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GENDER EQUALITY

IN HARM REDUCTION SERVICES

Integrating Gender-specific Services in Harm Reduction Programs in the Middle East & North Africa (MENA) Region



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List of Abbreviations

CSO	Civil Society Organization
FWID	Female Who Injects Drugs
FWUD	Female Who Uses Drugs
FSW	Female Sex Workers
GBV	Gender Based Violence
HIV	Human Immunodeficiency virus
HR	Harm Reduction
IEC	Information, Education and Communication
IPV	Intimate Partner Violence
KH	Knowledge Hub
MENA	Middle East and North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MMT	Methadone Maintenance Treatment
NSP	Needle Syringe exchange Program
OST	Opioid Substitution Treatment
OR	Operational Research
MSM	Men who have Sex with Men
PWID	People Who Inject Drugs
MTCT	Mother-To-Child Transmission
M&E	Monitoring and Evaluation
STI	Sexually Transmitted Infection
VCT	Voluntary Counseling and Testing



Foreword


Several years ago, gender equality became a widespread theme which sparked a great deal of interest in several areas and fields. Global movements highlighted the need for gender equality especially in the access to and availability of services.

In 2013, the Middle East and North Africa Harm Reduction Association (MENAHRRA) conducted a qualitative operational research on harm reduction and women who use drugs across five countries in the MENA region. The results of the study showed major gaps and numerous shortcomings in gender specific services available to women in the region.

To build on the results of the operational research, this manual, which was developed in consultation with various stakeholders in the region, aims to compliment the results of the study and attempts to fill some of the gaps that have been identified. MENAHRRA encourages the civil society of the region, working in the harm reduction field, to use this manual in order to improve the level of gender specific services available for women and female youth in the region.

We hope that this manual will bridge the gaps in tools and knowledge to help create a better environment and access to care and services for women who use drugs in the region. We would like to take this opportunity to thank all those who contributed to the production of this manual. MENAHRRA would also like to thank Ms. Ola Ataya for all her efforts in creating this manual, those who took part in providing their feedback to make this tool practical and applicable to the region, and the MENAHRRA team for all their hard work.

MENAHRRA would also like to thank our partners in the Harm Reduction Consortium and the Robert Carr civil society Networks Fund for making this manual possible.


Elie Aaraj
Executive Director
MENAHRRA

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We hope that this manual will encourage policy makers and program managers in the MENA region to include a gender perspective and promote equality and human rights for women and girls in their harm reduction programs.

This manual was edited by Ms. Jennifer Ghazal and designed by Mr. John Abou Elias.

Ola Ataya
Consultant

Introduction

According to the UN Office on Drugs and Crime (UNODC) World Drug Report published in 2013, substance abuse has continued to rise in both developing and developed countries since the 1990s despite international efforts and an ongoing “war on drugs.”¹ Similarly, the pattern of injecting drug use among women is growing worldwide (European Monitoring Centre for Drugs and Drug Addiction Annual Report 2006). Although the actual proportion of women who inject drugs in the Middle East and North Africa (MENA) region is unknown, anecdotal data from the region implies similar growing trend in injecting drug use among women as seen elsewhere in the world.

People Who Inject Drugs (PWID) all experience stigmatization, vulnerability, marginalization and high risks for HIV and other infectious diseases among other risks and vulnerabilities. This is even worse for Females who Inject Drugs (FWID) who are often ignored and less visible within PWID community.

Despite the specific needs that drug using women have along with the vulnerabilities they experience, many of them still face extremely difficult barriers in accessing harm reduction services. The social stigma and the gender-related factors, coupled with the male-dominated policy and service design directed mainly towards male needs have reduced female’s access to health care and treatment. Poverty, stigma, domestic violence, police harassment, and fear of losing custody of their children are only some of the barriers hindering or preventing females who use drugs from seeking medical and counseling services. And for those who ask for medical care, they are likely to be denied access or receive substandard services from doctors and nurses who are not trained and not prepared to deal with their issues.

Due to a combination of biological, social, and cultural factors, women’s drug use is different from men’s². Compared to their male counterparts, women who inject drugs experience significantly higher mortality rates; an increased likelihood of injecting-related problems; faster progression from first drug use to dependence; higher rates of HIV; and higher levels of risky injecting and/or sexual risk behaviors³. Women who inject drugs are more likely than their male counterparts to have a sexual partner who injects drugs, and to be dependent on them for help acquiring drugs and injecting. They are more prone than non-injecting females who use drugs to intimate partner violence⁴. Relationship dynamics can make it difficult for women to access harm reduction services, enter and complete drug treatment (if desired) or practice safer drug use and safer sex⁵.

¹ United Nations Office on Drugs and Crime (UNODC), “World Drug Report”, 2013. http://www.unodc.org/unodc/secured/wdr/wdr2013/World_Drug_Report_2013.pdf.

² El Bassel N, Terlikbaeva A & Pinkham S (2010) HIV and women who use drugs: double neglect, double risk, *Lancet*, Vol. 376, Issue 314–312, 9738.

³ Roberts A et al (2010) on Behalf of the Reference Group to the United Nations on HIV and Injecting Drug Use, *Women Who Inject Drugs: A Review of Their Risks, Experiences and Needs*, National Drug and Alcohol Research Centre (NDARC), University of New South Wales, Sydney, Australia.

⁴ *ibid*

⁵ *ibid*

Research has shown that females who use drugs (FWUD), especially those who have been incarcerated, are faced with higher levels of abuse, discrimination and violence than men⁶.

Female who uses drugs experience considerable barriers to accessing healthcare and service provision, thus resulting in barriers to the prevention of blood-borne and sexually transmitted infections⁷. They face difficulties in accessing effective harm reduction (HR) services. These difficulties can include the relationships dynamics which impede women from seeking treatment as easily as men, imprisonment of drug using women who do not have the chance to enter harm reduction programs and very often are punished for even possession of drugs and the social stigma that follows women's drug use⁸.

Recognizing the importance of gender inequality, and particularly violence against women in increasing women's vulnerability to HIV and other infectious diseases, several international organizations and donors have prioritized the need to address gender inequality and violence against women within their strategies.

A significant expansion of gender-specific harm reduction programs and the number of beneficiaries they serve, as well as an expansion of the services provided by those programs, are essential for improved access of vulnerable women and their children to life-saving services. Gender-specific services targeting girls and women aim at addressing their specific needs, challenging the unequal power relations and harmful gender norms.

Mainstreaming gender in harm reduction services seeks to reduce gender-related barriers, including stigma and discrimination, to accessing services while also improving the uptake, the quality and the outcomes of services, by tailoring those to the needs of women and girls.

Why this manual?

This manual generally aims at guiding MENA countries on how to include a gender perspective and promote equality and human rights for women and girls in their harm reduction programs. It specifically aims at improving the uptake of the services for FWID in the MENA region.

The manual is designed to provide information and guidance on strategies and interventions aiming at integrating gender-specific services into harm reduction programs. It provides information needed to fill the gap in knowledge on how to improve access to gender specific harm reduction services for FWID in the MENA region.

⁶ ibid

⁷ Drug User Peace Initiative: A War on Women who Use Drugs. International Network of People who Use Drugs (INPUD) 2014

⁸ Operational Research on the Context, Service Needs and Factors Influencing Service Uptake - Women Injecting Drug Users in the Middle East and North Africa Region (MENA)

The manual:

- Provides information and presents experiences and practical approaches from different MENA countries
- Provides information on gender-specific needs and challenges that may hinder Females who Inject Drugs' HR service uptake and strategies that help address those needs & challenges
- Provides guidance on approaches and meaningful strategies to increase uptake of harm reduction services by females

The manual takes into account the cultural, religious, social, and other specificities of the MENA countries.



Who can use this manual?

The manual can serve as a useful tool for all those working in the fields of harm reduction, health, and gender. It helps policy makers and program managers in the MENA region to make evidence-based and human rights-based program decisions that will lead to more effective approaches to programming.



How to use the manual?

The manual is a tool that can be used as:

- an information guide;
- a guidance resource by those working in health, gender, and harm reduction programs
- a useful tool in programming, project design, advocacy, and mobilization efforts on promoting gender equality in harm reduction;
- a tool for awareness-raising on gender-specific HR services
- an advocacy tool, along with the “Operational Research on the Context, Service Needs and Factors Influencing Service Uptake - Women Injecting Drug Users in the Middle East and North Africa Region (MENA)

Information from the manual can also be useful for awareness-raising and advocacy campaigns on specific occasions such as, the Global Day of Action- June 26; International Overdose Awareness Day- August 31, World AIDS Day – December 1, etc.



How was the manual developed?

The manual is one of the products of a project implemented by MENAHRA in cooperation with the Harm Reduction Consortium and the funding of the Robert Carr civil society Networks Fund (RCNF). It is the fruit of a process that involved a large number of different and complementary activities. Below is a summary of the main milestones in its journey:

- **Operational Research on the Context, Service Needs and Factors Influencing Service Uptake - Women Injecting Drug Users in the Middle East and North Africa Region (MENA):** In 2013, MENAHRA conducted an operational research (OR) to understand the context of drug use among FWID and factors which hinder or facilitate access to harm reduction services. The purpose of the OR was to provide recommendations for harm reduction programs in the region on how to improve the uptake of services for FWID in the MENA region. By understanding factors that are bottlenecks for effective implementation of harm reduction services for FWID, policy makers and program managers in the MENA region can make evidence based program decisions that will lead to more effective approaches to programming.
- **Regional consultative workshop on Gender Equality in Harm Reduction Services:** In 2015, MENAHRA conducted a 4-day consultative workshop in Lebanon that brought together a large multidisciplinary group of specialists and representatives of CSOs from different MENA regions who work in the fields of health, gender, and harm reduction to discuss ways of integrating gender specific services in harm reduction programs. The workshop aimed at providing CSOs from the region with a forum in which to discuss their experiences, raise their key concerns, and outline the gaps in providing services to FWID.

The manual on Integrating Gender Specific Services to Harm Reduction Programs in the MENA Region includes recommendations drawn from:

- Operational Research conducted by MENAHRA;
- Globally agreed-upon guidelines on harm reduction and gender mainstreaming
- Feedback and recommendations from the workshop and the consultative process exploring how to address the gaps in providing harm reduction services to FWID.



Keywords and Concepts

Gender :

Gender refers to the social attributes and opportunities associated with being male and female and the relationships: (a) between women and men;(b) between girls and boys;(c) among women; and (d) among men. These attributes, opportunities and relationships are socially constructed and are learned through socialization processes. They are context/time-specific and changeable. Gender determines what is expected, allowed and valued in a women or a man in a given context. In most societies there are differences and inequalities between women and men in responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities.

UNAIDS definition of gender as a socially constructed set of norms, roles, behaviors, activities, and attributes that a given society considers appropriate for women and men, with the inclusion of people who identify themselves as transgender. The intricacy of the issue expands with the understanding of diverse gender identities, a person's deeply felt internal and individual experience of gender that may or may not correspond with the sex assigned at birth.

Sex disaggregated data

For a gender analysis, all data should be separated by sex in order to allow differential impacts on men and women to be measured.

Intimate partner violence (IPV)

Behavior within an intimate relationship that causes physical, sexual, or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behaviors. IPV is one of the most common forms of violence against women.

Masculinities

Socially constructed definitions and perceived notions and ideals about how men should or are expected to behave in a given setting. Masculinities are configurations of practice structured by gender relations and can change over time. Their making and remaking is a political process affecting the balance of interests in society and the direction of social change.

Gender equity

The principle and practice of fair allocation of resources, programs, and decision-making to both women and men (process of being fair to both women and men). Gender equity means fairness of treatment for men and women, according to their respective needs. This may include equal treatment or treatment that is different but which is considered equivalent in terms of rights, benefits, obligations and opportunities.

Gender equality

A situation in which women and men enjoy the same status and have equal opportunities to enjoy their full human rights and potential to contribute to national, political, social, and cultural development and to benefit from the results.

Equality of sexes means:

- Women and men having the same rights and obligations;
- Everyone having the same opportunities in society;

Gender equality is also about justice and about sharing responsibilities, both in the family and society.

Gender mainstreaming

Strategy that aims at achieving gender equality) refers to a strategy for recognizing, acknowledging, responding to and integrating the needs and concerns of both women and men in programs and policies at all levels. It aims to achieve gender equality, which is promoted by a solid body of international law.

The strategy of mainstreaming is defined in the ECOSOC (Economic & Social Council) agreed conclusions, 1997/2, as: "...the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in all areas and at all levels. It is a strategy for making women's as well as men's concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres so that women and men benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality."

Gender roles

A gender role is a set of social and behavioral norms that are generally considered appropriate for either a man or a woman in a given time or context. There is a clear difference between the functions set by society for men and women, either within the family or in external relationships.

The separation in gender roles between men and women results from the social, economic, and cultural context which assigns activities and roles to individuals on a gender basis. So those roles defined by society are as follows:

- Acquired
- Change through time
- Differ within and across cultures
- Both men and women play various roles in the workplace namely: production, reproduction (care), social services and the management of society and political activities



Gender typing

The acquisition of a traditional masculine or feminine role.

Gender typing refers to the process by which children acquire the values, motives, traits and behaviors viewed as appropriate for males and females within a culture.

Gender stereotype

Gender stereotypes are over-generalizations about the characteristics, differences and attributes of an entire group based on gender. Gender stereotypes create a widely accepted judgment or bias about certain characteristics or traits that apply to each gender.

In gender stereotyping, people make inaccurate, overly simplistic generalizations of others based upon their gender. These assumptions are untrue because they do not take into account that every individual is unique and that there are individual differences between people. Gender stereotypes can lead to discrimination (and usually justify discrimination) and reinforce and perpetuate gender inequality.

Harm reduction

People marginalized by high-risk behaviors have the right to access a continuum of service options and strategies that include outcomes such as reduced harm, abstinence, and enhanced quality of life.

The philosophy of harm reduction recognizes the resilience of people who engage in these behaviors and aims to reduce stigma associated with them.

Harm reduction does not promote or enable harmful behaviors, nor does harm reduction protect individual participants from experiencing the consequences of the choices they make.

Harm reduction is a set of practical strategies that reduce the negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use, to abstinence.

Harm reduction strategies meet drug users “where they’re at,” addressing conditions of use along with the use itself. – *Harm Reduction Coalition*

“**Harm reduction**” refers to policies, programs, and practices aimed at reducing drug-related risks and harms by advancing the health and human rights of people who use drugs. As Harm Reduction International notes, “The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.”⁹ This approach recognizes that “people unable or unwilling to abstain from drug use can still make positive choices to protect their own health in addition to the health of their families and communities.” Harm reduction thus seeks to create an enabling environment for people who use drugs to protect their health and other human rights by providing them with evidence-based information, services, and resources. Gender inequalities, harmful gender norms and gender-based violence continue to contribute to HIV-related vulnerability.

⁹ Harm Reduction International, What is Harm Reduction: A position statement from the International Harm Reduction Association (2010). www.ihra.net/what-is-harm-reduction.

Harm reduction is an approach/strategy that is implemented following a set of 9 interventions

The **Nine Key Harm Reduction** Interventions are:

1. Needle and syringe programs (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counseling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programs for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC) 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 (TB)



Why does the MENA region need gender-specific harm reduction services?

Gender shapes the experience of drug use and the risks associated with it. For women who inject drugs, the stigma of drug use, and specifically injection drug use, is added to existing gendered discrimination and negative attitudes towards females who use drugs. These factors combined can push women into behaviors that increase their risk of HIV and create barriers hindering their access to HR services. There is a higher likelihood that women drug users provide sex in exchange for housing, sustenance, and protection, suffer violence from partners, dealers or family; and have difficulty insisting that their sexual partners use condoms. Women who use drugs may also rely on men to inject them with drugs and acquire drugs and injection equipment, which increases the likelihood of injection with contaminated equipment.

Gender-specific services within harm reduction and drug treatment programs are rare or nonexistent in most countries. Generally, services remain gender-neutral or male-focused. Many existing services inadvertently exclude women, do not respond to their specific needs, and the existing discriminatory policies and social stigma drive women who use drugs away from care and expose them to human rights abuses. This neglect in developing & implementing gender-specific interventions represents missed opportunities for improved health outcomes. It means that FWID are and will remain more vulnerable and at risk much more than their male counterparts in nearly all aspects of their lives.

¹⁰ WHO, UNODC, UNAIDS. Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users (2012 Revision)
Available at http://apps.who.int/iris/bitstream/10665/77969/1/9789241504379_eng.pdf

Overall, there is insufficient data on FWID and most countries do not collect gender-disaggregated data on drug use and treatment (including needle & syringe programs, Opioid substitution programs and/or antiretroviral therapy). Data disaggregated by gender should be collected to assess & monitor any disparity in HR service access¹⁰. Collecting sufficient information and investigating the circumstances Female who uses drugs face helps address this gap in knowledge and also helps to formulate policies and programs that better serve girls and women who use drugs; hence improving the availability, accessibility, affordability and acceptability of HR interventions by FWID.

Research from around the world shows that male and females who inject drugs face different risks¹¹⁻¹². Research focused on the risk behavior of IDUs demonstrates that females who inject drugs face a higher risk of HIV infection than males who inject drugs. Also, women are more likely to have sexual partners who inject drugs. These risks are added to women's greater biological vulnerability to HIV through unprotected vaginal intercourse.

Limited studies from the MENA region on FWID hinder understanding of this vulnerable population. Recent studies describe female IDUs as a hidden population in the region that encounters higher stigma than male IDUs, which is believed to result in the low use of harm reduction services. Recent studies have also shown that FWID in the region have generally lower socio-economic statuses than men IDUs and that drug use is associated with poverty, mental problems and violence¹³⁻¹⁴.

To address the gap in knowledge on the issues of Females who Inject Drugs, their needs, and the resources needed for their assistance, MENAHRA, with the financial support of the Global Fund to Fight Aids, Tuberculosis, and Malaria, conducted a thorough investigation into the lives and needs of WIDUs in six countries of the MENA region: Afghanistan, Egypt, Lebanon, Morocco, Pakistan, and Tunisia. The study aimed at exploring the context of drug use among FWID to describe their gender-based needs and to identify the factors influencing their uptake of harm reduction services. The study helped in setting important recommendations on how to improve access and uptake of HR services among FWIDs in the region.

The findings of the study were discussed thoroughly and validated during a regional consultative workshop on gender & harm reduction (Beirut, Lebanon - September 2015). Civil society organizations (CSOs) from different MENA regions presented their experiences in integrating gender-specific services into their harm reduction programs, the challenges they face and the existing opportunities.

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

12 El-Sawy, H, Hay, MA, & Badawy, A. (2010). Gender differences in risks and pattern of drug abuse in Egypt. *Egyptian Journal of Neurology, Psychiatry and Neurosurgery*, 47(3), 413-418

13 Abou Raddad, Leith J. et al. (2010). Characterizing the HIV/AIDS epidemic in the Middle East and North Africa: Time for strategic action. www-wds.worldbank.org

14 El-Sawy, H, Hay, MA, & Badawy, A. (2010). Gender differences in risks and pattern of drug abuse in Egypt. *Egyptian Journal of Neurology, Psychiatry and Neurosurgery*, 47(3), 413-418

Highlights on the Status of FWID in the MENA region

The operational study (Women Injecting Drug Users in the MENA Region: Context, Service Needs and Factors Influencing Service Uptake –, MENAHRA 2013) along with a thorough consultative process highlighted the main findings regarding the status and needs of FWID in the MENA region.

Heroin was found to be the most commonly-used drug by females in most MENA countries, except Tunisia where Buprenorphine was more prevalent. Most FWID were poly-drug users, using drugs such as cocaine, cannabis, and prescription drugs such as sedatives or pain killers separately or simultaneously with heroin.

The most used HR services among females in the MENA region were HIV testing services and this is followed by the use of needle distribution services.

Drug use is often initiated by men, encouraged by social networks, and motivated by problems related to poverty and breaking gender norms. *HR programs should use men as entry points to identify Female who uses drugs; they should also engage men in their harm reduction services and activities. These programs should also use social networks to reach out to FWUD.*

With respect to injecting drug use habits among FWIDs in the MENA region, drug use usually proceeds from oral drug use and smoking to injecting. *Thus, harm reduction programs need to target all Female who uses drugs and not only injectors.* Injecting is not socially acceptable for women who are faced with stigma and discrimination, and thus they hide this activity from men. *Harm reduction services should prioritize females and guarantee protection for confidentiality.*

Women inject alone, in groups in various settings including nightclubs, homes, and streets, and frequently with men. *Thus, various entry points need to be created for outreach to capture females in different settings.*

Sharing needles was highlighted as a common practice among FWID in the MENA region. Females have limited awareness of risks of sharing needles. *Thus, gender-specific HR services need to promote awareness on risks of sharing injecting equipments.* Sharing is mostly due to reluctance of pharmacist to sell needles, fear of being arrested by police and/or inadequate financial capacities. *Thus, gender-specific HR programs need to focus their efforts on advocacy and awareness-raising on the importance of provision of needles in the prevention of infectious diseases. Moreover, there is a need for advocacy and awareness on HR services among police and internal security forces.*

Additional social and gender-specific factors that encourage needle-sharing include the fact that sharing after a partner is considered a sign of love, trust and commitment. Women do not choose to share needles, and they often have limited freedom of movement. *Hence, raising awareness of risks associated with needle-sharing should target both males and females. There is a need to prioritize females in needle distribution.*

Among females in the MENA region, witnessing overdose is common. Overdose related mortality is one of the leading causes of death for people who use drugs worldwide. Factors inducing an overdose include mixing drugs, consuming a higher dose than usual, relapse after a period of abstinence and trying new drugs. Lack of knowledge about overdose management prevails. Seeking medical assistance for an overdose is not common mainly due to fear of being arrested. *Hence, there is a need to educate females to recognize signs of overdose and to involve non-drug users (when possible) such as parents, partners and friends in trainings on overdose management. Moreover, there is a need to establish a network of friendly healthcare services where females can seek help for overdose cases. There is also a need to train health care workers, especially ER workers on overdose management and patient confidentiality. Advocacy on hospital-base policies for proper overdose management and patient confidentiality is fundamental.*

FWID in the MENA region experience a wide variety of health needs and challenges that can be summarized as follows:

Sexual & Reproductive Health: Unwanted pregnancies and unsafe abortions are the main reproductive health problems that women drug users face. This is in addition to menstrual irregularities, pregnancy complications (miscarriage and stillbirth) and general loss of sexual desire. Condom non-use, sexually transmitted infection acquisition, contraceptive misuse, and non-consensual sex are common among Female who uses drugs. *Hence, HR programs and services should include family planning as well as sexual and reproductive health services, including distribution of condoms and contraceptives, accurate and comprehensive sexual health education including education on HIV prevention, follow up services for pregnant women and awareness-raising on the harms of unsafe abortion.*

Physical Health: Feelings of fatigue and physical weakness, lack of appetite (particularly due to heroin use) are common among FWID. Self-care behaviors are generally lacking among FWID in the MENA region. Females who use drugs practice unhealthy coping behaviors (including excessive use of sleeping pills and/or psychotropic medications) to deal with the pains associated with withdrawal. Infectious diseases including STI's and viral Hepatitis and HIV are common. Severe vein damage is also common. *Thus, FWID's targeted services should educate females on safe injection skills, provide STI and HIV specific services and support females in managing withdrawal symptoms. Moreover, self-care strategies and behaviors as well as the importance of self-care should be highlighted within services.*

Psychological Health: Depression is common among FWID, followed by anxiety, stress, and sleeping disorders. Feelings of worthlessness, sadness, hopelessness, isolation, self-blame, and internal stigma/self-stigma are prevalent and are associated with suicidal thoughts and suicidal attempts. *Psychological support and psychiatric care and counseling should be integrated into HR services. Activities aiming at improving FWID's sense of self-esteem and confidence should be integrated into HR services.*

Unsafe Sexual Practices: A growing body of evidence has shown the intimate relationship between sexual and injection-related HIV risk among IDUs. Most IDUs are sexually active and many engage in a range of sexual behaviors that increase their risk of HIV.

A number of factors make it difficult for females to insist that their partners use condoms. Some women engage in unsafe sexual practices, such as having multiple partners or engaging in unprotected and/or forced sex. Gender-related factors undermine condom use among women and increase their risk of infection. These factors include sexual and domestic abuse, fear of abandonment, cultural expectations about male desire and female acquiescence, and poverty. *HR services targeting FWID should aim at improving knowledge on safe sexual practices and risks associated with unsafe sexual practices. They should also include (when possible) couple counseling and education on assertiveness and negotiation skills.*

Socio-Cultural Vulnerabilities

Violence - Besides gender based violence (GBV), all forms of violence (physical, sexual, emotional, verbal, economical, and sometimes legal) against females who inject drugs are common in the MENA region. Violence deeply affects FWID's lives and their health. It is usually practiced by intimate partners, male drug users, and drug dealers as well family, police and the community. The perceived lack of legal protection, fear of being arrested, and the sense of self-stigma and self-worthlessness usually prevents women from reporting violence experiences to authorities. Hence, HR programs should train, advocate and work on raising awareness on gender equality. Counseling for female survivors of violence should be integrated into HR services. Programs should engage families (when possible) and partners in activities aiming at ending violence against FWID. Cooperation with women- and human rights- organizations to address violence against women and to contribute in developing policies and legislations against violence towards FWIDs should be considered.

15 Kelly JF, Westerhoff, CM. Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*. 2010; 21(3): 202–207.

16 UNODC, UNAIDS. Women and HIV in prison settings (2008). Available at www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf

Lakobishvili E. Cause for alarm: The incarceration of women for drug offences in Europe and Central Asia, and the need for legislative and sentencing reform (International Harm Reduction Association, 2012). Available at www.ihra.net/contents/1188

17 UNODC, UNAIDS. Women and HIV in prison settings (2008). Available at www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf

Financial challenges - The socio-cultural context creates burdens for females to finance drugs. Most FWID lose their financial resources due to their drug use. This increases their social instability and makes them more vulnerable to abuse, exploitation, and sometimes forces them to “commercial sex” or “survival sex” or sex work which is perceived as humiliating by FWID in the MENA region. HR programs need to consider income-generating activities for drug users and should prioritize women in such activities. These programs need to pay attention to transportation costs and other expenses that might hinder access to their services.

Stigma- The World Health Organization states that illicit drug dependence is the most stigmatized health condition in the world¹⁵. The experience of stigma can have wide ranging impacts on an individual’s health and general quality of life. This includes limiting economic and social participation and willingness to access treatment or support for other health and social concerns, such as physical health problems, mental health problems, and homelessness

Females who inject drugs face intense social stigma and internal stigma. Stigma against females who uses drugs is driven by social judgments, intersecting stigmas regarding sex work and gender, and a lack of trust and usually leads to stereotyping and labeling. Moreover, drug users stigmatize themselves, sometimes feeling they are “bad people” who “do not deserve services or respect.” Stigma and discrimination were reported frequently and manifested in various ways, such as distancing, rejection, humiliation, and denial of rights.

Incarceration - An increasing number of women are being incarcerated for drug-related offences worldwide. Drug offences are one of the primary reasons why women enter the prison system¹⁶. Available evidence has shown how the incarceration of women for low-level dealing can be damaging not only to women themselves but also to their children and families. Alternatives to incarceration in the case of non-violent crimes can alleviate the burden on the justice and penal systems and avoid these preventable negative consequences. Strict laws that criminalize all forms of drug use usually contributes to creating a culture of intolerance and fear, incarceration at the expense of supportive services, contributes to increased internal and social stigma, increase in infectious diseases, and sometimes, an interruption in treatment.

Women in prison often experience harms and discrimination; they are more likely to share syringes unsafely, to experience higher rates of HIV and viral hepatitis, to be exposed to sexual violence advanced by the prison guards, and to lose custody of their children. (See UNODC¹⁷ Technical guide that details a prison specific comprehensive package of 15 specific interventions required to respond to HIV in closed settings along with recommendations concerning gender responsiveness and broader prison and criminal justice reforms).

HR programs should include free legal aid for women who inject drugs, including women who inject drugs and female sexual partners of people who inject drugs to enable access to legal remedies in case of violence, abuse, exploitation, unjust imprisonment, or losing custody over their children.

Rights violations - The types of rights violations women experience include deprivation from children, denial of family inheritance, home evictions, and the denial of the right to work and schooling. *HR programs and services should include advocacy activities that aim at protecting and advocating for the rights of FWID.*

Around the world, criminalization of drug use and possession “creates more harm than the harms it seeks to prevent.” Repressive drug laws and policies disproportionately punish people who use drugs compared to those who sell or produce drugs. They also perpetuate stigma, risky forms of drug use, and negative health and social consequence—not only for those who use drugs, but the wider community as well.

The criminalization of drug use is incompatible with human rights and health rights. Advocacy must continue to press for decriminalization and/or de-penalization of drug use, for the availability of scientifically evidence drug treatments and harm reduction interventions.

Changes in social relations - Drug use usually results in social seclusion, marginalization, loneliness and rejection by family, distancing from children, marital and relationship problems and lost friendships. *Hence, HR programs should include activities that rebuild and promote a supportive social network for FWID.*

Factors influencing Uptake & Access to HR Services

Access to care is limited among FWID in the MENA region as is the case in all countries around the world. Childcare responsibilities and fear of the loss of child custody can pose formidable barriers to drug harm reduction services. Opposition from male partners and social stigma can also make females less likely to visit service sites.

There are multiple factors that influence Female who uses drugs’ access to and uptake of services at the individual, interpersonal, service, government and policies, and socio-cultural levels.

Main barriers:

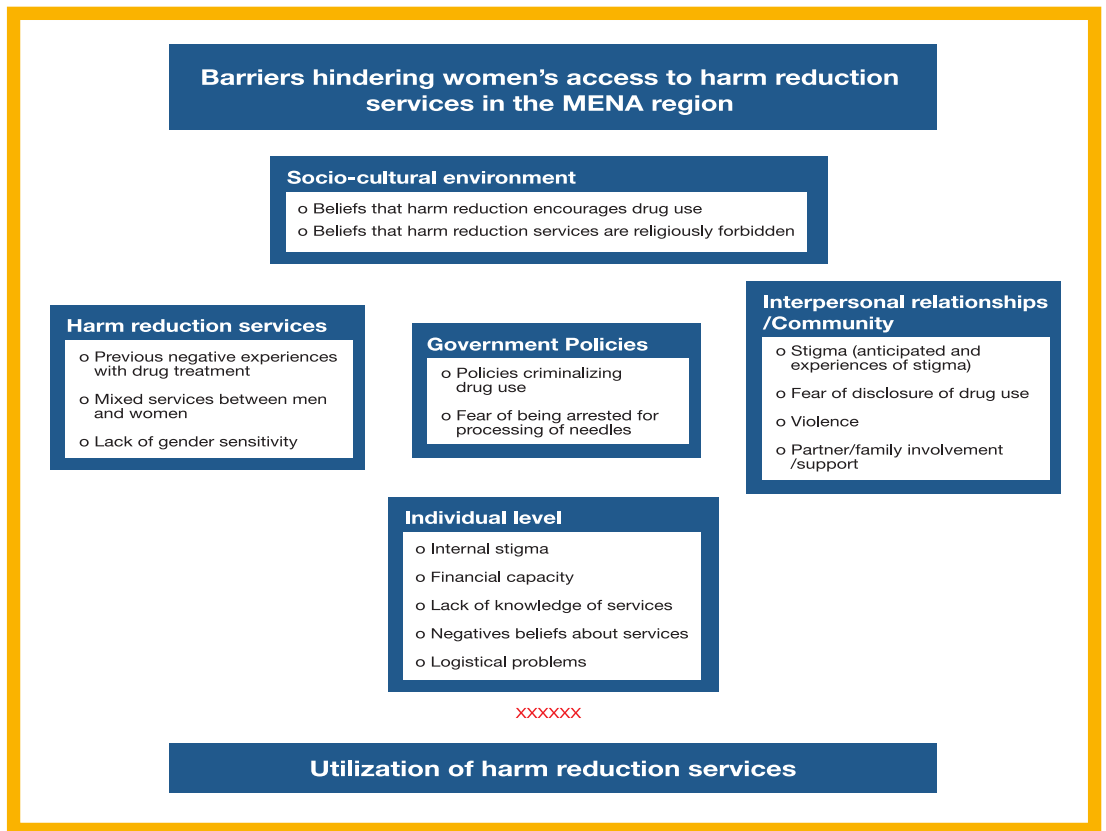
At the individual level, self-stigma, sense of worthlessness, poor motivation for self-care, and fear of being arrested and having their children forcibly removed by the state combined with financial constraints limit FWID’s access to and use of existing services.

At the interpersonal level, absence or insufficiency of social support, social stigma and sometimes violence are the main barriers to access existing services.

At the level of services, absence of gender-specific services that address the specific needs of females limit FWID’s access to and use of existing services.

At the government and policy levels, arbitrary arrests due to drug use or even carrying needles are the main barrier to accessing care. This is in addition to discriminatory laws and policies that prevent many FWID from accessing the benefits of harm reduction programs.

Among socio-cultural factors, negative attitudes towards HR services, the intense social stigma associated with FWUD; besides gender based restrictions, are among the main barriers to the uptake of and access to HR services.



An illustration of the main barriers that hinder FWUD from accessing HR services (Operational Research on the Context, Service Needs and Factors Influencing Service Uptake - Women Injecting Drug Users in the Middle East and North Africa Region (MENA))

Motivators:

At the individual level, poor health status and particularly frequent illnesses and general weakness combined with willingness to change under the influence of the poor health condition and awareness of health risks, besides pregnancy, motherhood and needs of children often motivate FWID to access and use existing services.

At the interpersonal level, supportive relationships (friends, partner and sometimes parents) and positive examples including new relationships and presence of persons who have gone through similar experiences and succeeded in behavioral change are usually the main facilitators to accessing care.

At the level of services, gender-sensitive services have the potential to encourage females to seek HR services. HIV and hepatitis testing, distribution of basic harm reduction kits including needles and condoms, availability of substitution therapy, psychological and social services facilitate FWID's access and uptake of services. Another important factor is the non-judgmental and supportive attitude of service providers, besides the convenience of time (service hours) and place (location of service center).



Gender-specific Harm Reduction Services: Strategies and approaches

Designing Harm Reduction Services that Address the Needs of Females Who Use Drugs

The challenges, risks, and harms faced by females who use drugs (FWUD) and specifically females who inject drugs (FWID) in the MENA region accentuate the value and need for harm reduction services that reach out to this vulnerable group and address the specific needs of females. Gender-specific harm reduction services are essential for improved access of vulnerable FWID to life saving services and would increase the uptake and improve the outcomes of these interventions.

To be effective, the services provided and their resources must be tailored towards the needs of people and their specificities. These services should provide more accessible, comprehensive and effective care for females by addressing their needs in a holistic way and respecting their human rights and freedom of choice.

The design and implementation of gender-specific HR services require a thorough understanding of the needs and vulnerabilities of FWID, understanding the factors influencing females' uptake of and access to existing health care services, in addition to paying much consideration to the prevailing socio-cultural context.

Gender mainstreaming into harm reduction programs and services requires interventions that are directed at 3 main aspects: 1) Direct service delivery 2) Creating an emotionally and physically safe environment and 3) Changing policies and procedures on how the services are delivered.

This section offers some guidance on gender-specific harm reduction services. It is not intended to be prescriptive. It recommends the flexible implementation according to the evolving nature of the social context, cultural values, socio-economic factors, existing needs, and different policies.

Harm reduction programs targeted towards female who uses drugs (FWUD) can benefit from the suggested interventions and activities that address the different needs of Female who uses drugs. In this section are strategies and approaches that are recommended within harm reduction services and programs:

Addressing health needs:

Females who use drugs usually experience a wide spectrum of health risks resulting from drug use or associated with its use. These require interventions that address physical, reproductive and sexual, as well as psychological wellbeing. Interventions within harm reduction programs should involve services on the different levels of promotion, prevention, and therapy/treatment.





Physical health:

- Sterile injecting equipment/ needle & syringe exchange (NSP)
- OST, Methadone Maintenance Therapy (MMT), other drug treatments
- Overdose prevention and management
 - ◇ Access to tools and kits in order to prevent and manage overdose, such as use of a range of treatment options for Opioid dependence. These treatments include psychosocial support, Opioid substitution and maintenance treatments such as Methadone and Buprenorphine, and treatment with Opioid antagonists such as Naltrexone.
 - ◇ Naloxone¹⁹ to be made available to people who are at risk of Opioid overdose or those likely to witness an Opioid overdose
 - ◇ Trainings to be organized in the management of Opioid overdose –
 - ◇ Monitoring trends in drug use and related harm, to better understand when Opioid dependence and Opioid overdose is occurring and ensure the optimal availability for medical purposes.
- Distribution of hygiene kits
- HIV, Hepatitis B&C, testing and treatment (HTC)
- Hepatitis B Vaccination
- TB prevention, diagnosis, and treatment
- STI prevention, rapid testing, and treatments
- Information Education and Communication (IEC) including:
 - ◇ Information, education and communication on the health risks associated with drug use, which will assist drug users to cease or modify their drug-taking behaviour.
 - ◇ Information, education and communication on safer injecting practices.
 - ◇ Information, education and communication on the safer use of non-injected drugs.
 - ◇ Information, education and communication on:
 - 1) HIV prevention, treatment and life with HIV.
 - 2) Hepatitis prevention, treatment and life with hepatitis.
 - ◇ Vaccination against hepatitis A and B
 - ◇ HIV & Hep B&C prevention education, information, and referral
 - ◇ Self-care strategies and behaviors
 - ◇ Principles of general health and well being
 - ◇ Information on poly drug use including legal and illegal drugs

¹⁹ Naloxone (also known as Narcan®) is a medication called an “opioid antagonist” used to counter the effects of opioid overdose, for example morphine and heroin overdose. Specifically, naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. Naloxone is a nonscheduled (i.e., non-addictive), prescription medication. Naloxone only works if a person has opioids in their system; the medication has no effect if opioids are absent. Although traditionally administered by emergency response personnel, naloxone can be administered by minimally trained laypeople, which makes it ideal for treating overdose in people who have been prescribed opioid pain medication and in people who use heroin and other opioids. Naloxone has no potential for abuse. Naloxone may be injected in the muscle, vein or under the skin or sprayed into the nose. Naloxone that is injected comes in a lower concentration (0.4mg/1mL) than Naloxone that is sprayed up the nose (2mg/2mL). It is a temporary drug that wears off in 20-90 minutes.



Sexual and reproductive health:

- Free condom distribution
- Contraceptive methods (other than condoms)
- Services for STIs and prevention of mother-to-child transmission (PMTCT)
- Diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynecological morbidities; promotion of sexual health, including sexuality counseling;
- Pre- & post-natal care
- Maternal and child support
- Couples counseling (aimed at ensuring that the responsibility for reducing HIV and health risks is equally shared between both partners)
- Follow up services for pregnant women and awareness raising on the harms of unsafe abortion
- Prevention of unsafe abortion and post-abortion care
- Specialized services during pregnancy (when specialized services for pregnant drug-using women are provided, women are motivated to seek care)
- Information, education and communication on sexual health and reproductive rights.
 - ◊ Safe sex skills and negotiation skills
 - ◊ Educational services, counseling and training for sex workers on safe sex and negotiation skills to promote the use of condoms
 - ◊ Parenting skills
 - ◊ Family planning awareness
- Advocacy for safe drug treatment options for pregnant women, women in maternity wards, and women with small children
- “Women’s packets” including shampoos, sanitary pads, condoms, pregnancy tests, vitamins, deodorant and lip balms as well as diapers and other supplies for mothers with infants
- Pediatric consultations
- Distribution of baby formula and diapers
- A network of “friendly doctors”(Referring clients to doctors who were informed about, sensitive to, and understanding of the realities of women who use drugs proves to be a key component)
- Counseling and case management (Programs also offer female clients tailored information and tools on how to prevent sexually transmitted diseases)
- Outreach and mobile STI/HIV testing and counseling for FWUD and sex workers



Emotional, psychological and mental health:

- Psychological support, counseling and management to address the psychological needs of FWUD
- Support group sessions and psychosocial activities aiming at reducing self-stigma, promoting sense of self-esteem and self-worth, assertiveness, and negotiation skills among FWUD
- Individual and group counseling sessions
- Specialized services for females survivors of sexual and physical abuse or rape
- Counseling on self-care
- Counseling on suicide prevention
- Couple and relationship counseling services
- Life skills training (including training on effective communication, negotiation and assertiveness skills, problem solving skills...)

Violence:

- Prevention and management of GBV
- Counseling for “survivors” of violence should be integrated into HR services
- Housing, support and shelter for survivors of violence directly or through referral to and links with women organizations
- Family counseling and reconciliation sessions
- Cooperation with women- and human rights-organizations to address violence against women and to contribute in developing policies and legislations against violence towards FWID
- Training, including:
- Gender equality training and community-based initiatives that address gender inequality and gender norms
- Training service providers on identification and detection of abuse and violence, including IPV
- Trainings that use principles of methods from adult education to target gender and sexual norms should be considered for prevention of IPV
- Violence prevention, including legal support and training on skills to avoid potentially violent situations

Financial difficulties:

- Provision of vocational training and support with income-generating activities that would support the females economically while also promoting their sense of autonomy and self-worth
- Providing transportation costs to harm reduction programs
- Free-of-charge medical care (medical tests, medical consultation fees, and medications.



Financial difficulties:

- Provision of vocational training and support with income-generating activities that would support the females economically while also promoting their sense of autonomy and self-worth
- Providing transportation costs to harm reduction programs
- Free-of-charge medical care (medical tests, medical consultation fees, and medications)

Referral mechanisms between harm reduction services and other supportive services need to be established and strengthened in order to better tailor, support and meet the needs of FWUD.

Legal aid:

- Free legal aid for female who use drugs, including females who inject drugs and female sexual partners of people who inject drugs – that enables access to legal remedies in case of violence, abuse, exploitation, unjust imprisonment or losing custody over their children.
- Legal counseling and trainings on “know your right” for women.
- Advocacy activities that aim at protecting and advocating for the rights of FWID
- Advocacy for the decriminalization and/or de-penalization of drug use, for the availability of scientifically evidence drug treatments and harm reduction interventions (An example of an advocacy campaign is: Campaigns – Support! Don’t Punish. For more information on the campaign guidelines and calls:
http://www.menahra.org/images/pdf/2015_Guide_for_the_Global_Day_of_Action_-_en.pdf)
- Engaging civil society organizations at country and regional levels – taking advantage of international human rights mechanisms (including women’s rights instruments) to advocate for human rights and gender sensitive approaches to drugs and criminal justice policies
- Police custody and prison can be good entry points for HR services.
- Training of police and law enforcement on human rights and harm reduction.
- HR services should include right based approaches that would create awareness of human rights among women, families and police and enhance law enforcement





Incarceration:

- Prison systems should provide access to the comprehensive package of harm reduction interventions and health services. UNODC²⁰ details a prison specific comprehensive package of 15 specific interventions required to respond to HIV in closed settings (along with recommendations concerning gender responsiveness and broader prison and criminal justice reforms). These include:
 - ◇ Developing gender-sensitive legislative frameworks, penal policies, and prison rules
 - ◇ Regular capacity-building programs of prison staff to build knowledge on HIV prevention.
 - ◇ Research conducted on HIV in prisons; HIV risks for women in prison and responses provided should be monitored and evaluated on a regular basis.
 - ◇ Health authorities in prison should encourage and support the development of peer-based education initiatives and educational materials designed and delivered by prisoners themselves. Prison authorities should also encourage the development and support of self-help and peer-support groups that raise the issues of HIV and AIDS from the perspective of the women themselves.
- Ensure that governments adhere to the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (The Bangkok Rules)
- Advocating for changes in the legal system –working toward revision of Criminal Codes and decriminalization of drug use and thereby treating drug use as a health issue, not as a crime. Criminalization of people who use drugs contributes to the stigmatization, exacerbated discrimination against and increases social exclusion of drug users. Mandatory minimum sentencing for trafficking often fails to distinguish between quantities carried, and even lower-end sentences can be very harsh.
- Facilitating partnerships between police and national security agencies and HIV prevention initiatives for FWUD and FWID to reach agreement on mutually acceptable harm reduction strategies is critical for creating environments conducive to risk reduction- which should also be offered to men, Men who have Sex with Men(MSM), Transgender (TG), and boys and girls who use drugs.

²⁰ UNODC, UNAIDS. Women and HIV in prison settings (2008). Available at www.unodc.org/documents/hiv-aids/Women_in_prisons.pdf



Increasing awareness and fighting stigma and discrimination

This includes educational strategies that involve provision of accurate information about the consequences and risks of drug use and information on available services in each specific area. It also includes activities to reduce stigma and discrimination against people who use drugs, and specifically females who uses drugs, and raise public awareness and understanding of harm reduction principles, policies and programs among professionals in the health, social and criminal justice systems, officials in all levels of government, and the general public.

- Training and education to all staff (from management level to direct service providers and all those working with drug users) to adopt empathetic, non-judgmental and supportive attitudes towards drug users. This also involves sensitizing them on the negative effects of stigma (see Annex A – Tool for Self Evaluation of Service Provider Attitude towards Drug Users)
- Outlets for feedback on the service and the policies
- Community level awareness campaigns
- Community events as a tool for unifying allies while engaging drug users
- Collaboration with religious leaders who have a key role to play in all dimensions of HR and in changing the public view and reducing stigma against drug users.
- Religious Leaders' Guide by MENAHRA (2014) for communicating with people who use drugs and their surrounding communities.
- **The International Overdose Awareness Day** – August 31 to raise awareness on drug overdose and reduce stigma related to overdose
- **World AIDS Day** – December 1 is an opportunity to remind the world that the Human Immunodeficiency Virus (HIV) remains one of the most transmitted viruses at the global level and in the Middle East and North Africa region.
 - ◊ On this occasion, MENAHRA calls to increase efforts to stop the spread of HIV and its impact on the society by providing universal access to treatment without exception, in addition to promoting behavior change to decrease risk of contraction and increasing access to prevention materials.
- **June 26th is the International Day against Drug Abuse and Illicit Trafficking. Campaigns – Support! Don't Punish.** This campaign aims at raising awareness regarding the risks resulting from the criminalization of people who use drugs, the need to reduce these risks, and the need to promote other harm reduction services that respect the human rights of people who use drugs.





Harm Reduction Interventions in Egypt

Harm reduction interventions targeting PWUD were established in Egypt in 2008; they were funded by international organizations and implemented by NGOs with active linkages to high risk groups including PWID, MSM and Female Sex Workers (FSW). The delivered services encompass outreaching PWID by the former ones working as outreach staff, briefing them on the services delivered at the intervention sites and escorting or referring them to the service delivery sites. Harm reduction intervention model implemented in Egypt include the following services which are offered anonymously and free of charge: peer education on safe sex and safe injection, HIV voluntary counseling and testing using rapid test kits for fast delivery of results, and medical services for those in need with special focus on management of sexually transmitted infections. In addition, the services include distribution of behavior change communication booklets and brochures, needles and condoms also provided free of charge. Methadone is not distributed through current harm reduction interventions implemented in Egypt and neither HCV diagnosis nor management is provided through current interventions

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Reference: Harm Reduct J. 2013; 10: 17. Harm reduction approach in Egypt: the insight of injecting drug users

Female-Specific Services in Egypt

Among the services provided by the Egyptian NGO: Friends

- ◇ Engaging a team of outreach workers consisting of females
- ◇ Referral services to mother and child care centers for child and mother health
- ◇ Psychological counseling for FWUD and sex workers and referral to a network of friendly doctors
- ◇ Distribution of sterile injection equipment
- ◇ Information on safe injection
- ◇ Overdose prevention education and overdose management
- ◇ Legal aid and support to females who are newly out of prisons with the financial support of the training unit at the Organization of Freedom from Addiction & AIDS
- ◇ Free vocational training for FWUD (hair & makeup, embroidery)



Female-Specific Services in Pakistan

The Organization for Social Development (OSD) based in Rawalpindi, Pakistan provides services that include HIV/AIDS prevention, treatment and care for females who use and inject drugs and partners of HIV-infected FWUDs in Rawalpindi and its surroundings. Outreach workers are recruited from the same community of female drug users. Outreach workers are provided with information, education & communication (IEC) material for distribution to increase awareness on harm reduction. The activities implemented within the service include:

- ◇ VCT services
- ◇ Basic health care
- ◇ STI diagnosis and syndrome management
- ◇ Hepatitis-B vaccination
- ◇ Detoxification.
- ◇ Peer education training
- ◇ Hygiene Kits (shampoo, anti-lice lotion, surf, sanitary napkins, condoms etc.)
- ◇ Distribution of condoms and sterile syringes
- ◇ Vocational training services
- ◇ Female doctors, gynecologists and psychologists providing needed sexual, reproductive and psychological health services
- ◇ LAB test including VCT, HEP-B & C, STIs, Blood CP, Lungs X-Ray, Urine Test, Ultra Sound, and Sputum.
- ◇ Day care centers for children of FWUDs are available inside prisons
- ◇ Relevant IEC material developed by different organizations are distributed at the centers
- ◇ Medical support, individual counseling, family counseling and psycho-social support available in the centers
- ◇ Referral to vocational training centers (stitching, embroidery, flowers decoration, candle making, computer classes, cooking classes)

To improve access to the centers, transportation is made available for bringing clients to the centers.

Memorandums of understanding are signed with different detoxification centers, vocational training centers, testing labs, government hospitals, HIV Special Clinic and referral mechanisms to those service provider agencies were established.



Among the services provided by the Egyptian NGO: Friends of People Living with HIV/ Egypt

Women-focused Outreach

This approach:

- ◇ Work to change men's attitude towards women, particularly to FWID and supports the resolution of gender-related problems with men's cooperation.
- ◇ The women-focused outreach to male and female who inject drugs is crucial because woman's decisions, are often heavily influenced by the choices and attitudes of the men around her
- ◇ Work with MWID serves two purposes:
 - a) Recruiting more females into harm reduction program.
 - b) Providing MWID with more information on the new approach of work and reasons to do, so that the program will become more popular among beneficiaries of both sexes. This helps to normalize women's attendance of harm reduction services

Services:

- ◇ FWID with drug- using experience as outreach workers
- ◇ Opportunities for people who inject drugs to bring their partners
- ◇ Outreach in the street
- ◇ Dissemination of information about the available services for women
- ◇ Distribution of information material
- ◇ Outreach and mobile STI/HIV testing and counseling
- ◇ Distribution of clean syringes and male condoms
- ◇ Distribution of "women packages" with sanitary napkins, skin cream, and pregnancy tests
- ◇ Counseling and training to develop safer sex skills
- ◇ Distribution of condoms
- ◇ Proper counseling and support for women diagnosed with HIV while pregnant
- ◇ Violence prevention, including legal support and training on skills to avoid potentially violent situations
- ◇ Parenting skills (how to avoid losing the custody of your child, how to talk to your child about drugs)
- ◇ Training lawyers and social workers who are willing to provide services and be engaged in the program and its activities
- ◇ Training doctors who are willing to provide services to FWID's
- ◇ regular seminars with the specialists most needed by FWID (gynecologists, lawyers, etc.) to improve
- ◇ Communication between clients and specialists, increasing the service utilization
- ◇ training and campaigns on defending women's rights and rights of women who use drugs
- ◇ Referrals for testing for HIV, hepatitis B and C, STIs, when not provided on-site
- ◇ Follow-up system
- ◇ Service providers' in-depth training on gender



Female-Specific Drop-in Center in Iran

A female-specific drop-in center, supervised by Sari Health Center, was founded in Mazandaran Province, Sari, Iran, in 2005 with the authorization of the Ministry of Health and Medical Education. Its goal was to control HIV/AIDS and STIs among FSWs and other vulnerable and substance dependent women. It enhances the safety and security of vulnerable women and provides support, training, and health services for female injecting drug users and FSWs. At present, there are Drop in Centers (DICs) in 15 provinces of Iran. About 190 vulnerable women visit the female-specific DIC in Sari, Iran, to receive education as well as doctor and midwifery examinations every month. This center is supervised by Sari Health Center.

Hepatitis B Virus test and rapid HIV test are performed on all women on their first visit and free condoms are provided for them. The DIC in Sari conducts advocacy workshops for clients on HIV, condom use, and negotiation skills for condom use for women, sexual health, healthy drug injection, and STIs on a regular basis. A Pap Smear Test and vaginal examination for the diagnosis of cervicitis are performed at least once a year. Warm meals are distributed once a week in the center. Currently, 19 substance dependents are being treated with Methadone while a training-workshop on tailoring is being held to financially support the clients. A number of these cases were referred to support organizations.

Reference: Drug Use and High-Risk Sexual Behaviors of Women at a Drop-In Center in Mazandaran Province, Iran, 2014


<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4539583/pdf/ijpbs-09-1047.pdf>

Reference: Dolan, K., Salimi, S., Nassirimanesh, B., Mohsenifar, S. & Mokri, A. (2011), 'The Establishment of a methadone clinic for women in Tehran', *Journal of Public Health Policy*, 32(2): 219-230







Guiding Principles for Gender-Specific Harm Reduction Programs & Services

The ways in which programs are designed and implemented play an important role in their success. The key principles presented here emphasize both core values and sound program design and implementation considerations.


-  **Including clients in program development and implementation:** FWUD are best able to provide insight into how programs should be designed to meet their needs. Organizations should involve them in both situation assessments and service delivery as volunteers, outreach workers, peer educators, and program leaders and advocates. Programs should adopt a participatory approach that involves civil society and drug users in drug policy-making and in design, implementation, and monitoring & evaluation of harm reduction services.


Competent outreach workers can help bring prevention services to the hard-to-reach people who inject drugs (who can serve as a safe entry point to FSWs and MSM who inject drugs) and help establish trust between them and other health and social services. Outreach workers who were former people who inject drugs help clients feel cared for, instead of fearful or threatened. Participants of FGDs valued outreach workers and described them as "...they could understand ...do not speak in a judgmental manner and draw from their experiences to help us modify unsafe behaviors ²¹".


-  **Guaranteeing personal safety and confidentiality:** Gender-sensitive harm reduction programs should place particular emphasis on guaranteeing personal safety and confidentiality in order to gain the trust of female clients. Increasing outreach efforts and utilizing peer or volunteer networks help establish that trust. This is particularly true in attracting new female clients. The location, outreach and timing of program activities and services must be planned in ways to minimize risk of further violence and stigma.
-  **Do no harm:** Interventions can result in a backlash against women from their partners, families, and from the surrounding community. It is important to be aware of this and to include strategies to monitor unintended consequences, promote women's safety, and mitigate such backlash.
-  **Investing in staff education:** It is vital to allocate resources and time to ongoing staff training and education. This ensures that the most vulnerable women are not turned away because staff feels unprepared to deal with complicated and troubling cases.
-  **Staff burnout prevention:** Interventions are also needed due to the stressful nature of work in harm reduction and drug treatment. HR programs should pay attention to staff care activities that aim at promoting the wellbeing of staff and alleviating their stress.


²¹ Harm Reduct J. 2013; 10: 17. Harm reduction approach in Egypt: the insight of injecting drug users.




-  **Data and information on gender-specific harm reduction:** Programs should contribute to strengthening information systems on drug production, distribution and use and prioritize the collection of data disaggregated by sex. Moreover, documenting experiences is fundamental to improving gender-specific HR services. Recording what works well for girls and women — as well as policies and practices that discriminate against or exclude FWUD — is essential for successful advocacy. Key partners, including government agencies and other service providers, can only be engaged if best practices or existing gaps are communicated to them.

-  **Secondary exchange through peers:** Many women fear exposing themselves as drug users because this can only lead to stigmatizing and discriminatory treatment. Most harm reduction programs working with women allow clients to pick up syringes, condoms, and hygienic kits and then distribute them among friends who use drugs. After receiving these supplies indirectly, women develop a more trusting attitude toward the programs.

-  **Human rights approach:** HR programs must be driven by a human rights approach and strive to promote gender equality. They should recognize that violence against girls and/ or women violates the fundamental principle of equality between women and men that is enshrined in international and regional human rights laws and instruments (e.g. Convention on the Elimination of All Forms of Discrimination against Women, or CEDAW). It involves challenging unjust or unequal distribution of power between men and women that underlies violence against women and HIV risk and actively promoting an equitable balance of power between women and men. Adopting a human rights approach also means that program staff are duty-bearers, and thus, are responsible for promoting and upholding human rights. This includes for example, upholding, respecting, and supporting a woman's right to make her own decisions in relation to the violence she experiences (e.g. choosing not to leave or report an abusive relationship to authorities). It means giving women information and options they can use to make informed choices and decisions about their lives, including reproductive decisions. It also means promoting the rights of sex workers to not be subjected to violence.

-  **Community mobilization to end violence against women and girls:** GBV prevention depends on changing community norms pertaining to gender equality and the acceptability of violence against women; thus, interventions targeted at individuals are not enough. Community mobilization programs can change violence-related attitudes and behaviors and promote more equitable relationships between men and women. GBV prevention requires that society hold perpetrators accountable rather than blame the victim. Ensuring gender-specific harm reduction programs often requires cooperating with women organizations and mobilizing coalitions and referral networks of service providers in the community to work together. Changing norms is essential for helping survivors get help from families and community services.



 **Advocacy work:** Harm reduction programs should strive towards ensuring supportive legal and policy environment. Advocacy work aims at influencing decision making to develop, establish, or change policies. It helps establish programs and services and to sustain them. This involves raising awareness, promoting knowledge, documenting good practices, and monitoring & evaluating HR programs in order to challenge the different forms of opposition towards HR services and to protect the rights of drug users and people living with HIV/AIDS.

Advocacy work includes: activities to ensure high-level political and professional support for harm reduction and policy reform; reform of laws, policies and practices related to injecting drug use and HIV, ensuring they do not impede service delivery and/or violate human rights; legal aid and “know-your-rights” training for people who use drugs, ideally integrated into curative and preventive service delivery sites; social mobilization and campaigns for people who use drugs to better understand the law and their rights; interventions addressing the double stigma and discrimination related to HIV and drug use; training and/or sensitization for police, judges and prison staff in evidence and human rights-based approaches to drug use and HIV; and support to ensure that basic needs and underlying psychosocial vulnerabilities are addressed.

 **Monitoring & Evaluation of gender-specific harm reduction services:**

Monitoring and Evaluation (M&E) usually inform decision making about sustaining, improving or even discontinuing a program. M&E efforts on harm reduction usually contribute to the knowledge base on program- and service-effectiveness. Integrating gender equality into harm reduction programs usually involves a process of 3 steps:

- (1) Identification of the gender-related obstacles to and opportunities for achieving a particular program objective in a particular setting;
- (2) Designing and implementing activities aimed at reducing those gender-related obstacles.
- (3) Adding indicators to M&E plans to measure the success of the activities designed to lower gender-related obstacles.

Gender-related indicators in the context of gender-specific harm reduction programs and services are process indicators; they measure success in reducing gender-related obstacles to access and uptake of HR services. Gender-related indicators are additions to, not replacements for, indicators that assess changes in health status.

(Check Annex B – Gender sensitivity indicators)

Simply, gender-specific harm reduction services can monitor, evaluate and report on the outcomes of their interventions. This helps them to identify strengths and weaknesses within the service, and thereby, highlights areas which require improvement. On the other hand, this exercise helps them to compile data that can assist in advocacy for gender-specific interventions.



Challenges

Programs targeting Females who use drugs might be faced with a number of challenges that can influence the effectiveness and efficiency of interventions. The most common challenges faced by harm reduction programs in the MENA region were discussed during the regional workshop on Integrating Gender-specific Services in Harm Reduction (Beirut, Sep-2015). In this section, we highlight some challenges and some possible interventions to reduce the impact of those challenges and deal with them effectively:

Challenges	Possible interventions
<p>Challenges related to the surrounding environment:</p> <ul style="list-style-type: none"> • Poor understanding by the surrounding environment of harm reduction strategies and services; hence, field workers might be faced with problems (including poor cooperation and/or negative attitudes) during their field work • Stigma and negative attitudes by the community towards FWUD and specifically sex workers • Cultural norms and practices that reinforce gender inequality 	<p>Community barriers will always exist. Health care providers should take every opportunity possible to explain in clear culturally relevant terms the goals of their harm reduction strategies.</p> <p>Given the distrust that exists in various communities around drug related harm reduction initiatives, building community relations is an indispensable part of harm reduction programs.</p> <p>Some possible interventions that might be implemented:</p> <ul style="list-style-type: none"> ◇ Interventions that increase awareness on harm reduction philosophy, strategy and interventions and the value of HR ◇ Advocacy and educational campaigns on different related occasions ◇ Building supportive relationships with the community and the different institutions and key persons ◇ Working with religious leaders (MENAHRRA Religious Leaders Guide), key persons and the media to help promote positive attitudes towards drug users ◇ Gender equality training and community-based initiatives that address gender inequality and gender norms
<p>Challenges related to policies, legislations and police:</p> <ul style="list-style-type: none"> • Policies and procedures • Police Interference in field activities 	<p>Harm reduction programs should strive towards ensuring supportive legal and policy environment.</p> <ul style="list-style-type: none"> ◇ Activities to ensure high-level political and professional support for harm reduction and policy reform ◇ Reform of laws, policies and practices related to injecting drug use and HIV ◇ Ensuring that police men do not impede service delivery and/or violate human rights ◇ Training and/or sensitization for police, judges and prison staff in evidence and human rights-based approaches to drug use and HIV





Challenges	Possible interventions
<p>Challenges related to access:</p> <ul style="list-style-type: none">• Difficulty in reaching females who uses drugs	<p>Competent female outreach workers can help as safe entry points by bringing HR services to the hard-to-reach FWID and help establish trust between them and other health and social services. Outreach workers who were former PWUDs help clients feel cared for.</p> <ul style="list-style-type: none">◇ Recruiting females as outreach workers◇ Secondary exchange through peers◇ Engaging male partners of FWID in harm reduction interventions
<p>Challenges related to harm reduction services:</p> <ul style="list-style-type: none">• Attitudes of harm reduction workers• Some programs, in their improper implementation of gender-sensitive services, contribute to reinforcing potentially damaging stereotypes, – for example, that women are the weaker sex and are in need of protection• Poor knowledge on gender among harm reduction programs• Difficulty talking about sex and safe sex practices in some communities• Gender-sensitive programs require funding	<p>To put harm reduction into practice, it is important to convey acceptance and support individuals to become the experts in their own lives. The service provider, regardless of their beliefs, should not show disapproval of active drug use as it can destroy the therapeutic relationship and the individual's sense of self-worth.</p> <p>Talking about sex is often difficult, it is important for workers to find ways to discuss safer sex practices more openly with individuals. It is helpful to speak with individuals using terms they will understand and acknowledge that they may find the discussion difficult. When talking about sex it is essential to consider the individuals experience, understanding and beliefs about sex.</p> <ul style="list-style-type: none">◇ Training (and on-going supervision and technical support) of harm reduction workers on gender and cultural effects on gender socialization◇ Training (and on-going supervision and technical support) of harm reduction workers on effective communication skills and empathy◇ Establishing a code of conduct for working with FWID within all HR programs and training workers on the code of conduct and procedures to be followed in case of breaching the code of conduct policies◇ Training HR workers on ways of ending stigma and discrimination◇ Monitoring of proper implementation of gender-specific harm reduction services◇ Networking and Advocating for funding of female-specific services within gender-specific harm reduction services



Challenges	Possible interventions
<p>Challenges related to other service providers and existing opportunities:</p> <ul style="list-style-type: none">• When referral, stigma and negative attitudes towards FWID in other service providing organizations• Inability of harm reduction services to find proper work opportunities for FWUD• Some employers refuse recruiting FWID	<ul style="list-style-type: none">◇ Implementing trainings and regular capacity building for service providers on gender-specific harm reduction◇ Supporting other service provider institutions to establish a code of conduct for working with beneficiaries◇ Advocacy and educational campaigns on different related occasions◇ Building relationships with the community and the different institutions and key persons



Annex A

Tool for Self-Evaluation of Service Provider Attitude towards people who use drugs

This is a simple anonymous tool that helps those who work with drug users to reflect on their attitudes towards drug use and people who use drugs.

This is a self-evaluation tool. There is no right or wrong answer.

Statement	Strongly agree	Agree	Disagree	Strongly disagree
1. Sometimes, I am faced with prejudiced feelings and thoughts towards people who use drugs that I cannot prevent				
2. I am faced with prejudiced feelings and thoughts towards females who use drugs that I cannot prevent				
3. I know how to avoid language and terms that stigmatize people who use drugs				
4. I sometimes tend to judge people who cannot stop using drugs				
5. If a woman is pregnant, she has a responsibility to stop using drugs				
6. People who use drugs can have very meaningful input in developing policies and programs at my organization				
7. Engaging former drug users as outreach workers is very helpful				
8. I find it hard to work with sex workers among females who use drugs				
9. People who use drugs cannot take care of children				
10. I feel I can easily treat females who use drugs (FWUD) as capable and intelligent persons				





Annex B

Gender Sensitivity Indicators

- 1) Is the service provided to females who use drugs (FWUD) in a separate space (a women-only space) or at a location where a woman feels comfortable?
- 2) Is the service easily accessible by females (given the transportation costs and the gender-related restrictions on movement)?
- 3) Is the service delivered in a context or environment that is physically safe for females who use drugs (FWUD)?
- 4) Is the service provided to females who use drugs (FWUD) at a separate time (a women-only time) or at times convenient for women?
- 5) Is the service delivered in a context or environment that is emotionally safe for girls & women?
- 6) Did the staff receive specific training in this service?
- 7) Did the staff receive training in gender & gender equality?
- 8) Are the service providers aware of the needs and vulnerabilities of females who use drugs (FWUD) in the specific context?
- 9) Do the service providers treat FWUD participants as intelligent & capable persons?
- 10) Does the service take into account women's roles, socialization, and/or relative status within the larger culture and/or within the PWID culture?
- 11) Does the service minimize the risk of HIV-infection among females who inject drugs (e.g. selling sex for money/drugs/other, being unable to inject on one's own, having no control over the situation while using drugs, domestic or intimate partner violence)?
- 12) Is the service based upon baseline assessment of needs? (Based upon evidence for its need & relevance such as epidemiological data, focus group sessions, scientific literature, need assessment reports...)?

This tool was adapted & contextualized from Developing Gender-Sensitive Approaches to HIV Prevention among Female Injecting Drug Users– International HIV/AIDS Alliance, 2011



Annex C

Ethical code

1. The staff will treat clients in a human and kind manner, regardless of their sex, gender, ethnicity, religion, age or sexual orientation.
2. The staff will adopt an attitude of respect, non-judgment and avoid any stigmatizing terms.
3. The staff should emphasize the drug user's ability to care for herself or himself
4. The staff will never intentionally harm clients, whether physically or mentally, neither will attack them literally or by mockery.
5. The staff will never treat clients in a biased manner or expose them to the risk of being treated in such manner by other staff members.
6. The staff should treat clients with courtesy and motivate (without pressuring) them to change their lives for their own good or advantage only, assisting them in their recovery.
7. The staff members should observe confidentiality; they should not divulge private information of present or former clients and their family members to anybody, save the relevant staff members.
8. The staff members should have no sex with clients, neither have any financial nor other relations that can be interpreted as exploitation of clients for the benefit of the staff.
9. The staff members should not use their authority over clients for their private interests.
10. The staff members are not allowed to drink alcohol or take other substances that alter consciousness.
11. The staff members should take care of their colleagues.
12. The staff members should engage in regular training and capacity building, and should develop their professional qualifications.
13. The staff members should never use client-related information except for research, service monitoring and improvement & with the informed consent of the client.



Annex D

Ideas and Suggestions for Implementing Gender-specific Harm Reduction Programs and Services

The proper design and implementation of gender-specific harm reduction services require a thorough understanding of the needs and vulnerabilities of FWID, understanding the factors influencing females' uptake of and access to existing health care services, in addition to paying much consideration to the prevailing socio-cultural context and its impacts on FWID.

While planning and designing gender-specific HR services, we need to remember that the needs of women who use drugs go far beyond their health. It is often concerns about housing, legal affairs, stigma, child custody, and/or domestic violence that drive their decision-making.

Gender mainstreaming into harm reduction programs and services requires interventions that are directed at 3 main areas:

- 1) Direct service delivery
- 2) Creating an emotionally and physically safe environment
- 3) Changing policies and procedures



The following pages present a list of the main activities that can be implemented under each of the three main areas.





Direct Service Delivery

Direct service delivery involves implementing services that address the various needs and challenges faced by females who use drugs. These include services and interventions that address the health needs of females, services that address violence including IPV, services that respond to the need for financial and legal support.

Depending on the most common and urgent needs faced by FWUD in the community; harm reduction programs can integrate different services. Here is a list of useful and effective interventions:

Services related to physical health:

- Sterile injecting equipment/ needle & syringe exchange (NSP)
- OST, Methadone Maintenance Therapy (MMT), other drug treatments
- Overdose prevention and management
 - ◇ Access to tools and kits in order to prevent and manage overdose, such as use of a range of treatment options for Opioid dependence. These treatments include psychosocial support, Opioid substitution and maintenance treatments such as Methadone and Buprenorphine, and treatment with Opioid antagonists such as Naltrexone.
 - ◇ Naloxone to be made available to people who are at risk of Opioid overdose or those likely to witness an Opioid overdose
 - ◇ Trainings to be organized in the management of Opioid overdose – Monitoring trends in drug use and related harm, to better understand when Opioid dependence and Opioid overdose is occurring and ensure the optimal availability for medical purposes.
- Distribution of hygiene kits
- HIV, Hepatitis B&C, testing and treatment (HTC)
- Hepatitis B Vaccination
- TB prevention, diagnosis, and treatment
- STI prevention, rapid testing, and treatments
- Information Education and Communication (IEC) including:
 - ◇ Information, education and communication on the health risks associated with drug use, which will assist drug users to cease or modify their drug-taking behaviour.
 - ◇ Information, education and communication on safer injecting practices.
 - ◇ Information, education and communication on the safer use of non-injected drugs.
 - ◇ Information, education and communication on 1) HIV prevention, treatment and life with HIV and 2) Hepatitis prevention, treatment and life with hepatitis.
 - ◇ Vaccination against hepatitis A and B
 - ◇ HIV & Hep B&C prevention education, information, and referral
 - ◇ Self-care strategies and behaviors
 - ◇ Principles of general health and well being
 - ◇ Information on poly drug use including legal and illegal drugs



Services related to sexual and reproductive health:

- Free condom distribution
- Contraceptive methods (other than condoms)
- Services for STIs and prevention of mother-to-child transmission (PMTCT)
- Diagnosis and treatment of sexually transmitted infections, including HIV infection, reproductive tract infections, cervical cancer, and other gynecological morbidities; promotion of sexual health, including sexuality counseling;
- Pre- & post-natal care
- Maternal and child support
- Couples counseling (aimed at ensuring that the responsibility for reducing HIV and health risks is equally shared between both partners)
- Follow up services for pregnant women and awareness raising on the harms of unsafe abortion
- Prevention of unsafe abortion and post-abortion care
- Specialized services during pregnancy (when specialized services for pregnant drug-using women are provided, women are motivated to seek care)
- Information, education and communication on sexual health and reproductive rights.
 - ◊ Safe sex skills and negotiation skills
 - ◊ Educational services, counseling and training for sex workers on safe sex and negotiation skills to promote the use of condoms
 - ◊ Parenting skills
 - ◊ Family planning awareness
- Advocacy for safe drug treatment options for pregnant women, women in maternity wards, and women with small children
- “Women’s packets” including shampoos, sanitary pads, condoms, pregnancy tests, vitamins, deodorant and lip balms as well as diapers and other supplies for mothers with infants
- Pediatric consultations
- Distribution of baby formula and diapers
- A network of “friendly doctors”(Referring clients to doctors who were informed about, sensitive to, and understanding of the realities of women who use drugs proves to be a key component)
- Counseling and case management (Programs also offer female clients tailored information and tools on how to prevent sexually transmitted diseases)
- Outreach and mobile STI/HIV testing and counseling for FWUD and sex workers



Services related to emotional, psychological and mental health:

- Psychological support, counseling and management to address the psychological needs of FWUD
- Support group sessions and psychosocial activities aiming at reducing self-stigma, promoting sense of self-esteem and self-worth, assertiveness, and negotiation skills among FWUD
- Individual and group counseling sessions
- Specialized services for females survivors of sexual and physical abuse or rape
- Counseling on self-care
- Counseling on suicide prevention
- Couple and relationship counseling services
- Life skills training (including topics on self awareness, effective communication, negotiation and assertiveness skills, problem solving and decision making skills, coping skills, etc).

Services focusing on the issue of violence:

- Prevention and management of GBV
- Community-based initiatives that address gender inequality and gender norms
- Counseling for “survivors” of violence should be integrated into HR services
- Interventions that engage men in GBV prevention
- Housing, support and shelter for survivors of violence directly or through referral to and links with women organizations
- Family counseling and reconciliation sessions
- Cooperation with women- and human rights-organizations to address violence against women and to contribute in developing policies and legislations against violence towards FWID
- Training, including:
 - ◇ Gender equality training and community-based initiatives that address gender inequality and gender norms
 - ◇ Training service providers on identification and detection of abuse and violence, including IPV
 - ◇ Trainings that use principles of methods from adult education to target gender and sexual norms should be considered for prevention of IPV
 - ◇ Violence prevention, including legal support and training on skills to avoid potentially violent situations



Services related to legal support:

- Free legal aid for female who use drugs, including females who inject drugs and female sexual partners of people who inject drugs – that enables access to legal remedies in case of violence, abuse, exploitation, unjust imprisonment or losing custody over their children.
- Legal counseling and trainings on “know your right” for women.

Services focusing on financial difficulties:

- Provision of vocational training and support with income-generating activities that would support the females economically while also promoting their sense of autonomy and self-worth
- Providing transportation costs to harm reduction programs
- Free-of-charge medical care (medical tests, medical consultation fees, and medications)

Referral to other services:

Referral mechanisms between harm reduction services and other supportive services need to be established and strengthened in order to better tailor, support and meet the needs of FWUD.





Emotionally and physically safe environment

Harm reduction programs usually aim at providing people with the space and environment to make objective, sound and healthy choices. For HR services to be effective and appropriate, they should take the following principles into consideration:

- Including clients in program development and implementation, thus ensuring a participatory approach throughout the different phases of the program.
- Recruiting female outreach workers (including outreach workers who were former FWUD) to help clients feel cared for, instead of fearful or threatened
- Gender-sensitive harm reduction programs should place particular emphasis on guaranteeing personal safety and confidentiality in order to gain the trust of female clients. Increasing outreach efforts and utilizing peer or volunteer networks help establish that trust.
- The location, outreach and timing of program activities and services must be planned in ways to minimize risk of further violence and stigma.
- HR programs should pay considerable attention to advocacy activities that aim at promoting a culture of knowledge and rights.
- Investing in staff education. This includes:
 - ◇ Training (and on-going supervision and technical support) of harm reduction workers on gender and cultural effects on gender socialization
 - ◇ Training (and on-going supervision and technical support) of harm reduction workers on effective communication skills and empathy
 - ◇ Establishing a code of conduct for working with FWID within all HR programs and training workers on the code of conduct and procedures to be followed in case of breaching the policy of the code of conduct
 - ◇ Training HR workers on ways of ending stigma and discrimination
 - ◇ Monitoring of proper implementation of gender-specific harm reduction services
- Programs should contribute to strengthening information systems on drug production, distribution and use and prioritize the collection of data disaggregated by sex.
- Documenting experiences is fundamental to improving gender-specific HR services
- Monitoring & Evaluation of gender-specific harm reduction services



Changing policies and procedures

Numerous policy-related barriers directly and indirectly affect FWUD, hindering their access to and benefit from existing HR services. Inadequate attention has been given, to date, to rectify gender inequalities in harm reduction programming. HR Programs and services need to advocate for improved services and the elimination of policy, legal and social obstacles. Here is a list of some suggested activities:

- Advocacy activities that aim at protecting and advocating for the rights of FWID
- Advocacy for the decriminalization and/or de-penalization of drug use, for the availability of scientifically evidence drug treatments and harm reduction interventions
- Engaging civil society organizations at country and regional levels – taking advantage of international human rights mechanisms (including women’s rights instruments) to advocate for human rights and gender sensitive approaches to drugs and criminal justice policies
- Police custody and prison can be good entry points for HR services.
- Training of police and law enforcement on human rights and harm reduction.
- HR services should include right based approaches that would create awareness of human rights among women, families and police and enhance law enforcement

Incarceration:

- Prison systems should provide access to the comprehensive package of harm reduction interventions and health services. UNODC details a prison specific comprehensive package of 15 specific interventions required to respond to HIV in closed settings (along with recommendations concerning gender responsiveness and broader prison and criminal justice reforms). These include:
 - ◊ Developing gender-sensitive legislative frameworks, penal policies, and prison rules
 - ◊ Regular capacity-building programs of prison staff to build knowledge on HIV prevention
 - ◊ Research conducted on HIV in prisons; HIV risks for women in prison and responses provided should be monitored and evaluated on a regular basis.
 - ◊ Health authorities in prison should encourage and support the development of peer-based education initiatives and educational materials designed and delivered by prisoners themselves. Prison authorities should also encourage the development and support of self-help and peer-support groups that raise the issues of HIV and AIDS from the perspective of the women themselves.





- Ensure that governments adhere to the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (The Bangkok Rules)
- Advocating for changes in the legal system –working toward revision of Criminal Codes and decriminalization of drug use and thereby treating drug use as a health issue, not as a crime.
- Facilitating partnerships between police and national security agencies and HIV prevention initiatives for FWUD and FWID
- **Advocacy work to reduce stigma and discrimination** and ensure a supportive legal and policy environment. Advocacy work aims at influencing decision making to develop, establish, or change policies. It helps establish programs and services and to sustain them. This involves raising awareness, promoting knowledge, documenting good practices, and monitoring & evaluating HR programs in order to challenge the different forms of opposition towards HR services and to protect the rights of drug users and people living with HIV/AIDS.

Advocacy work includes:

- ◇ Interventions that increase awareness on harm reduction philosophy, strategy and interventions and the value of HR
- ◇ Advocacy and educational campaigns on different related occasions
- ◇ Building supportive relationships with the community and the different institutions and key persons
- ◇ Working with religious leaders (MENAHRRA Religious Leaders Guide), key persons and the media to help promote positive attitudes towards drug users
- ◇ Gender equality training and community-based initiatives that address gender inequality and gender norms

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GENDER EQUALITY

IN HARM REDUCTION SERVICES

Integrating Gender-specific Services in Harm Reduction Programs in the Middle East & North Africa (MENA) Region







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