

Chapter I.

Women and drugs

1. There is growing awareness of the importance of appropriately incorporating a gender perspective into drug-related policies and programmes. The Political Declarations of 1998³ and 2009⁴ incorporate gender considerations, and both the General Assembly⁵ and the Commission on Narcotic Drugs⁶ have given increasing attention to this aspect over the past 10 years. In addition, the General Assembly, in its resolution on the 2030 Agenda for Sustainable Development,⁷ underlined the critical importance of gender equality and the empowerment of women. In the outcome document of the thirtieth special session of the General Assembly, entitled “Our joint commitment to effectively addressing and countering the world drug problem”,⁸ Member States are encouraged to address the specific needs of women in the context of drug policy. The Commission on Narcotic Drugs, the main policymaking body of the United Nations system for drug-related matters, has adopted a number of resolutions with regard to the situation of women as it relates to the world drug problem. To contribute to the advancement of gender-sensitive policies to address this issue, the Commission has highlighted the specific needs of women, most recently at its fifty-ninth session, held in March 2016, when it adopted its resolution 59/5, entitled

³Political Declaration adopted by the General Assembly at its twentieth special session, devoted to countering the world drug problem together (General Assembly resolution S-20/2, annex).

⁴Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem (see *Official Records of the Economic and Social Council, 2009, Supplement No. 8 (E/2009/28)*, chap. I, sect. C).

⁵General Assembly resolutions 58/138, 61/143, 63/241 and 70/182.

⁶Commission on Narcotic Drugs resolutions 52/1, 55/5 and 59/5.

⁷General Assembly resolution 70/1.

⁸General Assembly resolution S-30/1, annex.

“Mainstreaming a gender perspective in drug-related policies and programmes”.

2. Recognizing the importance of gender-responsiveness, the International Narcotics Control Board (INCB) has devoted the first chapter of the present annual report to the topic of women and drugs. However, owing to the multifaceted nature of this subject, it cannot be dealt with in an exhaustive manner in only one chapter. Moreover, data on women drug users are sparse, further complicating analysis. For those reasons, the present chapter is limited to some salient aspects: drug-related harms, special populations, prevention and treatment, and rehabilitation for drug dependence.

3. Drug-dependent women may face many difficulties: they can experience high levels of stigmatization; they can be ostracized by their family or community; they may be subjected to violence from partners or family members; and they may turn to, or be coerced into, sex work to support their drug use or that of their partner. In addition, they lack access to gender-sensitive treatment for drug dependence. The limited data available at the global level show that women drug users are increasing in number among youth and prison populations. Few countries provide adequate levels of drug-dependency treatment to women, and virtually all countries need to expand gender-sensitive treatment if they are to achieve the highest attainable standard of health for women.

4. Criminal justice data indicate that an increasing number of women are arrested for drug-related crimes. The incarceration of women involved in drug-related offences may have a catastrophic effect on their children, particularly if they are the primary caregivers. Additionally,

female prisoners have very high levels of drug dependence but rarely have access to treatment and rehabilitation services.

A. Prevalence and patterns of drug abuse

5. Women and girls comprise one third of people who use drugs globally. In 2010, the global estimated number of women dependent on amphetamines was 6.3 million; women dependent on opioids numbered 4.7 million; and women dependent on cocaine numbered 2.1 million. Women had a high prevalence of amphetamine dependence (0.31 per cent) in South-East Asia and Oceania, of opioid dependence (0.25 per cent) in Oceania, and of cocaine dependence (0.22 per cent) in North America and Latin America. Also in 2010, an estimated 3.8 million women injected drugs globally, corresponding to 0.11 per cent of the world female population.⁹ Drug-use patterns among women reflect differences in opportunities to use drugs, which are a result of the influence of their social or cultural environment.

6. Generally, women start using drugs later than men do, and their use is strongly influenced by partners who also use drugs. However, once women start abusing drugs, their rate of consumption of cannabis, opioids and cocaine progresses more rapidly than among men, and they tend to develop a substance use disorder more quickly than men do. In the case of methamphetamines, women begin using them at an earlier age than men, and they are more likely to have a methamphetamine use disorder than men. Compared with men, women who use heroin are younger, likely to use smaller amounts and for a shorter time, are less likely to inject the drug and are more likely to be influenced by drug-using sexual partners. Often, someone else, typically their partner, will administer a woman's first injection of drugs.

7. Women in high-income countries have a higher level of drug use than women in low- and middle-income countries. In terms of abuse of all drugs, the gap between women and men is narrower among the youth population than among the adult population. Women also constitute a large proportion of those abusing prescription

drugs. The Pompidou Group of the Council of Europe reported that the use of prescription drugs by women increases according to age group, peaking among women in their thirties. Although data are limited, both Germany and Serbia reported that fatal overdoses owing to prescription drug abuse were more common among women than among men.¹⁰ Studies show that women are more likely to use prescription drugs, such as narcotic analgesics and tranquillizers (e.g., benzodiazepines), for non-medical purposes.¹¹ This is compounded by the greater vulnerability of women to depression, anxiety, trauma and victimization compared with men. Women report using drugs to cope with stressful situations in their lives, and there is evidence that women are significantly more likely than men to be prescribed narcotics and anti-anxiety medications.¹²

8. The prevalence of illicit drug use, drug abuse by injection and drug dependence is consistently higher among women who have sex with women. Among transgender women, drug abuse, including by injection, is also common, ranging from approximately 30 per cent in the United States of America, to 42 per cent in Australia and up to 50 per cent in Portugal and Spain. However, a study carried out in 2004 in Pakistan found that fewer than 2 per cent of transgender women had injected drugs in the previous year.¹³

B. Initiation into, reasons for and circumstances of drug abuse

9. Both drug abuse and drug abuse by injection typically begin in adolescence and early adulthood. Particularly vulnerable young people, such as those who are homeless, may begin injecting in their early teenage years. Women, like men, take drugs for a variety of reasons, including experimentation, peer pressure, to escape or to

¹⁰Marilyn Clark, *The Gender dimension of non-medical use of prescription drugs* (Strasbourg, Council of Europe, 2015).

¹¹L. Simoni-Wastila, G. Ritter and G. Strickler, "Gender and other factors associated with the nonmedical use of abusable prescription drugs", *Substance Use and Misuse*, vol. 39, No. 1 (2004), pp. 1-23; 2007 *ESPAD Report: Substance Use Among Students in 35 European Countries* (Stockholm, Swedish Council for Information on Alcohol and Other Drugs, 2009).

¹²UNODC, *The Non-Medical Use of Prescription Drugs: Policy Direction Issues* (Vienna, 2011).

¹³Sarah Larney and others, "Global epidemiology of HIV among women and girls who use or inject drugs: current knowledge and limitations of existing data", *Journal of Acquired Immune Deficiency Syndromes*, vol. 69, supp. 2 (June 2015).

⁹Harvey A. Whiteford and others, "Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010", *The Lancet*, vol. 382, No. 9904 (2013), pp. 1575-1586.

relax. Factors such as personality or environment can lead to a woman progressing from drug abuse to drug abuse by injection. Additional factors may include being subject to physical or sexual abuse during childhood, involvement in sex work and socializing with persons who abuse drugs by injection.

10. Some women report using substances to relieve stress or negative emotions or to cope with divorce, loss of child custody or the death of a relative. Women with substance use disorders have often experienced a difficult upbringing and conflict within the family, as well as having had to prematurely take on adult responsibilities. They often have a family member who is drug-dependent, and many women identify relationship problems as a factor leading to substance use. Additionally, mood and anxiety disorders often predate the onset of substance abuse problems. Other reasons given by women for abusing drugs are to aid with dieting, to counter exhaustion, to relieve pain, and as self-medication for mental health problems.

1. Biological factors

11. Dependence on drugs is determined by a combination of biological, environmental, behavioural and social factors. Factors increasing the risk of dependence include being male, having a novelty- and sensation-seeking temperament, early defiant behaviour and conduct disorders, poor school performance and inadequate sleep. Women may face unique issues when it comes to substance use, in part related to biological factors.

12. Dependence develops when a person's neurons adapt to repeated drug exposure and only function normally in the presence of the drug. Genetic variability can determine to a large extent an individual's risk of dependence. Therefore, understanding the role of genetic factors may assist in the treatment of drug dependence. It is thought that genetic factors account for between 40 and 60 per cent of a person's vulnerability to addiction. Studies of twins have revealed that the likelihood of heritability of addictive disorders, on a scale from 0 to 1, ranges from 0.39 for hallucinogens to 0.72 for cocaine.¹⁴ A meta-analysis of studies of twins conducted by Verweij and others (2010) estimated that, among females, 59 per cent of problematic cannabis use could be attributed to shared genes, while among male twins, just 51 per cent was attributed to shared genes.

¹⁴Laura Bevilacqua and David Goldman, "Genes and addictions", *Clinical Pharmacology and Therapeutics*, vol. 85, No. 4 (2009).

13. Women may face unique issues when it comes to substance use, in part influenced by differences based on biology and distinctions related to gender norms. Research has determined that women's experience of drugs and the ability to recover from drug use can be impacted by hormones, the menstrual cycle, fertility, pregnancy, breast-feeding and menopause. In human studies, the follicular phase of the menstrual cycle, in which estradiol levels are high and progesterone low, is associated with the greatest responsivity to stimulants. A study investigating response to cocaine administration found that women in the luteal phase reported lower ratings of feeling high than women in the follicular phase or men.¹⁵ Research has also found different effects of monoamine oxidase A (MAO-A) (an enzyme that breaks down monoamine neurotransmitters, e.g., serotonin) genotypes on female psychopathology and behaviour.¹⁶ There is also evidence that childhood sexual abuse and intimate partner violence constitute unique risk factors for antisocial behaviour and drug use among women and can predict relapse many years later.¹⁷

2. Social and environmental factors

14. Some countries have high levels of unemployment, drug availability and crime that result in an environment likely to foster problematic drug use. It has been suggested that there is a reciprocal relationship between low socioeconomic status and drug use. Living in poverty can create chronic stress, which affects an individual's mental health, from which drugs can provide some temporary reprieve. Additionally, albeit to a lesser extent, drug abuse may lower socioeconomic status. In the case of women, the impact of these factors is often exacerbated. For example, an investigation by the United Nations Office on Drugs and Crime (UNODC) into the impact of drug use on the family unit in Afghanistan found strong links between drug use, unemployment and poverty.¹⁸ Over half of those who had been employed prior to using drugs had subsequently lost their jobs, and over one third of the children interviewed said that they had been forced to leave school because of drug abuse by a family member. Communities with high levels of drug use often have

¹⁵Mehmet Sofuoglu and others, "Sex and menstrual cycle differences in the subjective effects from smoked cocaine in humans", *Experimental Clinical Psychopharmacology*, vol. 7, No. 3 (1999), pp. 274-283.

¹⁶J. Kim-Cohen and others, "MAOA, maltreatment, and gene-environment interaction predicting children's mental health: new evidence and a meta-analysis", *Molecular Psychiatry*, vol. 11 (2006), pp. 903-913.

¹⁷Office of Research on Women's Health, "Research summaries, FY 2011" (Bethesda, Maryland, National Institutes of Health, 2011).

¹⁸UNODC, *Impacts of Drug Use on Users and Their Families in Afghanistan* (Vienna, 2014).

poor access to social support, health care and community organizations, making it more difficult for residents to receive assistance to break the cycle of drug abuse and poverty.

15. A large study of nearly 3,000 people who use drugs in India¹⁹ found that almost 10 per cent were women. Many of the women were illiterate, and very few had received any vocational training. Most were using heroin. The women commonly reported both physical and psychological problems resulting from their drug abuse, including miscarriages or terminations. About half of the women who took part in the study engaged in sex work to support their drug use, increasing their risk of contracting HIV, which, in turn, in the case of pregnancy or breastfeeding, can be transmitted to the child. Marital conflict was a common reason given for starting to abuse drugs.

C. Drug-related harm

1. HIV infection, overdose and other negative health consequences

16. Studies of drug abuse and its related harms often do not specifically consider women, in turn limiting the accurate assessment of how various issues affect women who use drugs. Furthermore, most research is undertaken in high-income countries, thus limiting the global understanding of the situation. Nevertheless, a reasonable amount of data on HIV among women has been generated, providing some indication of the problem, given the link between injecting drug use and the risk of HIV infection. HIV prevalence among female drug users can range vastly, from low levels in several countries to over 50 per cent in some others, such as Estonia and the Philippines. In the United Republic of Tanzania, 72 per cent of women who abuse heroin by injection are HIV positive, compared with 45 per cent of men. In Senegal, HIV prevalence among women who abuse drugs by injection is three times higher than among men.

17. Overall, even in generalized epidemics in sub-Saharan Africa, female sex workers are 12 times more likely to be HIV positive than the general female population. Similarly, in other environments with medium or

¹⁹India, Ministry of Social Justice and Empowerment, and UNODC, Regional Office for South Asia, “Women and drug abuse: the problem in India—highlights of the report” (New Delhi, 2002).

high prevalence of HIV, or generalized HIV epidemics, the likelihood of HIV infection was found to be high.²⁰ Female prisoners also have higher rates of HIV infection compared with both the general population and male prisoners.²¹

18. Women who inject drugs frequently report sharing needles, giving reasons such as being unaware of the risks, being unable to obtain needles from pharmacies and being afraid of being caught by police. Some women report that they share needles with their partner as a sign of love or trust. Poor injecting techniques cause vein injuries with severe complications. Women injecting drugs face problems such as fatigue, weight loss, withdrawal pain, depression and suicidal tendencies; many also have sexually transmitted infections and hepatitis. For these women, access to health care is mainly hindered by the stigma attached to women who abuse drugs by injection.

19. In 2012, more than 15,000 women died from drug overdoses in the United States. Between 1999 and 2010, the number of deaths related to the use of prescription opioid painkillers among women in the United States increased by a factor of 5, while the rate for men increased by a factor of 3.6. A review of mortality data in the United Kingdom of Great Britain and Northern Ireland from 2007 to 2008 revealed larger increases in overdoses (of all substances) among women than among men (17 per cent for women and 8 per cent for men). In particular, there was an 8 per cent increase in the number of deaths of women from heroin/morphine overdose and a 20 per cent increase in the number of deaths of women from cocaine overdose during that period.²²

2. Mental illness

20. The dual occurrence of substance use disorder and mental illness is difficult to diagnose and treat and is more common in women than men. If women who suffer from this dual occurrence are not treated they will have poorer clinical outcomes than women with a single disorder. In Europe, co-morbid major depression is more frequent in women with substance use disorders than in

²⁰Stefan Baral and others, “Burden of HIV among female sex workers in low-income and middle-income countries: a systematic review and meta-analysis”, *The Lancet*, vol. 12, No. 7 (2012), pp. 538-549.

²¹Kate Dolan and others, “People who inject drugs in prison: HIV prevalence, transmission and prevention”, *International Journal of Drug Policy*, vol. 26, Suppl. No. 1 (2015), pp. S12-S15.

²²Silvia Martins and others, “Worldwide prevalence and trends in unintentional drug overdose: a systematic review of the literature”, *American Journal of Public Health*, vol. 105, No. 11 (November 2015).

men with such disorders. Among this group of women, the prevalence of major depression is twice as high among women in the general population.²³ Individuals with a dual diagnosis have a poorer prognosis, require more intense supportive care and have a higher risk of suicide compared with those with a single diagnosis.²⁴ Effective treatments for dual diagnosis focus equally on both types of disorders and deliver services in a fully integrated manner.

21. A comparison between female prisoners with a dual diagnosis and those with severe mental illness alone found that the first group was more likely to have more immediate service needs once released, such as housing, and were more likely to reoffend. Once in prison, women are at risk of acquiring major depressive and anxiety disorders. Furthermore, whereas psychiatric symptom prevalence has been noted to decline among men who have been convicted, this is not found to be the case among women who are held as pretrial detainees.

3. Violence

22. Globally, it is estimated that one in three women has experienced physical or sexual violence. Rates of physical and sexual violence suffered by women undergoing drug treatment are very high, ranging from 40 to 70 per cent.²⁵ Such violence has adverse consequences on the mental, physical and reproductive health of women. About 20 per cent of women who have experienced violence will develop a psychiatric disorder, such as depression or post-traumatic stress disorder. An investigation by UNODC into the impact of drug use on the family unit in Afghanistan found that drug use increased the likelihood of domestic violence.²⁶ In a review undertaken in 2015, the Pompidou Group of the Council of Europe found that women who used drugs were subjected to more violence than women who did not use drugs. Rates of violence were found to be even higher among drug-using women who were pregnant or who engaged in sex work.²⁷

²³EMCDDA, *Comorbidity of Substance Use and Mental Disorders in Europe* (Luxembourg, Publications Office of the European Union, 2015).

²⁴Stephanie Hartwell, "Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system", *Criminal Justice Policy Review*, vol. 15, No. 1 (March 2004).

²⁵Mayumi Okuda and others, "Mental health of victims of intimate partner violence: results from a national epidemiologic survey", *Psychiatric Services*, vol. 62, No. 8 (August 2011).

²⁶*Impacts of Drug Use on Users and Their Families in Afghanistan*.

²⁷Thérèse Benoit and Marie Jauffret-Roustide, *Improving the Management of Violence Experienced by Women Who Use Psychoactive Substances* (Strasbourg, Council of Europe, 2016). Available at www.coe.int/.

4. Imprisonment

23. The proportion of women involved in drug offences is increasing. Over the last 30 years, the number of women incarcerated in the United States for drug-related offences increased by over 800 per cent, compared with a 300 per cent increase for men. Two thirds of women in federal prisons in the United States are incarcerated for non-violent drug offences. In Europe and Central Asia, more than 25 per cent (and up to 70 per cent in Tajikistan) of women prisoners have been convicted of drug-related offences. In Latin America, between 2006 and 2011, the female prison population almost doubled, with 60 to 80 per cent incarcerated for drug-related offences.

24. Women who have little formal education or who lack employment opportunities are those most frequently found to be involved in the drug trade. Most women who are arrested for acting as drug couriers have no previous criminal convictions and many are foreign-born. In Argentina, 9 out of every 10 foreign female prisoners with drug convictions were couriers, and the overwhelming majority were first-time offenders.²⁸ These female inmates have no family, social or institutional ties to the country in which they are held and are often serving long sentences.

D. Special populations who use drugs

1. Female prisoners and their children

25. Although men outnumber women by a ratio of 10 to 1 in prison populations, the number of incarcerated women is increasing. Over the last 15 years, the number of women in prison has increased by about 50 per cent.²⁹ In 2015, over 700,000 women and girls were held in penal institutions throughout the world as either pretrial detainees or as convicted and sentenced prisoners.³⁰ Prevalence of drug use among female prisoners is much higher than among male prisoners. Globally, between 30 and 60 per cent of women abused drugs in the month before being imprisoned, compared with between 10 and 50 per cent of men.

²⁸Corina Giacomello, "Women, drug offenses and penitentiary systems in Latin America", IDPC Briefing Paper (International Drug Policy Consortium, 2013).

²⁹Roy Walmsley, "World Female Imprisonment List", 3rd ed., World Prison Brief (London, Institute for Criminal Policy Research, Birkbeck, University of London, 2015).

³⁰Ibid.

26. When women are imprisoned, family life is often greatly disrupted: in Latin America, a third of female prisoners lose their homes, and just 5 per cent of children remain in their own home once their mother has been imprisoned. A study done in Brazil revealed that most children continue to be cared for by their mother when their father is imprisoned; however, in the event of a mother being incarcerated, just 10 per cent of children remain in their father's care. In Latin America, most incarcerated women are first-time offenders and, as primary caregivers to their children, their incarceration often means that their children either accompany them to prison or become homeless.

27. Owing to an insufficient number of female prison facilities, women are often imprisoned far from their homes, making it difficult to receive visits. Separation from their communities, homes and families has a considerably detrimental impact on the mental well-being of female prisoners. Female prisoners have significantly higher levels of psychiatric conditions than male prisoners. Such conditions include depression, bipolar disorder, psychosis, post-traumatic stress disorder, anxiety, personality disorder and drug dependence.

28. A large proportion of women incarcerated worldwide are in pretrial detention. Some have been detained for years; often longer than the sentence they are potentially facing. In Pakistan, over half of all female prisoners interviewed for a UNODC study were on trial, and one fifth of them had spent over a year awaiting trial. An inspection of nine prisons in the country found virtually no recreational facilities, educational services or health services for women or children, and no vocational training for women. In one prison, 60 inmates shared one washroom and eight of the nine prisons had unsafe drinking water, leading to waterborne diseases. Medical facilities were inadequate and lacked any mental health services. Most of the specialist women's health care was being provided by non-governmental organizations, rather than the Ministry of Health or the Prison Department. In small towns, female prisoners had given birth in prison without any medical assistance.³¹

29. Several South American countries have amended their national legislation pertaining to pretrial detention for pregnant women and nursing mothers. The amendments allow such women to serve pretrial periods at home.

³¹UNODC, *Females Behind Bars: Situation and Needs Assessment in Female Prisons and Barracks* (Islamabad, 2011).

30. Countries wishing to reduce the numbers of women incarcerated have the possibility of making use of the provisions of article 3, subparagraph 4 (c), of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988,³² which clearly provides for alternatives to incarceration, stating that "in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as, when the offender is a drug abuser, treatment and aftercare."

2. Sex workers

31. Female sex workers who abuse drugs by injection face major health risks, the threat of violence and social marginalization. Many countries have severe punishments, including the death penalty, for people who engage in sex work. There is a high correlation between drug use and sex work: drug dependence may account for a woman's entry into sex work as a means to support that dependence; women may also engage in drug use to cope with the demands and nature of sex work.

32. Globally, rates of drug abuse and HIV infection and incidences of imprisonment are high among female sex workers. In Myanmar, one third of female sex workers interviewed for a study reported using amphetamine-type stimulants for occupational reasons, exacerbating the risks of HIV infection and other sexually transmitted infections. Sex workers who used drugs were three and a half times more likely to report having a sexually transmitted infection than other sex workers.³³

33. Female sex workers use amphetamine-type stimulants for increased energy and weight control. Cambodian sex workers interviewed for one study also stated that use of amphetamine-type stimulants use increased their overall confidence and control with clients. However, use of amphetamine-type stimulants is associated with risky sexual behaviour and higher rates of sexually transmitted infection. Furthermore, chronic use of amphetamine-type stimulants can lead to paranoia and aggressive behaviour.³⁴

³²United Nations, *Treaty Series*, vol. 1582, No. 27627.

³³Katie Hail-Jares and others, "Occupational and demographic factors associated with drug use among female sex workers at the China-Myanmar border", *Drug and Alcohol Dependence*, vol. 161 (April 2016).

³⁴Marie-Claude Couture and others, "Correlates of amphetamine-type stimulant use and associations with HIV-related risks among young women engaged in sex work in Phnom Penh, Cambodia", *Drug and Alcohol Dependence*, vol. 120 (January 2012).

3. Pregnant women

34. Drug dependence is strongly correlated with unwanted pregnancies, poor birth outcomes and child abuse or neglect. Utilization of drugs during pregnancy may lead to premature births, newborns with a low birth-weight and postpartum haemorrhage. Women who use drugs during their pregnancy are also more likely to be admitted to intensive care units during labour and to suffer higher incidences of infant mortality.

35. Prenatal exposure to drugs can result in an array of emotional, psychological and physical disorders. Children who have been exposed to drugs while in the womb may suffer significant developmental problems that require additional care, resulting in both personal and societal costs. Children exposed to a drug-using environment are at a significantly higher risk of both physical and sexual abuse, as well as neglect.

36. Babies whose mothers used cannabis during pregnancy may exhibit neurological development problems; exposure to cannabis in early life may adversely affect brain development and behaviour. Later on, those children are likely to demonstrate impaired attention, poor learning and memory skills, impulsivity and behavioural problems at school. They also have a higher likelihood of using cannabis as adults.

E. Prevention of and treatment and rehabilitation for drug dependence

1. Prevention of drug abuse

37. Programmes for the prevention of substance use disorders in special populations vary across countries. The primary objective of drug abuse prevention is to help people, particularly young people, avoid initiation into the use of drugs or, if they have already started using drugs, to avoid becoming dependent. Prevention programmes are frequently targeted at children and families at risk, prisoners, people living with HIV/AIDS, pregnant women and sex workers. As part of such programmes, particular regard should be paid to the stigma associated with drug use, especially for women. Specific interventions should be developed that enable women to participate in prevention programmes.

38. The provision of evidence-based integrated treatment to pregnant women can have a positive impact

on child development, the emotional and behavioural functioning of the mother and parenting skills.

2. Barriers to accessing treatment

39. According to the World Health Organization (WHO), most Governments have no specific budget allocation for the treatment of substance use disorders. Furthermore, the incorporation of drug prevention and treatment services into national health systems is uncommon. Specialized drug treatment for pregnant women (available in 31 per cent of countries) and sex workers (available in 26 per cent of countries) is low and coverage is poor. However, drug treatment services for pregnant women exist in 61 per cent of countries in Europe, and 40 per cent of countries in South-East Asia have such services for sex workers.³⁵

40. Globally, women make up one third of people who abuse drugs but just one fifth of those who are in treatment. Women encounter significant systemic, structural, social, cultural and personal barriers to accessing substance abuse treatment. At the structural level, the main obstacles include a lack of childcare services and judgmental attitudes to women who abuse drugs, especially if they are pregnant. Often, residential treatment programmes do not admit women with children.

41. Women who use drugs may not seek treatment for fear of losing custody of their children. Other reasons for low uptake of treatment by women include hostile attitudes of medical staff or clinics being inundated with male clients, making them uninviting for female clients.

42. In many countries, women who abuse drugs face stigma. Therefore, women may be reluctant to disclose their abuse of drugs and may be hesitant to access health services, including drug treatment, for fear of discrimination. Women and girls who use drugs may lose the support of their family, find themselves with limited employment opportunities and turn to sex work, further exacerbating the stigma they face.

43. Pregnant women may be afraid to seek help because of the possible involvement of the authorities and the legal or social repercussions this could entail. However, if pregnant, drug-abusing women remain untreated, it can have major implications for the health of their babies. Some of the factors that motivate women to enter treatment are pregnancy, parenthood and a partner's entry

³⁵WHO, *Atlas on Substance Use (2010): Resources for the Prevention and Treatment of Substance Use Disorders* (Geneva, 2010).

into treatment. If a woman's partner leaves treatment, she is likely to leave as well. There is much debate as to whether couples should enter rehabilitation together or separately: although many experts claim that a couple must separate to overcome dependency, many couples have successfully completed treatment together. Nevertheless, relationships rarely survive if only one person stops using drugs.

44. In general, fewer women than men who need to access treatment are able to do so. This is particularly true in low- and middle-income countries; in Afghanistan, despite the high rates of opium and heroin use among women, women make up only 4 per cent of those in treatment; in Pakistan, that figure is 13 per cent. In some regions of the world, such as the Middle East, women generally still fulfil the traditional role of taking care of the household while men go to work. When women step outside of that role by using drugs it can lead to stigma, which prevents women from seeking treatment for their drug dependence.

45. Access to drug treatment increased for women in the Islamic Republic of Iran when women-only drug treatment services were introduced. Prior to the introduction of such services, fewer than 20 per cent of women using drugs had accessed treatment in the previous 10 years. Positive outcomes from the women-only clinics resulted in an increase in the number of such clinics in the country.

3. Treatment outcomes

46. Although population-based studies demonstrate no clear differences between men and women when it comes to staying in and completing treatment programmes, there are certain factors to consider. Two factors that significantly aid in predicting the treatment outcome for women are dual diagnosis and a history of trauma. It is therefore important for treatment programmes to address those issues in order to increase their effectiveness.

47. Although providing exclusively female treatment programmes is still a novel approach, such programmes have been positively endorsed by women. Women who participate in them feel that they are better understood and can more easily relate to other female attendants. Some women report that they feel unsafe or are harassed in mixed-gender programmes. In women-only programmes, clients report that the availability of individual counselling, the absence of sexual harassment and the provision of childcare services are important.

48. In order for treatment services to be gender-sensitive, they should also offer a non-punitive environment and present a positive attitude towards women and their needs. In countries where the provision of drug treatment to women is a recent development, staff are likely to require training to address any biases that they may hold and to ensure non-judgmental treatment. Women are just as likely as men to remain in treatment once it is initiated, but multiple factors increase the likelihood of this taking place. These factors include a patient-centred approach to treatment, on-site childcare facilities and trauma or sexual abuse counselling. Treatment programmes should also provide women with skills, knowledge and support to enable them to change their substance use behaviour when they return to their family and re-enter their community. The rehabilitation process needs to prevent a relapse into substance use by providing women with the skills required to control the impulse to use drugs. The ultimate goals of the rehabilitation process are to assist women in regaining control of their lives, improve their personal health and allow them to re-establish healthy relationships with their children, families and communities.

49. Many studies support the finding that treatment is effective for men and women alike, with minimal differences in treatment-related outcomes. However, women have been found to be more receptive than men to treatment for methamphetamine dependence. The first type of treatment offered to women who use drugs should be voluntary, as compulsory treatment should be limited to exceptional cases. The use of compulsory drug detention centres has been criticized by a number of United Nations organizations.³⁶ Among other reasons, women detained in such centres are particularly vulnerable to sexual violence and abuse.

F. Recommendations

50. INCB encourages Member States to collect and share data, disaggregated by age, sex and other relevant factors, when providing information through the annual report questionnaire and when reporting to the Commission on Narcotic Drugs.

51. All Governments are encouraged to collect gender-disaggregated data on participation in drug use prevention programmes and access to treatment services, to allow the efficient allocation of resources. Targeted

³⁶International Labour Organization and others, "Compulsory drug detention and rehabilitation centres", joint statement, March 2012. Available at www.unodc.org.

interventions, based on research, can be particularly effective in meeting the specific needs of female drug users.

52. Efforts to prevent and treat drug abuse among women should be better funded, coordinated and based on evidence. In addition to Governments, stakeholders such as non-governmental organizations and academia can provide treatment and generate data for a better understanding of drug use by women.

53. Governments should give priority to providing easily accessible health care for drug-dependent women. Special groups such as drug-dependent women who are pregnant need the enhanced services of a specially trained multidisciplinary team. Prenatal care could include testing for HIV and other sexually transmitted infections in order to improve the detection and management of those conditions, but such measures should not be punitive.

54. Drug treatment programmes should be able to guarantee personal safety and confidentiality with women-only spaces or times. Services become more accessible when childcare and interventions or strategies for women engaged in sex work or women who have experienced gender-based violence are provided. In order to mainstream gender equality, policymakers should work to improve the availability, accessibility, affordability and acceptability of services for women who use drugs.

55. Women's right to health includes the right to be free from torture, non-consensual treatment and experimentation. Drug treatment programmes should be held to the same standards of safety and efficacy as programmes for the treatment of other ailments. Furthermore, inhumane or degrading forms of treatment of drug users, such as compulsory drug detention centres, should be eliminated in favour of voluntary, residential and evidence-informed alternatives in the community.

56. Governments should ensure the provision of drug abuse prevention services and evidence-based treatment, especially in communities experiencing social disintegration. Strategies should address high-risk groups, such as pregnant women, sex workers and prisoners.

57. Efforts to eliminate the stigma associated with drug dependence, particularly among women, should be given high priority. Governments need to show leadership if discrimination is to be eliminated. Women who use drugs, engage in sex work or have HIV infection need protection and better access to services.

58. The United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)³⁷ specifically refer to substance abuse treatment programmes and recommend the provision of gender-sensitive, trauma-informed, women-only substance abuse treatment programmes in the community. They also recommend that women's access to such treatment should be improved, for crime prevention as well as for diversion and alternative sentencing purposes. They emphasize the need to ensure respect for the dignity of women in prison and to avoid any source of physical or sexual violence.

59. INCB encourages Governments to take into consideration the specific needs and circumstances of women subject to arrest, detention, prosecution, trial or the implementation of a sentence for drug-related offences, including appropriate measures to bring to justice perpetrators of abuse of women in custody or in prison settings for drug-related offences. Governments should draw, as appropriate, on the Bangkok Rules, the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules)³⁸ and the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).³⁹

³⁷General Assembly resolution 65/229, annex.

³⁸General Assembly resolution 45/110, annex.

³⁹General Assembly resolution 70/175, annex.

