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Women and drug policy in Eastern and Southern Africa

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SUMMARY

Gender equality is recognized as a fundamental human right and is enshrined in international frameworks such as the UN's Sustainable Development Goals[1] and international treaties such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979.[2] In pursuit of this goal, there have been campaigns in recent decades to incorporate a 'gender lens' – to understand and address gender inequalities – across different policy areas. Drug policy is no exception: provisions to mainstream gender considerations have begun to form part of policy frameworks globally and regionally, including in Eastern and Southern Africa.

This background paper reviews the available evidence on how women's experiences differ from men's in terms of their participation in drug economies (as users, suppliers and members of communities heavily affected by drug markets) and how gender shapes their experiences of drug policy, including policing, prisons, health and social care. It aims to situate Eastern and Southern Africa within global trends.

Broadly speaking, women's experiences in drug markets and of drug policy may differ from men's for many of the same reasons that gender inequality persists in other spheres of life. These include gender discrimination and patriarchal ideologies that marginalize women, a lack of economic empowerment, victimization through gender-based violence, and the fact that women are more likely to be carers for children and other dependent family members, which places them under additional economic and social stress.[3] In a context where drug use and possession for personal use are widely criminalized and people who use drugs (PWUD) are stigmatized and forced to the fringes of society, gender as a social structure plays an integral role in women's pathways to drug use and addiction.[4]

Many of the same patriarchal norms that shape women's experience also shape those of LGBTQ+ (lesbian, gay, bisexual, transgender, queer and other minority) communities. This paper also reviews the evidence on how drug policy treats (and often mistreats) these communities in Eastern and Southern Africa.

Finally, this paper explains how a lack of gender-disaggregated data on drug markets and the impact of drug policies can often render women's experiences invisible, meaning that information that could be revealing about how women experience drug markets is lost. This can frustrate attempts to develop evidence-based drug policy.

WOMEN'S DIFFERING EXPERIENCES OF DRUG USE

Globally, the majority of PWUD are men. According to data from the UN Office on Drugs and Crime (UNODC), published as part of the 2022 World Drug Report, the differences between men and women's use rates are particularly pronounced for opioids such as heroin, cocaine, cannabis and new psychoactive substances. For cocaine, for example, just 27% of users are estimated to be women. However, for other drug types, the gap between men and women's use rates appears to be narrowing.[5] For drug such as amphetamines and recreationally used sedatives, trends suggest an almost 50–50 split between men and women.[6]

This gender gap is reflected regionally. Surveys in Eastern Africa have found that men report much higher levels of substance use in the region than women.[7] Some studies of PWUD also report higher rates of male use. In a 2021 epidemiological survey of injecting practices among PWUD in Kigali, Rwanda, 81% of respondents were male.[8] Similarly, a study of participants at Mozambique's first drop-in centre for PWUD, established in Maputo in 2018, found that over 90% of PWUD screened at the centre were male.[9] These studies may reflect sampling techniques that privilege men's experiences and recruit from settings that male PWUD are more likely to access. But they also reflect the global estimates that drug use, particularly of opiates such as heroin, is predominantly male, and that Eastern and Southern African countries appear to reflect global trends.

However, despite making up a smaller proportion of the overall drug-using population, women's experiences of drug use differ from those of men, often in ways that expose them to greater harm. Globally, evidence suggests that women who use drugs (WWUD) tend to progress more rapidly than men to drug-use disorders,[10] meaning that they are over-represented in the proportion of PWUD requiring support and medical treatment.

The impact of drug use on mental health has also been found to differ between men and women.[11] The evidence base in Eastern and Southern Africa on this issue has been growing in recent years. Research in Dar es Salaam has found that women who inject drugs report higher levels of mental health problems, such as anxiety and depression, than men who inject drugs.[12] Substance use – specifically of methaqualone – was associated with symptoms of depression among adolescent girls and young women in a study conducted in Cape Town, South Africa.[13]

Women are more likely to experience social stigma because of their drug use. Substance use-related stigma is a significant barrier to health care among PWUD in general,[14] but gender appears to be an exacerbating factor. A 2021 systematic review of the global literature on substance use-related stigma found that qualitative research showed that WWUD experience higher levels of drug use-related stigma than men, and concluded that more quantitative research is needed 'to understand the role of stigma in heightening the disproportionate harms experienced by WWUD'.[15] Patriarchal ideologies about women and their role in society – particularly their role as mothers – mean that behaviour judged to be deviant from the norm is criticized more harshly than for men.[16] This has knock-on effects on WWUD's family relationships, social support networks, and ability to access economic opportunities and health services.

Women may be more likely to engage in some behaviours while using drugs that put them at risk. For example, WWUD, particularly young women, are often introduced to substance use by male partners. In Kenya, one study found that 74% of women who inject drugs in low-income urban areas had been introduced to drug use by a sexual partner.[17] Another study, which interviewed women who inject drugs in Nairobi, found that most of the women interviewed had been introduced to drug use between the ages of 11 and 17 by male partners.[18] These women's relationships with men who use drugs were a key factor in their continued drug use. This can mean that women are dependent on men for the supply of drugs and injecting equipment such as needles and syringes, and therefore have less control over the risk of using contaminated equipment. [19] Research in Rwanda has similarly found that WWUD are more likely than men to share drug injecting equipment, which means increased exposure to viruses such as hepatitis C and HIV.[20]

Studies have found that WWUD are also more likely to experience gender-based violence at much higher rates than women who do not use drugs.[21] This includes physical and sexual violence by intimate partners and non-partners. A 2022 study of the experiences of WWUD in Dar es Salaam found that more than half of participants (62%) reported experiencing physical violence in the past year, and almost a third experienced sexual violence in the same period.[22] Other studies have reported high levels of coercive behaviour by partners of WWUD.[23] While physical violence is in itself a threat to the lives and safety of WWUD, it also affects their ability to negotiate safe drug-using practices and access health care. Research has also found gender-based violence to be more prevalent among sex workers and women living in vulnerable socio-economic conditions. These groups intersect, meaning that some WWUD are vulnerable on multiple levels.[24]

WWUD are also more likely to experience housing instability and homelessness, as shown by a growing body of literature on this topic globally.[25] In the first of its kind in Eastern and Southern Africa, a 2022 study documenting WWUD communities in Dar es Salaam found that 35% were classified as 'housing unstable'.[26]

Women who use drugs and women who engage in sex work are two overlapping communities.[27] WWUD may engage in sex work to support basic needs and drug use.[28] In Eastern Africa, studies in Dar es Salaam and Kampala, for example, have found that the majority of WWUD who participated in their studies reported engaging in sex work.[29] This is associated with an increased risk of HIV infection and other diseases.[30] Research in Tanzania has found that women who inject drugs are more likely to report engaging in commercial sex work than men who inject drugs, including using sex to obtain drugs and money to support drug use.[31] Conversely, women sex workers may turn to drug use as a coping mechanism in light of the exposure to violence and risk that sex work can entail. A study of female sex workers in informal settlements in Nairobi reported very high rates of psychoactive substance use.[32] A 2019 study in coastal Kenya reported that many sex workers interviewed smoked heroin and other drugs before sex work. This, the women reported, gave them with the 'courage' to engage in sex work and, if necessary, to stand up to potentially abusive clients.[33]

Engaging in both sex work and drug use puts WWUD at a doubled risk of experiencing gender-based violence.[34] It also puts these women at greater health risk for HIV and hepatitis C. Sex work, like drug use, carries a high level of social stigma and discrimination. Women who are both sex workers and drug users are therefore doubly stigmatized, and are more likely to be treated abusively and denied access to health services.[35]

It has been widely argued that the criminalization of drug use increases the risks associated with it.[36] These risks include fatal and non-fatal overdose and the transmission of viruses associated with unsafe injecting drug use.[37] Among the many reasons for this is the fact that criminalization of drugs means that drug use is largely hidden and out of reach of medical interventions, leaving users dependent on drug supplies, often with no way of verifying whether they might be contaminated with adulterants, and without access to safe injecting equipment. Criminalization also renders discussing drug use taboo, undermining education and public information sharing about safe drug use, and increasing discrimination and social exclusion.[38] The Joint United Nations Programme on HIV/AIDS (UNAIDS) includes criminalization of drug use and possession for personal use as a variable in measuring whether laws and policies are 'punitive and discriminatory' in ways that increases the risk of HIV infection.[39]

This is a particular concern for women, as criminalization of drug use pushes them into vulnerable scenarios, such as reliance on male partners for injecting equipment and at higher risk of gender-based violence. A 2021 global mapping of harm reduction for women who use drugs by the Women and Harm Reduction International Network found that the criminalization of drug use is a key barrier to accessing these services for women who use drugs around the world.[40] Therefore, the fact that countries in Eastern and Southern Africa largely criminalize possession for personal use and drug use is an active barrier to health and gender equality.

DISPARITIES IN ACCESS TO HEALTH SERVICES

As discussed in the previous section, women are at greater risk of harm associated with their drug use and often have different patterns of drug-using behaviour. They are also more likely to have other needs that may affect how or whether they access health services, such as caring for children or other family members; more likely to be socio-economically disadvantaged and to have less control over their own finances, or may have other health needs related to pregnancy or sexual health. Therefore, health interventions to support WWUD need to be designed to address their needs. The UNODC and World Health Organization international standards for the treatment of drug use disorders recommend that 'treatment services should be gender-sensitive and oriented towards the needs of the populations they serve'.[41]

However, women are reported globally to have less access to harm reduction services and drug use treatment services than men.[42] As a proportion of PWUD, they are consistently under-represented in enrolment in these services.[43] The UNODC identified this 'treatment gap' as a 'global problem' in its World Drug Report 2022, calling on countries to tailor interventions to women, youth and other at-risk groups in line with the international standards. [44] Interventions, the report states, should ensure that 'women are safe and not stigmatized, can exercise childcare responsibilities, have access to sexual health care and [are] supported with regard to other social, economic or legal needs, have support to address trauma and comorbid mental health disorders, with priorities given to pregnant women'.[45]

This treatment gap is reflected in Eastern and Southern Africa. The first iteration of the Global Drug Policy Index, a tool designed to provide a data-driven analysis of global drug policies, reviewed four countries in Eastern and Southern Africa in its 2021 findings (Mozambique, South Africa, Uganda and Kenya). In all four countries, women were found to have a moderate or severe lack of access to harm reduction services. This reflected the Index's global findings: women and LGBTQ+ communities were found to face differential obstacles in accessing harm reduction services in every country surveyed.[46]

A growing body of literature has described this treatment gap in Eastern and Southern Africa and investigated the drivers behind it. Several studies have outlined how discrimination against WWUD is a barrier to their access to health services: women in Kenya and Tanzania have reported being de-prioritized by health workers if their drug use is known or if they present injection-related injuries and health conditions;[47] other research has found that a lack of privacy and

confidentiality in harm reduction services prevents women from using these services for fear that their drug use will become public.[48] While these discriminatory attitudes affect all drug-using populations, it has been reported globally to be particularly acute for women.[49]

Discrimination also shapes women's drug use so that interventions are less likely to reach them. Another study on the low enrolment of women in methadone-assisted treatment in Dar es Salaam found that greater discrimination against WWUD compelled them to use drugs in private or more hidden areas, away from outreach teams and community organizations, which focused on outdoor areas where men who inject drugs tended to congregate. It was recommended that expanding outreach, including by women peers, to the places where WWUD actually use drugs could increase enrolment in the methadone programmes.[50] Similar dominance of male clients in harm reduction programmes has been found globally.[51]

In other cases, women's health as drug users is not prioritized over the needs of men. A 2016 study working with poor young WWUD in Cape Town found that women's needs were simply 'not on the agenda' and that, with limited resources for drug outreach programmes in the city, there was a perception among providers that reaching WWUD populations would simply not be an efficient use of these resources, as they make up only a small proportion of the PWUD population.[52] The health care system was also found to be unresponsive to the different health needs of these women – which can span social, psychological, sexual and physical health services – leaving them to navigate a complex and unwieldy system. Injecting drug use is also a barrier to accessing other services, such as maternal and child health care services, as studies in East Africa have found.[53]

Some of the other risk factors associated with women's drug use, such as gender-based violence, also affect their ability to access health care. A 2017 study in Tanzania found that gender-based violence was a factor contributing to low rates of access to methadone treatment for women who use heroin.[54] Gender-based violence has also been identified as a barrier to adherence to HIV care programmes, according to research from government HIV facilities in Kenya.[55] This means that these women face the double challenge of both the violence itself and the barrier it poses to overcoming their addiction.

A review published in 2021 by the Women and Harm Reduction International Network, which mapped the availability of harm reduction services for women who use drugs, found that there are several entities in Eastern and Southern Africa that offer specialized interventions for women, mainly health NGOs based in major cities. Although these services provide essential interventions, the dedicated support offered by these organizations is scarce and scattered across the region, rather than systematically integrated into health systems.[56]

Disparities in health outcomes

The fact that women's drug use often exposes them to a higher risk of harm and that they are under-served proportionally in access to harm reduction and drug use treatment services is reflected in poorer health outcomes for WWUD globally. Available data suggests that WWUD report higher rates of diseases such as HIV and hepatitis C than men, including in Eastern and Southern Africa.[57]

People who use drugs, and particularly people who inject drugs, are among the groups at the highest risk of HIV infection globally and so are identified as a 'key population' for HIV prevention and treatment. Drug harm reduction programmes are therefore part of global strategies to reduce HIV infections worldwide, as well as other associated diseases such as viral hepatitis B and C, and tuberculosis. Similarly, mitigating HIV risk is an essential part of building effective drug policy.[58]

In 2020, 9% of new HIV infections globally were among people who inject drugs.[59] East and Southern Africa is no exception to the trend of PWUD being at particular risk: a 2017 study in Dar es Salaam found that the prevalence of HIV infection among a (predominantly male) sample size was three times higher than in the general population.[60]

Women and girls in Eastern and Southern Africa already live in a context where they are at greater risk of HIV infection than their global peers.[61] According to 2021 data released by UNAIDS, Eastern and Southern Africa is the region most heavily affected by HIV in the world.[62] About 55% of all people with HIV live in the region. Although progress has been

made against the HIV epidemic in the region since 2010, women still account for the majority of new infections.[63] According to analysis from UNICEF, women and girls aged 15–24 are at the highest risk of new HIV infections in the region. [64] The smaller subset of WWUD in East and Southern Africa are therefore at the intersection of these risks, where they are at greater risk of contracting HIV for both geographical and behavioural reasons.

THE IMPACT OF DRUG LAW ENFORCEMENT ON WOMEN

In a context where all forms of drug use and possession are criminalized, the police are one of the main institutions through which PWUD interact with the state. However, evidence gathered by civil society and academic research in Eastern and Southern Africa reflects global trends of women being subjected to abusive treatment by the police, linked to discriminatory perceptions of their drug use.[65]

Research by the South African Network of People Who Use Drugs (SANPUD) and Harm Reduction International with WWUD in Ethekwini, South Africa, found that these women were confronted with a law enforcement ecosystem that viewed them as 'undeserving of even basic respect and dignity', and that they were more likely than other groups to be discriminated against by police officers.[66] Research in Kenya,[67] Tanzania[68] and Zimbabwe[69] has documented similar discrimination against WWUD. Discriminatory attitudes from police have been documented to affect all groups of PWUD in the region.[70] However, stigma and discrimination are compounded for women, as gendered, patriarchal attitudes meet discriminatory views of PWUD.

These attitudes can manifest in police violence against WWUD, including physical violence, which has been reported to researchers in Kenya,[71] South Africa[72] and Tanzania.[73] Reports of sexual assault by law enforcement officers are widespread across the region. A 2013 Human Rights Watch study in Tanzania found that WWUD reported being forced to have sex with police officers in exchange for release from custody.[74] These allegations have been repeated over the years, not only in Tanzania, where reports have documented sexual abuse of WWUD engaged in sex work by police,[75] but also further afield – similar reports have been made in recent years in Zimbabwe,[76] South Africa[77] and Kenya.[78]

The stigmatization of WWUD is also reflected in police denying them access to basic rights, such as access to justice. WWUD in South Africa and Kenya have reported being dismissed and not listened to when attempting to report being victims of crimes such as rape.[79] Others have also reported instances of arbitrary arrest and unjustified stop and search, leading to a situation where for WWUD 'their mere existence is routinely criminalized'.[80] A 2021 study in Tanzania reported that routinely negative interactions with the police due to the illegality of sex work and drug use resulted in WWUD engaged in sex work to avoid contact with the police rather than report being victims of rape.[81] A 2016 study detailing the experiences of poor, young WWUD in Cape Town documented how police corruption– which, in South Africa's Western Cape, is strongly linked to gangs and control of drug markets – affected them, as they reported that 'when young women turned to the police for help with violent, gang-involved boyfriends, they often "did not come to help" and noted that "policemen say you cannot open a case against that man"'.[82]

In other places, police behaviour can be a barrier to WWUD's access to the right to health, for example by confiscating sterile injecting equipment or medication. In Kenya, the criminalization of possession of drug paraphernalia means that the police are implementing laws that are fundamentally in conflict with harm reduction principles.[83]

These experiences of WWUD in Eastern and Southern Africa in their interactions with the police reflect what has been documented around the world. Globally, women who use drugs are often victims of violence at the hands of the police, instead of being given the protection that law enforcement agencies should provide.[84]

Women's roles in drug trafficking organizations

Another way in which women interact with the police in drug law enforcement is through their involvement in drug trafficking, as members of organized crime networks. Research focusing specifically on the role of women in drug supply chains remains scarce, although the evidence base on other issues related to women and drugs has improved in recent years.[85] This is true in Eastern and Southern Africa and has been noted globally.[86] It has been argued that representations of women within organized crime networks have historically relied on stereotypes, portraying them exclusively as victims or defined by their romantic or familial relationships with members of organized crime groups.[87] There are no comprehensive quantitative data sets that track trends in the number of women arrested or convicted for drug-related offences worldwide.[88]

However, the available information suggests that, both globally and in Eastern and Southern Africa, membership of criminal groups involved in drug markets is a predominantly male phenomenon. For a special focus on women and drug markets conducted for UNODC's 2018 World Drug Report, 98 countries provided crime data disaggregated by gender during the period 2012–2016. Of all people arrested for drug-related offences, 90% were men.[89] Studies of gang membership have explored how concepts of masculinity are conceptualized within gangs in Kenya and South Africa, largely because this membership is so male-dominated and a significant part of the passage to adulthood for young men in key neighbourhoods.[90]

Despite being a minority in organized crime groups, women hold a variety of roles within drug trafficking organizations, including as leaders of trafficking groups, dealers and intermediaries.[91] Research based on interviews with female gang members in Cape Town reported that women can be full members of gangs, participating in violence and gang activities such as drug dealing.[92]

However, the most well-documented role of women within drug trafficking organizations in Eastern and Southern Africa is as drug transporters or drug mules. Several studies in the region – including Tanzania,[93] Zimbabwe[94] and South Africa[95] – have reported that women are often recruited as drug transporters because police are less likely to view them as suspects. A 2022 study based on interviews with incarcerated women in South Africa serving sentences for narcotics crimes found that some women were recruited to act as mules out of economic necessity, while others were deceived and unknowingly took on the role.[96] Transporting drugs places women at the forefront of drug markets, where they are most likely to encounter law enforcement and be arrested. This puts them at greater risk of police violence and abuse than the predominantly male leaders of organized crime networks.

LGBTQ+ COMMUNITIES AND DRUG POLICY

The discussion of women's rights in relation to drug policy in Eastern and Southern Africa is inextricably linked to broader questions of how gender identity and sexual expression shape key communities' experiences of drug policy, for several reasons. First, LGBTQ+ communities include women, such as trans, lesbian and bisexual women. A comprehensive assessment of women's experience of drug policy must therefore include these groups. Second, the experiences of LGBTQ+ communities, in relation to drug policy but also more broadly in many areas of life, are often shaped by the patriarchal and heteronormative ideologies that shape women's experiences.

Despite the fact that these groups have unique needs in terms of their ability to exercise their human rights, the rights and needs of LGBTQ+ communities have not been widely addressed in global drug policy debates. In 2018, a report by the Office of the High Commissioner for Human Rights (OHCHR) called on UN member states to adapt their drug policies 'to address the specific needs of women, children and youth, and members of groups in a situation of vulnerability', extending this recommendation for the first time to include the needs of lesbian, gay, bisexual, transgender and intersex people.[97]

Research around the world has shown that rates of substance use are consistently higher among LGBTQ+ people than among their cisgender and heterosexual counterparts.[98] While the reasons for this difference are undoubtedly complex, it has often been attributed, in part, to the higher rates of discrimination, harassment and violence that LGBTQ+ people often experience, leading people to turn to substance use as a coping mechanism.[99] Although

granular data on rates of substance use among LGBTQ+ groups in Eastern and Southern Africa is scarce, a 2019 study in nine countries in the region surveying these groups found very high rates of reported substance use and experiences of sexual and physical violence, and harassment.[100]

Transgender people and men who have sex with men are identified as 'key populations' for targeted HIV prevention and treatment, along with PWUD, sex workers and prison populations. These 'key populations' are internationally identified among HIV prevention workers as groups who, because of specific behaviours, are at higher risk of HIV infection than the general population.[101] A 2021 review of the current data on HIV among key populations in Africa reported that an estimated 25% of new infections in Eastern and Southern Africa are among these key populations, although these groups represent a much smaller proportion of the total population.[102]

However, the available evidence highlights that, despite their health needs, LGBTQ+ populations face significant barriers to accessing health care services. Discrimination and anti-LGBTQ+ stigma have been shown to affect 'every step of the HIV care continuum', according to the 2021 review, including discouraging people from seeking testing, accessing treatment and being retained in treatment.[103]

Overall, LGBTQ+ communities in Eastern and Southern Africa face many of the same challenges as PWUD, particularly WWUD. They face challenges in accessing health care due to discrimination and are subject to police harassment and criminalization of their behaviour. The criminalization of homosexuality legitimizes social stigma and discrimination, and reduces the ability of these key groups to exercise their human rights.

Homosexuality is criminalized in many countries in Eastern and Southern African.[104] Activists in the region report that criminalization has hindered access to health services and contributed to a culture of homophobia and transphobia.[105] Even in countries where LGBTQ+ rights are enshrined in law, discrimination continues to prevent fully equal access to the right to health.[106] Although there are success stories of outreach programmes targeting harm reduction approaches, HIV and reproductive health for LGBTQ+ PWUD in the region, these programmes are not widespread.[107]

The criminalization of homosexuality means that LGBTQ+ communities are subject to greater police surveillance than the general population, which can put them at risk of police harassment and violence.[108] This is recognized in the Southern African Development Community (SADC) regional strategy for HIV prevention, treatment and care among key populations, published in 2018, which states that the lack of a protective legal environment for men who have sex with men and transgender people puts them at risk of abuse by law enforcement.[109] LGBTQ+ people are far more likely to be victims of sexual and physical violence.[110] As the SADC strategy notes, this violence is perpetrated by law enforcement, but also by many other groups.[111]

A report by Human Rights Watch in 2020 documented how a 'crackdown' on LGBTQ+ communities in Tanzania created an environment in which these groups were subjected to harassment and degrading treatment by the police, and public health interventions such as drop-in sexual health centres and community outreach for HIV prevention targeted at LGBTQ+ groups were disrupted.[112] People who use drugs were also affected by the withdrawal of essential services during this period. The same organization recorded similar discrimination against LGBTQ+ groups and PWUD in Tanzania in 2013.[113] Police hostility towards LGBTQ+ groups has also been documented in other countries in Eastern and Southern Africa, such as Namibia and Lesotho,[114] and Kenya.[115]

This means that PWUD who are also members of LGBTQ+ communities face discrimination on both fronts. It also means that many of the key policy areas around LGBTQ+ rights – including access to health and justice – are the same as those being addressed by drug policy activists around the world. Initiatives to reform institutions – from health services to law enforcement – can be aligned to advance LGBTQ+ rights and the rights of PWUD.

WOMEN DRUG OFFENDERS AND THEIR EXPERIENCE IN THE PENAL SYSTEM

Women make up a small minority of the prison population in Eastern and Southern Africa. The latest data available through the World Prison Brief, which monitors prison populations globally, suggests that less than 10% of prisoners in the region are women,[116] which is below the global average.[117]

Globally, however, women convicted of drug-related offences tend to be over-represented in prison populations.[118] In 2018, the UNODC reported that 35% women in prison worldwide were convicted of a drug-related offence, compared to 19.6% of male prisoners.[119] Analysis has suggested that this is because women are typically involved in lower-level drug offences, such as possession for personal use, use or as drug couriers, which puts them at a proportionally higher risk of arrest than men.[120] The availability of gender-disaggregated data on the number of women imprisoned for drug-related offences is low in many countries in Eastern and Southern African.[121] However, the available analysis suggests that the region reflects the global trend and that drug offences are a major cause of women's incarceration.[122]

In recent years, there have been growing calls from several international bodies for the reform of incarceration for low-level drug offences. The UN Working Group on Arbitrary Detention stated in 2021 that 'imprisonment for drug-related offences should be a last resort and (…) used only for serious offences, with diversion or a decision not to prosecute used most often for lesser offences'.[123] The 2021 UN Common Position on Incarceration emphasizes that many countries have no or limited provision for alternatives to incarceration, even for low-level drug offenders.[124] At the regional level, the African Union Plan of Action on Drug Control also recommends that courts consider alternatives to incarceration for non-violent drug offences, particularly for women and children.[125] These positions recognize that drug-related imprisonment is a significant driver of prison overcrowding.

This is a particular issue for women, who are globally more likely to be convicted of the kind of non-violent drug offences that could be addressed through alternatives to incarceration.[126] The high costs to states of keeping these women in prison could be re-directed towards support and rehabilitation programmes. As outlined in the previous sections, women involved in drug economies are more likely to experience other forms of victimization such as gender-based violence, housing insecurity and poverty.[127] Interventions that support WWUD and those convicted of use and possession offences could aim to support women through these challenges and have a longer-term impact on their lives.

Women also have different needs than men in prison. As they are more likely to be the primary caregivers of dependent children, incarceration of women for drug offences has an intergenerational impact. As women's prisons are generally fewer and more dispersed, women may be incarcerated far from home without access to their children or families.[128] Surveys of women's health rights in prisons in Zimbabwe and Malawi have found that the needs of children who remain in prison with incarcerated mothers are often inadequately met.[129] Therefore, exploring alternatives to incarceration for women convicted of non-violent drug offences could reduce the intergenerational impact of incarceration.

Broadly, reports suggest that women in Eastern and Southern Africa are often incarcerated in conditions that violate their human rights. These rights are enshrined in regional frameworks such as the Protocol to the African Charter on the Rights of Women in Africa, which guarantees 'the right to integrity and security of women, pregnant and nursing mothers in detention'.[130] Research on gender inequalities and the health rights of women prisoners in Zimbabwe and Malawi reported that discrimination and stigma against women prisoners – many of whom are incarcerated for drug-related offences – limit their access to health services, particularly in relation to HIV care.[131] This reflects a wider analysis of access to health care for women in prison across the continent, which found that a lack of access to women's health care is a norm across the region.[132] In Madagascar, prolonged pre-trial detention (including for drug offences) has kept thousands of people, including women and their dependent children, in life-threatening overcrowded prison conditions.[133] Investigations into a women's prison in Maputo, Mozambique, revealed that inmates were being forced into prostitution by prison guards, including women incarcerated for drug-related offences.[134]

The evidence outlined above covers a broader issue of prisoner's rights in Eastern and Southern Africa. This is particularly relevant to women's rights and drug policy debates for several reasons. First, many of the women held in

the conditions described above have been convicted of drug-related offences. As international frameworks exhort states to treat non-violent offenders through alternatives to incarceration, these women are therefore unnecessarily subjected to inhumane treatment that harms them and their families, and their presence in prison systems contributes to overcrowding and strains the limited resources available.

As stated in the UN System Common Position on Incarceration, 'Incarceration has a particularly negative impact on women and their dependents in terms of safety, exposure to gender-based violence, mental health and stigma, owing in part to the lack of gender-responsive prison management practices and rehabilitation programmes'. [135] The shortcomings observed in penal systems across the region have a particularly negative impact on women, in part because their health and social needs differ from those of the broader, male, prison population.

In addition, some of the barriers to health care experienced by women in prison in Eastern and Southern Africa are specifically related to drug use. An analysis of the barriers to harm reduction faced by WWUD by SANPUD and Harm Reduction International identified the lack of availability of these services to women in prison as one of many barriers faced by WWUD.[136] Drug policy reform is therefore linked to the wider context of penal reform in the region.

THE ABSENCE OF GENDER-DISAGGREGATED DATA ON DRUGS AND DRUG POLICY

While research on women and drugs has increased exponentially around the world in the last five years,[137] comprehensive gender-disaggregated data on drugs and drug policy is still an unrealized ideal. There are significant gaps in the academic research in this area. Recent studies in Eastern and Southern Africa have highlighted the lack of research that is currently available on the lived experiences of women who inject drugs,[138] patterns of substance abuse and rates of diseases such as HIV among WWUD,[139] barriers to accessing harm reduction services among WWUD,[140] and the role of women in criminal groups and drug trafficking organizations,[141] among other topics. This contributes to a reinforcing cycle in which drug policy is not designed for WWUD, whose presence and needs are not recognized. State-collected data on drug economies is also rarely disaggregated by gender.[142] Even where such data is collected, it is often not done with the intention of programming around gender dimensions, but as a standard element of police reporting.

The 2018 UN World Drug Report included a section on women and drugs, lamenting the global lack of availability of gender-disaggregated data on drug policy.[143] Since then, expert consultations to update the Annual Reporting Questionnaire (ARQ), the tool through which the UNODC collects data from member states for the World Drug Report, have recommended that a gender dimension be included in all aspects of data collection.[144] However, few African countries regularly submit data through the ARQ, so the picture for the region remains opaque. For the 2021 World Drug Report, only 23% of African UN member states responded to the questionnaire.[145]

A lack of data on drug economies that includes women or is disaggregated by gender has meant that the experiences of women in the drug economy – and the impact of drug policy on women – have been rendered invisible. This includes data collected by states to measure the impact of drug policy, as well as research by academics and civil society on drug-related health issues, criminal justice and drug law enforcement. This contributes to a gender-blind approach to drug policy, where the role of women in drug economies is not seen and therefore not addressed by the state.

The size of the WWUD population is routinely underestimated, in part due to the nature of drug support and outreach. A 2013 study identifying programmatic gaps in harm reduction services among male and female drug users in Dar es Salaam found that outreach at regular drug-using hangouts, known as *maskanis*, disproportionately enrolled men into harm reduction programmes as this approach did not take into account women involved in sex work or with caring responsibilities for dependent children.[146] Similar research in other regions has found that women are less likely to use public areas for drug consumption and are more likely to under-report drug use.[147]

THE DEVELOPMENT OF LEGAL AND POLICY FRAMEWORKS RELATING TO WOMEN AND DRUGS

Despite the body of evidence showing that they are a key minority group when it comes to drugs and human rights, women have been described as 'the missing component' of international drug policy,[148] as frameworks designed specifically at upholding their rights have been slow to develop. [149] The three main UN drug policy conventions make no recognition of issues faced by women with respect to drug use, drug law enforcement or their involvement in illicit drug markets.[150]

However, with gender equality enshrined in virtually all major international human rights treaties, UN human rights bodies have taken steps to put a spotlight on women and drug policy. Reports from the OHCHR have repeatedly called on member states to adopt drug policies that take into account the specific needs of women and LGBTQ+ communities, highlighting the mass incarceration of women, the exacerbation of poverty, discrimination in access to health and physical violence levelled at WWUD by police as key impacts of drug control policies on women.[151] Other human rights bodies have also highlighted the excessive use of incarceration against women for drug-related offences and the need for gender-sensitive approaches in national drug policies and programmes.[152]

Over time, gender equality has become more mainstreamed in international drug control debates. In 2009, the UN Political Declaration and Plan of Action on Drugs called on member states to 'take into account the specific needs and circumstances that women face with regard to drug problems' and recognized systemic issues such as the lack of demand reduction services for women in general, and pregnant women in particular.[153] Other UN drug control body resolutions have since followed this lead. The UN Commission on Narcotic Drugs has adopted resolutions on promoting the needs of women in harm reduction programmes and international cooperation to address the involvement of women and girls in drug trafficking.[154]

The 2016 UN General Assembly Special Session on Drugs (UNGASS) has been described as a watershed moment for gender mainstreaming in drug policy, with the inclusion of a chapter on cross-cutting human rights issues in drug control, including 'youth, children, women and communities', as one of the seven pillars of the UNGASS outcome document.[155] The document urged states to ensure that a gender perspective is incorporated at all stages of drug policies and programmes. Policy initiatives around the UNGASS also helped put the gender element firmly on the international drug policy agenda.

These seven pillars have been replicated in regional policy documents, such as the African Union Plan of Action on Drug Control for 2019–2023.[156] This document recognizes the role of women in drug use and supply, including high rates of HIV and hepatitis transmission, particularly among young people and women who inject drugs, and the regular recruitment of women, particularly from low-income backgrounds, as drug mules. It sets targets for member states, including on access to health services for WWUD, to sensitize 'the prosecutorial and judicial authorities regarding age and gender appropriate judicial outcomes' and consider 'court diversion and proportionality in sentencing for drug offences'. Similarly, the East African Community Regional Policy on Prevention, Management and Control of Alcohol, Drugs and Other Substance Use includes the aim to 'prevent and reduce the uptake of alcohol, drugs and other substances among young people and other vulnerable populations including women and children, in order to allow them to realize their full potential'.[157] The international and regional documents serve as a guide for national policies. For example, Zimbabwe's National Drug Master Plan states in its introductory text that the UNODC – as part of the international institutions on drug control – promotes gender equality, and that the African Union has recommended that cross-cutting issues, including women's rights, be considered in drug policy.

In practical terms, what a gender-sensitive drug policy might look like has been articulated in a number of recommendations made by civil society and international organizations, as well as academic research. These have focused on several key elements:

- Increasing the use of alternatives to imprisonment for women convicted of drug-related offences.[158]
- Collecting and using gender-disaggregated data on drug use and drug-related health and social services.[159]
- Ensuring access to gender-appropriate health care for WWUD: including drug dependence treatment, harm reduction and other services such as reproductive health and HIV prevention and treatment services. These services should be accessible to all WWUD, including pregnant women and those with childcare needs.[160]
- Ensuring support for cases of women suffering gender-based violence is accessible to WWUD. [161]
- Ensuring access to gender-appropriate health care for WWUD in state custody (prison or pre-trial detention). [162]
- Implementing measures to reduce violence and abuse against WWUD by police and prison services, including functioning mechanisms for reporting abuse.[163]
- Developing gender-sensitive training on issues relating to women and drug policies for criminal justice officials, including police, policymakers, prosecutors, judges and probation officers. [164]
- Ensuring that drug laws and policies take into account the special needs of pregnant women and mothers, for example by developing policies to protect families from the arbitrary removal of child custody from WWUD. [165]

Regionally, some gender-sensitive indicators have been incorporated into national drug policy frameworks in Eastern and Southern Africa. A comparison of five different countries in the region that have articulated a national drug strategy in a policy document is included below. As the table shows, most of the specific gender objectives focus on two main themes: improving access to health care for WWUD and improving gender-disaggregated data collection. While these are part of the framework of gender-sensitive drug policies proposed by UN bodies and civil society, they do not cover the full range of challenges faced by WWUD. For example, none of the policy documents reviewed include targets to explore alternatives to incarceration, to improve police accountability in dealing with WWUD or to support WWUD affected by gender-based violence.

Country/region	Policy document	Gender-sensitive targets and language
Zimbabwe	National Drug Master Plan (2020–2025)	■ Includes the Ministry of Women Affairs as one of the parties responsible for achieving demand reduction and identifying and profiling high-risk groups for drug use. ■ Includes a target to run drug use prevention programmes aimed at pregnant women, sex workers and men who have sex with men, as part of a broader 'demand reduction' set of measures.
Mauritius	National Drug Control Master Plan 2019–2023	■ Identifies gender mainstreaming as one of three 'critical cross-cutting issues', along with capacity building and respect for and observance of human rights. ■ Includes the Ministry of Gender Equality, Child Development and Family Welfare as part of the institutional framework on drug use. ■ Includes a target on increasing the capacity of the existing in-patient women's drug treatment facilities. This includes sub-targets to increase the staff and facilities available for women's drug treatment.
Kenya	National authority for the campaign against alcohol and drug abuse, Strategic Plan 2019–2022	■ Does not mention women, gender mainstreaming or key populations such as female sex workers. ■ Includes objectives on rehabilitation targeting 'vulnerable populations', but does not specify what these are.
Seychelles	National Drug Control Master Plan 2019–2023	■ Includes a target on improving access to harm reduction services for WWUD, including the introduction of gender-responsive laws, policies and programmes and the creation of harm reduction services specifically for WWUD. ■ Includes a target on improving access for WWUD to sexual and reproductive health and pre-and post-natal care.

Country/region	Policy document	Gender-sensitive targets and language
South Africa	National Drug Master Plan 2019–2023	■ Identifies 'improved access to gender and youth sensitive health and social services' as an activity that would contribute to reducing the harms of drug use. ■ Aims to monitor and disaggregate by gender the number of people seeking harm reduction treatment. ■ Identifies women, particularly pregnant women, LGBTQ+ communities and sex workers as target populations. However, does not include key indicators to monitor how these target populations are identified and supported.

CONCLUSION

The primary aim of this paper has been to bring together the available evidence on how drug policy treats women in Eastern and Southern Africa. From this, it has sought to make a case for why drug policies should explicitly take gender into account in their design and implementation.

Women's experiences of drug use differ from those of men, and women are often at greater risk of harm. They are treated more harshly by society and the state because of their drug use. Broader issues of gender inequality intersect with the issues created by punitive drug laws to create a situation in which many women are put at risk. This has a knock-on effect on families, wider communities, and other issues such as HIV prevention and treatment. In situations where resources are limited, practitioners may prioritize populations that are the easiest to reach or the largest groups: in this case, often men. This means that women – and LGBTQ+ communities – are underserved even by outreach programmes designed to target hard-to-reach communities.

Several countries in the region have set out key objectives related to women and drug policy, reflecting international shifts towards a 'gender sensitive' approach in this policy area. However, when translated into specific targets and goals for government agencies, these intentions to create gender sensitivity are not yet uniform or comprehensive. Support for WWUD in the justice system, from arrest and pre-trial detention to prison and parole, is currently a blind spot for policymakers in the region, who appear to have focused their efforts primarily on the health-related aspects of women's drug use. In part, a lack of adequate data collection also creates a shaky foundation for evidence-based policymaking.

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