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Trainers guide to facilitate workshop for service providers o­n gender-responsive HIV services for women who inject drugs

August, 2017

# Acronyms

AIDS Acquired Immune Deficiency Syndrome

ART Antiretroviral Treatment

BBVs Blood Borne Viruses

DAAs Direct Acting Agents (HCV treatment)

EHRN Eurasian Harm Reduction Network

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

INPUD International Network of People Who Use Drugs

INWUD International Network of Women Who Use Drugs

MCH Maternal and Child Health

M&E Monitoring and Evaluation

NSP Needle and Syringe Program

OST Opioid Substitution Therapy

PEP Post-exposure prophylaxis

PITC Provider-initiated HIV testing and counselling

PLHA People Living With HIV/AIDS

PMTCT Prevention of Mother to Child Transmission

PWID People Who Inject Drugs

SRH Sexual and Reproductive Health

STI Sexually Transmitted Infection

TB Tuberculosis

UNODC United Nations Office of Drug Control

UNAIDS Joint United Nations Programme on HIV/AIDS

WHRIN Women’s Harm Reduction International

WID Women Who Inject Drugs

WHO World Health Organization

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# Training Guidelines

## Purpose

The modules in this training guide are designed to support training workshops and provide information for trainers regarding service needs for Women who Inject Drugs (WID). The modules consist of slides, handouts and background information for training participants to better understand how to plan, implement and manage programs. The workshop provides a foundation for increasing awareness and knowledge of, and for examining issues related to, the planning of programs for WID to scale; recruiting, training, supervising, and monitoring the quality of programs once implemented. By combining theory with complementary activities, pragmatic techniques and examples, the workshop will assist program managers and implementers to better understand various planning and human resources considerations.

## Background

UNODC, a co-sponsor of UNAIDS, is the convening agency for HIV and people who use drugs. Together with national and international partners, including civil societies, UNODC supports the implementation of large-scale and wide-ranging evidence-informed and human rights-based harm reduction interventions for HIV and in prison settings.

UNODC has developed this training manual and package to be used and adapted at country level. It is based on a practical guide (Addressing the specific needs of women who inject drugs - Practical guide for service providers on gender-responsive HIV services, 2016[[1]](#footnote-1)), and is intended for training community based organizations, governmental and non-governmental managers or implementers of harm reduction programmes. The workshop presents key objectives, priorities and rationales that should inform the design and implementation of services for WID.

The development of this workshop 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).

## Training participants

This workshop is designed to provide instructive information 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.

## Facilitators

It is recommended that the facilitator first read the policy brief[[2]](#footnote-2) and the practical guide[[3]](#footnote-3) and all the topics covered in the modules in order to gain a better understanding of the context and scope of each module within the overall workshop.

Before the training, it is recommended that the facilitators familiarise themselves with the modules, adapt to the local context (for example if exist gender disaggregated data on HIV situation among PWID/ on access to harm reduction services or to specific cultural situation.)

The trainer should also compile available sex disaggregated epidemiological and service coverage data and other relevant information (such as whether there is a network of women who use drugs in the country) to present in a short summary at the beginning of the workshop.

In all instances, facilitators should seek to implement the training guide interactively, applying adult learning principles and constantly seeking input from participants, rather than simple delivery of information. Optional *trainer tips* are provided as examples. Animated, enthusiastic, well-prepared and informed facilitation will produce optimal learning outcomes.

## The training guide

Each module has been designed to cover theory, discussion and/or activities. It is crucial that adequate time is given for discussion and/or activities to occur.

The training guide includes a series of PowerPoint slide presentations. Guiding text to accompany each slide is presented below each slide. Handouts (including various guidelines and case studies) are limited to pre and post assessment questions, a workshop evaluation form and the participant workbook.

## The participant workbook

Participants receive a workbook after pre-assessment during the introductions module. It contains all slides with note spaces for trainees and includes various guidelines and case studies and space for completing activities and other exercises. Facilitators should familiarize themselves with the workbook and draw attention to relevant sections throughout the workshop.

## Evaluating the workshop

Evaluation is an important part of the training process. A workshop evaluation form that assesses the training (including theory, discussions and activities) is included in this guide. This assists the facilitator to assess participants’ reaction to the workshop and to assess the effectiveness of the workshop. It is often useful to prepare a report based on the results of these forms to assist other facilitators to provide similar workshops in future. Such a report should include:

* name of the workshop, where and when it was held;
* organisers of the workshop;
* facilitators’ names and organisations (where applicable);
* name and contact information for organisations represented
* trainers’ comments on major issues that arose during the workshop;
* number of participants – disaggregated by gender - and the organizations they represent
* results of anonymous workshop evaluation, highlighting significant results; and
* recommendations for changes to modules, methods, participant selection, etc.

A pre and post training knowledge assessment form is also included in this guide.

## Workshop completion certificate

All participants will receive certificates upon the successful completion of the workshop.

## Materials required

Materials required to facilitate the training workshop include:

* LCD projector (for PowerPoint slides) or overhead projector
* computer with PowerPoint slides or printed overhead slides
* flipcharts, a stand, at least 10 marker pens (various colours)
* whiteboard or blackboard (plus whiteboard marker pens or chalk)
* training guide workbook for each participant
* pre and post training assessment
* evaluation forms (end of the workshop)
* certificates of completion/attendance

## Training Schedule

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| **Day 1** |  |  |
| **Time** | **Timing** | **Session** |
| *9:00 – 9:40* | *40 mins* | *Introduction and pre-assessment* |
| *9:40 – 10:40* | *60 mins* | *Module 1 – Harm Reduction* |
| *10:40 -11:00* | *20 mins* | *Break* |
| *11:00 – 12:00* | *60 mins* | *Module 1 - Harm reduction (cont’d)* |
| *12:00 – 13:00* | *60 mins* | *Lunch* |
| *13:00 – 14:00* | *60 mins* | *Module 2 – Focusing on women as a critical priority* |
| *14:00 – 15:00* | *60 mins* | *Module 3 – Key implementation considerations* |
| *15:00 – 15:20* | *20 mins* | *Break* |
| *15:20 - 16:40* | *80 mins* | *Module 3 - Key implementation considerations (cont’d)* |
| *16:40 – 17:00* | *20 mins* | *Wrap Up* |

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| **Day 2** |  |  |
| **Time** | **Timing** | **Session** |
| *9:00 – 9:20* | *20 mins* | *Housekeeping and Recap* |
| *9:20 – 10:40* | *90 mins* | *Module 4– Additional Services Components* |
| *10:40– 11:00* | *20 mins* | *Break* |
| *11:00 – 12:00* | *60 mins* | *Module 5: Key elements in mobilizing WID* |
| *12:00 – 13:00* | *60 mins* | *Lunch* |
| *13:00 – 14:30* | *90mins* | *Module 6: Service Management and Capacity Building* |
| *14:30 – 14:50* | *20 mins* | *Break* |
| *14:50 – 15:10* | *60 mins* | *Module 7: Prisons and service continuity* |
| *15:10 – 16:40* | *90 mins* | *Module 8: Planning gender responsive services - Part 1 (SWOT Analysis)* |
| *16:40 – 17:00* | *20 mins* | *Wrap Up* |

|  |  |  |
| --- | --- | --- |
| **Day 3** |  |  |
| **Time** | **Timing** | **Session** |
| *9:00 – 9:20* | *20 mins* | *Housekeeping and Recap* |
| *9:20 – 10:00* | *40 mins* | *Mod Planning gender responsive services – Part 2* |
| *10:00 – 10:20* | *20 mins* | *Break* |
| *10:20 – 11:50* | *90 mins* | *Planning gender responsive services (cont’d)* |
| *11:50 – 12:30* | *40 mins* | *Post assessment, Evaluation and Wrap Up* |

# Module content overview

**Module: introduction (40 minutes)**

* House Keeping
* Pre-assessment
* Setting rules

**Module 1: Harm Reduction (120 mins)**

* Harm reduction principles
* Harm reduction and women who inject drugs
* Comprehensive package
* Activity: “Which consideration for which service?’
* Values clarification Activity: Gender stereotypes

**Module 2: Focusing on women as a critical priority for service providers (30 mins)**

* Activity: Awareness test
* Day in the life Activity
* Women and harm reduction services

**Module 3: Key implementation considerations for services responding to the needs of women who inject drugs (110 minutes)**

* Service delivery and integration
* Discreet and accessible service locations
* Women-only spaces and/or times
* WID-specific outreach
* Activity: Case study 1: Peer-driven intervention reaching women who use drugs in Ukraine.
* Activity: Stigma
* Addressing stigma and discrimination
* Advocacy to remove service access barriers to WID and promote their health and human rights
* Resourcing
* Data
* Activity: Data collection
* Participatory planning, implementation and evaluation

**Module 4: Additional service components to initiate or strengthen components for women who inject drugs (90 mins)**

* Housekeeping and recap
* Sexual and reproductive health
* Prenatal and postnatal care activity
* Gender-based violence and related services
* Services tailored for WID who are engaged in sex
* Parenting
* Activity: Childcare
* Couples counselling
* Legal aid (relevant to WID needs)
* Providing psychosocial and ancillary services and commodities
* Income-generating services
* Activity: gender transformative

**Module 5: Key elements in mobilizing women who inject drugs (60 mins)**

* Developing and strengthening WID collectives
* Gender specific peer services
* WID leadership opportunities
* Activity: supporting WID collectives

**Module 6: Service management and organizational capacity building (90 mins)**

* Activity: Gender inequalities
* Staffing issues
* Staff training and competency
* Staff development, mentoring and succession planning.
* Measuring gender equality within harm reduction services
* Activity: gender audit

**Module 7: Prisons and service continuity (60 mins)**

* Pre-release
* Treatment and care continuity
* Wrap up activity and day 2 evaluation.

**Module 8: Planning gender responsive services (3 hours, 40 mins)**

* Planning exercise
* Post assessment
* Evaluation
* Certificates
* Closing

# Background

Given the wide range of contextual variables (such as epidemiological factors, resource availability, extent and types of structural barriers, socio-cultural issues, staff experience, etc.) that may impact on the provision of women-specific harm reduction services, this workshop is expected to build capacity for the design and implementation of services for women who inject drugs, but not to prescribe specific sets of protocols to be followed for particular types of women-specific services. However, workshop activities support identification of key gap areas and needs in action plan form for respective countries.

This workshop offers suggestions for mainstreaming gender into existing services for people who inject drugs however in some settings women require services provided separately from or in addition to services targeting men. The main purposes of this workshop 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; and
* 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.

# Introduction

* House Keeping
* Setting rules exercise
* Workshop overview
* Pre-assessment

## Training objective:

To welcome participants and provide an overview of training objectives and programme.

## Learning objectives:

By the end of the session, participants should have increased knowledge about:

* fellow participants, including their situations and aspirations;
* the training objectives and programme;
* the epidemiological and other available information on WID in their country

## Resources:

1 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours).

## Handouts

Pre-assessment *(in trainer guide annex*), participant workbooks.

## Time: 40 minutes (including two activities).

**Trainer notes:**

Provide basic housekeeping information, such as the location of toilet facilities, availability of tea/coffee and expected breaks.

**Activity-** *Introductions*

**Methodology:** Large group discussion.

**Time:** 15 minutes

**Description:** Go around the room and invite participants to introduce themselves to the larger group by stating their name, their job title, and the organisation they work for. Facilitator to then present short summary (5-10 mins) of available national epidemiological data, harm reduction service coverage and status or organizing among women who use drugs.

**Trainer notes:**

Distribute pre-assessment questions to each participant.

Allow 10 mins to complete. Collect assessment forms.

Distribute and introduce the participant workbooks.

Introduce the training schedule, briefly describing each module. Ask participants if there are topics that are not mentioned that they would like addressed, time permitting. This provides an opportunity for participants to share some of their expectations for the workshop.

**Activity:** *‘The Rules’*

**Methodology:** Large group discussion.

**Time:** 15 minutes

**Description:** This activity is designed to both set rules for the workshop and to ‘set the scene’ for the content.

***Slide: ‘*The Rules’**

* **All participants must arrive 15 minutes before training, i.e. 8.45am and leave at 4:45pm. No exceptions**
* **Participants must ask for permission from the facilitators to leave the room at any time during the training**
* **Participants must ask permission to speak**
* **Participants must not speak unless spoken to**
* **Participants must be accompanied if they leave the training room**
* **Participants must have permission from trainers to talk to anyone, in or outside the training room**
* **Do not question the trainers’ ability, experience or authority. We know what we are talking about.**
* **These rules are NON-NEGOTIABLE**

**Trainer Notes:**

At commencement of this activity, inform the participants that a set of ‘rules’ have been devised to ensure that the training workshop runs smoothly. Show the participants the ‘rules’.

Ask participants how they feel about these rules. Usual responses might be that they are not fair, that participants weren’t involved in their development, that the rules are too rigid, participants are not children, etc.

[Note: If anyone is taking the rules seriously, immediately inform the group that the rules are not real.]

Inform the participants that these rules are similar to the rules imposed on women in many countries. Ask participants to comment on the following:

• How do they think women may feel about these restrictive rules?

• Are women likely to comply? Why?

• How are ’rule breaking’ women perceived?

Ask the participants how they feel about not being involved in the formulation of the rules. Are they likely to follow them? Why? Why not? Would they prefer to be involved in the rule making? How might you feel about an organisation that listened to your opinions?

Explain to the large group that they now have the opportunity to set the rules for the training workshop. Ask participants to brainstorm some rules that they would be willing to follow for the duration of the workshop. Depending on the cultural and the specific characteristics of the workshop participants, the facilitators may want to consider rules such as:

Arrive on time for the beginning of each session and after each break;

One person speaks at a time; it is also important to ensure that quieter voices are heard

Comments should be made to the whole group – no side conversations with people sitting nearby

Discuss ideas or opinions, and not the person expressing them

Smoking only during the break in designated places and never in the training room

Switch off mobile phones in the training room

Write all the brainstormed suggestions for workshop rules on a sheet of blank paper. Ask participants to vote, by a show of hands, for the rules that they would like to establish for the workshop. On a new sheet of paper, the facilitator should note the rules that most participants agreed with. Put this sheet of paper stating the agreed rules in clear view of the participants, and keep it there until the end of the workshop.

Discuss what it means for participants to be listened to and have their opinion respected. Discuss how this might compare to organisations that provide services to WID.

# Module 1 – Harm reduction

* Harm reduction principles
* Harm reduction and women who inject drugs
* Comprehensive package
* Values Clarification – Gender stereotypes activity

## Training objective:

To provide an overview of harm reduction principles and what services are required to meet the needs of WID

## Learning objectives:

By the end of the session, participants should have increased knowledge about:

* Principles which underpin gender responsive services
* Comprehensive package
* Improving relevance for women – “which consideration for which service’ activity
* Awareness of gender stereotyping

## Resources:

15 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours), equipment for demonstrating use of the female condom

## Handouts

See Handbook

## Duration: 120 minutes

## Methodology:

Presentation, group work, values activity

**Slide 1: WID services are strongest when they:**

* **Are voluntary, and set within an enabling environment**
* **Are physically accessible, affordable, non-judgmental, unrationed**
* **Are not restricted by criteria such as sex/gender, employment status (including sex work), criminal justice history), substance use status or pregnancy status**

**Trainer notes:**

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

* Are physically accessible, affordable, equitable, non-judgmental, non-discriminatory and unrationed.
* Are not restricted by socio-demographic 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.

**Slide 2: Core principles:**

* ***Gender mainstreaming***
* ***Non-discrimination***
* ***Informed choice and consent without coercion***
* ***Confidentiality***
* ***Respect***
* ***Access for all*.**
* ***Working in partnership***
* ***Build and sustain comprehensive services***
* **Promote, respect and enforce the *human rights of clients***
* ***Accountability***
* ***Empower***
* ***Meaningful participation***

**Trainer notes:**

All harm reduction services should 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 all.
* *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.
* *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 both public and private social sectors.
* *Build and sustain comprehensive services*—linking HIV prevention, treatment and care services, reproductive and sexual health, and 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.

**Slide 3: The WHO/UNODC/UNAIDS Comprehensive Package for HIV and injecting drug use**

1. **Needle and syringe programmes**
2. **Opioid substitution therapy and other evidence-based drug dependence treatment**
3. **HIV testing and counselling**
4. **Antiretroviral therapy, including treatment literacy**
5. **Prevention and treatment of sexually transmitted infections**
6. **Condom programmes for people who inject drugs and their sexual partners**
7. **Targeted information, education and communication for people who inject drugs and their sexual partners**
8. **Prevention, vaccination, diagnosis and treatment for viral hepatitis**
9. **Prevention, diagnosis and treatment of tuberculosis**

**10. Opioid overdose prevention and community management**

Trainer notes:

This ‘comprehensive package” is from the 2012 edition of the [WHO, UNODC, UNAIDS *Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*](http://www.unaids.org/sites/default/files/sub_landing/idu_target_setting_guide_en.pdf#http://www.unaids.org/sites/default/files/sub_landing/idu_target_setting_guide_en.pdf) and in the [WHO *Consolidated Guidelines on HIV prevention, Diagnosis, Treatment and Care for Key Populations*, from 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).

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

**Slide 4: Needle and syringe programmes (NSPs)**

**NSPs:**

* **Provide sterile injecting equipment**
* **Link to health services and referrals**
* **Information**

**To increase access for WID:**

* **Range of service models**
* **Peer outreach**
* **Non-judgemental service for pregnant WID**
* **Respond to needs**
* **Easy and regular access**

**Trainer notes:**

* NSPs provide clients with injecting equipment (sterile needles, syringes, sterile water, filters and puncture proof disposal containers) to prevent sharing and reuse of used equipment.
* They are sometimes the first contact with a health care system for people who inject drugs.
* NSPs represent a valuable opportunity to provide information on risks for blood borne viruses (BBVs) as well as referrals to relevant services.

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. Efforts to meet this objective might include:

* 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 suitablelocations supporting secondary distribution and peer delivery, including to women’s homes where appropriate; and
* offering access to NSPs in a supportive and non-judgemental manner to women who continue to inject drugs during pregnancy.

NSPs can more successfully serve women by ensuring that services, information and referrals responding to the specific needs of women (including to legal and social support services, child care, and sexual and reproductive health), are easily and regularly available.

**Slide 5: Opioid substitution therapy (OST)**

**Most effective drug dependence treatment in reducing injecting and HIV transmission risk**

* **Reduces fatal overdose**
* **Associated with health and lifestyle improvements**
* **Can reduce a woman’s dependence on her partner for drugs and injections**
* **Reduces risk of miscarriage and encourages contact with antenatal care services**

**Trainer notes:**

* Agonist opioid substitution therapy (OST) as maintenance is highly effective in reducing injecting behaviours that put opioid-dependent injectors at risk for HIV. In addition, OST has been demonstrated to improve both access and adherence to ART and to reduce mortality (however OST must never be a prerequisite for ART).
* 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 dependence on a 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.

**Slide 6: Improving OST access**

* **Child friendly**
* **Integrating with other services**
* **Prioritising pregnant clients**
* **Ensuring continuity (including maternity hospitals and prisons)**

**Trainer notes:**

Outcomes for women are better when gender-specific factors are accounted for in treatment. Outpatient programmes can support women clients by, for example:

* allowing children to be with their mothers (and improving child-friendliness in other ways);
* integrating the service with other support and care services, including prenatal and maternal services;
* prioritising WID who are pregnant. (Heroin use can result 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 for women in prisons

**Trainer tip:** *Before introducing this slide, run a quick brainstorm on ways to improve OST access for WID.*

**Slide 7: HIV testing and counselling**

* **Peer referral or trained peer-based HTC**.
* **Consent, confidentiality, counselling, correct, connection**
* **Pre-test information/education/communication recommended for pregnant WID**
* **Provider initiated testing and counselling- No coercion**
* **Post-test gender based violence counselling**

**Trainer notes:**

* Strategies to increase access to HIV testing and counselling for WID, include: assisted peer referral, outreach through mobile clinics, trained peer-based HTC in community settings, self-testing and being directed to HTC services through harm reduction or drug dependence services.
* Counselling and testing services achieve optimum impact when they follow the “5 C’s” principles—**consent, confidentiality, counselling, correct** test results and **connection** to follow-up services. Value is enhanced when they are delivered respectfully and without coercion, judgement, stigma or discrimination.
* Comprehensive pre-test information for women who are or may become pregnant should include information on the risks of transmitting HIV, 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.

Other crucial HTC-related considerations:

* PITC is recommended for WID who are pregnant or living with TB or hepatitis C, provided that it is in no way coercive. 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.

**Slide 8: Antiretroviral therapy (ART) - including treatment literacy**

* **improve ART access for WID**
* **involve HIV clinicians and psychosocial supports**
* **continuum of care**
* **Post-exposure prophylaxis**

**Trainer notes:**

* WID generally have disproportionately limited access to ART compared with other key affected populations or the general population. More WID living with HIV decide to initiate and sustain treatment where there is access, affordability, availability and acceptability of ART.
* Involve HIV clinicians in harm reduction services or assist referrals to WID-friendly HIV clinics to boost ART access and uptake. WID may need support to improve treatment literacy or to access adequate shelter, nutrition and sanitation—all of which can help with adherence.
* ART programmes should be part of a continuum of care 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.
* 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).

**Slide 9: PMTCT**

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, postpartum interventions in the context of on-going ART)**
4. **Providing appropriate treatment, care, and support to mothers living with HIV, their children and families**

**Trainer notes:**

* 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 organise the provision of, antiretroviral drugs for pregnant and nursing WID living with HIV. This can be implemented on-site or arranged through referrals.
* WHO recommends four approaches, or ‘prongs’, of a comprehensive PMTCT strategy (*as in slide 9*).

**Slide 10: Prevention and treatment of sexually transmitted infections (STIs)**

* **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**

**Trainer notes:**

All WID—and their sexual partners— should have access to acceptable, effective and high-quality STI services. A comprehensive STI service package includes these elements (*in slide*) at a minimum.

**Trainer tip:** *Ask participants to contribute elements they would expect to see in a comprehensive STI package before revealing slide 11.*

**Slide 11: Condom programmes**

* **Distribution of male and female condoms**
* **Information about where else to get them**
* **How to use them**
* **Role playing, encouragement and reinforcing negotiation skills, couples counselling, and/or group-based couple’s intervention,**
* **During pregnancy**

**Trainer notes:**

Harm reduction programmes are urged to offer all of the following services:

* distributing male and female condoms and lubricants directly to WID or informing them where they can be obtained easily and affordably;
* IEC on how to put a condom on their male sexual partners and how to use female condoms;
* Condom negotiation skills

Various methods to actively empower women to negotiate condom use include role playing, encouragement and reinforcing negotiation skills, couples counselling, and/or group-based couple’s intervention.

It is important that WID continue to use condoms during pregnancy to reduce the risk of vertical transmission.

Trainer tip: *Bring equipment for demonstrating use of the female condom to the session and invite/guide a participant to demonstrate.*

**Slide 12:** **Targeted information, education and communication (IEC)**

* **Helps reduce BBV and overdose risk practices**
* **Ensure IEC for WID is gender specific**
* **Meaningfully involve WID**
* **Example topics: drugs and pregnancy, safer injecting, effects of opioids on reproductive cycle etc.**

**Trainer notes:**

* Targeted information, education and communication (IEC) can help to sustain positive change in HIV and overdose risk practices.
* Harm reduction service providers should review existing IEC materials to fully incorporate gender-specific information and needs.
* Women-specific HIV and harm reduction IEC materials are best reviewed and developed by 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.

**Slide 13:** **Prevention, vaccination, diagnosis and treatment for viral hepatitis**

* **WID need better access to diagnosis and treatment for hepatitis B and C**
* **Contraception during treatment with ribavirin**
* **Promote access to new HCV treatments**
* **Pregnancy and breastfeeding for WID living with HCV not discouraged**
* **HBV vaccination – rapid schedule (21 days) recommended**

**Trainer Notes:**

* Hepatitis C and B are the two most common forms of viral hepatitis that substantially affect people who inject drugs. Increased and regular access to diagnosis and treatment are therefore vital.
* Women receiving treatment for HCV with interferon and ribavirin 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 should are told to follow the same precautions.
* New medicines (Direct Acting Agents – or DAAs) with higher success rates in clearing the HCV and reduced complications have been introduced. As these therapies become more widely available, harm reduction programme personnel can keep WID informed.
* 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, approximately 4-8% of births. The risk greatly increases, to 17-25% of births, if the mother is co-infected with HIV. Hepatitis B virus (HBV) vertical transmission rates are around 10-20% for most women with co-infected with HIV.*)
* It is safe for women with hepatitis C to breastfeed their babies if specific precautions are followed. (*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. Shorter vaccine schedules (at 1, 7 and 21 days) are more likely to increase completion rates for HBV vaccination and can be offered by drug dependence treatment sites, needle and syringe programmes, and other harm reduction services that engage regularly with PWID.

**Slide 14:** **Prevention, diagnosis and treatment of tuberculosis (TB)**

* **Staff capacity building on TB**
* **Create and maintain referral pathways**
* **Advocacy for TB services to be WID-friendly**

**Trainer notes:**

Early diagnosis and treatment are the primary means of controlling TB. All harm reduction staff would benefit from training on TB transmission, signs and symptoms, prognosis, treatment and prevention. Service providers should implement:

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

**Slide 15: Opioid overdose prevention and community management**

* **Training for WID and their peers on overdose management including naloxone administration and access to naloxone**
* **Naloxone dose in pregnancy**

**Trainer Notes:**

* As overdose remains a primary cause of death among people who inject drugs, targeted information should also focus on overdose prevention and information how to respond to overdose. This should include training for WID and their peers and family, on resuscitation and on the role of naloxone.
* Assist WID in accessing naloxone.
* If a pregnant woman has an opioid overdose, ideally the naloxone dose will be sufficient to ensure respiration without precipitating withdrawal symptoms (which can harm the pregnancy).

## Activity: “*Which consideration for which service?*’

**Methodology:** Large group discussion.

**Time:** Up to 10 minutes

**Objective:** To demonstrate how in general the same sorts of adjustments apply to most services in order to achieve gender sensitivity for women in preventing HIV. The activity will show that many of the implementation considerations apply to some or all of the essential services.

**Description:** Ask participants to split into pairs and complete the activity ‘*Which consideration for which service*?’ in their workbooks.

They need to read the descriptions of the services, then link the nine original interventions to elements that can make each of the services more relevant to women.

Participants can draw a line between each of the elements (*in their workbooks*) so they match with the right service. When all groups are completed ask group to feedback answers. Highlight that some of the elements (such as outreach to suitable locations), can apply to more than one service.

***Correct Answers***

1. Needle and syringe programmes = 6
2. Opioid substitution therapy and other evidence-based drug dependence treatment = 1
3. HIV testing and counselling = 8
4. Antiretroviral therapy, including treatment literacy = 9
5. Prevention and treatment of sexually transmitted infections = 7
6. Condom programmes for people who inject drugs and their sexual partners = 2
7. Targeted information, education and communication for people who inject drugs and their sexual partners (including overdose) =3
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis = 4
9. Prevention, diagnosis and treatment of tuberculosis (TB) = 5

**Answer selection (jumbled)**

1. Enrolment benefits WID by reducing their risks of HIV transmission, fatal overdose, being arrested, and being abused and subjected to other forms of violence.
2. Harm reduction programmes should make female condoms easily accessible to clients, promote their use, and distribute both male and female condoms (plus lubricants).
3. Information on safer injecting that is tailored for WID who rely on partners or friends to inject them
4. Women should 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
5. Creation and maintenance of active referral pathways between TB treatment services and services for WID that include integrated screening and testing programmes
6. Can be provided through a range of service models, such as outreach to suitable locations, and peer delivery to women’s homes where appropriate;
7. All WID—and their sexual partners—greatly benefit from consistent access to acceptable, effective and high-quality STI services.
8. Counselling on gender-based violence (GBV) is recommended as part of post-test counselling.
9. Directly provide, or organise the provision of, antiretroviral drugs for pregnant and nursing WID living with HIV.

**Activity.** Values clarification “*Gender stereotypes*”

**Methodology:** Divide participants into two teams.

**Time:** 5 mins to explain activity, 2 mins to discuss at conclusion of workshop

**Objective:** Participants will identify when gender stereotypes are being used.

**Description:** Ask each team to nominate a List-keeper. During the rest of the workshop, participants to share any gender stereotypes they hear mentioned with their team list-keeper. The team with the most listed stereotypes will win at the end of the workshop.

**Trainer notes:**

Discuss the definition of ‘gender stereotypes”.

Gender stereotypes are simplistic generalizations attributing differences and roles of individuals and/or groups of women and men according to gender.Stereotypes create a widely accepted judgment or bias about certain traits that apply to each gender. If someone behaves differently from how their gender is portrayed, then they don’t conform to the norm. Gender stereotypes threaten to create unequal or unfair (and therefore ‘sexist’) circumstances for those who defy assumptions about his/her gender**.**

***Trainer tip:*** *Ask participants to give examples of gender stereotypes from advertisements they have seen on TV or elsewhere recently.*

# Module 2: Why focusing on Women is a critical priority for service providers

* Awareness test
* Day in the life Activity
* Women and harm reduction services

## Training objective:

To provide participants with an understanding of the context for harm reduction services for women.

## Learning objectives:

By the end of the module, participants should have increased knowledge about:

* The types of issues faced by and particular needs of women who inject drugs
* Gender and the harm reduction package

## Materials/supports required:

4 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours), downloaded copy of video for activity: Awareness Test. (<https://www.youtube.com/watch?v=3ZTuYKkIGq4&app=desktop>)

## Session duration: 60 mins

**Activity:** *Awareness test*

**Methodology:** Video competition

**Time:** 10 minutes

**Objective:** Participants increase awareness of need to provide services for WID

**Description:** Ask participants ‘why are we running this workshop”? Play the video at: [**https://www.youtube.com/watch?v=3ZTuYKkIGq4&app=desktop**](https://www.youtube.com/watch?v=3ZTuYKkIGq4&app=desktop)

Explain that if we are not paying attention, we tend to not notice. Likewise, if we are not looking for the gaps in services for women, or not looking at the particular needs WID may have, then we won’t see them.

**Slide 2. Activity. “***A day in the life”*

**Methodology:** Group discussion

**Time:** 50 mins

**Objective:** Identify needs of WID and barriers faced in accessing services.

**Description:** Use the slide for discussion about the typical day in the life of WID as a large group.

**Trainer notes:**

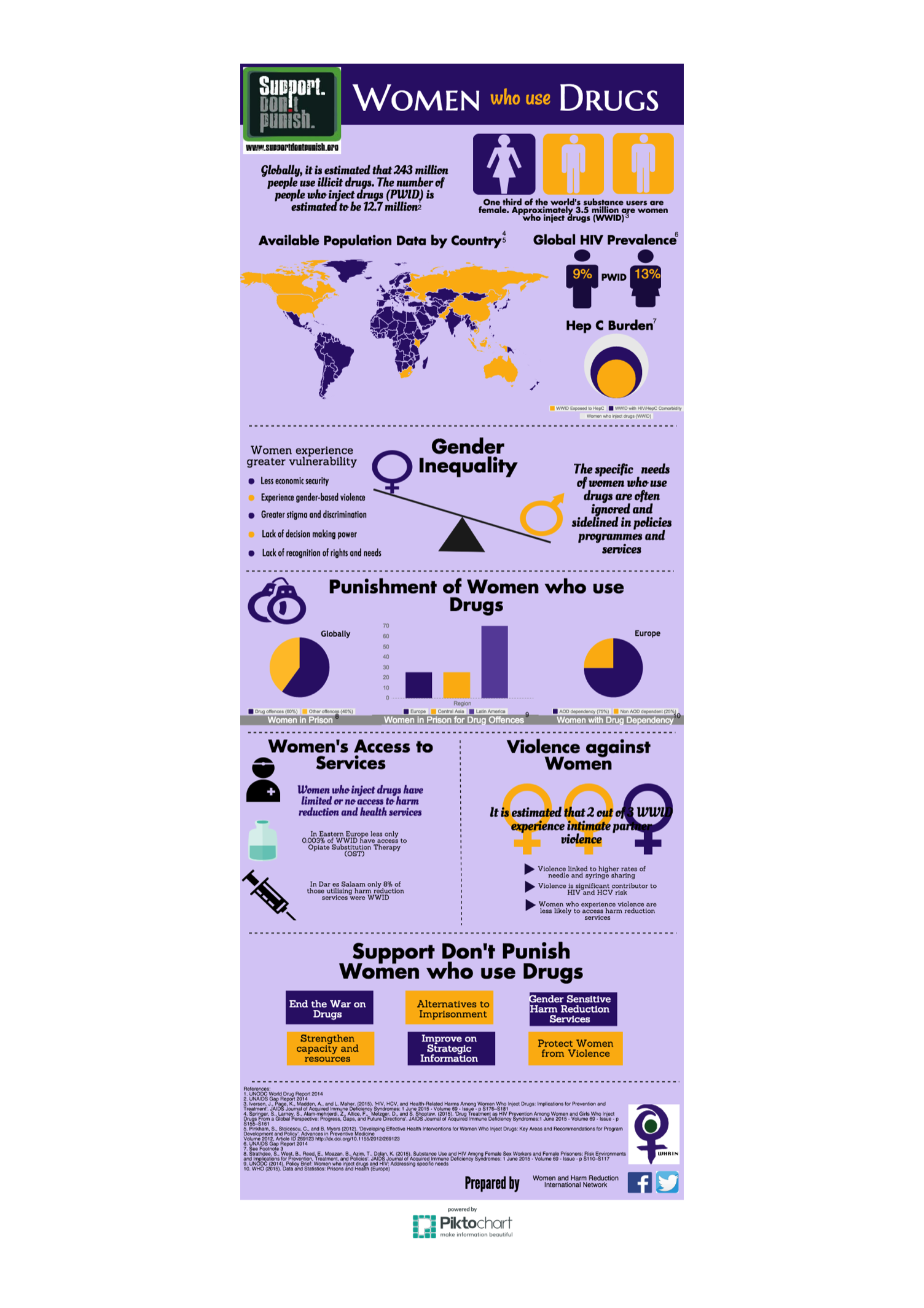
Facilitator to avoid stereotypes and highlight the ingenuity and resilience required among WID in order to maintain a habit as well as other demands in life.

Ask participants whether they would like to add other elements to the ‘day in the life’ picture.

Ask what differences there are for WID and other PWID.

As issues are identified, facilitator to note them and fill in any gap areas.

**Slide 3: WHRIN info graphic**

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**Trainer notes:**

Invite different participants to read out or summarise different sections of the info graphic.

**Slide 4: Crucial to focus on WID**

* **generally greater HIV and HCV prevalence**
* **gender based violence**
* **gender norms (as a barrier)**
* **second on needle**
* **sex work overlaps**
* **increased stigma and discrimination**
* **criminalization of drug use in pregnancy**
* **child custody**
* **sexual and reproductive health rights violations**
* **lack of services**

**Trainer notes:**

Referring to the list of key barriers that have been identified, including those listed in slide 4, ask participants what their services could do to overcome some of the barriers.

(*Leads to module 3 on implementation considerations*).

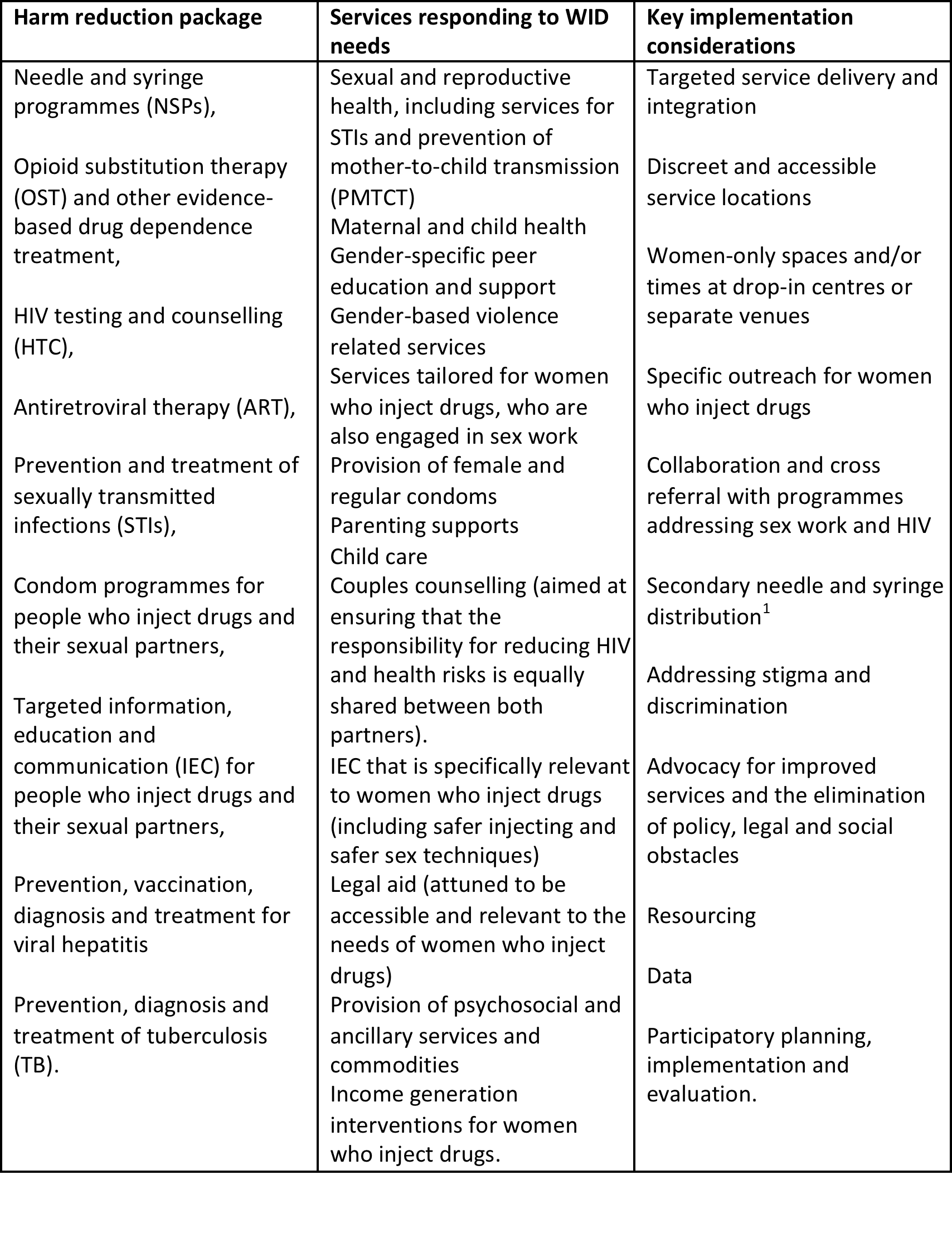
Trainer Tip: *Ask participants to read the universal periodic review extract that provides an example of criminalisation of drug use in pregnancy.*

**Slide 5: Table**

**Trainer notes:**

Acknowledging solutions from participants, introduce and describe the slide 4 table.

This table summarizes services and implementation considerations covered by the practical guide. The first column lists the core harm reduction services; column two provides examples of additional services for WID; the third column lists some implementation considerations. The next module will explore implementation considerations.



# Module 3: Key implementation considerations for services responding to the needs of women who inject drugs

* Service delivery and integration
* Discreet and accessible service locations
* Women-only spaces and/or times
* WID-specific outreach
* Addressing stigma and discrimination
* Advocacy to remove service access barriers to WID and promote their health and human rights
* Resourcing
* Data
* Participatory planning, implementation and evaluation

## Training objective:

To provide participants with knowledge of adapting existing services to improve relevance and access for WID.

## Learning objectives:

By the end of the module, participants should have increased knowledge about how services might be adjusted or added to improve access and relevance for WID

## Materials/supports required:

8 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours), prepared identity cards for the Stigma Activity.

## Session duration: 120 minutes

**Slide 1: Module 3: Key implementation considerations for services responding to the needs of women who inject drugs**

**Trainer notes:**

This module addresses methodological and other implementation considerations in developing harm reduction services for WID and are not exhaustive. The health and broader human rights of WID are much more likely to be recognized and responded to when they are meaningfully involved in all discussions and decisions pertaining to them.

**Slide 2:**

* **Service delivery and integration**
* **Discreet and accessible service locations**
* **Women-only spaces and/or times**
* **WID-specific outreach**
* **Addressing stigma and discrimination**
* **Advocacy to remove service access barriers to WID and promote their health and human rights**
* **Resourcing**
* **Data**
* **Participatory planning, implementation and evaluation**

**Trainer notes:**

It is vital that service delivery is integrated with the needs of WIDs. These considerations will ensure that services are responsive to their needs. We will consider each of these factors in turn.

**Slide 3: Service delivery and integration**

* **establish linkages with relevant services**
* **integrate family planning, maternal health care and primary care**
* **build staff capacity**
* **establish relationships with health care providers**
* **ensure that other health services welcome women regardless of drug use status**
* **introduce elements for WID into other services**

**Trainer notes:**

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 this is not possible, strong referral linkages should be developed with relevant external service providers, as available.

**Trainer tip:** *Refer participants to Case Study 9 (Belarus prison referral network) and allow a few minutes for them to read through. While this study applies to working with prisons, it also provides a good example of developing referral linkages.*

Useful steps might include the following:

* establish working linkages with providers of services such as those focusing on or offering support for sex workers, sexual and reproductive health, PMTCT, maternal and child health, gender-based violence, legal support and evidence-informed drug dependence treatment;
* [integrate harm reduction services with family planning, maternal health care and within primary care facilities](http://www.whatworksforwomen.org/chapters/25-Structuring-Health-Services-to-Meet-Womens-Needs/sections/75-Structuring-Health-Services-to-Meet-Womens-Needs/evidence);
* build staff capacity for WID-friendly service delivery, assisted referral and low-threshold access processes;
* establish relationships with health care providers—for example, by training ‘friendly doctors’;
* ensure 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; and
* introduce harm reduction elements for WID into other health services, such as providing OST in maternity hospitals and women's prisons.

**Slide 4: Location and service hours**

* **discreet**
* **accessible,**
* **low threshold**
* **opening hours adjusted**
* **women-only spaces**
* **mobile services**

**Trainer notes:**

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.)

Opening hours can be adjusted to suit the availability of WID. Decisions regarding opening hours are best made after consulting with clients.

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 thatthey 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.

**Trainer tip:** *Refer participants to Case study 7: Reaching out to WID through the Harm Reduction Community Container project in Mauritius. Ask participants to identify the elements described in the case study that might enhance access for WID.*

**Activity:** *Stigma*

**Methodology:** Role play

**Time:** 20 minutes

**Objective:** Participants increase awareness of effects of stigma and discrimination

**Description:** Randomly assign the following identities to participants:

1. Male teacher
2. Single mother injecting drugs and working in sex industry
3. Male lawyer who injects drugs
4. Sex working young man
5. Young woman living with HIV
6. Pregnant injecting drug user, unemployed, partner unemployed
7. Woman engineer, drinks wine
8. Male politician vegan in public, cruel to animals in private
9. Young girl from privileged family
10. Young boy from under-privileged family
11. Cannabis smoking successful business man
12. Alcoholic female diplomat
13. Female pilot
14. Housewife with large valium habit
15. Transgender woman doctor
16. Male dentist tobacco smoker
17. Actress injecting heroin
18. Woman homeless, unemployed injecting drugs
19. Successful journalist snorts cocaine on weekends
20. Male arsonist – doesn’t take drugs or alcohol, employed as firefighter

Prepare a space where participants can stand in a line and take up to twelve steps forward. Explain that each participant is to assume the identity and circumstances of their role consistently throughout the activity.

Ask everyone to stand up against a wall and explain that the aim is to get as far across the room as possible. Participants can take a small step forward if they can say ‘yes’, remain where they are if ‘no’.

**Questions:**

1. Do you have access to a computer to send an email?
2. Can you afford a cup of coffee?
3. Could you go to work today? (Whether or not you have a job?)

(*Check when people do not step forward for this question. Ask why they could not go? Being a person who injects drugs does not automatically equate with being unable to work*).

1. Would you not be sacked if there were a test for illicit drugs at work today?
2. Is it impossible for you to be charged for child abuse for using drugs while pregnant?
3. Are you unlikely to be subject to violence in your lifetime?
4. Could your work never be set back by pregnancy without maternity leave?
5. It’s Saturday night and you and your friends are all searched by the drug squad who are arresting anyone with drugs. Would you definitely go home that night?
6. If you were caught on Saturday, would you be able to raise $500 to go free?
7. Do you have somewhere to sleep tonight?
8. Would you trust the police to help you?
9. Are you a man?

With participants still standing where they are, ask everyone to read out their identity.

Ask those left towards the back of the room to share on how it felt to be left behind. Ask the group to return to their seats. Once seated, ask group for comments. Enquire what would need to change for those left behind to move forward? What might/does their own service do to assist those ‘left behind’?

**Slide 5: Outreach. Addressing stigma.**

* **Specific outreach efforts**
* **PDI**
* **Staff training to eliminate discrimination**
* **Training for referral agencies to improve capacity**
* **Links to existing legal services and supports.**
* **Campaigns.**

**Trainer notes:**

* Where harm reduction services have a low proportion of women, specific outreach efforts may be necessary.
* Models such as peer-driven intervention (PDI) demonstrate some success in rapidly reaching hidden populations, including WID in some settings. PDI is a chain-referral outreach model that relies on selected and trained peers who earn nominal rewards (e.g., monetary stipends) to educate and recruit new and diverse clients for harm reduction services.
* All harm reduction staff should be trained to understand and remove stigma and discrimination against WID in all levels of service provision.
* Training, cross training and other support can be provided to referral network agencies to improve their capacity to work with WID.
* Work with WID to ensure they are informed of their rights and to linked to existing legal services, complaints mechanisms, and supports.
* Targeted campaigns and public campaigns can also be considered.

**Activity:** Case study 1: *Peer-driven intervention (PDI) reaching women who use drugs in Ukraine.*

**Methodology:** Group discussion

**Time:** 20 mins

**Objective:** To understand the viability of PDI in respective country contexts.

*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% 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 organisation; 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 organisation.*

*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.*

**Trainer notes:**

Background for case study: 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.

Models such as peer-driven intervention (PDI) demonstrate some success in rapidly reaching hidden populations, including WID in some settings. PDI is a chain-referral outreach model that relies on selected and trained peers who earn nominal rewards (e.g., monetary stipends) to educate and recruit new and diverse clients for harm reduction services.

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.

*Ask participants whether this approach work in your country? Why/why not? (If it wouldn’t work, what method/s would you apply?).*

**Slide 6: Advocacy**

* **Engage range of stakeholders**
* **Protect human rights and improve access to health**
* **Sustainable funding**
* **Coordination for continuum of care**
* **Target local officials**
* **WID should lead advocacy**
* **Support development of WID networks**
* **Work with WID groups or networks**

**Trainer notes:**

These advocacy steps and activities that could be prioritized on behalf of and for WID:

* engage 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—to raise awareness about needs and how to address them
* seek to promote laws, policies and practices that improve access to health services for WID and protect their human rights (including their right to health). (*For example, those that encourage access to prenatal and maternal services and de-emphasize punitive approaches to pregnancy and drug use*).
* seek to secure sustainable funding for services targeting women who inject drugs. Some of the key services are not necessarily costly; others, meanwhile, can sometimes be shared with other non-governmental organisations (NGOs) and/or local government agencies.
* promote effective multi-sectoral coordination and cooperation for a continuum of care for WID; and
* target 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. 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. Support for 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.

**Trainer tip:** *Draw participant attention to case study 2: Advocacy. Stop Violence Against Women who Use Drugs in Tanzania and Zanzibar. Ask participants whether similar actions would be effective in their country. What else could they try?*

**Slide 7: Data**

* **sex-disaggregated data to monitor service access**
* **lack of data not an excuse for inaction**
* **confidentiality**
* **plan for gathering, analysing and using data**

**Trainer notes:**

* Reliable data is needed for planning, resource allocation, advocacy and monitoring and evaluation. The collection of sex-disaggregated data is necessary to monitor any disparities in harm reduction service access.
* Any lack of data is not an acceptable excuse for inaction. WID-specific interventions are necessary in every context. Developing and implementing them can take place while simultaneously investing in any necessary research and data collection initiatives required to develop the evidence base.
* Confidentiality is a core priority for all data collected. The use of unique identifier codes or similar models is recommended, particularly in countries where drug use is criminalized.
* Develop a policy and plan for gathering and analysing sex-disaggregated data and using it to make appropriate modifications to service design and implementation.

**Slide 8: Apply qualitative indicators such as:**

* **client satisfaction**
* **access to basic services**
* **incidence of GBV**
* **use of gender stereotypes**
* **change in discriminatory attitudes**
* **WID organisations established or strengthened**
* **WID engagement**

**Trainer notes:**

Qualitative data can identify factors that may impact on successful implementation of WID-specific services. Develop and apply qualitative indicators that can detect improvements or deterioration in particular areas of women’s lives, such as:

* 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 organisations 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; and
* whether and to what extent WID feel they have been supported, consulted, included and involved to influence social processes.

**Activity:** *Data collection*

**Methodology:** Large group discussion.

**Time:** 5-10 minutes

**Objective:** Participants will identify potential gaps in their existing data collection systems.

**Description:** Ask participants to give examples of what data they collect at their service. Encourage discussion that focuses on what information they might be missing about their clients. With this in mind, what additional data might they commence collecting? Why?

**Slide 9: Participatory involvement**

* **Meaningful engagement**
* **Involving from earliest stages, all processes**
* **Investment in meaningful engagement**

**Trainer notes:**

* The meaningful engagement of women from communities (e.g., WID networks, women living with HIV, other civil society organisations, community leaders) is vital. (Refer participants to the IDUIT – on the reading list on participant handbook- for further information on meaningful involvement of people who use drugs).
* Involvement from the earliest stages of all processes is invaluable, including in all monitoring and evaluation efforts. WID and their community groups can be regularly asked to provide their perspective on improvements, challenges, the development of services, etc. (*Remind participants to Case study 6: COUNTERfit Women’s Harm Reduction Program for example*).
* To fully leverage the unique strengths of communities in responding to HIV among WID, investments are needed to build the capacity of community‑based organisations and to increase the meaningful engagement of WID in the development, implementation and evaluation of services.

# End of Day 1:

**Activity:** Wrap up on Day 1

**Methodology:** Large Group Discussion

**Time:** 5-10 minutes

**Objective:** Participants will reflect on the day’s program and to identify key learnings of the day.

**Description:** Ask each person what was one thing they had learned or thought was interesting from the day. If time permits, ask participants what they might do with this information when they return to their organisation.

**Complete day 1 wrap up**

# Day 2 – Housekeeping and recap

## Time: 20 minutes

**Trainer notes:**

Ask participants if there were any questions from the previous day. Inform participants of any housekeeping issues.

# Module 4: Additional services to initiate or strengthen components for women who inject drugs.

* Sexual and reproductive health, including STI services, PMTCT and cervical cancer screening
* Prenatal and postnatal care
* Gender-based violence and related services
* Services tailored for WID who are engaged in sex work
* Parenting
* Childcare
* Couples counselling
* Legal aid (relevant to WID needs)
* Providing psychosocial and ancillary services and commodities
* Income-generating services
* Gender transformative services

## Training objective:

To provide participants with an understanding of particular services that may improve WID engagement with HIV and harm reduction services.

## Learning objectives:

By the end of the module, participants will have increased knowledge about gender specific harm reduction services.

## Materials/supports required:

12 Slides: Module 4

## Session duration: 90 mins

**Slide 2: Overarching issues**

* **Meaningful engagement**
* **Specific modifications and additions vary**
* **Work with gender roles to** 
  + - 1. **meet immediate goals**

**ii) combat harmful gender inequalities**

**Trainer notes:**

* The meaningful engagement of WID is an overarching priority for the effectiveness and sustainability of any harm reduction service targeted for them. Ensure that staff are supported to provide non-judgemental, WID-friendly service.
* Specific modifications and additional services to initiate or strengthen components for WID will vary depending on the context.
* It is important to understand the gender roles that exist in PWID communities and how to work within these differences to:
  + i) meet immediate goals
  + ii) explore the potential to combat harmful gender inequalities in the longer term.

**Trainer tip**: *Ask participants how the gender context in the country might especially impact on WID.*

**Slide 3: Examples of additional services**

* **Sexual and reproductive health,**
* **Prenatal and postnatal care**
* **Gender-based violence services**
* **Services tailored for WID who are engaged in sex work**
* **Parenting**
* **Childcare**
* **Couples counselling**
* **Legal aid**
* **Psychosocial and ancillary services and commodities**
* **Income-generating services**

**Trainer notes:**

Here (again) is a list of the sorts of additional services that can be applied and that are complementary to harm reduction approaches. This module will unpack these example services.

**Trainer tip***: Ask participants what services among the list they currently link with. Are there others?*

*Direct participants to Case Study 3 for an example of service provision for WID including several of these additional service elements.*

**Slide 4: Sexual and reproductive health**

* **Staff trained in SRH**
* **Priority SRH needs**
* **Family planning**
* **WID friendly physicians**

**Trainer notes:**

* Harm reduction services are more appropriate and relevant when delivered by staff who are trained and supported to understand the sexual and reproductive health (SRH) needs of WID.
* Among the priority SRH needs are pre-conception support with access to contraception, PMTCT, STI services, and cervical cancer screening. (*All of these services can be incorporated into harm reduction services and v ice versa*.)
* WID are likely to benefit from safe and discreet family planning services, including pregnancy tests, counselling support and termination services.
* Harm reduction services should establish linkages with WID-friendly doctors and gynaecologists—especially women themselves—to run clinics or offer appointments at service locations

**Trainer tip:** *Ask participants that don’t have SRH services, what alternatives might there be?*

**Slide 5: Prenatal and postnatal care services**

* **Antenatal care, pregnancy test kits**
* **Accurate information on effects of substances**
* **Opioid withdrawal, pregnancy and priority OST access**
* **Non-judgmental service provision**
* **Diagnosis and treatment of HIV, hepatitis B and C, and STIs**
* **Referral network**

**Trainer notes:**

* Harm reduction programme staff can educate WID about the potential need for antenatal care and provide them with home pregnancy test kits if possible. (*It is not uncommon for WID to have irregular or absent periods; therefore, they may not realise that they are pregnant until late into their second or even the third trimester*.)
* Staff should provide accurate information regarding the risks and harms to pregnancy associated with the continuing use of drugs and certain other substances. Harm reduction service providers can explain to heroin users the potential dangers to the foetus of abrupt withdrawal and to refer those clients to OST if requested.
* Develop linkages and referral pathways across other relevant service providers, including gynaecologists and obstetricians. The overall goals are to 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.
* 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.

**Trainer tip:** *Ask participants to give examples of how they currently manage the sexual health of WID. Encourage discussion about how existing services were or could be modified.*

**Slide 6. Activity.** *Prenatal and postnatal care referral network*

* **Brainstorm competition**
* **Services not limited to those pre-existing in your country.**

**Methodology:** Brainstorm competition

**Time:** 5 minutes

**Objective:** Enhance participants understanding of the scope of the pre and postnatal care

**Description:** Divide participants into two groups, offering a small prize to the group that can identify the most relevant services associated with pre and post-natal care (whether or not they already exist in their country).

Groups are given 5 minutes to develop a list and then an appointed group rapporteur will take turns to read out new services (repeats not accepted).

The group with the most services wins. (See sample list below – and use the list to add missing elements to the groups lists before awarding honours).

* 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
* OST
* Resources for care for the baby after birth
* Information on infant feeding options, nutritional counselling and support
* Information on vaccines and other preventive measures
* Postpartum 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

**Slide 7: Breastfeeding, drugs and HIV**

* **Breastfeeding if using drugs?**
* **Breastfeeding and living with HIV**
* **WHO Guidelines**
* **Benefits of breastfeeding generally outweigh risks.**

**Trainer notes:**

Drug use is not a contraindication for breastfeeding. WID mothers should be encouraged and supported to breastfeed. The mother should be informed that the benefits of continued breastfeeding far outweigh the disadvantages, even with continued drug use.

WHO HIV treatment guidelines include resources and recommendations regarding PMTCT and breastfeeding for women living with HIV. All those who work with WID should familiarise themselves with the guidelines. 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

**Trainer tip:** *Ask participants if they have any objections to WID breastfeeding. If so, why?*

**Slide 8: Gender-based violence and related services**

* **Direct and referral support**
* **Assisting with violation reporting**
* **Services for sexual assault survivors**
* **Women’s shelters**
* **Legal support**
* **Anti-violence interventions**
* **Raising awareness**

**Trainer notes:**

WID are disproportionately affected by gender-based violence (GBV). Harm reduction programmes can directly support and/or link closely with organisations that specialize in violence against women to assist WID who have experienced violence.

Other services offered as part of a comprehensive response to GBV might include:

* ensuring that WID are aware of their rights and also given information about where and how to report on police misconduct;
* providing or offering assisted referral to survivors of sexual assault with clinical care where women who have been raped can access post-exposure prophylaxis (PEP) and emergency contraception; and offered STI services and psychosocial support. Steps can be taken to link clinical care for survivors of sexual assault with community-led responses to violence.
* supporting the development of safety strategies and violence prevention sessions for WID.

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, care services for WID can enhance the enabling environment for access to the key services and prevent violence against women who use drugs.

**Trainer tip:** *Ask participants to read Case Study 4: EHRN’s Women Against Violence campaign. What supports are available in your country for WID who have experienced GBV? Do any GBV services exclude WID (e.g. women’s shelters?). What would be your organisation’s ideal response to GBV against WID? What would you need to change/modify to achieve this?*

*Point to the additional EHRN resource reference, “Law Enforcement and Women who use Drugs” (cited in the participant handbook) for those seeking more examples of addressing police violence against women who use drugs.*

**Slide 9: Services tailored for WID who are engaged in sex work**

* **Link harm reduction and sex worker services**
* **Staff aware of issues**
* **Non-judgmental and informed client interactions**

**Trainer notes:**

* 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 on-site at the harm reduction service, at sex worker project sites and through outreach to locations frequented by sex workers.
* Services that are tailored effectively 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, commodities and services related to sex work and/or injecting drug use.
* Training is also vital for all harm reduction personnel, whose work is 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 or drug use choices.

**Trainer tip:** *Ask participants to read Case study 6****:*** *COUNTERfit Women’s Harm Reduction Program. Would this sort of service work in your context? What variations would you make?*

**Slide 10: Parenting supports and childcare**

* **Challenging context- health not necessarily a priority**
* **Housing, legal issues, immediate safety, food**
* **Childcare and access to vital services**
* **Facilities for children in in-patient treatment units**

**Trainer notes:**

* Many WID experience stigmatisation and marginalisation from their families and communities. Other concerns about housing, child custody, etc. may be more pressing.
* Harm reduction services can support WID with links to housing, assistance around safety issues, and a range of child care and health issues (e.g., nutrition, feeding and keeping babies clean and comfortable, immunization monitoring, etc.), and broader parenting advice. WID who have limited family support may require additional assisted referral to other agencies.
* Provision of basic childcare services is fundamental in improving service access and needed to allow clients to utilize HTC and other counselling and testing services as well as treatment access.
* Harm reduction services can also advocate with in-patient drug dependence treatment facilities to provide on-going child care and education on-site for the entire duration of individuals’ stay

**Activity:** *Childcare*

**Methodology:** Discussion

**Time:** 10 mins

**Objective:** Explore potential to strengthen or initiate childcare in harm reduction services

**Description:** Ask participants if their organisation provides childcare opportunities. What was required to make it happen? For organisations that do not offer childcare, are there opportunities to do so? How so?

**Slide 11: Couples counselling and legal aid (relevant to WID needs)**

* **Counselling for safer injecting and safer sex**
* **Equal sharing of responsibility**
* **Equal access to health services goals**
* **Legal services for WID**

**Trainer notes:**

* Couples-based counselling can enable safer-injecting and safer-sex practices. Often, these practices result from safer-sex negotiation within the context of on-going 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.
* Legal support should be integrated into services provided on-site or through paralegal peer outreach activities and include legal literacy covering specific issues related to WID and women living with HIV.
* Comprehensive harm reduction services provide referrals to reliable and quality legal services. The most useful legal support will include family law, intimate partner violence, and criminal laws around drug use as well as sex work.

**Slide 12: Providing psychosocial and ancillary services**

* **Ancillary services build familiarity and trust**
* ***Examples of ancillary services?***
* **Job training, micro-financing, job placement etc.**
* **Gender transformative services**

**Trainer notes:**

Ancillary services build relevance and trust between harm reduction services and WID.

If it is not possible for a harm reduction programme to meet all such needs directly, then it can still seek to establish linkages with other organisations that can provide the service or commodity. The harm reduction programme can build these ancillary services into future funding proposals for direct provision.

*Ask participants what sorts of ancillary services their organisation provides (or could provide) for WID. They should include:*

* separate toilets and showers;
* laundry facilities;
* nutritional support;
* pregnancy test kits;
* condoms (male and female);
* child care products (formula, diapers, etc.); and
* feminine hygiene items (shampoo, sanitary napkins, etc.).

Income-generating interventions can help women to achieve some degree of financial independence. Potentially useful interventions focus on job training, microfinance, and access to employment among other things. Harm reduction programmes may be able to obtain funding for such opportunities by including them in funding proposals.

**Trainer tip*:*** *Ask participants to read case study 5: Providing psychosocial and ancillary services in Tanzania, as a clear example of the benefit of providing such services.*

**Activity:** *Transformative*

**Methodology:** Discussion

**Time:** 10 mins

**Objective:** To understand the types of services that may be gender transformative

**Description:** *Ask participants what they understand ‘gender transformative’ to mean. Are ancillary services and income generation potentially gender transformative? How so?*

(Gender transformative services create opportunities for individuals to actively challenge gender norms, promote positions of social and political influence for women in communities, and address power inequities between persons of different genders).

In theory, both ancillary and income generation supports hold potential to be gender transformative in that may contribute to improving economic independence for women who inject drugs.

# Module 5: Key elements in mobilizing women who inject drugs.

## Training objective:

To provide participants with information on key elements for mobilizing WID communities

## Learning objectives:

By the end of the module, participants should have increased knowledge about meaningful involvement of women who inject drugs, be able to identify WID groups in the country if they exist; understand how to support national WID networks and know how to join INWUD and/or WHRIN.

## Materials/supports required:

4 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours).

## Session duration: 60 minutes

**Slide 1: Key elements in mobilizing WID**

* **All level engagement support**
* **Network support**
* **Empowerment**
* **Raising awareness**
* **Women’s groups**
* **Participatory approach**

**Trainer notes:**

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.

This can be achieved 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 they can work 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, to improve their ability to respond to WID needs;and
* 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. Incorporating a participatory approach from the outset will improve the quality and impact of mapping and client recruitment methods.

**Trainer tip:** *Ask participants how their service encourages a participatory approach with WID. Which approaches tend to work better/worse?*

## Slide 2: Developing and strengthening WID collectives

* **spaces to meet**
* **discreet advertising**
* **organisational support**
* **resources for peer education**
* **up to date information on relevant research**
* **engage with the group**

**Trainer notes:**

* Many of the best programmes have been initiated and are led by WID themselves. WID groups may benefit from assistance in mobilising or require spaces in which to meet, perhaps on-site at a service provider drop-in centre or in another location of their convenience.
* These groups or networks can be supported through discreet advertising to other women with similar interests from the service and through outreach.
* Structural and organisational assistance might also be useful, such as by supporting members to identify key issues that they want to prioritise and address.
* Service providers also could offer resources to support peer education and information on the latest research that affects WID.
* Harm reduction 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.

*Draw participant attention to the* [Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs: Practical Guidance for Collaborative Interventions (the "IDUIT")](http://www.unodc.org/documents/hiv-aids/publications/Implementing_Comprehensive_HIV_and_HCV_Programmes_with_People_Who_Inject_Drugs_PRACTICAL_GUIDANCE_FOR_COLLABORATIVE_INTERVENTIONS.pdf) - *which includes sections on supporting networks and setting up drop in centres.*

**Slide 3. Assist the collective with:**

**Assist the group with:**

1. **stakeholder linkages**
2. **funding and training opportunities**
3. **other group determined objectives**

***At minimum, employ WID as volunteers, as paid staff, and/or as managers in WID-focused services.***

**Trainer notes:**

Assist the group—where possible and as requested—with

1. forming linkages with other stakeholders,
2. looking for funding and training opportunities for group members, and
3. other objectives determined by the group or network.

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. Case study 6: COUNTERfit Women’s Harm Reduction Program, provides a good example of such involvement.

**Trainer tip:** *Review case study 6 from COUNTERfit and ask participants to discuss how the service involves WID.*

**Slide 4: Gender specific education and outreach**

* **Improves communication and use of HIV services**
* **Improves service acceptability**
* **Supporting WID communities** 
  + **Training and supporting**
  + **Common goals.**
  + **Forming or linking with existing networks**

**Trainer notes:**

Peer education and outreach improve communication, uptake and adherence to HIV prevention and treatment 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. Recruiting women who use drugs can also help attract new clients.

Effective capacity-building activities for mentoring and supporting WID community mobilisers generally are guided by the following principles and strategies:

* Communication skills training for WID as staff and for leadership positions enable WID community mobilisers to communicate clearly with various stakeholders such as funders, government agencies, the media, and international organisations, etc.
* Supporting community mobilisers 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. (*It can also be useful in some cases to link with mainstream women’s and feminist organisations to increase traction for advocacy, especially on issues that are relevant for other groups of women (e.g., violence)*.)

*(The following paragraph is copied in the participant workbook).*

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.

Women who use drugs who are interested to join INWUD can do so by completing the membership application at: <http://www.inpud.net/en/get-involved>

Harm reduction workers, women who use drugs and others who are interested in advancing access to services for women who use drugs can apply for membership by writing to the moderator: [Sue Purchase <sue.purchase@gmail.com>](mailto:Sue%20Purchase %3csue.purchase@gmail.com%3e)

**Activity:** *Supporting collectives*

**Methodology:** Small group discussion

**Time:** 30 minutes

**Objective:** Enhance participants capacity to engage with WID community

**Description:** Divide participants into two groups and have them select a rapporteur. Present one question at a time giving the group rapporteur 5 minutes to keep notes for each question. After question 3, have the rapporteurs present for each group – alternating which group goes first for each question and not repeating ideas from the previous group.

***Participant presentation (10 mins)***

*1. Does your service currently support WID community mobilisers? How did it commence?*

*(if there is no current women’s group, what might be done to help start one?)*

*2. What is (or would be) required to maintain the support?*

*3. How might you identify WID community mobilisers? What might they do to connect with them?*

# Module 6: Service management and organizational capacity-building

* Staffing issues
* Staff training and competency
* Staff development, mentoring and succession planning.
* Measuring gender equality within harm reduction services

## Training objective:

To provide participants with knowledge and methods to realign service management to better address the needs of WID.

## Learning objectives:

By the end of the module, participants should have increased knowledge about service management and organizational capacity building for initiatives targeting WID.

## Materials/supports required:

6 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours).

## Session duration: 60 Minutes

**Slide 1: Service management and organizational capacity-building**

* **Staffing issues**
* **Staff training and competency**
* **Staff development, mentoring and succession planning.**
* **Measuring gender equality within harm reduction services**

**Trainer notes:**

This module covers these 4 elements. But first we need to consider gender inequalities…

**Slide 2: Responding to gender inequalities**

* **Involve WID in decision making**
* **Employ WID in outreach**
* **Staff training on WID**
* **Gather sex disaggregated data**
* **Provide women-specific services**
* **Develop specific initiatives**

**Trainer notes:**

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; and
* developing initiatives, activities, and strategies that i) promote empowerment of both women and men, ii) challenge harmful gender norms, and iii) challenge and seek to eliminate gender-based violence or inequities in injecting practices, such as women going 'second on the needle'.

**Activity:** *Gender inequalities*

**Methodology:** Small group work

**Time:** 10 mins

**Objective:** To problem solves specific gender inequality issues

**Description:**Divide group into teams of three. Ask participants if their service is aware of gender inequalities. What inequalities are there? How are they addressed? Could there be other approaches? Share solutions with the larger group.

**Slide 3: Staffing issues**

* **Employ peers**
* **Reflect WID community composition in peer recruitment**
* **Staffing gender ratio**

**Trainer notes:**

* Meeting the needs of WID is more likely achieved by employing women with a history of drug use and who are identified as such in networks of people who use drugs.
* Ideally recruit from a range of WID networks—including those focused on youth, mothers, or sex workers—to fully reflect WID community composition 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*.)

**Trainer tip:** *Ask participants to share about experience in employing WID. What are the barriers? Benefits? How might they be overcome?*

**Slide 4: Staff training and competency**

* **Client autonomy**
* **Gender-sensitivity training**
* **Education as advocacy**
* **Improving competency in the referral network agencies**

**Trainer notes:**

* Competent workers respect and appreciate the dignity of peer staff and clients and accept that WID have a right to manage their own lives. This includes their decision to use drugs.
* Gender-sensitivity training is especially valuable when it includes specific sessions on attitudes and beliefs regarding WID.
* Education can target health care workers, police and prison staff, all of whom are likely to more appropriately engage with WID when they are educated about drug use, harm reduction, and a rights- and health-based approach to drug use.
* Education for service staff as well as referral network agencies and other external parties (e.g., police) should include information on WID-specific issues and stigma.

**Slide 5: Staff development, mentoring and succession planning**

* **Gender sensitivity principles apply**
* **Workforce development with succession planning**
* **Maternity leave**
* **Performance evaluation includes gender sensitive principles**

**Trainer notes:**

Service provision can be improved when staff are supported to promote appropriate services for WID in their own work. One way is to ensure that gender-sensitivity principles form a component of staff development and mentoring.

Succession planning identifies key staff members who, over time, can take on more responsibility and be considered for leadership opportunities. 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 assist the growth of management skills. Regardless of the context, service providers have an organisational responsibility to provide maternity leave since so much of the focus is and should be on women. Succession planning should incorporate a backup staff member while any staff members are on leave.

Staff performance evaluations can include assessment of how individuals incorporate gender-sensitive principles in their work. Staff input and feedback can be sought regarding how to improve services to meet the needs of WID.

**Slide 6: Measuring gender equality within harm reduction services**

* **Flexible hours, childcare, policies that encourage more flexible gender roles?**
* **Policies reflect gender sensitivity and equity?**
* **Gender equity considered during recruitment?**
* **Capacities of staff in gender issues and working with WID?**
* **Allocation of financial resources for WID-specific services?**
* **Organisational culture includes consultation with women staff and WID?**
* **Women’s organisation established or strengthened?**

**Activity:** *Gender audit*

**Methodology:** Small group work

**Time:** 20 minutes

**Objective:** Participants will identify steps towards gender equality in their workplace.

**Description:** Divide participants into groups representing their different organisations. Ask them to work together in answering the listed measuring questions (*slide 6*), then report back to whole group.

*(NB: While the last question was addressed in module 5, it is retained here to remind participants that it should be included as part of harm reduction service assessment).*

**Trainer notes:**

It is beneficial to measure the extent to which gender-sensitive principles are integrated into services, organisational structures, policies and procedures, gender ratios, etc.

* Are there provisions for flexible working hours for both women and men, child care provision, and policies that encourage more flexible gender roles?
* Do policies reflect gender sensitivity and equity? (*if so, how?)*
* 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? (*specify*)
* Is there allocation of financial resources for WID-specific services?
* Does the organisational culture include participation and consultation with women staff and WID?
* Have women’s organisations been established or strengthened?

# Module 7: Prisons and service continuity.

## Bangkok Rules

## Key harm reduction services in prisons

## Pre-release

## Case management approach

## Treatment and care continuity

## Training objective:

To provide participants with an understanding of the importance of service continuity within closed settings

## Learning objectives:

By the end of the module, participants should have increased knowledge about how to implement service continuity for WID in closed settings

## Materials/supports required:

6 PowerPoint slides, LCD projector, computer, whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours).

## Session duration: 60 minutes

**Slide 1. Module 7 Prisons and service continuity**

* ***Consequences***
* **Women should not be imprisoned for personal use**
* **Trend towards over-incarceration of women who use drugs**

**Trainer notes:**

There is growing consensus that WID, especially those with children, should not be imprisoned solely for personal drug use. Yet women continue to be incarcerated for minor drug-related offences. Most of these women have not committed any violent crimes and are often first-time offenders.

**Activity:** *Consequences*

**Methodology:** Brainstorm

**Time:** 3 minutes

**Objective:** To understand the implications of incarceration for WID

**Description:** Facilitator to lead a brainstorm with the whole group to identify consequences of incarceration for WID.

**Trainer notes:**

Be sure to include:

* Negative effects on health and welfare
* Lack of harm reduction services in women’s prisons
* Incarcerated women often have a higher prevalence of blood-borne viruses and STIs and more health problems in general than male prisoners,.
* 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.
* Women in prison may also experience loss of custody of their children. Once released, they may not be able to regain custody,
* Women with criminal records may be denied access to educational or employment opportunities.

**Trainer tip:** Ask participants to read *Case study 7:* *Climbing rates of incarceration of women who use drugs. Then discuss status of incarceration of women in their country.*

**Slide 2. The Bangkok Rules**

* **The Bangkok Rules (i.e., the United Nations Rules for the Treatment of Female Prisoners and Non-Custodial Measures for Women Offenders—adopted by the UN General Assembly in 2010)**
* **Rule 45 (Group 1)**
* **Rule 46 (Group 2)**
* **Rule 47 (Group 3)**

**Trainer notes:**

Some of the most notable standards regarding the sentencing and treatment of women prisoners are included in the UN’s Bangkok Rules.  Your country is a signatory to these rules.

**The Bangkok Rules** (i.e., the United Nations Rules for the Treatment of Female Prisoners and Non-Custodial Measures for Women Offenders—adopted by the UN General Assembly in 2010)

**Trainer tip*:***  *(If there is internet available and participants have smartphones or laptops). Split the participants into 3 groups. Each group is assigned a “Bangkok Rule’ to find online (or in the guide). First team to identify their rule wins. Each team reads out their rule. Allow 10 mins for the exercise.*

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 organisations, 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.

**Trainer tip:***Discuss the implications of both the Bangkok Rules and the prisons services list in your country context.*

*What are the potential implications for harm reduction service providers?*

**Slide 3. Key harm reduction services in prisons.**

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**

**Trainer notes:**

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. (*As listed in slide*).

Advocate for the implementation of this package—and where possible, coordinate directly with local prisons to provide the interventions. Women in prisons should have equivalent access to gender-sensitive health and HIV services as their non-incarcerated counterparts in the community.

**Trainer tip:** *Ask participants if they have linkages with prisons. What services currently exist? Are they involved in advocacy for additional services?*

*Ask group to brainstorm potential advocacy strategies that might be effective?*

**Slide 4: Pre-release**

* **Early pre-release planning**
* **Client-centered approach**
* **Referral process**
* **Monitoring mechanism**

**Trainer notes:**

* WID as well as all other prisoners are better able to reintegrate into communities when pre-release preparations start early. Ideally 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 develop a service plan that ensurescontinuity of access to health and other services after release.
* The plan should be developed with the client and identify referral processes and mechanisms to track the client’s access to services.

**Slide 5: Case management approach**

* **Post-release considerations**
  + **Reconnecting with family and children**
  + **Treatment continuity and access to support services**
* **Case management** 
  + **pre-release planning**
  + **women case managers**
  + **longitudinal support**

**Trainer notes:**

In transitioning from prison to the community, challenges may include reuniting with children, continuity of OST and ART or TB treatment and on-going access to mental health or other support services.

To manage these issues, it is recommended that

1. pre-release planning services adopt a case management approach that is advocacy based;
2. case managers be informed when an inmate is to be released; and
3. case management services to develop a client-driven post-release plan begin 3-6 months before release date.

In low-resource settings, the following 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;
* advocating and deliver training to key prison personnel regarding the benefits to prisoners and to the prison system in general;
* undertaking on-going 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.

Be cautious to not overload workers with unrealistic number of cases

* identifying key services in the community and establishing a network of ‘trusted service providers’ with formal memorandums of understanding (MoUs).

If feasible, case managers should consider maintaining contact with each case for approximately one year. Both case managers and clients benefit when a support system, such as professional mentoring, has been established for each case manager,.

**Slide 6: Treatment and care continuity**

* **ART, OST, TB and viral hepatitis treatment maintenance inside and outside.**
* **Liaise with local prison authorities for post arrest, maintenance for duration (including any prison transfers), and pre-release.**

**Trainer notes:**

* The health 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 afterward, 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.

**Trainer tip:** *Ask participants to review Case study 9:**Belarus prison referral network as an example of post release support for WID.*

# Module 8: Planning gender responsive services

The module consists of 2 activities. The first is a SWOT analysis where participants will identify where their current services can be strengthened to deliver gender responsive services.

The second activity, based on the findings of the SWOT analysis, the participant will develop a draft implementation plan to integrate a gender responsive service into their existing services.

## Activity: *SWOT Analysis*

**Training objective:** To provide participants with an opportunity to evaluate the strengths and weaknesses of existing programs in providing gender responsive services.

**Learning objectives:** By the end of the activity, participants should have increased knowledge about:

• Effective approaches currently used for WID.

• Where existing programs might be strengthened

**Resources:** Whiteboard (plus whiteboard marker pens), flipcharts with blank paper, marker pens (various colours).

**Methodology:** Small group work, large group discussion and brainstorming.

**Duration:** 10 minutes explanation of exercise; 50 minutes for group work**;** 30 minutes facilitated discussion.

**Trainer notes:**

Ask participants to break into smaller groups of agencies that provide similar services or in similar geographical areas servicing similar clients.

Provide each group with blank paper and ask each group to consider the strengths of programs that provide services to WID.

Each group should also consider what the weaknesses of existing services might include. During this process, each group could also consider what opportunities exist to provide services in a new or different way.

At the completion of the exercise, bring the group together and ask each group to present their results to the larger group. The results will be used in the Activity on Day 3.

Figure 1: SWOT Analysis – Participants work in small groups to fill in the boxes above

After each group has presented, lead the group in a facilitated discussion to highlight the common themes that occur across agencies in the strengths and weaknesses of approaches to WID. Keep notes of these on the whiteboard for day 3. Additionally, facilitate discussion regarding the importance of networking and information sharing amongst agencies to further expand services to WID communities.

Instruct participants that the SWOT analysis will be used in Day 3: Activity 2. *Integrating gender responsive services into current service delivery*

# End of Day 2:

**Activity:** *Wrap up of Day 2*

**Methodology:** Large Group Discussion

**Time:** 5-10 minutes

**Objective:** Participants will reflect on the day’s program and to identify key learnings of the day.

**Description:** Ask each person what was one thing they had learned or thought was interesting from the day. If time permits, ask participants what they might do with this information when they return to their organisation.

# Day 3:

**Activity:** *Integrating gender responsive services into current service delivery*

**Training Objective:** Participants will develop a plan for integrating gender responsive services into their service delivery

**Learning Objective:** By the end of the session, participants should have a draft plan for integrating gender responsive services

**Resources:** Blank paper, marker pens (various colours)

**Time:** 40 minutes group work; 50 minute group discussion

**Description:** Review SWOT analysis outcomes.Break group into groups of four (preferably with organisations who have identified the same gap in services or are in the same geographical area).

With their own SWOT Analysis in mind, ask participants to develop an implementation plan for integrating a component of gender responsive services.

The framework of the plan should include the following:

1. Objectives
2. Activities to support each objective
3. Output indicators
4. Timeline
5. Identification of stakeholders and/or working partners for each activity
6. Resources required for implementation

Each group will present their draft plan and discuss the practicality of the activities identified in the plan. It is also a good opportunity to identify other interested partners/stakeholders from different groups who can contribute technical input in the implementation plan.

Each participant will complete their own plan in the workbook to be used when they return to their respective services.

# End of Day 3:

**Activity:** *Wrap up*

**Methodology:** Large Group Discussion

**Time:** 5-10 minutes

**Objective:**

**Description:** The two teams List-keepers to take turns reading out gender stereotypes they heard. The team with the most listed win.

Complete day 3 evaluation (*form in annex of trainer guide*) – 10 mins

Ask participants to complete the post training assessment and evaluation– 20 mins

Present certificates (5 mins). Close workshop.

# Pre and post training assessment

Please answer the following using a scale where 1 is Strongly Agree and 7 is Strongly Disagree.

[Provide answer space with scale for each question and space to elaborate as required]

1. Harm reduction services have a key role to play in expanding access for women who inject drugs to HIV prevention and related services.

2. I have good knowledge of how to work with women who inject drugs to prevent HIV.

3. I am comfortable working with women who inject drugs.

4. I have the skills to work with women who inject drugs in preventing HIV.

5. I know how and who to approach to better collaborate on comprehensive services for women who inject drugs.

6. I would feel comfortable approaching women who inject drugs to collaborate on HIV prevention.

7. Training on services for women who inject drugs is important.

8. Meaningful involvement of women who inject drugs is important.

9. Harm reduction services can partner with women who inject drugs in advocacy and public health promotion.

10. Harm reduction services can do more to meet the needs of women who use drugs in prisons.

# Workshop Evaluation

Dear participants of the workshop!

You successfully participated in the workshop for service providers on gender-responsive HIV services for women who inject drugs, sponsored by UNODC. UNODC always strives for continuous quality improvement of our programs to meet the educational needs and requirements of participants. In this context, we’d like to solicit your feedback and to ask you to share with us your experience, comments and recommendations for the course. We offer our participants to fill in the anonymous evaluation forms. The provided information will not be made available for the third parties. The collected data are intended for the internal use only: for assessment and evaluation of delivered workshop. Please fill in all required fields.

Thank you for your time.

* General information

|  |  |
| --- | --- |
| Title of the workshop | Workshop for serviceproviders on gender-responsive HIV services for women who inject drugs |
| **Data** |  |
| Country |  |
| Gender |  |
| CSO or LEA delegate |  |

* Importance of the topic and its impact on professional competence/practice

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
| **The topic of the course is important for my practice** |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
| The content of the course completely answers to my expectations |  |  |  |  |  |
| I know how to apply my new knowledge and skills into practice |  |  |  |  |  |

Do you have a specific plan of putting your new knowledge into practice? Yes - No – (did not respond – )

|  |
| --- |
| Please, briefly describe your plan |
|  |
| In your opinion, which type of support you will need to make your action plan real? |
|  |

* Methodology / efficiency of training

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How do you assess the training methodology?** | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
| The goals and objectives of training were clearly identified |  |  |  |  |  |
| The teaching methods used were appropriate for the learning objectives and variable as needed |  |  |  |  |  |
| The workshop content was presented in logical sequence and in an easily accessible form |  |  |  |  |  |
| Interactive elements, included into the workshop materials, facilitated better understanding of the content |  |  |  |  |  |
| I’m satisfied with new knowledge and skills, which I obtained during the workshop |  |  |  |  |  |

**The course duration was:** too long too short optimal

* Trainers

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How do you assess the professional competence of your trainers?** | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
| The trainers had wide experience in the topic |  |  |  |  |  |
| The trainer always answered my questions |  |  |  |  |  |
| The trainer answered my questions timely and on high professional level |  |  |  |  |  |

* Participants

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
| The job climate supported cooperation |  |  |  |  |  |
| The experience of other participants was useful for me |  |  |  |  |  |
| I’m going to stay in touch and share opinions about this topic with some participants in future |  |  |  |  |  |

* Achievement of learning objectives

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **By your opinion, did you achieve the workshop objectives?** | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
|  |  |  |  |  |  |

|  |
| --- |
| What was the new knowledge and experience that you managed to obtain in addition to the pre-defined goals and objectives of the workshop? |
|  |

* **Course management and organizational issues**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How do you assess the overall workshop management and organization?** | Strongly  disagree | Disagree | Undecided | Agree | Strongly agree |
| - In general, I’m satisfied with workshop management |  |  |  |  |  |
| - In my opinion, I’ve got sufficient pre-training information (the general information about workshop, list of topics, other technical details) |  |  |  |  |  |

|  |
| --- |
| In your opinion, what type of information/documents you felt missing? |
|  |

|  |
| --- |
| As long as many important aspects were not covered by this questionnaire, we gladly welcome any additional comments, offers and recommendations. |
|  |

* The overall score

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Excellent  **++** | Good  **+** | Fair  **0** | Could be better  **-** | Poor  **--** |
| How would you score the overall workshop? |  |  |  |  |  |

* The translation quality

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Excellent  **++** | Good  **+** | Fair  **0** | Could be better  **-** | Poor  **--** |
| How would you score the quality of provided translation? |  |  |  |  |  |

Please, tick one

|  |  |  |
| --- | --- | --- |
| Will you recommend the course to other candidates? | Yes | No |

Thank you very much!

1. UNODC INPUD Addressing the specific needs  of women who inject drugs  Practical guide    
   for service providers  on gender-responsive  HIV services, 2016 <http://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf> [↑](#footnote-ref-1)
2. UNODC UNWOMEN WHO INPUD (2015) Policy Brief - Women who inject drugs and HIV: Addressing specific needs http://www.unodc.org/documents/hiv-aids/publications/WOMEN\_POLICY\_BRIEF2014.pdf [↑](#footnote-ref-2)
3. UNODC INPUD Addressing the specific needs  of women who inject drugs  Practical guide    
   for service providers  on gender-responsive  HIV services, 2016 <http://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf> [↑](#footnote-ref-3)