

DRUG USER PEACE INITIATIVE
A WAR ON WOMEN WHO USE DRUGS

drug war
peace



Drug User Peace Initiative

A War on Women who Use Drugs

Introduction: Invisibility, Inequality, and Stigma	1
Health, Healthcare, Service Provision, and Harm Reduction	2
<i>Disproportionate Burdens of Blood-Borne Infections</i>	2
<i>Lack of Harm Reduction; Barriers to Service Provision</i>	2
Violence	3
Incarceration – Driving Violence and Infections	4
Interference with Bodily Integrity, Motherhood, Domestic Space, and Family Life.	5
<i>Domestic Intrusions</i>	5
<i>Pregnancy</i>	5
Sex Work and Drug Use	6
<i>Stigma, Discrimination, and Criminalisation</i>	6
Conclusions: Moving Forward	7

Introduction: Invisibility, Inequality, and Stigma

The so-called ‘war on drugs’ is, in reality, a war on people who use drugs.¹ But this is not a symmetrical war: instead, the war on drugs is a lens through which various other wars are fought, with certain groups being subject to disproportionate abuse, human rights violations, stigma, and police attention. As was noted in the *Violations of the Human Rights of People who Use Drugs* document of INPUD’s *Drug User Peace Initiative*, the war on drugs has notably been a war on people of colour, on young people, and on the poor.

In particular, women who use drugs have been subject to gender-specific stigma, discrimination, and social exclusion.² Endemic and widespread sexism, inequality, and discrimination against women in general all intersect with, and exacerbate, the harms and human rights violations to which people who use drugs are subject:

“Many of the vulnerabilities experienced by women who use drugs illicitly are a compound of those that are experienced by women in general, in addition to those faced by all people who use illegal drugs. Culturally embedded power imbalances that exist between men and women around the world often leave women exposed to increased stigma, abuse, violence and coercion” (The Global Coalition on Women and AIDS, 2011: 3)³

Women who use drugs are more heavily stigmatised, as well as being frequently ignored, invisibilised, and sidelined in the formation of policy and approaches to harm reduction and service provision.

People who use drugs already make up a hidden population due to criminalisation and stigma, which makes population size estimates tricky. Women who use drugs are all but invisible, with very little data as to the size of this community. Though around 40% of people who use drugs in the US, for example, are estimated to be women, figures are not available for women who inject drugs.⁴ Furthermore, the majority of states do not collect data that is disaggregated

1 ‘Drug use’ should be taken to refer to the non-medically sanctioned use of psychoactive drugs, including drugs that are illegal, controlled, or prescription.

2 The Global Coalition on Women and AIDS, 2011, *Women who use drugs, harm reduction and HIV* (Geneva: The Global Coalition on Women and AIDS)

3 Ibid.

4 Pinkham S., Myers B. and Stoicescu C., 2012, Developing effective harm reduction services for women who inject drugs, in *The global state of harm reduction: Towards an integrated response* (Harm Reduction International), available at http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf (last accessed 17 October 2014)

by sex on syringe and needle programmes, antiretroviral therapy coverage, or opiate substitution programmes.⁵

“lack of data is disquieting, as it makes it difficult to assess whether at a country level there are gendered disparities in access to these essential services, or the degree to which available services are responsive to women’s needs. This may have a negative impact on efforts to improve harm reduction service coverage and, consequently, on efforts to curtail the HIV epidemic within this population” (Pinkham et al., 2012: 127)⁶

“Compared to male drug users, information has been limited for female drug users regarding HIV prevalence and their risk behaviours. Though smaller in number, the situation of female drug users could be more serious than that of male drug users” (Ghimire et al., 2013: 1239)⁷

Systemic and global discrimination towards women feeds directly into the greater vulnerability of women who use drugs to numerous harms. In this document, INPUD highlights how women have come to be disproportionately harmed by prohibition, criminalisation, stigma and discrimination, and social exclusion.

Health, Healthcare, Service Provision, and Harm Reduction

Disproportionate Burdens of Blood-Borne Infections

There are many harms which can be associated with drug use, and these harms stem to a great extent from global prohibition, from the ‘war on drugs’.

Though prevalence and incidence of blood-borne infections such as HIV and hepatitis C is high amongst people who inject drugs generally, **women who inject drugs display substantially higher prevalence and incidence of blood-borne infections**. In some of the countries that are worst affected by the HIV pandemic, HIV incidence is reported to be as high as 85% amongst women who use drugs, 20% higher than incidence among people who use drugs generally.⁸ In numerous EU countries, average HIV prevalence can be as much as 50% higher amongst women than amongst men who use drugs.⁹

Lack of Harm Reduction; Barriers to Service Provision

High prevalence of HIV and hepatitis C amongst people who inject drugs is fuelled by a considerable lack of comprehensive harm reduction services, due to opposition to such interventions. In addition, stigma and discrimination act as barriers preventing people who use drugs from accessing what services are available.

For women who use drugs, discriminatory views widely held about people who use drugs are compounded by sex- and gender-specific barriers to accessing services, and women have been sidelined in the formation of service and healthcare provision policy. Harm reduction

5 UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who inject drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

6 Pinkham S., Myers B. and Stoicescu C., 2012, Developing effective harm reduction services for women who inject drugs, in *The global state of harm reduction: Towards an integrated response* (Harm Reduction International), available at http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf (last accessed 17 October 2014)

7 Ghimire, B. et al., 2013, Vulnerability to HIV infection among female drug users in Kathmandu Valley, Nepal: a cross-sectional study. *BMC Public Health* 13: doi:10.1186/1471-2458-13-1238

8 The Global Coalition on Women and AIDS, 2011, *Women who use drugs, harm reduction and HIV* (Geneva: The Global Coalition on Women and AIDS)

9 Pinkham S., Myers B. and Stoicescu C., 2012, Developing effective harm reduction services for women who inject drugs, in *The global state of harm reduction: Towards an integrated response* (Harm Reduction International), available at http://www.ihra.net/files/2012/07/24/GlobalState2012_Web.pdf (last accessed 17 October 2014)

interventions and service provision are frequently tailored primarily for men who inject drugs, and do not take the needs of women into account. This applies also to harm reduction services available in closed settings such as prisons (where availability of harm reduction is a very rare exception to the rule).¹⁰

“Women who inject drugs often have limited or no access to harm reduction or general health services. This situation is especially acute in many countries with concentrated HIV epidemics among people who inject drugs” (UNODC et al., 2014: 2)¹¹

Women who use drugs are more likely to experience problems with healthcare and service providers, and can be made to feel they are unworthy of receiving assistance. Women additionally face breaches of confidentiality in the context of healthcare and service provision in relation to their drug use and HIV status. Not only does this serve to disincentivise women who use drugs from seeking service provision and from disclosing their drug use – therefore acting as a barrier to the prevention and treatment of blood-borne infections and the provision of well-focused harm reduction – but being outed as a drug user and/or as living with HIV increases the likelihood of experiencing exclusion from families and communities, harassment, abuse, and violence.¹² Women who use drugs can additionally face social exclusion, ostracisation, and loss of child custody (discussed further below) when making contact with healthcare and service providers. Service providers can also fail to provide suitable environments and support for women and mothers, such as childcare facilities, and additional barriers stem from strict opening hours, the distance women may have to travel to services, and staff not having suitable gender- and sex-specific training.

“To date, inadequate attention has been given to rectifying gender inequalities in harm reduction programming. Strategies and policies are urgently needed to address this gap as a first step towards improving the safety, health and well-being of women who inject drugs” (UNODC et al., 2014: 1)¹³

“Structural barriers stem from issues around the functioning of treatment services and include; lack of child-care, unsafe or indiscreet locations, rigid service schedules, long waits, bureaucratic hurdles, and lack of sufficient services provisions. Personal barriers stem from internal issues within the injector and include: fear of partner violence, fear of losing their children to government bodies where injection is illegal, personal financial concerns and fear of losing their partnership” (Roberts et al., 2010: 18)¹⁴

Violence

Violence perpetrated against women who use drugs is fed by broad gender inequalities and widely held discriminatory and sexist views about women, which intersect with the discriminatory stereotypes often held about people who use drugs in general. Women who use drugs experience harassment and violence, including sexual violence, perpetrated by the police

¹⁰ Ibid.

¹¹ UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who inject drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

¹² The Global Coalition on Women and AIDS, 2011, *Women who use drugs, harm reduction and HIV* (Geneva: The Global Coalition on Women and AIDS)

¹³ UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who inject drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

¹⁴ Roberts, A., Mathers, B. and Degenhardt, L., 2010, *Women who inject drugs: A review of their risks, experiences and needs* (Reference Group to the United Nations on HIV and Injecting Drug Use), available at http://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf (last accessed 9 October 2014)

and state. Stigma and discrimination – and the gender-based and/or drug-userphobic¹⁵ violence and sexual violence that they drive – serve to increase vulnerability of women who use drugs to blood-borne infections, as well as sexually transmitted infections.^{16,17}

Not only do women experience state-sponsored violence, as well as exclusion from – and barriers to – service and healthcare provision, but women who use drugs additionally experience violence and marginalisation from within their communities and families, and can have difficulties negotiating safer sex and safer injecting practices with their intimate and domestic partners.^{18,19} As with state-sponsored violence, such violence, notably domestic violence and intimate partner violence, increases vulnerability to infections such as HIV and hepatitis C, as well as serving as a barrier to accessing service and healthcare provision.

“Women who inject drugs experience high rates of intimate partner violence, which negatively affects their ability to practise safe sex and safer drug use. Punitive policies are frequently associated with police abuses, including physical and sexual violence against women who inject drugs. Gender-related violence of this kind makes women reluctant to access harm reduction services even if they are available, often because they fear being harassed or abused simply for trying to enter facilities” (UNODC et al., 2014: 3)²⁰

Incarceration – Driving Violence and Infections

Prohibition has resulted in drug-related offences being amongst the principal causes for women to go to jail, with women predominantly incarcerated for drug use and possession-related offences, and not for violent crimes.

The negative impacts of incarceration upon health and wellbeing disproportionately impact women. Harm reduction is rarely available in closed settings such as pre-trial detention and prison systems, and those harm reduction services that are available in prison systems rarely have a gendered focus. As a result, women are more likely than men to share injecting equipment, and display higher incidence of HIV and hepatitis C.²¹ Furthermore, women are vulnerable to sexual abuse and violence in prison which, as with police violence and abuse in wider society, exacerbates risk of HIV and viral hepatitis. Women who are incarcerated in forced ‘treatment’ centres in countries such as Vietnam and China, as discussed in some detail in the *Violations of the Human Rights of People who Use Drugs* paper of INPUD’s *Drug User Peace Initiative*, are especially at risk of violence, including sexual violence and torture, given the lack of monitoring of these institutions and the fact that incarceration takes place without due process, in violation of the human rights of detainees.

15 At present, there is no commonly-used term to denote discriminatory and phobic views towards people who use drugs. ‘Drug userphobia’ is not a universally accepted term, though it has had some use in academic literature and on social media.

16 Jürgens, R., Csete, J., Amon, J. J., Baral, S. and Beyrer, C., 2010, People who use drugs, HIV, and human rights. *The Lancet*: DOI:10.1016/S0140-6736(10)60830-6

17 World Health Organization (WHO), 2005b, *Violence against sex workers and HIV prevention*, available at <http://www.who.int/gender> (last accessed 31 March 2012)

18 Roberts, A., Mathers, B. and Degenhardt, L., 2010, *Women who inject drugs: A review of their risks, experiences and needs* (Reference Group to the United Nations on HIV and Injecting Drug Use), available at http://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf (last accessed 9 October 2014)

19 The Global Coalition on Women and AIDS, 2011, *Women who use drugs, harm reduction and HIV* (Geneva: The Global Coalition on Women and AIDS)

20 UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who inject drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

21 The Global Coalition on Women and AIDS, 2011, *Women who use drugs, harm reduction and HIV* (Geneva: The Global Coalition on Women and AIDS)

Further to detrimentally impacting women's health, incarceration is disruptive for women's families and their children: children can end up accompanying their mother to prison and therefore spend their childhood essentially being incarcerated themselves. The imprisonment of mothers can also result in child homelessness, driving cycles of inequality, poverty, and social exclusion.²²

Interference with Bodily Integrity, Motherhood, Domestic Space, and Family Life

Domestic Intrusions

Further to facing intimate partner and domestic violence, women who use drugs face violence and disruption in their domestic space perpetrated by the state. As discussed in the *Violations of the Human Rights of People who Use Drugs* document of INPUD's *Drug User Peace Initiative*, when the authorities become aware of women using drugs, this can follow through into intrusions into domestic space by social services, healthcare workers, and/or the police. This can result in disruptive altercations and confrontations, and can also result in women being removed from their homes, and losing child custody (whether or not parenting ability is impaired). Such is the stigma attached to drug use that it is assumed by default that women who use drugs are unfit parents.²³ Again, this all serves to act as a barrier to seeking healthcare, service provision, harm reduction, social service assistance, or any state-sponsored support:

"in countries where injecting drug use is criminalised many women have purposefully stayed out of treatment for fear of the repercussions to themselves and their children." (Roberts et al., 2010: 17)²⁴

Pregnancy

There is a long history of foetuses being prioritised over the welfare of women, and this was the case during the early years of the HIV/AIDS pandemic, when women were denied access to drug trials just *in case* they were pregnant. Similarly, though opiate substitution is safe and recommended for use by women with opioid dependence during pregnancy,²⁵ pregnant women can be denied appropriate opiate substitution services due to ignorance and stigma on the part of healthcare providers, and can also be denied access to other harm reduction interventions and to antiretroviral therapies.²⁶ This is enormously detrimental and counterproductive, since it serves only to increase distress and harm for the mother *and* for the foetus. In addition, pregnant women who use drugs can face criminal prosecution ostensibly for endangering their foetus²⁷, as discussed in the *Violations of the Human Rights of People who Use Drugs* document of INPUD's *Drug User Peace Initiative*:

22 UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who inject drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

23 Ibid.

24 Roberts, A., Mathers, B. and Degenhardt, L., 2010, *Women who inject drugs: A review of their risks, experiences and needs* (Reference Group to the United Nations on HIV and Injecting Drug Use), available at http://www.unodc.org/documents/hiv-aids/Women_who_inject_drugs.pdf (last accessed 9 October 2014)

25 WHO/UNODC/UNAIDS, 2004, *WHO/UNODC/UNAIDS position paper: Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention*, available at http://www.who.int/substance_abuse/publications/en/PositionPaper_English.pdf (last accessed 10 November 2014)

26 The Global Coalition on Women and AIDS, 2011, *Women who use drugs, harm reduction and HIV* (Geneva: The Global Coalition on Women and AIDS)

27 International Network of People Who Use Drugs (INPUD), International Network of Women who Use Drugs (INWUD), the Women and Harm Reduction International Network (WHRIN), National Advocates for Pregnant Women (USA) (NAPW), SisterReach, the Sexual Rights Initiative, Family Law & Cannabis Alliance (USA) (FLCA), and Native Youth Sexual Health Network, 2014, *Universal Periodic Review of United States of America 22nd Session*, available at http://www.inpud.net/INWUD_Joint_Shadow_Report_FINAL_DRAFT_2-1.docx (last accessed 18 September 2014)

“In many countries, pregnant drug users face criminal sanctions if they continue to use prohibited drugs. In the United States, cocaine users have been convicted on a number of charges including foetal abuse, delivering drugs to a minor, and even murder; this is despite a body of evidence showing cocaine to be no more harmful to a pregnancy than cannabis, and less harmful than alcohol” (The Global Coalition on Women and AIDS, 2011: 6)²⁸

As we can see from the above quotation, such interventions are driven by the stigmas and misconceptions that surround illicit drug use. Concern surrounding women using (certain) drugs during pregnancy has fed widespread moral panics, which have intersected with broader racism and classism, with a notable example of racist and unfounded exaggeration and concern in the United States about ‘crack mothers’.²⁹

Since women who use drugs are often viewed as unfit mothers, women have been forced and/or coerced into terminating pregnancies, giving up their children (as discussed above), and being sterilised.³⁰ Notable examples of these practices include Russia and Ukraine, and there have also been instances of women who use drugs being offered cash incentives to undergo sterilisation in the United States and the UK.^{31,32} As discussed elsewhere in this *Drug User Peace Initiative*, such practices are nothing short of eugenic, since they are policies that aim to prevent certain people who are viewed as undesirable, deviant, and eugenically/genetically/morally deficient from procreating.

Sex Work and Drug Use

Stigma, Discrimination, and Criminalisation

As with people who use drugs, sex workers are disproportionately exposed to increased risks, notably including those related to violence, HIV, and STIs. Stigma and discrimination substantially exacerbate these risks for sex workers.³³ The additional risks to sex workers are often – as with those that affect people who use drugs – driven and exacerbated by criminalising and punitive laws and policies (on buying and/or selling sex, as well as of surrounding activities such as soliciting, procuring, and kerb crawling).³⁴ Criminalisation sanctions and encourages police harassment and abuse of sex workers, displacing sex work into the margins and distancing sex workers from service provision and harm reduction (therefore acting as a barrier to HIV, STI and blood-borne infection prevention and treatment initiatives).³⁵ Many of the additional risks faced by sex workers are strikingly similar to the harms that can be associated with drug use. Sex workers who use drugs³⁶ therefore experience two interconnected layers of risk and vulnerability

28 Ibid.

29 Humphries, D., 1999, *Crack Mothers: Pregnancy, Drugs, and the Media* (Columbus: Ohio State University Press)

30 UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who inject drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

31 Charity offers UK drug addicts £200 to be sterilised. *BBC News*, 17 October 2010, available at <http://www.bbc.co.uk/news/uk-england-london-11545519> (last accessed 14 October 2014)

32 Kleeman, J., 2010, Should drug addicts be paid to be sterilised? *The Guardian* 12 June, available at <http://www.theguardian.com/society/2010/jun/12/barbara-harris-sterilise-drug-addicts-alcoholics> (last accessed 14 October 2014)

33 UNAIDS, 2009, *UNAIDS Guidance Note on HIV and Sex Work* (Geneva: UNAIDS)

34 Ibid.

35 Rekart, M. L., 2005, Sex-Work Harm Reduction. *The Lancet* 366: 2123–2134

36 Though some people may sell sex and use drugs, sex work and drug use should not be conflated and causation between the two should not be assumed. Indeed, these very assumptions feed into the stereotyping assumption that both sex workers, and people who use drugs, can experience: people who sell sex are incorrectly generalised as using drugs and having drug dependencies, and women who use drugs are frequently assumed to sell sex, whether they do or not. Furthermore, assumptions that sex workers are invariably cisgender women additionally serve to marginalise and invisibilise those who are not (though this document focuses explicitly on women who use drugs). Such assumptions should be challenged.

in contexts that have detrimental and punitive drug *and* sex work laws and policies, as well as experiencing two sets of stigma and discrimination.

Sex workers who use drugs suffer from double stigma, and double criminalisation. This means that the harms, discrimination, social exclusion, and marginalisation experienced by people who use drugs and by sex workers are compounded for this group.

“For example, women who inject drugs who are also sex workers are further stigmatized due to the additional negative impact of the criminalization of sex work. In such contexts, they are even more restricted in their access to HIV-related services and their capacity to negotiate condom use.” (UNODC et al., 2014: 3)³⁷

It is clear that, as with people who use drugs, sex workers who use drugs require comprehensive and high-quality sex work- and drug use-targeted harm reduction services in order to mitigate and reduce risk.^{38,39} But the double stigmatisation of sex workers who use drugs results in even more significant barriers to accessing service provision, healthcare, and harm reduction. Concern over discriminatory or disparaging responses from service providers can lead sex workers who use drugs to avoid accessing services and healthcare, or to withholding information relating to drug use and/or sex work. Targeted services (either explicitly for people who use drugs, or for sex workers) can also fail to take nuanced and variable realities into account. This can lead to inadequate and/or discriminatory services being provided for sex workers who use drugs. A failure of service providers to offer suitable referral can compound the problem.

Conclusions: Moving Forward

Women who use drugs are all but invisible in terms of data collection and in terms of service provision and harm reduction. Women who use drugs experience exclusion from services and healthcare and are all too often not catered for appropriately by services that are available. Women who use drugs experience considerable barriers to accessing healthcare and service provision, thus resulting in barriers to the prevention of blood-borne and sexually transmitted infections. Women who use drugs are more likely to experience violence, both perpetrated by the state, and in their homes and family contexts. Women who use drugs experience gross violations of their human rights, including arbitrary incarceration, interference with their bodily integrity, and interference with their families. Women who use drugs and sell sex are subject to compounded stigma, discrimination, and social exclusion.

It is clear that prohibition and criminalisation serve to drive and exacerbate many of the harms associated with drug use. It is also clear that **due to gender- and sex- based stigma and discrimination, harms associated with drug use are substantially greater for women.** As long as prohibition is supported and drug use is criminalised, there will be little incentive to improve drug policies, let alone to specifically end the war on women who use drugs.

“the UNODC actively provides support to strengthen drug law enforcement in countries that retain the death penalty for drug crimes. Countries will be less inclined to improve their national drug policy and harm reduction programming, as long as the policies of the UN system are not harmonised and directed towards prioritizing the human rights, health and wellbeing of women and girls injecting drugs” (The Global Coalition on Women and AIDS, 2011: 3-4)

37 UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who Inject Drugs and HIV: Addressing specific needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

38 Rekart, M. L., 2005, Sex-Work Harm Reduction. *The Lancet* 366: 2123–2134

39 Cusick, L., 2005, Widening the harm reduction agenda: From drug use to sex work. *International Journal of Drug Policy* 17: 3–11

A WAR ON WOMEN WHO USE DRUGS

In addition to dismantling of prohibitionist legislation, targeted services and harm reduction are required that take women into account, and sex- and gender-specific information needs to be gathered. More than this, services and harm reduction are required that take people's variable and individual requirements into account; they must cater for the specific needs of all people who use drugs, whatever their background, context, or work.

“access to the interventions... should not be restricted by socio-demographic or other criteria, such as sex/gender, employment status and profession – including sex work or imprisonment, substance use status or pregnancy status” (UNODC et al., 2014: 4)⁴⁰

In the planning, formation, and development of appropriate, holistic, and comprehensive policy, the participation of those for whom this pertains is absolutely imperative. **Without the meaningful participation of women who use drugs, interventions and policies are bound to fall short, if not to fail.**

40 UNODC, UN Women, World Health Organization and INPUD, 2014, *Policy Brief – Women who Inject Drugs and HIV: Addressing Specific Needs*, available at https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf (last accessed 8 October 2014)

JOIN THE GROWING MOVEMENT FOR PEACE
WWW.DRUGUSERPEACEINITIATIVE.ORG

INPUD

The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs and its impact on our community's health and rights. INPUD will achieve this through processes of empowerment and international advocacy.
www.inpud.net

Copyright © International Network of People who Use Drugs (INPUD) 2014

These papers of the *Drug User Peace Initiative* are part of INPUD's work under Bridging the Gaps – Health and Rights for Key Populations. In this programme, almost 100 local and international organisations have united to reach 1 mission: achieving universal access to HIV/STI prevention, treatment, care and support for key populations, including sex workers, LGBT people and people who use drugs. Bridging the Gaps is funded through the Netherlands Ministry of Foreign Affairs. Go to www.hivgaps.org for more information.

The production of these documents of the *Drug User Peace Initiative* has been made possible with the financial support [in part] of the Robert Carr civil society Networks Fund and supported [in part] by a grant from the Open Society Foundations.

Principal author: Jay Levy; Design: Better World Advertising; Copyeditor: Nine. Additional acknowledgements and thanks to Eliot Albers, Jude Byrne, Hazel Moore, Terry White, and Anastacia Ryan and the Global Network of Sex Work Projects (NSWP) for their input and feedback.

Published by

INPUD Secretariat

Unit 2C05, South Bank Technopark

90 London Road

London

SE1 6LN

www.inpud.net

