

22 December 2023

Exploring sexual and reproductive health and rights among women who use illegal drugs in Australia



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Acknowledgement of Country

We acknowledge the Traditional Owners of the Lands on which this report was produced, including the Boon Wurrung people of the Kulin Nation (where the Burnet Institute is located). We pay respect to all Aboriginal and Torres Strait Islander people and recognise their cultural, spiritual, and educational practices, their ongoing connection to Lands, Waters, and Communities, and that 'sovereignty was never ceded'.



Acknowledgement of people who use drugs and women

We acknowledge all the people who have lost their lives to drug use, the consequences of ongoing structural and legal frameworks that criminalise drug use, and the stigma and discrimination that is perpetuated against people who use drugs and continues to place people's lives at risk. We acknowledge that women experience gender-based oppression, discrimination, and violence. We acknowledge that women who use drugs have strength and make vital contributions to their families and our community. We thank the women with living and lived experience of drug use who have generously contributed to the data sources presented in this report. Real people and real lives that give meaning to the work.



Burnet Institute
85 Commercial Rd
Melbourne, VIC 3004
burnet.edu.au

Suggested citation: Sophia Schroeder, Bek Petrovic, Shelley Walker, Daisy Gibbs, Samantha Colledge-Frisby, Anna Wilkinson, Rebecca Winter, Ashleigh Stewart. Exploring sexual and reproductive health and rights among women who use illegal drugs in Australia; December 2023. Burnet Institute, Melbourne, Australia. doi: <https://doi.org/10.82213/pz91-qf71>.



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Burnet Institute
National Drug Research Institute, Curtin University

Prepared by:

Sophia Schroeder
Bek Petrovic
Shelley Walker
Daisy Gibbs
Samanatha Colledge-Frisby
Anna Wilkinson
Rebecca Winter
Ashleigh Stewart

Other contributors:

Professor Paul Dietze

Contact:

Dr Ashleigh Stewart, Ashleigh.stewart@burnet.edu.au



Table of contents

Executive Summary	8
Introduction	9
Aims and research questions	12
Methods	13
Participant recruitment.....	13
Data collection.....	14
Analysis.....	14
A reflection on data collection by the primary interviewer	16
Results	17
Participant characteristics.....	17
Reproductive health	17
Menstrual cycles.....	17
Pre-menstrual syndrome (PMS).....	18
Menopause.....	18
Contraception and prevention of sexually transmissible infections (STI)	19
Cervical cancer screening and breast checks	20
Pregnancy and post-natal care.....	21
Intersection of drug use and pregnancy	21
Breastfeeding	22
Sexual activity.....	23
Sex and pleasure	23
Sex work and health care	24
Barriers accessing and using healthcare services	25
Previous negative experiences.....	25
Psychosocial barriers.....	26
Socio-economic barriers.....	26
Physical access barriers.....	28
Importance of non-judging, supportive, and coordinated healthcare responses	28
Discussion	30



Conclusion	32
Declarations.....	33
Acknowledgments	33
CReDIT Author Statement	33
Budget report	33
References	34



Executive Summary

The criminalisation of drug use means people subsequently experience considerable social and health-related harm. This includes poverty, unstable housing, incarceration, physical injury, insufficient preventive and primary care, non-communicable diseases, and communicable infections. People who use illegal drugs experience marginalisation, stigma, and discrimination from the community and healthcare providers, exacerbating the risk of poor health. Women are at higher risk of poor social and health outcomes, driven by structural and systemic gender-based bias, discrimination, and violence. Women who use illegal drugs therefore face the compounding effects of gender and drug use. There are an estimated 30,000 Australian women who inject drugs, yet little is known about their health priorities and healthcare service access. Critically there is limited data regarding their sexual health literacy, needs, priorities, and access of sexual and reproductive health services.

As a starting point, in addressing the gap in evidence on the sexual and reproductive health needs of women who use illegal drugs, an exploratory qualitative study was conducted in 2023, by the Burnet Institute. Our study highlights that there are aspects of sexual and reproductive health and healthcare access unique to women who use drugs. Women shared experiences of navigating a complex, often siloed, and discriminatory healthcare system. Women's sexual and reproductive health needs overlapped with addiction and drug treatment, general primary care, oral health, and infectious diseases. The need for comprehensive, accessible, and understandable information relevant to age and stage of life in a variety of mediums was stark. Importantly, women expressed a need for a trusted source of information and a trusted, consistent, healthcare provider or service.

This study provides new insights into the health needs of women who use drugs. Women generously shared their stories about sensitive aspects of their lives. Listening to women and their needs, and highlighting their strengths and capabilities is critical to inform next steps. This study highlights that women urgently need comprehensive healthcare, co-located healthcare providers and/or multidisciplinary providers. Women want sexual health and reproductive health, but information that explicitly recognises and includes the context of drug use. There remain substantial gaps however in the evidence needed to respond to the needs of women who use drugs, particularly younger women and pregnant women who use drugs; understanding their health needs is a critical next step.



Introduction

Illegal drug use is a major contributor to morbidity and premature mortality (Colledge et al., 2019; Degenhardt et al., 2017). Methamphetamine and injecting drug use are characterised by particularly high levels of drug-related harm, marginalisation, and experiences of stigma (Degenhardt et al., 2023; Goodyear et al., 2021). Although men have a higher prevalence of methamphetamine and injecting drug use, emerging evidence suggests the sex-gap in substance use is narrowing (McHugh et al., 2018; UNODC, 2022). In Australia, it is estimated that 30,000 women inject drugs annually, accounting for one third of the estimated injecting population. In 2019, approximately 1% of Australian women over 18 years of age reported using methamphetamine (Australian Institute of Health and Welfare 2020). Understanding the health priorities of women who use drugs remains a critical gap in the literature, with research largely focussed on men who use drugs and their health needs.

In this report, we focus on cis-gender women, that is women whose sex and gender identity overlap. Specifically, we refer to individuals who have female reproductive organs and were biologically assigned female sex at birth, and who self-identify and were socialised as a woman.

Women who use drugs experience greater excess mortality than their male counterparts (Larney et al., 2015). Women who inject drugs are more likely to inject with a used syringe, require peer assistance with injecting, and some evidence suggests that they are at higher risk of reporting injecting-related infections (Larney et al., 2017). In many studies of people who inject drugs, being female is reported as an independent predictor of HIV and hepatitis C infection (Iversen et al., 2015; Larney et al., 2015). Among people using methamphetamine, females are more likely to experience sexual violence (Bach et al., 2020), and are less likely to report receiving drug treatment compared to men (McKetin et al., 2007). Despite these known differences, the experiences and voices of women who use drugs remain poorly understood, with little attention paid to the sex- and gender-specific needs of women.

Sexual and reproductive health care that caters to the needs of women who use drugs is essential and should address needs across the reproductive life course. This includes health care and support for menstrual health including menopause, contraception, pregnancy and postnatal care, sexually transmitted infections and cervical screening (Azim et al., 2015).

Menstrual health and hygiene are directly related to knowledge and management of the menstrual cycle, including selfcare and help seeking for menstrual discomfort and abnormalities, with poor menstrual health linked to low self-esteem and poor mental well-being (Keiser et al., 2020). Little is known about menstrual health and hygiene among women who use illegal drugs, however, some estimates suggest up to 80% of women report experiencing menstrual poverty (Keiser et al., 2020). As women who use illegal drugs move through the reproductive lifecycle, understanding the impact and management of menopause is crucial. Issues relating to menopause can be complicated by opioid use, with symptoms such as hot flushes misdiagnosed as opiate withdrawal (Johnson et al., 2008). Illegal drug use has also been shown to affect the onset of menopause, with



a US study showing women using heroin and/or cocaine were two and a half times more likely to experience early onset menopause (Schoenbaum et al., 2005).

Women who use illegal drugs have high rates of pregnancy and poor pregnancy outcomes (Black et al., 2012; Homsup et al., 2018; Maher et al., 2017). This includes higher rates of pregnancy terminations (Cornford et al., 2015), miscarriage (Scheidell et al., 2022), and babies born preterm and at low birthweight (Homsup et al., 2018) compared to the general population. Among women with substance dependence, estimates show up to 80% of women report having an unintended pregnancy (Black et al., 2012; Heil et al., 2011); this compares to 40% of women in Australia's general population (Bearak et al., 2022; Rowe et al., 2016). Unintended pregnancies have been linked with poor maternal and neonatal outcomes, including infants born at low birthweight (Hall et al., 2017; Kost & Lindberg, 2015). Advancements and increased uptake of contraceptives have contributed to decreases in unintended pregnancies in Australia and elsewhere (Richters et al., 2016). However, women who use illegal drugs are less likely to use highly effective contraception than the general population (Terplan et al., 2015). To date, little research has explored contraceptive use among women engaging in injecting drug use and whether this differs to the broader population of women who use illegal drugs.

Perceived infertility due to drug-induced amenorrhea has been identified as a common reason for not using contraception among women who inject drugs (Mburu et al., 2018). Use of some psychiatric medications has been linked to menstrual irregularities such as amenorrhea (Lania et al., 2019), which could be impacting women with substance dependence due to high rates of mental illness among this population (Colledge et al., 2020; Santo et al., 2022). However, the current evidence base for linking dependent opioid use and menstrual irregularities is poor (Lania et al., 2019), and given the widespread use of opioid medications and growing opioid crisis in many parts of the world, understanding this link is crucial.

Women who inject drugs report higher rates of sex work compared to women not injecting drugs (Valencia et al., 2020). Studies have shown that women who use drugs and who report sex work are more likely to report condomless sex, thus increasing their risk of HIV and other sexually transmissible infections (STIs) (Medina-Perucha et al., 2019). A study in the United States found that women who injected drugs were more likely to report syphilis, chlamydia, gonorrhoea, and genital herpes compared to women not injecting drugs (Brookmeyer et al., 2019). Similarly, the link between methamphetamine use and high risk sexual behaviours is well established (Hittner, 2016). Women who tested positive for chlamydia or gonorrhoea were more likely to report methamphetamine use compared to women who tested negative (Stahlman et al., 2013), suggesting a need for strengthening risk prevention and STI testing among this group.

Gender-based violence has also been linked to poor sexual and reproductive health outcomes for women (Grose et al., 2021). Women who report experiencing gender-based violence also report higher numbers of sexual partners, STIs, unplanned pregnancy and abortion (Grose et al., 2021). Studies of women who use illegal drugs have reported high rates physical or sexual intimate partner violence (Valencia et al., 2020), with gender inequity identified as a contextual factor that



increases vulnerabilities for negative sexual and reproductive health outcomes among women who inject drugs (Vartika et al., 2017). It is estimated that more than 90% of women who use illegal drugs report experiencing gender-based violence, most perpetrated by men using alcohol or other drugs (Plaza-Hernández et al., 2023). Understanding and promoting sexual and reproductive health for women who inject drugs requires an understanding of the impact of gender-based violence experienced by women.

Women who use drugs are faced with a range of sex- and gender-specific health risks and barriers to healthcare access (National Institute on Drug Abuse (NIDA), 2021). Women who use drugs have a unique and specific experience of stigma (Lee & Boeri, 2017; Meyers et al., 2021), which is known to reduce service access (Gibson & Hutton, 2021) and is particularly heightened for women who are pregnant (Weber et al., 2021). Further, harm reduction services typically neglect women's sex-specific needs and have been described as 'masculine spaces'. This creates a barrier to healthcare access for women and contributes to the observed sex disparities in accessing harm reduction and drug treatment services (Colledge-Frisby et al., 2023; UNODC, 2022).

Women who inject drugs may experience inequitable access to preventive public health measures designed to support women's health (Owens et al., 2020; Pinkham et al., 2012). Existing evidence on the experiences of women who inject drugs globally suggests that in many settings this population faces limited access to some essential health services, including reproductive health care and prevention of mother-to-child HIV transmission. Discriminatory practices may result in the exclusion of women who use drugs from women's shelters and other special health and social services for at-risk women (Pinkham et al., 2012; Shapoval & Pinkham, 2011). Internationally, women who use drugs are often forgotten by services for people who use drugs due to their sex, and neglected by services for high-risk women and people with HIV due to their drug use (Pinkham et al., 2012).

A clear example of the neglect of women who use drugs is that the current Victorian women's sexual and reproductive health plan 2022–30 fails to identify women who use/inject drugs as a priority population, nor identifies the necessity of offering sexual and reproductive health services within substance use services (Victorian Department of Health, 2022). This is, in part driven by public health research historically focussing on men who use drugs (McHugh et al., 2018), perpetuating the male-oriented nature of harm reduction services (Boyd et al., 2018; Goldenberg, 2020). There are limited data regarding Australian women who use/inject drugs, their sexual health literacy, and accessing of sexual and reproductive health services. The gap in understanding of specific women's health issues among women who use drugs must be addressed to inform the development of effective approaches for tailored service provision and support of women's sexual and reproductive health and rights.



Aims and research questions

This study aims to engage women who use or inject drugs in a scientific inquiry that seeks to:

1. Explore their experiences and understanding of sexual and reproductive health and rights;
2. Understand barriers and enablers of achieving and maintaining sexual and reproductive health, including accessibility of services; and
3. Identify their priorities and matters of concern related to achieving and maintaining wellbeing as defined by them.

We sought to answer the following research questions:

1. How do women who use/inject illegal drugs understand and manage their sexual and reproductive health?
2. What role does sexual and reproductive health play in the experience of wellbeing (or lack thereof) among women who use/inject drugs?



Methods

This study used a qualitative research design involving in-depth interviews to examine the sexual and reproductive health experiences and understanding of women who use drugs.

A working group was established to provide project oversight and input into the study design, including research aims, participant recruitment, data collection methods, and data analysis processes. The working group involved women researchers with experience in the field of alcohol and other drugs and qualitative research methods, and women fieldworkers/researchers who conducted interviews with participants who use drugs.

Ethics approval for the study was obtained from the Alfred Hospital Ethics Committee (project number: 453/23).

Participant recruitment

Participants were recruited from two longstanding prospective cohort studies of the Burnet Institute, including the Melbourne Injecting Drug User Cohort Study (SuperMIX) (Van Den Boom et al., 2022) and the Understanding Methamphetamine Use in Victoria Study (VMAX) (Quinn et al., 2021).

The ongoing SuperMIX cohort was established in 2008 (N=1303 in 2023) and is focused on understanding the health and socio-economic outcomes, drug use patterns and health service use experiences of people who inject drugs (Van Den Boom et al., 2022). Eligibility included being at least 18 years of age, injecting at least monthly for six months prior to baseline interview, and residing in urban Melbourne, Victoria. An initial criterion that participants were younger than 30 years of age has since been relaxed. The VMAX cohort (N=744 in 2023) commenced in 2016 and examines long-term patterns of methamphetamine use, service use, health, and wellbeing outcomes over time (Quinn et al., 2021). Eligibility includes being over 18 years of age; residing in metropolitan Melbourne or regional/rural Victoria; and at least monthly use of methamphetamine primarily via non-injecting routes of administration (e.g., smoking, snorting) in the last six months. Annual follow-up surveys are completed with participants of both studies.

We used purposive convenience sampling methods to recruit participants into the current qualitative study. Eligibility for the study included: 1) being known to the working group as a cis-gender woman; 2) reported use of any drugs within the past 12 months; and 3) residing in Melbourne or regional/rural Victoria at the time of interview.

Participant recruitment was facilitated by fieldworkers/researchers from the SuperMIX and VMAX studies, given they already had established and trusting relationships with participants in these studies. To enhance the potential for information-rich data, participants were purposively selected from those who matched eligibility criteria and for whom it was considered would feel comfortable discussing issues related to their sexual and reproductive health.



Once potential participants were identified, they were contacted (via phone call or in-person) to learn more about the study and what participation would involve. If women agreed to participate, a time and place was organised to complete the consent process and interview. Participation was voluntary and involved verbal informed consent.

Data collection

Interviews were conducted between October and November 2023, three women researchers of the project working group conducted the interviews either individually or in pairs. Women were given the choice to complete interviews in-person or via telephone, at a time and location of their choice. Given the topics of investigation were sensitive and involved the discussion of intimate and personal details, in-person interviews were conducted in private spaces where the women felt safe to share this kind of information.

A semi-structured interview schedule was used to guide the interview process, which included broad open-ended questions to allow participants to explore issues of interest that may otherwise have remained uncovered. To establish rapport, interviews opened with an invitation for participants to share a little bit about themselves, before exploring the following domains: perceptions and experiences of sexual and reproductive health and rights and general wellbeing; challenges and facilitators to addressing sexual and reproductive health needs (including those related to alcohol and other drug use, social circumstances, and self-determination/agency); access to and engagement with health professionals and services; and motivations, priorities and goals driving their reproductive health and wellbeing decisions and actions.

Interviews were audio-recorded using an electronic recording device and were approximately 60 minutes in duration. Participants were reimbursed \$AU50 to acknowledge their time and expertise.

Interviews were transcribed verbatim by a professional transcription service with a signed confidentiality agreement. Transcripts were checked for accuracy and de-identified, including removing names of participants and any other identifiable information such as names of other people or places.

Analysis

Data was analysed using a rapid thematic deductive/inductive approach (Braun & Clarke, 2012; Fereday & Muir-Cochrane, 2016).

Transcripts were read by members of the research team and discussed to determine agreed upon broad understandings of the content of interview data. NVivo qualitative data software (QSR International, 2023) was used to manage and organise data. Deductive codes were established in NVivo that represented interview topics of investigation and study aims; extracts of data in transcripts were assigned to these codes. As the coding process progressed and new ideas, experiences, views, perspectives, and areas of interest were identified inductively, new codes and subcodes were established to represent these emerging themes. The inductive process also



involved collapsing, merging or removing codes and sub-codes as the analysis progressed. In the quotes that are presented below, pseudonyms are used to protect the identity of participants.



A reflection on data collection by the primary interviewer

The 11 women interviewed represent a severely disadvantaged demographic marked by socio-economic hardships. Their engagement in the research provides insights into the challenges faced by this marginalised group including childhood trauma, family and sexual violence, homelessness, poverty, and child removal.

In recruiting participants, the foundation of an existing relationship proved instrumental in creating a safe and open space for the women to share their experiences on deeply sensitive topics. As a familiar person of trust in the lives of these women, our already established rapport facilitated a depth of dialogue that extended conversations beyond conventional interactions.

To overcome any potential barriers to participation, the interviews were mostly conducted in a public health study (research) van, parked outside of the participant's homes. This approach ensured that challenges relating to accessibility would not impact the women's ability to participate. Being in a familiar environment provided extra comfort, removing the fear of having to navigate returning home alone after a potentially triggering conversation, further enabling a more personal and intimate conversation.

Recognising the sensitivity of the discussion points, and in line with trauma-informed practices for research, a pre-interview telephone conversation was completed approximately 48 hours prior to the interview. This discussion not only provided the women with time to reflect on their experiences but, more importantly, this pre-consent step in our recruitment, provided women with the agency to withdraw from the research if they felt the forthcoming discussion would be triggering. One participant exercised this option, emphasising the importance of respecting the potential for re-traumatisation when discussing the lived and living experiences of this group of women.

The interviews were intentionally intimate to create a space where the women, who were empowered to leave the discussion at any time, felt supported whilst sharing their experiences. Despite the interview focus being on sexual and reproductive health, it became apparent that these areas made up a small fragment of their lives and that considerations of their sexual and reproductive health were consistently overshadowed by multiple other competing and complex needs.

As the main interviewer, a deep sense of gratitude and admiration for the eleven women emerged and despite the significant challenges faced by these women, author BP was able to witness a shared resilience that speaks to their remarkable strength. Their openness to share their stories, even in the face of emotional discussions, highlights not only their courage but a desire to be heard.



Results

In the following section we present participant characteristics followed by the results of our analysis of participant transcripts, which are presented via five key domains:

1. **Reproductive health:** experiences of menstrual cycles; pre-menstrual syndrome (PMS); menopause; contraception and prevention of STIs; and cervical screening testing and breast checks.
2. **Pregnancy and post-natal care:** experiences of the intersection of drug use and pregnancy; and breastfeeding.
3. **Sexual activity:** experiences of sex and pleasure; and sex work and healthcare.
4. **Barriers accessing and using healthcare services:** previous experiences, psychosocial barriers, socio-economic barriers, lack of knowledge; physical access barriers.
5. **Importance of non-judging supportive and coordinated healthcare responses.**

While our aim was to explore participants' understandings and experiences of sexual and reproductive health and rights, findings highlight how these issues occupied one component of their complex life experience. Considerations of their sexual and reproductive rights were often overshadowed by more pressing issues related to socio-economic disadvantage (e.g., poverty, housing instability, child protection involvement), structural violence and systemic abuse, and a profound sense of disempowerment.

Participant characteristics

Interviews were conducted with 11 women ranging in age from 38 to 60 years, with an average age of 47 years. Two women lived in rural Victoria, and the remainder resided in metropolitan Melbourne. Excluding one woman who smoked methamphetamine, all participants had experiences of injecting drug use (heroin and/or methamphetamine). While not asked consistently, interview data suggests that a minimum of eight participants had experience of opiate agonist therapy (Methadone, Buprenorphine).

Reproductive health

Menstrual cycles

Reflecting on their menstruation, several women recounted experiencing amenorrhea for extended periods in their lives. Participants attributed their lack of a menstrual cycle to the impacts of ongoing and high-volume drug consumption on their bodies, with one participants' diagnosis of polycystic ovarian syndrome also being a contributing factor.

When I was younger, I didn't have my period for about - because I was using heavy, I didn't have it for about eight years... This was in my 20s. (Interview 4)

For all women, their periods had changed in intensity and severity over the course of their lives, which was reportedly influenced by childbirth, hormonal contraception, changes to drug



consumption and other less tangible factors. Several women spoke of severe period pain which they managed with pain medication, or times in their lives where their bleeding was so severe that they sought medical advice:

I did have to take tablets to stop bleeding because a few years back my period wouldn't stop. It just would not stop. A week had gone, two weeks ago had gone, three weeks had gone. I'm like, oh my God, it was driving me crazy. (Interview 9)

Two women also discussed increasing their drug use to manage their period pain and/or avoid having periods altogether, once they discovered this was possible.

I: So, you were using drugs as a way of stopping your bleeding.

R: Yeah. Like getting rid of my weight and the bleeding at the same time. So, I just used the speed to get along with that. Even the heroin I didn't bother with at that stage because I knew it was basically the amphetamines that were making it stop. ... But no one ever told me that beforehand. (Interview 10)

When women were asked about accessing period products (including the cost), some participants said community health centres and Needle Syringe Programs (NSPs) typically provided period products free of charge. No participants reported instances of being unable to access products when needed.

Pre-menstrual syndrome (PMS)

A few interviewees described symptoms of PMS and the effect it had on their moods and social functioning. One participant reflected that a key reason for not identifying the cyclical pattern of her menstrual cycle experience sooner was that drug use and the effects of drug withdrawal had been a primary and salient explanation. It was only after seeking out information on the internet and noting down her experience that this participant understood her changing hormone levels as contributing to negative mental health symptoms. At the time of interview, she had developed strategies to help manage her symptoms and felt a vast improvement in her quality of life.

I have googled and I think that's too how I became aware myself and worked on my mood issues and that. Just I thought, hang on, I know what's happening. Let's work on it and see how you go. ... just these little techniques that, yeah, they weren't even an effort to do. It was just recognising, okay, you're slipping into that shitty, crappy mood. Change the mood, you know, set. You know, don't think so depressive. Think of something that's happy and something to look forward to and, yeah, it's worked. (Interview 1)

Menopause

Most participants felt that menopause was their current or next 'big thing', but did not feel well informed about what to expect and how to prepare. Consequently, participants said they had a lot of questions around the 'change of life' as they called it, and few had been able to confirm that they were pre-menopausal. Most participants still experienced periods and those who had not bled



in over 12 months had to date been unable to seek contact with a trusted GP to discuss these matters.

I don't know much about that (menopause) and, yeah, so that's my next sort of thing. Like, okay, what age do I expect to go through the change of life? What do I look for when you're going through the change of life? What sort of other signs and symptoms? Your period stops, obviously, but what are the other sort of signs or what's the sort of average age that women go through change of life? Or is it just totally different for every woman? (Interview 1)

I just googled it...I found that it lasts for like seven years. I'm like, "Yay!" [laughs] And I speak to other people on the bus and they're like, "It goes forever." [laughs] I should just stop asking people. (Interview 8)

Participants described experiencing several symptoms that led to them assuming they may be pre-menopausal, including a change in frequency and volume of blood, change in sex drive, sweating and hot flushes. Participants' prescription medication (including Seroquel [used for the treatment of mood disorders] or opioid agonist treatment [OAT]) made it difficult for them to clearly identify the cause of such symptoms. Several participants experienced hot sweats as a side effect of methadone maintenance therapy. Some women also described how having hot flushes caused social anxiety and fear of discrimination, because they feared people assumed this was related to their drug use as opposed to the effects of menopause.

I hate that because, yeah, I just straight away, think people are looking at me like a drug user because, you know sweating up, you know and at times when you really super sweating up, like people just look at you a bit weird. (Interview 6)

Contraception and prevention of sexually transmissible infections

Regarding contraception, the women described being offered and taking up a range of contraceptive methods over their life course through their primary care providers as well as justice health for women with a history of criminal justice involvement. Contraceptive methods used included: condoms, intrauterine device (IUD), contraceptive implant (Implanon NXT®), Depo Provera (administered in prison), oral contraception, and voluntary sterilisation following pregnancy.

When I was younger, it was just condoms and then after the kids, I got the Implanon, and that I think is brilliant, yeah, because I didn't have to worry for five or seven years, I think. (interview 4)

When I was younger, on a shorter [prison] sentence, I asked for the Depo Provera injection, so that when I get out, I don't get pregnant. (Interview 3)

At the time of interviews, several participants reported not using any contraception. Reasons for this decision included that they thought they were infertile (based on having unprotected sex and



never falling pregnant, PCOS), and/or had not had their period in years and thought they were perimenopausal, and/or were no longer sexually active. Only one participant had undergone tubal ligation. Several participants were still using long-acting contraceptive methods (contraceptive implant [Implanon NXT®, intrauterine device), and of those, two were overdue to have these removed.

Some participants had engaged in STI testing as part of prison health, antenatal care, or sex work but there was no mention of regular testing at their GPs. Participants reported that because they were either in stable monogamous relationships or no longer sexually active, they did not currently engage in STI testing. While all participants were asked about STI testing, none of the interviews involved a discussion on diagnosis and management of any STIs.

Cervical cancer screening and breast checks

All interviewees described engaging in cancer prevention screenings, including cervical screening testing and breast checks. Regarding cervical screening testing, four women had previously returned abnormal results and had pre-cancerous or cancerous cells removed from their cervix. Others reported that they had never returned abnormal results and had been following the screening recommendations, and two women were overdue (last screening had occurred between five to eight years ago) and engaged with screening to varying degrees as described below. Several women described checking their breasts regularly but not recently having seen a health professional. Some women described having engaged with health professionals for yearly check-ups as part of routine care, and others were due for mammograms but had not made or attended their appointments. One woman who identified being at risk of bowel cancer said she had not re-engaged with care, and one woman said she was overdue for hepatitis C-related liver disease follow-up.

Preventive cancer screenings had been initiated by women (chiefly breast checks) but was predominantly provider-initiated. A participant with prior experience of CIN-2 cervical cancer and successful intervention said:

That's one thing I have always been on top of, my Pap smears. I make sure I get them done and yeah, I do my own breast checks. (Interview 1)

Another participant, who had lost two close people in her life to breast cancer, said it made her proactive in checking her own breasts:

I do check my boobs all the time, only because we lost (my partner's) mum and his sister all in a week's time frame, both to breast cancer. (Interview 6)

Most women engaged in cervical screening testing when directly prompted by their healthcare providers (usually a GP, but sometimes whilst incarcerated in prison). Participants who might have responded well to doctor-initiated care but did not have a steady GP also missed out on doing their regular screening. Concerningly, in one case, this was despite an increased risk of developing



cervical cancer. This participant did not express locus of control around changing that, saying she was ‘just useless with that sort of stuff’:

I'm meant to be doing six-month check-ups, but yeah, I just, I don't know, me being me, just sort of slips and all of a sudden time gets away, and it's been five years. ... Yeah, and it's all changed now, like I don't even know like whether they probably even do it at the clinics now, do they? Or you got to go somewhere else? Or..? I'm not sure. (Interview 6)

Pregnancy and post-natal care

Experiences of unwanted pregnancy were common among interviewees. Several women had terminated pregnancies over the course of their fertile and sexually active years. All but one participant had birthed children—predominantly in late teenage and early adulthood years, thus most of their children were themselves adults now. Several women had teenagers at home and one participant was still caring for pre-teens.

Participants reflected on pregnancy and post-natal experiences as a time of more regular engagement with health services, more thorough health checks, and overall better linkage to social support services. This seemed important particularly for women who were in abusive relationships at the time and did not have access to other sources of social support.

...because I was up in the country, the services were very limited, but I had a fantastic midwife nurse as well as my family doctor. So, I spoke more to the midwife nurse about my depression and stuff. She was quite good, but because my ex-husband, he was very controlling, I could only see her for so long and then I had no contact. So, yeah, I didn't have a great deal of people to talk to when I was going through my postnatal depression. So, it was quite horrible at that time. (Interview 1)

Several participants described being diagnosed with hepatitis C as part of their antenatal care but did not remember any discussions about how this might affect their pregnancy or the health of their baby, or what their treatment options were. For two women, antenatal care was the only time in their lives they had been offered and/or taken up STI testing.

Intersection of drug use and pregnancy

Not all participants’ pregnancies were experienced from the perspective of a person who uses/injects drugs. That is, several women became pregnant prior to initiating heroin and/or methamphetamine use. Some women who smoked cigarettes and/or marijuana continued to do so during their pregnancies. However, for women who discovered they were pregnant while actively involved in opioid or amphetamine use, all recalled rapidly reducing their drug consumption (e.g., by eliminating heroin or amphetamine use and managing this by accessing methadone).

With my son, it was different. I was on methadone. I got on the methadone because I was pregnant and a user. I did not want to lose him to a miscarriage because of hanging out



(withdrawing from opioids). So, I got on the methadone and when I went to hospital, he was like more or less called a methadone baby, you know. He was in hospital for about a week, maybe 9-10 days or something, withdrawing from methadone, the poor little thing. [laughs] All he did was sleep it off. [laughs] I had to wake him to feed him, but he was a great baby, he was. (Interview 3)

In reflecting on how their drug consumption may have influenced their antenatal care, one participant said:

Honestly, I didn't go to all my appointments, which I know is terrible, but nobody was there to push me, like being so young. I mean it's up to me, I know, but no, I didn't have a doctor to make sure ... well, I've got my family doctor, but I did all the major ones like drinking the syrup (Methadone) and, you know, at the hospital, but I had no problems. (interview 4)

Several participants remembered pregnancy as a time when multiple layers of stigma intersected, which negatively impacted their ability to achieve and maintain their own health and wellbeing. Women felt judged for being pregnant and having a history of drug use, which was exacerbated if they were also a young mother. Some women described feeling stigmatised if they were also in an abusive relationship. Participants recalled being denied particular medications (because of their history of drug use) and feeling overly monitored or treated differently by healthcare providers (including being separated from other patients while in hospital).

Nonetheless, overall, experiences of pregnancy and post-natal care was described as positive because their connectedness to services and social support stood in stark contrast to the social isolation they felt today:

You've got them connections when your kids are younger and you feel a part of all these things (healthcare and support services), but then as they get older, people go their different ways and it's like, "Oh, what am I doing? I'm by myself again." Yeah. So, it's so important you've got to re-engage with different things and at different stages. (Interview 1)

Breastfeeding

Most women who had birthed children discussed experiences of breastfeeding, which several described as pleasurable and important for connecting with their child. All, however, identified retrospectively that they had been provided insufficient information about how drug use might influence breastfeeding. All women had been careful to reduce the impacts of drug use on their unborn babies, however some resumed using drugs while breastfeeding.

Call me silly. It's a long time ago, I was young, but I wasn't aware that using went through the breast milk as well, and luckily, nothing ever ... yeah, I don't know. A little bit goes through or, yeah, but everything was all good. (Interview 4)



The same participant described how her fear of consequences—drawing the attention of the Department of Health and Human Services, and potentially losing the custody of her children — prevented her asking for the advice she felt she needed.

You know, I was too scared. Child protection and everything. ... We need somebody that doesn't go straight to Child Protection, that you can work with the person because if I had that, if I had somebody that I could talk to and work with, I believe I would've opened up and I could have got help that way, but I was too scared because Human Services, bang, you know. (...) and some people, like their partners too, like depending on what question, you know. Yeah. I think there should be something before, you know, Human Services, or it gets that far, trying to help the person and give them advice and, yeah, because I believe that that would've, yeah, it would've made a big difference with me. (Interview 4)

Sexual activity

Sex and pleasure

Participant narratives suggested that sex and sexual pleasure were not priorities. Whether partnered or not, all women described not being as sexually active as compared to when they were younger:

It has slowed down and that's one thing I wanted to talk to you guys about. It's like something that doesn't faze me at all anymore. Like it's like not that I'm not interested in that, but I can go months without it and it doesn't worry me, where my partner, he nearly died. [laughs] (Interview 1)

Drug use intersected with sex in two ways. Firstly, several participants had previously engaged in sex work to be able to afford drug consumption:

Sex is something I do only for pleasure these days... In the past, I have used sex to support my drug habit and help me pay bills and that. I worked on the street. (Interview 3)

Secondly, several participants described illegal and prescription drugs as having a negative impact on their sex drive. None of the women could remember ever using drugs to enhance their sexual pleasure.

Women who currently enjoyed an active sex life or could recall experiencing pleasure from sex were in the minority. Most women said their experiences of sex had not been positive and/or that their sexual desires had waned over the years.

If I think about sex, no I can't be bothered with it doll. (Interview 6)

Several women also contextualised their aversion to sex with early experiences of trauma and abuse (including forced sexual activity). Consequently, several women described never having been able to experience pleasure through physical/sexual intimacy.



I've never been very sexually active. I think that's because of ... when I was younger, you know, I've had a few things happen that, you know, but yeah, it's turned me off. (Interview 4)

I don't like touch. I don't like being touched. I don't like sex. I haven't had any really good experiences. I mean probably the best sex I had was with my son's dad and that was before I fell pregnant and I can't even think of that as an enjoyment thing because of what he did afterwards, you know what I mean? Because of his behaviour, what he did to me after. I can't even look at that time and see it as a positive, you know. (Interview 9)

One woman (interview 11) shared that she was curious about her lack of sex drive, and described feeling “numb down there”, being “hard to please”, possibly “mentally locking it” and felt curious about understanding why. This woman had worked as a sex worker for many years, and like other interviewees described a desire for emotional intimacy and connection. She had wanted to access a sex therapist, but the financial cost meant this was inaccessible, given that:

They're going to charge an arm and a leg, you know, because it could be seen as a greed or a want, not a need or a necessity to be interested in sex. You can still create life and have no interest in making, in the process of it, you know. (Interview 11)

And while she was accepting of her lack of interest, personally, it did influence her perception of possibility for finding a life partner:

It's nothing to do with the men, you know, and my relationships have broken down because I have no interest in having a sex life with them, you know. I'll give you everything of me internally, but I've no interest in that and, yeah, you know. That's probably why I'm very closed off now because all I've got to give is my word, my character and the vulnerable parts of me and those parts get really, really hurt when I don't give them the most important part, which is sex. (Interview 11)

Sex work and health care

None of the four participants who reported engaging in sex work in their past described working under the protection of an agency. However, there appeared to be a ‘collective’ through which they accessed GPs for blood tests and cervical screening testing in their 20s and 30s, and all had been aware of community health services in their areas where they could seek STI testing, condoms, period products, and sterile needles and syringes. One participant also mentioned sex work stigma as preventing her from speaking openly with her health provider at the time:

I was too embarrassed. Now, not so much because I don't do it anymore. I suppose, while you're still doing it, there's a bit of shame. I felt a bit ashamed that I was doing that for work, but then I look at it as, well, I'm not hurting anyone. I'm not stealing or robbing or whatever. Yeah. So, I've accepted it more and I think it's more accepted in the community than what it used to be, you know. (Interview 3).



Barriers accessing and using healthcare services

Participants experienced multiple barriers to attending health care services and appointments including physical access issues, previous negative experiences, psychosocial barriers, socio-economic factors, stigmatising attitudes and lack of trust in healthcare providers, and health literacy. Many also experienced fears, which were grounded in past negative experiences and a sense of futility.

Previous negative experiences

Many participants reported profoundly negative healthcare experiences including involving cancer prevention screenings, which reduced their willingness to engage in care. The following quote epitomises one such experience, and explains her fear of engaging with healthcare services today:

Before my oldest daughter, I did have a miscarriage. The Women's Hospital gave me a Pap smear; at 16 weeks, a miscarriage. They wouldn't take responsibility, but yeah, because two days later, I spotted blood and when they went and did an ultrasound, the piercing of the water, the baby's inside, the water was all leaking. So, they pierced me before and so they said, "Look, you have to terminate this pregnancy because otherwise you're going to die and your baby's going to die. Your baby's going to die no matter what, but you'll die too because you'll get an infection of having a dead body inside you." (Interview 10)

Negative experiences prevented some participants engaging with healthcare services entirely. From their point of view, they had not been treated respectfully including not feeling listened to or believed, and not taken seriously, by healthcare providers, which reduced their own trust in service providers.

Every time I went to someone, they told me I was mental ... I had mental problems when I didn't. (Interview 5)

Other participants were concerned about attending an appointment that would lead to the identification of a potentially life-threatening illness; most lacked trust that a diagnosis would lead to treatment and being cured. Knowing people who had died of cancer, in spite of leading 'healthier' lives, compounded this fear and prevented them seeking care.

I don't know what it is. I can't say it's because I haven't got a car. [laughs] I don't know. Maybe I'm scared of what the results might be. I don't know. Not really. Maybe in the back of my mind, I am. (Interview 3)

Sometimes I think it's better off not knowing if you're not in immense pain. Like obviously with the Pap smear and that, yeah, that's something they can do with cervical cancer or breast cancer. You can get that easy early, but other things, yeah, living blissfully ignorant. You know, I don't know. I might be fine, probably am. It doesn't seem to be the way I'm going to go, but you never know. (Interview 8)



Psychosocial barriers

Several women experienced depression and debilitating anxiety, including many who described their situation as one of profound social isolation. Although neighbours and religious organisations had brought relief to some women, most women described experiences of suboptimal psychological wellbeing.

One participant, who had lost her teeth in a violent incident, rarely left the house in order to avoid stares and discrimination; this meant she also avoided healthcare appointments:

Some days, I just don't want to leave the house. ... I try not to go out. I even wear a mask still just to cover my teeth. It just makes me not want to go out, you know, yeah. (Interview 4)

In the context of social isolation and potential avenues for support, participants expressed a wish for a counsellor or someone to speak to in times of need:

It would be really good, I think what would help me is just having a worker, like someone like you or somebody that I can speak to. Like there's a ... like I can't use the computer. I can read and write, you know, but I'm not the best because I didn't do my schooling and I need glasses. I know I'm not 16, I'm not a kid, I'm 44, but I've never really looked after myself and helped myself to get in any organisations or any help. I think it would really be good for me if I had someone that would come over, you know, once a month even or something and just say, "Hi. How are you?" Yeah. I would really like that, to be honest, but yeah. (Interview 4)

Where would be or who would I approach to see a woman sort of counsellor or doctor to just be able to have there to chat to when I needed them, you know, at the severe times? You know, when I feel like it's the end of the world and you just want that person to talk to and just direct you and let you know, "No, everything's okay, you know." Like it's not all the time you want them, but just when you feel you do need to have a chat, it's nice to know you've got that regular same person than someone different all the time. Yeah. (Interview 1)

Socio-economic barriers

Overall, participants experienced health and social support systems as unsupportive and described them as unable to cater to their compounding and specific experiences of marginalisation and disempowerment. Many interviewees were experiencing financial hardship. Healthcare costs therefore posed a huge barrier to making and attending doctor's appointments:

If I feel sick, I will go to the doctor, but there are other things I should be getting checked, which I always put off. And now like just getting an ultrasound, they want \$120. And I can't come up with that money. So, that's been put off because of financial reasons. The actual service itself is easy to access, but it's the money, you know. (Interview 3)



I've seen no one because my doctor is [doctor's name] and he went from bulk-billing to now at \$70 a visit. ... And I lost my job back in April, and so I haven't seen anyone since then. (Interview 1)

The following quote captures the many systems that women have to navigate when dealing with matters as essential as having access to finances and psychological support. There is a profound disconnect in communication between these multiple services and systems – and this gap occurs at the expense of participants' wellbeing and social functioning:

And then, you know, having no money, having constantly like ... I couldn't jump. I went to jump on the train the other day, for instance. I had no money for a myki, and no ticket. That delayed me. I missed an appointment with my job ... see, they had got me, I'm not even supposed to be having appointments with them. Centrelink just have them put the information over. My psychologist is aware of it and every two weeks, there's something here, it's going again and again, the same thing. She books appointments. She doesn't tell me because I'm waiting, and you get a three-month grace period to get all your forms and everything that you need to claim Disability. Yeah. So, I'm in that grace period, but Centrelink just hasn't gone on the computer to the job agency that it's okay. So, after this, I'm going to go to Centrelink and I'm going to get a piece of paper. It's nearly the end of it now. I've been through this for three months with them. Every week, I swear. I ring up and I'm like, no one does nothing. Centrelink, "No, it's their fault," SYC (not-for-profit social support agency), "No, it's their fault." And then I end up just ringing the psych and going, "Please, you know," like my psychologist, "You know I don't have to," and he fixes it all up, but then again next week, I get thrown in new workers every time. They think I'm a mess or, you know, a case, I don't know, but I get new workers every two to three months, and I have to, not explain, but you know, why I'm there crying and they're like ... they do it after I have my counselling session as well, like of course I'm going to be up, you know, but that's nearly over. There's nothing out there that I know of. (Interview 4)

Several of our interviewees also described feeling at a loss for where to turn. Not having been linked in with healthcare services for a long time, potentially having little computer literacy or no access to the internet, all contributed to unanswered questions:

So much has changed now, like I don't even know like whether they even do it (Pap smears) at the clinics now. (Interview 6)

In the context of changes over time, several participants also remarked that they were experiencing an information desert. Where previously there was an abundance of pamphlets and posters alerting them to potential opportunities for maintaining their health and wellbeing, today they felt stuck without knowing who to ask or what to search for online:

I wouldn't know where to go. I'd feel uncomfortable talking to my local GP about it (sex drive sexual health). Yeah, I'd be stuck in that position because I wouldn't know who to really reach out to. Yeah, I'd have to Google, you know, where to find it and then it's hard



to work out what wording, you know, when you are googling, what wording to put in to get the right sort of professional help that you want. So, yeah, I'd be a bit stuck in that situation. (Interview 1)

Regarding health literacy, one participant thought that the need to engage with sexual and reproductive health services had become obsolete now that she was no longer sexually active:

I haven't even thought about that (getting a Pap smear) ... because I haven't had sex. (Interview 5)

Physical access barriers

Several participants experienced difficulties engaging with specialised sexual and reproductive health services due to their geographical location, lack of affordable transport options, and opening hours.

It's two big, two long different bus rides [to get to the specialist] and I just don't know the area. ... So, the times when I had gone, I was lucky and got a lift off somebody, but yeah. ... I would definitely go if there was something closer... Well, I missed a few appointments because you got to be there before 1 or before 12. (Interview 4)

Women who were dealing with chronic pain and mobility issues experienced compounding effects on service access; the effort and cost of getting to appointments on time created access barriers.

If there were a neighbour to drive me, it wouldn't be a problem. (Interview 6)

Importance of non-judging, supportive, and coordinated healthcare responses

Poor experiences with the health system were common for the women in this study. Despite this, some participants shared stories of individuals within the healthcare system who were non-judging, caring and supportive, who made them feel valued, visible, and cared for. These experiences were important for ensuring they accessed the services they needed:

I had a social worker at the hospital through having my third child, and because I kept in contact with her and after having my child, I kept counselling with her, and she picked up that there was a problem within my relationship, which there was. So, she then started doing partner counselling for me and my ex-husband and, yeah, she hooked me up with a lot, linked me in with a lot of services down at Geelong. So, yeah, it was just having that one social worker that then linked me in with the specific right services and people that I needed. Yeah. It was really good. ... yeah, sometimes, you don't know which way to just make that first leap and if you get just some advice on which way to sort of angle, it just helps you so much, just that one little bit of advice that, yeah, can really help you out. Yeah. (Interview 1)



Having a trusted GP was a critical factor in participants' engagement (or lack thereof) with health services. Approximately half of the women expressed that a 'traditional family doctor' was something they were acutely missing in their lives; most indicated their desire for a female doctor. Having such a consistent doctor who understood their health needs (including issues related to their mental health and history of drug use) was considered important by all participants. While some participants' report that OAT prescribers played a supportive and broader role, others described experiencing this care as limited, and were hoping to find another doctor to assist with their general health and wellbeing:

I wasn't actually bringing up the topics that I wanted to. Yeah. I was only sort of more seeing him to get my injections. Yeah. That was all. He was basically just my methadone doctor to start with and then moved on to the Buprenorphine injection. So, yeah, I didn't really talk to him about anything else. There was one time I did get sick and, yeah, I had to see another doctor at the clinic. So, yeah, I do have to find that solid doctor to talk about now I'm getting older, yeah, because I know there is going to be different health issues that come up. Yeah. So, I do have to find that doctor just for in future and, yeah, just to talk about these certain topics. Yeah. (Interview 1)

If I knew that there was a doctor, particularly a lady doctor that I could understand who bulk billed and who wasn't leaving anytime soon, that I could stick with her for a while and yeah, I'd love that. (Interview 7)



Discussion

We conducted an exploratory qualitative study involving 11 people who identified as women and had reported experiences of illegal drug use. Our study highlights that women with a history of illegal drug use share the health challenges of many women, but that there are aspects of their sexual and reproductive health experiences and healthcare access that are unique. Women's sexual and reproductive health needs intersected with addiction medicine and drug treatment, infectious diseases, stigma, psychosocial and socio-economic needs, and deficits in social support. Women in this study shared experiences of navigating a complex, often siloed, and discriminatory healthcare system, resulting in suboptimal, delayed, or absent vital preventive and primary care. Women were interested in and concerned about their bodies and health, but often lacked access to comprehensive, and user-friendly information. Critically, women expressed a need for information about their sexual and reproductive health that also explicitly acknowledges their experiences as someone who uses drugs. Women shared varied and complex experiences of sex, enjoyment of their sex lives, and social and emotional connection to families, partners, and their community. Findings also revealed how a profound lack of trust in healthcare services (often due to stigma, discrimination, or suboptimal care), created barriers to access. Importantly, our study highlights the needs of a neglected population.

Women reported engagement with a range of healthcare services, although there were substantial barriers to ongoing access or satisfaction. Their engagement with healthcare was often in response to short-term needs (e.g., pregnancy, STI testing) or opportunistic engagement with health services (e.g., incarceration, visiting OAT providers). Comprehensive services that addressed their drug treatment needs in conjunction with sexual and reproductive health needs were lacking. The exception was experiences during pregnancy, where participants described holistic support that addressed their health and social needs. Our findings highlight an opportunity to increase linkage between services/service providers, reduce complexity of care provision, and enhance the cross-specialising of healthcare providers. Expanding the skills, knowledge, capabilities and confidence of community healthcare services that provide drug treatment, harm reduction services, and other specialist care may be important for addressing the sexual and reproductive health needs of women who are not pregnant. Bringing together healthcare providers of different specialties into one shared location might increase women's engagement with sexual and reproductive healthcare, facilitate greater continuity of care, and increase their trust in health services, providers, and information. That said, women's experience of stigma and discrimination highlights a major failing of care provision. The negative consequences of stigma and ways to resolve this challenge are well-documented though remain critical to address (Broady et al., 2023; Farrugia et al., 2021; Treloar et al., 2022).

During interviews, women frequently asked broad questions about their own sexual and reproductive health. Some participants expressed that while they were curious, they had not found avenues or opportunities to have their questions answered. Despite self-awareness of gaps in their knowledge, women described barriers such as not knowing what to ask for, not knowing who to



ask, and not knowing where they could go to get this information. For many participants the most common and pressing sexual and reproductive-related health concern was pre-menopause or perimenopause. Given Australia's injecting drug use population is aging (Sutherland et al., 2022), it is also likely that many women who inject drugs are experiencing unmet complex health issues as they age, which may be complicated by their drug use and existing co-morbidities (Monteleone et al., 2018). This increasing complexity of maintaining health with age means more than ever, women who use drugs require information they understand. Increasing women's sexual and reproductive health knowledge empowers them to make decisions, and enables choice and autonomy, as recognised in current Victorian health policy (Victorian Department of Health, 2022).

It is important that interventions aimed at increasing knowledge and capabilities consider the technological skills and health literacy of the target population. Women described the challenge of searching online for information or services they needed; sexual and reproductive health literacy was a clear competency gap for accessing help (Australian Institute of Health and Welfare, 2022). Social marketing has been shown to be effective at increasing awareness of health issues among people who use drugs (e.g., naloxone education to prevent opioid overdose (Sumnall et al., 2023), hepatitis C education to increase the uptake of hepatitis C testing and treatment (Helsper et al., 2017), and education about the risks of sharing injecting equipment to increase the uptake of sterile injecting equipment (Bodkin & La Salvia, 1997)). However, the critical elements of successful health promotion include having images and messages that are relatable and resonate with the target audience; a successful example is the 'It's your right' campaign targeted at hepatitis C testing and treatment (EC Australia, 2023). Furthermore, a clear call to action is needed that is supported by existing infrastructure. Our study shows a substantial unmet need for information and an opportunity to increase women's knowledge. The design of any interventions to increase knowledge, however, would require specific consultation with the community who are most affected.

Women in this study described how sex was not a feature in their lives. Some women alluded to complex trauma impacting their relationship with sex, and ability to enjoy intimate physical relationship/s. Other women described experiencing a waning of their sexual desires. Sexual pleasure and satisfaction have been recognised as an essential, but neglected, component of overall health, and sexual and reproductive health (Ford et al., 2019). Among over 3000 mid- and later-life adults who resided in the United States, men and women who self-rated very good or excellent health were more likely to be sexually active (Lindau & Gavrilova, 2010). There may be a role for health services to recognise that woman who use drugs need support and care to enjoy their sex lives, thus improving their overall health and quality of life (von Hippel et al., 2019). However, it was outside the scope of this study to further probe women's sexual and intimate physical relationships, and the role of pleasure in their lives. The data does highlight that this lack of sexual activity may be creating a barrier to healthcare; women perceived that they did not require specific healthcare or services because they were not sexually active. There is an opportunity for services to increase women's participation in sexual and reproductive healthcare



through communicating their relevance and benefit to women who use drugs regardless of their sexual activity.

There are limitations to this study that need to be considered when interpreting the findings. The study was intentionally exploratory, and the interview schedule was broad. The study sought to understand women's health priorities as they relate to sexual and reproductive health, which encompasses a wide range of experiences that are inextricably linked to a woman's life course. While the findings are broad, they offer critical preliminary insights into multiple domains that should be interrogated further. Majority of participants were midlife (average age 47 years) therefore our findings predominantly relate to that phase in a woman's life. The study did not provide contemporary insights into aspects of sexual and reproductive health that younger women experience such as puberty, early experiences of sexuality, pregnancy, childbirth, and the post-natal period. Future research is needed, therefore, to understand these diverse needs across the lifespan. Furthermore, capturing the views and experiences of sub-population groups of women who use drugs (such as women with a disability, women from culturally diverse backgrounds, First Nations women, and trans women) is needed to ensure their unique needs are understood.

Conclusion

This qualitative study provided preliminary insights into some of the health concerns and priorities of women who inject drugs and use methamphetamine. Sexual and reproductive health were not recognised as immediate priorities for women, who named several significant barriers to healthcare access and satisfaction more broadly. However, women were interested in understanding their own sexual and reproductive health and had awareness of gaps in their knowledge, challenges with access to information and described delayed or avoidance of care. Increasing the provision of effective education, improving service provision, and reducing barriers should be a public health priority for sexual and reproductive healthcare providers.



Declarations

Acknowledgments

The authors acknowledge the women that generously gave their time and energy to this study and shared their personal stories and reflections. This study was funded by the Jean Hailes Foundation for Women's Health. The authors acknowledge the Victorian Operational Infrastructure Program's contribution to the Burne Institute.

CRedit Author Statement

Sophia Schroeder: Conceptualisation; Funding acquisition; Methodology; Formal analysis; Data Curation; Writing - Original Draft. **Bek Petrovic:** Investigation; Resources; Writing - Original Draft; Writing- Review and Editing. **Shelley Walker:** Supervision; Methodology; Formal analysis; Writing - Original Draft; Writing- Review and Editing. **Daisy Gibbs:** Methodology, Investigation, Writing – original draft (methods), Writing – Review and Editing. **Samantha Colledge-Frisby:** Conceptualisation, Methodology, Writing – reviewing and editing, Project administration. **Anna Wilkinson:** Funding acquisition; Supervision: Writing - Original Draft; Writing- Review and Editing. **Rebecca Winter:** Conceptualisation; Writing - Review and Editing. **Ashleigh Stewart:** Conceptualisation; Funding acquisition; Writing - Original Draft; Writing- Review and Editing; Project administration.

Budget report

As of the current period, the women's health qualitative study has utilised AUD\$3,983.10 out of the allocated funding of AUD\$15,000. The breakdown of expenses is as follows:

1. Research costs: AUD\$3,983.10

This category includes costs associated with professional transcribing of participant interviews and participant reimbursement.

2. Personnel costs: AUD\$0.00

Personnel costs encompass costs to cover research staff salaries for their time contributed to undertaking this research study and preparation of the research report. The initial budget allocated AUD\$9,500 to research staff costs. In agreement with Working Group Heads, no costs were recovered for research staff time, and this was provided in-kind.

Remaining budget: **AUD\$11,016.90**

Remaining funds will be allocated towards continuing research efforts to extend the project into 2024 including additional participant recruitment, data collection and analysis, and output such as peer-reviewed publications. A portion of the project funds has been earmarked for the dissemination of findings to ensure widespread accessibility and utilisation of the study's valuable insights and elevation of the sexual and reproductive health needs of women who use drugs.



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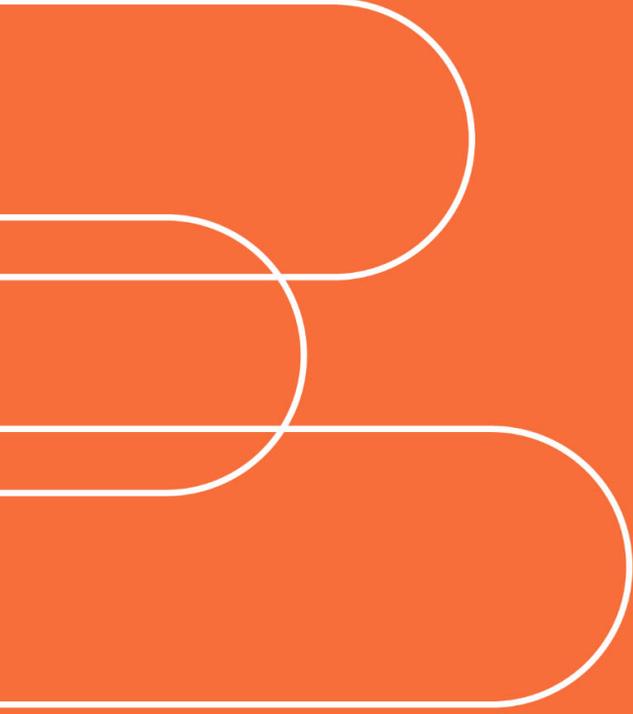
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AUSTRALIA

85 Commercial Road
Melbourne, Victoria, 3004
t + 61 3 9282 2111
e info@burnet.edu.au

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