# A FACILITATOR'S GUIDE:

## Integrating harm reduction and sexual and reproductive health and rights

Women who use drugs
have a right to sexual
& reproductive health

## FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live. As a result, 1.7 million people were infected with HIV in 2020 and 680,000 died of AIDS-related illness. Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

## WOMEN AND HARM REDUCTION INTERNATIONAL NETWORK (WHRIN)

Women and Harm Reduction International Network (WHRIN) is a global network formed in 2009. Led by women who use drugs, our goal is to improve the availability, quality, relevance and accessibility of health, social and legal services for women who use drugs. We work together to ensure that national, regional and international implementers and other bodies have policies and programmes which promote and support harm reduction services that reduce the adverse health, social, and economic consequences of drug prohibition for women.

## THE ACADEMY OF PERINATAL HARM REDUCTION

The Academy of Perinatal Harm Reduction provides evidence-based, inclusive, affirming education for parents and providers. Our work is informed by lived experience and is focused on the intersection of substance use and reproductive health.

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# ABBREVIATIONS

| | |
|---|---|
| **ATS** | Amphetamine type stimulants |
| **D & E** | Dilation and evacuation |
| **DIC** | Drop-in-centre |
| **EVA** | Electric vacuum aspiration |
| **FAS** | Fetal alcohol syndrome |
| **FGM/C** | Female genital mutilation/cutting |
| **HCV** | Hepatitis C virus |
| **HIV** | Human immunodeficiency virus |
| **HPV** | Human papilloma virus |
| **INGO** | International non-governmental organisation |
| **IPPF** | International Planned Parenthood Federation |
| **IUD** | Intra uterine device |
| **LGBT+** | Lesbian, gay, bisexual, transgender, +[1] |
| **MDMA** | Methylenedioxy-methamphetamine, commonly known as ecstasy |
| **MVA** | Manual vacuum aspiration |
| **NAS** | Neonatal abstinence syndrome |
| **NGO** | Non-governmental organisation |
| **NOW** | Neonatal opioid withdrawal |
| **OST** | Opioid substitution therapy |
| **PEP** | Post-exposure prophylaxis |
| **PVT** | Prevention of vertical transmission<br>(prevention of parent-to-child transmission is also commonly used) |
| **PrEP** | Pre-exposure prophylaxis |
| **RTI** | Reproductive tract infection |
| **STI** | Sexually transmitted infection |
| **SRHR** | Sexual and reproductive health and rights |
| **TB** | Tuberculosis |
| **UNFPA** | United National Population Fund |
| **UNICEF** | United Nations International Children's Fund |
| **WHO** | World Health Organization |
| **WHRIN** | Women and Harm Reduction International Network |

1. The + here represents other sexualities and gender non-conforming identities, such intersex, non-binary, gender diverse, queer or asexual.

# INTRODUCTION

In 2020, the Women and Harm Reduction International Network (WHRIN) and Frontline AIDS published the guide *Advancing the sexual and reproductive health and rights of women who use drugs*, which has been translated into Bahasa Indonesia, French and Portuguese. This manual has been designed for workshop facilitators to train community-based and peer-led harm reduction service providers to put this guide into practice.

To ensure community-based and peer-led organisations have ownership of this manual, a working group of partners from India, Kenya, Nepal and Nigeria contributed to the curriculum's development at all stages. The headings, sub-topics and learning objectives have been discussed with and validated by members of this working group. Between July and October 2021, fortnightly meetings were held with the working group to ensure the training course is relevant and applicable. Working group members have also contributed to case studies, the design of workshop activities, and the key messages of each module.

The members of the curriculum working group were: Fisayo Alao, YouthRISE, Nigeria; Akpan Aniedi, DHRAN, Nigeria; Pemu Bhutia, Alliance India; Rita Gatonye Muthoni, WRADA, Kenya; Sikinai Juma, MEWA, Kenya; Catherine Mwangi, Women Nest, Kenya; Charan Sharma, IDUF, India; Parina Subba, Dristi, Nepal and Nandini Thapa, IDUF, India.

# WORKSHOP AUDIENCE AND OBJECTIVES

## TARGET AUDIENCE

This workshop is for community-based and peer-led harm reduction service providers, including:

- Peer staff and peer leaders
- Outreach workers, social workers, counsellors
- Medical workers (e.g. nurses, doctors, midwives)
- Programme staff (e.g. project/programme coordinators, technical advisors)
- SRHR and gender focal points in field teams

## WORKSHOP OBJECTIVES

To support community-based and peer-led harm reduction organisations to strengthen their services for women and gender non-conforming people who use drugs.

## WORKSHOP CURRICULUM

The workshop curriculum consists of 10 modules structured around specific sessions/topics, each of which is around 2 hours/120 minutes long. It can be delivered as in-person or online training. The curriculum is designed to be rolled out from Module 0 to Module 10 in order, but each module can be delivered as a stand-alone unit, depending on the needs of community members and programmers.

**WHRIN and Frontline AIDS understand 'women' to include anyone who identifies as a woman, whether cisgender or transgender. But we also recognise the barriers facing other gender-diverse or gender non-conforming people (including intersex, trans-men/trans-masculine, gender non-binary people, or other people who do not identify as either men or women) AND their biological/physio-logical needs in relation to their sexual and reproductive health and rights (SRHR), based on the bodily characteristics they were born with. To represent this we use the phrase 'women and gender non-conforming people who use drugs' throughout this guide, as this is inclusive of women in all their diversity and gender non-conforming people who use drugs.**

The learning objectives are presented per modules and session in the following table.

**TABLE 1: HEADING TOPICS, SUB-TOPICS AND LEARNING OBJECTIVES**

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 0** | **Introduction** | Introduction and presentation | • To introduce participants and the rules of the workshop<br>• To understand the objectives of the curriculum |
| **MODULE 1** | **Gender** | Gender norms and stereotypes | • To understand the harms of gender norms and gender inequality<br>• To understand the compound effect of gender stereotyping for women and gender non-conforming people who use drugs |
| | **SRHR services and harm reduction services** | Introduction to sexual rights and reproductive rights and linkages between sexual and reproductive health and rights services and harm reduction programmes | • To understand sexual rights and reproductive rights and the importance of the continuum of care (for SRHR services)<br>• To list advantages and challenges in integrating SRHR services with harm reduction programmes |
| **MODULE 2** | **Sexuality and sexual health** | Introduction to sexuality and sexual health | • To explain a positive approach to sexuality and sexual health<br>• To discuss myths and reality related to drug use and sexuality |
| | **Sexual and reproductive health** | The female and male sexual and reproductive systems | • To identify the bodily characteristics (anatomy and physiology) of male and female sexual and reproductive systems |
| | | Hygiene and menstruation | • To explore intimate hygiene and menstruation<br>• To understand the menstrual cycle and list common menstrual hygiene materials |
| **MODULE 3** | **Gender-based violence** | Types of gender-based violence and intimate partner violence | • To understand the importance of primary prevention and identify the signs and symptoms of gender-based violence<br>• To draw a safety plan and social support mapping<br>• To define a comprehensive package of quality post-violence care and referral services for women and gender non-conforming people who use drugs in relation to gender-based violence and intimate partner violence |

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 4** | **Contraception and family planning** | Basic information on contraception and contraceptive choice | • To explore misbeliefs associated with contraception and the full range of contraceptive methods<br>• To know the main components of family planning and contraceptive services |
| | | Contraceptive counselling | • To provide quality counselling on contraception and contraceptive choice to women and gender non-conforming people who use drugs<br>• To identify the main barriers to accessing contraception and potential approaches to overcome these barriers |
| **MODULE 5** | **Safe abortion and post-abortion care** | Safe abortion and post-abortion care services and referrals | • To identify the main barriers to access safe abortion and/or post-abortion care<br>• To know how to provide counselling related to abortion issues<br>• To map health services for abortion and post-abortion care to refer women and gender non-conforming people who use drugs |
| **MODULE 6** | **Perinatal and newborn care** | Pregnancy and drug use | • To understand the advantages and limits of OST or drug use during pregnancy and breast/chestfeeding<br>• To facilitate group discussion on perinatal and newborn care for women and gender non-conforming people who use drugs |
| | | Newborn care and neonatal abstinence syndrome (NAS)/ neonatal opioid withdrawal (NOW) management | • To identify neonatal abstinence syndrome (or neonatal opioid withdrawal) in babies and provide appropriate care<br>• To list key steps to begin perinatal and newborn care services in the programme |
| **MODULE 7** | **HIV and STIs** | HIV and STIs: basic information and prevention | • To explain basic information about HIV and other STIs, including ways of transmission, prevention and testing<br>• To provide counselling on dual protection strategies to prevent both transmission of HIV/STIs and unintended pregnancy among women and gender non-conforming people who use drugs |
| | | Prevention of vertical transmission | • To inform and refer pregnant people who use drugs living with HIV to appropriate services |
| | | Condom use and condom negotiation | • To enhance capacities to negotiate condom use |
| **MODULE 8** | **Cervical cancer** | Basic knowledge about cervical cancer | • To understand HPV infection, pre-cancerous lesions and cervical cancer |
| | | Prevention, screening, treatment and vaccination | • To provide counselling to prevent and screen for cervical cancer<br>• To know how to refer women and gender non-conforming people who use drugs to appropriate vaccination or treatment services. |
| **MODULE 9** | **Integration of SRHR services** | Define programmatic actions to improve integration and access to SRHR for women and gender non-conforming people who use drugs | • To identify gaps in the provision of essential SRHR services in organisations providing harm reduction services<br>• To map appropriate services that offer client-oriented, non-judgmental SRHR services for women and gender non-conforming people who use drugs<br>• To develop short-term and mid-term action plans to improve access to and integration of SRHR with harm reduction services |
| **MODULE 10** | **Advocacy strategy** | Define advocacy strategies to improve integration and access to SRHR for women and gender non-conforming people who use drugs | • To identify gaps and barriers to accessing SRHR for women and gender non-conforming people who use drugs in the country<br>• To prioritise key actions and targets for advocacy |

# WORKSHOP ORGANISATION AND REQUIREMENTS

## WHO SHOULD FACILITATE THIS WORKSHOP?

To facilitate this workshop you need to be competent and experienced in leading workshops and facilitating group discussions. You should have experience in using a range of interactive facilitation methods and activities, such as role play, leading exchanges and debates, brainstorming, discussing case studies, designing action plans and facilitating group work.

## NUMBER OF PARTICIPANTS

We recommend a maximum of 12 participants for online training and 18 for in-person training.

## MATERIALS FOR IN-PERSON WORKSHOPS

**IT**

- A video projector, screen and external speakers
- Laptop computers for the facilitator(s) and note taker/rapporteur

**MATERIALS**

- Flipchart paper and stands
- Coloured marker pens
- Sticky notes (Post-it) in three colours
- A4 paper
- Photos/ images of famous monuments in the area or photos/images of famous food dishes
- Scotch tape/blu-tack

## PLANNING THE WORKSHOP

We suggest you read through the entire manual in advance.

This will help you prepare for the debates and questions, adapt the content to the context, and provide correct information about services for referrals. It will also help you feel comfortable with the content of the curriculum and confident in its delivery – this is vital for making participants feel safe. This is especially important when working with people who may be marginalised, stigmatised or have experiences of discrimination and violence.

Consider the following tips:

- The content of each session can be adjusted to suit your participants' level of experience in each setting. It will also need to be adapted to local languages.
- Zoom can be used for the online workshop. Here are some tips on making Zoom workshops work well:
  - It is a good idea to do a test with participants a few days before to explain Zoom's main functionalities (i.e. chat, webcam, virtual breakout rooms). Having participants register in advance can also increase the safety of the workshop.
  - If interpretation is needed, Zoom's simultaneous translation function is recommended to ensure the sessions keep to the recommended time.
  - Make sure that all the participants have access to an individual computer, with a good internet connection, a microphone and a webcam.
  - Provide data bundles to participants with poor or unreliable internet connections.
  - Basic online tools, such as Mural, Google Jamboard and Klaxoon, can be used for brainstorming and note-taking if available.
  - Online polls, such as Mentimeter, are useful for quiz exercises, and Wheel of Names is an interactive game that can be used to improve individual participation.

**OPENING THE WORKSHOP**

To begin the workshop, it is a good idea to factor in an additional 40 minutes to allow for introductions, agree ground rules and run through the workshop's learning objectives and duration. You can use *Module 0: Introduction and opening* below to do this, or you can adapt this into your own welcome session.

## A GENERAL WARNING

It is important to be aware that this workshop is based on clinical and technical standards approved by the international community, such as the World Health Organization (WHO) and the Guttmacher-Lancet Committee on SRHR and has been developed using a human rights approach. It is also aligned with international treaties and conventions (see annexes for references).

The content might be very sensitive in some cultures and religions. Certain topics can also trigger flashbacks, negative memories and/or distress. It is essential to tell all participants in advance that topics can be sensitive, and that they should seek help and psychological support during the course of the workshop if they need it. It is a good idea to prepare referrals in advance for any participants who may need support to enjoy their sexual and reproductive rights. Try to foster a respectful tone with participants when discussing sensitive topics, and ensure a safe learning environment, one which is without expressions of judgmental, shaming or hurtful attitudes or opinions. Emotional reactions to 'shocking' scenarios can be reduced by ensuring participants have a framework for setting things in context. As a workshop facilitator, it is your role to guide participants to a reasoned analysis. You must also look after your own well-being and be prepared to connect with counsellors or other national or international resources to de-brief after the workshop.

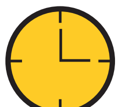
**GENDER-INCLUSIVE LANGUAGE**

Much of this manual speaks to the needs of women and girls who use drugs. These needs might differ from the needs of men who use drugs, particularly in regard to their SRHR. However, we recognise that men and boys also have SRHR needs and concerns, and that there are more than two genders.

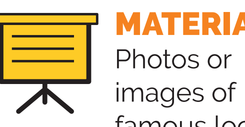
We have tried to use gender-inclusive language throughout this manual. In some cases, this has meant adopting gender-neutral terms (e.g. using 'person' rather than 'woman' or 'man'). In other areas though we recognise that using gender-neutral terms can make invisible the particular and varied experiences that women in their diversity have *as women*, especially where their gender overlaps with other characteristics that carry more or less power and privilege, such as race, age, sexuality and class. For this reason, we have tried to include what is known as 'gender-additive' or 'gender-expansive' language. This recognises, for example, that not all people who menstruate, become pregnant, give birth or feed their infants with human milk identify as women or girls. Some intersex people, transgender men, gender non-binary people and other gender non-conforming people also have female bodily characteristics and female bodily functions. And in some settings these groups of people may face particular barriers in accessing information, products and services in relation to their SRHR and menstrual hygiene as well as experiencing high rates of rights violations when accessing sexual and reproductive healthcare and in other healthcare settings.[2]

2. For more guidance on gender-inclusive language in perinatal care settings, please see NHS Brighton and Sussex University Hospitals (2021), *Gender inclusive language in perinatal services.*

# Module 0
## Introduction and opening



**TIME**
40 minutes



**MATERIALS**
Photos or images of famous local monuments or famous food dishes from the area

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| MODULE 0 | Introduction | Introduction and presentation | • To know the other participants and the rules of the workshop<br>• To know the objectives of the curriculum |

**TIPS FOR ONLINE FACILITATION**
Prepare a list or set of images of famous local monuments or dishes then ask each member to present by choosing one of the dishes or monuments they like most. You can inform the participants to send you a private message if they are feeling uncomfortable or need a break. If available, it is a good idea to also share a WhatsApp number for a standby counsellor.

## INTRODUCTION (40 MINUTES)

### INTRODUCTION AND PRESENTATION

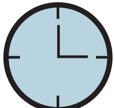
40 minutes

**PPT Module 0: Introduction**

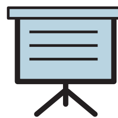
**Photos or images of famous local monuments or famous dishes from the area**

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Welcoming words and introduction to the curriculum: 10 minutes**<br><br>**Presentation: 25 minutes**<br>Each participant chooses one of the photos/images.<br>Each participant has one minute to introduce themselves, giving their name (or a nickname), position within the organisation, and why they chose this photo/image.<br>The facilitator/s should also introduce themselves.<br><br>**Golden rules: 5 minutes**<br>Invite participants to suggest golden rules they can all agree to, to ensure the safety, comfort and full participation of all participants. List them on the flipchart. | **Introduction to the curriculum**<br><br>**Main workshop objective:** To support community-based and peer-led harm reduction providers to strengthen their services for women who use drugs.<br><br>**The importance of the meaningful involvement of women and gender non-conforming people who use drugs**<br>Support the meaningful involvement of women and gender non-conforming people who use drugs at all levels and stages:<br>• To integrate SRHR in harm reduction programmes through the planning, implementation, monitoring and evaluation of SRHR services<br>• In the development and structure of networks of women and gender non-conforming people who use drugs to jointly advocate with governments, health services and other institutions to provide more effective and relevant SRHR services<br>• In empowering women and gender non-conforming people who use drugs and training them on SRHR<br>• In raising awareness on the needs and issues of women and gender non-conforming people<br><br>**Presentation**<br>The participants get to know each other, the facilitator gets to know the participants. The diversity of participants' profiles is important.<br><br>**Golden rules**<br>These might include punctuality, telephones being off/on silent, participation, respect, confidentiality, putting into practice the meaningful involvement principle and method.<br>The group may want to define in advance the best strategy to use if someone is feeling triggered: For instance, the group could agree on a common sign to ask for a break without having to explain why or raising the issue with the facilitator. |

# Module 1
## Gender, sexual and reproductive health and rights and harm reduction



**TIME**
2 hours 15 minutes



**MATERIALS**
- Pens
- Flipchart (+two shapes of bodies drawn)
- **PPT 1**: Gender, sexual and reproductive health and rights and harm reduction
- **Handout 1**: Cards with the words describing the portrait of the 'good' man and the 'good' woman
- **Handout 2**: Key definitions and genderbread person
- **Handout 3**: Case study
- **Handout 4**: Cross the line exercise
- **Handout 5**: Extract of IPPF's sexual and reproductive rights declaration, and the Guttmacher-Lancet Commission's definition of SRHR
- **Handout 6**: Sticky notes (Post-it) with specific services (harm reduction and SRHR)

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 1** | **Gender** | Gender norms and stereotypes | • To understand the harms of gender norms and gender inequality<br>• To understand the 'compound effects' of gender stereotyping for women and gender non-conforming people who use drugs |
| | **SRHR services and harm reduction services** | Introduction to sexual rights and reproductive rights and linkages between SRHR services and harm reduction programmes | • To understand SRHR and the importance of the continuum of care for SRHR services<br>• To list the advantages and challenges in integrating SRHR services with harm reduction programmes |

## TIPS FOR ONLINE FACILITATION

**EXERCISE 1. PORTRAITS: 10 MINUTES**
Ask the participants to split into virtual breakout rooms in groups to discuss the different cards with the words describing the portrait of the 'good' man and the 'good' woman. Share the cards in advance by email or type them in the chat. The groups can use a Word document to copy-paste the words to each of the portraits. They can discuss their choice.

**EXERCISE 2. THE ROLES OF WOMEN AND MEN (GAME): 15 MINUTES**
Ask the participants to use the 'reactions' or 'emojis' buttons to answer if they consider whether this role is attributed to a 'good' man or a 'good' woman, and ask them to explain or justify their choice. Alternatively, create a Klaxoon link with the different questions in different notes, which the participants can then move to a category called 'the good man' or 'the good woman'.

**EXERCISE 3. CASE STUDY: 20 MINUTES**
Email the case study to the participants in advance and use a slide in shared screen mode to note down ideas. Alternatively, share your screen while reading the case study and use a virtual whiteboard to gather ideas.

**EXERCISE 4. CROSS THE LINE EXERCISE: 15 MINUTES**
Ask the participants to take two pieces of paper and write on one piece AGREE (in green) and on the other DON'T AGREE (in red). Participants will need to turn their camera on to show their position by holding up the relevant paper. If bandwidth makes it difficult for some participants to use cameras, they can type their answer in the chat or use agreed 'reactions' to signal their response.

**EXERCISE 5. CONTINUUM OF CARE: 15 MINUTES**
The two groups can discuss in two virtual rooms then type the services in a shared online document so they can see the contribution of the other groups. You should share a selection of words in advance to avoid duplication. A second option is to organise a group discussion in which you ask the participants where to put each of the services. You can write the answers directly in a document while sharing your screen.

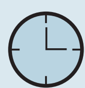
**EXERCISE 6. GROUP EXERCISE: 15 MINUTES**
Open virtual rooms and the participants can note down their list in a Word document.

## TO PREPARE IN ADVANCE

This module invites participants to reflect on the way young people are socialised into gender roles and to think critically about the ways this impacts unfairly on everyone, but particularly girls and women in their diversity and gender non-conforming people. In advance, prepare a list of gender norms and stereotypes that are commonly held or heard in the context where you are delivering the workshop. You should also prepare some tips or solutions on how to deal with and overcome these stereotypes. You could also challenge your own gender stereotypes and invite the participants to do so as well.

# GENDER (55 MINUTES)

## GENDER NORMS AND STEREOTYPES (1/3)



**10 minutes**

**Flipchart (+two shapes of bodies drawn)**
**PPT 1: Gender and sexual and reproductive health and rights**
**Handout 1: Cards with the words describing the portrait of the 'good' man and woman**

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 1. Portraits: 10 minutes**<br>Divide the participants in two groups.<br>Use two flipcharts with two shapes of bodies drawn on each flipchart: one representing the 'good' man, the other representing the 'good' woman.<br>All groups have the same cards (Handout 1). The aim to be the first group to finish each drawing.<br>To do this, each group needs to select cards to stick to the portrait of either the 'good' man or woman.<br>You can discuss the words that have not been selected and use these to discuss the concept and definition of gender norms. You can also invite participants to add more gender norms to the portraits to characterise 'good' men and women in their context. | It is important to emphasise that the 'right' answers in this exercise do not have to represent the participants' own beliefs or views, but reflect commonly held norms or attitudes about how 'good' men and women should behave. |

## GENDER NORMS AND STEREOTYPES (2/3)

**15 minutes**

**Handout 2: Key definitions and the genderbread person**

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 2. Game of the roles of women and men: 15 minutes**<br>You can use this activity to assess the level of participants' understanding of the gender norms and stereotypes attached to different roles in the community.<br>Ask the participants to move quickly in front of the flipchart with the portrait of the 'good' man or woman to express their opinion for each of the following questions:<br>Who has the role for:<br>• Income generation?<br>• Household chores?<br>• Hard manual labour?<br>• Budgeting?<br>• Disciplinary measures?<br>• Responsibilities?<br>• Child raising?<br>Ask the participants to explain why they chose this flipchart. | Go through key definitions using Handout 2.<br>Gender norms describe the set of social rules and expectations regarding what it 'means' to be male or female, and what girls/women and boys/men should be and do. These norms vary from place to place and can change over time. They have a very powerful influence on us in many different ways. For instance, they influence how others view and treat us, both informally in social interactions and formally such as in the law, and how we perceive ourselves and our potential. Transgression of gender norms is policed through violence and other social punishments. Patriarchal culture (which privileges men) and gender norms determine how people are treated, and the power dynamics between and among people due to how communities define them. These things also define how people identify and understand their gender.<br>Gender norms tend to assign women certain roles, usually limited to the private sphere, and men certain roles, usually associated with the public sphere. Examples of some gender norms and roles are:<br>• Men are decision-makers<br>• Men are masculine in appearance and actions<br>• Women are homemakers<br>• Women are feminine in appearance and actions |

## GENDER NORMS AND STEREOTYPES (3/3)

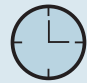
| | | | |
|---|---|---|---|
| | 30 minutes | | Handout 3: Case study |

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 3. Case study: 20 minutes**<br>Based on the case study (see Handout 3), guide a discussion with the group, asking:<br>*What are the types of norms and stereotypes faced by the woman who uses drugs in the case study?*<br>*Who expresses these norms or stereotypes (e.g. family members, community, health professionals)?*<br>*What are the specific harms and consequences of these gender stereotypes?*<br>Write on a flipchart the relevant harms and add some yourself if needed. Examples are:<br>• Overburdening<br>• Stigma<br>• Discrimination<br>• Low self-esteem and lack of confidence<br>• Fear to access support<br>• Violence (physical, emotional and sexual violence)<br>• Lose child custody<br>Then ask:<br>*Do you think you also hold your own stereotypes about women and gender non-conforming people who use drugs, or other marginalised women like sex workers, women living with HIV and transgender women?*<br>*Do you think these views might impact the range of services you provide and the way you provide them?*<br><br>**PPT presentation: 10 minutes** | These gender roles do not occur due to 'natural' differences between the sexes. Rather they are constructed, and come to seem natural because they are deeply embedded in our societies, through things such as culture and religion.<br>They have a profound effect on every aspect of life, such as our economic lives, our SRHR, our representation in decision-making, our domestic and community care roles.<br>A sex or gender stereotype is a generalised view or preconception about the physical – including the biological, emotional and cognitive (thinking)– characteristics that are or should be possessed by women and men.<br>Gender stereotyping is both a common consequence and frequent cause of discrimination against women and gender non-conforming people. It is also a contributing factor in rights violations, ranging from the right to an adequate standard of living to freedom from gender-based violence.<br>Gender norms and stereotypes are a product of patriarchy (which privileges men over other people), heteronormativity (which privileges heterosexuality above any other types of sexuality) and binary understandings of gender (which only recognises two 'opposing' genders: that of men and women).<br>Gender norms and stereotypes have an impact on what and how services are delivered to women and gender non-conforming people who use drugs<br>Gender inequality, gender norms and stereotypes, and sexual norms prevent many people from accessing SRHR services, as well as other health services, including basic healthcare. This is because some individuals are seen as 'deserving' of these services and some are seen as transgressive (non-deserving).<br>It is very important for harm reduction professionals to consider the impact of gender norms and stereotypes in how they work with people who use drugs and challenge their own personal values and beliefs about gender throughout this training and beyond.<br>Everyone has an opinion and attitude about gender, and they have a right to their opinion, but if their attitude may be harmful to themselves or others it is important to challenge it.<br>Transgender people and other gender non-conforming people also experience harm from gender-stereotypes, including serious discrimination leading to social and economic marginalisation.<br>In particular, gender inequality, harmful gender norms and gender-based discrimination and violence prevent women and gender non-conforming people from accessing SRH services and fulfilling their rights.<br>Gender inequality means that women and gender non-conforming people don't enjoy the same status as men and are not enjoying the same rights. Gender equality means that men, women and gender non-conforming people are sharing the same opportunities for full realisation of their human rights.<br>Gender-based discrimination is the result of 'compound stigma', which is when multiple layers of stigma (e.g. based on gender, race/ethnicity, age, and other factors) overlap. This is because gender stereotypes are frequently concerned with a specific group of women (e.g. women of childbearing age), rather than with women as a whole. For example, both women and men who use drugs may face stigma, but women who use drugs are often doubly stigmatised because drug use is seen as going against strongly held norms and expectations about being a woman – such as childcare and modest behaviour. |

| SEQUENCE | KEY MESSAGES |
| --- | --- |
| | Women and gender non-conforming people who use drugs are at high risk of violence based on social norms and stereotypes, backed by laws that attempt to dehumanise, infantilise (treat them like children), exclude and isolate them. These laws put them even more at risk of sexual violence and other forms of violence. Due to such prejudices, many women who use drugs have lost custody and even visitation rights with their children.<br>Women and gender non-conforming people who use drugs face barriers to representation. Because they might not conform to society's view on gender, they are also excluded from meaningful participation in society.<br>In addition, women and gender non-conforming people who use drugs are often thought to be incompetent, broken, dishonest and/or unreliable. These views, coupled with punitive (punishing) drug laws and policies, prevent women and gender non-conforming people who use drugs from reaching their potential as equal members in the community.<br>The overlap of different stigma from drug use and related risk behaviours makes it difficult for women and gender non-conforming people who use drugs to access their sexual and reproductive rights. |

## SRHR SERVICES AND HARM REDUCTION SERVICES (1 HOUR 10 MINUTES)

### SEXUAL RIGHTS AND REPRODUCTIVE RIGHTS AND LINKAGES BETWEEN SRHR SERVICES AND HARM REDUCTION PROGRAMMES (1/2)

| | | | |
| --- | --- | --- | --- |
|  | **25 minutes** | | **Handout 4: Cross the line exercise**<br>**Handout 5: Extract of IPPF Declaration on sexual and reproductive rights and definition of SRHR by the Guttmacher-Lancet Commission** |

| SEQUENCE | KEY MESSAGES |
| --- | --- |
| **Exercise 4. Cross the line: 15 minutes**<br>Mark a virtual line in the room then read a series of statements and ask the participants to cross the line to one side (left) if they agree, to the other side (right) if they disagree.<br>Once all the participants have moved to one side or the other ask them to explain their choice (see Handout 5).<br><br>**PPT presentation: 10 minutes** | **Introduction of main concepts and definition of sexual and reproductive rights**<br>Sexual and reproductive rights are human rights that apply to sexual and reproductive health. The right to sexual and reproductive health is an integral part of the 'right to the highest attainable standard of physical and mental health', as enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights.<br><br>**Sexual rights can include:**<br>• The ability to seek, receive and give information about sexuality<br>• The right to be free from violence, pressure or coercion from a partner, and to practice safer sex<br>• The right to say 'no' and the right to a consensual marriage (above the legal age) and/or partnership - The choice of sexual partner(s)<br>• The right to decide to be sexually active or not<br>• The right to pursue a satisfying, safe and pleasurable sex life<br>• Freedom to discover and develop one's sexuality<br>• Freedom from harmful practices like genital mutilation and bride price<br><br>**Reproductive rights are the rights** of people to decide whether to give birth to a child or not, without discrimination, coercion or violence. They allow women to control their own reproduction.<br><br>**Reproductive rights can include:**<br>• The choice to have children and freedom to decide if, when, and how many<br>• The right to correct information, choices and services related to reproductive health, including family planning, pregnancy and maternal care<br>• Freedom from forced sterilisation |

45 minutes

Handout 6: Sticky- notes (Post-it) with specific services (harm reduction and SRHR)

## SEQUENCE

### Exercise 5. Continuum of care: 15 minutes

Divide the participants into three groups.

Each group can pick and choose one sticky note (post-it) and discuss if this specific service is available only through SRH services or harm reduction services, or already integrated.

Once they agree, they should stick the sticky note with a name of a specific service (harm reduction or SRHR) in one of the three circles then pick another one.

You can give examples to help, such as:

- STI testing, and treatment is available in both
- Sterile equipment to inject drugs is only available in harm reduction services.

Once all the sticky notes are stuck in the circles, ask participants to have a look at the finished chart as a way to highlight the SRHR services that are not yet in the middle circle.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

SERVICES PROVIDED BY BOTH

HARM REDUCTION SERVICES

### Exercise 6. Group exercise: 15 minutes

Divide the participants in two groups.

Ask each group to list the advantages and disadvantages of linking and integrating SRHR services into harm reduction programmes.

### Report back to the group: 5 minutes

### PPT presentation: 10 minutes

Wrap up the points that have been raised and complete the presentation with a summary of important services. Emphasise the importance of the continuum of care.

## KEY MESSAGES

A continuum[3] of care should be established, covering all the stages of human life (child/adolescent/adult/elder), one that links SRHR with HIV prevention, care and treatment and other harm reduction services. This aims to ensure a continuum of adapted services are available at all stages of life but also a continuum in terms of accessibility (from services delivered at the community level, in health centres or harm reduction centres, but also in hospital).

**Advantages**

**Improve access and increase uptake:** Joining up SRHR and harm reduction interventions and services can increase access to and uptake of both things. It also enables providers to tailor their programmes to the needs of different groups, especially to the specific needs of women and gender non-conforming people who use drugs and sex workers who use drugs.

Ensuring the meaningful involvement of women and gender non-conforming people who use drugs is also key to increasing service uptake.

**Provide better care:** Joining up services can improve the quality of care by providing a comprehensive service in one place.

**Reduce stigma:** Integrating services in different ways to suit specific needs can reduce stigma and discrimination relating to HIV, other health issues or drug use. Programmes that meet the SRHR needs of women and gender non-conforming people in a more holistic (rounded) and positive way, rather than simply focusing on drug use or HIV infections, may be more attractive and less stigmatising.

**Increase efficiency** (time and resources): Joining up services can result in increased effectiveness and efficiency, and less duplication of effort and competition for resources. It can also lead to better use of human and material resources for health.

**Disadvantages**

Integration can have **its challenges too**. Potentially, it can (or can be perceived to) overburden services and facilities, and be a drain on already limited resources, unless carefully planned. Many service providers may be introducing women-specific services for the first time but will not be experienced in supporting women who use drugs. Ensuring women and gender non-conforming people who use drugs are involved from the outset will improve the quality of the integration of those services and reduce the challenges.

Present the comprehensive package of interventions for harm reduction and SRHR

3. A continuum is something that is made up of a collection of stages or elements.

# HANDOUT 1

## CARDS WITH THE WORDS DESCRIBING THE PORTRAIT OF THE 'GOOD' MAN AND 'GOOD' WOMAN

| | |
|---|---|
| Having sexual desire and strong libido | Being chaste and not interested in sex |
| Having many partners | Having used drugs in the past/using drugs |
| Wearing revealing clothing | Carrying condoms |
| Being sensitive | Looking for health advice and seeking health |
| Drinking alcohol | Being jealous and possessive of their partner |
| Providing economic stability | Having children |

# HANDOUT 2
## KEY DEFINITIONS

**Source:** Frontline AIDS (2021), *Good practice guide: gender-transformative approaches to HIV* and IPPF (2008), *Sexual rights: IPPF Declaration, adopted by the IPPF Governing Council on 10 May 2008.*

#### SEX
Refers to a biological determination of 'male' and 'female', based on both visible and invisible bodily characteristics. Bodily characteristics related to sex include primary sex characteristics (e.g. penis, vagina), which are often used to assign a binary male/female identity at birth. They also include hidden characteristics, such as hormones, chromosomes, and internal reproductive organs, and secondary sex characteristics (e.g. Adam's apple, facial hair, breasts) which emerge during puberty. Sex is often seen as being in line with gender, and considered fixed and binary, although this is not necessarily the case. In addition to the diversity of gender identities, there is also a lot of diversity in bodily characteristics that bring the man/woman binary into question, such as found in intersex people, women athletes with high testosterone and men with gynecomastia (overdeveloped breast tissue), to name a few. **(See the genderbread person below for a more detailed discussion of the difference between sex and gender.)**

#### GENDER
Relates to the characteristics – ranging from gender roles to physical appearance – that societies attribute to the notions of 'masculine' and 'feminine'.

#### GENDER IDENTITY
A person's internal, deeply held sense of one's own gender. When this conforms with the sex the person was assigned at birth, their identity is called 'cisgender' (for example, a person born with female bodily characteristics and assigned female at birth who identifies as a woman; or a person born with male bodily characteristics, and assigned male at birth, who identifies as a man). When a person's gender identity does not conform with the sex they were assigned at birth, they are 'transgender' or 'gender non-conforming'. For example, a person born with female bodily characteristics who is assigned female at birth but who identifies as masculine (transgender man / trans-masculine) or as neither a man or a woman (gender non-binary).

#### GENDER NON-CONFORMING
An umbrella term to describe anyone whose gender identity and/or sexual orientation does not follow heteronormative expectations about how they should look or act based on the sex they were assigned at birth, or who fall outside of the man/woman binary.

#### SEXUAL ORIENTATION
Emotional, romantic or sexual feelings toward other people or no people. While sexual activity involves the choices someone makes regarding their behaviour, someone's sexual activity does not define their sexual orientation. Sexual orientation is part of the human condition and all people have one. Typically, it is attraction that helps determine orientation.

#### GENDER NORMS
From birth, we tend to be socialised to behave and dress according to gender norms. These norms vary from place to place and can change over time. They have a very powerful influence on us in many different ways. For instance, they influence how others view and treat us, both informally in social interactions and formally such as in the law, and how we perceive ourselves and our potential. Transgression of gender norms is policed through violence and other social punishments. Patriarchal culture and gender norms determine how people are treated, and the power dynamics between and among people due to how communities define them. These things also define how people identify and understand their gender.

#### GENDER EQUALITY
Equality is the absence of discrimination in opportunities, the allocation of resources or benefits and access to services. Gender equality refers to a measurable, equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value, should be accorded equal treatment, and that their rights, responsibilities and opportunities do not depend on their sex. Gender equality refers to both women and men's ability to: share equally in the distribution of power and influence; have equal opportunities, rights and obligations in the public and private spheres, including in terms of work or income generation; have equal access to quality education and capacity-building opportunities; have equal possibility to develop their full potential; have equal access to resources and services within families, communities and society at large, and be treated equally in laws and policies.

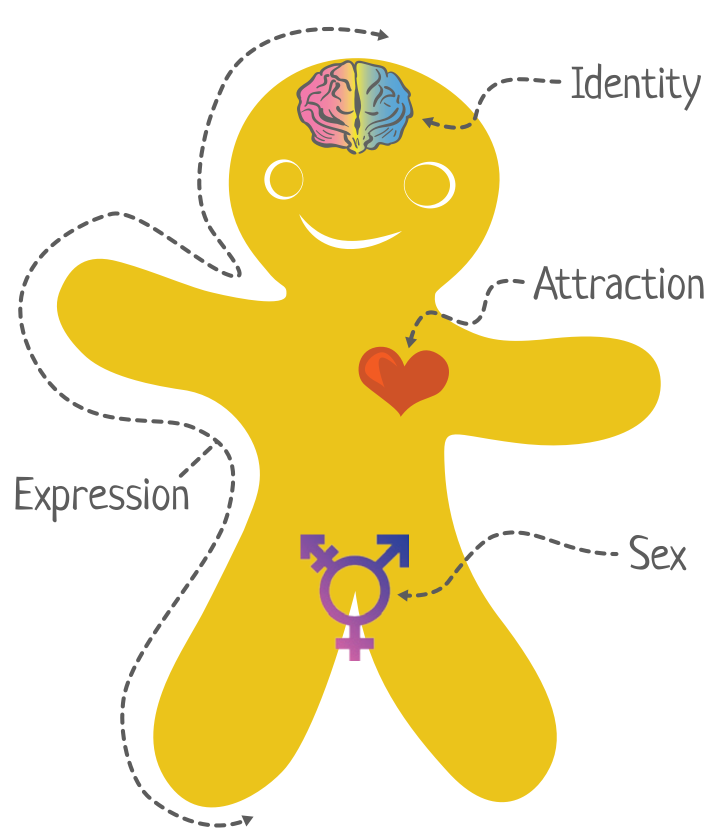
#### GENDER EQUITY
Equity is fairness and justice in the distribution of benefits and responsibilities. The concept of gender equity recognises that women, men and gender non-conforming people have different needs and power and that these differences should be identified and addressed in a manner that rectifies the imbalance between the sexes.

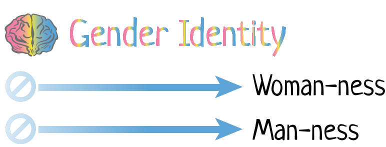
# HANDOUT 2
## GENDERBREAD PERSON

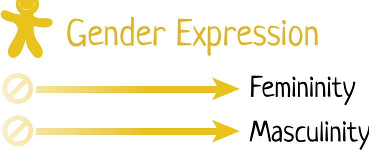
**Source:** itspronouncedmetrosexual.com. Use Genderbread Person v4.0, which can be found at www.genderbread.org.

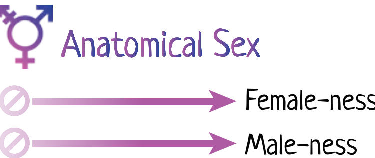
You can find notes to help break down the terms at www.genderbread.org/wp-content/uploads/2017/02/Breaking-through-the-Binary-by-Sam-Killermann.pdf.

The Genderbread Person v4






Identity ≠ Expression ≠ Sex
Gender ≠ Sexual Orientation

Sex Assigned At Birth
☐ Female ☐ Intersex ☐ Male

and/or (a/o)

Women a/o Feminine a/o Female People
Men a/o Masculine a/o Male People

Romantically Attracted to...
Women a/o Feminine a/o Female People
Men a/o Masculine a/o Male People

Genderbread Person Version 4 created and uncopyrighted 2017 by Sam Killermann

For a bigger bite, read more at www.genderbread.org

# HANDOUT 3
## CASE STUDY

My name is Noleya. As a young girl I started drinking alcohol when I was in secondary school, and it got so bad that I started getting drunk and being involved in a lot of fights. Because the other girls were afraid of me and didn't want to play with me, I started mixing more with boys in school. They introduced me to smoking cannabis. The drugs made me feel like I was tougher than all the other girls. Sometimes, when I didn't have money to pay for the cannabis, one of the boys of the group would offer to buy it for me in exchange for sex. I accepted as I didn't know what else to do. When I was 17, I really wanted to please my boyfriend and to have sex with him. I wanted to buy condoms at the pharmacy, but I was too ashamed to ask for them and be perceived as a bad girl so in the end we had sex without condoms. Then a new boy came to our school and joined our group and introduced us to injecting drugs. I enjoyed the feeling from injecting, and he became my boyfriend. Even though sometimes he would beat me up, I couldn't tell my parents because they knew the boy was a drug user and would know that I had started taking drugs. Meanwhile, my parents were worried about my health and started to control me and ask me to stay more at home. I didn't want to stay at home because I had to clean the house and take care of my little brother and couldn't go outside to earn money by cleaning the cars like all my other friends. Finally, my boyfriend moved to another city, and I started hanging out with some other girls who were injecting in a group of six friends. After a year I had a new boyfriend and I became pregnant. At first, I didn't want to continue the pregnancy but I didn't know what to do or where to go. As I didn't have contact with my family anymore because I was still injecting drugs, I decided to have my own family. A neighbour told me to go to the healthcare centre for consultation, but I had no antenatal care because I was too afraid of the doctors. I didn't want to tell them that I was injecting and I was afraid the doctors would discover it. After few months of pregnancy, I decided to enter into an OST [opioid substitution therapy] programme and I finally gave birth to a bouncy boy. But my partner left me, and I started to use drugs from time to time. I finally lost custody of my child.

# HANDOUT 4
## CROSS THE LINE EXERCISE

- A woman cannot go for family planning without the consent of her husband.
- A woman who is married should never refuse to have sex with her husband.
- A girl can be married at 13 years old, if the parents agree.
- A woman who is sexually active before marriage is a prostitute.
- Women should undergo female genital cutting to reduce sexual urges and ensure faithfulness to their husband.
- A woman who is not yet married should not have a child.
- A woman who is just married should immediately have children to prove her fertility.
- A woman who uses drugs shouldn't have children.
- Transgender women are really men pretending to be women.
- A person's sexuality is their own choice.
- A woman who chooses to be a lesbian can't expect to have children.

# HANDOUT 5
## EXTRACT OF IPPF DECLARATION ON *SEXUAL AND REPRODUCTIVE RIGHTS*

**SEXUAL RIGHTS ARE HUMAN RIGHTS RELATED TO SEXUALITY[4]**
IPPF affirms that sexual rights are human rights. Sexual rights are constituted by a set of entitlements related to sexuality that emanate from the rights to freedom, equality, privacy, autonomy, integrity and dignity of all people.

**The ten sexual rights are:**

**ARTICLE 1 Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender**
All human beings are born free and equal in dignity and rights and must enjoy the equal protection of the law against discrimination based on their sexuality, sex or gender.

**ARTICLE 2 The right to participation for all persons, regardless of sex, sexuality or gender**
All persons are entitled to an environment that enables active, free and meaningful participation in and contribution to the civil, economic, social, cultural and political aspects of human life at local, national, regional and international levels, through the development of which human rights and fundamental freedoms can be realized.

**ARTICLE 3 The rights to life, liberty, security of the person and bodily integrity**
All persons have the right to life, liberty and to be free of torture and cruel, inhuman and degrading treatment in all cases, and particularly on account of sex, age, gender, gender identity, sexual orientation, marital status, sexual history or behaviour, real or imputed, and HIV/AIDS status and shall have the right to exercise their sexuality free of violence or coercion.

**ARTICLE 4 Right to privacy**
All persons have the right not to be subjected to arbitrary interference with their privacy, family, home, papers or correspondence and the right to privacy which is essential to the exercise of sexual autonomy.

**ARTICLE 5 Right to personal autonomy and recognition before the law**
All persons have the right to be recognized before the law and to sexual freedom, which encompasses the opportunity for individuals to have control and decide freely on matters related to sexuality, to choose their sexual partners, to seek to experience their full sexual potential and pleasure, within a framework of non-discrimination and with due regard to the rights of others and to the evolving capacity of children.

**ARTICLE 6 Right to freedom of thought, opinion and expression; right to association**
All persons have the right to exercise freedom of thought, opinion and expression regarding ideas on sexuality, sexual orientation, gender identity and sexual rights, without arbitrary intrusions or limitations based on dominant cultural beliefs or political ideology, or discriminatory notions of public order, public morality, public health or public security.

4. See IPPF (2006), *Sexual rights: an IPPF declaration*. Available at www.ippf.org/sites/default/files/sexualrightsippfdeclaration_1.pdf

**ARTICLE 7** **Right to health and to the benefits of scientific progress**
All persons have a right to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and access to sexual health care for prevention, diagnosis and treatment of all sexual concerns, problems and disorders.

**ARTICLE 8** **Right to education and information**
All persons, without discrimination, have the right to education and information generally and to comprehensive sexuality education and information necessary and useful to exercise full citizenship and equality in the private, public and political domains.

**ARTICLE 9** **Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children**
All persons have the right to choose whether or not to marry, whether or not to found and plan a family, when to have children and to decide the number and spacing of their children freely and responsibly, within an environment in which laws and policies recognize the diversity of family forms as including those not defined by descent or marriage.

**ARTICLE 10** **Right to accountability and redress**
All persons have the right to effective, adequate, accessible and appropriate educative, legislative, judicial and other measures to ensure and demand that those who are duty-bound to uphold sexual rights are fully accountable to them. This includes the ability to monitor the implementation of sexual rights and to access remedies for violations of sexual rights, including access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition and any other means.

### DEFINITION OF SEXUAL AND REPRODUCTIVE HEALTH (GUTTMACHER-LANCET COMMISSION ON SRHR, MAY 2018)[5]

Sexual and reproductive health is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right.

**The Commission advances a comprehensive package of SRHR interventions comprising seven clinical areas in addition to access to information, education, counselling and services to support sexual health and well-being. The Commission also recognises and explicitly acknowledges the SRHR needs of a number of hither-to underserved populations, including people who inject drugs, LGBT populations, young people and sex workers.**

### COMPONENTS OF SRHR

- Gender-based violence
- HIV/AIDS and other STIs
- Contraception
- Maternal and newborn health
- Abortion
- Infertility
- Reproductive cancers

SRHR needs and issues around sexuality and sexual health are addressed through

| Services | Education | Counselling | Information |
|---|---|---|---|

### SRHR NEEDS ARE UNIVERSAL

However, some groups have distinct SRHR needs

- Adolescents ages 10-19 years
- Adults ≥ 50years
- Sex workers
- Displaced people and refugees
- People of diverse sexual orientations, gender identities, and sex characteristics
- People with disabilities
- People who inject drugs
- Racial and ethnic minorities, immigrant groups, indigenous peoples
- Disadvantaged: poor, rural, less educated, living in urban slums

4. Starrs, AM et al. (2018), 'Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission', *Commissions for the Lancet journals*. Available at www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

# HANDOUT 6

## STICKY NOTES (POST-IT) WITH SPECIFIC SERVICES (HARM REDUCTION AND SRHR)

List the following services for comprehensive harm reduction interventions and the additional services and components of SRHR to copy in sticky notes*:

HIV prevention (including condoms)
Harm reduction interventions (including needle and syrine progarmmes, opioid substitution therapy and overdose management with Naloxone)
HIV, AIDS and other STI testing and counselling
HIV/STI treatment and care (including PEP)
Prevention and management of viral hepatitis
Prevention and management of gender-based violence
Contraception
Maternal and newborn health
Safe abortion and post-abortion care
Services for infertility
Cervical cancer treatment

*Based on WHO recommendation for the comprehensive package for prevention and treatment of HIV among people who inject drugs.

**COMPREHENSIVE PACKAGE FOR THE PREVENTION AND TREATMENT OF HIV AMONG PEOPLE WHO INJECT DRUGS**

**A) HEALTH SECTOR INTERVENTIONS**

1. HIV prevention (including condoms)
2. Harm reductions interventions (incl. NSP, OST, Naloxone)
3. HIV testing and counselling
4. HIV treatment and care (including PEP)
5. Prevention and management of viral hepatitis, TB and mental health issues
6. Sexual and reproductive health interventions

**B) CRITICAL ENABLERS**

1. Supportive legislation, policy and funding (including decriminalisation of drug use and possession)
2. Addressing stigma and discrimination
3. Available, accessible and acceptable health services for key populations
4. Enhanced community empowerment
5. Addressing violence against people from key populations

Source: WHO 2016

**COMPONENTS OF SRHR THAT SHOULD BE MADE UNIVERSALLY AVAILABLE**

- Gender-based violence
- HIV/AIDS and other STIs
- Contraception
- Maternal and newborn health
- Safe abortion and post-abortion care
- Services for infertility
- Cervical cancer treatment

SRHR needs and issues around sexuality and sexual health are addressed through:

- Services
- Education
- Counselling
- Information
- Individuals should have autonomy and choice in accessing these services.

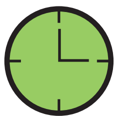
Based on the Guttmacher-Lancet commission, components of SRHR

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

SERVICES PROVIDED BY BOTH

HARM REDUCTION SERVICES

# Module 2
## Sexuality, sexual and reproductive health



**TIME**
2 hours 30 minutes

**MATERIALS**
- Flipchart
- Pens: black, red, blue, green, yellow
- PPT Module 2: sexuality, sexual and reproductive health
- Sticky-notes (Post-it) or sheets of paper
- Sticky notes (Post-it) with name of organs
- Drawings of the male/female internal and external sexual and reproductive organs, labelled
- Drawings of the male/female internal and external sexual and reproductive organs, labelled with 'a' 'b' 'c' in place of the organs' names
- Small prize (e.g. bag of sweets/fruit)
- PPT: Quiz show: myth or reality (with questions and answers)
- Cards REALITY (green) / MYTH (red)
- Cards of the menstrual cycle with days
- **Handout 1:** Quiz show: myth or reality
- **Handout 2:** Male and female sexual and reproductive organs
- **Handout 3:** The menstrual cycle
- **Handout 4:** Table of common hygiene products

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 2** | **Sexuality and sexual health** | Introduction to sexuality and sexual health | • To explain positive approaches to sexuality and sexual health<br>• To discuss myths and reality related to drug use and sexuality |
| | **Sexual and reproductive health** | The female and male sexual and reproductive system | • To identify the bodily characteristics (anatomy and physiology) of male and female sexual and reproductive systems |
| | | Hygiene and menstruation | • To explore intimate hygiene and menstruation<br>• To understand the menstrual cycle and list common menstrual hygiene materials |

## TIPS FOR ONLINE FACILITATION

**EXERCISE 1. SNOWBALL FIGHT: 15 MINUTES**
To keep the anonymous part of the game and allow participants to share all their ideas, encourage participants to use the private chat mode and send their suggestions only to you. After people have done this, collect five words and share them to everyone using the whole group chat. Once all the words have been shared to everyone, the rest of the game can continue. Type the words in different colours in a Word document, or use an online virtual whiteboard, jamboard or Klaxon. You can share your screen to allow participants to follow in a dynamic way.

**EXERCISE 3. KNOW YOUR BODY: 15 MINUTES**
In advance, send the drawing of the shape of a body (in a Word document). Organise the participants into three groups of virtual breakout rooms to discuss the correct names and informal terms for the external sexual organs. One person can share their screen to write down the answers in the Word document. Then ask the groups to return to the main virtual classroom to present their answers.

**EXERCISE 4. GROUP EXERCISE: LOOK AT MY BODY MORE CLOSELY: 15 MINUTES**
Use a PPT slide or a Word document with the drawings of the male/female internal and external sexual and reproductive organs, labelled with 'a' 'b' and 'c' in place of the organs' names. While sharing your screen, ask the participants to name each sexual and reproductive organ by calling out and putting in the chat the different names. Write the names onto the drawings as they are agreed upon.

**EXERCISE 6. GROUP EXERCISE: GIVE ME YOUR SECRET: 10 MINUTES**
Open up virtual breakout rooms to allow discussion in small groups. Present the different types of menstrual hygiene materials by sharing your screen.

## TO PREPARE IN ADVANCE

Prepare some examples about the influence of religion and culture on sexuality in the local context. You should also prepare some examples of the impact of cultural and religious norms and beliefs about menstruation. For instance, in some religions, women and girls are not allowed to take part in religious ceremonies or celebrations during menstruation, or in some communities, women and girls are not allowed to use water sources during menstruation.

**FACILITATOR'S NOTE:**

*While menstruation is often seen as an issue that affects only women and girls, it's important to remember that some gender non-conforming people who don't identify as women or girls may also menstruate, such as intersex, trans-masculine and gender non-binary people. Because of this, it is important to use gender-inclusive language when talking about menstruation (see the introduction for more on this). Given some cultural expectations and stereotypes about menstruation, it's also important to bear in mind that people who don't identify as women or girls, but who menstruate nevertheless, may face particular barriers in accessing menstruation information and commodities (such as sanitary products), or the privacy and dignity to carry out menstrual hygiene, as is their right.*

*It is important to link this module with the Module 1, and remind participants that there are other modules to be referred to.*

***Exercise 3**. Know your body is a good opportunity to challenge binary ideas about biological sex/bodily characteristics, which are often seen as either male or female and as being fixed like that. But in reality, these things sit on a spectrum, with some people being born with both male and female bodily characteristics (intersex) and others changing their bodily characteristics through hormone treatment and gender reassignment surgery.*

*Try to consult a trusted doctor before the session in relation to the menstruation needs of transgender, intersex and other gender non-conforming people in case there are questions about this at the end of the module.*

You should be able to unpack and neutralise any stigma around menstruation and hygiene by preparing in advance then providing clear information about how someone's situation (such as being homeless or not having access to water and soap or menstrual hygiene products) has a direct impact on the ability of some people who use drugs to take care of themselves during menstruation. It is important to remind participants that access to such things are a human right (the right to dignity).

It is also a good idea to think about some questions that are likely to be asked during this session and prepare some answers. For instance:

***Question:** Is it hygienic to have sex during menstruation?*

***Possible answer:** There is no physical reason not to. It is ok to have sex during menstruation, and you can explore having sex in a different way (in the shower, for instance). People can still become pregnant or get HIV or STIs while on their period, so it is a good idea to practice safer sex by using condoms. It is also ok to not want to have sex during menstruation.*

# SEXUALITY AND SEXUAL HEALTH (45 MINUTES)

## INTRODUCTION TO SEXUALITY AND SEXUAL HEALTH (1/2)

**25 minutes**

**Flipchart**
**Pens: black, red, blue, green**
**Sticky notes**
**PPT Module 2: sexuality, sexual and reproductive health**

### SEQUENCE

**Exercise 1. Snowball fight: 15 minutes**

The participants are given sticky notes (post-it) and are invited to write down all the words that come to mind in relation to 'sexuality': one word per sticky-note. The exercise should be done anonymously to encourage participants to write whatever they want to.

They should then scrunch their notes into balls, and throw them at each other like snowballs when you call the start of the 'snowball' fight.

Each participant then collects the sticky notes in balls around them and reads them out loud.

Write them down on a flipchart then ask the participants what they think of the list with the following questions:

***Are there words that apply more to cisgender women, cisgender men, transgender women and transgender men, and other gender non-conforming people?***

Draw a circle in a different colour, depending on whether the words apply more to men or women, or gender-diverse people

***Are there words that are related to health or disease?***

Draw a circle in a fourth colour.

***Are there words that are related to intimacy and relationships?***

Draw a circle in a fifth colour.

**PPT presentation: 10 minutes**

Emphasise the positive aspects of sexuality and sexual health.

Discuss the factors that influence sexuality (e.g. religion, culture), and topics such as when to start having sex and what kind of sex is acceptable.

### KEY MESSAGES

According to WHO's definition of **sexuality**:

Sexuality is a **central aspect of the human person** throughout life, and includes **biological sex**, **gender identity** and **role**, **sexual orientation**, **eroticism**, **pleasure**, **intimacy** and **reproduction**. Sexuality is influenced by several factors such as: biological, psychological, social, economic, political, **cultural**, moral, legal, historical, **religious** and spiritual.

**Emphasise why sexuality is important.**

According to WHO's definition of **health**:
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

According to WHO's definition of **sexual health**:
**Sexual health** is **fundamental to the overall health** and **well-being** of individuals, couples and families. Sexual health, requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, **free of coercion, discrimination and violence**. The ability of men and women to **achieve sexual health and well-being** depends on their:

- access to comprehensive, good-quality information about sex and sexuality
- knowledge about the risks they may face and their vulnerability to adverse consequences of unprotected sexual activity
- ability to access sexual health care.

Sexuality and sexual health-related issues are wide ranging, and encompass sexual orientation and gender identity, sexual expression, relationships, and pleasure. They can also include negative consequences such as: HIV, STIs and reproductive tract infections (RTIs) and adverse outcomes (such as cancer and infertility), unintended pregnancy and abortion, sexual violence and harmful practices (such as female genital mutilation/cutting).

## INTRODUCTION TO SEXUALITY AND SEXUAL HEALTH (2/2)

**20 minutes**

**PPT: Quiz show (with the questions and answers)**
**Cards REALITY (Green) /MYTH (red)**
**Handout 1: Quiz show myth or reality**

### SEQUENCE

**Exercise 2. Quiz show: myth or reality: 15 minutes**

Read the following statements and give the participants 30 seconds to raise their card to show whether they think the statement is myth or reality (**REALITY** in green, **MYTH** in red).

Ask one person to explain their answer then read the correct answer (See Handout 1).

**Discussion and conclusion: 5 minutes**

### KEY MESSAGES

Refer to Handout 1 for complete answers

**1. People who use (opioid) drugs don't enjoy sex**
Myth and reality. People who use drugs can enjoy sex. Opioids, when taken over long periods of time and in relatively high doses, decrease production of certain hormones, specifically androgen and testosterone.

**2. People on OST don't enjoy sex**
Myth and reality. Methadone and buprenorphine generally have effects on people similar to those caused by heroin and other opioids.

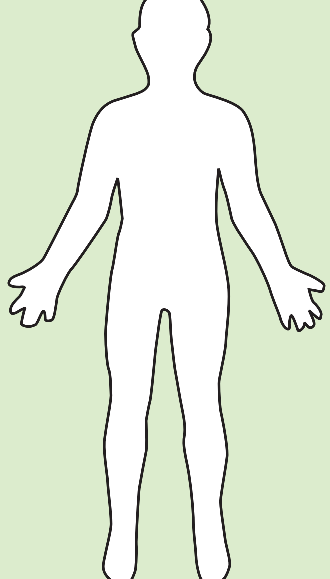
**3. Mixing drugs helps increase sex drive**
Myth and reality. Different drugs have different effects on people. Mixing drugs can have very dangerous effects, so it is safer to avoid doing this.

| SEQUENCE | KEY MESSAGES |
|---|---|
| | **4. Having sex while on stimulants makes sex feel better**<br>Reality. Amphetamine type stimulants (ATS) are known to increase sex drive, keep sex going longer and reduce sexual inhibitions.<br><br>Different people respond differently to different substances, and although there are some common reactions, there are also differences between drugs. Both ATS and opioid use can lead to unsafe sexual practices like having unprotected sex, multiple and concurrent sexual partners and rough or aggressive sex, all of which increase the risk of HIV and STI transmission.<br><br>**Don't listen to myths - look for correct information and ask harm reduction providers about sex and drug use!** |

## SEXUAL AND REPRODUCTIVE HEALTH (1 HOUR 45 MINUTES)

### THE FEMALE AND MALE REPRODUCTIVE SYSTEM

| | | | |
|---|---|---|---|
| | **40 minutes** | | **Sticky notes (Post-it) with name of organs**<br>**Handout 2: Male and female sexual and reproductive organs** |

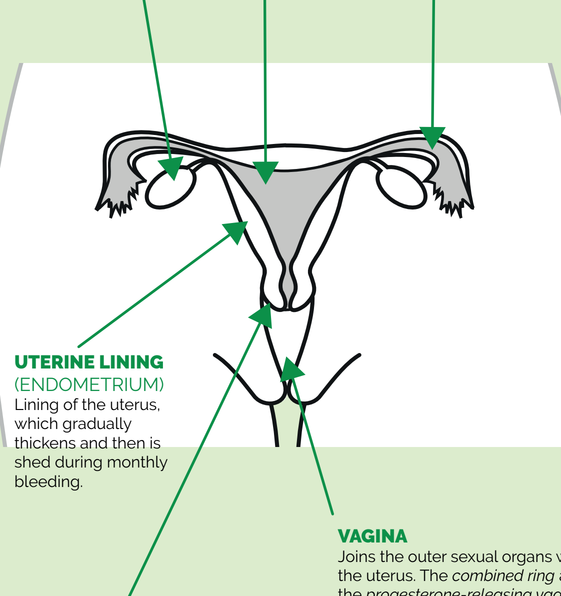
| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 3. Group exercise: Know your body: 15 minutes**<br>Break participants into two groups and provide each group with a very large piece of chart paper (or tape multiple pieces of chart paper together) and colour pens.<br>One participant from each group should lie down on the chart paper and another should loosely trace the body shape onto the chart paper (as seen below).<br>Once you have two body shapes, ask each group to draw and label external sexual organs for one shape body (one group for the male, the second for the female).<br>If people seem embarrassed about working in mixed sex groups, they can work in single-sex groups. In this case, ask the male group to work on the male body and vice versa.<br>Encourage the participants to write the names of the organs in their local language or to write down commonly-used terms without worrying about the technical terms. Ask one member of each team to present their work to the entire group. Ask other participants not to correct the spokespeople, even if they don't agree.<br> | See **Handout 2: Male and female sexual and reproductive organs [italicise the title] for complete messages** |

| SEQUENCE | KEY MESSAGES |
|---|---|

### Exercise 4. Group exercise: Look at my body more closely: 15 minutes

In plenary (the whole group), ask each participant to pick and choose one post-it then stick it correctly to a male or female sexual and reproductive organ, according to the drawings below.

Once all the post-its have been stuck, ask the group if they want to change something then put the correct name on the correct organs. Ask the group to discuss the functions of these organs.




### Female internal genital organs

**Vagina:** the hollow stretchable tube that connects the vaginal opening to the cervix and uterus. It is also known as the birth canal. Important functions of the vagina include: route for menstrual blood to leave the body, its role in sexual pleasure, passage for the baby to come out of the uterus during vaginal delivery.

**Cervix:** the narrow, lower part of the uterus. It has an opening that connects the uterus to the vagina. This opening allows menstrual blood to leave the uterus and sperm to enter into the uterus.

**Uterus (womb):** where a fertilised egg develops into a foetus.

**Fallopian tubes/ or uterine tubes:** two narrow tubes that carry eggs from the ovaries to the uterus. Sperm travels into the fallopian tubes to fertilise the egg.

**Ovaries:** two organs that store eggs. There are thousands of eggs present in each ovary when someone is born. During puberty, an egg starts maturing in one of the ovaries every month. This mature egg is then released in the fallopian tube on its way to the uterus. This process is called ovulation and continues until menopause.

| SEQUENCE | KEY MESSAGES |
|---|---|

**PUBIC HAIR**
Hair that grows during puberty and surrounds the female organs

**CLITORIS**
Sensitive ball of tissue creating sexual pleasure

**INNER LIPS**
(LABIA MINORA)
Two folds of skin, inside the outer lips, that extend from the clitoris

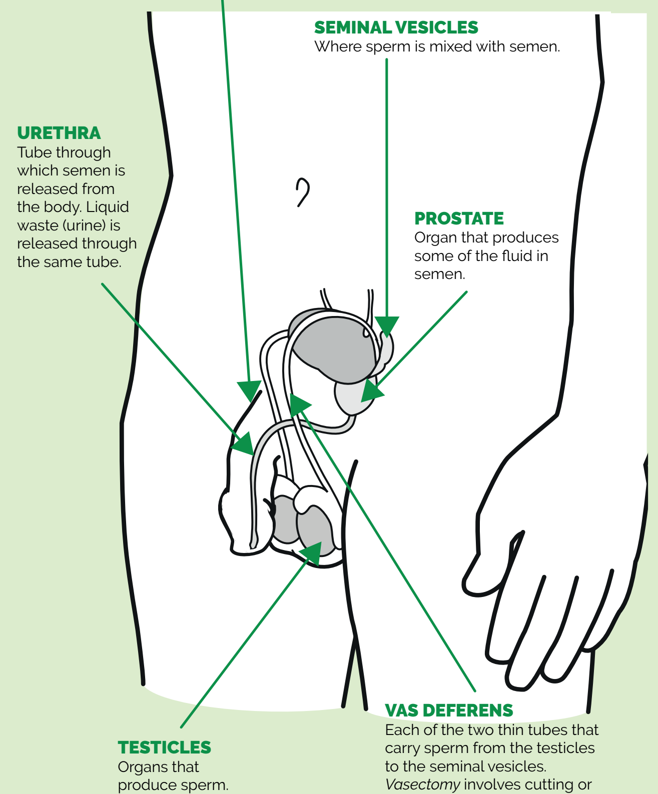
**URETHRA**
Opening where liquid waste (urine) leaves the body

**OUTER LIPS**
(LABIA MAJORA)
Two folds of skin, one on either side of the vaginal opening, that protect the female organs

**VAGINAL OPENING**
The man's penis is inserted here during sexual intercourse. Blood flows from here during monthly bleeding.

**ANUS**
Opening where solid waste (feces) leaves the body

**PENIS**
Male sex organ made of spongy tissue. When a man becomes sexually excited, it grows larger and stiffens. Semen, containing sperm, is released from the penis (ejaculation) at the height of sexual excitement (orgasm). A *male condom* covers the erect penis, preventing sperm from entering the woman's vagina. *Withdrawal* of the penis from the vagina avoids the release of semen into the vagina.




### Female external genital organs

**Vulva:** the external part of the female reproductive organs, located between the legs. This includes the labia, clitoris and the vaginal and urethral openings.

**Outer labia or, labia majora (or outer lips):** a thick fold of skin that is fleshy, covered by pubic hair, and connected to the thighs.

**Inner labia or labia minora (or inner lips):** softer folds of skin, inside the outer lip that cover the vaginal and urethral opening. The inner and outer lips meet together in the pubic area.

**Clitoris:** situated at the upper end of the vulva where the two inner lips meet. The clitoris contains many nerve endings and is highly sensitive to touch, leading to sexual excitement and pleasure.

**Opening of the urethra:** located below the clitoris, between the inner lips and in front of the vaginal opening. This is the outer opening of the tube that connects to the urinary bladder (urethra) from where urine passes out. It is quite small.

**Opening of the vagina:** located below the urethral opening. This is where the penis, fingers or sex toys can be inserted during sex and where tampons can be inserted during menstruation. It is also where menstrual blood and a foetus comes out of the body.

**Hymen:** a thin membrane that covers the opening of vagina. This breaks during sexual intercourse, or even vigorous sports like horse riding or cycling, which can lead to slight bleeding and pain.

**Anus:** opening located behind the vulva where solid waste (faeces) leaves the body. The area separating the vulva and anus is known as the perineum.

### Male internal genital organs

**Testes or testicles:** organs that produce sperm and male hormones.

**Vas deferens:** thin tubes that carry sperm from testicles to seminal vesicles.

**Seminal vesicles:** two sac-like structures that attach to vas deferens. This is where sperm is mixed with semen.

**Prostate glands:** located below the urinary bladder. Produce a fluid that helps nourish the sperms.

**Cowper's glands:** located beneath the prostate gland. Produce a fluid directly into the urethra.

**Urethra:** a tube that empties the bladder and carries urine, pre-ejaculate, and semen to the urethral opening.

**Anus:** opening where solid waste (faeces) leaves the body.

**SEQUENCE**

**UNCIRCUMCISED**

PENIS
SHAFT
FRENULUM
FORESKIN
GLANS
URETHRAL OPENING
SCROTUM (BALLSACK)
ANUS

### PPT presentation: 10 minutes

To present the correct terms and functions with drawings.

**KEY MESSAGES**

### Male external genital organs

**Penis:** the male organ for sexual intercourse. It has a long shaft extending from the lower portion of the belly and a bulbous head, known as the glans penis. During sexual arousal, the spongy tissue of the penis gets filled with blood leading to an erection.

**Urethral opening:** located at the tip of the glans. Urine, pre-ejaculate and semen come out of the body through the urethral opening.

**Scrotum:** sack of thin, loose skin containing the testicles.

## HYGIENE AND MENSTRUATION (1/2)

30 minutes

**SEQUENCE**

### Exercise 5. Brainstorming: 10 minutes

Discuss the following questions:

*What do you know about menstruation?*

*What do you call it in local language or slang?*

*What age does it start?*

*How long does it last?*

*Do all women menstruate? Until when?*

*How do women and some gender non-conforming people who use drugs take care of themselves during menstruation? What are the main challenges they face?*

Note the key points.

### Exercise 6. Group exercise: Give me your secret: 10 minutes

Stick two flipcharts on a wall or board with headings as below.

| OPEN | SECRET |
|---|---|

On the top of the flipcharts write the following definitions:.

- Open: Something you would easily talk about in public, with anyone.
- Secret: Something people do not share or talk about with anyone.

Give the participants two sticky notes each, and ask them to write down, on their own, a practice in regards to menstruation or intimate hygiene to put on one of the flipcharts. Tell them not to hesitate to mention the most secret practices or taboos around menstruation and intimate female hygiene.

Ask the participants to take two minutes to look at all the sticky-notes.

***Tip:*** *you can give participants some examples to get them started, such as:*

*Open: different types of hygiene products, the pain felt during menstruation.*

*Private: the colour of menstrual blood, sex during menstruation, the smell that comes during menstruation.*

**KEY MESSAGES**

### Hygiene and menstruation

**Cultural practices and taboos** around menstruation **impact negatively on the lives of women and girls**, and reinforce gender inequities and exclusion. **Access to hygiene** is part of dignity and **is a human right**. It is important to discuss the need for women to have access to services and correct information related to menstruation.

Trans-masculine/transgender men, gender non-binary and some other gender non-conforming people will menstruate, even if they don't identify as women.

**How do I take care of myself during menstruation?**
Common infections related to poor intimate hygiene are cystitis, urinary tract infections and vaginal mycosis. Poor menstrual hygiene can also impact on the psychosocial wellbeing (e.g. stress levels, fear and embarrassment, and social exclusion during menstruation).

**Certain practices are more likely to increase the risk of infection.** Using unclean rags, especially if they are inserted into the vagina, can introduce bacteria that could lead to infection. Prolonged use of the same pad or tampon and douching (forcing liquid into the vagina/extreme washing) both upset the normal balance of yeast in the vagina. Wiping from back to front following defecation or urination can cause contamination with anal bacteria.

## SEQUENCE

### Conclusion and PPT presentation: 10 minutes

Highlight:

- Specific issues for sex workers and the impact on their work
- Tips for marginalised women who use drugs and/or are living in poor conditions or on the streets

## KEY MESSAGES

For women and gender non-conforming people who use drugs who are living in very precarious environments or living on the streets, some of the following tips can be provided:

- Map out the area where you can access soap and water, including NGOs.
- If you cannot access soap and water, applicator tampons can be easier to use and change. Find a place to dispose of used materials in advance.
- In case of heavy flow, use both pads and a tampon at the same time.

For sex workers:

- If you or your client is uncomfortable with vaginal intercourse during menstruation you can propose alternatives.
- If available, black condoms can be useful during times of low blood loss.

## HYGIENE AND MENSTRUATION (2/2)

**35 minutes**

**Handout 3: The menstrual cycle**
**Handout 4: UNICEF's table of common hygiene products (2019)**

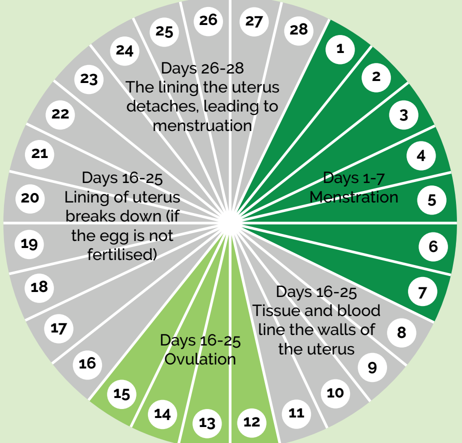
## SEQUENCE

### Exercise 7. Puzzle: 15 minutes

Divide the group in two. Ask each group to correctly stick the pieces of the puzzle to show the menstrual cycle. Do this as a race between groups to make it more fun – and give the winning group a prize (e.g. bag of sweets/fruit).

**THE MENSTRUAL CYCLE:**

| DAYS | PROCESS |
|---|---|
| 1-7: | menstruation |
| 8-11: | tissue and blood line the walls of the uterus |
| 12-15: | ovulation |
| 16-25: | lining of uterus breaks down (if the egg is not fertilised) |
| 26-28: | the lining detaches, leading to menstruation |




## KEY MESSAGES

### Basic information about the menstruation cycle

Menstruation is a natural process linked to the reproductive cycle of women and girls and some gender non-conforming people. It is not a sickness and is a sign of good health. But if not properly managed it can result in health problems.

**What is menstruation?**
Menstruation is a natural bodily function and a sign of reproductive health. It is when bleeding from the uterus comes out of the vagina. Menstruation usually occurs every month for two to seven days. People generally experience some lighter flow and some heavier flow days during their menstrual period. Menstruation starts during puberty, normally between 10 to 18 years old, but may start earlier or later.

**Menstrual cycle** (from UNICEF's *Flow with it babe! Let's talk about feminine hygiene*)

The menstrual cycle is **usually around 28 days** but can vary from 21 to 35 days. The days of the cycle start with menstruation, Days 1 to 5 to 7. Following menstruation, tissue and blood start to line the walls of the uterus to prepare the uterus for receiving a fertilised egg.

**Ovulation occurs between 12th to 15th day** from the first day of last menstrual cycle. This is also the most fertile period. Around Day 14 of each cycle an egg is released from one of the ovaries (ovulation) and moves into the uterus through the fallopian tubes. If the egg is not fertilised, the lining of the uterus then detaches and is shed through the vagina along with blood.

If the woman or person has sex around the time of ovulation sperm may reach the fallopian tubes and fertilise the egg. The fertilised egg travels down to the uterus, thus starting pregnancy.

If the egg is not fertilised (Day 16 to 25), the lining detaches from the uterus (Day 26 to 28), leading to menstruation.

LINK: Nemours KidsHealth video The Menstrual Cycle

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Discussion and presentation PPT: 10 minutes**<br><br>**Brainstorming: 5 minutes**<br>What are the most common sanitary materials used in your community? What are the constraints of each (cost/slow to dry etc.)?<br><br>**Presentation PPT: 5 minutes**<br>To end this module, you can also bring in different types of menstrual hygiene materials and distribute them to participants to have a look at, or leave them on a table so people can have a look at the end of the session. | There is normal variation in the length of the menstrual cycle, the amount of blood loss and the degree of pain and discomfort experienced by women and girls at different ages during their menstrual cycle. The absence of periods (amenorrhea) is normal during the following periods:<br>• During pregnancy<br>• During frequent breastfeeding (lactational amenorrhea)<br>• At the time of menarche (when menstruation first begins)<br>• When food intake is severely limited<br>• Following menopause when menstruation ceases<br>Apart from those periods, not all cisgender women and girls, or people with female reproductive organs menstruate for different reasons.<br>Irregular or absence of menstruation can occur. It can be related to different factors, including using drugs. The use of heroin or methadone among women can cause irregular menstruation or absence of menstruation (amenorrhea). This is because heroin or methadone impacts hormones, including gonadotropin, progesterone and luteinising hormone.<br>However, this doesn't mean that you are not fertile, and you still need to use contraception if you don't plan to be pregnant.<br>Cisgender women and people with female reproductive organs can also have health disorders, such as endometriosis, so it is important to check with a health professional.<br>If you experience a health disorder in regards to menstruation check with a health professional.<br>Sex workers or their clients may prefer alternatives to vaginal intercourse during this period. They may also use black external condom if available or female condoms/<br>For non-binary people and trans-men, hormones may alter their menstruation and it is advised to consult a doctor.<br><br>**Key messages for hygiene products for menstruation**<br>**Menstrual cloth** Use for 2 to 4 hours, insert in your underwear to absorb the blood.<br>**Disposable pad** Use for 3 to 6 hours, insert in your underwear to absorb the blood.<br>**Tampon** (with or without applicators) Use for a maximum of 8 hours, insert into the vagina.<br>**Menstrual cups** Use for 6 to 12 hours, insert into the vagina.<br>Different hygiene products for menstruation are suitable for different people, depending on their state of health, age and other characteristics.<br>Too often, the lack of the basics, such as water, soap, menstrual hygiene materials and housing, is blamed on women and gender non-conforming people who use drugs as if they themselves are unhygienic. It is important to remind participants that service providers need to respect the dignity of women and gender non-conforming people who use drugs and recognise the context in which they live.<br>Actions for harm reduction programmes: in your drop-in centres it is important to provide access to water, soap, and free menstrual materials for women and gender non-conforming people who use drugs. |

# HANDOUT 1
## QUIZ SHOW: MYTH OR REALITY

### 1. PEOPLE WHO USE (OPIOID) DRUGS DON'T ENJOY SEX
**Myth *and* reality.** People who use drugs can enjoy sex. Opioids, when taken over long periods of time and in relatively high doses, decrease production of certain hormones, specifically androgen and testosterone. This has varied side effects in people of different genders. People of all genders can experience decreased sex drive, depression, weight gain, loss of muscle and sweating. People who have periods may also experience menstrual irregularities and people with penises can experience erectile dysfunction. However, apart from the quantity and the duration of opioid use, this also depends on personal characteristics.

### 2. PEOPLE ON OST DON'T ENJOY SEX
**Myth *and* reality.** Methadone and buprenorphine generally have effects on people similar to those caused by heroin and other opioids. But OST is usually prescribed in doses that are too low to affect sexual health - or will have less of an effect on sexual health than herion. Sex drive and enjoyment of sex can actually increase after switching from heroin to methadone or buprenorphine.

### 3. MIXING DRUGS HELPS INCREASE SEX DRIVE
**Myth *and* reality.** Different drugs have different effects on people, so a person may feel a counter-balancing effect happening with certain combinations of drugs, including alcohol. Mixing drugs can be very dangerous though, so it is safer to avoid doing this.

### 4. HAVING SEX WHILE ON STIMULANTS MAKES SEX FEEL BETTER
**Reality.** Amphetamine type stimulants (ATS) and other stimulants, such as cocaine, are known to increase sex drive, keep sex going longer and reduce sexual inhibitions.

# HANDOUT 2

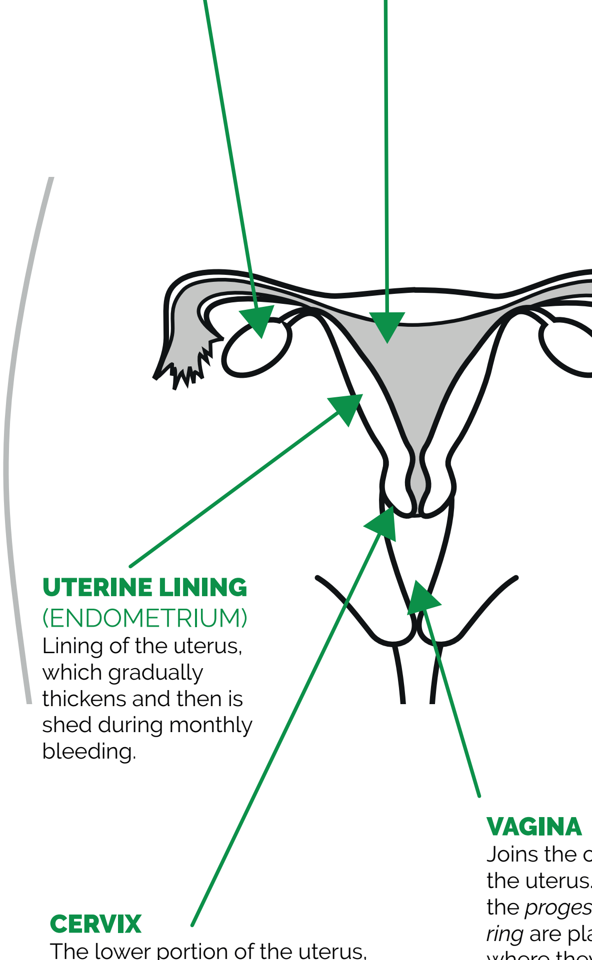
## MALE AND FEMALE SEXUAL AND REPRODUCTIVE ORGANS

**Images sources:** WHO, USAID and John Hopkins (2018), *Family planning, a global handbook for providers, new edition* and Sarah House, Thérèse Mahon and Sue Cavill (2021), *Menstrual hygiene matters, a resource for improving menstrual hygiene around the world.*

**WOMB** (UTERUS)
Where a fertilised egg grows and develops into a fetus. *IUDs* are placed in the uterus, but they prevent fertilisation in the fallopian tubes. *Copper-bearing IUDs* also kill sperm as they move into the uterus.

**OVARY**
Where eggs develop and one is released each month. The *lactational amenorrhea method (LAM)* and hormonal methods, especially those with estrogen, prevent the release of eggs. *Fertility awareness methods* require avoiding unprotected sex around the time when an ovary releases an egg.

**FALLOPIAN TUBE**
An egg travels along one of these tubes once a month, starting from the ovary. Fertilisation of the egg (when sperm meets the egg) occurs in these tubes. Female sterilisation involves cutting or clipping the fallopian tubes. This prevents sperm and egg from meeting. IUDs cause a chemical change that damages sperm before they can meet the egg in the fallopian tube.



**UTERINE LINING** (ENDOMETRIUM)
Lining of the uterus, which gradually thickens and then is shed during monthly bleeding.

**CERVIX**
The lower portion of the uterus, which extends into the upper vagina. It produces mucus. *Hormonal methods* thicken this mucus, which helps prevent sperm from passing through the cervix. Some *fertility awareness methods* require monitoring cervical mucus. The *diaphragm, cervical cap*, and *sponge* cover the cervix so that sperm cannot enter.

**VAGINA**
Joins the outer sexual organs with the uterus. The *combined ring* and the *progesterone-releasing vaginal ring* are placed in the vagina, where they release hormones that pass through the vaginal walls. The *female condom* is placed in the vagina, creating a barrier to sperm. *Spermicides* inserted into the vagina kill sperm.

### FEMALE INTERNAL GENITAL ORGANS

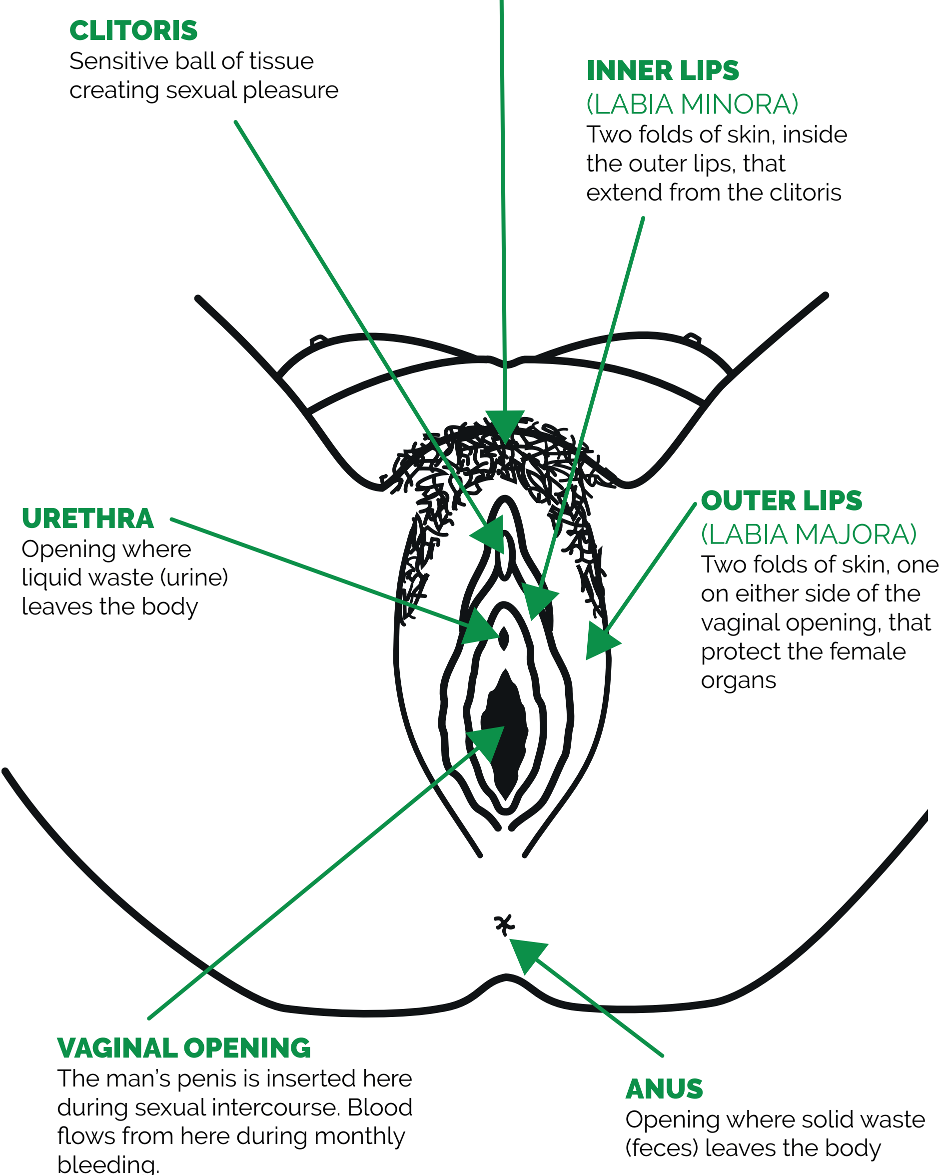
**Vagina:** the hollow stretchable tube that connects the vaginal opening to the cervix and uterus. It is also known as the birth canal. Important functions of the vagina include: route for menstrual blood to leave the body, its role in sexual pleasure, passage for the baby to come out of the uterus during vaginal delivery.

**Cervix:** the narrow, lower part of the uterus. It has an opening that connects the uterus to the vagina. This opening allows menstrual blood to leave the uterus and sperm to enter into the uterus.

**Uterus (womb):** where a fertilised egg develops into a foetus.

**Fallopian tubes/uterine tubes:** two narrow tubes that carry eggs from the ovaries to the uterus. Sperm travels into the fallopian tubes to fertilise the egg.

**Ovaries:** two organs that store eggs. There are thousands of eggs present in each ovary when someone is born. During puberty, an egg starts maturing in one of the ovaries every month. This mature egg is then released in the fallopian tube on its way to the uterus. This process is called ovulation and continues until menopause.




## FEMALE EXTERNAL GENITAL ORGANS

**Vulva:** the external part of the female reproductive organs, located between the legs. This includes the labia, clitoris and the vaginal and urethral openings.

**Outer labia or labia majora (or outer lips):** a thick fold of skin that is fleshy, covered by pubic hair, and connected to the thighs.

**Inner labia or labia minora (or inner lips):** softer folds of skin, inner to the outer lip and covering the vaginal and urethral openings. The inner and outer lips meet together in the pubic area.

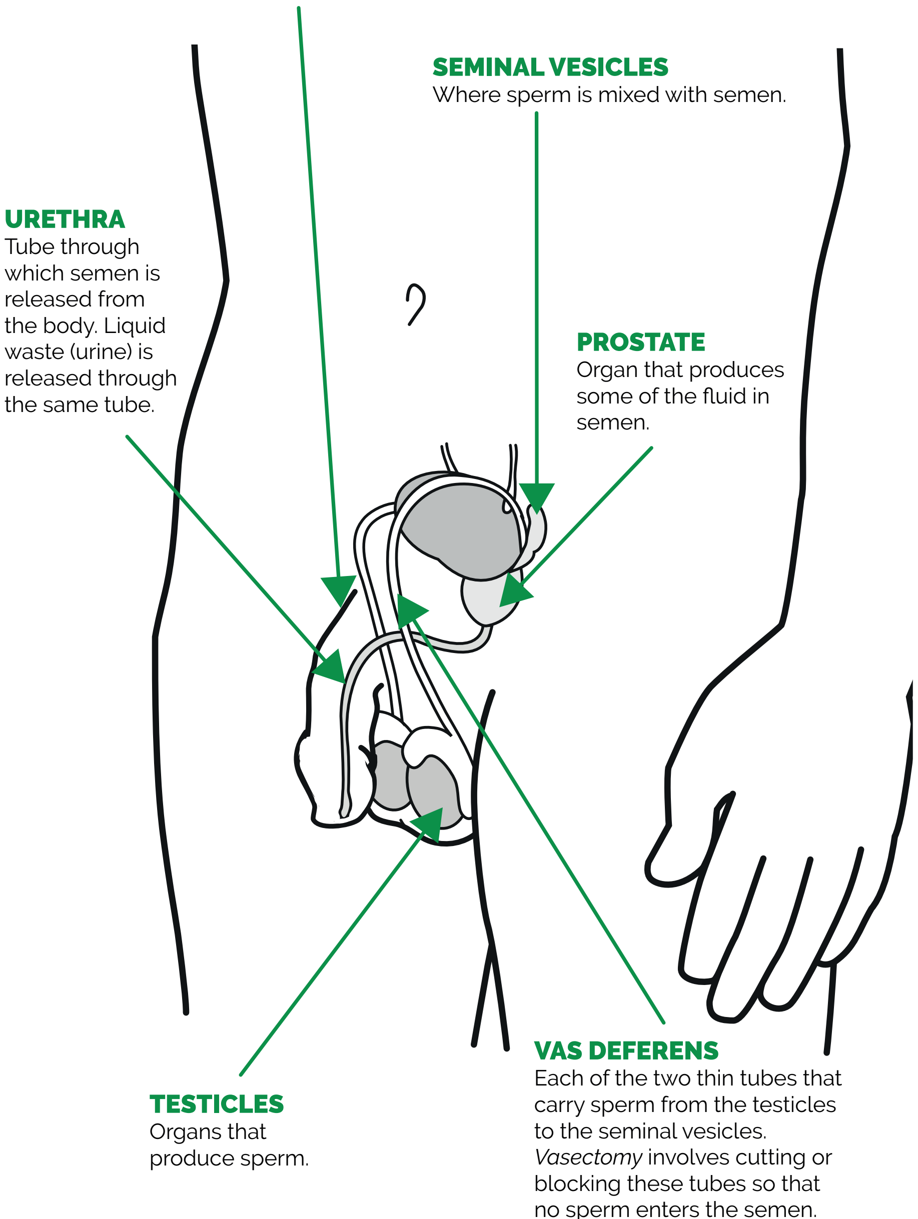
**Clitoris:** situated at the upper end of the vulva where the two inner lips meet. The clitoris contains many nerve endings and is highly sensitive to touch, leading to sexual excitement and pleasure.

**Opening of the urethra:** located below the clitoris, between the inner lips and in front of the vaginal opening. This is the outer opening of the tube that connects to the urinary bladder (urethra) from where urine passes out. It is quite small.

**Opening of the vagina:** located below the urethral opening. This is where the penis, fingers or sex toys can be inserted during sex and where tampons can be inserted during menstruation. It is also where menstrual blood and a foetus comes out of the body.

**Hymen:** a thin membrane that covers the opening of the vagina. This breaks during sexual intercourse, or even vigorous sports like horse riding or cycling, which can lead to slight bleeding and pain.

**Anus:** opening located behind the vulva where solid waste (faeces) leaves the body. The area separating the vulva and anus is known as the perineum.




**MALE INTERNAL GENITAL ORGANS**

**Testes or testicles:** organs that produce sperm and male hormones.

**Vas deferens:** thin tubes that carry sperm from testicles to seminal vesicles.

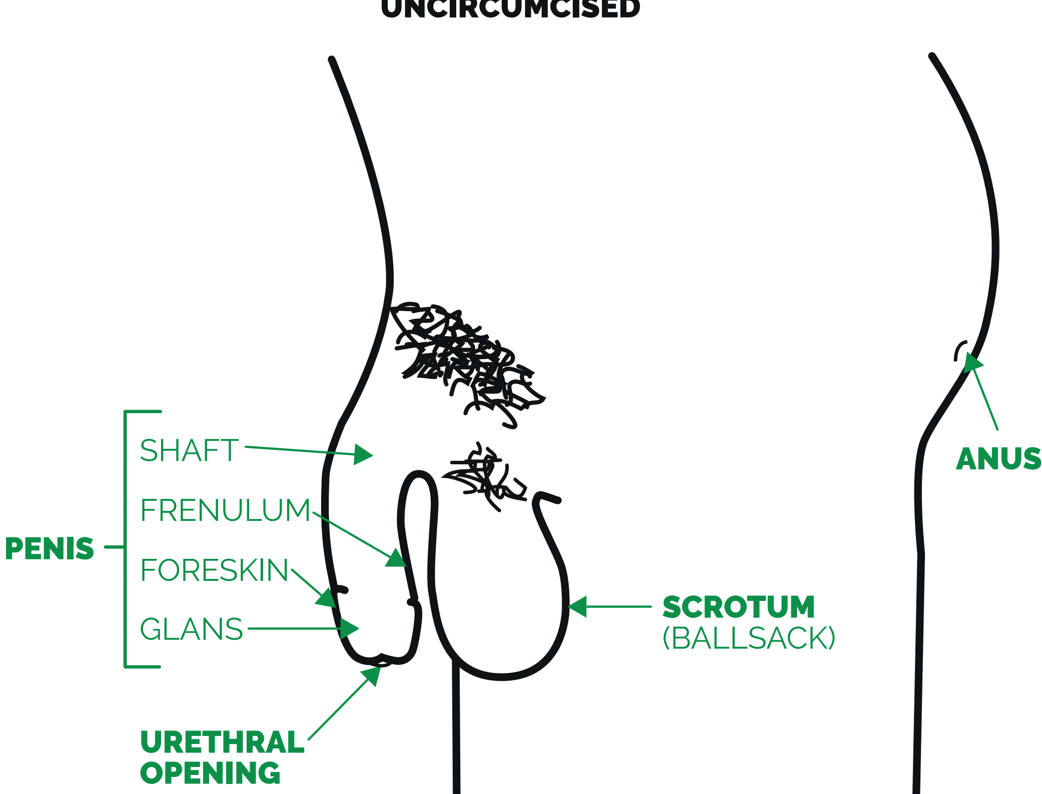
**Seminal vesicles:** two sac-like structures that attach to vas deferens. This is where sperm is mixed with semen.

**Prostate glands**: located below the urinary bladder. Produce a fluid that helps nourish the sperms.

**Cowper's glands:** located beneath the prostate gland. Produce a fluid directly into the urethra.

**Urethra:** a tube that empties the bladder and carries urine, pre-ejaculate, and semen to the urethral opening.

**Anus:** opening where solid waste (faeces) leaves the body.




## MALE EXTERNAL GENITAL ORGANS

**Penis:** the male organ for sexual intercourse. It has a long shaft extending from the lower portion of the belly and a bulbous head, known as the glans penis. During sexual arousal, the spongy tissue of the penis gets filled with blood leading to an erection.

**Urethral opening:** located at the tip of the glans. Urine, pre-ejaculate and semen come out of the body through the urethral opening.

**Scrotum:** sack of thin, loose skin containing the testicles.

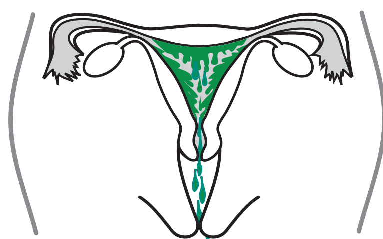
**Source image:** Planned Parenthood

## WORDS FOR EXERCISE 4
## GROUP EXERCISE: LOOK AT MY BODY MORE CLOSELY

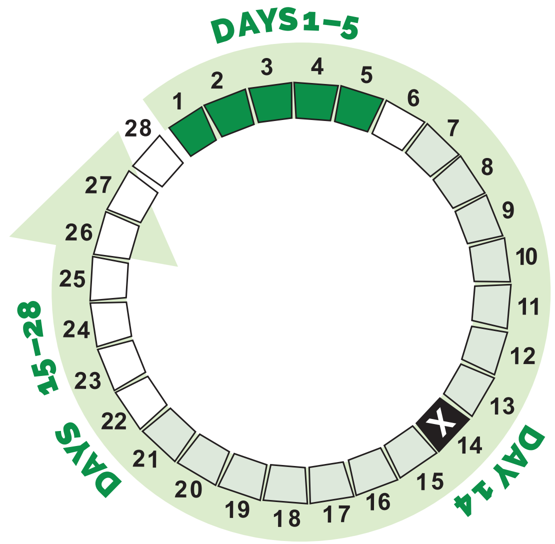
| | | |
|---|---|---|
| Pubic hair | Scrotum | Anus |
| Penis | Urethral opening | Testicles |
| Epididymis | Vas deferens | Seminal vesicles |
| Prostate glands | Cowper's glands | Labia majora |
| Urethra | Opening of the urethra | Clitoris |
| Anus | Vagina | Ovaries |
| Cervix | Vulva | Hymen |
| Uterine tubes | Uterus (womb) | Opening of the vagina |

# HANDOUT 3
## THE MENSTRUAL CYCLE

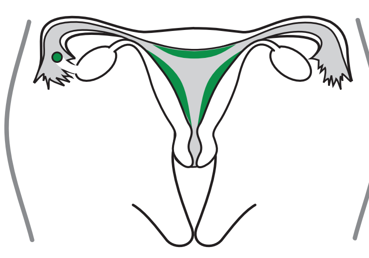
### 1. DAYS 1–5: MONTHLY BLEEDING



**Usually lasts from 2–7 days, often about 5 days**
If there is no pregnancy, the thickened lining of the womb is shed. It leaves the body through the vagina. This monthly bleeding is also called menstruation. Contractions of the womb at this time can cause cramps. Some women bleed for a short time (for example, 2 days), while others bleed for up to 8 days. Bleeding can be heavy or light. If the egg is fertilised by a man's sperm, the woman may become pregnant, and monthly bleeding stops.

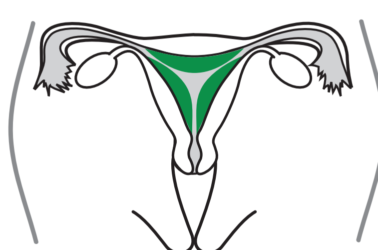



### 2. DAY 14: RELEASE OF EGG



**Usually occurs between days 7 and 21 of the cycle, often around day 14**
Usually, one of the ovaries releases one egg in each cycle (usually once a month). The egg travels through a fallopian tube towards the womb. It may be fertilised in the tube at this time by a sperm cell that has travelled from the vagina.

### 3. DAYS 15–28: THICKENING OF THE WOMB LINING



**Usually about 14 days long, after ovulation**
The lining of the uterus (endometrium) becomes thicker during this time to prepare for a fertilised egg. Usually there is no pregnancy, and the unfertilised egg cell dissolves in the reproductive tract.

## PIECES OF THE PUZZLE

| | |
|---|---|
| DAYS 1-7 | DAYS 8-11 |
| DAYS 12-15 | DAYS 16-25 |
| DAYS 26-28 | OVULATION |
| MENSTRUATION | TISSUE AND BLOOD LINE THE WALLS OF THE UTERUS |
| THE LINING OF UTERUS BREAKS DOWN (IF THE EGG IS NOT FERTILISED) | THE LINING DETACHES, LEADING TO MENSTRUATION |

# HANDOUT 4
## COMMON MENSTRUAL HYGIENE MATERIALS

| | MENSTRUAL CLOTH | REUSABLE PAD | DISPOSABLE PAD | MENSTRUAL CUP | TAMPON |
|---|---|---|---|---|---|
| **Insertion** | – | – | – | Yes | Yes |
| **Reusable** | Max. 1 year* | 1+ year | – | 5-10 years | – |
| **Wear time** | Approximately 2-4 hours* | Approx. 3-6 hours | Approx. 3-6 hours | Approx. 6-12 hours | Max. 8 hours |
| *There is a lack of guidance on safe wear and lifetime of cloths. The stated timeframes are estimates. | | | | | |
| **Supportive supplies needed** | Soap for handwashing, laundry detergent, bucket for washing, clothesline, storage bag, underwear, scissors. | Soap for handwashing, laundry detergent, bucket for washing, clothes line, storage bag, underwear. | Soap for handwashing, underwear, lidded bins inside toilet. | Soap for handwashing, container for boiling. | Soap for handwashing, lidded bins inside toilet stall. |
| **Supportive environment needed** | Sufficient water for washing (daily), private washing space, drying space, solid waste management system. | Sufficient water for washing (daily), private washing space, drying space. | Solid waste management system in place from on-site to end point. | Water for sterilisation (one time per cycle), hygienic space for storage, water inside toilet stall. | Solid waste management system in place from on-site to endpoint. |

**From:** UNICEF (2019), Guide to Menstrual Hygiene Materials

Different hygiene products for menstruation are suitable for different people who have periods, depending on the state of their health, age and other characteristics.

# Module 3
## Gender-based violence

**TIME**
2 hours 10 minutes

**MATERIALS**
- Flipchart
- Colour pens
- Cards in green (True) and red (False)
- **Handout 1:** Quiz: gender-based violence questions and answers
- **Handout 2:** Extract from the Declaration on the Elimination of Violence against Women
- **Handout 3**: Case study
- **Handout 4:** The Wheel of Power and Control
- **Handout 5:** Individual safety plan
- **Handout 6:** Social support map
- **PPT Module 3:** Gender-based violence

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 3** | **Gender-based violence** | Types of gender-based violence and intimate partner violence | • To understand the importance of primary prevention and to identify signs and symptoms of gender-based violence<br>• To draw a safety plan and social support mapping<br>• To define a comprehensive package of quality post-violence care and referral services for women and gender non-conforming people who use drugs who experience gender-based violence and intimate partner violence |

### TIPS FOR ONLINE FACILITATION

For the quiz on gender-based violence, prepare in advance an online poll using Mentimeter (for example) then send the link to participants to create an engaging and live quiz session. To do the quiz session, share your screen to show the results of the poll for each statement.

If people have poor internet connectivity, an alternate solution is to ask participants in advance to prepare their own answer cards. They can do this by cutting a sheet of A4 paper in two then writing in big letters 'True' on one piece and 'False' on the other or use colour pens to draw a circle in red and one in green and colour in the middle. The participants can then use their webcam to show the answer card they choose for each question.

### TO PREPARE IN ADVANCE

It is a good idea to print the gender-based violence quiz questions and answers as a handout to share with participants, or you can share it virtually by emailing it to participants at the end of the session.

You should beware that it is likely that some participants will have experienced gender-based violence. So be careful with the words you use, and be prepared for one or more people to want to share their story. Be ready to pause and deal with strong emotions among participants, and refer people to counselling services if needed.

# GENDER-BASED VIOLENCE (2 HOURS 15 MINUTES)

## TYPES OF GENDER-BASED VIOLENCE AND INTIMATE PARTNER VIOLENCE (1/3)

**10 minutes**

**Pens**
**PPT Module 3: Gender-based violence**
**Handout 1: Quiz on gender-based violence questions and answers**
**Cards green (True) and red (False)**
**Handout 2: Extract from the Declaration on the Elimination of Violence against Women**

### SEQUENCE

**Exercise 1. Quiz show on gender-based violence: 10 minutes**

| Statement | Answer |
|---|---|
| **1** Gender-based violence is not a huge problem, but became popular because there is international funding for it. | **F** |
| **2** Worldwide, an estimated 1 in 3 women will experience physical or sexual abuse in her lifetime. | **T** |
| **3** Most gender-based violence is perpetrated by strangers. | **F** |
| **4** Gender-based violence concerns only women and girls. | **F** |
| **5** There is no sexual violence between married couples. | **F** |
| **6** Child, early, and forced marriage are types of gender-based violence. | **T** |
| **7** Sex workers are less likely to experience rape or sexual violence because it is their job. | **F** |
| **8** Women who use drugs are more likely to experience intimate partner violence than women in the general population. | **T** |

*See answers in Handout 1*

### KEY MESSAGES

**Definition (UNFPA)**

**Gender-based violence is any act of violence that is inflicted upon an individual because of his or her gender or sexual orientation**. Gender-based violence is a **global public health epidemic** that affects mostly women and girls but can also affect men and boys, especially if they don't conform to gender stereotypes, and transgender persons. It is deeply rooted in gender inequality and can have severe consequences.

Gender-based violence is a **violation of fundamental human rights** as such:

- The right to life
- The right to security and body integrity
- The right to equal protection
- The prohibition of torture and other cruel, inhuman or degrading treatment

(See Handout 2: Article 3 of the Declaration on the Elimination of Violence against Women)

Most perpetrators are intimate partners – including clients of sex workers – although sometimes perpetrators are family members, friends, acquaintances, strangers, doctors, teachers, colleagues, military, prison guards, rehabilitation staff or police officers.

## TYPES OF GENDER-BASED VIOLENCE AND INTIMATE PARTNER VIOLENCE (2/3)

**50 minutes**

**Handout 3: Case study A, B and C**
**Handout 4: The wheel of control and power**

### SEQUENCE

**Exercise 2. Case-study: 20 minutes**

Divide the participants in three groups and give one case study to each group.

Ask each group to identify and list:

- The different signs or symptoms of gender-based violence
- The types of gender-based violence the woman has experienced
- What has been done

**Report back: 15 minutes**

**PPT presentation: 15 minutes**

### KEY MESSAGES

Violence can take different forms and is **classified according to two criteria:**

1. Type of violence
2. Type of perpetrators or the link between the perpetrators and the victim/survivor

There are several types of violence:

- Physical violence (e.g. hitting, kicking, punching, slapping, restraining). Physical abuse can also include not giving psychoactive substances to someone who is dependent, not giving HIV treatment or hormone therapy.
- Sexual violence (e.g. sexual abuse and rape, sexual sadistic pleasure at the expense of the partner, condom refusal)
- Emotional/psychological violence (e.g. stigmatisation, harassment, verbal abuse)
- Economic and social violence (e.g. blackmail, discrimination, control of budget)
- Exploitation and trafficking of human beings, including sex trafficking
- Harmful practices (e.g. female genital mutilation, honour killings, forced marriages, early marriages, sex-selective abortion)

Lesbian women and other LGBT+ people also face additional risks and specific forms of sexual violence, such as homophobic rape (sometimes called 'corrective rape', see definition in Annex Two) and other kinds of crimes.

| SEQUENCE | KEY MESSAGES |
|---|---|
| | Violence can also be classified according to perpetrator categories:<br>• Violence by an intimate partner<br>• Violence by the family<br>• Community violence<br>• Institutional / state violence (includes violence by police, prison wardens, and in health settings)<br>Present The Wheel of Control and Power against women (Handout 4)<br><br>**Focus on female genital mutilation/cutting**<br>**WHO's definition:**<br>Female genital mutilation/cutting (FGM/C) **comprises all procedures that involve partial or total removal of the external female genitalia**, or other **injury to the female genital organs**.<br>FGM/C is performed early in life on girls (0–14 years), **is an extreme form of discrimination against women and a violation of their human rights**—i.e. their right to health, security, and physical integrity, and to be free from torture and cruel, inhuman, or degrading treatment. FGM **is associated with a range of complications**, including severe bleeding, problems urinating, infections and complications in childbirth, and can lead to death.<br>There are **structural enablers of gender-based violence,** including prohibitive and coercive drug legislation and policy, stigmatising policy and legislation against women, or against women living with HIV, homophobic and transphobic legislation and laws.<br>There is a wide range of **consequences of gender-based violence**, including:<br>• **Physical consequences**, such as chronic pain, STIs, HIV, unintended pregnancy<br>• **Psychological consequences**, such as shame, depression, feelings of insecurity, guilt, post-traumatic stress disorder and complex post-traumatic stress<br>• **Socio-economic consequences**, such as social exclusion, family rejection and loss of resources<br>In addition, failure to address gender-based violence and intimate partner violence experienced by women and gender non-conforming people who use drugs has been found to increase the likelihood of continued drug use, relapse and leaving drug treatment programmes.<br><br>**HIV and gender-based violence**<br>Gender-based violence is a direct and indirect risk factor for HIV transmission. And living with HIV is a risk factor for gender-based violence. Gender-based violence can also stop people accessing treatment or remaining in care. Living with HIV also exposes women and gender non-conforming people to new forms of violence, such as coerced or forced sterilisation, and other violations of their sexual and reproductive health and rights.<br>**The followings signs or symptoms can alert providers to possible gender-based violence:**<br>• Chronic pain<br>• Headaches<br>• Sleep disturbances<br>• Depression<br>• Repeated consultations without apparent reason<br>• Anxiety/stress<br>• Withdrawn or aggressive behaviour |

## TYPES OF GENDER-BASED VIOLENCE AND INTIMATE PARTNER VIOLENCE (3/3)

1 hour 10 minutes

**Handout 5: Individual safety plan**
**Handout 6: Social support map**

### SEQUENCE

**Exercise 3. Draw a safety plan and social support map: 40 minutes**

Ask the participants to take 10 minutes on their own to start to draw their own individual safety plan.

In pairs, ask the participants to develop a social support map. To do this, one person should take the role of the harm reduction provider and the other should take the role of a woman or gender non-conforming person. The harm reduction provider should support the beneficiary to develop their own map by following the different steps in Handout 4.(20 mins)

Discussion: 10 minutes

Discuss the following points with the group:

- Ideally, creating individual safety plans and social support maps should be done as part of larger or long-term services that engage women and gender non-conforming people who use drugs.
- Safety plans should be adapted for sex workers, including strategies to reduce the risks of violence from clients.

**Exercise 4. The World Café: 20 minutes**

Divide the participants into three groups (Groups 1, 2 and 3).

Ask them to provide a list of services/activities for either:

1. Primary prevention: before violence occurs to reduce incidents of violence
2. Secondary prevention: offering a comprehensive package of post-violence care and referral services for gender-based violence
3. Secondary prevention: offering a comprehensive package of services for sexual violence, including rape

Ask Group 1 to work on the first prevention topic, Group 2 to work on the second and Group 3 to work on the third. Each group should list the actions/services that can be offered for their prevention topic on a flipchart.

After 5 minutes, ask the groups to change and try to complete the list of another group, then after 5 more minutes ask them to change again to complete the last flipchart.

The whole group can then take 5 minutes to look at what the other groups have written on each of the flipcharts.

**PPT presentation and conclusion: 10 minutes**

### KEY MESSAGES

**'Red flags' include:**

- Vague complaints that have no obvious physical cause
- Wounds and blow marks or injuries that do not match the explanation of how they were sustained, or refusal to reveal the cause
- A partner who is overly attentive, controlling, or unwilling to leave someone's side
- Physical injury during pregnancy
- A history of attempted suicide or suicidal thoughts
- Delay between injury and the seeking of treatment

BEWARE: Women and gender non-conforming people often have reasons for staying in a violent situation. For example:

- Fear of withdrawal if their partner procures drugs
- Fear of losing custody of their children
- Extremely low self-esteem, which leads them to believe they won't be able to cope on their own

It is important not to judge someone's choices. It is important to apply the 'Do no harm' principle, which means enabling someone to receive support and remain alive until the moment they can get out of the situation of violence.

**What can be done?**

There are different prevention strategies:

- Primary prevention: prevent gender-based violence before it occurs
- Secondary prevention: reduces the short-term consequences of gender-based violence (within 72 hours for sexual violence)

**Primary prevention includes:**

- Community services to change social, economic and gender norms that normalise gender-based violence
- Training harm reduction providers on gender-based violence
- Group education for men and boys, combined with community outreach
- Women-only safe spaces and/or times within harm reduction sites
- Information and education materials to promote the post-violence support that is available
- Supporting women to develop a personalised safety plan and social support map
- Advocating for domestic violence shelters to open their doors to women and gender non-conforming people who use drugs

For harm reduction implementers, if gender-based violence services cannot be provided directly, it is important to be able to link people to hotlines and other support and assistance services for women and gender non-conforming people in situations of violence.

**Secondary prevention:**

A comprehensive post-violence care package consists of:

- Medical examination and follow up
- Referral to /or provision of continuous psychosocial support, trauma therapy and follow up
- Self-help groups
- Referral to /or provision of protective orders and emergency shelters
- Referral to/or provision of legal support services and/or accompaniment to make a complaint

| SEQUENCE | KEY MESSAGES |
|---|---|
| | In case of rape and sexual violence, in addition to the above services:<br>• Emergency contraception and PEP for HIV prevention within 72 hours<br>• Access/referral to safe abortion if needed<br>• Screening and treatment for STIs<br>• Referral to legal services, including medical examination and medical certificate<br>**Quality** is essential in offering the above services to survivors of gender-based violence. This means:<br>• Confidentiality<br>• A timely response, within 72 hours<br>• Asking for consent<br>• Prioritising safety<br>• Avoiding questioning the survivor's word<br>• Avoiding interrupting the person to ask questions<br>• Not forcing the person to talk<br>**Gender-based violence must be addressed in the context of ending all forms of discrimination, advancing gender equality and the empowerment of women and gender non-conforming people, and creating a world in which all women and gender non-conforming people enjoy all their human rights.**<br>**Critical enablers are:**<br>• Supportive legislations, policies and funding (including the decriminalisation of drug use, drug possession and sex work)<br>• Addressing stigma and discrimination<br>• Availability, accessibility, acceptability (quality) and affordability of sexual and reproductive health services, including gender-based violence services for women and gender non-conforming people who use drugs<br>• Enhancing women's community empowerment and engaging men to promote positive masculinity<br>• Transforming social and gender norms to challenge the acceptability/normalisation of all forms of gender-based violence<br>• Addressing violence against women in all their diversity and gender non-conforming people |

# HANDOUT 1

## GENDER-BASED VIOLENCE QUIZ: QUESTIONS AND ANSWERS

| | | |
|---|---|---|
| 1 | Gender-based violence is not a huge problem, but became popular because there is international funding for it. | F |
| 2 | Worldwide, an estimated 1 in 3 women will experience physical or sexual abuse in her lifetime. | T |
| 3 | Most gender-based violence is perpetrated by strangers. | F |
| 4 | Gender-based violence concerns only women and girls. | F |
| 5 | There is no sexual violence between married couples. | F |
| 6 | Child, early, and forced marriage are types of gender-based violence. | T |
| 7 | Sex workers are less likely to experience rape or sexual violence because it is their job. | F |
| 8 | Women who use drugs are more likely to experience intimate partner violence than women in the general population. | T |

**1. FALSE**
Gender-based violence has been described by the World Health Organization (WHO) as a **global public health problem of epidemic proportions** and a fundamental violation of human rights.

**2. TRUE**
According to **WHO data from 2013**, one in every three women will be beaten, coerced into sex or abused in some other way during her lifetime – most often by someone she knows.

**3. FALSE**
Most perpetrators are intimate partners, defined as past or current spouse or sexual partners, although they are sometimes family members, friends, acquaintances, strangers, teachers, doctors, colleagues, prison guards, rehabilitation centre staff, military, or police officers.

**4. FALSE**
Violence against women and girls is one of the most prevalent human rights violations in the world. Although most gender-based violence is inflicted on women and girls, men and boys can also be affected, particularly during childhood, and violence is more likely if they do not conform to social norms regarding sexual orientation and gender identity. (Source: Lancet)

**5. FALSE**
Rape and sexual violence can occur between married couples, although many countries don't acknowledge 'marital rape' as a crime. Sexual violence can occur from intimate partners who are female or male, and within relationships that are long-term or casual.

**6. TRUE**
Child, early and forced marriage are forms of gender-based violence. Child marriage is widespread: around 1 in 3 girls in low- and middle-income countries are married before they are 18. **According to UNFPA, 37,000 child marriages happen every day**. Child marriage is a violation of human rights. It compromises the development of girls (and boys). Moreover, it often results in early and/or unintended pregnancy and increases risks of maternal deaths, unsafe abortion, HIV, poor health, poor education and social isolation. (Sources: UNFPA/UNICEF)

**7. FALSE**
Because of punitive laws, stigma and discrimination against sex work, sex workers experience a high-level of violence in general, and sexual violence in particular, from clients and also from the police, military etc. Sex workers who use drugs experience greater levels of police sexual violence, rape, harassment and abuse, including invasive strip and cavity searches. (Source: **The Global Network of Sex Work Projects and The International Network of People who Use Drugs**, (2015) *Briefing paper sex workers who use drugs: experiences, perspectives, needs and rights, ensuring a joint approach*)

**8. TRUE**
Data indicates that women who use drugs are more likely to experience intimate partner violence and non-partner sexual violence than women who do not. In places with harsh laws and policies on drug use and sex work, sex workers who use drugs experience overlapping layers of risk caused by the combined effects of criminalisation, stigma and discrimination – especially where compulsory rehabilitation exists.

# HANDOUT 2

## EXTRACT FROM THE UNITED NATION'S 1993 DECLARATION ON THE ELIMINATION OF VIOLENCE AGAINST WOMEN

Women are entitled to the equal enjoyment and protection of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. These rights include:

**(a)** The right to life;
**(b)** The right to equality;
**(c)** The right to liberty and security of person;
**(d)** The right to equal protection under the law;
**(e)** The right to be free from all forms of discrimination;
**(f)** The right to the highest standard attainable of physical and mental health;
**(g)** The right to just and favourable conditions of work;
**(h)** The right not to be subjected to torture, or other cruel, inhuman or degrading treatment or punishment.

# HANDOUT 3

## CASE STUDY A, B AND C

### CASE STUDY A

This case study is adapted from a true story; names and places have been changed.

My name is Jo and I work with an NGO in India. In 2016, we implemented the WINGS pilot project, which aimed to end domestic violence. During this project, I met several women who experienced different types of gender-based violence, including Sujama. This is her story.

Sujama was born in a poor family in a village on the outskirts of the city. Her parents were casual workers, and hardly managed to make ends meet with their meagre earnings. Her childhood was filled with taking care of her younger siblings, cooking food for the family, and helping her mother with housework. When Sujama was 14, she was married off to a 35-year-old man. This was a child marriage. Sujama went to live at her husband's house, and by the age of 15 she had a son. Her husband was an abusive man who drank every day. Soon the beatings started, but Sunita had nowhere to turn to for help. Her parents disowned her when she asked for help. The abuse went on for many years until her husband died of liver cancer. Her son was 25 years old when I met her. He also started to drink alcohol and soon he was depending upon her for money for all kinds of expenses. If she did not give him money, he would beat her severely. She was doing house work for others and earned about 2000 rupees a month, which he would snatch away. In 2016, when we met, Sujama had no motivation to talk about herself and how she felt, and always sat quietly in a corner. During one session, I saw that she had several marks that were black and blue. She didn't want to tell me about them, and sometimes remained quiet during the session She was afraid of being kicked out of the house, and she had no relatives or friends to ask for support. I encouraged her to attend every support group meeting, where other women like her shared their stories, and she felt better knowing that she was not alone. I also told her about myself and my struggles, and eventually she started to open up. She started working on a safety plan and goal setting with me and my colleagues in the organisation. We went through regularly to see if it needed any changes. We then introduced her to her legal rights and took her to the doctor who worked for our organisation for a general check-up. She started taking care of her health. One day, when her son hit her again, she informed us and we took her to the women's police section where she was able to file a formal complaint. This step gave her a much-needed boost. Since then, she has referred other women who are experiencing violence and has become an active member of the women's groups. She is now helping other women to stand their ground and is living a peaceful life.

### CASE STUDY B

This case study is adapted from a true story; names and places have been changed.

My name is Uma and I met Munni in 2016, when I started to work in drop-in-centre (DIC) in a city in India. Munni was 25 and had a 5-year-old daughter. When I met Munni, I noticed she had many cut marks on her face and hardly ever smiled. She was a sex worker and would find her customers in and around the Pune railway station in the late evenings and nights. She would come to the DIC during the day and leave when it closed. The father of her child was a drug dealer in Mumbai and a very violent man. If she even looked at another man, he would beat her, cut her face, and force her to have sex. She ran away from Mumbai and came to Pune in 2012.

In Pune, she got registered at the DIC and was referred to OST. She and her daughter would have the afternoon meal provided at the DIC and we also arranged for her to receive vitamin supplements for her and her daughter, plus lentils, oil and rice from another NGO. We encouraged her to attend support group meetings, which were conducted every week at the DIC by the female staff. These meetings really helped her to share, and learn of ways to cope. She regularly consulted with the psychologist at the DIC and slowly she was able to heal from the trauma of her past. Another NGO close by was able to provide accommodation and support to her daughter. This gave Munni time to earn and create a plan for her and her daughter's future. Today, Munni is a peer educator and earns a salary. Her daughter is doing well and has been enrolled in school. Munni's goal is to educate her daughter and make her a big success in life. Munni is one of the bravest and determined women I have ever met and I learnt a lot from her – she was truly an inspiration to me!

### CASE STUDY C

This case study is adapted from a true story; names and places have been changed.

Mrs Any is a 32-year-old sex worker who injects drugs. She lives in the Coastal region of Kenya. She is from a strict religious family, where women are not allowed to carry out certain activities. Her family practiced female genital mutilation on her when she was 9 years old. Their aim was to keep her virginity until marriage and to increase her 'value' upon marriage. Eventually, when she was an adolescent, she left her hometown and moved to Mombasa with her aunt and cousin. At home she was injecting drugs in secrecy, and when she experienced withdrawal symptoms she would tell her family that she was suffering from malaria. She developed multiple abscesses, due to poor injecting techniques. Through peer-led referral she was finally enrolled in a harm reduction programme.

Mrs Any returned to her hometown and married a man from her village. She was accessing harm reduction services and was offered HIV testing. She accepted, but was really afraid when she got a positive result. She was enrolled in HIV treatment with regular counselling sessions and decided to disclose her status to her partner. Unfortunately, things turned sour, with episodes of humiliation and threats. One day she came back to the drop-in centre (DIC) and was crying. She described episodes of violence to the counsellor. This counsellor encouraged her to report it to the police but, due to the fear of being thrown out and having financial support withdrawn, she was reluctant to do so. After six months, they finally divorced, and in order to survive and facilitate her drug use and shelter, Mrs Any started exchanging sex for money and other resources (transactional sex). After a while she met a new partner to whom she disclosed her status.

Things were running smoothly until COVID-19 hit the country and measures were put in place to minimise the spread of the infection. The couple had financial difficulties because of all the COVID-19 measures and restrictions (e.g. curfew, reduction of tourists). One day, Mrs Any was caught by a police officer at night, after the curfew. She tried to pay him with what she had made that night but he asked for more. She feared to report the case to the DIC. After a few difficult months, in April 2021, the harm reduction service introduced mental health and gender-based violence sessions for female clients and couples. Here, she learnt about different forms of gender-based violence and how to report it. She found she could share her story and asked for support.

One day, during a big fight with her partner at her home, a neighbour with whom she had previously had the courage to talk about her situation, had to break down the door, pick her up and escort her to the DIC. The paralegal officer picked up the case and accompanied her to the police to report the incident. After multiple dialogues, the partner managed to understand his own violence and to stop his violent behaviour. Mrs Any also gained a lot of confidence and self-esteem and started to sell fruit to have a small income.

# HANDOUT 4

## THE WHEEL OF POWER AND CONTROL

A domestic abuse service has developed a wheel representing the most common abusive behaviours or tactics that are used against women in the USA.

PHYSICAL VIOLENCE SEXUAL

**USING COERCION AND THREATS**
Making and/or carrying out threats to do something to hurt her, to commit suicide, to report her to welfare • making her drop charges • making her do illegal things.

**USING INTIMIDATION**
Making her afraid by using looks, actions, gestures
• smashing things
• destroying her property
• abusing pets
• displaying weapons.

**USING ECONOMIC ABUSE**
Preventing her from getting or keeping a job • making her ask for money • giving her an allowance • taking her money • not letting her know about or have access to family income.

POWER AND CONTROL

**USING EMOTIONAL ABUSE**
Putting her down • making her feel bad about herself • calling her names • making her think she's crazy • playing mind games • humiliating her • making her feel guilty.

**USING MALE PRIVILEGE**
Treating her like a servant • making all the big decisions • acting like the 'master of the castle' • being the one to define men's and women's roles.

**USING ISOLATION**
Controlling what she does, who she sees and talks to, what she reads, where she goes • limiting her outside involvement • using jealousy to justify actions.

**USING CHILDREN**
Making her feel guilty about the children • using the children to relay messages • using visitation to harass her • threatening to take the children away.

**MINIMISING, DENYING AND BLAMING**
Making light of the abuse and not taking her concerns about it seriously • saying the abuse didn't happen • shifting responsibility for abusive behaviour • saying she cause it.

PHYSICAL VIOLENCE SEXUAL

# HANDOUT 5
## INDIVIDUAL SAFETY PLAN

This individual safety plan is adapted from the WINGS project (WINGS stands for Women Initiating New Goals for Safety).

WINGS is an evidence-based and highly adaptable tool to identify and address intimate partner violence and gender-based violence that women from marginalised groups experience.

For more detailed strategies, please see Columbia University (2016), **WINGS: A Screening, Brief Intervention and Referral to Treatment (SBIRT) Model for Addressing Intimate Partner Violence.**

### SAFETY PLAN THIS PLAN IS FOR: ______________________

It is a good idea to practice how to get out of your house safely. What doors, windows, elevators, stairs or fire escapes would you use? Consider which exits are safest. Below, write down how you would get out.

- [ ] If I decide to leave I will: ______________________
- [ ] In order to leave quickly, I can keep my purse, identification and bus/autorickshaw/train fare ready and put them in [place]: ______________________
- [ ] I can tell a person that I trust about the violence and request them to call the police [or someone who can help] if they hear suspicious noises coming from my house.

  One person I can tell is: ______________________

  Another person I can tell is: ______________________
- [ ] I can teach my children how to use the phone and call the police *[In circumstances where women prefer not to involve the police, alternatives such as the following can be discussed and included instead]*
- [ ] I can hang specific coloured cloth from my window as a pre-decided sign to a trusted neighbour that I am facing a violent incident. The colour of the cloth will be: ______________________
- [ ] I can use a code word with my children or my friends so that they call for help. My code word will be: ______________________ *[I will inform my neighbour(s)/child(ren) of this sign/codeword.]*
- [ ] It's a good idea to decide where you can go if you have to leave your house. Decide this even if you don't think you will experience any violent incident.
  If I have to leave my home I will go to: ______________________
- [ ] I can also teach these strategies to some or all of my children
- [ ] Try to avoid arguments in the bathroom, kitchen, near weapons, or in rooms without access to an outside door
- [ ] When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as: ______________________
- [ ] I will use my judgement and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I am/we are out of danger.

*Safety Tip: CODE WORDS should not raise suspicion from partner, but should not also be 'everyday' language that might confuse people. Some examples of code words are: "Aunt _____ has not returned my phone call today". Code words for children need to be appropriate for their age. For example, a code word for a 13-year old girl may be: "Your cousin_____ called you today and wants you to call her back today". For a younger child: "Your grandmother called today and wanted to talk with you about something". Most children under the age of 5 will be too young to understand how to operate under code language, so you will need to figure out who you can trust with this task.*

**Once you have finalised the safety plan, take five minutes to set one goal for yourself for the coming weeks (for example, I will join the next support group meeting/counselling session).**

# HANDOUT 6

## SOCIAL SUPPORT MAP

### STEP 1: INTRODUCE THE SOCIAL SUPPORT MAPPING ACTIVITY

Encourage the person to identify their own strategies that suit them and their living context. Mention the following points to them:

- In addition to developing a safety plan, it may also help to reach out to family and/or friends if you are afraid that your partner might hurt you.
- There may be times when it is safer for you to stay with a trusted friend or family member.
- Friends and family can also support you by taking care of your children or helping you financially if you need to leave.
- Ensure your personal mobile is always charged.
- If you own or have access to a car, make sure it always has enough petrol in it to drive to a pre-determined safe place (e.g. a friend, family member or shelter/organisation).

### STEP 2: CREATE A SOCIAL SUPPORT MAP

Adapted from Columbia University (2016), *WINGS: A Screening, Brief Intervention and Referral to Treatment (SBIRT) Model for Addressing Intimate Partner Violence*.

Ask your client(s) to answer the following questions:

1. Can you tell me the names of one to five people that you trust? Let's write their names on the sheet of paper.
2. Which of these people can give you emotional support? We'll mark these with a heart.
3. Which of these people can give you practical support, like giving you a place to stay, watching your children, or lending you money? We'll mark these with a star.

Ask your client(s) to identify steps they can take to expand and strengthen their social network by reaching out to supportive members:

1. Can you think of two things you can do to strengthen your support from family or friends in the next week?
   - This may mean calling someone who you like to hang out with and asking to get together for a coffee, a drink or a walk so you have a chance to connect with them.
   - It may mean calling, texting, e-mailing or sending a letter to someone who you have lost touch with but you would like to reconnect with.
   - It may mean choosing someone who you trust and respect to talk with about the relationship conflict or abuse that you are experiencing, so that you can get their advice or support on how to deal with it.

2. Looking at the social network map that you create:
   - What are some ways that you think of to expand or strengthen your relationships with family members or friends who you can turn to for practical and emotional support?

Summarise the ideas, steps or strategies that your client comes up with for expanding and strengthening their network. Then ask them to identify two specific steps they can take in the next week to strengthen their support network.

Tell your client that, by coming up with ideas for strengthening their social support network and for engaging in the process, they are taking a major step forward in protecting themselves.

1. Can you tell me the names of one to five people you trust? Let's write their names on this list

**PEOPLE I TRUST**

1

2

3

4

5

2. Which of these people can give you emotional support? We'll mark these with a heart symbol. ♥

3. Which of these people can give you practical support, like giving you a place to stay, watching your children or lending you money? We'll mark these with a star. ★

**STEPS TO INCREASE SUPPORT**

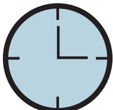
Can you think of two things you can do to strengthen your support from family or friends in the next week?

1. This may be calling someone who you like hang out with to get together for coffee/a drink or a walk so that you have a chance to connect with him or her.
2. It may mean calling, texting, emailing, or sending a letter to someone who you have lost touch with but who you would like to reconnect with.
3. It may mean choosing someone who you trust and respect to talk with about the relationship conflict or abuse that you are experiencing so that you can get their advice or support on how to deal with it.

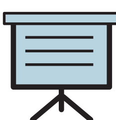
In the next week, I can do the following to strengthen my support:

In the next week, I can also do the following to strengthen my support:

# Module 4
## Contraception and family planning



**TIME**
1 hour 50 minutes



**MATERIALS**
- Flipchart
- Colour pens
- **Handout 1:** Cards on contraceptive method and profiles
- **Handout 2:** Modern contraceptive methods and arguments to address myths and misconceptions
- **Handout 3:** Contraception stories
- **Handout 4:** Table to improve access to contraception
- **PPT Module 4:** Contraception

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 4** | **Contraception and family planning** | Basic information on contraception and contraceptive choice | • To explore misbeliefs associated with contraception and the full range of contraceptive methods<br>• To know the main components of family planning and contraceptive services |
| | | Contraceptive counselling | • To provide quality counselling on contraception and contraceptive choice for women and gender non-conforming people who use drugs<br>• To identify the main barriers to accessing contraception and potential way to overcome these barriers |

### TIPS FOR ONLINE FACILITATION

**EXERCISE 1. GAME: YOUR PERFECT MATCH: 15 MINUTES**
Select one participant to choose a card from A, B or C (contraceptive methods), then ask them to choose a card from D, E or F (individuals' profiles). Read the cards out loud and ask the participant to explain if this method (A, B or C) fits with the profile they have chosen (D, E or F) and to explain why. Repeat this with other participants until all the explanations have been covered.

**EXERCISE 2. ROLE PLAY: 20 MINUTES**
Open enough virtual breakout rooms to allow all the participants to be in pairs. Email the participants Handout 3: Contraception stories. Go from room to room to observe and support. Instead of asking one or two pairs to present their role play, ask the pairs to swap roles and discuss.

**EXERCISE 3. BRAINSTORMING: 15 MINUTES**
Prepare the following categories in a Klaxoon page:
- Legal
- Financial
- Geographical
- Norms/attitudes
- Quality of services
- Religious and cultural

Ask the participants to generate virtual sticky-notes (at least one sticky-note with a type of barrier for all the categories). Or participants can generate sticky notes then let you put them under the correct category. Wrap up all the ideas by reading them out. (This process is also suitable for all group discussions.) Alternatively, you can use other online tools, such as Mural or Jamboard, to enable participants to write their ideas then organise them at the end under the main categories.

**EXERCISE 4. WHAT DO YOU NEED TO DO TO ADDRESS THE BARRIERS?: 15 MINUTES**
Open enough virtual breakout rooms and ask the group to take notes of their discussion in a Word document or PPT slide to be able to share their screen when they report back to the group.

## TO PREPARE IN ADVANCE

You can prepare for this module by contacting sexual and reproductive health organisations (such as the Family Planning Association or IPPF member organisations) in your neighbourhood to find out about locally-available contraceptives and family planning services.

# CONTRACEPTION (1 HOUR 50 MINUTES)

## BASIC INFORMATION ON CONTRACEPTION AND CONTRACEPTIVE CHOICE (1/2)

**15 minutes**

**PPT Module 4: Contraception**
**Handout 1: Cards on contraceptive method and profiles**

### SEQUENCE

**Exercise 1. Game: Your Perfect Match: 15 minutes**

Give half of the participants a card with a profile and the other half a card with a name (and drawing) of a contraceptive method.

Ask the participants with the contraceptive methods to walk around the room to meet their 'perfect match'. Each of the participants with a card of a contraceptive method should speak to the participants with the profiles to find out who they are so they can work out which contraceptive method would suit that profile best.

Once they find the profile they think matches, they should stay in that pair. They can then exchange views on why they feel this method is a good match for the woman with that profile and see if they agree with each other.

*Note: If the perfect match is not available, the participants have to find another match and discuss the pros and cons for this choice!*

### KEY MESSAGES

Everyone may have different needs and preferences for a contraceptive method. These are likely to change over the course of someone's (reproductive) life and according to their circumstances.

There are pros and cons to all contraceptive methods, and consideration is required to see how they fit in with a person's lifestyle, priorities and needs at any given time.

## BASIC INFORMATION ON CONTRACEPTION AND CONTRACEPTIVE CHOICE (2/2)

**25 minutes**

**Handout 2: Modern contraceptive methods and arguments to address myths and misconceptions**

### SEQUENCE

**Discussion relating to Exercise 1: 10 minutes**

Ask one or two pairs to very briefly present the perfect match they have chosen and explain their choice with one or two reasons.

- Ask the whole group: *What were the main beliefs associated with contraception that emerged during the game? What else do they know?*

You can give examples, such as:

- Pills are too complicated for a young woman who use drugs.

List these beliefs on the flipchart.

**PPT presentation: 15 minutes**

Present the main effective methods of contraception and family planning services (contraception services), plus emergency contraception and dual protection. Include information about fertility and infertility.

### KEY MESSAGES

There are a lot of beliefs and misconceptions associated with contraceptive methods. For example:

- Contraception can cause infertility.
- Women lose libido with hormonal contraception.
- Contraception can cause birth defects.

Health professional and harm reduction providers may also share these beliefs. The lack of accurate information will impact and limit people's choices around pregnancy prevention. The fact that professionals will propose to some people a method they feel is more appropriate for them and their circumstances, without asking their preference, limits someone's right to choose the method that is right for them.

**The main effective methods of contraception are:**

- **Hormonal methods:** implants, pills (progestogen and combined), IUD, injectables
- **Other effective methods:** Copper IUD, vasectomy and female sterilisation
- **Barrier methods:** internal (female) and external (male) condoms, diaphragm
- **Other methods** exist but are less effective and women have less control over them (for instance, natural methods of withdrawal).
- **Emergency contraception** is not the same as abortion because it prevents a pregnancy from happening (whereas abortion ends a pregnancy that has already begun). An emergency contraceptive pill can be taken up to 72 hours AFTER intercourse to prevent pregnancy, but the sooner someone uses emergency contraception the more effective it is. Someone who uses emergency contraception should take a pregnancy test if they do not menstruate in the following three weeks.

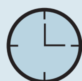
| SEQUENCE | KEY MESSAGES |
|---|---|
| | • **Dual protection:** Dual protection strategies prevent the transmission of HIV and STIs as well as preventing unintended pregnancy. For example, women and some gender non-conforming people who use psychoactive drugs and/or take part in psychedelic festivals involving unprotected sex and MDMA use may prefer to use the barriers methods that are best for preventing HIV, STIs and unintended pregnancy (i.e. condoms).<br>**Methadone and contraception**<br>There is no evidence that methadone is incompatible with contraceptives.<br>**HIV treatment and hormonal contraception**<br>There is no evidence of incompatibility between antiretroviral treatment and hormonal contraceptives.<br>**Fertility desires and choices**<br>When discussing contraceptives, a lot of focus is on the prevention of pregnancy rather than on the planning and spacing of children. But it is important to consider the fertility desires and choices of women who use drugs, including women living with HIV, sex workers and young women.<br>**Infertility:** both men and women can be infertile, but women are often the ones that are 'blamed' for infertility. Contraceptives do not cause infertility. Infections, some reproductive cancers, abnormalities of the reproductive tract (including blocked fallopian tubes), fibroids, or long-term hormone use in trans-women can cause infertility.<br>**Key family planning contraception services include:**<br>• Accurate information on a wide range of methods<br>• Counselling about the desire to have children<br>• Availability of condoms and lubricants and other contraceptives methods<br>• Emergency contraception<br>• Encouraging shared responsibility between partners<br>• Addressing infertility issues and their social consequences |

**CONTRACEPTIVE COUNSELLING (1/2)**

| | | | |
|---|---|---|---|
| | 30 minutes | | Handout 3: Contraception stories |

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 2. Role play: 20 minutes**<br>Divide the group in pairs and distribute the three different stories with different profiles and roles.<br>Ask one person to play the role of the woman who use drugs, and the other to play the role of the health professional/harm reduction provider.<br>Ask one or two pairs to present their role play if they agree.<br>**Debriefing and discussion: 10 minutes**<br>As a debriefing, ask the whole group the following:<br>• *Do you think the counsellor provided accurate information?*<br>• *As a client, do you feel you were given a choice (informed choice)? Why?*<br>• *As a counsellor, did you feel you could respect the choice of the woman?*<br>• *In your opinion, what are the most important skills to provide counselling on contraception?*<br>Remind participants about the key messages of counselling skills. | **Key messages on counselling skills**<br>The importance of providing accurate information, non-judgmental attitudes, active listening, clear communication without technical jargon and using simple language.<br>Always respect the rights of women and gender non-conforming people who use drugs to:<br>• Confidentiality<br>• Privacy<br>• Informed choice<br>• Non-discrimination<br>Respect these rights regardless of someone's age, family or social status, sexual behaviour, kind and frequency of drug use, etc.<br>**Beware:** Coercing (forcing) women and gender non-conforming people who use drugs to adopt long-acting or potentially irreversible methods of contraception, like implants and sterilisation, to prevent them from having children is a violation of human rights. |

## CONTRACEPTIVE COUNSELLING (2/2)



40 minutes

**Handout 4: Table to improve access to contraception**

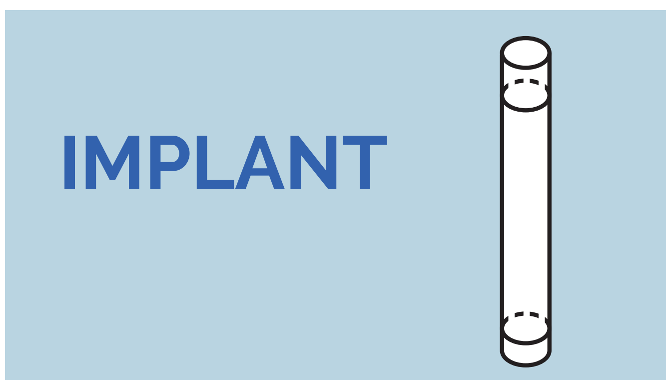
| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 3. Brainstorming: 15 minutes**<br>Invite participants to discuss the main barriers to contraception access.<br>Write their suggestions on a flipchart and organise them in different categories, such as legal, financial, geographical, norms and attitudes, quality of services, religious and cultural.<br><br>**Exercise 4. What do you need to do to address the barriers? 15 minutes**<br>Divide participants into three groups of five or six people. Ask each group to consider the different barriers and propose approaches/actions to overcome them.<br>Then ask each group to think of two or three solutions/ actions to improve access to contraception in their organisation/community.<br>Ask one person from each group to report back (10 minutes)<br><br>**Synthesis PPT presentation: 10 minutes** | **Some key barriers to accessing contraception are:**<br>• Lack of access to services<br>• Legal restrictions and lack of access to services for those 'under age' (under 18 or 16 years old, unmarried women, criminalised populations, excluded communities, etc.)<br>• Low quality of services (such as lack of confidentiality)<br>• Stigmatisation and fear of stigma and hostility<br>• Fear of violence or coercion to adopt long-acting or irreversible methods of contraception (e.g. implants/sterilisation)<br>• Negative provider attitudes (judgemental) and/or internalised stigma<br>• Gender-based violence<br>• Lack of autonomy in making health decisions<br>• Lack of meaningful involvement of women and gender non-conforming people who use drugs in service provision<br>• Conflicting beliefs about female sexuality and contraceptive needs<br>• Lack of financial means<br>• Lack of knowledge, misbelief or fear of side effects, perceived health risks<br>• Non-recognition of the sexuality of certain groups (e.g. teenagers, people with disabilities)<br>• Limited choice of methods in the country/area<br><br>**The main approaches to overcome barriers at different levels**<br>**Political level:** advocacy to improve political efforts to prioritise legal, funding and programmatic efforts on SRHR and ensure supply chain stability<br>**Programmatic level:** availability of appropriate services, involvement and training of health professionals, support for the meaningful involvement of women and gender non-conforming people, and the development of skills and structures in communities and networks of women and gender non-conforming people who use drugs<br>**Community level:** empowerment of communities of women and gender non-conforming people who use drugs, participation from the wider community, participation and buy-in from men<br>Example of concrete actions to overcome barriers:<br>• Stocking new contraceptive methods, thereby expanding available options<br>• Making emergency contraceptive pills available through peer outreach<br>• Introducing new services, such as individual or couples counselling on contraception<br>• Supporting women and gender non-conforming people who use drug to develop leaflets or other communication materials on contraception and the importance of individual choice when selecting contraceptive methods |

# HANDOUT 1
## CONTRACEPTIVE METHODS AND PROFILE CARDS

Print three copies of the three cards for the contraceptive methods group

Print three copies of the three cards for the profiles group

Front

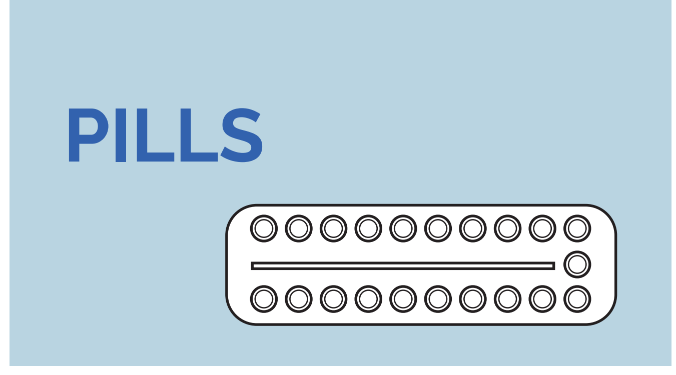



Back

Front

Back

Front




Back

Front

A young, unmarried woman in her early 20s who uses drugs

Back

Front

A woman who uses drugs who is also a sex worker

Back

Front

A married woman who uses drugs who just had her third child

Back

# HANDOUT 2

## MODERN CONTRACEPTIVE METHODS AND ARGUMENTS TO ADDRESS MYTHS AND MISCONCEPTIONS

Adapted from Reproductive Health Access Project (2020), *Sexual and Reproductive Health & Rights Toolkit, Tool 3.4 Factsheet: contraceptives.* Available at www.reproductiveaccess.org

| METHOD | HOW TO USE | IMPACT ON BLEEDING | THINGS TO KNOW |
|---|---|---|---|
| **External condom/ male condom** | • Use a new condom for each penetration<br>• Condom needs to be replaced every 15 – 30 minutes<br>• Use a polyurethane condom if allergic to latex | None | • Available at many stores<br>• Can be put on as part of sex play/foreplay<br>• Can help prevent early ejaculation<br>• Can be used for oral, vaginal and anal sex<br>• Protects against HIV and other STIs<br>• Can decrease penile sensation<br>• Can cause loss of erection<br>• Can break or slip off<br>• Does not need a prescription |
| **Internal condom/ female condom** | • Use a new condom each time you have sex<br>• Use extra lubrication as needed | None | • Can be put in as part of sex play/foreplay<br>• Can be used for anal and vaginal sex<br>• May increase vaginal/anal pleasure<br>• Good for people with latex allergy<br>• Protects against HIV and other STIs<br>• Can decrease penile sensation<br>• May be noisy<br>• May be hard to insert<br>• May slip out of place during sex |
| **Diaphragm** | • Put in vagina each time you have sex<br>• Use with spermicide every time | None | • Can last several years<br>• Costs very little to use<br>• May protect against some infections, but not HIV<br>• Using spermicide may raise the risk of getting HIV<br>• Should not be used with vaginal bleeding or infection<br>• Raises risk of bladder infection |
| **Emergency contraception pills (see also extra text below the table)** | • Works best the sooner you take it after unprotected sex<br>• You can take it up to five days after unprotected sex<br>• If pack contains two pills, take both at once | • Your next period may come early or later<br>• May cause spotting | • Available at pharmacies, health centres or healthcare providers<br>• People of any age can get progestin emergency contraception without a prescription<br>• May cause stomach upset or nausea<br>• Progestin emergency contraception does not interact with testosterone, but we don't know whether another type of emergency contraception called ulipristal acetate does or does not<br>• Ulipristal acetate emergency contraception requires a prescription<br>• May cost a lot |
| **Implant** | • A clinician places it under the skin of the upper arm<br>• It must be removed by a clinician | • Can cause irregular bleeding and spotting<br>• After one year you may have no period at all<br>• Cramps often improve | • Long lasting (up to five years)<br>• You can become pregnant right after it is removed<br>• It may lower the risk of uterine lining cancer, ovarian cancer and polycystic ovary syndrome<br>• May cause mood changes<br>• Efavirenz-based ART may reduce the implant's effectiveness (however, the study that found this also found the implant is still one of the most effective reversible contraceptives and emphasised that women living with HIV should receive appropriate counselling to choose the method that suits their situation and context).[6] |

6. See https://www.guttmacher.org/journals/ipsrh/2015/02/efavirenz-based-art-may-reduce-effectiveness-contraceptive-implants

| METHOD | HOW TO USE | IMPACT ON BLEEDING | THINGS TO KNOW |
|---|---|---|---|
| **Copper IUD** | • Must be placed in uterus by a clinician<br>• Usually removed by a clinician | • May cause cramps and heavy monthly bleeding<br>• May cause spotting between monthly bleeding | • May be left in place for up to 12 years<br>• You can become pregnant right after removal<br>• It may lower the risk of uterine lining cancer, ovarian cancer and polycystic ovary syndrome<br>• In rare cases, the uterus can be injured during placement |
| **Progestin IUD** | • Must be placed in uterus by a clinician<br>• Usually removed by a clinician | • May improve cramps<br>• May cause lighter monthly bleeding, spotting, or no periods at all | • May be left in place between three and seven years, depending on which IUD you choose<br>• You can become pregnant right after removal<br>• It may lower the risk of uterine lining cancer, ovarian cancer and polycystic ovary syndrome<br>• In rare cases, the uterus can be injured during placement |
| **Pill** | • Take the pill daily | • Often causes spotting, which may last for many months | • Can improve pre-menstrual syndrome (PMS) symptoms (including mood swings, tender breasts, food cravings, fatigue, irritability and depression)<br>• Can improve acne<br>• Helps prevent cancer of the ovaries<br>• This method contains oestrogen – it is unclear if oestrogen interacts with testosterone<br>• You can become pregnant right after stopping the pills<br>• May cause nausea, weight gain, headaches, change in sex drive – some of these things can be addressed by changing the brand<br>• For women who use drugs it may increase the risk of vein problems, such as varicose veins or venous thrombosis |
| **Progestin-only pills** | • Take the pill daily | • Can make monthly bleeding more regular and less painful<br>• May cause spotting in the first few months | • You can become pregnant right after stopping the pills<br>• It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome<br>• May cause depression, hair or skin changes, change in sex drive |
| **Shot / Injectable** | • Get a shot every three months<br>• Give yourself the shot or get it in a medical clinic | • Often decreases monthly bleeding<br>• May cause spotting or no period | • Each shot works for 12 weeks<br>• Private for user<br>• Helps prevent cancer of the uterus<br>• May cause weight gain, depression, hair or skin changes, change in sex drive<br>• It may lower the risk of uterine lining cancer, ovarian cancer, and polycystic ovary syndrome<br>• Side effects may last up to six months after you stop the shots |
| **Sterilization (women): tubal ligation/ligature** | • This method blocks or cuts the fallopian tubes<br>• A clinician reaches the tubes through two small cuts in your belly or through your vagina | None | • Permanent and highly effective<br>• Reversal is difficult<br>• The risks include infection, bleeding, pain, and reactions to anaesthesia |
| **Sterilisation (men): vasectomy** | • A clinician blocks or cuts the tubes that carry sperm from the testicles | None | • Permanent and highly effective<br>• It is more effective, safer and cheaper than tubal procedures to sterilise a woman<br>• Can be done in the clinician's office<br>• No general anaesthesia needed<br>• Reversal is difficult<br>• Risks include infection, pain and bleeding<br>• It takes up to three months to work |

## ARGUMENTS TO ADDRESS MYTHS AND MISCONCEPTIONS

**1. CONTRACEPTIVE METHODS CAN CAUSE INFERTILITY**

Contraception does not cause infertility. A number of different factors in both the male and female reproductive systems can cause infertility. Other factors such as environmental exposure to pollutants and toxins, or lifestyle factors, such as smoking, excessive alcohol consumption and obesity, can affect fertility. (Source: WHO)

**2. WOMEN LOSE LIBIDO WITH HORMONAL CONTRACEPTIVES**

The sexual side effects of hormonal contraceptives are not well studied, particularly with regard to impact on libido. There appears to be mixed effects on libido, with a small percentage of women experiencing an increase or a decrease, and the majority being unaffected. Not only could low libido be associated with hormone levels, physical, psychological and emotional factors can also reduce libido. (Source: Lara Burrows et al. (2012), **The effects of hormonal contraceptives on female sexuality: a review**.)

**3. CONTRACEPTIVE METHODS CAN CAUSE BIRTH DEFECTS**

Correct use of contraception does not increase the risk of birth defects. Correct use of contraception prevents pregnancy-related health risks for women, especially for adolescent girls, and reduces maternal and infant mortality, when multiple births are separated by less than two years. (Source: **WHO**)

# HANDOUT 3
## CONTRACEPTION STORIES

*In each scenario, one person should play the role of the service provider and another should play the role of the woman.*

**STORY 1:** A young woman is coming to the DIC to see a peer educator and to get a safe-injection kit (syringes, etc.). She is explaining that she was advised by her cousin to take a long-acting contraceptive method and she wants to have more information because she is afraid. She is very reluctant at the beginning of the counselling.

**STORY 2:** A married woman is in between two contraceptive methods; she has stopped pills and wants to change to an IUD. In the meantime, she has been using condoms with her husband but a condom burst last night and she is panicking. The outreach worker is talking with her about the next workshop at the DIC, which is about contraception, while she is explaining her story. There are other women close by who are a bit too curious about her story.

**STORY 3:** A woman who uses drugs and is also a sex worker is using a copper IUD because she has a regular partner with whom she is not using condoms. She has heavy monthly bleeding, which is inconvenient for her and wants to change contraceptive methods. She is coming to the DIC for her regular meeting with the psychosocial counsellor and will start to ask questions about other contraceptive methods.

# HANDOUT 4
## TABLE TO IMPROVE ACCESS TO CONTRACEPTION

### SOME KEY BARRIERS TO ACCESSING CONTRACEPTION ARE:

- Lack of access to services
- Legal restrictions and lack of access to services for those 'under age' (under 18 or 16 years old, unmarried women, criminalised populations, excluded communities, etc.)
- Low quality of services (such as lack of confidentiality)
- Stigmatisation and fear of stigma and hostility
- Fear of violence or coercion to adopt long-acting or irreversible methods of contraception (e.g. implants/sterilisation)
- Negative provider attitudes (judgemental) and/or internalised stigma
- Gender-based violence
- Lack of autonomy in making health decisions
- Lack of meaningful involvement of women and gender non-conforming people who use drugs in service provision
- Conflicting beliefs about female sexuality and contraceptive needs
- Lack of financial means
- Lack of knowledge, misbelief or fear of side effects, perceived health risks
- Non-recognition of the sexuality of certain groups (e.g. teenagers, people with disabilities)
- Limited choice of methods in the country/area

### THE MAIN APPROACHES TO OVERCOME BARRIERS AT DIFFERENT LEVELS

Political level: advocacy to improve political efforts to prioritise legal, funding and programmatic efforts on SRHR and ensure supply chain stability

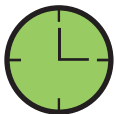
Programmatic level: availability of appropriate services, involvement and training of health professionals, support for the meaningful involvement of women and gender non-conforming people, and the development of skills and structures in communities and networks of women and gender non-conforming people who use drugs

Community level: empowerment of communities of women and gender non-conforming people who use drugs, participation from the wider community, participation and buy-in from men

Example of concrete actions to overcome barriers:

- Stocking new contraceptive methods, thereby expanding available options
- Making emergency contraceptive pills available through peer outreach
- Introducing new services, such as individual or couples counselling on contraception
- Supporting women and gender non-conforming people who use drug to develop leaflets or other communication materials on contraception and the importance of individual choice when selecting contraceptive methods

# Module 5
## Safe abortion and post-abortion care



**TIME**
1 hour 55 minutes

**MATERIALS**
- Flipchart
- Pens
- **PPT Module 5:** Safe abortion and post-abortion care
- **Handout 1:** Cards: the reason why
- **Handout 2:** Extract of Article 14 of the Maputo Protocol
- **Handout 3:** A long journey
- **Handout 4:** Language guide to avoid stigmatising language
- **Handout 5:** Scenario for role play
- **Handout 6:** Mapping poster
- Link to video on medical abortion and on surgical abortion

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 5** | **Safe abortion and post-abortion care** | Safe abortion and post-abortion care services and referrals | • To identify the main barriers to access safe abortion and/or post-abortion care<br>• To know how to provide counselling related to abortion issues<br>• To map health services for abortion and post-abortion care to refer women and gender non-conforming people who use drugs |

### TIPS FOR ONLINE FACILITATION

**EXERCISE 1. RAISE YOUR HANDS IF: 10 MINUTES**
Ask participants to use the online 'raise hands' option then count the hands raised.

**EXERCISE 2. THE REASON WHY: 15 MINUTES**
Read and paste the questions in the chat from the three cards before creating three virtual breakout rooms for small group discussions. Instead of a drawing, give the participants a pre-designed PowerPoint slide with a river, or a Klaxoon with a pre-designed drawing of a river. Ask the participants to use the sticky-notes mode to write and stick their reasons on the drawing. Alternatively, use a simple jamboard, virtual whiteboard or a Word document to write down the main decisions and reasons.

**EXERCISE 5. BRAINSTORMING: 5 MINUTES**
Both you and the participants can write down the brainstorming ideas using a virtual whiteboard or jamboard if available, or use the chat.

**EXERCISE 6. ROLE PLAY: 20 MINUTES**
Open up enough virtual breakout rooms for all the groups.

**EXERCISE 7. PARTICIPATIVE MAPPING FOR REFERRAL TO SAFE-ABORTION AND POST-ABORTION CARE SERVICES: 15 MINUTES**
Share the tool, with a different column to fill in for each of the groups, in two virtual breakout rooms.

### TO PREPARE IN ADVANCE

For this particular session, it is important to state that all information shared by participants will remain confidential and to respect the principle of anonymity. In advance, think about how you can create a secure learning environment to allow for free discussion. The content of this module is sensitive, and it is important to be careful with the terms used (see Handout 4: Language guide to avoid stigmatising language).

Be prepared that one or more people may want to share their own story. Be ready to pause and deal with strong emotions among the participants. You should also be prepared to refer people to relevant services designed for women and gender non-conforming people who use drugs. You can refer back to the previous modules if needed, such as contraception services (for the post-abortion care session).

You can also prepare for this session by reading IPPF's **most frequently asked questions page** and **teaching resource**.

| Question | Answer |
| --- | --- |
| **Does increasing access to abortions mean more abortions?** | **Abortion happens everywhere. They occur as frequently in countries where they are banned as in the least restrictive countries.** |

**QUESTIONS & ANSWERS**
You should prepare some key information and data to complete the PowerPoint presentation (using IPPF, IPAS, and WHO as sources). For instance, the presentation contains key global facts on abortion, but it is also a good idea to prepare some local statistics, such as:

- The number of induced abortions in the local context
  Please refer to **www.guttmacher.org/fact-sheet/induced-abortion-worldwide/** or national data

- The number of unsafe induced abortions in the local context and their causes
  Please refer to national data, Guttmacher or IPPF

- The abortion laws and any legal restrictions in the country you are working in as well as socio-cultural barriers that prevent people from accessing safe abortion and/or post-abortion care

  Please refer to:
  **https://abortion-policies.srhr.org/**,an online database that contains comprehensive information on abortion laws, policies, health standards and guidelines

  **www.womenonwaves.org/en/map/country** for information about abortion per country and access to misoprostol

  **http://worldabortionlaws.com**: this is the World Abortion Map from the Center for Reproductive Rights, which provides updates on the legal status of abortion across the globe
  **https://www.guttmacher.org/state-policy/explore/overview-abortion-laws**

- The different methods available in the context and affordability

During Exercise 6, which examines how to address barriers, note down the ideas raised and keep them to use in Module 10.

# SAFE ABORTION AND POST-ABORTION CARE (1 HOUR 55 MINUTES)

## SAFE ABORTION AND POST-ABORTION CARE SERVICES AND REFERRAL (1/3

1 hour 20 minutes

**PPT Module 5: Safe abortion and post-abortion care**
**Link to video on medical abortion**
https://vimeo.com/291915797
**Link to video on surgical abortion**
https://vimeo.com/291916852
Both are around 3 minutes long.
**Handout 1: The 'reason why' cards**
**Handout 2: Extract of Article 14 of the Maputo Protocol**
**Handout 3: A long journey**

### SEQUENCE

**Exercise 1. Raise your hands if: 10 minutes**

Ask these questions to allow participants to realise how big a problem unsafe abortion is:

- *Raise your hand if you had a friend or relative who has had an unintended pregnancy?*
- *Raise your hand if you know someone who uses drugs who has had an unintended pregnancy?*
- *Raise your hand if you know someone who uses drugs/or a friend who tried to terminate their pregnancy?*
- *Raise your hand if you know someone who uses drugs/or a friend who suffered from the consequences of unsafe abortion?*

Ask if one person wants to explain briefly what happened to this person after the unsafe abortion.

**PPT presentation: 10 minutes**

**Video: 5 minutes**

### KEY MESSAGES

**Definition of abortion:** An abortion is a procedure to end a pregnancy. It's also sometimes known as a termination of pregnancy. (Source NHS)

**Safe abortion** is a pregnancy termination carried out by a skilled person in safe conditions. There are two types of safe abortion. One ends a pregnancy through medication, the other through a surgical procedure.

**Therapeutic abortion** is performed when a pregnancy endangers the physical or mental health of a woman.

**Spontaneous abortion** (also referred to as miscarriage) occurs without intervention.

The following abortion methods are safest if correctly performed by skilled persons:

Safe methods during **first trimester**:

- **Vacuum aspiration** (manual or electric vacuum aspiration MVA/EVA) (up to 12 to 14 weeks of pregnancy)
- **Medical abortion with mifepristone and misoprostol** (or misoprostol alone) (up to 10 weeks): safe if correctly taken, using a good quality product and supervised by a qualified professional

Safe methods during **second trimester**

- Dilation and evacuation (D&E): the skills needed to perform a D&E are greater than for an MVA/EVA, which is done in earlier pregnancy.
- Medical method

**Focus on pain management**

For medical abortions, people will experience bleeding, and may have intense cramping, vomiting and diarrhoea. For surgical abortions, most people who are awake for the procedure describe the discomfort as intense period cramps.

People on OST may not receive accurate information about pain control. Some abortion providers are not comfortable with managing pain in people who use drugs or who are receiving OST.

People on OST who are going to have an abortion should take their regular dose, and if their abortion involves mild or deep sedation, and they feel safe enough to tell the team performing their abortion about their medications, they can ask them to contact their OST provider for information. The abortion provider may be able to increase the dose of opioids they give during the procedure to help with discomfort.

**Unsafe abortion**

An unsafe abortion is one that is performed by an unskilled person or in an environment that does not conform to minimal medical standards, or both.

Some of the most dangerous methods of unsafe abortion include:

- The use of sharp sticks, a coat hanger or chicken bone, inserted through the vagina and cervix into the uterus
- Herbal preparations inserted into the vagina
- Ingestion of toxic substances, such as bleach

| SEQUENCE | KEY MESSAGES |
| --- | --- |

- Infliction of trauma, such as hitting the abdomen, falling or jumping from the top of stairs or a roof
- Misuse of medication, bought on the black market (leading to poor drug quality, incorrect dosing, inadequate information)
- Unskilled providers performing dilation and curettage in unhygienic settings, causing uterine perforations and infections

Many of these methods are not effective in terminating a pregnancy, but they are all dangerous and can leave lasting damage. They can even lead to death.

**Risks and complications of unsafe abortion**
Unsafe abortion can lead to immediate health risks (such as infections and haemorrhage), they can also lead to death. There can also be long-term complications, such as uterine perforation, damage to the genital tract and internal organs, which can affect someone's physical and mental health and well-being throughout their life. Unsafe abortion also has financial implications for women and communities.

**Key data worldwide**

- Three out of ten pregnancies end in induced abortion.
- Each year, 6 out of 10 unintended pregnancies end in induced abortion.
- Nearly half of all abortions are unsafe (45%).
- Unsafe abortion is one of the five leading causes of maternal deaths in resource-constrained countries.
- The risk of dying from an unsafe abortion is highest in Africa.
- The greater the level of unmet contraceptive needs, the higher the abortion rate.

(Sources: WHO and IPAS)

**Exercise 2. The reason why: 15 minutes**

Divide participants into three groups: A-B-C

Give each group a 'reason why' card (A-B-C) with a question on it.

Ask the groups to think about all the possible answers to their question.

Ask them to write their answers in a drawing of a river. The river represents the decision and each of the currents represents a reason for this decision.

**Report back: 5 minutes**

Ask each group to have a look at the other drawings.

**PPT presentation: 5 minutes**

Everyone who chooses to have an abortion has their own reasons to do so. Access to legal, safe and comprehensive abortion care, including post-abortion care, is essential for the attainment of the highest possible level of sexual and reproductive health. (WHO)

Various protocols and conventions protect the sexual and reproductive rights of women. For instance, since 1994, when the International Conference on Population and Development in Cairo took place, countries have agreed that: *"Every individual has the right to decide freely and responsibly – without discrimination, coercion and violence – the number, spacing and timing of their children."*

In 179 countries, laws permit abortion based on specific grounds but these are largely very restrictive. Only 73 countries authorise access to abortion on request of the person (with a gestational limit).

The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa – or the 'Maputo Protocol' – is the first official human rights document to authorise abortion, under certain conditions, as a human right.

To date, 42 out of the 55 African countries have ratified the Maputo Protocol. But despite being binding, it is not always implemented.

Extract of Article 14 of Maputo Protocol (Handout 2) states:

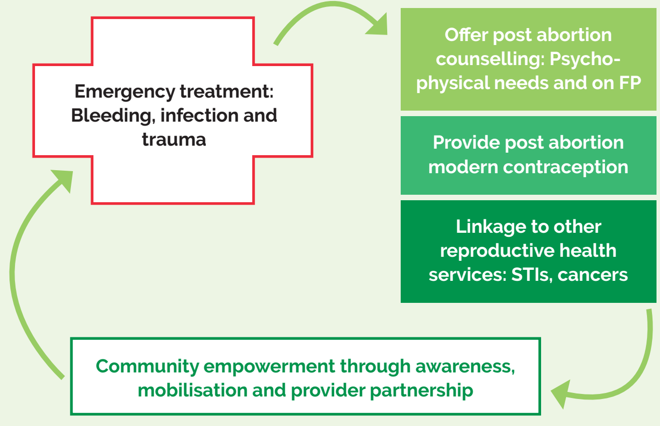
> States Parties shall protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 3. Case study: A long journey: 15 minutes**<br>Read the case study and ask participants to identify all the barriers and restrictions the woman in the case study is facing in accessing abortion and post-abortion care services.<br>Ask the group to give examples of other types of barriers not mentioned, such as geographical, costs, and stigma.<br>Prepare in advance a summary of legal barriers in the country and discuss them with the group.<br><br>**Exercise 4. Interactive discussion and PPT presentation: 15 minutes**<br>Ask: How can we address the barriers?<br>Note participants' ideas and keep them for use in Module 10 (on advocacy). | **Barriers and restrictions**<br>• Restrictive laws (and penalties for women, health providers and the person/s who assist)<br>• Geographical barriers<br>• Administrative restrictions and unnecessary requirements, such as mandatory waiting periods, mandatory counselling, provision of misleading information, third-party authorisation (such as the husband or family members, including parents for minors), medically unnecessary tests that delay care, mandatory police reports in case of rape<br>• Poor availability of services<br>• High cost and other financial barriers<br>• Stigma and negative attitudes from professionals<br>• Family and relatives opposed<br>• Objection of healthcare providers<br>• Complex administrative procedures (such as having to consult with two doctors)<br>• Lack of correct information<br>• Other barriers relating to religious and cultural norms (for instance, abortion being seen as a sin that will bring disaster or a curse) |

**SAFE ABORTION AND POST-ABORTION CARE SERVICES AND REFERRAL (2/3)**

| | | | |
|---|---|---|---|
| | 35 minutes | | **Handout 4: Language guide to avoid stigmatising language**<br>**Handout 5: Scenario for role play** |

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 5. Brainstorming: 5 minutes**<br>Ask the group:<br>*What are the attitudes to adopt when counselling a woman who wants to terminate her pregnancy?*<br>*What are the other characteristics required?*<br><br>**Exercise 6. Role play: 20 minutes**<br>Divide the participants into groups of four people.<br>Based on one of the role play scenarios, ask one participant in each group to play the role of the counsellor and one to play the role of the woman who uses drugs in need of information/services for safe-abortion or post-abortion care. It is also possible to have one person play the role of the support person who accompanies the woman.<br>Ask the remaining one or two people in each group to watch the role play and make notes on the things to be improved upon and the positive points relating to the counsellor's qualities and attitudes.<br>Report back in each group: the observers should then provide positive feedback and advice to improve practice.<br><br>**PPT presentation: 10 minutes** | **Attitude and characteristics for counselling**<br>• The counselling should take place in a safe environment (where there is trust and no stigma).<br>• Ensure confidentiality and respect for people's privacy.<br>• Detail the possible options (abortion, continuing with the pregnancy, adoption) and the legal framework.<br>• Give priority and scope for the person to make their own decisions about whether to continue with a pregnancy, free from judgement or coercion and on the basis of sound, evidence-based advice.<br>• Respect the choice of the pregnant woman or person.<br>• Assess support around the pregnant woman or person.<br>• Collect informed consent (either in writing or orally, depending on the situation) if they choose to have an abortion.<br>• Offer appropriate referral for further services.<br>• Follow up/accompany if needed.<br>**The different components of post-abortion care**<br>Post-abortion care is an important – potentially lifesaving – health intervention given to someone experiencing complications, usually bleeding or infection, due to an incomplete abortion or miscarriage.<br>Medical care, including medication or surgery, is given to evacuate the uterus. Left untreated, an incomplete abortion can lead to death or disability.<br>Post-abortion care has three components:<br>1. Emergency treatment for complications. Includes immunising against tetanus following an unsafe abortion. |

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 7. Participative mapping for referral to safe-abortion and post-abortion care services: 15 minutes**<br>Divide the participants into two groups. Ask them to create a participative poster with details of institutions/locations where harm reduction providers can refer women and gender non-conforming people who use drugs to receive safe-abortion care counselling and services and post-abortion care services.<br><br>One group should create a poster with the following columns:<br>• Public health facility (primary/secondary/tertiary)<br>• Private sector<br>• Pharmacy<br><br>The second group should create a poster using these columns:<br>• INGO<br>• Local organisation<br><br>**Report back: 10 minutes**<br>Each group presents to the other and receives feedback to complete its own poster.<br>Then combine the posters to create one complete, comprehensive participatory mapping. | **2.** Other services, including contraception/family planning counselling. A wide range of modern contraceptive methods (including emergency contraception) should be offered. Psychosocial support services, HIV/STI prevention, counselling, identification of violence, and post-violence care should also be offered.<br>**3.** Community empowerment and support groups<br>Post-abortion care must be available, whatever the legal context.<br>(Source: Ngalame, AN. et al (2020) Improving Post Abortion Care (PAC) Delivery in Sub- Saharan Africa: A Literature Review)<br><br>The five core components of the post abortive care (PAC) model |

# HANDOUT 1

## THE CARDS: THE REASON WHY

| A | B | C |
| --- | --- | --- |
| What are all the reasons for someone who uses drugs to decide to terminate a pregnancy? | What are all the reasons someone who uses drugs will continue an unwanted pregnancy? | What are all the reasons why it may be difficult for a harm reduction implementer to discuss safe abortion with someone who uses drugs? |

# HANDOUT 2

## EXTRACT OF ARTICLE 14 OF THE MAPUTO PROTOCOL

(official name: the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa)

Article 14 Health and Reproductive Rights
1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
a) the right to control their fertility;
b) the right to decide whether to have children, the number of children and the spacing of children;
c) the right to choose any method of contraception;

2. States Parties shall take all appropriate measures to:
c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

# HANDOUT 3

## A LONG JOURNEY

*Based on a true story; the name has been changed.*

I am Unala, I am 30 years old and I want to share my story. At the age of 16, after going through mental, physical and sexual abuse from my partner, I decided to leave and go to my friend's house. After a few days I realised that I didn't have my regular period so I spoke to my friend's mother. After a few days, my friend's mom found a private clinic where it was possible to get a medical abortion. The cost of the transportation and consultation was very expensive so it took us a few weeks to collect the money. Once I arrived at the clinic, I felt that the nurse was judging me because I was a teenager. I carried so much guilt that I almost decided to leave the clinic.

It took a few more weeks for me to have a medical abortion because I needed to have the authorisation from my family, and I was afraid of the limit of the 12 weeks [after which abortion is illegal] and not being able to get the abortion.

Today, I share my story because I have seen lots of women who have gone through the journey I have been through and ended up holding more responsibilities than they should. Knowing my rights related to SRH has helped me now advocate for other women like me.

# HANDOUT 4

## LANGUAGE GUIDE TO AVOID STIGMATISING LANGUAGE

From IPPF (2015), *How to talk about abortion: a guide to rights-based messaging.*

### LANGUAGE GUIDE – HOW TO AVOID STIGMATISING LANGUAGE

| NOT RECOMMENDED | MORE ACCURATE/ APPROPRIATE | EXPLANATION |
|---|---|---|
| Abort a child | End a pregnancy<br>Have an abortion | 'Abort a child' is medically inaccurate, as the fetus is not yet a child.<br>'Terminate' a pregnancy is commonly used, however some people prefer to avoid this as terminate may have negative connotations (e.g. 'terminator' or 'assassinate') for some people. |
| Abortion is illegal | Abortion is legal under the following conditions...<br>Abortion is legally restricted | At the time of writing only four countries prohibit abortion in all circumstances, (Chile, El Salvador, Nicaragua and Malta). See the Center of Reproductive Rights' map at **http://worldabortionlaws.com/map** which provides updates on the legal status of abortion across the world. In most countries abortion is allowed under some circumstances, under varying legal restrictions. |
| Abortionist | Service provider<br>Abortion provider<br>Healthcare provider | Abortionist is a term used by those opposed to abortion.<br>Healthcare provider is usually a more accurate term to use than abortion provider, as most of those providing abortion services also provide other health services. |
| Baby<br>Dead fetus<br>Unborn baby<br>Unborn child | Embryo (up to week 10 gestation)<br>Fetus (from week 10 gestation onwards)<br>The pregnancy | The alternatives are medically accurate terms, as the embryo or fetus is not a baby.<br>When referring to the tissue examined following a surgical abortion, an appropriate term is 'products of conception'. However, this term is only useful for materials focused on medical details of abortion, as it is not commonly used or understood outside of medical or scientific contexts. |
| Conscientious objector<br>Conscientious objection | Provider refusal<br>Someone who refuses to provide abortion care/services | 'Conscientious objector' implies that those who do provide abortions are not conscientious individuals, which is incorrect. |
| Consequences<br>Dealing with the consequences | N/A | Tends to suggest an act of wrongdoing, placing unwarranted blame on the woman, and frames parenthood as punishment. The right to abortion should never be linked to how or why a woman becomes pregnant. |
| Female feticide<br>Gendercide<br>Aborting girls | Abortion on the basis of fetal sex<br>Sex selective abortion | The suffix '-cide' denotes 'killing' which is not appropriate when describing abortion. It is more accurate to describe the practice in terms of choosing to end the pregnancy based on the predicted sex of the fetus. See *Appendix 2: Sex selective abortion for more information on this topic.* |
| Get rid of | Choose abortion<br>Decide to end a pregnancy | Make it clear that abortion is about choice, and not imply it is done without much thought. |
| Keep the baby<br>Keep the child | Choose to continue the pregnancy<br>Continue the pregnancy | The term 'keep' implies a positive outcome which may not accurately reflect the situation. In addition it is medically inaccurate to describe the pregnancy as a baby or child (see earlier for explanation). It is more accurate to describe the situation as a pregnant woman choosing to continue with the pregnancy. |
| Late-term abortion | Abortion in second/third trimester<br>Abortion at XX weeks gestation | Late term could refer to any time in the second or third trimester – instead, if necessary, use terms that indicate the specific trimester or gestation. Use of 'late' may also imply that a women is late (and thus irresponsible) in seeking an abortion. |
| Mother<br>Father<br>Parent | Pregnant woman<br>Partner of a pregnant woman | Use of mother/father/parent during a pregnancy is value laden and assigns roles that the man or woman may not accept. It also implies that the fetus is a child, which is not accurate. |

| NOT RECOMMENDED | MORE ACCURATE/ APPROPRIATE | EXPLANATION |
|---|---|---|
| Partial birth abortion | Intact dilation and extraction | Intact dilation and extraction is the accurate description of a medical procedure used for abortions performed at 16 weeks gestation or later. |
| Prevent abortion<br>Reduce the number of abortions<br>'Safe, legal and rare' | Prevent unintended pregnancies<br>Reduce the number of unintended pregnancies | Women often seek abortion due to the occurrence of an unintended pregnancy. Therefore, it is unintended pregnancy that needs to be avoided and reduced, rather than abortion. |
| Pro-life | Anti-choice<br>Anti-abortion<br>Someone who is opposed to abortion | Pro-life implies that those who support legal abortion access are 'anti-life', which is inaccurate. Instead, use alternative terms to make it clear that you are referring to individuals opposed to anyone having an abortion. |
| Promote abortion | Promote choice<br>Raise awareness of availability of abortion services (or include specific information about the services available) | Providing abortions is about promoting choices and rights for pregnant women, not only abortion services. However, it is appropriate to include specific information about abortion services in many materials talking about abortion. |
| Repeat abortion<br>Multiple abortion | More than one<br>Abortion | 'Multiple' and 'repeat' can have negative connotations, such as 'repeat offenders'. Multiple and repeat also imply that each abortion experience for a woman is the same, whereas each abortion is surrounded by a unique set of circumstances. |

| AVOID USING THE FOLLOWING TERMS INTERCHANGEABLY | USE THE SPECIFIC TERM FOR WHAT YOU ARE REFERRING TO |
|---|---|
| Illegal abortion<br>Unsafe abortion | Illegal abortions do not comply with a country's legal framework, but may be safe if performed by a trained provider or when a woman has access to high quality medication, information and support to safely undergo a medical abortion.<br>Unsafe abortions are performed by un- or under-trained providers or in situations where women are unable to safely undergo a medical abortion due to lack of access to high quality medication, information or support. It is possible to have an unsafe, legal abortion. |
| Unwanted pregnancy<br>Unplanned or unintended pregnancy | Unwanted pregnancy is a pregnancy that a woman decides she does not desire.<br>Unplanned or unintended pregnancies refer to pregnancies that occur when a person is not trying to get pregnant.<br>An unplanned or unintended pregnancy may be either a wanted or unwanted pregnancy. |

# HANDOUT 5
## SCENARIO FOR ROLE PLAY

**1.POST-ABORTION CARE**
A woman who uses drugs has gone through a violent and unsafe method of abortion at home the day before. She has a regular partner and normally takes pills as her contraception method. But she forgot to take her pills for two days and asked her partner to use a condom. He refused and she finally accepted to have sex without a condom one time. She realised that she was pregnant after a few weeks but couldn't get to the private clinic because it was too far. Moreover, she was afraid of stigma and discrimination because of her drug use.

A friend told her that she can pay someone to carry out an abortion at her place. A curettage (scraping the womb and removing the contents) was done in a living room by this person who didn't have any medical background.

After the procedure, the woman was feeling very weak and shaking. She had a fever the whole night and abdominal pain. Her friend accompanied her to the clinic as she was now also bleeding heavily.

**2. ABORTION INFORMATION**
A woman who uses drugs was using condoms with her partner. They decided to stop using condoms to have a baby together. She got pregnant right away and has now had the baby. After giving birth, the woman stopped using drugs for a while, taking methadone instead. After a few months, she stopped breastfeeding and started to use heroin at the same time as taking methadone because the methadone dosage was incorrect. She didn't know how to explain this to the doctor, and she was very busy and tired with the newborn. She got pregnant again and decided to go to the clinic to receive information about abortion and the full range of appropriate, available contraceptive methods that she could choose from in the future.

# HANDOUT 6
## MAPPING POSTER

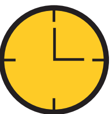
Fill in the different columns to describe the specific private or public structures where it is possible for a woman or gender non-conforming person who uses drugs to have access to care, services and medication related to safe-abortion/post-abortion.

It will help to map potential referrals for people who use drugs to receive safe-abortion care counselling and services and post-abortion care services.

Different groups can work on different columns to create a participative poster.

| Public health facility (primary/ secondary/ tertiary) | Private sector | Pharmacy | INGO | Local organisation |
|---|---|---|---|---|
| | | | | |

# Module 6
## Perinatal and newborn care



**TIME**
2 hours

**MATERIALS**
- Flipchart
- Colour pens
- **PPT Module 6:** Perinatal and newborn care
- **Handout 1:** General harm reduction strategies
- **Handout 2:** Example of best practices to avoid using stigmatising language related to perinatal and newborn care.
- **Handout 3:** Individual action plan

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 6** | **Perinatal[7] and newborn care** | Pregnancy and drug use | • To understand the advantages and limits of OST or drug use during pregnancy and breast/chestfeeding<br>• To facilitate group discussion on perinatal and newborn care for women and gender non-conforming people who use drugs |
| | | Newborn care and neonatal abstinence syndrome (NAS) / neonatal opioid withdrawal (NOW) management | • To identify neonatal abstinence syndrome (or neonatal opioid withdrawal) in babies and provide appropriate care<br>• To list key steps to begin perinatal and newborn care services in the programme |

### TIPS FOR ONLINE FACILITATION
To deliver these exercises online, you will need to create virtual breakout rooms for smaller group work.

**EXERCISE 5. BRAINSTORMING: 10 MINUTES**
The participants can use basic online tools, such as Mural, Jamboard and Klaxoon to note their ideas and share them with others.

**EXERCISE 6. INDIVIDUAL ACTION PLAN**
You can share the template with the participants by sharing your screen, or you can email it to participants before the session.

### TO PREPARE IN ADVANCE
You should prepare for this module by finding information and education materials in the local language on newborn care and breast/chestfeeding. It is also important to prepare some appropriate referrals for pregnancy and antenatal care services, including services for prevention of vertical transmission (PVT). This module can be linked with the Module 7 on HIV, STIs and PVT.

It is also important to be prepared to provide examples of common signs and symptoms of postpartum (after birth) depression, in case participants ask questions about it.

7. 'Perinatal' means during pregnancy and after giving birth (commonly defined as up to a year after birth).

# PERINATAL AND NEWBORN CARE (2 HOURS)

## PREGNANCY AND DRUG USE (1/2)

30 minutes

Flipchart and colour pens
PPT Module 6: Perinatal and newborn care

### SEQUENCE

**Exercise 1. Introduction: the Pros and Cons: 15 minutes**

Divide participants into two mixed-gender groups (it is important to include women in each group).

Ask the first group to list on a flipchart the 'pros' (benefits/advantages) and 'cons' (disadvantages) of continuing drug use during pregnancy and during breast/chestfeeding.

Ask the second group to list the pros and cons of OST during pregnancy and breast/chestfeeding.

**Report back: 5 minutes**

Ask one person from the first group to report back to all participants. Then asks the participants in the second group to add in any additional limits or benefits to the first presentation. Repeat this process with the second group.

**PPT presentation: 10 minutes**

### KEY MESSAGES

Although there is very little data definitively showing a cause-and-effect relationship, the use of illicit drugs during pregnancy can be associated with negative effects on the pregnant person, the fetus and/or the newborn child. However, there is a tendency for media, governments and even health services to overstate and sensationalise these effects. Other potentially harmful factors, such as homelessness, violence and poor nutrition, may have a greater impact on the health of the pregnant person, fetus and newborn than the use of illicit substances.

**Drug use during pregnancy**

Use of amphetamine type stimulants (ATS) during pregnancy –depending on how much is taken, frequency, and what form it is in – can be associated with preterm labour, hypertension (high blood pressure) and smaller birth weight (but still within the normal range for gestational age). This is true for both cocaine and methamphetamine use.

Use of heroin has been associated with potential risks, such as early labour, or overdose in the pregnant person resulting in possible fetal death. Heroin use during pregnancy has not been conclusively linked to birth defects, developmental problems or learning disabilities.

The risks to pregnancy of tobacco (cigarette smoking) and alcohol use, both of which are legal, are generally greater than that of illicit substances.

**OST during pregnancy**

OST is regarded as safe if the pregnant person is stabilised on OST during pregnancy, as OST does not cause damage to the fetus. Ideally, someone should be stabilised on OST before getting pregnant. Unlike heroin from the black market, the dosage of OST is known (eliminating the risk of overdose) and it is the same every day, so there is no risk of impurity. Women and gender non-conforming people receiving OST also have more opportunity for contact with a health professional.

It is not recommended to detox (or undergo medically supervised withdrawal) during pregnancy because the chances of returning to opioid use are significant, while the risk of overdosing is much higher after detoxing because of loss of tolerance. No one should ever be pressured or coerced into detox, especially when pregnant.

**Advantages and disadvantages of drug use during breast/chestfeeding**

It is important to assess each pregnant person individually when developing infant feeding plans throughout the perinatal period. Use of illicit drugs after delivery is potentially unsafe for the baby because it is not known what additives or impurities might be included in unregulated, black-market drugs that can then be passed on in human milk. It is therefore recommended that opioid dependent people opt for OST during breast/chest feeding.

Use of stimulants (including caffeine), depending on quantity, and type, can decrease the amount of milk produced, and may cause lactation to 'dry up' earlier. Some amount of ATS is passed on in human milk. This can be associated with poor sleep patterns and irritability in the baby.

As with all drugs taken during breast/chestfeeding, the potential risks should be weighed against the benefits of breast/chestfeeding. In low, irregular-dose scenarios, levels may not be high enough to pose a major problem. If someone who uses ATS decides to breast/chestfeed, it is recommended that they discard milk for 24 hours (for cocaine) or 48 hours (for methamphetamines) after use. During this time, if they wish to continue to breast/chestfeed, they should continue to pump to avoid discomfort and mastitis (inflammation of the tissue, which can cause pain, swelling, redness and infection).

| SEQUENCE | KEY MESSAGES |
|---|---|
| | **Overdoses**<br>Hidden substance impurities that are commonly found in drugs sold on the black market can present additional risks – particularly of overdose. In the context of opioid overdose in pregnant people, the use of naloxone has been noted as a potential miscarriage risk. However, it is important that peers, health workers and other potential first responders do not hesitate to administer naloxone in an overdose scenario, as this will still save the pregnant person's life. If they die, the fetus will also perish. The only difference from a typical overdose reversal is to use the left side for the recovery position, as this increases placenta blood flow.<br>**HIV and pregnancy**<br>For pregnant people who use drugs and are living with HIV, pre- and postnatal care are important to prevent transmission of HIV to the fetus or infants during pregnancy, delivery or breast/chestfeeding (see Module 7 on HIV and STIs). |

## PREGNANCY AND DRUG USE (2/2)

| | | | |
|---|---|---|---|
| | **30 minutes** | | **Handout 1: General harm reduction strategies (adapted from www.perinatalharmreduction.org)**<br>**Handout 2: Example of best practices to avoid using stigmatising language related to perinatal and newborn care (adapted from www.perinatalharmreduction.org)** |

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 2. Group exercise: Group counselling: 15 minutes**<br>Divide the participants into two groups and ask them to role-play a group counselling session on **perinatal and newborn care** with a group of pregnant women or gender non-conforming people who use drugs.<br>Ask each group to think of five questions they would ask to start the counselling. These should be open-ended questions* when possible. In addition, to prepare for the conclusion of the counselling session, ask each group to come up with some practical harm reduction advice they want to share (at least three points).<br>*An open-ended question is one that cannot be answered simply with a 'yes' or 'no'. It normally starts with a 'how', 'what', 'where' 'who', 'when' or 'why'. You can give an example of an open-ended question before the start of the exercise. For example: *"What strategies have you thought of to reduce your risk of opioid overdose during pregnancy?"*<br><br>**Reporting back to the group: 5 minutes**<br>Ask one member of each group to report back the work to all the participants.<br><br>**PPT presentation and wrap up: 10 minutes** | **Key messages at the end of the group counselling**<br>Type of questions to ask:<br>*What strategies have you thought of to reduce your risk of opioid overdose during pregnancy?*<br>*What are the pros and cons of continuing using drugs while you are pregnant?*<br>*What do you think about cocaine use while breast/chestfeeding?*<br>*If you plan to breast/chestfeed, how would you envisage to manage your drug use?*<br>*If you plan to start OST during or before your pregnancy, what do you know about OST and pregnancy?*<br>*Please describe sudden unexpected infant death (SUID) – previously known of as sudden infant death syndrome (SIDS) – if you have heard of it?*<br>Be careful of the words you use. For example, don't use 'born addicted', use 'neonatal opioid withdrawal' instead.<br>**Harm reduction advice: key messages**<br>• It can be risky to stop using opioids suddenly because opioid withdrawals may be associated with miscarriage or early labour.<br>• If you plan to reduce drug use, try to taper the dosage a little at a time as the pregnancy progresses.<br>• Try to buy drugs from a trusted source with consistent quantity and quality<br>• Keep a record of how much you use; this can help you to moderate your use, even if that was not your initial goal<br>• Set limits on where, when and how you use<br>• Avoid using drugs alone if possible<br>• Switch to safer methods (smoking instead of injecting, for example).<br>• Do not share your supplies<br>• Wash your hands with soap and water and clean the site with an alcohol pad before every injection.<br>There is a lot more advice you can give to prepare a woman or gender non-conforming person who uses drugs for pregnancy! (See Handout 1: General harm reduction strategies) |

**NEWBORN CARE AND NEONATAL OPIOID WITHDRAWAL (NOW) MANAGEMENT (1/2)**

30 minutes

**SEQUENCE**

**PPT presentation: 10 minutes**

**Exercise 3. Group exercise: Develop information, education and communication materials: 15 minutes**

Divide the participants into three groups.

Ask each group to develop an information and education material for pregnant people who use drugs about the symptoms of neonatal opioid withdrawal (NOW) and tips to care for a baby with NOW.

Each group can choose the type of material they would like to develop. It can be a set of posters for the DIC or an individual leaflet.

The groups can use local words, expressions, reassuring words, humour and drawings/images to make it attractive.

**Report back: 5 minutes**

Ask each group to present their poster/leaflet.

**KEY MESSAGES**

**What causes NOW[8]?**

Newborns whose mother or birthing parent took opioids during pregnancy — including prescribed painkillers, opioid substitution therapy, and/or illicit opiates — may experience NOW (neonatal opioid withdrawal) within 24 hours to five days after being born. The 'dangers' of NOW have generally been overstated. NOW is easy to treat and temporary, so it doesn't have a lasting negative impact. Prenatal exposure to opioids does not always result in NOW. Research has not yet determined why some babies develop NOW and require medication treatment and others do not.

**What are the signs of NOW?**

Withdrawal signs vary, from minor to more pronounced. If the signs are pronounced, they can be easily managed by a doctor.

Signs can include:

Irritability (easy disturbed or upset), tremors, restlessness (unable to lie still for any length of time), sleeping difficulties (baby cannot sleep after a feed), sweating, sneezing, yawning, nasal congestion, a sore red bottom (due to frequently dirty nappies), overstimulation, difficulty feeding, poor weight gain, vomiting, and diarrhoea.

These can be related to physiological withdrawal from any opioid (heroin, morphine, prescription pain killers, fentanyl, or treatments like buprenorphine and methadone etc).

**How is NOW treated?**

Depending on the severity of the signs, some NOW-diagnosed newborns may need medication and a longer stay in hospital. These medications are gradually tapered off.

NOW is not life threatening, and studies show that newborns with NOW do not develop any differently from other children.

Research shows that skin-to-skin contact, breast/chestfeeding, and caring for mother/birthing parent and baby in the same room ('rooming in') can significantly reduce a newborn's need for medication.

Some other tips to help are:

- Give a gentle massage to your baby
- Keep your baby away from loud music, bright light and smoke
- Handle your baby without sudden movement
- It may be difficult to deal with the signs, but it is important NOT to give any substances to your baby
- If the signs are obvious and do not go away, seek advice from a doctor, midwife or health professional.

There is some evidence that women with a history of drug use have elevated risk of postpartum depression. Postpartum depression (also called postnatal depression) is very common. If you have any signs of depression, don't be ashamed; go and consult a doctor or any trusted health professional or any support group.

People who drink excessive alcohol during pregnancy may experience fetal alcohol syndrome (FAS). The main consequences of FAS for the newborn are impaired growth, facial abnormalities, and damage to the central nervous system.

8. Previously, this has been called NAS (neonatal abstinence syndrome) but this is an inaccurate and misleading term – the preferred term is NOW

## NEWBORN CARE AND NEONATAL OPIOID WITHDRAWAL (NOW) MANAGEMENT (2/2)

30 minutes

Handout 3: Individual action plan

### SEQUENCE

**Exercise 5. Brainstorming: 10 minutes**

This brainstorm should answer this question: *What could be the key steps to start implementing perinatal and newborn care services in your harm reduction programme?*

Write down and organise the different steps as participants suggest them and add in additional ideas or propositions.

**Conclusion: 5 minutes**

Explain the link between this exercise and Module 9 to prioritise the actions and develop a joint action plan.

**Exercise 6. Individual action plan: 15 minutes**

Ask the participants to take 15 minutes to start to develop their own individual action plan (see Handout 3: Individual action plan). They can take it home to finalise it.

### KEY MESSAGES

There are multiple actions to start implementing perinatal and newborn care services in a harm reduction programme. For example:

- Sensitise and train harm reduction staff and other health service providers on stigma reduction. Train them to provide accurate, evidence-based information about drug use in relation to family planning, pregnancy and fetal health.
- Talk to women and gender non-conforming people who use drugs about their fertility desires and provide free pregnancy test kits and tailored information, including about outreach connections.
- Provide accurate, evidence-based and unbiased information for pregnant women and gender non-conforming people who use drugs on the effects of different drugs in pregnancy and how to minimise the effects.
- Encourage and support the creation of peer support groups for pregnant women and gender non-conforming people who use drugs. Once established, discuss with the group what themes they would like to explore beyond substance use, such as general knowledge about pregnancy (e.g. signs of early labour). Offer guest talks from suitably-skilled midwives or others who can provide unbiased, accurate and non-judgmental information.
- Ensure pregnant and breast/chestfeeding people who use drugs have access to peer support, through self-support groups for pregnant people who use drugs or for women and gender non-conforming people who use drugs.
- In addition, consider beginning a support group for parents to be.
- Provide referrals to antenatal care (including for preventing vertical transmission) with a trusted provider who can support the pregnant person's general health and well-being and the health of their fetus/child.
- Offer to accompany pregnant people to primary healthcare services and antenatal care services to avoid stigma and inaccurate information.
- Include these primary healthcare providers in cross-training opportunities to build their skills and eliminate stigma and discrimination when working with women and gender non-conforming people who use drugs.
- Increase the links between harm reduction providers and primary healthcare services, including those familiar with management of NOW.
- Prepare protocol for home delivery for OST for pregnant people who lack mobility or transport.
- Methadone programmes should offer dosing flexibility for pregnant people.
- Advocate to ensure that OST is available at the clinic where women or gender non-conforming people who use drugs give birth.
- Provide referrals to legal services and other support for women and gender non-conforming people who have lost custody of their child/children or are at risk of doing so.

# HANDOUT 1

## GENERAL HARM REDUCTION STRATEGIES

(Adapted from Harm Reduction Coalition and the Academy of Perinatal Harm Reduction (2020), *Pregnancy and substance use: a harm reduction toolkit*. See www.harmreduction.org, www.perinatalharmreduction.org.)

### GENERAL ADVICE FOR PREGNANT WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUGS

- Ensure your statutory documents and requirements are in order for ease of access to medical and social services.
- Engage with your local administration or employer to access available social services and health insurance for pregnancy and perinatal services.
- Mark down the dates, and use reminders, to attend all of your antenatal care clinics, and/or have a clinic buddy to remind you of the dates.
- If you are living with HIV, ensure your harm reduction service provider is aware and that you have the necessary information about preventing vertical transmission. Adhere to your treatment if you are already taking ART.

### HARM REDUCTION STRATEGIES RELATED TO PREGNANCY AND DRUG USE

- Find a good doctor who you are comfortable to have support your pregnancy
- If you are opioid dependent, avoid withdrawal as it can cause uterine contractions, miscarriage or early labour.
- If you are opioid dependent, consider the advantages of OST in pregnancy.
- If you use amphetamine-type stimulants, make a list of pros and cons of stopping or continuing use.
- If you plan to reduce drug use, try to taper the dosage very little at a time as the pregnancy progresses.
- Try to buy drugs from a trusted supplier who can provide drugs of consistent quantity and quality.
- If there is a drug testing/drug checking facility near you, try to have your drugs tested for impurities.
- Keep a record of how much drugs you are using.
- Set limits on where and when you use (while avoiding withdrawal if opioid dependent).
- Set limits of how often and how much you use (while avoiding withdrawal if opioid dependent).
- Avoid using drugs alone if possible.
- Switch to safer methods (e.g. smoking instead of injecting or using less or different types of drugs). If you are continuing to use, and/or are injecting opioids or other substances (meth, cocaine, etc.), do not share your supplies, wash your hands with soap and water, and clean the site with an alcohol pad before every injection.
- Take care of your health and body in general by getting enough sleep, eating healthily and drinking enough water.
- If using opioids, be sure you, your friends or family have naloxone (if available), and encourage friends and family to learn rescue breathing.

# HANDOUT 2

## AVOIDING STIGMATISING LANGUAGE RELATED TO PERINATAL AND NEWBORN CARE

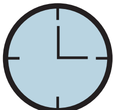
| BEST PRACTICES TO AVOID USING STIGMATISING LANGUAGE | | |
|---|---|---|
| **DON'T USE** | **DO USE** | **WHY** |
| addicted newborn<br>born addicted<br>crack baby | neonatal opioid withdrawal syndrome<br>baby with prenatal cocaine exposure | Infants are not addicted; they have prenatal substance exposure and/or physiological dependence. |

# HANDOUT 3

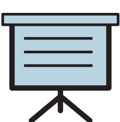
## INDIVIDUAL ACTION PLAN

| HOW WILL I USE THIS MODULE WHEN I GO BACK TO MY PROFESSIONAL OR PERSONAL LIFE? | WHAT CONCRETE ACTION CAN I MAKE IN MY POSITION? | HOW LONG DO I NEED TO START THIS ACTION? | WHAT RESOURCE OR SUPPORT DO I NEED TO START? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

# Module 7
## HIV and STIs

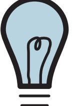


**TIME**
2 hours 25 minutes



**MATERIALS**
- Flipchart
- Pens
- Condoms
- **Handout 1:** Risk analysis game
- **Handout 2:** Table of STIs
- **Handout 3:** Factsheet on dual protection strategies to prevent transmission of HIV, STIs and unintended pregnancy
- **Handout 4:** Role play scenario
- **Handout 5:** Chemsex: safer ways to party and play
- **Handout 6:** Stories and facilitation guide for the 'Develop your strategy' exercise
- **Handout 7:** How to use internal and external condoms
- **PPT Module 7:** HIV and STIs

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 7** | **HIV and STIs** | HIV and STIs: basic information and prevention | • To explain basic information about HIV and other STIs, including ways of transmission, prevention and testing<br>• To provide counselling on dual protection strategies to prevent both transmission of HIV/STIs and unintended pregnancy |
| | | Preventing vertical transmission (PVT) | • To inform and refer pregnant people who use drugs living with HIV to appropriate services |
| | | Condom use and condom negotiation | • To enhance capacities to negotiate condom use |



### TIPS FOR ONLINE FACILITATION

**EXERCISE 1. BRAINSTORMING: 10 MINUTES**
The participants can use basic online tools, such as Mural, Jamboard and Klaxon, to note their ideas and share them with others.

**EXERCISE 3. COUNSELLING: 20 MINUTES**
**AND EXERCISE 4. DEVELOP YOUR STRATEGIES: 20 MINUTES**
Open enough virtual rooms so that everyone can work in pairs.

For the demonstration of condoms, use webcams. You can ask one of the participants in advance to get ready to do the demonstration at the end of the module or you can show a video demonstration.

### PREPARE IN ADVANCE

You should link this module to Module 6 (on perinatal and newborn care) for related questions. It is important to use the participants' knowledge to exchange experiences, as the topics of HIV and STIs may be quite well-known.

It is also important to refer to other sources and services for any questions related to starting HIV treatment, adherence and retention in care. You can also check this recent WHO recommendation on vertical transmission (page 20-21).

# HIV AND STIS (2 HOURS 25 MINUTES)

## HIV AND STIS: BASIC INFORMATION AND PREVENTION (1/2)

50 minutes

Flipchart
Pens
PPT Module 7: HIV and STIs
Handout 1: Risk analysis game. Cards with the situation (or image) and answers for each
Handout 2: Table of STIs

### SEQUENCE

**Exercise 1. Brainstorming: 10 minutes**

Ask the participants to share ideas and words associated with the following three words: HIV, AIDS, STIs, as quickly as possible.

This exercise has to be fast. You can ask one of the participants to write key notes on the flipchart.

**PPT presentation: 5 minutes**

**Exercise 2. Risk analysis game: 15 minutes**

Prepare two flipcharts with two columns on each: NO RISK in green, and RISK in red.

Break the participants into two groups and ask them to stick the cards with a situation (or image) in the correct column.

**Discussion and conclusions: 5 minutes**

Ask the participants to take five minutes to explore the flipchart of the other group. Then highlight and discuss the differences.

**PPT presentation: 15 minutes**

### KEY MESSAGES

**Basic information about HIV**

Definitions:

**HIV:** Human Immunodeficiency Virus attacks the immune system. It also destroys white blood cells in the immune system called CD4s and makes copies of itself inside these cells.

**AIDS:** is not a virus but a set of symptoms caused by HIV. A person is said to have AIDS when their immune system is too weak to fight off infection. AIDS is late-stage HIV/ advanced HIV infection. If left untreated it will lead to death. AIDS stands for:

**A**cquired (to get)
**I**mmune (the body's defence)
**D**eficiency (lack of resistance)
**S**yndrome (signs, symptoms of disease)

**Difference between HIV and AIDS:** HIV is a virus that reduces the' body's immune system. People who take antiretroviral treatment (ART) can protect or restore their immune system and live a healthy life.

**STIs:** Sexually transmitted infections are infections passed primarily by sexual contact, including vaginal, oral, and anal sex. Some STIs can be transmitted by skin-to-skin contact. Some can be passed to a baby before it is born, during childbirth, or via breast/chestfeeding. STIs such as HIV, HPV, syphilis, gonorrhoea, chlamydia, trichomonas, and herpes can have serious health consequences for men and women – including infertility, cervical cancer (HPV – see Module 8). AIDS or syphilis can be fatal if untreated.

HIV transmission requires an entry point, a vehicle (the infectious fluids) but also, sufficient quantity of the virus to allow infection.

**There are three main modes of infection for HIV virus:**

1. Through sex (vaginal, anal or oral)
2. Through blood. This can be via a cut from a contaminated object; through unsterilised tattooing, by sharing injecting equipment, through needlestick injury (rare), by an accident during an invasive medical procedure, or by contaminated blood transfusion.
3. Vertical transmission (parent to child) during pregnancy, delivery or breast/chestfeeding (which if not on effective HIV treatment).

There are five readily available bodily fluids which are likely to contain enough HIV to allow infection: blood (whole blood, plasma, etc.), sperm, pre-sperm fluid, vaginal secretions, and human milk. Other bodily fluids like saliva carry HIV, but generally the quantity of the virus is insufficient to allow infection. This is why HIV is not transmitted through kissing.

There are additional issues for people who use stimulant drugs, as they may experience dehydration and over-drying of the vaginal mucus and this increases the risk of cracks or tears in the vagina, which provide an entry point for infection and so increases the risk of HIV and other STI transmission.

**PEP**

PEP (post-exposure prophylaxis) means taking medicine to prevent HIV after a possible exposure. PEP should only be used in emergency situations and must be started within 72 hours after possible exposure to HIV.

| SEQUENCE | KEY MESSAGES |
| --- | --- |
| | **PREP**<br>Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medication to prevent people from acquiring HIV. It is mostly available in pill form (oral PrEP) but soon to be available in some countries as a vaginal ring (see below).<br>Someone who is HIV-negative takes antiretroviral medicines prior to possible exposure to HIV. Oral PrEP has shown impact in reducing new HIV infections in diverse groups. But it doesn't prevent STIs or pregnancy.<br>Ideally, anyone who stands to benefit from PrEP and is interested in using it should have access. However, making PrEP available for all people who use drugs is not universally recommended. This is because many people who use drugs who are living with HIV are not able to access ART, and so using limited resources to pay for PrEP for people who use drugs is ill advised, especially when there are other proven prevention methods (such as needle and syringe programmes). PrEP is also recommended in certain contexts for serodiscordant couples (when one person has HIV and the other doesn't) and adolescent girls who struggle to negotiate condom use with partners, for instance.<br>Many transgender people considering using PrEP have concerns about side effects and drug interactions, in particular whether PrEP might interfere with gender-affirming hormone therapy. But oral PrEP drugs do not raise or lower levels of gender-affirming hormones. Hormones taken by trans women appear to slightly lower levels of the PrEP drug tenofovir, but not enough to affect the efficacy of daily PrEP.<br>**PrEP vaginal ring**<br>A vaginal ring slowly releases the antiretroviral medicine dapivirine locally in the vagina over one month to prevent HIV. It is recommended by WHO. The ring, which is replaced monthly, can give people an HIV prevention option that is discreet and that they can control. Once it becomes more widely available, this prevention tool will be particularly relevant for women who struggle to take oral PrEP pills daily or negotiate condom use.<br>**Benefits of HIV testing**<br>• Knowing one's HIV status helps one to avoid and prevent HIV acquisition:<br>• HIV testing helps to increase and improve knowledge on HIV prevention<br>• It allows people who are HIV negative to remain so ,<br>• It assists people living with HIV to maintain their health protect themselves from re-infection and avoid onward transmission.<br>• It offers people diagnosed with HIV the opportunity to access ARV treatment, ARV information and care, and psycho-social/ peer support services.<br>**Focus on STIs**<br>Signs and symptoms of STIs differ between sexes, but include:<br>• Discharge from the penis or vagina (yellow-green, or abnormal vaginal discharge that is thick, itchy or has a foul smell)<br>• Pain or burning feeling when passing urine<br>• Painful sores, abnormal swelling or growth on genital organs, abnormal bleeding<br>STIs can be prevented through the following ways:<br>• As for HIV, early testing is important. A person diagnosed with an STI can get treatment and can help their recent partners tested and be treated as well if they need to be.<br>• If untreated, there is a risk of being re-infected or passing on the STI.<br>• Avoid sexual intercourse or use condoms during treatment to prevent onward transmission or being re-infected.<br>• Take the complete dose of medication as prescribed. |

## HIV AND STIS: BASIC INFORMATION AND PREVENTION (2/2)

25 minutes

**Handout 3: Factsheet on dual protection strategies to prevent transmission of HIV, STIs and unintended pregnancy**
**Handout 4: Role-play scenario**
**Handout 5: Chemsex: safer ways to party and play**

### SEQUENCE

**Exercise 3. Counselling: 20 minutes**

Organise the group into pairs (trying to mix profiles). Ask each pair to prepare a role-play using the scenario you give them; one will play the counsellor the other will play the client. If there is a group with three people, the third can be a friend or partner participating in the counselling session.

The objective of the counselling session is to discuss the risks of unsafe sex and dual protection strategies.

The counsellor should first discuss the risks with the client. (Use Handout 4 for this).

At the end of the role-play, ask the whole group to consider the following questions:

***Question:*** *What was Sarah's situation when she came to the counselling session?*

(**Answer:** Sarah decided to have unprotected sex with her boyfriend, despite not been sure about his fidelity.)

***Question:*** *What are the risks Sarah was exposed to or likely resulting consequences?*

(**Answer:** Sexually transmitted infections, unwanted pregnancy, HIV)

*What dual protection strategy did Sarah decide to use?*

*What are the other possible strategies she could use (for example, if she had other sexual partners)?*

**Conclusion and presentation: 5 minutes**

Ask the participants additional questions, such as, *"What are the other strategies you can think of?"*

### KEY MESSAGES

**Dual protection strategies can include:**

**Strategy 1:** condoms, plus another contraceptive method

**Strategy 2:** condoms, plus emergency contraception/PEP if condom fails

**Strategy 3:** selectively using condoms and another method (for example, using the pill with main partner, but the pill plus condoms with others)

**Strategy 4:** PrEP/PEP, plus condoms and another contraceptive method

(See *Handout 3: Factsheet* for complete set of messages.)

**Focus on chemsex**

Chemsex, also called chemfun, involves using drugs to enhance sex, often by increasing desire and reducing inhibitions.

Chemsex drugs change how you feel and behave. When you mix them with sex, you increase your risk of HIV and STIs, and unintended pregnancy.

Advice for people engaging in chemsex:

- Pack some protection
- Know your status
- Party with people you trust
- Set your limits
- Stay aware
- Set reminders

## PREVENTING VERTICAL TRANSMISSION (PVT) (1/1)

30 minutes

### SEQUENCE

**Exercise 4. Group discussion: 25 minutes**

Facilitate a group discussion around the following questions:

*What are the risks for people living with HIV who are pregnant and plan to have a baby?*

*How could transmission of HIV to the baby occur? What are some methods to prevent transmission?*

*What are the benefits of PVT services?*

*Where can a woman or gender non-conforming person who uses drugs access PVT services?*

Accompany the discussion by noting and organising key ideas.

**Conclusion and PPT presentation: 5 minutes**

### KEY MESSAGES

**Definition of PVT**

Prevention of parents-to-child transmission, or prevention of vertical transmission (PVT), is a programme that offers a range of services for women and gender non-conforming people of reproductive age living with HIV to maintain their health and prevent their infants from acquiring HIV.

**PVT services** should be offered before conception and throughout pregnancy, labour, and breast/chestfeeding.

There are three points of possible vertical transmission:

1. Before birth in the womb, through blood crossing the placenta (especially during the final trimester)
2. During delivery – the baby acquires HIV through cervical secretions or blood during childbirth
3. After birth through breast/chestfeeding.

Strategies to prevent babies acquiring HIV:

- Testing at four to six weeks after birth
- Testing at 18 months and/or when breast/chestfeeding ends
- ART initiation as soon as possible for HIV-exposed infants to prevent HIV acquisition

| SEQUENCE | KEY MESSAGES |
| --- | --- |
| | **Benefits of PVT**<br>PVT improves the health of both the parent and the child. It provides women and gender non-conforming people with an entry point into HIV treatment and retention in care as well as greater access to peer support and follow up. Infants benefit from early diagnosis and appropriate treatment (HIV prophylaxis and ARVs for infants that test positive) and care.<br>**Where can a woman or gender non-conforming person who uses drugs access PVT services?**<br>Referrals to trusted health facilities/ hospitals/ clinics/ one stop shops that provide friendly/welcoming services to women who use drugs. |

**CONDOM USE AND CONDOM NEGOTIATION (1/1)**

| | | | |
| --- | --- | --- | --- |
| | 40 minutes | | **Handout 6: Stories and facilitation guide for the 'Develop your strategy' exercise**<br>**Handout 7: How to use internal and external condoms** |

| SEQUENCE | KEY MESSAGES |
| --- | --- |
| **Exercise 4. Pair exercise: Develop your strategies: 20 minutes**<br>Put the participants in pairs and explain that they will work on different stories and find strategies, solutions and tips to negotiate condom use for the couple in their story. Give each group a different story.<br><br>**Discussion: 10 minutes**<br>Guide a discussion with the group using these questions:<br>*What could be the outcome of this story if they have unprotected sex? If they decide not to have sex?*<br>*Based on the outcomes from the different stories, what could be the answer to the sentences in Handout 6?*<br><br>**Conclusion and PPT: 10 minutes**<br><br>**Condom demonstration/internal and external: 5 minutes**<br>Demonstrate how to use internal or external condoms or ask a participant to volunteer to do so. | **Main key strategies/tips to negotiate condom use (for women and gender non-conforming people):**<br>• Offer to use an internal condom, so he doesn't have to wear one.<br>• Try a less risky way of being intimate, such as sensual massage or mutual masturbation.<br>• If available, explore the benefit of taking pre-exposure prophylaxis (PrEP). But this is only for HIV prevention, it will not protect you from other STIs or pregnancy.<br>• Think of how you would ask someone to use a condom, so that you will be ready when the time comes.<br>• Carry condoms with you, so you will be ready for any sexual situation.<br>• Practice putting on and taking off a condom.<br>• Consider including condoms in foreplay or during oral sex.<br>• Prepare responses to anticipated objections to condom use from your partner or client. For instance:<br>*"You don't love me"* = you can explain that if he loves you, he will want to protect your health.<br>*"I will pay more"*= explain that you would prefer to see him often and so want to protect the health of both of you.<br>**Consenting to sex includes the degree of safety you consent to. For example, if a person consents to sex with a condom, and their partner removes the condom during sex without informing them, this is rape. Everyone has the right to refuse unsafe sex (or sex that is unwanted for any reason). Many people, however, cannot or do not exercise this right.** |

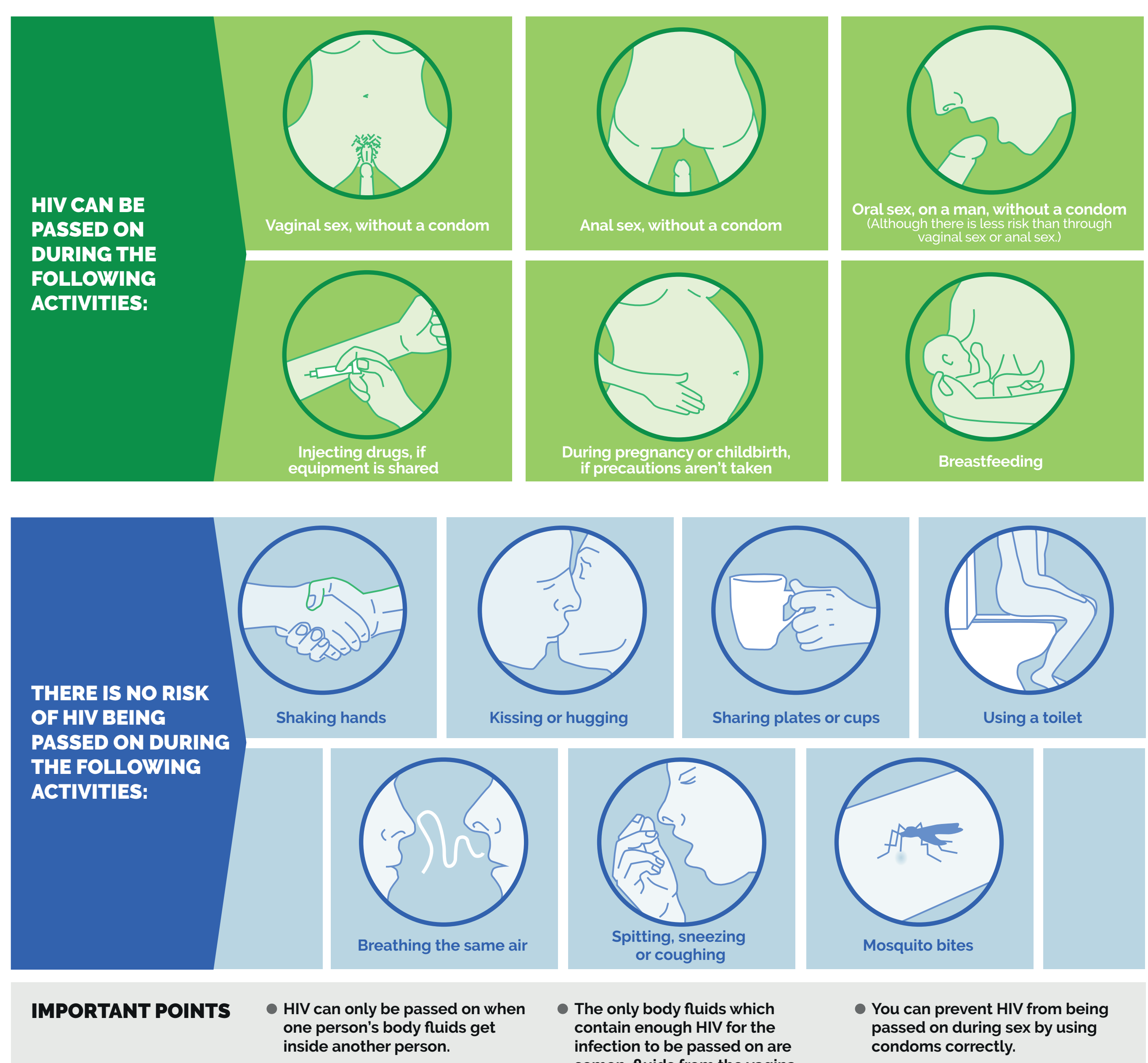
# HANDOUT 1

## GAME: RISK OR NO RISK

There is a risk of HIV infection if:

1. I am sharing sharp instruments with someone else (like a razor blade).
   **RISK:** If I use sharp instruments that have been used by someone with HIV, there is a risk. The risk of contracting Hepatitis C is also very high.
2. I am playing games or sports with friends, including friends living with HIV.
   **NO RISK** as there is no exchange of fluids.
3. I am having vaginal sex without using a condom.
   **RISK:** This risk is increased if I have a STI. This risk also increases if the sex is violent or vigorous, as this can create lesions that help the virus enter into the body.
4. I am sharing my needle with my partner
   **RISK:** HIV is fragile and cannot survive for long outside the body in the open air (in contrast to Hepatitis C virus, which can survive much longer). HIV can survive for several days in a small amount of blood that remains in a needle after use.
5. I am having oral sex for money using a condom
   **NO RISK:** If the condom is used correctly until the end of the oral sex, there is no risk of HIV infection.
6. I am having a blood transfusion with infected blood
   **RISK:** HIV in the donor blood will cause the recipient to acquire HIV
7. I am living with HIV and I breast/chestfeed my baby
   **RISK:** However, this risk can be reduced to a very low risk if the mother is on treatment (refer to PVT)
8. I am having anal sex, using a condom and lubricant
   **NO RISK:** If the condom is used correctly from beginning to end of the anal sex, there is no risk of HIV infection.
9. I am hugging and kissing my boyfriend/girlfriend
   **NO RISK:** cuddling/hugging involves no exchange of fluids, and HIV cannot be transmitted through saliva
10. I am using public toilets
    **NO RISK:** there is no exchange of fluids
11. I have mosquito bites
    **NO RISK:** HIV cannot be transmitted via mosquito bites
12. I had vaginal and/or anal sex using a condom but the condom broke or came off
    **RISK:** Refer to PEP protocol (post-exposure prophylaxis). You can reduce the risk of infection by accessing PEP (the sooner the better – within 72 hours). The course must be completed in adherence with the guidelines. And don't forget emergency contraception pills if not using dual protection!

## TRANSMISSION FACTS




**IMPORTANT POINTS**

- HIV can only be passed on when one person's body fluids get inside another person.
- The only body fluids which contain enough HIV for the infection to be passed on are semen, fluids from the vagina, moisture in the rectum, blood and breast milk.
- You can prevent HIV from being passed on during sex by using condoms correctly.

# HANDOUT 2
## TABLE OF STIS

**TABLE 1: STIS: TYPES AND POSSIBILITY TO CURE**

| STI | TYPE | SEXUAL TRANSMISSION | NONSEXUAL TRANSMISSION | CURABLE? |
|---|---|---|---|---|
| **Chancroid** | Bacterial | Vaginal, anal, and oral sex | None | Yes |
| **Chlamydia** | Bacterial | Vaginal and anal sex<br>Rarely, from genitals to mouth | From mother to child during pregnancy | Yes |
| **Gonorrhoea** | Bacterial | Vaginal and anal sex, or contact between mouth and genitals | From mother to child during delivery | Yes |
| **Hepatitis B** | Viral | Vaginal and anal sex, or from penis to mouth | In blood, from mother to child during delivery or in breast milk | No |
| **Herpes** | Viral | Genital or oral contact with an ulcer including vaginal and anal sex; also genital contact in area without ulcer | From mother to child during pregnancy or delivery | No |
| **HIV** | Viral | Vaginal and anal sex<br>Very rarely, oral sex | In blood, from mother to child during pregnancy or delivery or in breast milk | No |
| **Human papillomavirus (HPV)** | Viral | Skin-to-skin and genital contact or contact between mouth and genitals | From mother to child during delivery | No |
| **Syphilis** | Bacterial | Genital or oral contact with an ulcer, including vaginal and anal sex | From mother to child during pregnancy or delivery | Yes |
| **Trichomoniasis** | Bacterial | Vaginal, anal, and oral sex | From mother to child during delivery | Yes |

There are vaccinations for some STIs, such as HPV and Hepatitis B (see Table 2).

### TABLE 2: STIS SYMPTOMS, TREATMENT AND VACCINATION

| STI | SYMPTOMS FOR WOMEN | SYMPTOMS FOR MEN | CAN IT BE CURED? | IS THERE A VACCINE? |
|---|---|---|---|---|
| **Chancroid** | Painful sores on the genitalia; swollen lymph nodes on the groin. Women are often asymptomatic. | | Yes | No |
| **Chlamydia** | Most women are asymptomatic. Women who do have symptoms might have abnormal vaginal discharge or a burning sensation when urinating. | Often asymptomatic. Men with symptoms may have a pus-like discharge from their penis or a burning sensation when urinating. | Yes. Left untreated it can lead to pelvic inflammatory disease (PID) among women, which may lead to infertility. Complications among men are rare. | No |
| **Gonorrhoea** | Most women are asymptomatic; abnormal vaginal discharge or burning sensation when urinating. | Men often experience a discharge or a burning when urinating. Some men have no symptoms. | Yes. Left untreated it can lead to PID among women and may lead to infertility among both women and men. | No |
| **Hepatitis B** | Some people experience flu-like symptoms, jaundice, and dark-colored urine; others experience no symptoms. | | Although no medicine has been found that cures hepatitis B, in many cases the body clears the infection by itself. Occasionally it develops into a chronic liver illness. Small children and infants are at a much greater risk of becoming chronically infected. | Yes |
| **Herpes (herpes simplex virus)** | Recurrent episodes of painful sores on genitals or anus. | | No, but symptoms can be controlled through treatment. | No |
| **HIV (human immunodeficiency virus)** | HIV generally has no symptoms in its early stages. If left untreated, HIV leads to AIDS. People with AIDS may suffer various infections, cancers, and other life-threatening ailments. | | No, AIDS is a chronic, ultimately fatal disease, but treatment (antiretroviral therapy) dramatically slows the progress of the disease. | No |
| **Human papillomavirus (HPV)** | HPV can be asymptomatic. Some strains cause genital warts. Others cause cancer. This includes head, neck, and anal cancer; penile cancer in men; and – most commonly – cervical cancer in women. | | No, but symptoms can be controlled through treatment. Some cancers secondary to HPV are treatable. | Yes. HPV vaccines can protect both males and females against many strains for the virus. |
| **Syphilis** | Begins with one or more painless sores on the genitals, rectum, or mouth. The second stage may produce skin rashes, lesions on mucus membranes, fever and malaise. The latent stage begins when these symptoms go away. | | Yes, if treated in its early stages. Without treatment, infection remains in the body. The late stage of syphilis includes damage to internal organs and can be fatal. | No |
| **Trichomoniasis (trichomonas or trich)** | Women may experience frothy, yellow-green vaginal discharge with a strong odor. May also cause itching or discomfort during intercourse and urination. | Men are usually asymptomatic; sometimes mild discharge or slight burning with urination or ejaculation. | Yes | No |

# HANDOUT 3

## FACTSHEET ON DUAL PROTECTION STRATEGIES TO PREVENT TRANSMISSION OF HIV, STIS AND UNINTENDED PREGNANCY

Every couple needs to think about preventing STIs, including HIV, even people who assume they are not at risk. A harm reduction provider can assist by discussing what situations put a person at increased risk of STIs, including HIV, and clients can think about whether these risky situations occur in their own lives. If so, they can consider dual protection strategies. A person might use different strategies in different situations, or a couple might use different strategies at different times. The best strategy is the one that a person is able to practice effectively in the situation that they are facing.

**STRATEGY 1: CONDOMS, PLUS ANOTHER CONTRACEPTIVE METHOD**

Use condoms consistently and correctly, plus another contraceptive method. This adds extra protection from pregnancy in case a condom is not used or is used incorrectly, or breaks. Internal (female) condoms may be a good choice for women and gender non-conforming people who want to avoid pregnancy but cannot always count on their partners to use condoms.

**STRATEGY 2: CONDOMS, PLUS EMERGENCY CONTRACEPTION/PEP IF THE CONDOM FAILS**

Use condom consistently and use emergency contraception and post-exposure prophylaxis for HIV if the condom fails. Look for STIs signs after a few weeks.

**STRATEGY 3: SELECTIVELY USING CONDOMS AND ANOTHER METHOD**

For example, using the pill with your main partner, and the pill plus condoms with other partners. Depending on your situation, you may want to selectively use condoms consistently and correctly plus another contraceptive method with the occasional partner, and just the pill with your regular and main partner.

**STRATEGY 4: PREP, PLUS CONDOMS AND ANOTHER CONTRACEPTIVE METHOD**

People at high risk of HIV infection can use PrEP (pre-exposure prophylaxis), which contains antiretroviral drugs. One option is to take a PrEP pill every day. If taken consistently, this greatly reduces the risk of infection if exposed to HIV.

If available, the Dapivirine vaginal ring may be a good option, as it offers a safe and effective additional HIV prevention choice, and is recommended by WHO.

PrEP can be a part of any dual protection strategy. It can be used along with condoms and any other contraceptive method. Using PrEP and a hormonal contraceptive at the same time does not reduce the effectiveness of either one.

# HANDOUT 4
## ROLE-PLAY SCENARIO

Sarah is a sexually active 24-year-old woman who is living with her boyfriend. She isn't sure about his fidelity as she feels he is having sex with other young women. Sarah is not ready to have a child and she is afraid of syphilis because one of her friends has told her that it is very dangerous. But she wants to show her faithfulness to her boyfriend, so she accepts unprotected sex as a sign of mutual trust. She goes to the DIC to discuss this with the counsellor.

During the counselling session, Sarah will find her own dual protection strategy.

# HANDOUT 5
## CHEMSEX: SAFER WAYS TO PARTY AND PLAY

Sexualised drug-taking (including chemsex) is a practice in which intentional drug taking occurs before or during sex, where drugs are used to facilitate, initiate, prolong, sustain and/or to enhance sexual arousal, performance and pleasure. Chemsex is characterised by the use of the following most popular drugs: GHB/GBL (gammahydroxybutyrate/gammabutyrolactone), mephedrone (meph or meow), crystal methamphetamine (crystal meth). The risks related to this practice are transmission of HIV, hepatitis, and other STIs, increased by the number of sexual partners and unprotected sex.

Ways to prevent risks (adapted from **AVERT Chemsex and HIV**):

- **Pack some protection** – make sure you have lots of condoms and lubricant. You could also consider pre-exposure prophylaxis (PrEP) to protect you from HIV. Make sure you have access to sterile needles and syringes or smoking straws/pipes.
- **Know your status** – most HIV transmission happens among people who have recently acquired HIV (high viral load) and don't yet know that they are positive. Regular testing to check your status and to screen for other STIs will help to keep you and others healthy.
- **Party with people you trust** – plan in advance how you will look out for each other and be sure to tell someone where you are going if you leave with someone you don't know.
- **Set your limits** – before you get high, decide what you are prepared to do sexually and talk about which methods of protection you want to use.
- **Stay aware** – keep tabs on what drugs you've consumed and be aware when to stop. Don't share needles or syringes, straws or pipes.
- **Set reminders** – if you're taking PrEP to prevent HIV, or need to take HIV medication because you are living with HIV, use an alarm to make sure you take your pills at the right time.

# HANDOUT 6
## STORIES AND FACILITATION GUIDE FOR THE 'DEVELOP YOUR STRATEGY' EXERCISE

### STORY 1
A 17-year-old girl is having sex with a 25-year-old man who gives her gifts and sometimes gives her money to help with her expenses. He also provides her with heroin and helps her to inject when she has difficulties finding her veins. Sometimes he uses condoms, but this time he doesn't have a condom with him. She explains to him that they should wait and have sex another time, but he promises it will be okay without a condom. She already took money from him this week, and she also wants him to bring her to the DIC to get sterile injecting equipment. She feels she cannot refuse. They have sex without a condom.

### STORY 2
A couple, consisting of a 20-year-old woman who uses drugs and a man, meet to spend the night together and to have sex for the first time. They have only been dating for a few weeks. The woman tells her partner that she brought external condoms, but he says, "No way... those feel lousy!" She tries to insist but he becomes angry and asks if she really loves him or not. He is really insisting, threatening to leave her if she refuses to have sex today. Finally, she gives up arguing and they have sex without a condom.

### STORY 3
A transwoman sex worker is working in a bar. She brings one of the clients to her room at the back of the bar to have sex. This week was a bad week, and she didn't have a lot of clients. He is a nice client, and he explains that he is allergic to latex and cannot wear condoms. He is proposing to pay twice the price to have unprotected sex.

### FACILITATION GUIDE AND KEY RESPONSES
Based on the scenarios from the different stories, here are some responses to the following sentences:

### STORY 1.
***"It will be okay without a condom."***
"True, but I'll use the condom and do it in such a way that you'll get more aroused and pleasured from it."
"There is nothing okay about getting infected, an unwanted pregnancy or falling ill. It is not okay without a condom."
"Sex with a condom is more okay than no sex, as I won't have sex without a condom."

### STORY 2.
***"No way... those feel lousy!"***
"We can also use an internal condom and you don't have to do anything; I'll manage."

***"You don't love me if you use a condom with me."***
"I do love you, but I want both of us to be safe. You can't tell by looking at the face whether a person has STIs or not."
"I love you, and if you love me too let's get tested together. But until we do, we are using condom to stay safe."

### STORY 3.
***"I won't have sex with you if you insist on using a condom."***
"This condom is for both of us, if we use it, we would both be protected from HIV, STIs and pregnancy."
"If I told you I had an STI recently, would you still insist on not using a condom?

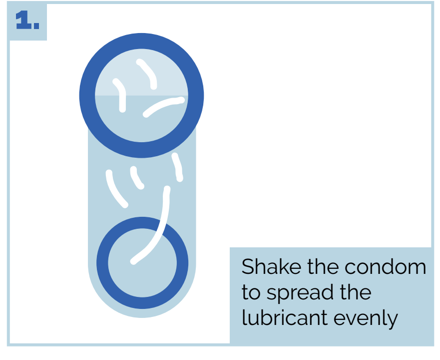
***"I will pay more if you allow me have sex with you without condoms."***
"Although I would love to be paid more, I'm not willing to risk infection for it."
"My body is my only source of income, and I can only earn money if I'm healthy, so I won't risk hardship by having sex without a condom and getting infected with HIV, STIs or getting pregnant."
"The money would be of no use if I contract HIV or an STI and fall ill, rather it would be spent on treatment and getting healthy. I would rather be healthy than sick and I think you would too."

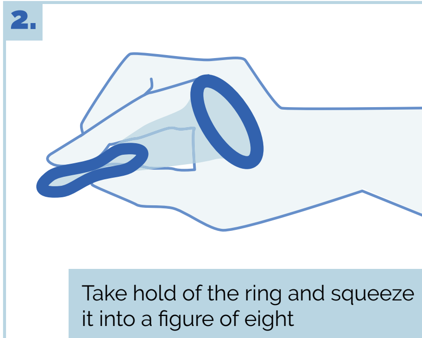
***"I am allergic to latex."***
"It's ok, as I have other type of condom without latex, which is for people like you." (Use an internal condom or external condom made of polyurethane.)

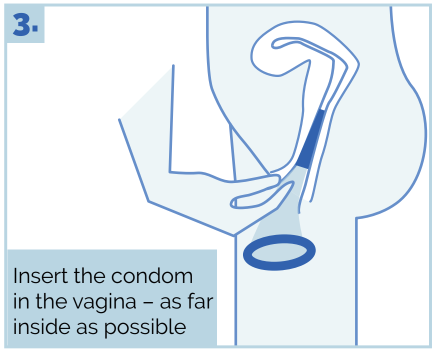
# HANDOUT 7

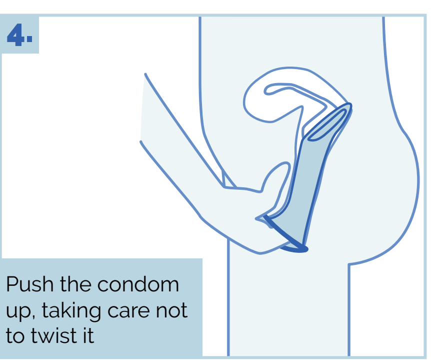
## HOW TO USE INTERNAL (FEMALE) AND EXTERNAL (MALE) CONDOMS

### HOW TO USE A FEMALE CONDOM


1. Shake the condom to spread the lubricant evenly


2. Take hold of the ring and squeeze it into a figure of eight


3. Insert the condom in the vagina – as far inside as possible


4. Push the condom up, taking care not to twist it

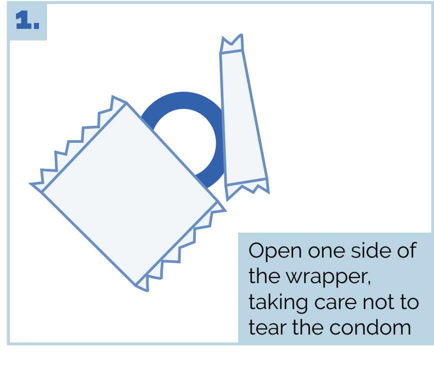
5. After sex, remove the condom and throw it in the bin

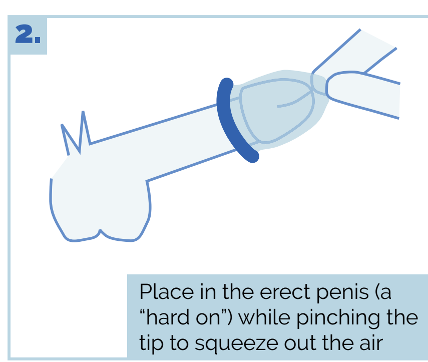
**SOME TIPS**

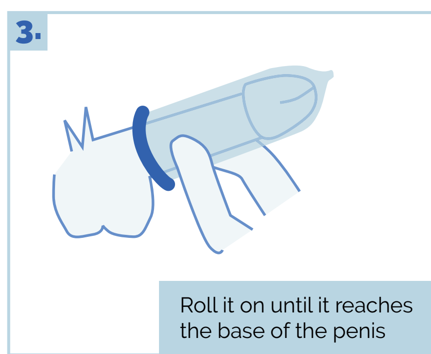
**I can put the female condom in several hours before I have sex.**

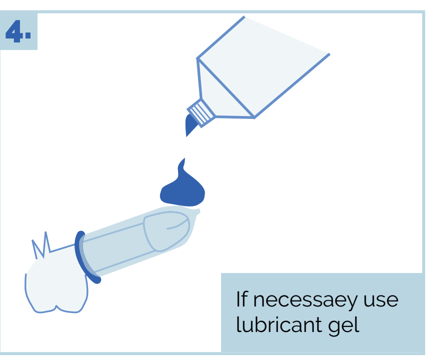
**I can also use it for anal sex, I just have to remove the ring inside the female condom.**

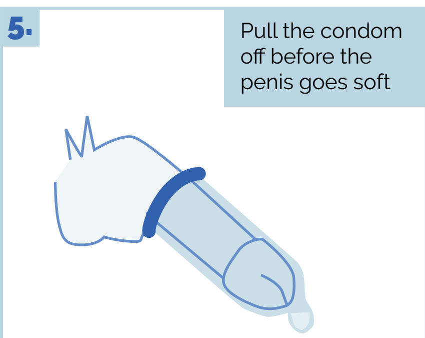
### HOW TO USE A MALE CONDOM

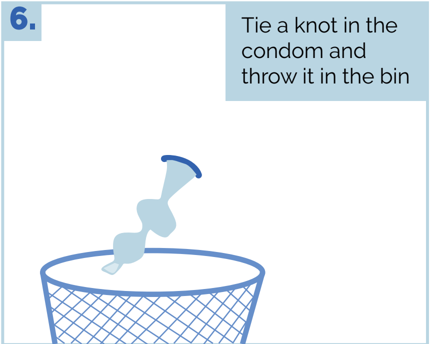

1. Open one side of the wrapper, taking care not to tear the condom


2. Place in the erect penis (a “hard on”) while pinching the tip to squeeze out the air

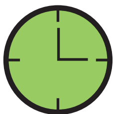

3. Roll it on until it reaches the base of the penis


4. If necessaey use lubricant gel


5. Pull the condom off before the penis goes soft


6. Tie a knot in the condom and throw it in the bin

# Module 8
## Cervical cancer



**TIME**
1 hour 45 minutes

**MATERIALS**
- Flipchart
- Colour pens
- **Handout 1:** Statements and answers (red and green cards)
- **Handout 2:** Readers' letters
- **PPT Module 8:** Cervical cancer

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 8** | **Cervical cancer prevention** | Basic knowledge about cervical cancer | • To understand infection with HPV, pre-cancerous lesions and cervical cancer |
| | | Prevention, screening, treatment and vaccination | • To provide counselling to prevent and screen for cervical cancer<br>• To know how to refer to appropriate services |

### TIPS FOR ONLINE FACILITATION

**EXERCISE 1. GIVE ME THE CORRECT ANSWER**

If the participants are all online using an individual computer, ask them to prepare their own cards in advance. They can do this by taking a sheet of A4 paper, separated into two pieces, (A5) and writing in big letters 'TRUE' on one piece and 'FALSE' on the other, or using colour pens to draw a circle in red (for false) or green (for true) and colouring in the middle. The participants can then use their webcam to show the card they choose. An alternative possibility is to use an online poll, like Mentimeter, for the game.

**EXERCISE 2. CHECKLIST FOR COUNSELLING**

Create three virtual rooms and organise participants in each room. One participant in each room can share their screen to note down the group's ideas and then present them to the rest of the participants.

**EXERCISE 4. THE FOUR READERS' LETTERS**

Create three virtual rooms and divide participants across the three rooms. At the start of the exercise, email *Handout 2: Readers' letters* to the member of each group who has been selected to report back. Ask this person to read the letters to the group.

### TO PREPARE IN ADVANCE

This module may bring a lot of new information to the participants. Ensure a secure learning environment to allow free discussion.

So that you are ready with recommendations for the last part of the training, which is about referring people to relevant services, it is recommended you prepare the following information in advance:

- What services are available for HPV screening (type of test available, including self-testing)?
- What is the national protocol (age and regularity of screening recommended)?
- What is the national protocol regarding vaccination (age and number of vaccine doses for girls and sex workers)? What is the cost? Where is it available?
- Which facilities offer treatment for precancerous lesions? How accessible are they?
- What services are available for cervical cancer treatment?

Keep notes from Exercise 3 and 4 to use in Modules 9 and 10. These notes can be used as a good place to start identifying advocacy priorities and action planning.

# CERVICAL CANCER PREVENTION (1 HOUR 45 MINUTES)

## BASIC KNOWLEDGE ABOUT CERVICAL CANCER (1/2)

20 minutes

**Flipchart**
**Pens**
**PPT Module 8: Cervical cancer**
**Handout 1: Statements and answers**
**One red card and one green card per participant**

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 1. Give me the correct answer: 20 minutes**<br>Give each participant a **red card** and a **green card** (A3 size).<br>Tell them you are going to read a statement and they should raise their green card if they think it is true and their red card if they think it is false.<br>Once all the participants have raised a card, give the correct answer and then read the next statement. Repeat until you've read all the statements out. | It is important to remove fear and wrong beliefs about cervical cancer.<br>Cervical cancer and HIV are both diseases of inequality and health disparity across and within countries.<br>Cervical cancer is the fourth most common cancer in women, worldwide.<br>Fear of casual transmission of cancer, fear of disability and death also contribute to stigma, including internalised-stigma.<br>There are a lot of factors that increase people's risk of cervical cancer.<br>Women, girls and gender non-conforming people experience many barriers to accessing primary and secondary cervical cancer prevention, screening, treatment and care especially those most at risk such as women who use drugs, women living with HIV, trans women and sex workers.<br>There is an urgent need to overcome those barriers, and harm reduction providers can play a key role.<br>With a comprehensive approach to prevent (through vaccination), screen and treat, cervical cancer can be eliminated as a public health problem. |

## BASIC KNOWLEDGE ABOUT CERVICAL CANCER (2/2)

15 minutes

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Interactive PPT presentation: 15 minutes** | Human papillomavirus (HPV) infection has been recognised by the WHO as the primary cause of cervical cancer.<br>HPV is a widespread virus that is transmitted sexually.<br>It is a very common, usually asymptomatic, viral infection.<br>Most HPV infections go away on their own, and only 10% may lead to the development of precancerous lesions.<br>Pre-cancerous lesions are easily diagnosed and treated. If they are not treated, they can lead to cancer.<br>Cervical cancer progresses very slowly, over between 10 and 20 years. Yet it can take only 5 to 10 years in people with weakened immune systems, such as those with HIV who are not on ARV treatment.<br>Cervical cancer has been identified as an AIDS-defining illness because of its higher prevalence and impact in women living with HIV.<br>There is no evidence that the use of illicit drugs causes cervical cancers.<br>The most common symptoms of cervical cancer are:<br>• Bleeding between periods<br>• Bleeding after sexual intercourse<br>• Post-menopausal bleeding<br>• Vaginal discharge with a strong odour<br>• Vaginal discharge tinged with blood<br>• Pelvic pain<br>If a woman or gender non-conforming person who use drugs experiences any of the above, they should see a doctor. |

| SEQUENCE | KEY MESSAGES |
|---|---|
| | **Cervical cancer is preventable.**<br>All sexually active women, including trans women who have had vaginoplasty, should be encouraged to undergo regular screening for cervical cancer.<br>Adolescents need access to combined HPV-HIV prevention, specifically HPV vaccination, condoms, sexual and reproductive health services, harm reduction services and/or PrEP.<br>Adult and older women and some gender non-conforming people with HIV require access to HIV treatment throughout their life and need more frequent cervical cancer screening than those who are not living with HIV.<br>Women living with HIV are six times more likely to get cervical cancer compared to those without HIV. For this reason, WHO recommends that women with HIV should be screened for cervical cancer every 12 months for the first three years following their HIV diagnosis, regardless of age.<br>Sex workers have an overall high prevalence of HPV, due to the nature of their work, so they are consequently at increased risk of cervical cancer. They are also made vulnerable by overlapping stigmas associated with cervical cancer, sex work and HIV. |

**PREVENTION, SCREENING, TREATMENT AND VACCINATION (1/2)**

40 minutes

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 2. Group exercise: Counselling checklist: 15 minutes**<br>Divide the participants into three groups and ask them to develop a checklist of three to five key messages (maximum) about cervical cancer that should be covered in a first counselling session with a woman or gender non-conforming person who use drugs.<br>Ask one group to work only on general counselling on cervical cancer. Ask the second group to work only on HPV vaccine. Ask the third group to work on primary prevention counselling.<br>Report back to the whole group: 10 minutes<br><br>**Exercise 3. Brainstorming: 5 minutes**<br>Ask the group:<br>*How could you also provide information to target men?*<br>*What are the messages you could provide?*<br><br>**Interactive PPT presentation:10 minutes** | **The five key messages for general counselling**<br>1. Cervical cancer is caused by human papillomavirus (HPV), and is a disease that can be prevented.<br>2. Condoms offer partial protection from HPV and may lower the risk of developing HPV-related diseases.<br>3. There are tests to detect early changes in the cervix (known as pre-cancers) that may lead to cancer if not treated.<br>4. Screening is recommended for every woman aged 30–49 years. Screening is relatively simple, quick and painless. For women living with HIV, screening every 12 months is recommended for the first 3 years following their HIV diagnosis, regardless of age.<br>5. There is a vaccine for girls/ and boys (the HPV vaccine) that can help prevent cervical cancer.<br>**The five key messages about the HPV vaccine**<br>1. There is a safe, effective vaccine that can protect against cervical cancer.<br>2. The HPV vaccine works best if received before sexual activity begins.<br>3. All girls between 9 to 14 years old (or according to the national programme) should receive the HPV vaccine.<br>4. HPV vaccines do not treat or get rid of existing HPV infections.<br>5. Girls who are already sexually active can also be given the HPV vaccine, although it may be less effective as they have already been exposed to HPV. It is also recommended for sex workers.<br>**The five key messages about primary prevention**<br>The following measures can decrease the risk of getting cervical cancer:<br>1. Delaying first sexual intercourse and the number of sexual partners.<br>People who engage in early sexual activity are more likely to be infected with HPV. Younger women are at greater risk of transmission with a single sexual act. Advocate against early marriage, which is a practice that still exists in some countries.<br>WHO recommends HPV vaccination for girls from 9 to 14 years old and before they become sexually active. |

| SEQUENCE | KEY MESSAGES |
|---|---|
| | Reducing the number of sexual partners: the more partners a person has, the greater the chance of STI transmission, including HPV and HIV, both of which increase the risk of cervical cancer. It is recommended sex workers keep practicing safe sex by using condoms and dental dams, regularly check for HIV and STIs, and have access to HIV treatment if they are living with HIV.<br>**2.** Using condoms to protect against STIs, and to offer partial protection from HPV. Condoms may lower the risk of developing HPV-related diseases and reduce the risk of cervical cancer. This is because coinfection with other sexually transmitted agents, such as those that cause herpes simplex, chlamydia and gonorrhoea, are risks factors for persistent HPV and development of cervical cancer.<br>**3.** Abstaining or reducing tobacco use: people who smoke tobacco products have a higher risk of almost all cancers, including cervical cancer.<br>**4.** Seeking treatment immediately if there are STI symptoms.<br>**5.** Regular HPV screening: this can detect early lesions so they can be treated before they have a chance to progress to cancer. It is important to go for regular screening, starting from the age of 30. Regular screening for sexually active women living with HIV should start as soon as they have been diagnosed with HIV, regardless of their age.<br>**Basic information involving men**<br>HPV can also threaten men's health: if it persists, it can increase the risk of cancer of the penis.<br>• HPV is sexually transmitted, but penetration is not essential as the virus can live on the skin, outside the genital area.<br>• Using condoms does not offer complete protection, but it has a role in the prevention of cervical cancer.<br>• Men can play a role in the prevention of cervical cancer, by encouraging their partners to be screened if they are over 30 years of age.<br>• Men whose partner is found to have precancer or cancer can support and assist them to get the recommended treatment, and by accompanying them to clinical appointments and learning about cervical cancer. |

**PREVENTION, SCREENING, TREATMENT AND VACCINATION (2/2)**

| | | | |
|---|---|---|---|
| | **30 minutes** | | **Handout 2: Readers' letters** |

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 4. Group exercise: the readers' letters: 20 minutes**<br>Divide the participants into three groups with mixed profiles. Each group is to imagine that they run a monthly newsletter for women and gender non-conforming people who use drugs.<br>Each group receives four readers' letters. Ask one of the participants in each group to read them to the rest of the group. Ask each group to prepare brief but clear answers to the readers.<br>You can give pointers, such as:<br>*Consider providing information about where to find trusted providers and how to get an appointment etc.*<br>**Discussion: 10 minutes**<br>At the end, consolidate the answers on a flipchart.<br>The objective is to create a complete mapping of the services available to respond to each of the situations in the letters. | Strong referral mechanisms are very important. It is important to refer women (and some gender non-conforming people) who use drugs to identified, trusted providers for screening and vaccination.<br>Family planning organisations or specialised organisations working with women's health can be contacted for referrals.<br>The referral network has to be identified with the participation of women and gender non-conforming people who use drugs themselves. They should also be involved in evaluating the quality of this referral pathway. |

# HANDOUT 1
## STATEMENTS AND ANSWERS

**1. CANCER IS A DISEASE CAUSED BY THE UNCONTROLLED GROWTH OF ABNORMAL CELLS IN THE BODY.**
**TRUE:** When cancer develops, it can prevent the normal functioning of the body. However, cervical cancer is treatable and curable, particularly if it is diagnosed when the cancer is in at an early stage. There are certain things that increase someone's risk of getting cervical cancer, and women and gender non-conforming people who use drugs are particularly likely to experience a number of them. These risk-factors include having HIV (the virus that causes AIDS), having health conditions that make it hard for the body to fight off illnesses, smoking, having untreated STIs, and having condomless sex with multiple partners.

**2. CERVICAL CANCER IS CAUSED BY POOR FEMININE HYGIENE.**
**FALSE:** Cervical cancer is caused by a virus, HPV. The cancer has nothing to do with intimate hygiene.

**3. WOMEN WHO USE DRUGS ARE MORE LIKELY TO GET CERVICAL CANCER THAN OTHER WOMEN.**
**FALSE:** All sexually active women are at risk of getting HPV and possibly developing cervical cancer. There is no evidence that the use of illicit drugs causes reproductive cancers in women.

**4. ONLY WOMEN WHO HAVE A LOT OF SEX CAN GET CERVICAL CANCER.**
**FALSE:** Cervical cancer is caused by a virus called HPV, which is sexually transmitted. Most men and women will get it at some point in their lives. Although HPV is sexually transmitted, penetrative sex is not required for transmission. It can also be transmitted through skin-to-skin genital contact.

**5. USE OF TAMPONS DURING MENSTRUATION CAN CAUSE CANCER OF THE CERVIX.**
**FALSE:** Putting tampons in the vagina cannot cause cancer. However, it is good practice to change tampons regularly and to interrupt tampon usage by using a sanitary towel from time to time.

**6. SCREENING CAN DETECT ABNORMALITIES BEFORE THEY BECOME CANCER.***
**TRUE:** Screening can detect lesions and abnormalities at a very early stage, before cancer develops. These can then be treated, and the development of cervical cancer prevented.

**Facilitator tip: You may need to adapt the answer to question six if there are no health services in the country that treat lesions. If this is the case, change this question to focus on the prevention and treatment of STIs, and emphasise the fact that cervical cancer progresses very slowly from pre-cancer to cancer, over the course of 10 to 20 years.*

**7. SCREENING IS LIKE A VACCINE: ONCE YOU HAVE HAD IT, YOU WILL NOT GET CERVICAL CANCER.***
**FALSE:** All women aged 30 and above should be screened regularly, every 5 to 10 years (depending on national protocol). For those living with HIV, global recommendations advise that screening start at the age of 25 and every 3 to 5 years. (Source: WHO)

**Facilitator tip: this answer needs to be adapted to national protocol.*

**8. SCREENING WITH A SMEAR TEST INVOLVES REMOVING PART OF THE CERVIX. THIS TEST IS PAINFUL.**
**FALSE:** A smear involves collecting cells from the surface of the cervix (by gently scraping the cells). It does not involve removing part of the cervix. The smear is performed like a gynaecological examination. It is unpleasant but not painful. It is also called a pap smear.

**SUMMARY RECONMMENDATIONS:**
**WHO SUGGESTS USING THE FOLLOWING STRATEGY FOR CERVICAL CANCER PREVENTION**

| For the general population of women | For women living with HIV |
|---|---|
| **Screen and treat OR Screen, triage and treat**<br>• **HPV DNA** as primary screening test<br>• Starting at age **30**<br>• **Every 5 to 10 years** screening interval | **Screen, triage and treat ONLY**<br>• **HPV DNA** as primary screening test<br>• Starting at age **25**<br>• **Every 3 to 5 years** screening interval |

# HANDOUT 2

## READERS' LETTERS: DEVELOPING A MAPPING OF REFERRAL SERVICES

**LETTER 1. CATHY**

Hello I am Cathy, my sister is back from the capital where she had been screened for cervical cancer by an NGO working with sex workers. She has precancerous lesions and doesn't know what to do and where to go now she is back in her hometown.

**LETTER 2. UMA**

Hello, I am 35 years old. I have used heroin in the past and I am on OST at the moment. I have heard of the prevention of cervical cancer on the radio, I have never done such a test, do you know where to go?

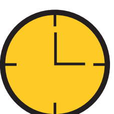
**LETTER 3. DIANE**

Hi I am a widow of 53 years of age. I am experiencing irregular bleeding when I am already in menopause stage. I am scared. What should I do?

**LETTER 4. JACK**

Hello, I am a mother of two teenage girls and I have heard about something that could prevent the infection of HPV, could you provide me more information?

# Module 9
## Integration of SRHR services



**TIME**
2 hours 20 minutes

**MATERIALS**
- Flipchart
- Pens
- Sticky Notes (Post its) – two colours
- **PPT presentation Module 9:** Integration of SRHR services
- **Handout 1:** Appropriate harm reduction services adapted to the needs of women who and gender non-conforming people use drugs (including their SRHR needs)
- **Handout 2:** Evaluating services and identifying gaps in the provision of SRHR services
- **Handout 3:** The '4 A' evaluation tool
- **Handout 4:** Referral mapping tool
- **Handout 5:** Action plan

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 9** | **Integration of SRHR services** | Define programmatic actions to improve integration and access to SRHR for women who use drugs | • To identify gaps in the provision of essential SRHR services in organisations providing harm reduction services<br>• To map appropriate services that offer client-oriented, non-judgmental SRHR services for women and gender non-conforming people who use drugs<br>• To develop short-term and mid-term action plans to improve the access to and integration of SRHR and harm reduction services |

### TIPS FOR ONLINE FACILITATION
Open enough virtual breakout rooms for this module, and share the different handouts in advance by email.

**EXERCISE 1. BRAINSTORMING**
Participants can use virtual whiteboards or a jamboard if available. Klaxon can also be used to share ideas in a white virtual board.

**EXERCISE 3. MAPPING**
Participants can use a Word document then create a table with two columns titled: 'Referral services that are functional', and 'Potential new referral services', or they can create a PowerPoint slide with two boxes. They can start by reporting the identified referral services from previous modules then adding new referral services (such as Module 3 on gender-based violence, Module 5 on safe-abortion, Module 7 on HIV, STIs and preventing vertical transmission, and Module 8 on cervical cancer).

### TO PREPARE IN ADVANCE
For Exercise 2, if the group is already advanced, you can propose they work directly on the '4 A' evaluation tool (Handout 3). You can also share this tool at the end of the module and ask participants to fill it out with other members of their organisation as homework.

# INTEGRATION OF SRHR SERVICES (2 HOURS)

## DEFINE PROGRAMMATIC ACTIONS TO IMPROVE INTEGRATION AND ACCESS TO SRHR FOR WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUG (1/3)

**20 minutes**

**PPT Module 9: Integration of SRHR services**
**Handout 1: Appropriate harm reduction programmes, adapted to the needs of women and gender non-conforming people who use drugs (including their SRHR needs)**

### SEQUENCE

**Exercise 1. Brainstorming: 10 minutes**

Ask the following questions:

*In your opinion, what are the characteristics of a harm reduction programme designed for women and gender non-conforming people who use drugs?*

*In your opinion, what are the characteristics of a harm reduction centre/DIC that is adapted to the needs, including the SRHR needs, of women and gender non-conforming people in terms of facilities and services?*

*In your opinion, what are the characteristics of providers working in a programme/centre adapted to the needs of women and gender non-conforming people who use drugs?*

**PPT presentation: 10 minutes**

### KEY MESSAGES

**Characteristics of appropriate harm reduction programmes, adapted to the needs of women and gender non-conforming people who use drugs (including their SRHR needs)**

**Programmatic features**

- Women who use drugs in all their diversity and gender non-conforming people are meaningfully involved in the design, implementation, monitoring and evaluation of all services, so that their needs are at the centre of each response and so that services are welcoming and responsive.
- Women and gender non-conforming people who use drugs are involved in planning and decision-making processes.
- Both individual and group activities are provided
- Includes services that are delivered in a centre and through outreach to reach the most at-risk women and gender non-conforming people.
- Women and gender non-conforming peers are trained and involved at all levels. Peer support, peer networks, peer outreach and other types of peer-led initiatives are facilitated.
- Sexual partners of women and gender non-conforming people who use drugs and other members of their support networks, such as relatives and friends, are involved.
- There is a strong referral network of sensitised or trusted services to improve the continuum of care. The referral network is safe for women who use drugs in all their diversity and for sex workers, transgender women, gender non-conforming people and women living with HIV. There is a list of local healthcare providers/ harm reduction providers supported by donors, or local authorities or government.
- Services at the community level are planned.
- Advocacy led by women and gender non-conforming people who use drugs is planned.

**Harm reduction centre and services**

- Recognition of the specific needs of women in all their diversity and gender non-conforming people.
- Services are welcoming and responsive to women in all their diversity and gender non-conforming people.
- Convenient opening hours and women/gender non-conforming-only hours. (Be careful of the risk of increasing stigma and discrimination relating to women and gender non-conforming people. It might be necessary to establish a separate women/gender non-conforming-only DIC.)
- Possibility of childcare or child's spaces.
- Convenient location/accessible for the women and gender non-conforming people who use drugs.
- Sufficient space and women/ and gender non-conforming-only spaces; facilities to bathe and wash clothes if possible, and toilets to allow proper menstruation hygiene.
- Privacy and confidentiality.
- Provision of accessible, non-judgemental information to allow individual, informed choice.
- A range of services is offered: the main components of SRHR (Modules 2 to 8) and the comprehensive harm reduction package. If requested by a woman or gender non-conforming person who uses drugs, help engage partners in couples counselling. Group discussions, 'sister-to-sister' talks and one-on-one sessions is available to help address concerns around the SRHR needs of women and gender non-conforming people who use drugs and their partners.

| SEQUENCE | KEY MESSAGES |
|---|---|

- An adequate supply of SRH commodities and essential medicines is available, such as pregnancy tests, a wide range of contraceptive methods (including condoms) and menstrual commodities.
- SRHR information and education materials are available on site on various issues, including gender-based violence, cervical cancer and perinatal and newborn care.
- If a needed service is not available in-house, women or gender non-conforming people who use drugs can be referred or accompanied to trusted providers and given clear information about these services.
- Many other services could be needed to respond to the needs of women and gender non-conforming people in all their diversity. These will vary by location and need to be defined by/ with the clients themselves.

**Providers**

- Staff are trained in SRHR, gender norms and gender equity.
- Staff are properly trained to engage respectfully with trans-women and gender non-conforming people (for example, through gender affirmation and proper pronoun use), and to understand and respond to the health needs and rights of trans-women and gender non-conforming people. Likewise, staff are trained to understand issues faced by, and work respectively with, sex workers.
- Peers are integrated in the team. Peers can include sex workers who use drugs, and women who use drugs from the LGBT+ community (lesbian, gay, bisexual, transgender and gender non-conforming).
- Ethical principles are respected, such as confidentiality, collection of informed consent, respect of individual choice, being non-judgemental, and there being no discrimination.
- A client-oriented approach is used and adequate time is given to client/provider interaction.

**Supporting the development and strengthening of collectives of women and gender non-conforming people who use drugs**

Many of the best programmes have been started by, and are led by, women and gender non-conforming people who use drugs themselves.

Apart from the involvement of women and gender non-conforming people who use drugs in the design, implementation, monitoring and evaluation of all services, groups led by these communities may also need support for mobilising, or need spaces in which to meet.

These groups or networks can be supported through discreet advertising to other women and gender non-conforming people with similar interests who use services and through outreach. Structural, methodological or organisational support can be provided to group members to identify key issues that they want to prioritise and address. Service providers could also offer resources to support peer education and the latest research that affects women and gender non-conforming people who use drugs.

Harm reduction providers can also assist these collectives by forming linkages with other stakeholders, looking for funding and training opportunities for group members, and being generally responsive to these groups' stated goals and needs.

But sometimes, communities of women or gender non-conforming people who use drugs cannot be accessed or identified. Or organised networks or groups of women and gender non-conforming people who use drugs are simply not established or connected with existing clients. In such instances, at the very least, service providers should make every effort possible to employ women and gender non-conforming people who use drugs as volunteers, paid staff, and/or managers in their women/ gender non-conforming-focused services. These peers can often breakdown some of the barriers that may stop women and gender non-conforming people who use drugs from accessing services. Recruiting women and gender non-conforming people who use drugs can also help attract new clients.

## DEFINE PROGRAMMATIC ACTIONS TO IMPROVE INTEGRATION AND ACCESS TO SRHR FOR WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUG (2/3)

| | 45 minutes | | Handout 2: Evaluating services and identifying gaps in the provision of SRHR<br>Handout 3: The '4 A' auto-evaluation tool |
|---|---|---|---|

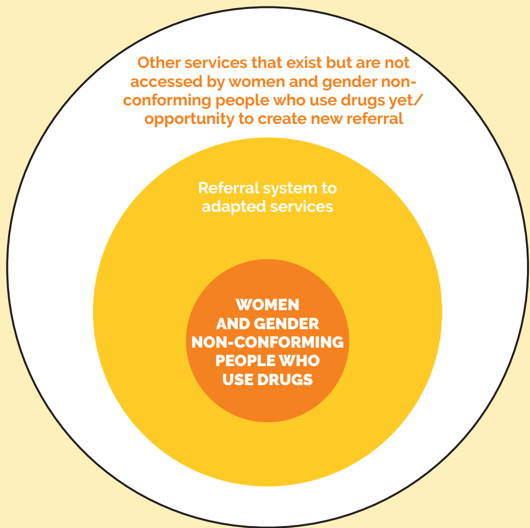
| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 2. Evaluation of services: 25 minutes**<br>Divide the participants into three groups. It is important to include peers and/or women or gender non-conforming people who use drugs in each group.<br>Ask each group to go through the checklist and tick the appropriate boxes to identify gaps in the provision of essential SRHR services in the organisation. Some gaps and barriers can be linked to Module 10 on advocacy.<br>Once each box has been ticked, the group should give a score of 1 for every 'yes' answer and 0 for every 'no'. They should then calculate their score and compare it against the 'ideal' score of 10.<br>Ask each group to note three priority areas that need to be improved. These areas for improvement should be realistic and should be able to be implemented over a short period (within the coming months). Then ask them to note down three elements for improvement that may need a mid-term commitment (within a year).<br><br>**Exercise 3: the '4 A' evaluation (20 mins)**<br>In the same groups, ask participants to do the same using Handout 3: the '4 A' evaluation. Explain that the 4 A's stand for accessibility, acceptability, availability and affordability and that this evaluation probes deeper into the quality of services, not just whether they are offered or not. Invite a short discussion on the importance of each of these qualities for women who use drugs if needed. | |

## DEFINE PROGRAMMATIC ACTIONS TO IMPROVE INTEGRATION AND ACCESS TO SRHR FOR WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUG (3/3)

| | 75 minutes | | Handout 4: Referral mapping tool<br>Handout 5: Action plan |
|---|---|---|---|

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 4. Mapping: 20 minutes**<br>Based on the previous sessions and mapping exercises done during Modules 2-8, develop a SRHR referral mapping.<br>The aim is to explore the SRHR services that are already integrated into the referral system for women and gender non-conforming people who use drugs, as well as other organisations that offer SRHR services and could be part of this system but are not yet accessed by women and gender non-conforming people who use drugs.<br>Each group should use the mappings that were done in the following modules to do this comprehensive mapping:<br>• Module 3 on gender-based violence<br>• Module 5 on safe-abortion<br>• Module 7 on HIV, STIs and preventing vertical transmission<br>• Module 8 on cervical cancer<br>Give the participants sticky notes (post-it) in different colours. Ask them to write the name of referral services that are adapted for, and accessed by, women and gender non-conforming people who use drugs in one colour. Then ask them to use another colour for services that exist but are not yet accessed but could be developed as part of the referral pathway. | |

| SEQUENCE | KEY MESSAGES |
| --- | --- |




### Exercise 5. Action plans: 40 minutes

Based on the gaps identified, both in the evaluation and mapping exercises, ask participants to work in small groups to develop short-term, mid-term action and long-term action plans to improve the access and integration of SRHR into harm reduction programmes.

Ask participants to describe:

1. **WHAT** action steps can be taken
2. **WHO** is/are in charge
3. **WHERE** the action can take place
4. **WHEN** it could be achieved
5. **HOW** to support the meaningful involvement of women and gender non-conforming people who use drugs

### Report back: 10 minutes

One group presents the short-term action steps. Another group presents the mid-term and another the long-term action steps

### Conclusion: 5 minutes

# HANDOUT 1

## HARM REDUCTION PROGRAMMES ADAPTED TO THE NEEDS OF WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUGS (INCLUDING THEIR SRHR NEEDS)

### PROGRAMMATIC FEATURES

- Women who use drugs in all their diversity and gender non-conforming people are meaningfully involved in the design, implementation, monitoring and evaluation of all services, so that their needs are at the centre of each response and so that services are welcoming and responsive.
- Women and gender non-conforming people who use drugs are involved in planning and decision-making processes.
- Both individual and group activities are provided.
- Includes services that are delivered in a centre and through outreach to reach the most at-risk women and gender non-conforming people.
- Women and gender non-conforming peers are trained and involved at all levels. Peer support, peer networks, peer outreach and other types of peer-led initiatives are facilitated.
- Sexual partners of women and gender non-conforming people who use drugs and other members of their support networks, such as relatives and friends, are involved.
- There is a strong referral network of sensitised or trusted services to improve the continuum of care. The referral network is safe for women who use drugs in all their diversity and for sex workers, transgender women, gender non-conforming people and women living with HIV. There is a list of local healthcare providers/harm reduction providers supported by donors, local authorities or government.
- Services at the community level are planned.
- Advocacy led by women and gender non-conforming people who use drugs is planned.

### HARM REDUCTION CENTRE AND SERVICES

- Recognition of the specific needs of women in all their diversity and gender non-conforming people.
- Services are welcoming and responsive to women in all their diversity and gender non-conforming people.
- Convenient opening hours and women/gender non-conforming-only hours. (Be careful of the risk of increasing stigma and discrimination relating to women and gender non-conforming people. It might be necessary to establish a separate women/gender non-conforming-only DIC.)
- Possibility of childcare or children's spaces.
- Convenient location/accessible for women and gender non-conforming people who use drugs.
- Sufficient space and women/gender non-conforming-only spaces; facilities to bathe and wash clothes if possible, and toilets to allow proper menstruation hygiene.
- Privacy and confidentiality.
- Provision of accessible, non-judgemental information to allow individual, informed choice.
- A range of services is offered: the main components of SRHR (Modules 2 to 8) and the comprehensive harm reduction package. If requested by a woman or gender non-conforming person who uses drugs, help engage partners in couples counselling. Group discussions, 'sister-to-sister' talks and one-on-one sessions is available to help address concerns around the SRHR needs of women and gender non-conforming people who use drugs and their partners.
- An adequate supply of SRH commodities and essential medicines is available, such as pregnancy tests, a wide range of contraceptive methods (including condoms) and menstrual commodities.
- SRHR information and education materials are available on site on various issues, including gender-based violence, cervical cancer and perinatal and newborn care.
- If a needed service is not available in-house, women or gender non-conforming people who use drugs can be referred or accompanied to trusted providers and given clear information about these services.
- Many other services could be needed to respond to the needs of women and gender non-conforming people in all their diversity. These will vary by location and need to be defined by/with the clients themselves.

### PROVIDERS

- Staff are trained in SRHR, gender norms and gender equity.
- Staff are properly trained to engage respectfully with trans-women and gender non-conforming people (for example, through gender affirmation and proper pronoun use), and to understand and respond to the health needs and rights of trans-women and gender non-conforming people. Likewise, staff are trained to understand issues faced by, and work respectively with, sex workers.
- Peers are integrated in the team. Peers can include sex workers who use drugs, and women who use drugs from the LGBT+ community (lesbian, gay, bisexual, transgender and gender non-conforming).

- Ethical principles are respected, such as confidentiality, collection of informed consent, respect of individual choice, being non-judgemental, and there being no discrimination.
- A client-oriented approach is used and adequate time is given to client/provider interaction.

Source: Adapted from Agir pour la planification familiales (Agir PF) and EngenderHealth (2015), *Manuel de Formation sur la Santé Sexuelle et Reproductive des Adolescents et des Jeunes, et l'Offre de Services Adaptés aux Besoins des Adolescents et des Jeunes* and INPUD (2020), *On the A-Gender: Community Monitoring Tool for Gender-Responsive Harm Reduction Services for Women who use Drugs.*

## SUPPORT THE DEVELOPMENT AND STRENGTHENING OF WOMEN WHO USE DRUGS' COLLECTIVES

Many of the best programmes have been started by, and are led by, women and gender non-conforming people who use drugs themselves.

Apart from the involvement of women and gender non-conforming people who use drugs in the design, implementation, monitoring and evaluation of all services, groups led by these communities may also need support for mobilising, or need spaces in which to meet.

These groups or networks can be supported through discreet advertising to other women and gender non-conforming people with similar interests who use services and through outreach. Structural, methodological or organisational support can be provided to group members to identify key issues that they want to prioritise and address. Service providers could also offer resources to support peer education and the latest research that affects women and gender non-conforming people who use drugs.

Harm reduction providers can also assist these collectives by forming linkages with other stakeholders, looking for funding and training opportunities for group members, and being generally responsive to these groups' stated goals and needs.

But sometimes, communities of women or gender non-conforming people who use drugs cannot be accessed or identified. Or organised networks or groups of women and gender non-conforming people who use drugs are simply not established or connected with existing clients. In such instances, at the very least, service providers should make every effort possible to employ women and gender non-conforming people who use drugs as volunteers, paid staff, and/or managers in their women/gender non-conforming-focused services. These peers can often breakdown some of the barriers that may stop women and gender non-conforming people who use drugs from accessing services. Recruiting women and gender non-conforming people who use drugs can also help attract new clients.

Source: Adapted from UNODC (2015), *Addressing the Specific Needs of Women who Inject Drugs*

# HANDOUT 2
## EVALUATING SERVICES AND IDENTIFYING GAPS IN THE PROVISION OF SRHR

This tool can be used as an exercise for implementers and clients (women and gender non-conforming people who use drugs in all their diversity) to check if services are tailored to their needs, to identify gaps in the provision of essential SRHR services in the organisation/association, and to collect new ideas on how to improve services in creative ways, even without extra funds.

**Step 1:** Please go through the checklist below and tick the appropriate boxes

| | ARE THE FOLLOWING AVAILABLE FOR WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUGS IN YOUR PROGRAMME? [Please tick 'Yes' or 'No'] | YES | NO |
|---|---|---|---|
| 1 | Full harm reduction service package, including provision of/ referral for OST and NSP and condom distribution | | |
| 2 | Education about how drugs affect menstruation, pregnancy and breast/chestfeeding | | |
| 3 | Individual and couples counselling on SRHR (HIV and STI prevention, contraception, infertility, pregnancy and newborn care) | | |
| 4 | A self-support group for newborn care and NOW management | | |
| 5 | Gender-based violence information, prevention, detection and provision, or referral for post-violence care and crisis women's accommodation | | |
| 6 | Education about abortion and referral to abortion services | | |
| 7 | Information and referral for preventing vertical transmission services | | |
| 8 | Counselling on cervical cancer, screening and HPV vaccination | | |
| 9 | Adapted facilities for women, including for transwomen and other gender non-conforming people (such as women-only spaces, access to water, hygiene commodities) | | |
| 10 | Availability of modern contraceptives methods (including the emergency pill) and pregnancy test kits | | |

**Step 2:** Score 1 for every 'yes' answer and 0 for every 'no'. Calculate the score, against the 'ideal' score of 10.

**Step 3:** Reflecting on your response to the items in the checklist, note three priority areas that need to be improved. Prioritise three areas that are feasible and can be implemented in the short-term (within the coming months) and three elements that may need more a mid-term commitment (within a year).

1. ______________________________

2. ______________________________

3. ______________________________

Take time to discuss how those priority areas can best be improved, even if no extra resources are available.

# HANDOUT 3

## THE '4A' EVALUATION TOOL: ACCESSIBILITY, ACCEPTABILITY, AVAILABILITY, AFFORDABILITY.

Participants should answer the different questions in the table by putting a YES or NO in the first column. If the answer is no, complete the second column. This exercise must be done with the participation of women and gender non-conforming people who use drugs who are using the services and/or other peers involved in service delivery.

Participants can also refer to the work that has been done during Module 1 to 8.

Some gaps can be linked with Module 10 on advocacy. For instance, if there is no affordable HPV screening test for women and gender non-conforming people who use drugs, advocacy action can be taken to push this issue to become a major public health recommendation at national level.

| **ACCESSIBILITY** | **YES OR NO?** | **IF NO:** describe what is missing or what could be improved |
|---|---|---|
| Is the harm reduction centre or DIC well located (easy to access with public transportation, short travel time)? | | |
| Are the opening hours at the harm reduction centre or DIC convenient for women and gender non-conforming people who use drugs? | | |
| Does the harm reduction centre or DIC have women-only hours or spaces? | | |
| Are there outreach interventions implemented specifically for women, gender non-conforming people and sex workers who use drugs? | | |
| | | |
| | | |
| | | |

| **ACCEPTABILITY AND QUALITY** | **YES OR NO?** | **IF NO:** describe what is missing or what could be improved |
|---|---|---|
| Does the harm reduction centre or DIC provide a non-judgmental, friendly environment for women and gender non-conforming people who use drugs in all their diversity? | | |
| Does the harm reduction centre or DIC have a separate area for providing services to women and gender non-conforming people only, including childcare services? | | |
| Does the harm reduction centre or DIC provide low-threshold services (no appointment needed, short waiting-times etc.)? | | |
| Are there counselling/examination rooms that provide visual as well as auditory privacy for women and gender non-conforming people? | | |
| Is the team respecting ethical principles with non-judgmental attitudes and have they been trained on the needs of women and gender non-conforming people who use drugs in all their diversity? | | |
| Are female and gender non-conforming peers involved in service provision? | | |
| Is there meaningful involvement of women and gender non-conforming people who use drugs in the programme? | | |
| | | |

| AVAILABILITY | YES OR NO within harm reduction services? | IF NO: describe what is missing or what would be part of a strong referral system |
|---|---|---|
| Is there counselling on drug use and sexuality, including chemsex, sexual health, menstruation and hygiene? | | |
| Is there counselling on STI and HIV prevention, testing and treatment, including dual protection? | | |
| Is there testing/screening and treatment for HIV and STIs? | | |
| Is there correct information on drug interactions between ARVs and hormones? (For trans-people living with HIV who are receiving hormone treatment, ART may need to be tailored – and hormone levels monitored – to avoid negative interactions.) | | |
| Is there counselling about pregnancy and breast/chestfeeding for women and gender non-conforming people who use drugs, including those living with HIV? | | |
| Are there group discussions and/or a self-support group for newborn care and NOW management? | | |
| Is there a referral system to trusted providers for pregnancy, perinatal and newborn care, including preventing vertical transmission services? | | |
| Are there any gender-based violence services? (This could include information, prevention, services to support someone to develop a personalised safety plan and social support map, detection of gender-based violence, and post-violence services.) | | |
| Are there comprehensive post-rape services, including medical examination, access to PEP, emergency contraception, HIV and STI testing/screening and treatment, immediate and ongoing psychosocial support, and accompaniment to police/legal services? | | |
| Are there individual and/or couples counselling services on contraception (including drug use/OST and contraception) and on infertility? | | |
| Is there correct information about abortion, abortion methods, and pain management? | | |
| Are there servics that are legal for medical or surgical abortion? | | |
| Are there post-abortion care services, including emergency treatment for abortion complications, tetanus immunisation and contraception counselling? | | |
| Is there cervical cancer information, screening for HPV, HPV vaccination and treatment of lesions services? | | |
| Are there safe-housing and legal aid services, including services for child custody? | | |
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| | | |

| **AFFORDABILITY** | **YES OR NO** | **IF NO:** describe what is missing or what could be improved |
|---|---|---|
| Is there an available, adequate and free supply of sterile needles and syringes, condoms (external and internal), and lubricants? | | |
| Are free menstruation products, including pads and tampons, available in the DIC/outreach? | | |
| Are free pregnancy tests available in the DIC/outreach? | | |
| Is there a free stock of modern contraceptive methods? | | |
| Are there emergency contraception pills in the DIC and with peers on outreach? | | |
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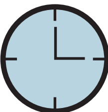
# HANDOUT 4
## SRHR REFERRAL MAPPING

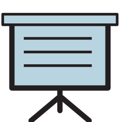
# HANDOUT 5
## ACTION PLAN

| **WHAT?** What action can be taken in a short-term period? | **WHO?** Who is/are in charge of carrying out this action? | **WHERE?** The location where the action/s take place, for instance, DIC, outreach, referral or community. | **WHEN?** What is the time needed for this step and when could it be achieved? | **HOW?** How to support meaningful involvement of women and gender non-conforming people who use drugs? |
|---|---|---|---|---|
| *For example:*<br>**1.** Develop information material on menstruation.<br>**2.** Implement group counselling for pregnant women.<br>**3.** Open the DIC for women-only hours on Saturday mornings. | *For example:*<br>A peer consultant who is aware of the local context, along with project staff or an external consultant with support from local staff. | *For example:*<br>DIC and outreach, and at community level. | *For example:*<br>Next month | *For example:*<br>Create a women/gender non-conforming group discussion about menstruation, develop a leaflet and test the first draft through outreach among women and gender non-conforming people who use drugs and collect feedback to finalise the leaflet. |
| **Review at three months** | | | | |
| **WHAT?** What action can be taken in a short-term period? | **WHO?** Who is/are in charge of carrying out this action? | **WHERE?** The location where the action/s take place, for instance, DIC, outreach, referral or community. | **WHEN?** What is the time needed for this step and when could it be achieved? | **HOW?** How to support meaningful involvement of women and gender non-conforming people who use drugs? |
| **1.**<br>**2.**<br>**3.** | | | | |
| **Review at 1 year** | | | | |

# Module 10
## Advocacy



**TIME**
2 hours



**MATERIALS**

- Flipchart
- Pens
- **PPT Module 10:** Advocacy
- **Handout 1:** What is advocacy?
- **Handout 2:** Template for setting advocacy actions and targets

| N° MODULE | HEADING TOPIC | SUB-TOPICS | LEANING OBJECTIVES |
|---|---|---|---|
| **MODULE 10** | Advocacy | Define advocacy strategies to improve integration and access to SRHR for women and gender non-conforming people who use drugs | • To identify gaps and barriers to accessing SRHR for women and gender non-conforming people who use drugs in the country<br>• To prioritise key actions and targets for advocacy |

### TIPS FOR ONLINE FACILITATION

**EXERCISE 1. GROUP WORK: WHAT IS ADVOCACY?**
Share the different words to be used in the exercise by email or by typing them in the chat.

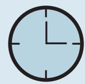
**EXERCISE 2. GROUP EXERCISE: IDENTIFY YOUR BARRIERS**
Email Handout 2 to participants in advance. Create virtual breakout rooms for the three groups and organise the participants in each room. One participant can share their screen to note ideas from the group and present it to the rest of the participants.

### TO PREPARE IN ADVANCE

Remind participants about the discussion raised during Module 9, as well as during previous modules, and the potential advocacy actions that have already been identified.

# ADVOCACY (2 HOURS)

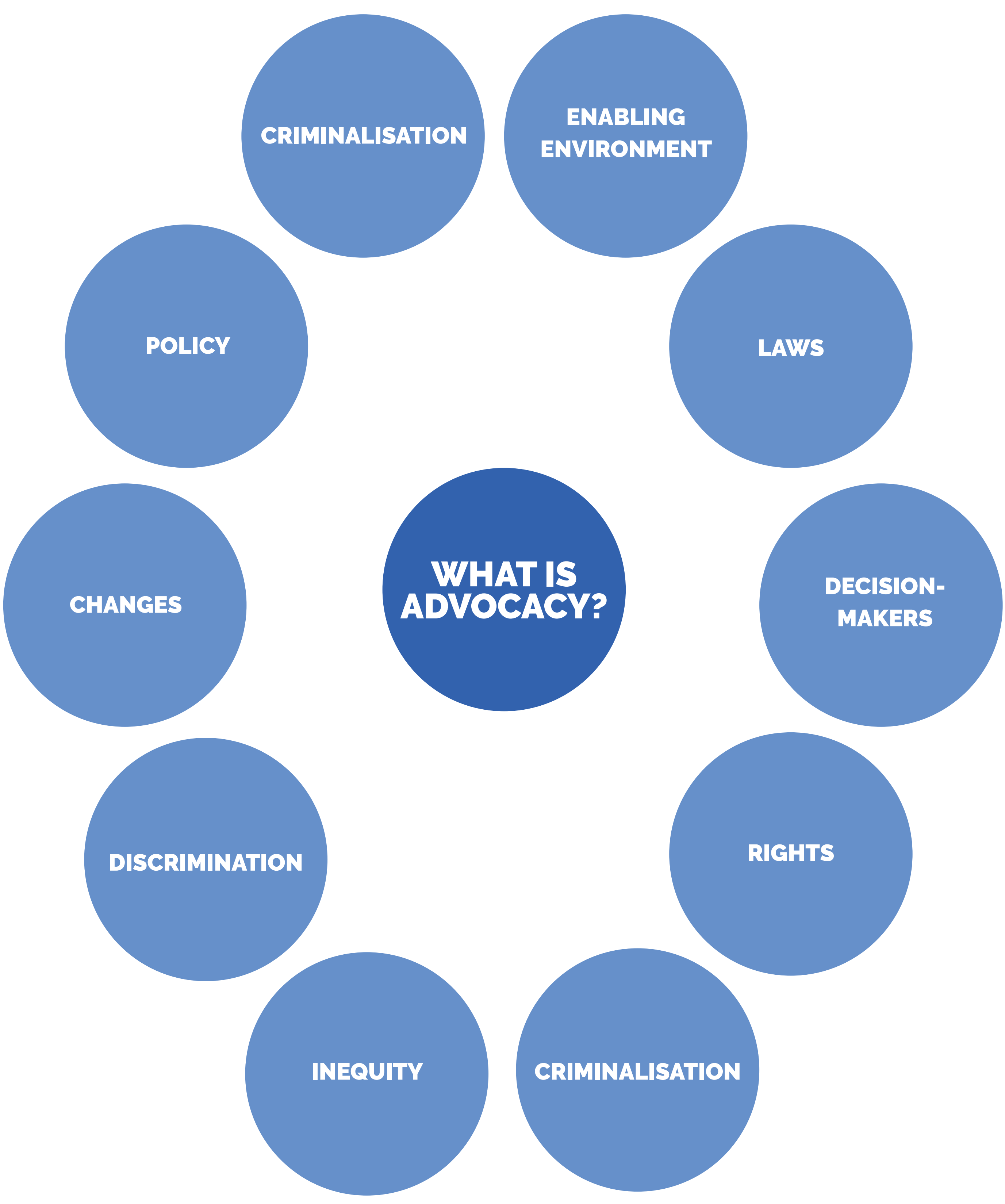
**DEFINE ADVOCACY STRATEGIES TO IMPROVE INTEGRATION AND ACCESS TO SRHR FOR WOMEN AND GENDER NON-CONFORMING PEOPLE WHO USE DRUGS (1/1)**

|  | 2 hours | | PPT Module 10: Advocacy<br>Handout 1: What is advocacy?<br>Handout 2: Template for setting advocacy actions and targets |
|---|---|---|---|

| SEQUENCE | KEY MESSAGES |
|---|---|
| **Exercise 1. Group work: What is advocacy? 10 minutes**<br>Divide the participants into three groups.<br>Ask each group to develop a concise explanation of advocacy for women and gender non-conforming people who use drugs, using the words in Handout 1.<br><br>**Report back: 5 minutes**<br><br>**PPT presentation: 10 minutes** | **Advocacy definition (links to Handout 1)**<br>Advocacy can contribute to creating an enabling environment and empowering communities.<br>Advocacy means applying strategies to influence decision-makers to bring about solutions to identified problems. It aims to bring about long-lasting changes in laws, policies, procedures and practices.<br>Advocacy is an essential process for addressing inequity because it is about challenging the laws, administrative regulations, procedures and (medical) practices that undermine the rights of women and gender non-conforming people who use drugs.<br>Harm reduction implementers with (networks of) women and gender non-conforming people who use drugs in all their diversity need to contribute to advocacy efforts.<br>Service providers can work with groups or networks of women and gender non-conforming people who use drugs to highlight the harmful impacts of criminalisation and discrimination on the health and human rights of women and gender non-conforming people who use drugs, in order to reduce these impacts.<br>Service providers can work with groups or networks of women and gender non-conforming people who use drugs to challenge inappropriate laws, administrative procedures, practices or policies and propose changes to:<br>• Protect and promote the SRHR of women and gender non-conforming people who use drugs to reduce violence, discrimination, stigma and rights violations<br>• Decriminalise drug use and drug possession, sex work, abortion, gender identity and expression and sexual orientation<br>• Uphold the freedom of women and gender non-conforming people who use drugs to make their own informed choices, and decisions around risk-taking behaviour<br>• Facilitate access to SRHR and harm reduction services for women and gender non-conforming people who use drugs<br>**Steps of advocacy:**<br>**1.** Define your issue<br>**2.** Set goals and objectives<br>**3.** Identify your target audience, decision-makers and influencers<br>**4.** Engage in partnership and identify allies<br>**5.** Assess resources<br>**6.** Plan advocacy actions<br>**7.** Create advocacy communication/messages<br>**8.** Develop a monitoring and evaluation plan<br>**9.** Take action!<br>**10.** Evaluate |
| **Exercise 2. Group exercise: Identify your barriers: 25 minutes**<br>Divide the participant into three groups.<br>Ask each group to identify the different types of barriers women and gender non-conforming people who use drugs experience in relation to accessing SRHR services **in their country.**<br>These should cover:<br>• Legal barriers<br>• Administrative procedure barriers<br>You can provide some examples, such as:<br>• Age of consent for HIV testing,<br>• Age of consent for access to contraception<br>• Approval of two different doctors and the consent of the husband for an abortion | **Advocacy strategies**<br>• **Media work:** increases the visibility of your cause, sensitises public opinion to your cause, and presents the arguments in favour of change. Actions include: press release, press dossier, open letter in the newspaper, newspaper insert or article, web banner, TV/radio spot, training journalists.<br>• **Lobbying:** this involves direct contact with your target decision-makers to explain your intentions, the changes you seek, and to convince them to act. Actions include: meetings policymakers, participating in ministerial working groups, organising field visits for decision-makers, participating in public consultations, proposing parliamentary questions. |

| SEQUENCE | KEY MESSAGES |
|---|---|
| Ask each group to think about different topics and come up with at least two barriers for each one, as follows:<br>**Group 1**<br>Abortion<br>Contraception<br>Cervical cancer<br>**Group 2**<br>Gender-based violence<br>HIV and STI prevention, testing and treatment<br>**Group 3**<br>Perinatal and newborn care, including NOW<br>Sexuality and menstrual hygiene<br><br>**PPT presentation: 10 minutes**<br><br>**Exercise 3. Group exercise: Take Action! 40 minutes**<br>Keep the same groups as Exercise 2.<br>Ask each group to prioritise one barrier they want to address through advocacy.<br>Criteria for prioritisation could be: importance and/or urgency, achievability, allies already identified to support the advocacy action.<br>After 10 minutes, ask the groups to set out the actions they want to take (e.g. media work, lobbying, public campaigning, litigation), and identify at least one target group for each action.<br><br>**Report back: 15 minutes**<br>Ask each group to present their key advocacy actions.<br><br>**Conclusion: 5 minutes** | • **Public campaigning:** this covers a variety of actions that aim to influence decision-makers indirectly. Public campaigning can sensitise a large number of people to your cause and gather together a sizeable support base. Actions include: petitions, demonstrations, letters to Members of Parliament, e-actions through social media, remembrance days.<br>• **Litigation:** take legal action to defend the rights of the people concerned.<br>**Defining advocacy targets**<br>**Primary targets** are the decision-makers who have direct responsibility for approving the desired change. It will be essential to convince these actors if you are to have a chance of achieving your advocacy objectives.<br>**Secondary targets** are individuals or groups who have a certain degree of influence over primary targets. Influencing second-level targets is often a necessary step towards convincing the first-level targets.<br>Examples of targets:<br>• Heads of state<br>• Ministers<br>• Political advisors<br>• Technical advisors<br>• Parliamentarians<br>• Representatives of local organisations<br>• Representatives of religious organisations<br>• Representatives of international agencies and/or financial and technical partners<br>• Local health authorities<br>• Celebrity figures (VIPs)<br>Your targets will depend of the context, and it is important to analyse this.<br>**Defining allies**<br>Allies are those who, although not part of your advocacy team, nevertheless support your work and your objectives.<br>Alliances/partnerships may be built with a diverse range of actors, including:<br>• Civil society groups<br>• Other NGOs (international, regional and local)<br>• Consultants, experts and academics<br>• Institutional actors (international institutions, donors, representatives of national authorities, parliamentarians) – although this is harder to achieve<br>**Advocacy can be done at different levels, including at the community level.**<br>Groups or networks of women and gender non-conforming people who use drugs should participate in and lead advocacy efforts, including those directed at the wider public to reduce discrimination. Support for the establishment and development of networks and groups of women and gender non-conforming people who use drugs is critical.<br>**Sometimes, advocacy is not necessarily something 'official' – it can be also simple and creative.** |

# HANDOUT 1
## WHAT IS ADVOCACY?



# HANDOUT 2
## TEMPLATE FOR SETTING ADVOCACY ACTIONS AND TARGETS

This handout can be printed or it can be emailed to participants for them to fill out as a Word document.

| GAPS/BARRIER IDENTIFIED | ACTION<br>Describe the kind of action you want to set up to address the identified gaps or barriers (media work, lobbying, public campaign, litigation etc.) | Targets |
|---|---|---|
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# OTHER HANDOUTS
## FEEDBACK ON THE MODULES

**OPTION 1**

**OPTION 2**

Give a score between 1 and 4 (4 is the best score) for the following items

| ITEMS | SCORE |
|---|---|
| Rhythm of the modules | |
| Variety of methods | |
| Dynamics of the group | |
| Quality of facilitation | |
| Quality of information | |

# OTHER HANDOUTS
## WORKSHOP EVALUATION FORM

(1 copy /participant)
Put a cross in the column of your choice

| | VERY SATISFIED (2) | SATISFIED (1) | NOT SATISFIED (0) |
|---|---|---|---|
| Environment and logistical organisation | | | |
| Content and level of information | | | |
| Accuracy of information | | | |
| Intersectionality (when different characteristics, such as age and gender, overlap) and focus on most-at-risk groups. | | | |
| Methods and activities (role play, brainstorming, etc.) | | | |
| Dynamics of the group | | | |
| Quality of the facilitation | | | |
| Duration of the workshop | | | |

What was the most useful thing you learned during the workshop?____________________

What was less/least useful?____________________

What was missing? ____________________

On a scale of **1 (least)** to **4 (most)**, to what extent did you feel the objectives of the workshop were met? Score each objective:

- ☐ To introduce participants and the rules of the workshop
- ☐ To know the objectives of the curriculum
- ☐ To understand harms of gender norms and gender inequality
- ☐ To understand the compound effect of gender stereotyping for women and gender non-conforming people who use drugs
- ☐ To understand sexual rights and reproductive rights and the importance of the continuum of care (SRHR services)
- ☐ To list advantages and challenges in integrating SRHR services with harm reduction programmes
- ☐ To explain a positive approach to sexuality and sexual health
- ☐ To discuss myths and reality related to drug use and sexuality
- ☐ To identify the bodily characteristics (anatomy and physiology) of male and female sexual and reproductive systems
- ☐ To explore intimate hygiene and menstruation
- ☐ To understand the menstrual cycle and list common menstrual hygiene materials
- ☐ To understand the importance of primary prevention and identify signs and symptoms of gender-based violence
- ☐ To draw a safety plan and social support mapping
- ☐ To define a comprehensive package of quality post-violence care and referral services for women and gender non-conforming people who use drugs, in relation to gender-based violence and intimate partner violence
- ☐ To explore misbeliefs associated with contraception and the full range of contraceptive methods
- ☐ To know the main components of family planning and contraceptive services
- ☐ To provide quality counselling on contraception and contraceptive choice to women and gender non-conforming people who use drugs
- ☐ To identify the main barriers to accessing contraception and potential approaches to overcome the barriers
- ☐ To identify the main barriers to access safe abortion and/or post-abortion care
- ☐ To know how to provide counselling related to abortion issues
- ☐ To map appropriated health services for abortion and post-abortion care to refer women and gender non-conforming people who use drugs
- ☐ To understand the advantages and limits of OST or drug use during pregnancy and breast/chestfeeding
- ☐ To facilitate group discussion on perinatal and newborn care for women and gender non-conforming people who use drugs
- ☐ To identify neonatal abstinence syndrome (or neonatal opioid withdrawal) in babies and provide appropriate care

- [ ] To list key steps to initiate perinatal and newborn care services in the programme
- [ ] To explain basic information about HIV and other STIs, plus ways of transmission, prevention and testing
- [ ] To provide counselling on dual protection strategies to prevent both transmission of HIV/STIs and unintended pregnancy among women and gender non-conforming people who use drugs
- [ ] To inform and refer pregnant people who use drugs living with HIV to appropriate services
- [ ] To enhance capacities to negotiate condom use
- [ ] To understand HPV infection, pre-cancerous lesions and cervical cancer
- [ ] To provide counselling to prevent and screen for cervical cancer
- [ ] To know how to refer women and gender non-conforming people who use drugs to appropriate services
- [ ] To identify gaps in the provision of essential SRHR services in organisations providing harm reduction services
- [ ] To map appropriate services that offer client-oriented, non-judgmental SRHR services for women and gender non-conforming people who use drugs
- [ ] To develop short-term and mid-term action plans to improve access to and integration of SRHR and harm reduction services
- [ ] To identify gaps and /barriers to accessing SRHR/harm reduction for women and gender non-conforming people who use drugs in the country
- [ ] To set up/prioritise key actions and targets for advocacy

- [ ] To what extent **(scale 1-5)** do you feel confident about putting into practice the knowledge acquired during this workshop for each module?

You can list the specific areas of knowledge/practice, up to 1 area per module

______________________________________________

Do you have any recommendations for future trainings/workshops? ______________________

______________________________________________

______________________________________________

______________________________________________

# ANNEXES

## ANNEX ONE: SOURCES AND REFERENCES: GENERAL POLICY DOCUMENTS

It can sometimes be useful to present relevant policy documents related to advancing a feminist agenda to end gender inequality. Examples include:

- The right to health for everyone and non-discrimination enshrined in the **United Nation's Universal Declaration of Human Rights** (1948) has been successfully used to achieve rights for women and girls and gender non-conforming people.

- The UN's **Political Declaration on Universal Health Coverage** (2019). Here, UN Member States call for the engagement of civil society in health system governance, in health policies and in the universal health coverage (UHC) review process. The political declaration recognises the 'fundamental importance of equity, social justice and social protection mechanisms as well as the elimination of the root causes of discrimination and stigma in healthcare settings to ensure universal and equitable access to quality health services' (para 14), and states that that a 'gender mainstreaming perspective' should be implemented when 'designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls with a view to achieving gender equality and the empowerment of women'.

- **Beijing Platform for Action**, **Beijing+25**, and the UN Women-led **Generation Equality**. The Beijing Declaration and Platform for Action calls for the involvement of women in HIV and AIDS policies and programmes, for laws to be amended and reviewed if they contribute to women's and girls' vulnerability to HIV and AIDS, the implementation of legislation, policies and practices to protect women and girls from HIV and AIDS-related discrimination, and the strengthening of national capacity to create and improve gender-sensitive policies and programmes on HIV and AIDS.

- **International Conference on Population and Development (ICPD)** and **ICPD+10**. This includes provisions to provide universal access to family planning and sexual and reproductive health services and reproductive rights, deliver gender equality, the empowerment of women, and equal access to education for girls.

- The **UN Convention on the Elimination of Discrimination against Women** (CEDAW) (1979) is the only convention on the list that explicitly addresses the rights of women and girls, and therefore can be used to hold governments to account through government and shadow reporting.

- The **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** (the Maputo Protocol) (2003). This is the first international legally-binding human rights instrument to recognise the intersection between women's human rights and HIV.

- Other international human rights instruments set out rights to health; the right to non-discrimination; civil and political rights; economic, cultural and social rights; and the rights of specific groups, such as people with disabilities, children, and women. These human rights legal instruments can be found here: **https://www.ohchr.org/en/instruments-and-mechanisms**

# ANNEXES

## ANNEX TWO: SOURCES AND REFERENCES: PER MODULE


### MODULE 1: GENDER, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, AND HARM REDUCTION

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