



**UNODC**

United Nations Office on Drugs and Crime



**Addressing the specific needs  
of women who inject drugs**

**Practical guide  
for service providers  
on gender-responsive  
HIV services**

**INPUD**

International Network of *People who Use Drugs*



UNITED NATIONS OFFICE ON DRUGS AND CRIME  
Vienna

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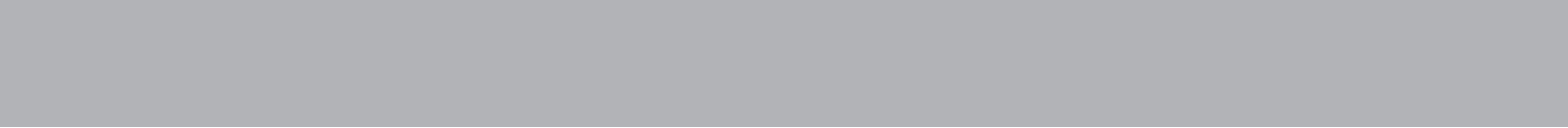
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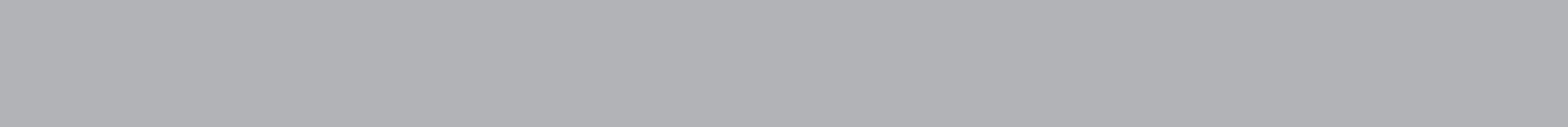
# Abbreviations and acronyms

AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
GBV	Gender-based violence
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HTC	HIV testing and counselling
IEC	Information, education and communication
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PDI	Peer-driven intervention
PEP	Post-exposure prophylaxis
PITC	provider-initiated HIV testing and counselling
PMTCT	Prevention of mother-to-child transmission
PWID	People who inject drugs
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WID	Women who inject drugs
WHO	World Health Organization
WUD	Women who use drugs



# INTRODUCTION

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HIV has long been a high-level health threat among people who inject drugs (PWID). The joint UNODC/WHO/UNAIDS/World Bank estimate for the number of PWID worldwide for 2013 is 12.19 million (range: 8.48–21.46 million).<sup>1</sup> About 1.65 million of those individuals are estimated to be living with HIV, a figure that corresponds to 13.5 per cent of the world's PWID being HIV-positive. That HIV prevalence level is several times greater than among the global general population and clearly indicates that the epidemic disproportionately affects PWID wherever they live.

The risks and potentially devastating health consequences are even greater for women, who represent in many countries a growing share of all people who inject drugs. HIV and injecting drug use are an often-ignored combination among women. As a result, women who inject drugs (WID) have less access than men to harm reduction services, even where they are in place, and are more likely than their male counterparts to acquire HIV.<sup>2</sup> Such discrepancies underscore the urgent need for improved efforts to better reach and support all WID.

## 1.1 Purpose of this *Guide*

The present *Practical Guide* offers suggestions for mainstreaming gender into existing services for people who inject drugs. At the same time, it acknowledges that, in some settings, women require services provided separately from or in addition to services targeting men. The main purposes of this *Practical Guide* are to:

- Assist harm reduction service providers to expand access to women who inject drugs through appropriate gender-sensitive and gender-specific services.
- Motivate and support harm reduction service providers to address gender issues within existing services and/or to develop gender-specific services.
- Provide advice on setting targets for scale-up to improve access to comprehensive HIV and care services, and thereby expand coverage among women who inject drugs.

This *Practical Guide* is intended for existing harm reduction and HIV-related service providers, managers, health-care workers and outreach workers, as well as those planning to work directly with women who inject drugs. Given the wide range of contextual variables (such as epidemiological factors, resource availability, extent and types of structural barriers, sociocultural issues, staff experience, etc.) that may have impact on the provision of women-specific harm reduction services, this *Guide* does not prescribe specific sets of protocols to be followed for particular types of women-specific services. Instead, it presents key objectives, priorities and rationales that should inform the design and implementation of services for women who inject drugs.

## 1.2 Methodology

This *Guide* builds on the comprehensive package of nine interventions for HIV among people who inject drugs, also called the harm reduction package,<sup>3</sup> which is detailed in the 2012 edition of the WHO,

<sup>1</sup>UNODC *World Drug Report 2015*.

<sup>2</sup>Ibid.

<sup>3</sup>For the purposes of this *Guide*, harm reduction is defined by the nine interventions of the “comprehensive package” of services as detailed in the WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*<sup>4</sup> and in the WHO *Consolidated Guidelines on HIV prevention, Diagnosis, Treatment and Care for Key Populations*, of 2014.<sup>5</sup>

The development of this *Practical Guide* on services addressing the specific HIV-related needs of women who inject drugs was overseen by a working group, formed in 2013, which included representatives from the International Network of Women Who Use Drugs (INWUD), the Women's Harm Reduction International Network (WHRIN) and the Eurasian Harm Reduction Network (EHRN). The working group also oversaw the drafting of a policy paper with similar focus and emphasis. Collectively, the two documents provide up-to-date information on key issues concerning HIV prevention, treatment and care related to women who inject drugs. Members of the UNODC-CSO (civil society organization) Group on Drug Use and HIV supported the preparation of both documents by providing an additional expert review.

UNODC published the policy brief in July 2014, together with the International Network of People Who Use Drugs (INPUD), the International Network of Women Who Use Drugs (INWUD), WHO, UN Women and UNAIDS.<sup>6</sup> Although the policy paper and this *Practical Guide* are complementary, this *Guide* has been designed to be read as a “stand-alone” document, if required.

### 1.3 Harm reduction principles

Harm reduction services for WID are most effective when offered on a voluntary basis in an enabling environment created by supportive policies and strategies. It is beneficial to seek to ensure that services:

- Are physically accessible, affordable, equitable, non-judgmental, non-discriminatory and unrationed.
- Are not restricted by sociodemographic or other criteria such as sex/gender, employment status and profession (including sex work), criminal justice history (including imprisonment), substance use status or pregnancy status.

Moreover, it is recommended that all harm reduction services be governed by the following core principles:

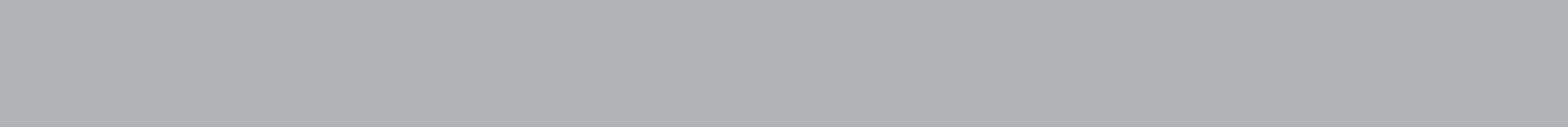
- *Gender mainstreaming*—based on the recognition that gender equality and equity are linked to human rights, fairness and social justice for women and men.
- *Non-discrimination*—treating all clients fairly regardless of age, sex, sexual orientation, gender identity, ethnicity, religion, class, occupation and drug use status.
- *Informed choice and consent without coercion*—through providing a full range of information and options to enable clients to make well-considered, voluntary decisions and respecting their autonomy in doing so.
- *Confidentiality*—respecting and safeguarding the privacy and autonomy of clients.
- *Respect*—treating each client with respect and dignity.

<sup>4</sup>WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revision.

<sup>5</sup>WHO *Consolidated Guidelines on HIV prevention, Diagnosis, Treatment and Care for Key Populations*, 2014.

<sup>6</sup>UNODC, INPUD, UN Women, UNAIDS, WHO *Women Who Inject Drugs and HIV: Addressing Specific Needs*, Policy brief, 2014.

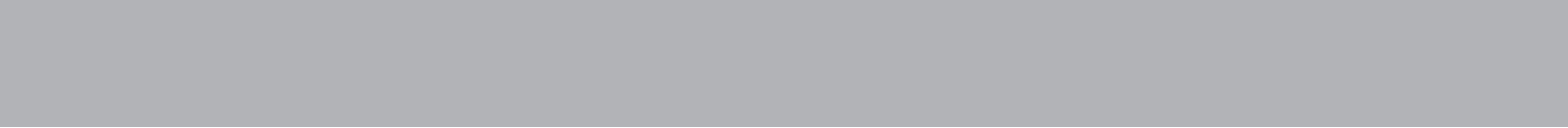
- *Access for all*—services are relevant to as many clients as possible, with respect to availability, affordability and acceptability.
- *Working in partnership* with government, civil society and all social sectors, both public and private.
- *Build and sustain comprehensive services*—linking HIV prevention, treatment and care services, reproductive and sexual health, as well as other related health services needed by clients.
- Promote, respect and enforce the *human rights of clients*, including the right to adequate health information and reproductive rights.
- *Accountability* of all staff, including service managers, for the achievement of gender-related goals and objectives.
- *Empower* individuals and communities through outreach and community education about HIV and associated gender inequalities.
- *Meaningful participation* of people who use drugs, including WID, in all aspects of the design, planning and delivery of harm reduction services—including involvement as decision makers, experts and implementers. Participation can be supported through peer-based skills development and capacity-building.





WHY FOCUSING ON  
WOMEN IS A CRITICAL  
PRIORITY FOR  
SERVICE PROVIDERS

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There are numerous public health and human rights reasons to target harm reduction and other HIV-related services at women. WID face a higher risk of acquiring HIV, viral hepatitis and other sexually transmitted infections (STIs) than their male counterparts.<sup>7</sup> Specific heightened risk factors include the fact that women are more likely than men to be “second on the needle”—i.e., they inject after, and often are injected by, a male partner. Also, WID who engage in practices such as sex work further enhance their vulnerability to HIV and other blood-borne infections.

WID, especially those who are involved in sex work, often experience physical and sexual violence from their clients and other intimate partners,<sup>8,9,10</sup> as well as from the police. Abuses can also occur when they are detained in closed settings. Gender-based violence is limiting the ability of WID to access services.<sup>11,12,13</sup> In general, the criminalization of sex work has a major impact on many women’s willingness and/or capacity to access HIV-related services and to negotiate condom use.

Other unique disincentives for WID to access health services include policies, practices or laws indicating drug use as a criterion for loss of child custody, for forced or coerced sterilization, or for involuntary abortion. Such practices are examples of gender-related stigma and discrimination that is widespread in some countries.

WID are often diagnosed with HIV late in pregnancy, or when already in labour.<sup>14</sup> Mother-to-child transmission rates among WID who are living with HIV are significantly higher than for other women living with HIV.<sup>15</sup> Many maternity clinics do not provide opioid substitution therapy (OST), a situation that may compel drug-dependent women or those on OST to leave appropriate care in order to seek drugs or medication<sup>16</sup>

Where harm reduction services are available, they are generally tailored primarily towards men; as a result, women who use drugs often find that their specific needs are unacknowledged, unaddressed and not “women-friendly”. For example, harm reduction programmes and projects may not be able to guarantee women’s personal safety and confidentiality and do not provide sexual and reproductive health (SRH) services, prevention of mother-to-child transmission (PMTCT) services, or child care. Staff may not be trained to provide gender-specific services such as support for WID who are sex workers or who are victims of gender-based violence (GBV).

In women’s prisons, harm reduction services are even sparser than the limited availability in men’s prisons. Further, because there are fewer women’s prisons, women are frequently incarcerated in locations far away from their residences, resulting in dislocation from support networks.

<sup>7</sup> UNODC *World Drug Report 2015*.

<sup>8</sup> Dunkle, K.L., and others, “Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa”, *The Lancet*; 363:1415–1421, 2004.

<sup>9</sup> Roberts, A., Mathers, B.M., and Degenhardt, L., *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs*, IDU Reference Group, 2010.

<sup>10</sup> UNAIDS *Unite with Women. Unite Against Violence and HIV*, 2014.

<sup>11</sup> Global Coalition on Women and AIDS, *Women Who Use Drugs, Harm Reduction and HIV*, 2011.

<sup>12</sup> Eurasian Harm Reduction Network, *Halting HIV by Reducing Violence against Women: The Case for Reforming Drug Policies in Eastern Europe and Central Asia*, 2012.

<sup>13</sup> UNODC *World Drug Report 2015*, [www.unodc.org/wdr2015/](http://www.unodc.org/wdr2015/)

<sup>14</sup> Wolfe, D., “Paradoxes in antiretroviral treatment for injecting drug users: access, adherence and structural barriers in Asia and the former Soviet Union”, *Int J Drug Policy*; 18(4):246-54, 2007.

<sup>15</sup> Thorne, C., and others, “Progress in prevention of mother-to-child transmission of HIV infection in Ukraine: results from a birth cohort study”, *BMC Infectious Diseases*; 9:40 doi:10.1186/1471-2334-9-40, 2009.

<sup>16</sup> Burns, K., *Women, Harm Reduction and HIV*, International Harm Reduction Development, Open Society Institute, 2009.

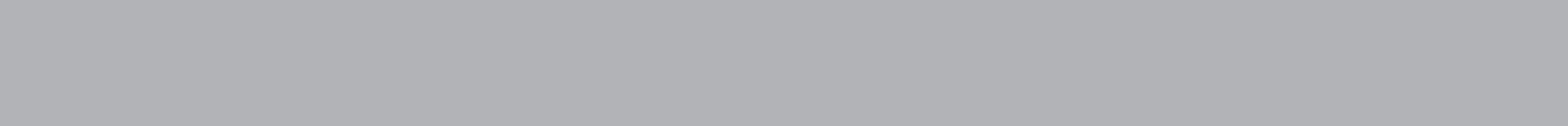
All of the imbalances and barriers noted above can be redressed through a range of services and methods that can be applied (many at low or no cost) in a broad spectrum of settings. Many of those are listed in the table below, with several described in greater detail throughout the rest of this *Practical Guide*.

Harm reduction package	Services responding to WID needs	Key implementation considerations
Needle and syringe programmes (NSPs)	Sexual and reproductive health, including services for STIs and prevention of mother-to-child transmission (PMTCT)	Targeted service delivery and integration
Opioid substitution therapy (OST) and other evidence-based drug dependence treatment	Maternal and child health	Discreet and accessible service locations
HIV testing and counselling (HTC)	Gender-specific peer education and support	Women-only spaces and/or times at drop-in centres or separate venues
Antiretroviral therapy (ART)	Gender-based violence related services	Specific outreach for women who inject drugs
Prevention and treatment of sexually transmitted infections (STIs)	Services tailored for women who inject drugs who are also engaged in sex work	Collaboration and cross-referral with programmes addressing sex work and HIV
Condom programmes for people who inject drugs and their sexual partners	Provision of female and regular condoms	Secondary needle and syringe distribution <sup>a</sup>
Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners	Parenting supports	Addressing stigma and discrimination
Prevention, vaccination, diagnosis and treatment for viral hepatitis	Childcare	Advocacy for improved services and the elimination of policy, legal and social obstacles
Prevention, diagnosis and treatment of tuberculosis (TB)	Couples counselling (aimed at ensuring that the responsibility for reducing HIV and health risks is equally shared between both partners)	Resourcing
	IEC that is specifically relevant to women who inject drugs (including safer injecting and safer sex techniques)	Data
	Legal aid (attuned to be accessible and relevant to the needs of women who inject drugs)	Participatory planning, implementation and evaluation
	Provision of psychosocial and ancillary services and commodities	
	Income generation interventions for women who inject drugs	

<sup>a</sup>Secondary distribution involves peer outreach workers as well as other services such as sexual health clinics, drug dependence treatment services and hospital emergency services. It is an important approach because it helps to maximize the accessibility of sterile injecting equipment.

KEY IMPLEMENTATION  
CONSIDERATIONS FOR  
SERVICES RESPONDING  
TO THE NEEDS OF WOMEN  
WHO INJECT DRUGS

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This chapter addresses methodological and other implementation considerations in developing harm reduction services for WID. The considerations, which follow from and expand upon the list in chapter 2, are not exhaustive.

An important factor to keep in mind for all of these considerations is the value of WID groups and networks. The full engagement of these community-based entities can help ensure the most effective decision-making and implementation processes. The health and broader human rights of women who use drugs are much more likely to be recognized and responded to when they are meaningfully and extensively involved in all discussions and decisions pertaining to them.

### 3.1 Service delivery and integration

The ideal way to support access to all necessary services for WID is through an integrated system that provides as many services as possible in one location (“one-stop shop”). Where services cannot be included on-site, strong referral linkages can be pursued and developed with relevant external service providers, as available. Potentially useful steps might include the following:

- Establishing effective working linkages with providers of services such as those focusing on or offering relevant support for sex workers, sexual and reproductive health, PMTCT, maternal and child health, gender-based violence, legal support and evidence-informed drug dependence treatment.
- Integrating harm reduction services with family planning, maternal health care and within primary care facilities.
- Staff training to build capacity for WID-friendly service delivery along with other measures such as assisted referral and low-threshold access processes.
- Establishing relationships with health-care providers—for example, by training “friendly doctors”.
- Ensuring that local health care facilities, including ART providers and antenatal clinics, welcome all women in need of treatment and care regardless of their drug use status.
- Introducing harm reduction elements for WID into other health services, such as providing OST in maternity hospitals and women’s prisons.<sup>17</sup>

### 3.2 Discreet and accessible service locations

In addition to ensuring that harm reduction services are discreet and geographically and physically accessible, it is important that services provided are low-threshold (e.g., no appointments are needed, short waiting times, etc.).

For optimal effect, opening hours can be adjusted to suit the availability of WID. More clients will be able to access harm reduction services if they are open at times that match the schedules and needs of women who are working or have child care and/or other routine responsibilities. Decisions regarding opening hours are best made after consulting with clients.

<sup>17</sup>See also WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revision (in particular, section 3.1, which discusses the monitoring of “drug user-specific” versus “general population” interventions).

### 3.3 Women-only spaces and/or times

Ensuring that dedicated women-only spaces are made available at drop-in centres or separate venues may be necessary in some contexts in order for women to feel that they can attend services safely. Providing mobile services might increase access of women who cannot come to harm reduction sites due to their remote location, childcare responsibilities, stigma or other reasons.

### 3.4 WID-specific outreach

In locations where harm reduction services have a low proportion of women, specific outreach efforts may be necessary. Secondary syringe distribution can also be an important model that attracts women into programmes.

#### Case study: Peer-driven intervention reaching women who use drugs in Ukraine

Harm reduction projects in Ukraine have been successful in reaching men who use drugs, but most have encountered challenges in reaching women. Some WID rely on male partners to obtain drugs and injecting equipment and are less likely to directly access harm reduction services. WID also face a number of barriers to their ability and inclination to access medical services; for example, mothers may be reluctant to discuss their drug use with medical service providers for fear of losing child custody.

In order to reach women who use drugs, the International HIV/AIDS Alliance in Ukraine introduced peer-driven intervention (PDI) in 2007. After piloting and evaluation, PDI was scaled up and by 2013 more than 6,000 PWID were reached, 30 per cent of whom were women.

To start the Alliance's PDI for women, a small number of peer volunteers were recruited through male partners or friends of women who use drugs and given comprehensive information about HIV, safer injecting and sexual practices, hepatitis and other harm reduction education priorities. Each recruit received three coupons with contact information of the organization; an offer of a fee for participating in the intervention; and commodities such as sterile syringes and needles, condoms (both male and female), information materials and HIV/STI testing. Volunteers then educated their peers and recruited them to participate in the programme by giving them coupons to be redeemed at the organization.

For some women, this was their first acquaintance with harm reduction services. The "bridge" was friendly and non-judgmental peers who provided a relevant and trusted introduction to harm reduction services. The success of the project suggests that PDI can be a powerful intervention that boosts engagement with women who use drugs as community champions, improves knowledge and increases access to HIV prevention commodities and services.

Additional information is available from the International HIV/AIDS Alliance in Ukraine ([www.aidsalliance.org.ua](http://www.aidsalliance.org.ua)).

Models such as peer-driven intervention (PDI) demonstrate some success in rapidly reaching hidden populations, including WID in some settings.<sup>18, 19</sup> PDI is a chain-referral outreach model that relies on

<sup>18</sup> Smyrnova, P., and others, "Rejuvenating harm reduction projects for injection drug users: Ukraine's nationwide introduction of peer-driven interventions", *International Journal of Drug Policy*; 23. 141–147, 2012.

<sup>19</sup> WHO *Guidance on the Prevention of Viral Hepatitis B and C among People Who Inject Drugs*, 2012.



selected and trained peers who earn nominal rewards (e.g., monetary stipends) to educate and recruit new and diverse clients for harm reduction services.<sup>20</sup>

In order to be responsive to local conditions, PDI should be pilot-tested and adapted as necessary. PDI does not perform equally well in all sites and contexts. Further research of the PDI model is needed to identify elements that may lead to varied outcomes and to better understand how the model can be more effective in reaching WID.

### 3.5 Addressing stigma and discrimination

All harm reduction staff should be trained to understand and remove stigma and discrimination against WID at all levels of service provision. Similarly, training, cross-training and other support can be provided to referral network agencies to improve their capacity to work with WID.

Among the basic steps that can have substantial benefits are for service providers to work with WID to ensure they are informed of their rights and to link those clients to existing legal services, complaints mechanisms and supports. Targeted campaigns and public campaigns can also be considered. An example of one such campaign, a training package for health-care workers, is discussed in the case study below.

#### Case study: Stigma reduction project in Australia

The impact of stigma and discrimination towards women who use drugs, while having a negative impact on their health and well-being generally, also has significant impact on their children. Stigma is “sticky” and the children of drug-using mothers are often made to carry the burden of exclusion. The Australian Injecting & Illicit Drug Users League (AIVL) has spent some years recently researching stigma and discrimination in the community, with market research indicating that women in the general community were a specific group that the organization may be able to influence in terms of creating some understanding around the lives and reality of women who inject drugs.

Therefore, in 2013 AIVL began a project aimed at women in the wider community to gently persuade them to see women who use drugs in a less wary manner. After much consultation and several focus groups, the idea of a book was identified as the most appropriate vehicle to deliver AIVL’s message. The belief was that a short yet beautiful book could assist readers to think beyond the stereotypes of women who use drugs and hopefully lead them to question some of their assumptions. Taking into account the busy lives and competing factors in the lives of many women, a brief yet pointed story was commissioned that does not dwell on injecting drug use but rather is used as an underlying theme of the story. It does not tell people what to think or how to respond, but rather poses questions to the reader. An important priority of the book was to make it visually appealing so that women who did not know what it was about would be drawn to it. The title, “Paper Planes”, has no connection with injecting drug use but invites women to pick it up, open it and read. Nothing in the story is confrontational or disturbing. Instead, it is more like a short story in a women’s magazine—though with a message. The book was launched at the 2014 International AIDS Conference and distributed to women’s groups and doctors’ surgeries.

<sup>20</sup>Smyrnova, P., and others, “Rejuvenating harm reduction projects for injection drug users: Ukraine’s nationwide introduction of peer-driven interventions”, *International Journal of Drug Policy*; 23. 141–147, 2012. For further reading on PDI, see also Broadhead, R., and others, “Peer-driven interventions in Vietnam and China to prevent HIV: a pilot study targeting injection drug users”, *Journal of Drug Issues*, 2009.

### 3.6 Advocacy to remove service access barriers to WID and promote their health and human rights

Effective advocacy programmes are developed on many levels simultaneously: individual, social network and community levels, in addition to the societal structure level. Depending on the relevant context and needs, the following are among the advocacy steps and activities that could be prioritized on behalf of and for WID:

- Engaging directly with a full range of stakeholders—such as health and HIV services, law enforcement, other relevant service providers and religious and other local community leaders—in order to raise awareness about needs and how to address them.
- Seeking to promote laws, policies and practices that improve access to health services for WID and protect their human rights (including their right to health). Policies in this regard might include, for example, those that encourage access to prenatal and maternal services and de-emphasize punitive approaches to pregnancy and drug use.
- Seeking to secure sustainable funding for harm reduction programmes and other services targeting women who inject drugs.
- Promoting effective multisectoral coordination, cooperation and continuum of care for WID.
- Targeting local police and other officials to improve relations between law enforcement personnel and people who use drugs, including WID. Particularly useful might be increased attention given to gender-sensitive policing (e.g., specific rules, conduct codes and instructions for police when interacting with women). At the same time, regularly reviewing laws, legal policies and practices can ensure increased and unhampered access to services.

Groups or networks of WID should participate in and lead advocacy efforts, including those directed at the wider public to reduce discrimination against WID. Advocacy that supports the establishment and development of networks of WID is critical.

Service providers can work with WID groups or networks to highlight the debilitating impacts of discrimination on the health and human rights of women who use drugs. The key objectives of such efforts are to encourage reform to redress these impacts.<sup>21</sup>

### 3.7 Resourcing

When developing future funding proposals, it is important that service providers allocate funds for WID-specific services. In most environments, existing information should be leveraged to estimate the unit costs for key interventions. Some of the key services are not necessarily costly; others, meanwhile, can sometimes be shared with other non-governmental organizations (NGOs) and/or local government agencies.

<sup>21</sup> Adapted from Australian Injecting and Illicit Drug Users League (AIVL), “*Why wouldn’t I discriminate against all of them?*”, A report on stigma and discrimination towards the injecting drug user community, Canberra, Australia, 2011.

## 3.8 Data

Reliable and consistent data is essential for planning, resource allocation, advocacy, and monitoring and evaluation if targets for universal access and gender mainstreaming are to be met. The 2012 WHO, UNODC, UNAIDS *Technical Guide* recommends the collection of sex-disaggregated data, which is necessary to assess and monitor any disparities in harm reduction service access.<sup>22</sup>

It is important to stress that the lack of data is not an acceptable excuse for inaction. WID-specific interventions are necessary and vital in every context. Developing and implementing them can take place while simultaneously investing in the necessary research and data collection initiatives required to further develop the evidence base.

Confidentiality is a core priority for all data collected. The use of unique identifier codes or similar models is recommended,<sup>23</sup> particularly in countries where drug use is criminalized.

### Sex-disaggregated data

Harm reduction providers and others working with and for women who use drugs are strongly encouraged to develop a policy and plan for gathering and analysing sex-disaggregated data and using it to make appropriate modifications to service design and implementation. Core components and priorities of such plans might include the following:

- Revising or developing information systems to be able to disaggregate routine service indicators (e.g., by sex and age).
- When modifying existing services or developing new initiatives, to be more WID-friendly, developing indicators that can measure the effectiveness of these services. This may require special or periodic studies or assessments.
- Training all staff on: (a) the importance of data protection; (b) the observance of human rights in collecting data; and (c) the reasons for and need to collect sex-disaggregated data.
- Training monitoring staff to collect, analyse and interpret data that can measure the progress of WID-specific services.
- Considering gender equity when setting targets for reaching clients with services and in service monitoring.

### Qualitative data

Qualitative data can be useful to identify factors that may have impacts on successful implementation of WID-specific services. However, observations and other types of qualitative data can also reveal how successful particular services have been in addressing some of the core sources of gender inequity. It therefore is useful to develop and measure qualitative indicators that can detect improvements or deterioration in particular areas of women's lives, such as:

<sup>22</sup> WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revision.

<sup>23</sup> WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2009.

- Client satisfaction with quality of services;
- Whether there is more equal access to basic social services;
- Reduction/increase in the incidence of gender-based violence;
- Reduction/increase in the use of gender stereotypes;
- Change (if any) in discriminatory attitudes towards WID
- Whether women's organizations have been established or strengthened through the project;
- The scope and impact of WID providing input into all stages of service design, implementation, monitoring and evaluation of programmes;
- Whether and to what extent WID feel they have been supported, consulted, included and involved to influence social processes.

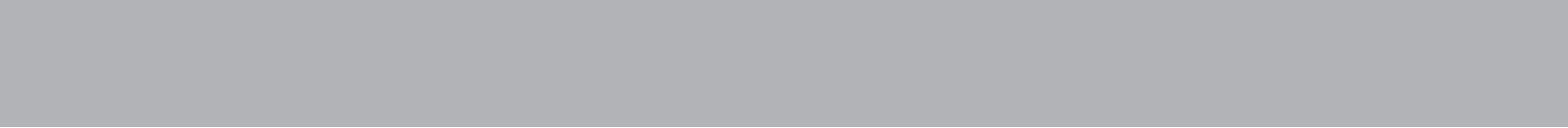
### **3.9 Participatory planning, implementation and evaluation**

As stated at the beginning of chapter 3, the meaningful engagement of women from communities (e.g., WID networks, women living with HIV, other civil society organizations, community leaders) is a vital overarching priority. Involving such individuals and organizations from the earliest stages of all processes is invaluable, including throughout all monitoring and evaluation efforts. Women who use drugs and their community groups can be regularly asked to provide their perspective on improvements, challenges, the development of services, etc.

Better and sustainable resourcing is necessary to achieve such objectives in nearly every context. To fully leverage the unique strengths of communities in responding to HIV among WID, investments are needed to build the capacity of community-based organizations and to increase the meaningful engagement of WID in the development, implementation and evaluation of services.

# HARM REDUCTION SERVICES

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The services listed in this section of this *Practical Guide* are organized as per the nine interventions of the comprehensive package for HIV among people who inject drugs that are detailed in the WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.<sup>24</sup> The *Technical Guide* proposes quality and target standards for communities as well as prisons.

Information particularly relevant for WID programming is highlighted for each of the interventions discussed in sections 4.1 through 4.9 below. Most of the information and suggestions are connected with, and thus can be considered alongside, the women-specific implementation issues and services detailed further in chapter 5. Collectively, the two chapters are intended to bring further clarity to the specific issues and needs of WID as they apply to the comprehensive package.

Applicable to the provision of all nine interventions listed below is the need to engage meaningfully with WID in providing services for them. Also universally important is for all staff to be supported to provide non-judgmental, WID-friendly services.

## 4.1 Needle and syringe programmes

Needle and syringe programmes (NSPs) provide clients with needles, syringes and other injecting equipment in an effort to prevent sharing and reuse of used equipment. They are sometimes the first contact with a health-care system for people who inject drugs, and thereby represent a valuable opportunity to provide them with information on risks for HIV and viral hepatitis as well as referrals to relevant services including those related to drug dependence, HIV testing and counselling and tuberculosis (TB).

Increasing women's access to sterile injecting equipment should be a top priority for all harm reduction service providers seeking to expand their reach among WID. In the absence of specific services for WID, efforts to meet this objective might include the following, in addition to the standard services provided through NSPs:

- The provision of a range of service models, including pharmacies, fixed-site, vending machines, mobile services and programmes within women-specific services such as day centres or family clinics.
- Outreach to suitable locations supporting secondary distribution and peer delivery, including to women's homes where appropriate.
- Offering access to NSPs in a supportive and non-judgmental manner to women who continue to inject drugs during pregnancy.

In general, NSPs can more successfully serve women by ensuring that services, information and referrals responding to the specific needs of women are easily and regularly available—including in regards to legal and social support services, childcare, and sexual and reproductive health (SRH).

<sup>24</sup>WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revision.

## 4.2 Opioid substitution therapy and other evidence-based drug dependence treatment

Globally, it is estimated that, even though one out of three people who use drugs is a woman, only one out of five of those in treatment is a woman.<sup>25</sup> This discrepancy underscores the importance of making evidence-informed drug dependence treatment more available and accessible to WID as part of improved efforts to reduce their risk of exposure to HIV, viral hepatitis and other blood-borne infections.

Opioid substitution therapy (OST) is the most effective drug dependence treatment to prevent HIV among people who are opioid dependent by reducing the frequency of injection. OST is also a key component of successful care for those living with HIV and other potentially deadly infections because those receiving it are more likely to be adherent to antiretroviral therapy (ART) and TB treatment regimens, for example. (It is critical to stress one additional point: despite its added benefits regarding adherence, OST uptake should never be a prerequisite for access to ART or treatment for TB and other infections.)

Enrolment in OST benefits WID by reducing their risks of fatal overdose, being arrested, and being abused and subjected to other forms of violence. It also can reduce a woman's dependence on her partner for drugs and injections, thereby helping her become more independent in safeguarding her health and well-being. Pregnant WID can benefit because OST uptake lowers the risk of miscarriage and encourages them to be in contact with antenatal care services.

Outpatient OST can better meet the needs of WID by providing drug dependence treatment that is tailored specifically for women. Evidence shows that outcomes for women are better when gender-specific factors are accounted for in treatment.<sup>26</sup> Outpatient programmes can support women clients by doing the following, for example:

- Allowing children to be with their mothers (and becoming more child-friendly in other ways as well).
- Integrating the service with a wide range of other support and care services, including prenatal and maternal services.
- Prioritizing WID who are pregnant. Heroin use, in particular, results in dramatic fluctuations in opioid levels in a woman's bloodstream. These fluctuations can lead to foetal withdrawal or overdose, which can be life-threatening to the foetus or have negative impacts on its development.
- Ensuring continuity of OST treatment for women in hospitals, including maternity hospitals and women in prisons.

Inpatient drug treatment programmes, meanwhile, can be more responsive to the needs of many WID when they are child-friendly and allow children to be with their mothers for the duration of the client's stay.

## 4.3 HIV testing and counselling

HIV testing and counselling (HTC) is an essential entry point to HIV prevention, care and life-sustaining treatment for people with HIV. By offering personalized counselling based on knowledge of one's HIV status, HTC can motivate behaviours to prevent HIV transmission and facilitate the access of persons

<sup>25</sup> UNODC *World Drug Report 2015*; [www.unodc.org/wdr2015/](http://www.unodc.org/wdr2015/)

<sup>26</sup> Roberts, A., Mathers, B., and Degenhardt, L., *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs*, National Drug and Alcohol Research Centre (NDARC) on behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use, 2010.



living with HIV to supportive counselling, to harm reduction services, to antiretroviral therapy (ART), and treatment for opportunistic infections.

HTC should be offered to WID at least annually. In addition to PITC, community-based HIV testing, linked to prevention treatment and care services, is critical to increase access for PWID to HTC. Increased uptake in HIV testing can also be achieved through self-testing.

Ideally, HTC services are part of an integrated programme of HIV prevention, care and treatment. Such a structure can help ensure that WID and their partners have access to HTC as frequently as required, at times and locations that are convenient. Specific strategies are needed to increase access to and uptake of HIV testing and counselling for WID. Among the most effective strategies in many contexts are assisted peer referral, outreach through mobile clinics, trained peer-based HTC or in other community settings, and being directed to HTC services through harm reduction or drug dependence services. Wherever and however they are offered, testing and counselling services are most useful when they aim to reduce barriers to WID's ART access and provide appropriate referrals to WID-friendly HIV clinics that are skilled in working with women who use drugs.

For WID as well as all other clients, counselling and testing services achieve optimum impact when they adhere to the “5 Cs” principles—consent, confidentiality, counselling, correct test results and connection to follow-up services. Similarly, their value is enhanced when they are delivered respectfully and without coercion, judgment, stigma or discrimination. Comprehensive pre-test information for women who are or may become pregnant typically also includes information on the risks of transmitting HIV to an infant, measures that can be taken to reduce mother-to-child transmission (including antiretroviral prophylaxis and infant feeding counselling), and the benefits to infants of early diagnosis of HIV.

The following other HTC-related considerations are also crucial in regard to WID:

- Provider-initiated HIV testing and counselling (PITC) is recommended for WID who are pregnant or living with TB or hepatitis C, provided that it is in no way coercive.<sup>27</sup> HIV-negative WID should be tested as early as possible in each new pregnancy. Repeat testing late in pregnancy should also be recommended to HIV-negative WID.
- Counselling on gender-based violence (GBV) is recommended as part of post-test counselling. Appropriate mechanisms such as referrals and follow-up can be included to ensure that the realities and risks of GBV are recognized and addressed.

#### 4.4 Antiretroviral therapy, including treatment literacy

WID can successfully adhere to and benefit from antiretroviral therapy (ART). However, in many settings and contexts, WID have disproportionately limited access to ART compared with other key affected populations or the general population.

There is little doubt that more WID living with HIV decide to initiate and sustain treatment where there is access, affordability, availability and acceptability of ART. Their ability to take this important step should not be blocked by misguided laws and policies stating that drug use and/or OST are contraindications for ART.

<sup>27</sup> WHO *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities*, 2007.

As part of efforts to boost ART access and uptake, it is important to involve HIV clinicians in harm reduction services or assist referrals to WID-friendly HIV clinics. WID may need support to improve treatment literacy or to access adequate shelter, nutrition and sanitation—all of which can help them remain adherent. Such supportive components highlight the value of positioning ART programmes as part of a continuum of care<sup>28</sup> that also includes sexual and reproductive health services, a close relationship with harm reduction services, and support to access services to diagnose and treat TB.

In addition, antiretroviral prophylaxis and infant feeding counselling are important interventions for the prevention of mother-to-child transmission (PMTCT). Comprehensive harm reduction programmes include mechanisms to directly provide, or organize the provision of, antiretroviral drugs for pregnant and nursing WID living with HIV. This vital PMTCT strategy can be implemented on-site or arranged through referrals.

WHO recommends four approaches, or “prongs”, of a comprehensive PMTCT strategy:

1. Primary prevention of HIV infection among women of childbearing age;
2. Preventing unintended pregnancies among women living with HIV;
3. Preventing HIV transmission from women living with HIV to their infants (including HTC, ART, safe delivery, safer infant feeding,<sup>29</sup> post-partum interventions in the context of ongoing ART);
4. Providing appropriate treatment, care and support to mothers living with HIV, their children and families.<sup>30</sup>

Post-exposure prophylaxis (PEP) is another valuable antiretroviral-based health practice. Access to it can be of particular benefit for WID who have been sexually assaulted or who have recently shared used injecting equipment (if it is known that the other person who used the equipment is living with HIV).<sup>31</sup>

ART programmes should be part of a continuum of care that includes sexual and reproductive health services and a close relationship with harm reduction services. Additionally, WID should receive support to access services to diagnose and treat TB.

Psychosocial support can be a vital component of comprehensive care, especially for WID who are living with HIV (and thus may face even greater stigma and discrimination). Family support may be useful to help relatives and partners understand the implications of the issues faced by WID living with HIV and the need for lifelong ART.

## 4.5 Prevention and treatment of sexually transmitted infections

All WID—and their sexual partners—greatly benefit from consistent access to acceptable, effective and high-quality services addressing sexually transmitted infections (STIs). A comprehensive STI service package includes the following, at a minimum:

<sup>28</sup>WHO *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach*, 2013; [www.who.int/hiv/pub/guidelines/arv2013/en/](http://www.who.int/hiv/pub/guidelines/arv2013/en/)

<sup>29</sup>Ibid.

<sup>30</sup>WHO *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*, 2014.

<sup>31</sup>See, for example, AVERT resources on PEP at: [www.avert.org/post-exposure-prophylaxis-pep.htm](http://www.avert.org/post-exposure-prophylaxis-pep.htm)

- Diagnosis of STIs
- Treatment
- Education
- Counselling on partner notification
- Condoms, as well as condom negotiation skills
- Assessment of client's perceptions of risk
- Follow-up
- Confidential HTC
- Promoting sexual communication between couples to support safer-sex practices

## 4.6 Condom programmes for people who inject drugs and their sexual partners

Harm reduction programmes are urged to offer all of the following services: distributing male condoms directly to WID or informing them where they can be obtained easily and affordably; educating them on how to put a condom on their male sexual partners; and providing female condoms (or informing WID where they are available) and teaching women how to use them.

Even with relevant commodities and information, WID may find it difficult to use condoms consistently and effectively. Attempts by WID to negotiate condom use with their partners may destabilise relationships and potentially precipitate violent situations. WID who are also engaged in sex work may experience violence from clients if they attempt to negotiate condom use. As such, women may be reluctant to raise the issue, particularly if there is a previous history of violence. Various methods can be used by harm reduction programme personnel to actively empower women to negotiate condom use. These include role playing, encouragement and reinforcing negotiation skills, couples counselling, and/or group-based couples intervention.

It is important that WID continue to use condoms during pregnancy to reduce the risk of vertical transmission.<sup>32</sup>

### Provision of female condoms

Studies have also shown that access to a wide range of contraceptive methods and STI/HIV prevention devices is a key factor in reliably and regularly practicing safer sex.<sup>33</sup> Among the various options, the use of female condoms for STI/HIV prevention is well documented and highly cost-effective.

The female condom allows women to actively initiate HIV prevention for themselves and their partners. The use of the female condom can empower women with a greater sense of self-reliance and autonomy, and enhance dialogue and negotiation regarding HIV prevention with their sexual partners.

<sup>32</sup> WHO *Towards Universal Access: Scaling up HIV Services for Women and Children in the Health Sector*, Progress report, 2008.

<sup>33</sup> For a summary of the evidence for female condoms, see: WHO *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations*, 2014.

Harm reduction programmes should make female condoms easily accessible to clients, promote their use and distribute both male and female condoms (plus lubricants).

#### 4.7 Targeted information, education and communication for people who inject drugs and their sexual partners

Targeted information, education and communication (IEC) can help to increase and sustain positive change in HIV risk practices.<sup>34</sup> Harm reduction service providers are encouraged to review existing IEC materials to ensure that they fully incorporate gender-specific information and needs. Depending on what is currently used and available, it may prove useful to develop new materials that take into account and integrate such gender-specific input.

Achieving the right balance and depth typically can only be successful when women-specific HIV and harm reduction IEC materials are reviewed and developed in consultation with the target audience. Fully representative materials might include, for example, information on safer injecting that is modified for WID who rely on partners or friends to inject them, the effects of opioids on reproductive cycles, drugs and pregnancy and breastfeeding in the context of HIV risk and drug use, etc.

#### 4.8 Prevention, vaccination, diagnosis and treatment for viral hepatitis

Hepatitis B and C are two of the most common and debilitating forms of viral hepatitis that substantially affect people who inject drugs. Increased and regular access to diagnosis and treatment are therefore vital services for the overall population.

Women are more likely than men to eliminate the hepatitis C virus from their systems both in terms of spontaneously clearing the virus and clearing the virus through treatment.<sup>35</sup> Yet even though treatment can be effective, numerous precautions should be taken. For example, women receiving treatment for hepatitis C with interferon and ribavirin—until recently the only viable option in almost all contexts—are urged to use two forms of contraception during treatment and for six months after completion of treatment to avoid pregnancy because of the risk of birth defects associated with the two medicines, especially ribavirin. Men receiving such treatment are told to follow the same precautions.

A number of new medicines have been introduced and are being developed that have higher success rates and reduced complications in clearing the hepatitis C virus (HCV). As these therapies become more widely available, harm reduction programme personnel can keep WID informed of access, opportunities and implications in terms of reproductive health.

Pregnancy is *not* discouraged for women living with hepatitis C. The risk of maternal-foetal transmission of viral hepatitis during pregnancy is relatively low—during normal childbirth, for example, the risk of vertical HCV transmission is approximately 4–8 per cent of births. It is essential to note that the risk greatly increases, to 17–25 per cent of births, if the mother is co-infected with HIV.<sup>36</sup> Hepatitis B virus (HBV) vertical transmission rates are around 10–20 per cent for most women co-infected with HIV.

<sup>34</sup> WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revision.

<sup>35</sup> Bakr, I., and others, “Higher clearance of hepatitis C virus infection in females compared with males”, *GUT International Journal of Gastroenterology and Hepatology*, 55(8): 1183–1187, 2006.

<sup>36</sup> WHO *Guidelines for the Screening, Care and Treatment of Persons with Hepatitis C Infection*, 2014.

Although the hepatitis B and C viruses have been found in breast milk, HCV is not transmitted through breast milk. Most experts agree that it is safe for women with hepatitis C to breastfeed their babies if specific precautions are followed.<sup>37</sup> For example, if the mother has cracked and bleeding nipples, breastfeeding should be stopped until the nipples have healed and bleeding has ceased.

No vaccine is currently available for hepatitis C. Effective vaccines do exist for hepatitis B, however, and all WID would greatly benefit from being vaccinated. Due to generally poor access to health care, shorter vaccine schedules (1, 7 and 21 days) for WID are more likely to increase completion rates for HBV vaccination. Services that could provide HBV vaccination on a rapid schedule include drug dependence treatment sites, needle and syringe programmes, and other harm reduction services that engage regularly with people who inject drugs.<sup>38</sup>

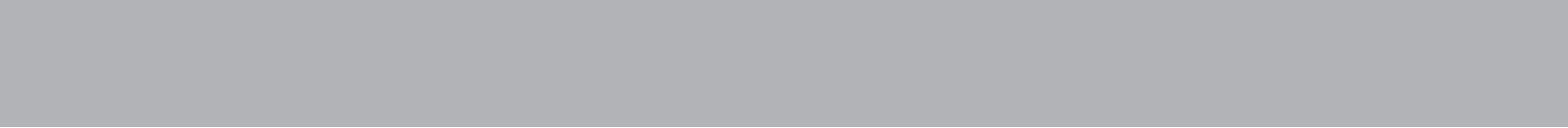
## 4.9 Prevention, diagnosis and treatment of tuberculosis

Early diagnosis and treatment of tuberculosis (TB) are the primary means of controlling the disease. To better serve WID and other clients, all harm reduction programmes would benefit from training on TB transmission, signs and symptoms, prognosis, treatment and prevention. In addition, WID are certain to benefit from the following steps taken by harm reduction service providers:

- The creation and maintenance of active referral pathways between TB treatment services and services for WID that include integrated screening and testing programmes.
- Advocacy for, and development of, mainstream TB services that are accessible and responsive to the needs of WID.

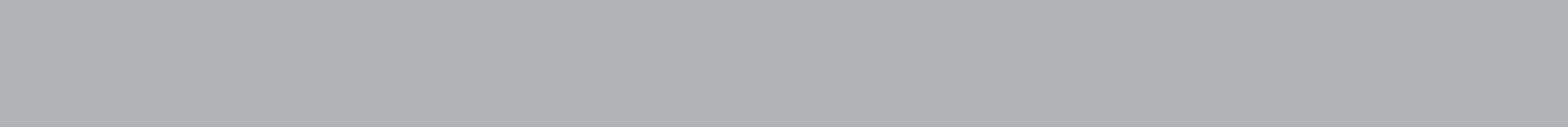
<sup>37</sup> Chun-Yan Yeung and others, “Vertical transmission of hepatitis C virus: current knowledge and perspectives”. *World J Hepatol* 6(9), 2014.

<sup>38</sup> WHO *Guidance on the Prevention of Viral Hepatitis B and C among People Who Inject Drugs*, 2012.



ADDITIONAL  
SERVICES TO INITIATE  
OR STRENGTHEN  
COMPONENTS FOR  
WOMEN WHO  
INJECT DRUGS

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Specific modifications and additional services to initiate or strengthen components for WID will vary depending on epidemiological and local contexts. It is important to understand the gender roles that exist in PWID communities and how to work within these differences to meet immediate goals and explore the potential to combat harmful gender inequalities in the longer term.

As noted elsewhere in this *Guide*, the meaningful engagement of WID is an overarching priority for the effectiveness and sustainability of any harm reduction service targeted for them. It bears repeating as well that there is substantial value in ensuring that staff are supported to provide non-judgmental, WID-friendly service.

## 5.1 Sexual and reproductive health, including STI services, PMTCT and cervical cancer screening

Harm reduction service staff, as well as those of mainstream services, can develop and deliver more appropriate and relevant services when they are trained and supported to understand the sexual and reproductive health (SRH) needs of WID.

Among the priority SRH needs of WID in most settings are pre-conception support and/or access to contraception, PMTCT, STI services and cervical cancer screening. All of these services can be incorporated into harm reduction services and vice versa. WID clients are also likely to benefit from easy and consistent availability of safe and discreet family planning services, including pregnancy tests, counselling support and termination services. Ideally, harm reduction programmes services are also able to establish linkages with WID-friendly doctors and gynaecologists—especially, though not necessarily exclusively, women themselves—who are willing to run clinics or offer appointments at service locations.

## 5.2 Prenatal and postnatal care

It is not uncommon for WID to have irregular or absent periods; therefore, they may not realize that they are pregnant until late into their second or even in their third trimester. Harm reduction programme staff thus offer valuable support when they educate WID about the potential need for prenatal care and provide them with home pregnancy test kits if possible.

Similarly, WID's ability to make fully informed decisions is improved when programme staff provide them with accurate information regarding the risks and harms to pregnancy associated with the continuing use of drugs and certain other substances. For example, alcohol use during pregnancy has been shown to have permanent developmental effects on children. Likewise, heavy tobacco use—including extensive exposure to second-hand smoke—can also be damaging to the foetus. Harm reduction service providers should be instructed to explain to heroin users the potential dangers to the foetus of abrupt withdrawal and to refer those clients to OST if requested.

It may be difficult for programme personnel to refrain from direct or inadvertent judgment in all of these areas. Yet their effectiveness is strengthened when they work under the assumption that, although the healthiest and safest option is avoidance of the use of any drug when pregnant, abstinence may not be a realistic option for clients.

Since so many factors are important to take into account at the intersection of WID and pregnancy, harm reduction programme staff often are unable to directly meet all of WID's needs on their own. Staff can support comprehensive service delivery and build capacity, however, by developing linkages and referral

pathways across other relevant service providers, including gynaecologists and obstetricians. The overall goals of all involved are similar: to better meet the needs of pregnant WID and ensure that information and care are delivered in a non-judgmental and non-stigmatizing manner to pregnant, delivering or nursing women who use drugs (including those who continue to do so).

Regardless of who or what directly provides them, comprehensive prenatal and postnatal care services for all WID are likely to include the diagnosis and treatment of HIV, hepatitis B and C, and STIs. Those who are HIV-positive also can be offered screening, prevention and treatment of opportunistic infections and other HIV-related conditions.

Listed below are other key interventions and services aimed at ensuring the highest quality maternal and infant health for WID. Harm reduction programme personnel may find themselves in the position of providing some of them directly or offering referrals developed through linkages:

- Assessing the pregnant woman, including in regards to pregnancy status (e.g., in which trimester, etc.) and birth and emergency plans;
- Delivering health information and education around HIV and HIV prevention, including safer sex;
- Counselling and support related to drug use and drug dependence treatment;
- HIV testing and counselling for WID and their partners, including couples counselling;
- PMTCT;
- Resources for care for the baby after birth;
- Information on infant feeding options, nutritional counselling and support;
- Information on vaccines and other preventive measures;
- Post-partum examination of the mother;
- HIV treatment, care and support for both mother and child and referral for prophylaxis and treatment of HIV-related conditions and other commonly associated conditions (e.g., TB);
- Provision of support to the women living with violence;
- Family planning information.

## **Breastfeeding and the use of drugs**

Drug use is not necessarily a contraindication for breastfeeding. Likewise, WID who are on OST, whether methadone or buprenorphine, should be encouraged and supported to breastfeed.<sup>39</sup>

## **Breastfeeding and living with HIV**

In July 2013, WHO issued new HIV treatment guidelines that include resources and recommendations regarding PMTCT and breastfeeding for women living with HIV.<sup>40</sup> The guidelines are especially relevant

<sup>39</sup> WHO *Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy*, 2012.

<sup>40</sup> WHO *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach*, 2013.

for low- and middle-income countries or other resource-limited settings. All personnel who support and work with WID would benefit greatly from familiarizing themselves with the guidelines and then using them as the basis of recommendations to clients. Among other things, the guidelines strongly encourage exclusive breastfeeding (when possible) for at least the first six months of an infant's life for mothers in low- and middle-income countries.

### 5.3 Gender-based violence and related services

WID are highly vulnerable to gender-based violence (GBV), which, for the purposes of this document, refers to physical, mental, emotional and other forms of abuse and harassment directed towards women.

Harm reduction programmes and other HIV-related services can help identify and respond to GBV by providing direct support to WID who experience it or linking closely with organizations and agencies that specialize in addressing violence against women. In some contexts, extra measures and protections may be required to enable WID to report abuse. Other services offered as part of a comprehensive response to GBV might include the following:

- Ensuring that WID are aware of their rights and also given information about where and how to report on police misconduct;
- Providing survivors of sexual assault with, or offering assisted referral to, clinical care where women who have been raped can access post-exposure prophylaxis (PEP) and emergency contraception;
- Offering STI services along with psychosocial support;
- Supporting the development of safety strategy and violence prevention sessions for WID.

Many women's shelters will not accept WID. Harm reduction service providers therefore are encouraged to establish strong relationships with women's shelters and ancillary social services to ensure that WID have access to the support they need and receive non-judgmental services from all such programmes.

It is also recommended that harm reduction programme personnel seek to link WID who experience GBV to appropriate legal support to prevent further recurrence. In some countries, women's rights are protected and enforced by law, and there are accountability mechanisms in place that make it fairly easy for them to safely and readily access support to prosecute human rights violations, including those perpetrated by police. Yet the reality is different in many other contexts, including countries with weak or limited laws and policies regarding women's rights. In such settings, harm reduction programmes can support WID by openly advocating legal and policy reform that benefits women and opens space and opportunities for them to achieve redress for violence and abuse.

#### Case study: EHRN's Women Against Violence campaign

The Eurasian Harm Reduction Network, in partnership with women who inject drugs and harm reduction organizations from Central and Eastern Europe and Central Asia, launched a campaign to reduce or eliminate police violence against women who use drugs (WUD).

The objective of the first year was to raise awareness of law enforcement on police violence against WUD by mobilizing and building their women's capacity to document and communicate police violence.

Key initial activities included:

- Developing community-based online instruments to document and report cases of police violence;
- Capacity-building for WUD to communicate about police violence;
- Using UN human rights instruments to advocate against police violence toward WUD;
- Organizing round tables and meetings with stakeholders, media and decision makers to present data collection and mapping results.

Outputs in later stages of the campaign included:

- Developing national and local strategies and action plans to respond to police violence against WUD;
- Establishing dialogue between WUD, decision makers and other stakeholders.

For more information, see <http://www.harm-reduction.org/>

Ideally there could be clear documentation of each occurrence of GBV reported to harm reduction workers, as this may be useful in future legal proceedings.<sup>41</sup> However, it must be recognized that clients have ultimate decision-making authority. Only if they give their consent, in the absence of coercion, should any legal action or reporting to police or other complaint agencies be undertaken.

Similar considerations underpin the notion that the safety of clients is paramount. Thus, harm reduction programme staff are strongly encouraged to carefully and fully assess the feasibility, safety and ethics of what the likely impacts and repercussions might be for a client, staff member involved and/or programme more generally to report GBV or human rights violations.<sup>42</sup> Regardless of what ultimately happens, staff members who provide GBV services are likely to need a range of different kinds of support from the organization—including in terms of debriefing or counselling, particularly in relation to emotional or stressful issues raised by clients.

Documenting and reporting incidents of GBV do not constitute a full response, of course. Harm reduction programmes can provide some other anti-violence interventions themselves, including counselling to identify violence, assessment of risks and triggers, and development of a safety plan and map social support networks. Training for relevant staff can help ensure the effectiveness of such interventions.

Raising awareness about violence against women who use drugs and training police and other the law enforcement officials to build their understanding of HIV prevention, treatment and care services for WID can significantly enhance the enabling environment for access to key services and prevent violence against women who use drugs.

Also, where possible, steps can be taken to link clinical care for survivors of sexual assault with community-led responses to violence. Full details of clinical care protocols can be found in WHO clinical and policy guidelines on *Responding to Intimate Partner Violence and Sexual Violence against Women*.<sup>43</sup>

<sup>41</sup> EHRN *Women against Violence: Concept Note of the Campaign*, 2014.

<sup>42</sup> Kaplan, K., *Harm Reduction Field Guide, Human Rights Documentation and Advocacy. A Guide for Organisations of People who Use Drugs*, Open Society Institute, 2009.

<sup>43</sup> The publication is available at: [www.who.int/reproductivehealth/publications/violence/9789241548595/en/](http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/)

## 5.4 Services tailored for WID who are engaged in sex work

As an overall group, WID are best served when harm reduction and sex worker services are closely linked. Services may be offered through referral or by providing them on-site, either at the harm reduction service, at sex worker project sites or through outreach to locations frequented by sex workers.

Services that are tailored effectively tend to include peer outreach workers who are aware of the overlap between and issues surrounding drug use and sex work and who can provide support, counselling and services related to sex work. With appropriate harm reduction training, these outreach workers can provide simple harm reduction services, such as needle and syringe services during outreach activities.

Training and education is also vital for all harm reduction personnel, whose work is fully supportive when they understand that sex work is a legitimate profession and that it is not their role to judge the appropriateness of a client's career choice. It is not acceptable for sex work to be portrayed as a cause of drug use, or vice versa. Information on safety strategies to prevent or avoid violence for sex workers is important and highly relevant to sex workers who use drugs.

## 5.5 Parenting supports

Many WID experience stigmatization and marginalization from their immediate and extended families as well as their communities. In some cases, WID may not have access to an extended family network where parenting skills can be acquired or supported. Concerns about housing, child custody, legal issues or domestic violence may be more pressing among them.

Harm reduction services can play a crucial role in supporting WID in overcoming many of these challenges, especially in terms of providing support on housing, safety issues and a range of child care and health issues (e.g., nutrition, feeding and keeping babies clean and comfortable, immunization monitoring, etc.), broader parenting advice and similar concerns. WID who have limited family support may require additional assisted referral to other groups or agencies.

Usually there is a shortage of services that specifically cater to WID and their children. These gaps and associated needs are further complicated in settings where drug use can be used as a criterion for removing custodial rights. However, where such supports can be provided in a discreet and safe context, they have also been shown to attract WID to harm reduction services.

## 5.6 Childcare

Provision of basic childcare services is fundamental in improving service access for women who have primary responsibilities for caring for young children. Reliable childcare can be especially useful in allowing clients to effectively utilize HTC and other counselling and testing services as well as treatment access. These services are accessible to WID with young children when, for example, there are dedicated facilities where children can play (and be adequately monitored) while their mothers receive services.

Harm reduction services and community-based organizations can further support their WID clients' childcare needs by advocating with in-patient drug dependence treatment facilities to provide ongoing child care and education on-site for the entire duration of the individual's stay.

## 5.7 Couples counselling

Couples-based counselling can build skills to better enable WID to implement and follow safer-injecting and safer-sex practices. Often, these practices result from safer-sex negotiation within the context of ongoing drug use with a view to facilitating the equal sharing of responsibility for reducing HIV and other health risks in a relationship.

Counselling support can also be directed to addressing strains and imbalances in relationships—including where a partner, as a means of control or in response to a perceived threat, resists a woman's involvement in harm reduction services.

## 5.8 Legal aid (relevant to WID needs)

Comprehensive harm reduction services provide referrals to reliable and quality legal services. The most useful legal support is available from individuals and organizations that specialize in issues of direct impact on most WID, including family law, intimate partner violence, and criminal laws around drug use as well as sex work.

Where possible, such legal support should be integrated into a harm reduction programme's full suite of services, be provided on-site or through paralegal peer outreach activities and include legal literacy covering specific issues related to women who inject drugs and women living with HIV.

## 5.9 Providing psychosocial and ancillary services and commodities

Some ancillary services have been detailed previously in this *Guide* (e.g., access to housing, emergency shelter, childcare, legal services, etc.). All of those have been shown to build relevance and trust between harm reduction services and WID. If it is not possible for a harm reduction programme to meet one or more of such needs directly, then it can still seek to offer clients reasonable options by developing and establishing linkages with other organizations, groups or individuals that may be able to provide the service or commodity. At the same time, the harm reduction programme might consider building these ancillary services into future funding proposals so it can provide them directly.

The following are among a wide variety of other commodities and ancillary services that can attract women to harm reduction services:

- Separate toilets and showers;
- Laundry facilities;
- Nutritional support;
- Pregnancy test kits;
- Condoms (male and female);
- Childcare products (formula, diapers, etc.);
- Feminine hygiene items (shampoo, sanitary napkins, etc.).

### Case study: Providing psychosocial and ancillary services in Tanzania

In 2010, when Médecins du Monde opened the first drop-in centre for people who use drugs in Tanzania, most of the attendees were male drug users. Recognizing that WID have different needs than men, staff members subsequently identified additional interventions to enhance access to harm reduction for women.

A weekly “women’s only” evening was initiated to enable WID to access services in a women-focused environment. Services include gender-based violence support and information, screening and care for STIs, and sexual health care by a gynaecologist. The drop-in centre offers a dedicated women’s room and bathroom and toys for children. Various commodities are provided in addition to sterile injecting equipment and condoms. Women can participate in peer education activities, a step that helped initiate and implement a women’s outreach service.

The “women’s night” is well attended with increasing uptake of harm reduction and other services such as HIV testing, sexual and reproductive health and referral to PMTCT. WID use the women’s spaces to share ideas concerning drug use, health, pregnancy, childcare and gender and family issues. For some, the service has been an entry point to becoming peer educators. Women report that ancillary services (e.g., showers, nutritional support and washing) are critical and improve access to health services and NSPs. Members of a self-support group are engaged in income-generating activities.

The benefits of a gender-sensitive service model relevant to WUD have attracted the attention of the Ministry of Health and Social Welfare, which has expressed interest in using this model when implementing other harm reduction programmes in Tanzania.

For more information, see: <http://old.medicinsdumonde.org/gb/International/Tanzania>

## 5.10 Income-generating interventions for WID

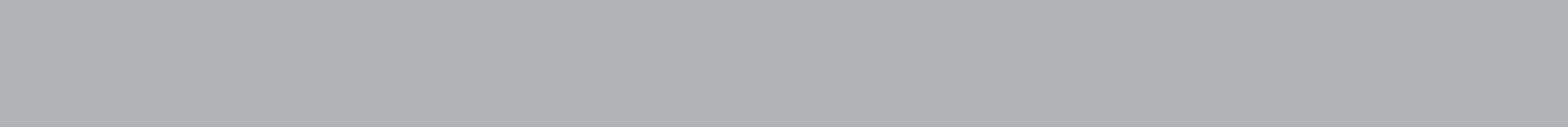
Income-generating interventions can help all clients, and often especially women, to achieve some degree of financial independence.<sup>44</sup> Potentially useful interventions in this area might focus on job training, microfinance and access to employment, among other things. Many harm reduction programmes may be able to obtain funding for such opportunities by including them in funding proposals.

### Case study: SASO’s women-focused interventions in India

The Social Awareness Service Organisation (SASO) is an HIV and harm reduction non-governmental organization that was established in 1991 by former drug users in Manipur, a state in north-east India. It provides a wide range of HIV and harm reduction services to drug users, their partners and families, and people living with HIV.

SASO implements a small-scale, innovative programme for WID. In addition to a range of harm reduction services, it runs a drop-in centre and a night shelter for homeless women who inject drugs. It is also developing vocational training and microcredit programmes that aim to increase the economic security of women who use drugs, because poverty and exploitation can make them more vulnerable to HIV and worsen their isolation and marginalization.

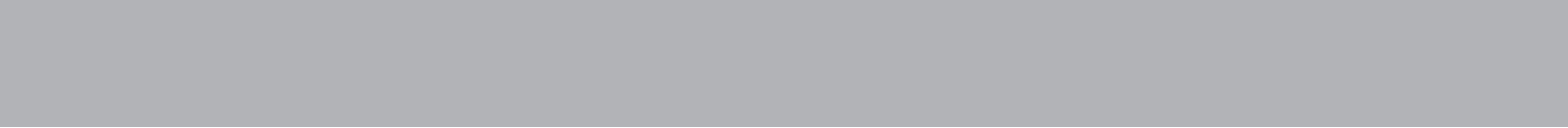
<sup>44</sup> International HIV/AIDS Alliance, *Good Practice Guide, HIV and Drug Use: Community Responses to Injecting Drug Use and HIV*, 2010.





KEY ELEMENTS IN  
MOBILIZING WOMEN  
WHO INJECT DRUGS

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As stressed throughout this *Guide*, WID's engagement and uptake of HIV-related services can be facilitated by ensuring that harm reduction services are available, accessible, affordable and acceptable to WID. Reaching and retaining women is best achieved when the services developed and targeted specifically for WID are effective, relevant and efficient. Service providers are most likely to succeed in these objectives when they play an active role in mobilizing and learning from clients, including by:

- Supporting the meaningful involvement of WID at all levels and stages in planning, implementation, monitoring and evaluation of all services for WID;
- Recruiting and training WID to provide peer education and support;
- Supporting the development of skills and structure in WID communities and networks so that they can work cooperatively with governments, health services and other institutions to provide more effective and relevant services;
- Empowering WID communities by providing knowledge, opportunities and means through which they can voice concerns, identify preferred outcomes and advocate for change;
- Raising awareness with other stakeholders of the specific issues affecting WID, thereby improving their ability to respond to WID needs;
- Supporting the development of women's groups.

Many service providers may be introducing women-specific services for the first time and lack pre-existing engagement with WID. In such cases, incorporating a participatory approach from the outset will improve the quality and impact of their mapping and client recruitment methods.

## Developing and strengthening WID collectives

Many of the best programmes have been initiated and are led by women drug users themselves, and this trend is one that can be supported in all contexts. In some cases, WID who are interested in health and rights issues related to drug use may spontaneously organize and then need assistance in mobilizing or require spaces in which to meet, perhaps on-site at a service provider or in another location of their convenience. These clients can be supported through discreet advertising to other women with similar interests from the service and through outreach. Structural and organizational assistance might also be useful, such as by supporting members in identifying key issues that they want to prioritize and address. When and if a group seems ready, additional structural assistance can be offered with the formation of a committee, where the group itself defines leadership, objectives and needs.

If a newly formed group is interested, a service provider also could offer resources to support peer education and information on the latest research that affects WID. Similarly, service personnel can highlight the importance of meaningful involvement of WID in services for WID and engage with the group in delivery, implementation, monitoring, evaluation and research issues.

The following are other potentially useful activities that service providers might take to support strengthened WID collectives:

- Assist the group—where possible and as requested—with: (a) forming linkages with other stakeholders; (b) looking for funding and training opportunities for group members; and (c) other objectives determined by the group or network. There are many examples from countries, including

Australia, Nepal and Tanzania, where peer-led harm reduction programmes also serve as headquarters for drug user organizations, and where women's groups have been formed.

- Engage with and work together with WID to map local WID populations and assess and improve the relationship between the service provider and local WID networks. Following this, it is expected that the service provider will be able and willing to actively engage WID in the delivery of services and leadership in local level HIV responses.

Sometimes WID communities cannot be accessed or identified, or simply are not established or maintained by existing clients. At the very least in such instances, service providers are urged to make every effort possible to employ WID as volunteers, as paid staff, and/or as managers in their WID-focused services.

## Gender-specific peer education and outreach

Peer education and outreach have been shown to improve communication, uptake and adherence to HIV prevention and treatment services. Peer workers often are uniquely positioned to enhance engagement with WID and improve the acceptability of services.

Gender-specific peer education involves peers who share not only a history of drug use but are of the same sex as the target group. Women peers often can counteract some of the barriers that may limit WID from accessing services, including by increasing trust and credibility and by providing a sense of personal safety or willingness to discuss personal issues. Recruiting women who use drugs and training them to provide peer support is thus a good strategy for service providers seeking to better ensure that WID clients find services relevant, credible and acceptable. These women-driven efforts can also help attract new clients.

### Case study: Reaching out to WID through the Harm Reduction Community Container project in Mauritius

Collectif Urgence Toxida (CUT) is a non-governmental harm reduction organization in Mauritius. Services provided by the organization include an NSP, basic health care (wound dressing, HIV testing, etc.), and referral to various health and social services. In 2013, CUT provided services to some 1,600 people who use drugs.

CUT developed and launched a community project titled "Harm Reduction Community Container" in an effort to identify and support members of hard-to-reach populations, including WID and young injectors. The project offers basic health care within the community in a refurbished cargo-type container. In addition, mobile teams walk throughout the community to meet vulnerable PWID, many of whom are reluctant to visit the stationary site. Services offered by these mobile teams include counselling on HIV, viral hepatitis and safe injecting practices as well as provision of sterile injecting supplies and condoms to PWID and their partners. About 60 per cent of mobile team workers are women, including some women with a history of drug use.

In 2013, women accounted for 42 per cent of the 1,600 clients reached by CUT, as opposed to 11 per cent accessing NSP sites across the country

For more information, contact: <http://www.cut.mu>

## WID leadership opportunities

Mentoring WID communities is a capacity-building process that can have long-term positive outcomes both for clients and for programmes and organizations that provide services to them. Effective capacity-building activities for mentoring and supporting WID community mobilizers generally are guided by the following principles and strategies:

- Training WID not only as staff, but also for leadership positions by focusing on communication skills. These skills enable WID community mobilizers to communicate clearly with various stakeholders such as funders, government agencies, the media and international organizations, etc.;
- Training and supporting community mobilizers to lead regular discussions with the aim of keeping WID communities working together toward common goals;
- Forming or linking with existing local, national or international networks such as INWUD and WHRIN.<sup>45</sup> It can also be useful in some cases to link with mainstream women's and feminist organizations to increase traction for advocacy, especially on issues that are relevant for other groups of women (e.g., violence).

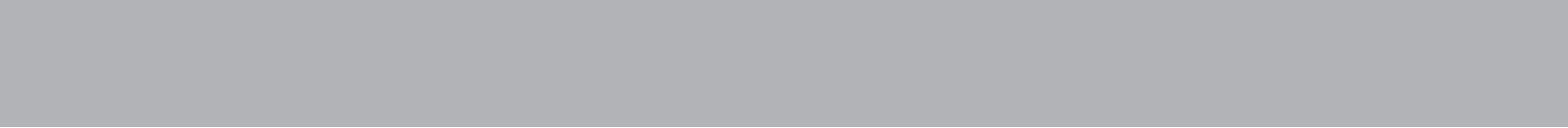
### Case study: Nepal Drug Users Prevention Association

The first step toward establishing the Association was the formation of the Advocacy Task Force of Women Who Use Drugs in Nepal in 2012. Members of the task force were involved with UNODC-supported projects; training provided to women ex-drug users as well as current users led to the formation of the task force.

Dristi Nepal provided a platform and continuous guidance for leading the group in an organized and structured manner, while the United States Agency for International Development (USAID) also helped in providing training and network strengthening activities. Members of the task force were also provided training to enhance skills such as office management, report writing, public speaking and leadership training. The workshop and the training increased the existing capacity and helped build in skills to carry out day-to-day organizational activities and to represent the group in national forums.

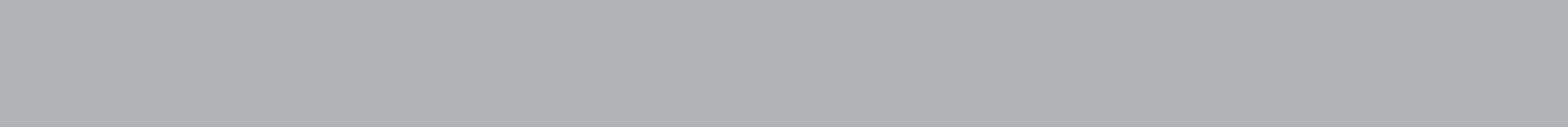
In 2014, the task force formally became the Nepal Drug Users Prevention Association. It now comprises skilled, motivated and enthusiastic members who have come together to effectively advocate for women who use drugs. The Association is preparing a constitution and drafting a strategic action plan, in which GBV will be a key issue, which will be disseminated among stakeholders.

<sup>45</sup>The International Network of Women Who Use Drugs (INWUD) represents the interests of WID in the International Network of People Who Use Drugs (INPUD). INWUD actively seeks to give greater voice to issues affecting women who use drugs, including by helping to channel the views and experiences of women who use drugs into advocacy efforts. The Women's Harm Reduction International Network (WHRIN) is a global platform that seeks to reduce harms for women who use drugs and to develop an enabling environment for the implementation and expansion of harm reduction resources for women.



SERVICE  
MANAGEMENT AND  
ORGANIZATIONAL  
CAPACITY-BUILDING

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Comprehensive and effective gender-specific programming recognizes and responds to gender inequalities in a variety of ways, including:

- Implementing measures to ensure the participation of both women and men in decision-making (this includes acknowledging the value of women-only forums in some contexts);
- Employment of both men and women in outreach work (and specifically acknowledging the value of women-only programmes in some contexts);
- Training for staff, volunteers and HIV-related service providers on the special needs of WID;
- Gathering sex-disaggregated service data;
- Providing specific services to meet the needs of both women and men;
- Developing initiatives, activities, and strategies that: (a) promote empowerment of both women and men; (b) challenge harmful gender norms; and (c) challenge and seek to eliminate gender-based violence or inequities in injecting practices, such as women going “second on the needle” (as discussed in chapter 2 of this *Guide*).<sup>46</sup>

## 7.1 Staffing issues

Meeting the needs of WID is more likely to be achieved by employing women with a history of drug use and who are identified as such in networks of people who use drugs. Service providers also tend to benefit when potential workers are recruited from a range of WID networks—including those focused on youth, mothers or sex workers—so as to fully reflect WID community composition in the locale as identified by initial mapping.

While an equal gender ratio among workers (both paid staff and volunteers) is ideal, staff composition may depend on the demographics of the target groups as well as cultural context. For example, in areas with a large number of women engaged in sex work, maximum impact may best be achieved with more female than male workers. Regardless of the situation with workers overall, the gender ratio in leadership and management roles should be balanced as much as possible. It is also important to note that women-only organizations have been successful in attracting and retaining WID clients.

## 7.2 Staff training and competency

Competent and effective workers respect and appreciate the dignity and worth of peer staff and clients and accept that WID have a right to make their own decisions and manage their own lives. This includes their decision to use drugs. Gender-sensitivity training is important for all staff, and such training is especially valuable when it includes specific sessions on attitudes and beliefs regarding WID.

Education, a key component of any advocacy effort, can be often undertaken by trained staff (and ideally clients, where possible). Common targets and recipients might include health-care workers, police and prison staff, all of whom are likely to more appropriately engage with and treat WID and other people who use drugs when they are educated about drug use, harm reduction, and a rights- and health-based approach to drug use.

<sup>46</sup>International HIV/AIDS Alliance, *Good Practice Guide. HIV and Drug Use: Community Responses to Injecting Drug Use and HIV*, 2010.

It is important that training and education for service staff as well as referral network agencies and other external parties (e.g., police) include information on WID-specific issues and stigma.

### 7.3 Staff development, mentoring and succession planning

Service provision can be improved when staff have opportunities to identify how they as workers might promote appropriate services for WID in their own work. One way to do this is to ensure that gender-sensitivity principles form a component of staff development and mentoring.

Succession planning is concerned with identifying key staff members who, over time, can take on more responsibility and be considered for leadership opportunities in senior roles. It is important to retain and develop women staff to provide the most effective services possible for WID.

Professional development support can be provided to support the growth of management skills over time. Regardless of the context, service providers have an organizational responsibility to provide maternity leave since so much of the focus is and should be on women. Succession planning therefore should incorporate a backup staff member while any staff members are on leave.

Careful consideration of staff performance evaluations is recommended to ensure that they reflect how individuals incorporate gender-sensitive principles in their work. Staff input and feedback can be sought regarding how each staff member might better service the needs of WID in her specific roles and responsibilities.

### 7.4 Burnout prevention

Burnout occurs when workers feel overloaded by the problems of others and feel helpless to change the situation. It is a common response to the chronic emotional strain of working intensely with other people.

Staff who provide services to WID may feel that, regardless of what they do, no change is occurring, or in fact may even be possible. Such feelings of hopelessness are especially common when they work with and provide services to women living in poverty and/or in an environment where GBV is common. Organizations and programmes operate more efficiently when they are aware of the potential for burnout—and not just for those working directly with WID, but all service staff—and take active steps to prevent, identify and manage burnout.

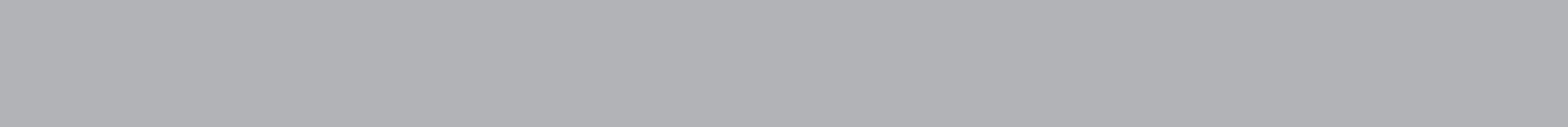
Burnout can be addressed through:

- Staff support mechanisms that may include regular supervision, mentoring, counselling and other forms of staff debriefing;
- Organizational mechanisms based on a realistic expectation of staff needs and expectations, including open and transparent communication, clear job roles, routine staff meetings and responsive staff feedback;
- Reducing staff stress by providing immediate and respectful feedback, rewarding good job performance, and the provision of relevant workforce development plans and career structures;
- Careful efforts to create a supportive organizational policy environment that (among other things) can: (a) address alcohol and other drug use by staff; (b) manage seriously disruptive incidents; and (c) provide an effective grievance procedure for staff.

## 7.5 Measuring gender equality within harm reduction services

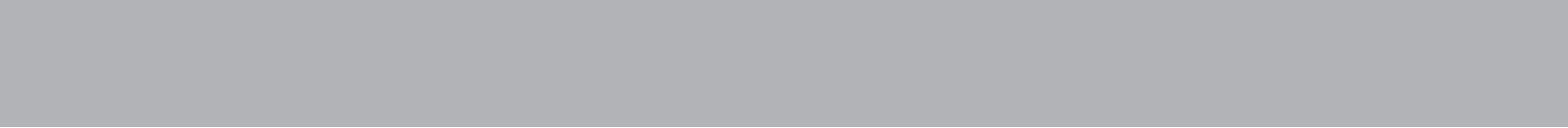
Service providers themselves often may find it expedient to develop measures to examine the extent to which gender-sensitive principles are integrated into services, organizational structures, policies and procedures, gender ratios, etc. When initiating such assessments, the following questions are among those that might be considered:

- Are there provisions for flexible working hours for both women and men, childcare provision and policies that encourage more flexible gender roles?
- Do policies reflect gender sensitivity and equity?
- Is gender equity considered during recruitment?
- What systems are in place to increase the technical capacities of staff in gender issues and internal capacity-building to meet WID's needs?
- Is there allocation of financial resources for WID-specific services?
- Does the organizational culture include participation and consultation with women staff and WID?
- Have women's organizations been established or strengthened?



# PRISONS AND SERVICE CONTINUITY

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A growing number of policymakers and advocates worldwide agree that WID, especially those with children, should not be imprisoned solely for personal drug use and possession of small amounts of drugs for personal consumption. However, women continue to be incarcerated for minor drug-related offences, and they remain one of the primary reasons why women enter prison systems.<sup>47, 48</sup> Most of these women have not committed any violent crimes and are often first-time offenders.<sup>49, 50</sup>

The consequences to their health and welfare are frequently dire. Incarcerated women often have a higher prevalence of blood-borne viruses and STIs and more health problems in general than male prisoners.<sup>51, 52</sup> Many women in prisons have experienced abuse and violence before incarceration and may also have been (and/or remain at great risk of becoming) victims of sexual violence perpetrated by prison guards.<sup>53</sup> Furthermore, women in prison may also experience loss of custody of their children. Once released, they may not be able to regain custody, and those with criminal records may be denied access to educational or employment opportunities.

Some of the most notable standards regarding the sentencing and treatment of women prisoners are included in the United Nations Bangkok Rules (see box below).

## The Bangkok Rules

(Formally, the United Nations Rules for the Treatment of Female Prisoners and Non-custodial Measures for Women Offenders—adopted by the United Nations General Assembly in 2010.)

### Rule 45

Prison authorities shall utilize options such as home leave, open prisons, halfway houses and community-based programmes and services to the maximum possible extent for women prisoners, to ease their transition from prison to liberty, to reduce stigma and to re-establish their contact with their families at the earliest possible stage.

### Rule 46

Prison authorities, in cooperation with probation and/or social welfare services, local community groups and non-governmental organizations, shall design and implement comprehensive pre- and post-release reintegration programmes which take into account the gender-specific needs of women.

### Rule 47

Additional support following release shall be provided to released women prisoners who need psychological, medical, legal and practical help to ensure their successful social reintegration, in cooperation with services in the community.<sup>a</sup>

<sup>a</sup>United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (Bangkok Rules), reproduced in Economic and Social Council resolution 2010/16, annex, United Nations document E/RES/2010/16 (22 July 2010).

<sup>47</sup> UNODC, UNAIDS *Women and HIV in Prison Settings*, 2008.

<sup>48</sup> Lakobishvili, E., *Cause for Alarm: The Incarceration of Women for Drug Offences in Europe and Central Asia, and the need for Legislative and Sentencing Reform*, International Harm Reduction Association, 2012.

<sup>49</sup> Eurasian Harm Reduction Network, *Submission to UN Special Rapporteur on Violence against Women: Call for Immediate Action to Stop Violence against Women Who Use Drugs*, 2012.

<sup>50</sup> Giacomello, C., *Women, Drug Offences and Penitentiary Systems in Latin America*, International Drug Policy Consortium, 2013.

<sup>51</sup> UNODC, WHO *Women's Health in Prison: Correcting Gender Inequity in Prison Health*, 2009.

<sup>52</sup> UNODC, UNAIDS *Women and HIV in Prison Settings*, 2008.

<sup>53</sup> Global Coalition on Women and AIDS, *Women Who Use Drugs, Harm Reduction and HIV*, 2011.

UNODC has identified a comprehensive package of 15 key harm reduction interventions and services that can help safeguard the health and safety of all PWID in prisons, including women.<sup>54</sup> The full list is presented below:

1. Information, education and communication (IEC)
2. Condom programmes
3. Prevention of sexual violence
4. Drug dependence treatment, including OST
5. Needle and syringe programmes
6. Prevention of transmission through medical or dental services
7. Prevention of transmission through tattooing, piercing and other forms of skin penetration
8. Post-exposure prophylaxis
9. HIV testing and counselling
10. HIV treatment, care and support
11. Prevention, diagnosis and treatment of tuberculosis
12. Prevention of mother-to-child transmission of HIV
13. Prevention and treatment of sexually transmitted infections
14. Vaccination, diagnosis and treatment of viral hepatitis
15. Protecting staff from occupational hazards

Harm reduction service providers meet the full needs of their current and potential clients when they advocate for the implementation of as much of this package as possible—and where possible, coordinate directly with local prisons to provide the interventions. In general, service providers are encouraged to advocate for and support the notion that women in prisons have equivalent access to gender-sensitive health and HIV services as their non-incarcerated counterparts in the community.

## 8.1 Pre-release

WID as well as all other prisoners are better able to reintegrate into communities when pre-release preparations start early. In an ideal situation for each inmate, all services within the prison, especially prison health, work together to develop an overall plan for client support after release.

A client-based approach is the most effective strategy to assess and develop a service plan that ensures continuity of care and access to health and other services after release. That plan is most likely to address the needs of the individual when it is developed in conjunction with the client and identifies referral processes and mechanisms to track the client's access to services.

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<sup>54</sup>UNODC, ILO, UNDP, WHO, UNAIDS *HIV Prevention, Treatment and Care in Prisons and Other Closed Settings: A Comprehensive Package of Interventions*, Policy brief, 2013.



## Case management approach

There are complex and unique social contexts that have an impact on each women transitioning from prison to the community. Significant challenges to women after they are released may include, for example, reuniting with children, continuity of OST and ART or TB treatment and ongoing access to mental health or other support services.

To manage these issues, it is recommended that: (a) pre-release planning services adopt a case management approach that is advocacy based; (b) case managers be informed when an inmate is to be released; and (c) case management services to develop a client-driven post-release plan begin 3–6 months before release date. In low-resource settings, the following other steps may assist in setting up an effective case management system to guide women transition from prison to community upon release:

- Establishing a working relationship with the prison authorities and providing relevant information as needed and on a timely basis.
- Advocating to train key prison personnel—and then providing the training, if necessary—so that they understand the benefits to prisoners and to the prison system in general.
- Undertaking ongoing advocacy to support prison personnel to act as equal partners in the design and implementation of case management support for prisoners.
- Selecting and training women case managers to work with women prisoners. Care should be taken to not overburden case managers with an excessive number of cases.
- Identifying key services in the community that will be required post release. If possible, this would include establishing a network of “trusted service providers” and formalizing arrangements by signing memorandums of understanding (MoUs).

In addition, it is recommended that case managers consider maintaining contact with each case for approximately one year. Both case managers and clients benefit as well when a support system, such as professional mentoring, has been established for each case manager.<sup>55, 56</sup>

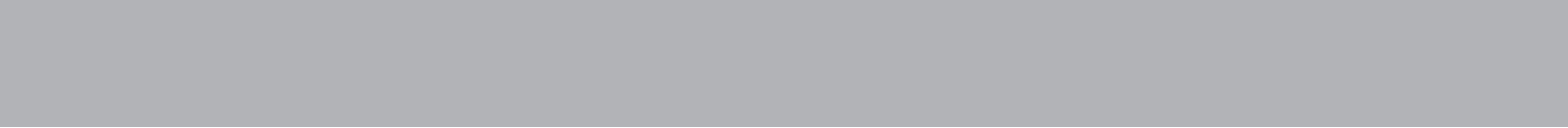
## 8.2 Treatment and care continuity

The health and well-being of clients depend on treatment continuity for all medical conditions and needs; therefore, for example, ART and treatment for drug dependence, TB and viral hepatitis should be maintained upon arrest, throughout incarceration and all steps afterwards, leading to reintegration into the community.

Harm reduction service providers can help ensure treatment continuity by liaising with local prison authorities to explore opportunities to develop HIV prevention and drug use-related assessment and treatment management plans for periods including post arrest, maintenance for duration (including any prison transfers) and pre-release.

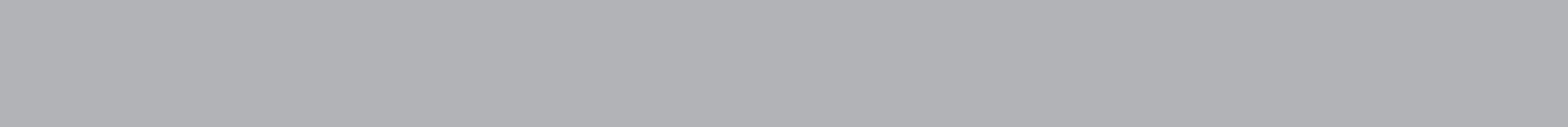
<sup>55</sup> Bartels, L., Gaffney, A., *Good Practice in Women Prison: A Literature Review*, 2011.

<sup>56</sup> Prison Reform Trust, *International Good Practice: Alternatives to Imprisonment for Women Offenders*, 2013.



ANNEX.  
ADDITIONAL  
RESOURCES

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## Selected international standards, agreements and human rights mechanisms that support gender-sensitive harm reduction policy and services

The quoted text in each entry below is copied directly from the selected sources. Links are provided for more detailed information.

### United Nations Fourth World Conference on Women

Platform for Action, strategic objective C (women and health):

1. “Increase women’s access throughout the life cycle to appropriate, affordable and quality health care, information and related services. Actions to be taken.”
2. “Strengthen preventive services that promote women’s health. Actions to be taken.”
3. “Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and reproductive health issues. Actions to be taken.”

Para. 106 (b): Calls on governments to “Reaffirm the right to the enjoyment of the highest attainable standards of physical and mental health, protect and promote the attainment of this right for women and girls and incorporate it in national legislation, for example; review existing legislation, including health legislation, as well as policies, where necessary, to reflect a commitment to women’s health and to ensure that they meet the changing roles and responsibilities of women wherever they reside.”

For more information: [www.un.org/womenwatch/daw/beijing/platform/health.htm](http://www.un.org/womenwatch/daw/beijing/platform/health.htm)

### Women out loud: how women living with HIV will help the world end AIDS

Reaching the 10 targets of the 2011 United Nations General Assembly Political Declaration on HIV and AIDS, 2012, [www.unaids.org/sites/default/files/media\\_asset/20121211\\_Women\\_Out\\_Loud\\_en\\_1.pdf](http://www.unaids.org/sites/default/files/media_asset/20121211_Women_Out_Loud_en_1.pdf)

“Women who inject drugs must have access to confidential and voluntary HIV counselling and testing. They also need reliable information and access to sexual and reproductive services for ending new infections in children and keeping mothers alive, as well as to protect their own health, free of stigma and discrimination.”

### Commission on the Status of Women on thematic issues: women, the girl child and human immunodeficiency virus/acquired immunodeficiency syndrome

(agreed conclusions of the fifth session, 6–16 March and 9–11 May 2001)

E/2001/INF/2/Add.2

Para. 4 (j): “Provide gender-sensitive prevention and treatment services for female substance abusers living with HIV/AIDS.”

**Report of the United Nations Secretary-General: International cooperation against the world drug problem**

(General Assembly, sixty-seventh session, 21 June 2012)

A/67/157

Para. 73 (e): “Urge Member States to renew their efforts to increase the coverage of interventions to prevent drug use and to increase access to services for the treatment, care and rehabilitation of people suffering from drug dependence that are based on scientific evidence, gender-responsiveness, human rights and the dignity of the patients.”

**Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover**

(report to the United Nations Human Rights Council, addendum, Mission to Viet Nam, 4 June 2012)

A/HRC/20/15/Add.2

Para. 63 (b): Recommendation to “Eliminate stigmatization and create an enabling environment, in which at-risk populations, including injecting drug users, female sex workers and men who have sex with men, are able to effectively access health care, by de-penalizing drug use and sex work.”

**Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover**

(annual report to the United Nations Human Rights Council, 27 April 2010)

A/HRC/14/20

Para. 64: “Although laws criminalizing HIV transmission and exposure were, on occasion, enacted to provide women with greater protection, applying these laws broadly has also resulted in women being disproportionately affected.”

**Concluding observations on the State report of Panama**

(Committee on the Elimination of Discrimination against Women, 5 February 2010)

CEDAW/C/PAN/CO/7

Para. 25: “The Committee ... also calls upon the State party to take all appropriate measures to protect women against the negative effects of overcrowding in prisons and to step up its efforts to provide professional training and conduct awareness-raising campaigns for all professionals working with women deprived of liberty. The Committee also calls upon the State party to investigate cases of abuses committed by police officers and punish the perpetrators of such crimes.”

**Concluding observations on the State report of Brazil**

(Committee on the Elimination of Discrimination against Women, 23 March 2012)

CEDAW/C/BRA/CO/7

Para. 32: “The Committee expresses its concern about the significant increase in the number of women and girls in prison in the State party. It takes note that a large proportion of them have been imprisoned for committing drug trafficking-related offences, in particular for having transported drugs (as ‘mules’) at the request of their partners. The Committee is further concerned at the precarious conditions and overcrowding of some detention facilities; the difficulties faced by women prisoners with access to justice, including the lack of interpretation services for indigenous women; the increasing reports of sexual violence in the prisons; and the lack of adequate health facilities and services for female inmates, in particular pregnant women.”

**Concluding observations on the State report of the United Kingdom of Great Britain and Northern Ireland**

(Committee on the Elimination of Discrimination against Women, 10 June 1999)

CEDAW/C/UK/3 and CEDAW/C/UK/4

Para. 313: “The Committee recommends that the Government intensify its efforts to understand the causes for the apparent increase in women’s criminality and to seek alternative sentencing and custodial strategies for minor infringements.”

**Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, Paul Hunt**

(report submitted to the Human Rights Council, addendum, mission to Romania, 21 February 2005)

E/CN.4/2005/51/Add.4

Para. 42: “Ensuring non-discrimination in the provision of health-care services is an essential component of the right to health. Marginalized populations face particular obstacles when seeking to access reproductive health services. The stigma associated with commercial sex work and injecting drug use, for example, affects how people engaged in these activities are often treated by health-care workers, especially when requesting services such as tests for sexually transmitted infections ... The Government is urged to take a broad approach to combating discrimination in all of its manifestations by providing diversity training to health-care workers and ensuring that procedural barriers do not become a denial of access to care.”

**Promoting strategies and measures addressing specific needs of women in the context of comprehensive and integrated drug demand reduction programmes and strategies**

(Commission on Narcotic Drugs (CND), resolution 55/5, 16 March 2012)

CND Resolution 55/5

Para. 2: “Encourages Member States to integrate essential female specific services in the overall design, implementation, monitoring and evaluation of policies and programmes addressing drug abuse and dependence, where needed.”

Para. 3: “Recommends that Member States consider and accommodate the specific needs of drug-dependent parents, including child care and parental education.”

Para. 4: “Also recommends that Member States, in designing, implementing and evaluating integrated drug prevention and treatment and HIV prevention programmes, take into account the needs of women who have experienced sexual and other violent trauma related to drug abuse”

### **Commission on the Status of Women**

(agreed conclusions on critical areas of concern identified in the Beijing Platform for Action, forty-third session; 1–12 March and 1 April 1999; 1999/17)

E/1999/INF/2/Add.2

Para. 4 (c): “Support research and dissemination of information on gender differences in the causes and effects of the use and abuse of substances, including narcotic drugs and alcohol, and develop effective gender-sensitive approaches to prevention, treatment and rehabilitation, including those specifically designed for pregnant women.”

### **Human rights and gender equality in health sector strategies: how to assess policy coherence**

WHO, 2011;

[www.ohchr.org/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf](http://www.ohchr.org/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf)

This guide includes a text box titled “Selected Action Oriented Policy Commitments to Human Rights and Gender Equality” that lists several key developments between 1983 and 2010.

## **Useful tools**

### **Targets and standards**

- WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, 2012 revision.  
[http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf)
- WHO *Consolidated Guidelines on HIV prevention, Diagnosis, Treatment and Care for Key Populations*, 2014.  
[http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431\\_eng.pdf?ua=1&ua=1](http://apps.who.int/iris/bitstream/10665/128048/1/9789241507431_eng.pdf?ua=1&ua=1)
- International HIV/AIDS Alliance, *Good Practice Guide. HIV and Drug Use: Community Responses to Injecting Drug Use and HIV*, 2010.  
[http://www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use\\_original.pdf?1405520726](http://www.aidsalliance.org/assets/000/000/383/454-Good-practice-guide-HIV-and-drug-use_original.pdf?1405520726)
- UNAIDS Guidelines, *Operational Guidelines for Monitoring and Evaluation of HIV Programmes for People who Inject Drugs: Monitoring and Evaluation at the Service Delivery Level*, 2011.  
[www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs/idu-service-delivery-level-guidelines](http://www.cpc.unc.edu/measure/tools/hiv-aids/operational-guidelines-for-m-e-of-hiv-programmes-for-people-who-inject-drugs/idu-service-delivery-level-guidelines)



- Moser, A., *Gender and Indicators Overview Report*, UNDP, 2007.  
[www.gsdr.org/document-library/gender-and-indicators](http://www.gsdr.org/document-library/gender-and-indicators) (Includes practical advice for developing gender mainstreaming indicators, including sections on poverty and GBV.)
- WHO *Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection*, 2013.  
[www.who.int/hiv/pub/guidelines/arv2013/en/](http://www.who.int/hiv/pub/guidelines/arv2013/en/)

### Gender

- International HIV/AIDS Alliance, *Approaches to Gender and Sexuality: Responding to HIV*, 2011.  
[http://www.aidsalliance.org/assets/000/000/741/GenderAndSexualityReport\\_original.pdf?1406302925](http://www.aidsalliance.org/assets/000/000/741/GenderAndSexualityReport_original.pdf?1406302925)

### Human rights

- Kaplan, K., *Human Rights Documentation and Advocacy: A Guide for Organisations of People who Use Drugs*, Open Society Institute, 2009.  
[www.opensocietyfoundations.org/publications/human-rights-documentation-and-advocacy-guide-organizations-people-who-use-drugs](http://www.opensocietyfoundations.org/publications/human-rights-documentation-and-advocacy-guide-organizations-people-who-use-drugs)

### Women and harm reduction

- *Women Who Use Drugs, Harm Reduction and HIV*, The Global Coalition on Women and AIDS, 2011.  
[www.ihra.net/contents/1143](http://www.ihra.net/contents/1143)
- Harm Reduction International, *The Global State of Harm Reduction: Towards an Integrated Response*, 2012. (See, in particular, the chapter titled “Developing effective harm reduction services for women who Inject drugs”.)  
[www.ihra.net/global-state-of-harm-reduction-2012](http://www.ihra.net/global-state-of-harm-reduction-2012)
- Ditmore, M.H., *When Sex Work and Drug Use Overlap: Considerations for Advocacy and Practice*, Harm Reduction International, 2013.  
[www.ihra.net/contents/1407](http://www.ihra.net/contents/1407)
- *Illicit Drug Use in Pregnancy: An Appropriate Response*, A position paper from the Women and Harm Reduction International Network (WHRIN) and the International Network of Women who use Drugs (INWUD), 2012.
- WHO, UNFPA, UNAIDS, NSWP, World Bank, *Implementing Comprehensive HIV/STI Programmes with Sex Workers. Practical Approaches from Collaborative Interventions*, 2013.  
[www.who.int/hiv/pub/sti/sex\\_worker\\_implementation/en/](http://www.who.int/hiv/pub/sti/sex_worker_implementation/en/)

### Meaningful involvement of people who use drugs

- Canadian HIV/AIDS Legal Network, International HIV/AIDS Alliance, Open Society Institute, “*Nothing About Us Without Us*”. *Greater, Meaningful Involvement of People Who Use Illegal Drugs: A Public Health, Ethical, and Human Rights Imperative*, International edition, 2008.  
[www.opensocietyfoundations.org/reports/nothing-about-us-without-us](http://www.opensocietyfoundations.org/reports/nothing-about-us-without-us)
- *Harm Reduction at Work: A Guide for Organizations Employing People Who Use Drugs*, Open Society Foundation, 2010.  
[www.opensocietyfoundations.org/reports/harm-reduction-work](http://www.opensocietyfoundations.org/reports/harm-reduction-work)

**Prisons**

- UNODC, ILO, UNDP, WHO, UNAIDS *HIV Prevention, Treatment and Care in Prisons and other Closed Settings: a Comprehensive Package of Interventions*, Policy Brief, 2013.  
[www.unodc.org/documents/hiv-aids/HIV\\_comprehensive\\_package\\_prison\\_2013\\_eBook.pdf](http://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf)
- UNODC, UNAIDS, WHO *HIV Testing and Counselling in Prisons and Other Closed Settings*, Technical paper, 2009.  
[http://www.who.int/hiv/pub/idu/tc\\_prisons/en/](http://www.who.int/hiv/pub/idu/tc_prisons/en/)
- UNODC, UNAIDS, WHO *HIV and AIDS in Places of Detention: A Toolkit for Policymakers, Programme Managers, Prison Officers and Health Care Providers in Prison Settings*, 2009.  
[www.who.int/hiv/pub/idu/detention\\_toolkit/en/](http://www.who.int/hiv/pub/idu/detention_toolkit/en/)
- UNAIDS, UNODC *Women and HIV in Prison Settings*, 2008.  
[www.unodc.org/balticstates/en/publications/prison-settings.html](http://www.unodc.org/balticstates/en/publications/prison-settings.html)
- WHO EURO UNODC *Women's Health in Prison. Correcting Gender Inequity in Prison Health*, 2009.  
[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/76513/E92347.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf?ua=1)

**NSPs**

- WHO *Guide to Starting and Managing Needle and Syringe Programmes*, 2007.  
[www.who.int/hiv/pub/idu/needleprogram/en/](http://www.who.int/hiv/pub/idu/needleprogram/en/)

**Drug dependence treatment**

- WHO, UNODC, UNAIDS *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*, Position paper, 2004.  
[www.who.int/hiv/pub/idu/position\\_paper\\_substitution\\_opioid/en/](http://www.who.int/hiv/pub/idu/position_paper_substitution_opioid/en/)
- WHO UNODC, UNAIDS *Reduction of HIV Transmission through Drug-dependence Treatment*, Policy brief, 2005.  
[www.unodc.org/documents/hiv-aids/reduc\\_HIV\\_trans\\_drug\\_dep\\_treat\\_eng.pdf](http://www.unodc.org/documents/hiv-aids/reduc_HIV_trans_drug_dep_treat_eng.pdf)

**Hepatitis**

- WHO *Guidance on Prevention of Viral Hepatitis B and C among People Who Inject Drugs*, 2012.  
[www.who.int/hiv/pub/guidelines/hepatitis/en/](http://www.who.int/hiv/pub/guidelines/hepatitis/en/)
- WHO *Guidelines for the Screening, Care and Treatment of Persons with Hepatitis C Infection*, 2014.  
[www.who.int/hiv/pub/hepatitis/hepatitis-c-guidelines/en/](http://www.who.int/hiv/pub/hepatitis/hepatitis-c-guidelines/en/)

**Resourcing**

- UNAIDS *Investing for Results. Results for People. A people-centred investment tool towards ending AIDS*, 2012.  
[www.unaids.org/sites/default/files/sub\\_landing/files/JC2359\\_investing-for-results\\_en.pdf](http://www.unaids.org/sites/default/files/sub_landing/files/JC2359_investing-for-results_en.pdf)
- Harm Reduction International, *The Global State of Harm Reduction. Towards an Integrated Response*, 2012. (See, in particular, chapter 3.5, which has case studies on funding and sustainability.)  
[www.ihra.net/global-state-of-harm-reduction-2012](http://www.ihra.net/global-state-of-harm-reduction-2012)

## Examples of indicators that can provide gender-sensitive information on harm reduction elements

The WHO, UNODC, UNAIDS *Technical Guide* provides a list of indicators and targets for planning and monitoring access to harm reduction services for people who inject drugs. As suggested in the *Technical Guide*, the indicators should be disaggregated according to gender and age group.

In addition, the following indicators could complement the above:

- An assessment of the number and needs of women who use drugs is/was conducted in the local area before commencing NSP services;
- Women in the community are involved in assessment, planning and decision-making processes of all NSPs;
- The number of women and gender ratio of professional staff:
  - The female technical staff-female client ratio;
  - The male technical staff-male client ratio;
- Gender responsive service (opening time, women's health services, etc.);
- The number of pregnant WID/WUD referred for PMTCT who got PMTCT;
- Gender-specific strategies exist for providing WID with access to IEC;
- The number of gender-sensitive IEC harm reduction materials distributed in the last 12 months;
- Gender-sensitive IEC harm reduction materials developed;
- The number of education sessions provided to WID on condom use negotiation;
- The number of education sessions provided to WID on female condom use;
- The number of free male condoms distributed in the last 12 months (gender-disaggregated data);
- The number of free female condoms distributed in the last 12 months (gender-disaggregated).







# UNODC

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