafe sexual practices with injecting partners [5]. Women injectors are often injected by their partners or are ‘last on the needle’ in a group, and tend to be more likely to be assisted while injecting, also increasing their risk of infection [2]. A proportion of women injectors engage in paid sex work and many more engage in other forms of transactional sex, where negotiation around condoms can be challenging, again increasing the exposure to HIV infection [and sexually transmitted infections (STIs)] [6].

Furthermore, women injectors have a range of specific health and social needs that require holistic services that are not a regular feature of standard harm reduction packages. For example, women injectors, particularly those with partners who also inject, are at a high risk of intimate partner violence, which is implicated in a loss of control over safe injecting and sexual practices and is correlated with an increased risk of HIV infection [7].

Women injectors also have a range of service needs around sexual and reproductive health, prevention of mother-to-child transmission and parenting and family preservation [8,9]. However, several studies have highlighted a suboptimal use of harm reduction services and have documented that women injectors can be extremely reluctant to access mainstream services due to stigma, discrimination and a fear of child removal for those who are mothers [8,9]. For example, a survey in Dhaka, Bangladesh found that, despite a high level of need, only a low proportion of women injectors were accessing sexual health testing and harm reduction services [10]. More than 50% of women injectors surveyed tested positive for syphilis and a high percentage had STI symptoms, but only 23% had ever received STI treatment and only 19% had ever had an HIV test. They were also roughly twice as likely to have been in police lock-up (63%) than having attended a needle exchange programme (36%).

Despite all this, many harm reduction services do not respond adequately to the specific needs of women who use drugs, providing only a generic package of needles/syringes, condoms and gender-neutral information, often in a male-dominated environment [11,12]. Nonetheless, there are some known components that may be learned from some positive examples in countries such as Ukraine [13] and Bangladesh [10]. At a minimum, gender-sensitive harm reduction packages could add supplies such as female-specific information materials and pregnancy tests and could have female staff members. Going further, new services that are highly relevant for women injectors could be integrated within harm reduction programmes; for example, partner counselling, addressing intimate partner violence and women’s legal rights, pre-exposure prophylaxis, mobile needle and syringe programmes (NSPs) specifically for women injectors, reproductive and sexual health services and family planning, parenthood and family preservation services. In places such as Northeast India, where women injectors are common, stand-alone facilities for women could be developed in a women-friendly format. Interventions based on social networks, peer-leadership and community mobilization should also be explored, but at present these effective interventions rarely incorporate a specific focus on women injectors.
Strategies to reach, attract and cater holistically to women injectors are needed. It is important that women injectors should be involved intimately in design and implementation, and greater research is needed to demonstrate the efficacy of such services.

Declaration of interests
None.

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References