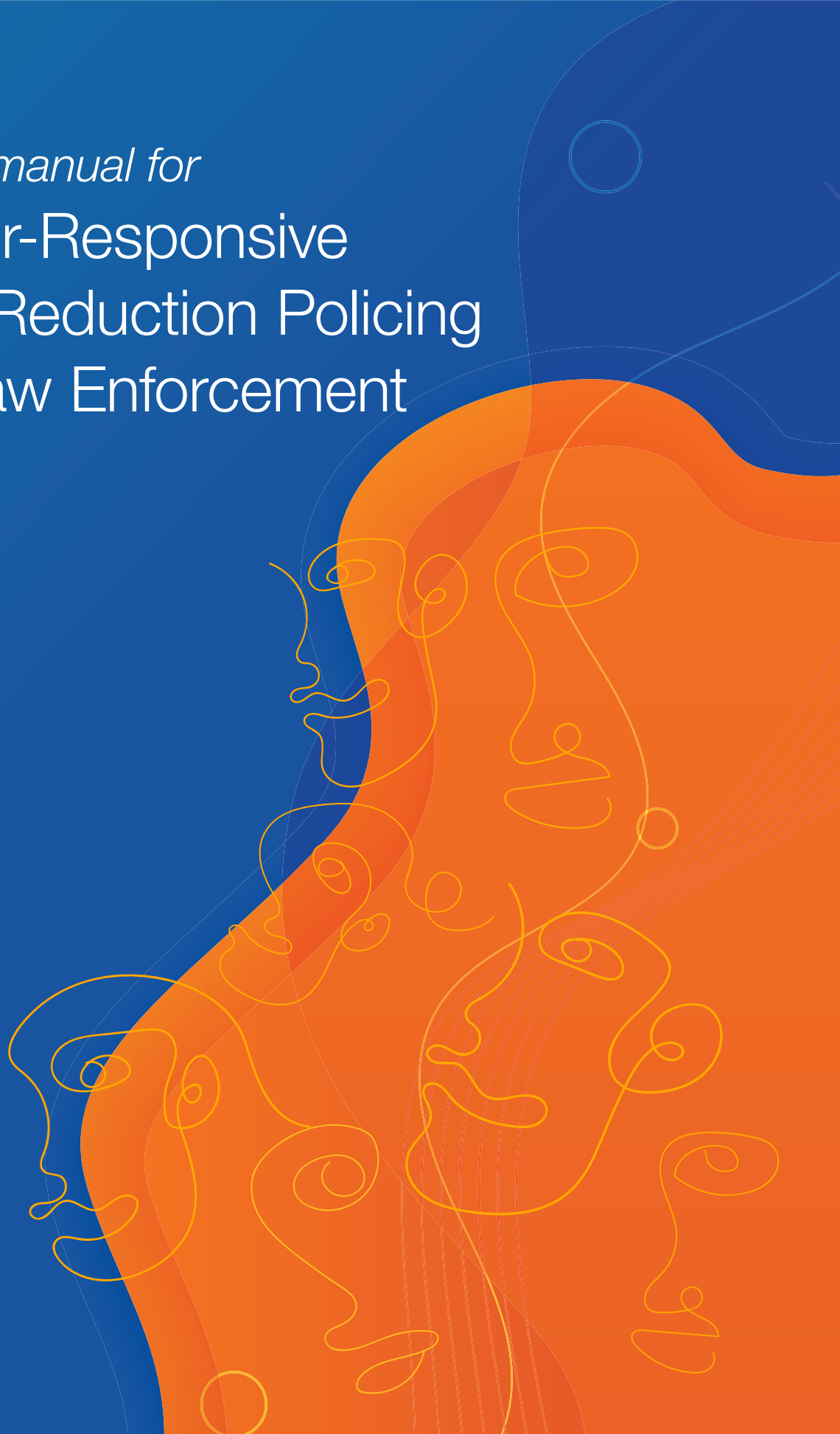


Training manual for
**Gender-Responsive
Harm Reduction Policing
and Law Enforcement
2020**



Authors: Jardine, Melissa & Burns, Katya

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Preface



This manual brings so much modern thinking to policing, across so many areas. I have been working in the field of harm reduction for more than 30 years, in many different countries and in many different settings. In every situation and jurisdiction and with every community, my experience is that the police are key partners in building the context for healthy lives – they are critical to health and wellbeing. Harm reduction is a pragmatic philosophy and approach, dealing with the world as it is, not as we would want it to be. Police are realists, by nature of their profession, and to be so they need to be fully informed, so as to navigate the competing legal frameworks and incentives of LE and PH.

Gender-responsive policing is also critically important, because bringing women into the criminal justice system for petty offences or for matters such as drug use or abortion which are really health issues is ruinous, for the women, their families and society. Gender-responsive police can “deflect” such women away from the criminal justice system, to everyone’s benefit.

This manual draws attention to trauma-informed policing, an area of growing importance for police, but to date under-addressed in police thinking and training. Understanding the impact of adverse childhood experiences or other trauma helps broaden the range of effective responses to behaviours otherwise simply seen as criminal.

The manual is co-authored by a former police officer, with a reference group including serving police, so it is designed with police for police. Others on the reference group, who were very active in bringing consumer perspectives to the manual, included representatives from the peer networks Women’s Harm Reduction International Network (WHRIN) and Resourcing Health and Education (RhED). With all this input and the vast experience of the authors, this Manual stands along in its usefulness to the serving police officer.



Prof Nick Crofts

Executive Director, Global Law Enforcement and Public Health Association

Acronyms and abbreviations

ACEs	Adverse childhood experiences
ARV	Antiretroviral (therapy)
ASEAN	Association of South East Asian Nations
DCAF	Geneva Centre for Security Sector Governance
DIC	Drop-in centre
EHRN	Eurasian Harm Reduction Network
FIDU	Female injecting drug user
FSP	Female sex partner
FSW	Female sex worker
KASH	Keeping Alive Societies' Hopes
KPs	Key populations
HIV	Human immunodeficiency virus
HIV+	HIV positive
IBBS	Integrated Biological and Behavioural Surveillance
IDU	Injecting drug user
INWUD	International Network of Women who Use Drugs
MoU	Memorandum of Understanding
OSCE	Organization for Security and Co-operation in Europe
ODIHR	Office for Democratic Institutions and Human Rights
PMTCT	Prevention of mother-to-child transmission
POP	Problem-Oriented Policing
PPT	Powerpoint presentation
PWID	People/person who inject drugs
PWUD	People/person who uses drugs
RhED	Resourcing Health and Education in the Sex Industry
SARA	Scanning, Analysis, Response, Assessment
SASO	Social Awareness Service Organisation
SRH	Sexual and reproductive health
SRHR	Sexual reproductive health and rights
STIs	Sexually transmitted infections
TB	Tuberculosis
WHIRN	Women and Harm Reduction International Network
WID	Women who inject drugs
WHO	World Health Organization
WUD	Women who use drugs
WINGS	Women Initiating New Goals for Safety programme
WLHIV	Women living with HIV
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNODC	United Nations Office on Drugs and Crime

Gloassary¹

Gender: Gender is about women and men, boys and girls and their relationship to each other in different groupings. Gender refers to the roles, behaviours, activities and attributes that a given society, at a given time, considers appropriate for men and women. Gender also refers to relations between groups of women and between groups of men. These roles and attributes are socially constructed and learned through socialization processes. As such, gender roles and relations are different between societies and at different points in history.

Gender analysis: This refers to careful and critical examination of how differences in gender roles, activities, needs, opportunities and rights/entitlements affect men, women, girls and boys in certain situations or contexts. A key element of gender analysis is the examination of women's and men's access to and control of resources—especially economic, political and knowledge resources and access to and control of time. Other important analysis factors that should be considered along with gender include age, poverty levels, ethnicity, race and culture.

Gender and sex: Gender and sex are different but interlinked. Gender is a social attribute and sex is a biological attribute where individuals are almost always clearly male or female. Society shapes and normalizes different roles and behaviours based on people's male or female sex and these socially determined roles and relationships are referred to as gender attributes. Sexual orientation also influences the roles and behaviours of individuals and different societies treat lesbian, gay, bisexual and transsexual people with differing degrees of expectations and discrimination.

Gender blindness: This term refers to the failure to recognize that the roles and responsibilities of men/boys and women/girls are assigned to them in specific social, cultural, economic, and political contexts and backgrounds. Projects, programs, policies and attitudes which are gender blind do not take into account these different roles and diverse needs. They maintain the status quo and will not help transform the unequal structure of gender relations.

Gender equality: Equality between men and women, or gender equality, refers to the equal rights, responsibilities and opportunities of women and men, boys and girls. Equality does not mean that women and men will become the same but that their rights and opportunities will not depend on whether they were born male or female. Gender equality implies that the interests, needs and priorities of both women and men are taken into consideration, recognizing the diversity of different groups of women and men. Gender equality is not a women's issue as it provides benefits for both men and women and is a key human right. Gender equality is also a precondition for, and indicator of, sustainable development.

Gender equity: Gender equity refers to specific measures that are designed to redress historical inequalities between men and women. There are many examples of gender equity and they apply across all sectors. Examples include taking steps to ensure girls and boys and women and men have equal access to health and education opportunities, designating temporary special measures to bring women into decision-making arenas and employment, and/or designing processes to ensure women can safely participate in economic life.

1 Source: Most of the gender definitions in this glossary are sourced or adapted from the UN Women website, trainingcentre.unwomen.org

Gender inclusive: Gender inclusiveness is a process and refers to how well women and men are included as equally valued players in initiatives. Gender-inclusive projects, programmes, political processes and government services are those which have protocols in place to ensure women and men (and boys and girls, where appropriate) are included and have their voices heard and opinions equally valued.

Gender mainstreaming: This is the process of assessing the implications for men and women of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a way to ensure women's and men's concerns and experiences are an integral dimension of all development efforts. The goal of gender mainstreaming is gender equality. Gender mainstreaming is a 'whole of government' responsibility.

Gender responsive: Gender responsiveness refers to outcomes that reflect an understanding of gender roles and inequalities and which make an effort to encourage equal participation and equal and fair distribution of benefits. Gender responsiveness is accomplished through gender analysis and gender inclusiveness.

Gender roles: Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies there are differences and inequalities between women and men in the responsibilities they are expected to take up, the activities that are considered normal or acceptable, access to and control over resources, and participation in decision-making.

Harm reduction: Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.²

Foreword



There are significantly higher HIV infection rates among women who inject drugs, compared to men who inject drugs. Gender-specific stigma about drug use decreases women's access to HIV, harm reduction and other health services. More than men, women fear people finding out that they use drugs, and this makes some women avoid needle syringe programs and dislike and avoid buying injecting equipment. Women who experience intimate partner or domestic violence can also be at higher risk of HIV infection, as well as female sex partners (FSPs) of people who use drugs which calls for the use of gender perspective for HIV prevention, treatment and care. By using a gender perspective for HIV prevention, police and law enforcement agencies can become more gender-responsive when faced with safety and security concerns and consider the specific needs of women and men, girls and boys.

Law enforcement agencies are increasingly recognising the detrimental effects and costs to the community for pursuing a punitive response, where alternatively, health-oriented approaches are more effective in securing community safety and wellbeing. Police and law enforcement officers have also started understanding how taking a public health and genderresponsive approach to their duties can significantly reduce harm to women in their jurisdictions and protect the whole community.

I am excited to present this training manual which aims to assist police and law enforcement agencies to increase their capacity to not only contribute to the National HIV response but to better promote and protect the human rights and needs of vulnerable communities like women at-risk of HIV and STIs. The manual will also prove to be useful as a supplement to the UNODC developed Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs as various modules in this guide are designed to build professional skills and knowledge regarding policing approaches that are transferable across a wide range of crime prevention and safety issues.

This training manual is produced with the hope that Law Enforcement Officials will use this manual to gain more confidence in planning and developing responses that are preventative, health-oriented, outside the criminal justice system, engage other agencies and communities, and reduce long term harms.

A handwritten signature in blue ink, appearing to read "Ashim Chowla".

Ashim Chowla
Chief Executive Alliance India



Introduction

Women and girls accounted for approximately 48% of new HIV infections in 2019 worldwide.³ Yet, interventions to prevent, reduce and treat HIV infection are often gender blind. Importantly, more attention is being given to the specific needs and realities that reduce harm to women in the context of the HIV response.⁴

There are many sociocultural factors that shape the HIV risks and vulnerabilities of women and girls, men and boys, as well as people of different sexual orientation or gender identities. In many countries, women's risk of HIV and sexually transmitted infections (STIs) may be the result of engaging in behaviours that are criminalised, such as injecting illicit drugs or sex work. Consequently, positive public health outcomes for women at-risk of HIV infection can intersect with, be dependent on or be hindered by laws, policies, and practices of the law enforcement sector.

Women may come into contact with the law enforcement sector for a wide range of reasons, including as survivors of violence or other crimes, witnesses, suspects or perpetrators of crimes. Depending on the nature of policing in specific contexts, police may perform a range of bureaucratic, problem-solving or mediation functions (e.g. regarding business disputes even though they may be civil matters). In some cases, women avoid police because they fear being arrested, having to pay bribes, coerced or sexually assaulted or harassed by officials who are mandated to protect them. It is essential that police and law enforcement officers understand how taking a gender-responsive approach to their duties can significantly reduce harm to women in their jurisdictions and protect the whole community.

This training guide aims to assist police and law enforcement agencies to increase their capability to better understand and take actions towards gender-responsive policing in relation to women at-risk of HIV and STIs.⁵

In developing the guide, particular attention is given to policing models and strategies that are already in use (e.g. problem-oriented policing) and situates the application of new knowledge about the role of policing and law enforcement in gender-responsive HIV prevention in this context. This approach extends insights from previous research which shows that where the public health outcomes of harm reduction interventions are consistent with professional and personal interests of police, they are more likely to support the interventions.^{6 7 8} The modules are also designed to build professional skills and knowledge regarding policing approaches which are transferable across a wide range of crime prevention and safety issues.⁹ Participants of this training will gain more confidence in planning and developing responses that are preventative, health-oriented, inclusive of opportunities outside the criminal justice system, such as engaging with relevant agencies and communities, and reduce long term harms.

3 UNAIDS 2020a.

4 Pinkham and Malinowska-Sempruch 2008.

5 It can be used as a supplement to the Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs (see Implementation Guidelines).

6 LEHRN Partnership 2010.

7 Jardine et al 2012.

8 Mittal et al 2016.

9 For example, see Scott, M., & Clarke, R. 2020 Eds. on Problem-Oriented Policing: successful case studies. Routledge, New York.

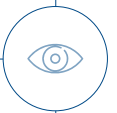
Importantly, there is significant scope for adjustments to policing and law enforcement practices to improve public health and safety outcomes through harm reduction approaches which are not reliant on legislative changes which this guide seeks to address.

In many countries, engagement and reform of police practice is not something “extra” to be funded after other HIV needs have been met. Rather, police reform and community-police cooperation is as crucial to HIV prevention among criminalized groups as a condom or a clean needle, and should be supported as a central part of HIV and AIDS programming.¹⁰

NOTE ON TERMINOLOGY:

This training guide prioritises the use of describing the actions of ‘policing’, rather than centering ‘police’ and ‘law enforcement officers’. This is for three main reasons:

- Emphasising policing, rather than law enforcement, draws attention to the nature of police work which is significantly wider in scope than enforcing the law, such as the significant discretionary possibilities available to officers.
- Referring to policing that encompasses a set of strategies, approaches and practices is more inclusive of the wider range of actors who carry out social control or regulatory enforcement activities.
- Focusing on policing contributes to advancing understanding of the theory and practice of policing approaches and creates space to reimagine how policing can be more effective.



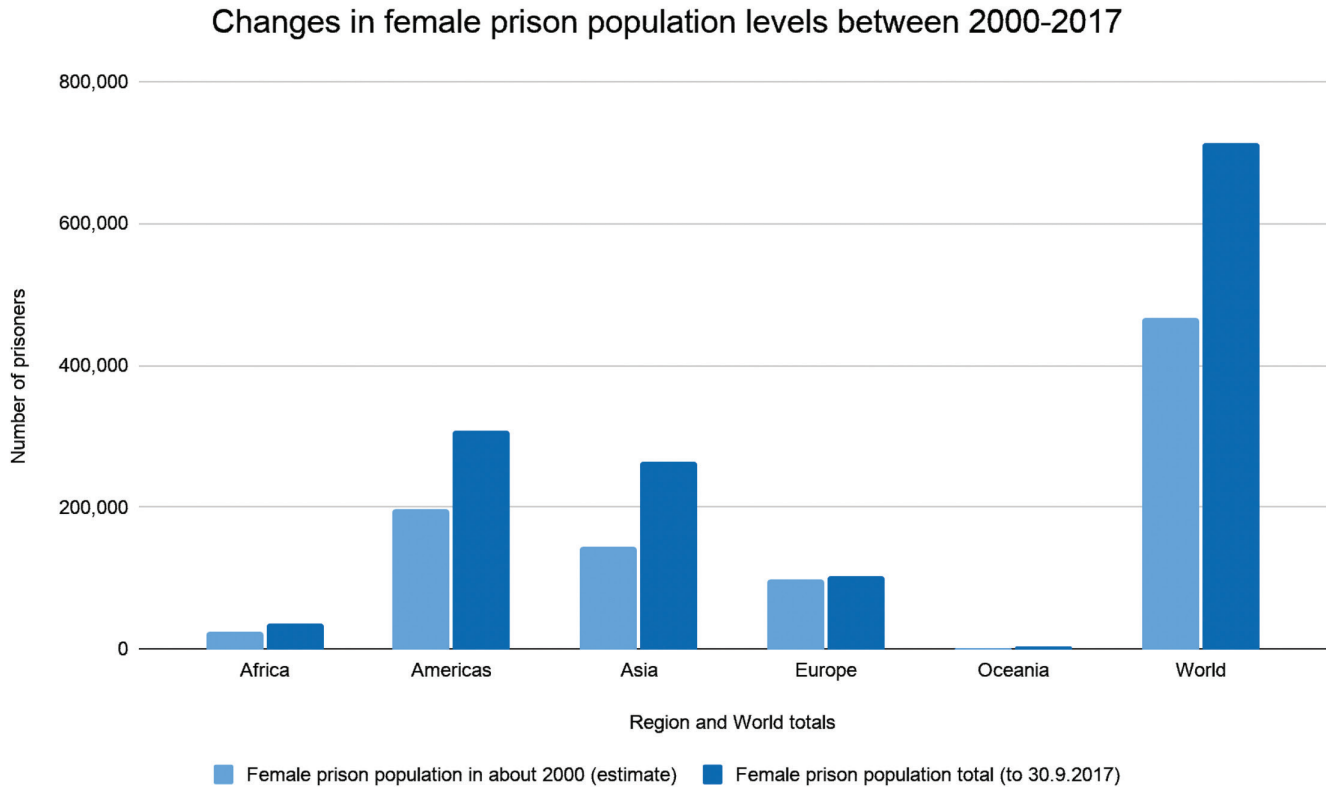
Background and rationale

Gender-responsive HIV prevention programs and services “explicitly consider and address unequal gender norms and roles, power dynamics and the distribution of resources according to gender and that counter discrimination faced by people in societies based on their gender or gender expression and improve their access to services”.¹¹

Women who inject drugs (WID) and female sex workers (FSWs) are particularly vulnerable to HIV infection, due to the typically criminalised nature of these activities. Specifically, women who inject drugs (WID) are at higher risk HIV infection and other sexually transmitted infections (STIs) than men.¹² Women who engage in sex work, and women who have little negotiating power with sex partners, can also be at higher risk of HIV and STIs. Women who experience intimate partner or domestic violence can also be at higher risk of HIV infection, as well as female sex partners (FSPs) of people who use drugs. It is essential to adopt a gender perspective to analyse and consider the impacts of gender on the different risks and needs of women to ensure women have equitable access to public health services and social supports.

Even though harm reduction services may be available in some areas, policing practices can hinder and obstruct women’s access to them. Moreover, even though women typically commit less or non-violent crimes, they can be incarcerated for petty and minor crimes. The figure below highlights an unacceptable trend of increasing levels of incarceration and running counter to international standards and agreements, such as the Bangkok Rules (See Module 5). Crucially, the nature of police intervention can determine whether women are directed into the criminal justice system with further health and associated risks, or along a pathway which focuses on support, referrals to services and empowerment.

Figure (Introduction) 0.1



Source: Adapted from IDPC & Inspire Project (2019). *Women, Incarceration and Drug Policy: Regional Dialogue in Southeast Asia: Summary Report*. p. 2.

11 UNAIDS. 2018.

12 UNODC, INPUD and LEAHN. 2016.

The role of police in navigating whether to enforce legislation which prohibits some risk behaviours, while observing the legal provision of harm reduction services is an important focus for creating an enabling environment for harm reduction and reducing harm to WID and female sex workers (FSWs). Subsequently, there are important reasons for engaging with police to improve outcomes for WID and FSWs.

Overview of HIV in the Asia region

While the overall number of HIV infections in Asia and the Pacific has decreased in recent years, some countries are experiencing significant increases. Among the worst affected since 2000 is the Philippines (+207%), Timor-Leste (+129%), Afghanistan (+116%) and Pakistan (+75%).¹³

In the Asia Pacific region in 2019, 98% of new HIV infections were among key affected populations and their partners.¹⁴ Key populations include: people who inject drugs, sex workers and their clients, transgender people, prisoners and other incarcerated people, and gay men and other men who have sex with men.

According to 2020 AIDS Data from UNAIDS:

- New HIV infections among 15 to 49 year olds in Asia and the Pacific in 2019, cis females accounted for 30%, cis males accounted for 62%, and among transgender people, 8%.
- Among the populations who have HIV, they include: 9% sex workers, 17% PWID, 21% clients of sex workers and sex partners of all key populations, 44% gay men and other men who have sex with men, 2% remaining population.
- Sex workers accounted for approximately 8% of the total number of new HIV infections in 2019¹⁵ and globally, female sex workers have a 30-times greater risk of acquiring HIV than the general population.¹⁶

Key affected populations can be more vulnerable to HIV infection due to the criminalisation of some behaviours. By using a gender perspective for HIV prevention, police and law enforcement agencies can become more gender-responsive when faced with safety and security concerns and consider the specific needs of women and men, girls and boys.

What is gender-responsive harm reduction policing?

With respect to HIV, the needs and realities among women and girls across countries and cultures can vary significantly. Subsequently, the optimum role for gender-responsive policing for public health varies according to a country's HIV epidemic, context and response.

There are a wide range of policing models or approaches that have been adopted and adapted over time to address safety and security concerns; however, structured and systematic implementation and evaluation are uneven. Nonetheless, insights from a range of policing strategies and approaches can be adapted and implemented to address contextual issues, ie., gender-responsive HIV prevention, rather than a single theoretical platform to achieve better results.

Drawing upon research on reducing public health harms by police and interventions which aim to improve responses to female survivors/victims of gender-based violence, gender-responsive harm reduction policing combines lessons from these models to address the specific needs of WID and FSWs (below is an adapted figure from a study by Natarajan and Babu¹⁷).

13 UNAIDS. AIDS Data 2020.

14 UNAIDS. AIDS Data 2020. p. 154.

15 UNAIDS. AIDS Data 2020. p. 8.

16 UNAIDS. AIDS Data 2020. p. 2.

17 Natarajan and Babu 2020.

While ‘harm reduction policing’ is not yet well recognised among policing scholarship,¹⁸ it is used here to refer to a way of thinking about policing practices in the context of public health outcomes, for example, HIV prevention. Notably, effective HIV prevention requires a holistic approach that takes into consideration housing and access to psycho-social support, among others, which police should consider when undertaking their duties.

Harm reduction policing: Harm reduction policing seeks to reduce the negative impacts of criminalisation of some behaviours on a wide range of public health and social outcomes. This is achieved through empowering police officers with knowledge and awareness of harm reduction approaches alongside improved understanding of decision-making processes underpinned by an ethics of care, so that police can actively apply approaches that will contribute to reducing harms associated with criminalised behaviours (e.g. drug use, sex work).

Gender-responsive: Gender responsiveness refers to outcomes that reflect an understanding of gender roles and inequalities and which make an effort to encourage equal participation and equal and fair distribution of benefits. Gender responsiveness is accomplished through gender analysis and gender inclusiveness.¹⁹

Gender-responsive harm reduction policing combines policing models that are already in use by police across the globe to varying degrees. It describes an approach where police and law enforcement officers draw on their knowledge of the benefits of harm reduction interventions in the context of policing and actively analyse, assess and determine what action, if any, they should take, while taking into account the specific needs and realities of a person’s gender identity (and other intersectional identities) and power differentials in the context of HIV prevention.

18 See Beckett 2015 and Kammersgaard 2019.

19 UNDP 2015.



Figure 1. Gender-responsive HIV prevention for policing and selected policing models

Harm reduction policing

Harm reduction policing seeks to build the capacity of systems to address health needs while validating the police mission to protect public and individual safety, security, order, and rights.²⁰ It is a pragmatic approach to responding to individual or community needs that reduce the adverse effects of, for example, drug use and sex work, and the impacts of criminalisation. It requires that police are supported by senior leaders and skilled in ethical decision-making at the intersection of law enforcement and public health which can be complex given the at-times competing legal frameworks and incentives. For example, in Cambodia, even though 100% of police sampled reported that they supported HIV prevention and harm reduction programs, 94% “thought arrest and detention an appropriate solution for reducing HIV transmission and drug use”.²¹

Harm reduction policing seeks to improve police officer knowledge of the negative impacts of criminalisation of some behaviours on a wide range of public health and social outcomes and for police to align this knowledge with policing practices that will contribute to reducing these harms (including health, social or economic harms²²).

Harm reduction approaches for drug use are also consistent with the police mandate to prevent crime. In Vietnam, police support for opioid substitution treatment for PWID increased when the crime reduction

20 OSF 2018.

21 Schneiders and Weissman 2016. p. 5.

22 Rigoni et al 2019.

benefits became apparent.²³ Similarly, China expanded opioid substitution services in conjunction with the realisation of the economic and public security benefits associated with that service.²⁴

Training officers for harm reduction policing can include occupational health and safety information for police about how to protect themselves from needlestick injuries while at work, as well as encouraging condom use, particularly for officers who may be working away from home for extended periods.

Problem-oriented policing

Herman Goldstein proposed “Problem-oriented policing” (POP) as an approach to draw greater attention to the end product of policing efforts in order to assess their effectiveness.²⁵ It encourages police to systematically “identify and appropriately address the underlying factors which make some locations crime ‘hot spots’ and which lead to repeated calls for assistance.”²⁶ The strategy adopts a four stage approach that includes: 1) Scanning; 2) Analysis; 3) Response; and, 4) Assessment. These stages enable an iterative process where responses can be modified, if necessary. The model aims to facilitate better ways of working for police over the long term, including harm reduction approaches to illicit drug use.²⁷

Community policing

Community policing involves the participation of the community in co-producing community safety and contributing to determining shared objectives, how police services are delivered and identifying local priorities. Better co-operation between police and key populations (people who use drugs, sex workers, men who have sex with men and others) contributes to a better work environment for police by encouraging more durable relationships, thus reducing adversarial interactions (conflict) and improving police officer safety.

The Kenyan civil society organisation, Keeping Alive Societies’ Hopes (KASH) began training police on health and human rights in a way that aligned with existing police reform efforts to improve community policing in order to reduce stigma associated with sex workers and break down barriers between them.²⁸ Primarily, this was to reduce police abuse and sexual assault of sex workers which exacerbated their HIV risk. However, there are limits to the benefits of community policing approaches with respect to harm reduction policing.

Footer et al. found that police were frustrated by community complaints about “social anxieties rather than actual crimes” which burdened their limited resources.²⁹ Some harm reduction approaches, such as drug consumption rooms, are perceived as “reducing public nuisance”, rather than primarily a public health approach, thus having a dual benefit.³⁰

Third-party policing/ Partnership policing/ Relationship policing

According to Mazzerole and Ransley, “third party policing occurs within a legal framework that establishes the authority for police to partner with or coerce third parties, the contexts in which they can do that, and the types of intervention this may produce.”³¹

While partnership policing has similarities to third-party policing, it can differ in the extent of formalisation

23 Jardine, Crofts et al 2012; and, Jardine, Khuat et al 2012.

24 Wenyuan Yin et. al. 2010.

25 Goldstein 1990.

26 Brown and Sutton 1997.

27 See Spooner et al 2004.

28 OSF nd. p. 11.

29 Footer et al 2020. p. 8.

30 Kammersgaard 2019.

31 Mazerolle and Ransley 2006.

and potential for coercion. Partnerships may be formalised through Memorandums of Understanding, written protocols and other structured forms of engagement which embeds accountability mechanisms, rather than through legislation.

Partnership policing recognises that achieving community safety is not only the responsibility, but is achieved through multiple stakeholders working together in a coordinated approach. The effective implementation and operation of HIV services for key populations have often seen a persistent dynamic of conflict with police who perceive their professional mandate as the continued enforcement of laws that criminalise HIV risk behaviours, exploit the often marginalised position of a HIV prevention service client or do not know or understand the legal basis and rationale for such services.³² To resolve these tensions, building partnerships between key stakeholders, for example, police, public health service providers, key populations (e.g. WID and FSWs), civil society organisations as well as government departments and other social services, has been used as a strategy to repair relationships and increase understandings of different positions. Ultimately, partnerships in this context aim to modify policing practices to ensure key populations can access HIV prevention and other support services, while building a shared vision for enhancing community safety and wellbeing.

The Prostitutes Collective of Victoria, Australia, started a program called ‘Ugly Mugs’ in 1986, to support sex workers in sharing information about dangerous clients with other sex workers and police to prevent violence and facilitate criminal investigations of offenders.³³ The St Kilda Police Station has jurisdiction for an area frequented by street sex workers and assigns liaison officers to strengthen relationships between police and sex workers, to provide support for legal enquiries and to sit on working groups with local sex workers and RhED.

Gendered policing

Half of the world’s population are women, yet police and law enforcement agencies have been slow to develop their capabilities to respond effectively to women’s safety and security needs which are integral to wellbeing. Gendered policing is being adopted especially to address gender-based violence through establishing women’s police stations and women and children’s protection desks.^{34 35} Special police units/cells and One Stop Centres also provide women with alternative methods to seeking support or reporting crimes or concerns to police.³⁶

Women who use or inject prohibited drugs or are sex workers are particularly vulnerable to mistreatment by police, and may have precarious living conditions and lack social supports. Even though women police may not necessarily act differently to their male colleagues, research shows that women are more likely to support community policing initiatives³⁷ and perceive themselves as more approachable and responsive to the needs of women.³⁸ Women police may be able to play an important enabling role for feminist harm reduction initiatives which seek to provide harm reduction services to women at home rather than through street-level outreach.³⁹

Importantly, gendered policing enables women officers to be deployed to service and police their own gender.⁴⁰ Natarajan referred to this approach as a form of “equity equilibrium” and as “a diversified model of policing and provides women with status and, for traditional societies, it also provides a path to equality”.⁴¹

32 Thomson et al 2016.

33 RhED. <https://sexworker.org.au/sex-workers/ugly-mugs/>

34 Natarajan and Babu 2020.

35 Sreekumaran Nair 2017.

36 Ibid.

37 McCarthy 2013.

38 INTERPOL, UN Women & UNODC 2020.

39 Ritterbusch et al. 2020.

40 Natarajan and Babu 2020. p. 10.

41 Natarajan and Babu 2020. p. 10.

Trauma-informed policing

Trauma-informed practices and responses seek to increase awareness about the impact of trauma on adults and children to better identify vulnerability and strengthen the case for prevention.⁴² Although the concept of trauma-informed policing is in its infancy, it provides a framework for identifying vulnerability, as well as guidance to increase early intervention and trust building police approaches. People who have unaddressed trauma resulting from adverse childhood experiences (ACEs)⁴³ may develop behavioral and physical health conditions, including mental health issues (e.g. post-traumatic stress, depression and anxiety). This can lead to substance use, homelessness or engaging in risk behaviour which may increase the likelihood of their contact with the criminal justice system, as well as victimisation. Trauma-informed policing seeks to ensure individuals are not re-traumatised through contact with police and are given relevant support.

A recent study of female sex workers who use drugs in Kazakhstan found that women who experienced higher levels of intimate and non-intimate partner violence, or had been incarcerated, faced increased odds of having a non-fatal overdose.⁴⁴ In addition, Indigenous women in Canada who have experienced child removal had over twice the odds of reporting an unintended overdose than Indigenous women who maintained custody of their children.⁴⁵

Consequently, identifying, responding to and preventing trauma associated with violence, following release from incarceration, Indigeneity and marginalisation, and preventing child removal, among others, may contribute to reducing overdose risk.

Restorative justice

Restorative justice is a community-based response to injustice that is based on principles of non-domination and empowerment.⁴⁶ It focuses on restoring victims, offenders and affected communities through healing, responsibility, respectful dialogue, moral learning, community caring and forgiveness.⁴⁷ Police can have a role in referring people to restorative justice programs, for example, through drug courts where a person may otherwise face imprisonment.⁴⁸ Principles of restorative justice have been adopted by harm reduction services to engage communities and people who may be perceived as “problematic” due to the criminalisation of drug use and sex work.⁴⁹ For example, people who use drugs were employed as restorative justice facilitators at a drop-in centre in Toronto which developed their listening, conflict prevention and problem-solving skills which empowered them to contribute to resolving conflicts.⁵⁰

42 Bateson et al 2019.

43 Adverse childhood experiences include: Abuse: physical, emotional, sexual; Neglect: physical, emotional; Household dysfunction: parental substance abuse, mother subject to physical abuse, parental mental illness, parental incarceration, parental separation/divorce. Hughes et al 2018, cited in Bateson et al 2019. p. 132.

44 El-Bassel et al 2020.

45 Thumatha et al 2020.

46 Braithwaite 2003.

47 Braithwaite 1999.

48 Grierson 2015. Restorative Justice: From adversarialism and blame to responsibility and reparation. Aotearoa Conference on Therapeutic Jurisprudence Weaving Strands: Ngā Whenu Rārangā 4th International Therapeutic Jurisprudence Conference University of Auckland 3-4 September 2015.

49 Rittenhouse 2014.

50 See Ontario HIV Treatment Network.

Procedural justice

The perception or demonstration of procedural justice in policing encounters with the public enhances police legitimacy and popular support.⁵¹ Where police demonstrate they are listening to the community, explaining police policies and practices during encounters with the community, and treating people with dignity, courtesy and respect, they are more likely to engender co-operation and support. This applies even where the result is to the detriment of an individual's self-interest.^{52 53}

People who inject drugs and sex workers are stigmatised because they may be seen to be transgressing laws and social norms making them vulnerable to police violence and exploitation. Training police in procedural justice is effective in reducing complaints against police and reducing police use of force,⁵⁴ and increasing satisfaction of police interactions with homeless people who inject drugs.⁵⁵ In India, citizens are more likely to support police-community relationships if they perceive the police to act fairly and respect individual citizen's rights in their encounters with the public.⁵⁶

Reassurance policing

Reassurance policing was developed at a time when crime was decreasing in the UK, but fear of crime was not.⁵⁷ Consequently, the role of police in maintaining order and security included reassuring the public they were safe through being visible, accessible and familiar in local neighbourhoods.⁵⁸

With respect to harm reduction, Footer et al. draw attention to the potential role of police in educating communities about the ineffectiveness of responding to calls which categorise female sex workers as a "public nuisance", so that community demands or expectations of police do not undermine public health outcomes.⁵⁹ Australia's New South Wales Police Force published guidelines to support officers in their interactions with communities by reassuring them that, with respect to needle and syringe programs (NSPs), police work collaboratively with NSPs which operate within a legal framework, help prevent the spread of HIV and hepatitis C in the community, reduce the number of used and discarded syringes and needles, and provide opportunities for drug users to get help with their drug problems.⁶⁰ Police are encouraged to provide citizens with a hotline number for needle collection.⁶¹

Implications for police training and practice

The importance of outlining these policing models is to highlight that many of the concepts underpinning gender-responsive harm reduction policing are already in use by police and law enforcement officers. While some police agencies may not refer specifically to these models by the labels above, the premises underpinning them are generally applied after adapting them for local contexts.

In sum, this training manual draws upon the premises of the models above to encourage policing practices that are effective in protecting the *whole* community by considering the different (and sometimes competing) needs or desires of individuals through consultation, engaging and empowering community members' involvement in problem-solving and explaining justifications for actions and responses to promote transparency and accountability.

51 Tyler and Fagan 2008.

52 Paternoster et al 1997.

53 Tyler 2006.

54 Wood et al 2020.

55 Alderson and Perrone 2019.

56 Nalla and Madan 2011.

57 Innes 2005.

58 Innes 2005.

59 Footer et al 2020. p. 9.

60 New South Wales Police Force 2013. p. 3.

61 Ibid.

Important principles and methods

Evidence-based policing

Evidence-based policing is an approach that emphasises using research evidence to underpin policing efforts and crime prevention effectiveness.⁶² Sherman described this approach as relying on the principles of using evidence to change policing practices and evaluate their effectiveness.⁶³ Pepper et al argue that evidence-based policing can better inform how to deploy scarce organisational resources, investigative processes and complex decision-making.⁶⁴ The College of Policing (UK) has adopted an ATLAS approach to encourage officers to: 1) Ask questions that challenge current practices; 2) Test and critically evaluate existing research and new ideas; 3) Learn from existing approaches and new ideas while considering how they work in workplace practices; 4) Adapt practices and policies using the best evidence available; and, 5) Share the outcomes across the service.⁶⁵

Evidence from research on HIV prevention through harm reduction approaches has demonstrated the negative impacts of some policing and law enforcement approaches which increase HIV risk, as well as evidence that police can act in ways that significantly reduce harm. For example, police actions can increase HIV risk for sex workers through confiscating condoms which may contribute to unprotected sex.⁶⁶ Moreover, training and sensitising police to harm reduction approaches is also an evidence-based way to increase police support for the interventions.^{67 68}

Training police officers to better understand their role in shaping HIV spread and prevention among people who inject drugs (PWID), sex workers and other key affected populations is effective in changing police officers' knowledge, attitudes and behaviours towards supporting public health approaches to prevent and reduce HIV transmission.⁶⁹

Gender mainstreaming

Gender mainstreaming is a process to ensure the implications for women and men are assessed in any planned action, including legislation, policies or programmes, in all areas and at all levels. While gendered policing described above refers to certain strategies in terms of deployment of women (including transgender women) police and responding to the needs of women and people with intersectional identities in the community in targeted ways. Transgender police officers are being deployed in some countries across the world, including in Tamil Nadu, India.⁷⁰ Gender mainstreaming refers to an overarching lens that cuts across all policing models and approaches.

Sex-disaggregated data

The collection, analysis and interpretation of sex-disaggregated data is essential to promote gender equity and to modify and inform policing and harm reduction responses. For example, police agencies should make informed choices about the recruitment, deployment and promotion of women police so that they are able to assess their capability for providing gender-responsive services. Similarly, agencies should ensure

62 Sherman 1998.

63 Ibid.

64 Pepper et al. 2020. p. 91.

65 Cited in Pepper et al. 2020. p. 92.

66 Footer et al.

67 Mittal et al 2016.

68 Tenni et al 2015.

69 Beletsky et al 2005 and Beletsky et al 2013.

70 India Today 2017.

sex-disaggregated data is collected in their interactions with the community to understand the different circumstances of women and men with regard to individual and community safety.

Human rights-based approaches

Policing and law enforcement activities must uphold and protect the human rights of everyone. Women who use drugs, who also may sell sex, are particularly vulnerable because they are often marginalised socially and economically. Stigmatisation, criminalisation, exclusion and exploitation – including at the hands of police – contravene human rights protections, such as the right to be treated with dignity and respect, and access to appropriate health services and treatment.

Overview of the training manual

This training manual supports the actions of law enforcement agencies to enhance police and law enforcement officers' overall capacity and effectiveness in building capability with respect to gender-responsive harm reduction policing.

Aims

The aims of this training guide is to increase the capacity of law enforcement teams in two overarching ways;

1. To increase participants' understanding of the importance and intersections of gender-responsive HIV prevention, harm reduction interventions and policing approaches.
2. To increase the capabilities of police and law enforcement officers and agencies to adopt gender-responsive harm reduction policing approaches to contribute to improved safety and public health outcomes for women.
3. To strengthen the capacity of police and law enforcement officers to support and partner with work service providers who work with women who inject drugs.

Terminal objectives

The overarching terminal objectives of the modules are as follows:

1. To increase police and law enforcement officer awareness about gender, gender (in)equality and harm reduction approaches relevant to policing strategies and practices.
2. To understand and apply, strategies, procedures and initiatives for gender-responsive harm reduction policing and law enforcement for HIV prevention for women who inject drugs, women who inject drugs and sell sex, women in closed settings, and women who are at-risk of HIV infection from sexual partners.
3. To build the participants' professional skills and knowledge in developing gender-responsive policing approaches that are preventative, not dependent on the criminal justice system, that engage other agencies and communities and reduce long term harms to women who inject drugs.

Additional reading for training police and law enforcement officers

The Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs⁷¹ provides guidance across a range of issues important for a similar audience and may be useful background reading for this women-focused training. The 2014 manual includes:

- **Module 1:** Overview of HIV and AIDS: Epidemiology, Prevention, Treatment and Care
- **Module 2:** Occupational Health and Safety: HIV and hepatitis
- **Module 3:** Overview of the role of law enforcement officials in public health and the importance of working with key populations
- **Module 4:** Risk and Vulnerability: Policing Key Populations and Protecting Human Rights
- **Module 5:** Introduction to drugs, policing and harm reduction
- **Module 6a:** The Comprehensive Package for Prevention of HIV, hepatitis and TB among People who Inject Drugs
- **Module 6b:** What can law enforcement officials do in a drug overdose situation?
- **Module 7:** Law enforcement and the use of discretion, drug diversion programmes and the role of ethical frameworks
- **Module 8:** Creating multi-sectoral partnerships to more effectively work with key populations to enhance the national HIV/AIDS response

Modules from the training manual above are included as suggested readings in relevant sections of this training guide.

Target Audience

The training guide is designed to be delivered to training groups of up to 30 participants of junior, middle and high ranking police and law enforcement officers. It should be made clear at the outset of the training that the content of the training has been endorsed by senior leaders. In order to meet the transformative objectives set in these modules, it is recommended that each workshop includes both male and female participants. It is preferable that the ratio of male and female participants is 50-50%. In many countries in the Asia region, the representation of women police and law enforcement officers is relatively low i.e., between 1-20%.^{72 73} While facilitators may not be able to influence how participants are selected for the training, it is important both men and women are trained because male police are more likely to be working in operational roles where they come into contact with women who use drugs, and women police are essential for providing gender-responsive services.

71 UNODC 2014.

72 Jardine 2018.

73 INTERPOL, UN Women & UNODC 2020.



Modules in this training guide

INTRODUCTORY MODULE:

Course overview and expectations

MODULE ONE:

Introduction to gender-responsive harm reduction policing

MODULE TWO:

Gender-responsive harm reduction for women who inject drugs

MODULE THREE:

Families and sexual partners of women who inject drugs

MODULE FOUR:

Policing and gender-responsive harm reduction

MODULE FIVE:

Harm reduction and women in closed settings

MODULE SIX:

Problem-solving, building partnerships and developing a gender-responsive plan for harm reduction policing

Module Brief: Each brief is a break-down of how the session will be delivered, at the beginning of each brief there will be:

- Module Overview:
- Aim: Based on the training guideline's terminal objectives.
- Learning objectives: A set of learning objectives to achieve the session aim.
- Required material
- Time: The overall time for the session.
- Useful learning materials and resources: A list or table which explains the materials needed for the module and any notes that support the facilitator with preparing them ahead of the module. These resources will also be added to a reference list.
- Case studies and activities: Each module is then broken down into activities which are further broken down into:
 - Purpose: Explaining the purpose of this activity (basically how it relates to the module objectives).
 - Time: The overall time for the activity.
- Facilitator Instructions: A step by step instruction of how to deliver the activity, including any respective timings of each component, including:
 - Action planning or reflection questions (if relevant)
 - Annexes (if required)

Implementation guidance

The first step in preparing a training program should always consist of a Learning Needs Analysis to understand the specific learning needs of the target audience and the capacities to deliver training, and may include:

- Identifying gaps in police knowledge about the purposes of harm reduction programs using a gender perspective;
- Exploring occupational incentives for police to act in contravention of legal harm reduction approaches to prevent HIV infection among women and how to disrupt or change them; and,
- Building levels of police officer confidence and capability to collaborate with harm reduction service providers and women's peer networks.

Importantly, different national and local contexts may mean the learning needs of police and law enforcement officers may vary in focus or depth.

To ensure sustainability of training, agencies should consider a Train the Trainer course to increase local capability in the subject matter.

The curriculum has been designed in-line with meeting the needs of learners with all three main learning preferences; Visual, Audio and Kinaesthetic (tactile learning). A mixed methodological approach has been used, including:

- Visual presentations
- Case Studies
- Reflective questioning

- Interactive group tasks developed around different skill-sets, such as: critical-analysis, problem solving and peer-learning/ sharing

Facilitation

There are a number of key facilitation approaches with respect to training police and law enforcement about gender-responsive HIV prevention approaches in order to successfully deliver the training and to maximise the learning of the participants. Peer-to-peer learning and gender-inclusive facilitation are important principles.

Peer learning refers to peers of the training participants. Within the harm reduction field, peer networks or peer-driven interventions are associated with improving rapport and reach within communities. Similarly, police peer-to-peer learning is also effective. Consequently, having a facilitator or co-facilitator who has policing experience and who has in-depth knowledge of harm reduction and gender-responsive approaches is essential.

The following criteria are recommended for the selection of facilitators based on the content in this manual:

- Role models with expertise in gender-responsive harm reduction interventions: the facilitator must role model respectful behaviour and attitudes towards people of all genders and diverse sexual orientations. They must also role model behaviours and attitudes that support human rights, non-discrimination and gender sensitivity.
- Good communication skills: the trainer must have good communication skills, verbal and non-verbal, and must be comfortable with public speaking.
- Professional experience: it is preferable that the facilitator is a serving or retired police or law enforcement officer. This is important because officers are typically more receptive to learning from their professional peers irrespective of whether they served locally or internationally.

The curriculum advocates a gender-responsive participatory approach; adapting the key principles of adult learning as defined by Malcolm Knowles 'Principles of Adult Learning', through a gender-lens. In taking this approach it is recommended that facilitators recognise the following:

Adults are autonomous and self-directed: the trainer should take on the role of facilitator, supporting the participants (learners) to be proactive partners in the 'learning-journey' of the course. Activities have been designed to enable this through group problem solving, analysis and encouraging peer-learning through group presentations.

This approach requires the participants to feel empowered to do so, in terms of feeling safe, secure and confident to share their opinions, ideas and ask questions. However, gender power dynamics at play within the cultural and professional context may mean that individuals may not feel confident in doing this, e.g., in a training room with a male majority, females may be self-conscious about sharing their ideas. Another example could be in a patriarchal cultural and professional context, male participants may feel uncomfortable discussing topics that require a level of personal reflection on emotions.

The facilitator should give consideration to these dynamics prior to the training, through:

- 1 Understanding the profile of participant group
 - a. Be culturally aware of the context in which the training is taking place and how this may impact on participant dynamics.
 - b. Where possible, carry out a gender-responsive training needs assessment to gather information on participants' goals and expectations of the training, as well as prior experience, qualifications etc. The former can inform adaptations to content or how expectations can be managed. The latter can be used to manage dynamics in terms of encouraging participants with different experience

to work with each other; and also by recognising and drawing on participants' existing expertise - which supports confidence building.

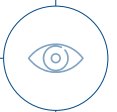
- c. At the beginning of every training course gather participant input on expectations for the course and any concerns participants may have.

2. Devising inclusive strategies

- a. The opening session of every training course should include the development of a set of 'ground rules' identified by the participants. The facilitator should emphasise the importance of women sharing their ideas and knowledge throughout the course.
- b. A facilitator should be constantly aware of the dynamics in a training room, especially with relation to gender. Recognising different personalities and how they are interacting with others will inform what strategies to employ, e.g. gently encouraging quieter participants to engage by asking them questions you are confident they will be able to answer or giving them a role, such as being the scribe in a group activity.
- c. Use strategies for mixing up participants and providing the opportunity for them to work with others throughout the course, e.g:
 - i. Number everyone 1-4, then ask all of the '1's' to work together '2's' etc.
 - ii. Get participants to form a line based on a variable such as how far they have travelled to make the training (the longest distance one and the shortest the other) or the day of the year they were born. Then count them along the line into groups e.g four per group.

IMPORTANT NOTE:

The guide was is primarily geared to police and law enforcement, and aims to support a safe space for police to learn among peers and to explore ideas that they may be hearing for the first time. The guide can also readily be adapted for mixed groups of participants from policing and law enforcement alongside other stakeholders, such as representatives from harm reduction service, peer and outreach workers, civil society and local authorities, among others. This enables participants to learn more from a variety of perspectives.



Evaluation of the training

The training evaluation includes pre and post reflections, as well as gauging how participants felt about the training and its utility in the course of their work. (See Handout 2.1 and Annex 1).

WORKSHOP SCHEDULE			
	Day 1: Policing approaches, Outreach, referral, and gender-based violence	Day 2: Condom negotiation and STIs, pregnancy, children and parents, HIV, safe injection	Day 3: Problem-solving, partnerships and planning
9:00-11:00 2 hrs	<p>9:00-9:10: Welcome from Alliance India</p> <p>9:10-9:30: Introductory Module: Overview of the training guide (and preparation)</p> <p>9:30-11:30: Module 1: Introduction to gender-responsive harm reduction policing</p> <p>Including group exercise on policing models</p>	<p>9:00 – 9:15: Recap of Day 1</p> <p>Module 4: Policing and Gender-Responsive Harm Reduction</p> <p>Part 1: Guest speaker</p> <p>Part 2: Benefits of gender-responsive harm reduction policing. Participatory discussion.</p>	<p>Morning team building exercise</p> <p>Module 6: Problem-solving, building partnerships and developing a gender-responsive plan for harm reduction policing</p> <ul style="list-style-type: none"> • Law and policing practice: ethical decision-making
11:00-11:30	Coffee break	Coffee break	Coffee break
11:30-13:00 1 hr 30 mins	<p>Module 2: Gender-Responsive Harm Reduction for Women who Inject Drugs</p> <p>Part 1: Why does gender matter when working with people who inject drugs? Participatory discussion</p> <p>Part 2: Women who inject drugs and sell sex: gender-specific vulnerabilities and needs.</p>	<p>Module 5: Harm reduction and women in prisons and police custody</p>	<p>Module 6: Problem-solving, building partnerships and developing a gender-responsive plan for harm reduction policing</p> <p>Groups present their implementation plans</p> <p>Closing Remarks</p>
13:00-14:00	Lunch	Lunch	Lunch
14:00-15:30 1 hr 30 min	<p>Module 2: Gender-Responsive Harm Reduction for Women who Inject Drugs</p> <p>14:00 – 14:45: Part 3: What is gender-responsive harm reduction?</p> <p>Group Exercise: video Bevel Up</p>	Site Visit	
15:30-15:50	Coffee break 16:00-16:20	Coffee break	
15:50-17.20 1 hr 30 min	<p>15:50 – 16:20: Module 3: Families and sexual partners of women who inject drugs</p> <p>Group Work:</p>	Site Visit	
17:20-17:30	Day evaluation and closure	Day evaluation and closure	

INTRODUCTORY MODULE:

Course overview and expectations

Module Overview:

Introductions, course overview and participant concerns and expectations.

Module Aims:

- Introduction to the participants
- Provide the participants with an overview of the course
- Allow the participants to introduce themselves
- List the participants' expectations of the course

Module Objectives (enabling):

(there are no learning objectives associated with this module)

Required material: Flip chart or board, markers, sticky notes

Time: 20 minutes

	Content	Time	Method/action	Handouts/aids
1	Facilitators introduction	3'	Presentation	
2	Course overview	4'	Presentation	
3	Introduction of participants and Hopes and Concerns activity	10'	Conversation	Sticky notes, markers and flip chart or board
4	Group dynamics and rules	3'	Conversation	

USEFUL LEARNING MATERIALS AND RESOURCES:

Crofts N., & Patterson, D. (2016). Police must join the fast track to end AIDS by 2030. *Journal of the International AIDS Society*, 19(Suppl 3):21153 doi.org/10.7448/IAS.19.4.21153

OSF. (nd). To Protect and Serve: How police, sex workers, and people who use drugs are joining forces to improve health and human rights. Open Society Foundations. New York.

UNODC. (2014). Training manual for law enforcement officials on HIV service provision for people who inject drugs.



Facilitator Instructions:

A step by step instruction of how to deliver the activity, including any respective timings of each component, including:

1.1 Facilitators introduction

Time: 3 minutes

- Introduce yourself to the participants

1.2 Course overview

Time: 4 minutes

- Briefly explain the context of this training.
- Explain to the participants why this training on gender-responsive policing and law enforcement in the context of public health is important.
- Consider using the elements below:

During this training, we will discuss the role of police and law enforcement officers in protecting public health, specifically with respect to the needs of women at-risk of blood-borne viruses (BBVs), such as HIV, and sexually transmitted infections (STIs).

Most police and law enforcement officers join their organisations because they want to contribute to improving the lifestyles and wellbeing of the community by making people feel safer and helping people.

The aim of this training is to help you and your organisation become more effective in your interactions with women in the community through gender-responsive policing.

In short, gender-responsive policing refers to making sure the police consider the specific impacts of their actions, behaviours, decisions and attitudes on women, men, girls and boys, so that everyone can be treated fairly, irrespective of their gender or other personal circumstances.

This training focuses on women and uses a gender perspective which focuses specifically on women who inject drugs and interrelated risks associated with engaging in sex work, risk of HIV transmission from partners and women in closed settings (e.g. police custody, detention centres and prisons). This includes transgender women, whose inclusion helps to ensure that police and trans-friendly..

We will also explore how to be gender-responsive in building partnerships to encourage policing practices that are effective in protecting the whole community by considering the different (and sometimes competing) needs or desires of individuals through consultation, engaging and empowering community members' involvement in problem-solving and explaining justifications for actions and responses to promote transparency and accountability.

- Present the agenda for the day(s).

1.3 Participant introductions and 'Hopes and Concerns' activity

Time: 10 minutes

This participatory method is useful for the opening session for training where the topic may be sensitive.

- Draw a vertical line down the centre of a flip chart or board at the front of the room
- At the top of one column write the word 'Hopes' and at the other write the word 'Concerns'.
- Hand participants adhesive backed paper notes or alternatively just postcard sized pieces of paper and make adhesive available near the flip chart board so they are able to stick their paper to the flip chart.
- Give each participant 4-6 pieces of paper and ask them to write different ideas on separate sheets.
- For 'hopes' they should write what they are hoping to get from the course e.g. to cover a specific topic, or a learning outcome such as a particular skill acquisition.
- For 'concerns' they should write what concerns they have about the course, in terms of course content or andragogy/methodology e.g. they are concerned it will include role plays or that they won't learn anything new etc.
- Reassure the participants that this is anonymous and encourage them to write whatever they personally think.
- Once all of the participants have finished sticking their paper to the flip chart or board, invite each participant to introduce themselves and ask them to say at least one hope or concern they have of the training that they added to the chart. (It may be useful to ask participants to include their position, rank, place of work and how long they have been an officer.)
- Following the introductions, the facilitator should read through them quietly and see if certain ones can be grouped together generically e.g. if a few people have identified a particular type of delivery method as a concern etc.
- The facilitator should work through the hopes and concerns, managing expectations, affirming hopes where relevant and addressing concerns.

1.4 Group dynamics and rules

Time: 3 minutes

- Explain to the participants that this training is a safe environment where they can speak freely. Ask participants to be respectful and sensitive to the learning process and that there will likely be a range of views discussed by the group.
- Draw the participants attention to the gendered nature of the training. Most police and law enforcement agencies are male-dominated, therefore it is important that the facilitator ensures female participants are encouraged and supported to actively take part in the discussions.
- Consider discussing and determining some of the basic rules to be observed during the training with the group, for example:
 - Question and answer dynamics
 - Appropriate respect for the facilitator, colleagues, guest presenters and any sensitive issues being discussed
 - Use of mobile phones during class times
 - Observing the scheduled class times

MODULE 1:

Introduction to gender-responsive harm reduction policing

Module Overview:

While the adverse consequences of policing and law enforcement activities on HIV risk are well documented, this module is designed to draw attention to recognised policing models which are already in practice (to varying degrees) that facilitate and support the effective operation of harm reduction interventions, particularly for women.

The historical, yet largely unacknowledged, role of police in public health is attracting increasing focus.⁷⁴ However, ensuring police and law enforcement agencies recognise, refine and enhance their capabilities in this field remains a challenge in some contexts.

This module presents a range of policing models that participants worldwide should have some familiarity with, whether by name, premise or methods.

The module has dual purposes for the training: firstly, to ensure participants are engaged through firmly situating gender-responsive harm reduction within current policing strategies and practices, thereby, countering perceptions that harm reduction is “not their job”;⁷⁵ and, secondly, to build the professional skills and knowledge of participants more broadly with regard to theoretical and practical strategies that they can apply to other crime and community safety issues. In this sense, the training functions as both a broad and targeted professional development opportunity, with the final module engaging participants in a group problem-solving exercise using a globally recognised methodology.⁷⁶

Importantly, this module outlines selected definitions and international frameworks as they relate to gender-responsive HIV prevention for police and law enforcement.

Module Aim:

- To introduce a range of policing models already in use which can be adapted and implemented for a gender-responsive harm reduction approach to policing.

Learning Objectives:

At the end of this module, participants will be able to:

- Define gender equality and why understanding gender is important for policing

74 See Global Law Enforcement & Public Health Association, glepha.com

75 LEHRN Partnership 2010.

76 Scott and Clarke 2020.

- Identify international and national legal frameworks and development goals as they relate to health, gender and policing.
- Describe selected policing models and their methods which can contribute to gender-responsive HIV prevention for policing
- Summarise four important principles and methods underpinning gender-responsive harm reduction policing

Required material: sticky notes, markers and flip board or chart, prepared print outs and cut up materials from Annex 2 for group activity.

Time: 90 minutes

	Content	Time	Method/action	Handouts/aids
1.1	Introduction to gender-responsive policing	25'	Presentation, brainstorming & conversation	Handout 1.1 Sticky notes, markers and flip chart or board
1.2	International frameworks for gender-responsive HIV prevention for policing and law enforcement	15'	Presentation & discussion	Handout 1.2
1.3	Important principles and methods underpinning the gender-responsive harm reduction policing	10'	Plenary discussion	
1.4	Gender-responsive HIV prevention for policing: connecting theory and practice	15'	Presentation	Handout 1.3
1.5	Understanding key aspects of the policing models for gender-responsive harm reduction	20'	Group activity & discussion	Materials from Annex 2. Handout 1.4
1.6	Conclusion and reflection	5'	Plenary discussion	

USEFUL LEARNING MATERIALS AND RESOURCES:

DCAF, OSCE/ODIHR, UN Women (2019) “Policing and Gender”, in *Gender and Security Toolkit*. Geneva: DCAF, OSCE/ODIHR, UN Women.

Hansen, F., & Palmer, M. on behalf of Law Enforcement and HIV Network. Statement of Support for Harm Reduction Policing.

INTERPOL, UN Women and UNODC. (2020). Women in Law Enforcement in the ASEAN Region.

OSF (2018). How law enforcement can advance public safety, public health, and public confidence. Open Society Foundations. New York.

Phillips, Sara K. (2018). ASEAN and HIV prevention amongst people who inject drugs: the need for an effective and sustainable response. Briefing paper, International Drug Policy Consortium.

UNODC. (2014). Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs.

- Module 3: Overview of the role of law enforcement officials in public health and the importance of working with key populations



Facilitator Instructions:

1.1 Introduction to the role of police and gender-responsive policing

Time: 25 minutes

- Introduce the focus of the module.
- Ask the participants why gender is important and how it relates to individual police officers' encounters in the community and for their organisation.
- Collect a few answers.
- Use the examples below as prompts if necessary:
 - Women are entitled to the same rights and opportunities as men, including protection from violence (including police violence) and the right to feel safe in the community and at home.
 - Women have the right to education and work, including with police and law enforcement institutions. Women police contribute to operational and strategic capabilities through responding directly to the needs of women and children, and by contributing diverse perspectives to high-level planning, prioritisation and risk assessments.
 - Public confidence and trust in police and law enforcement institutions is increased when people perceive them to be fair and their wellbeing, safety and security needs are met.
 - Share Handout 1.1 on gender definitions and terminology for reference.
- Ask participants to identify some of the roles of police
- Collect a few answers
- Complement and/or summarise with the ideas below.
- Follow up and ask participants to identify some gender-specific roles of police as they pertain to women and girls (if not mentioned already).
- Invite participants to reflect on the changing nature of community expectations of police and the challenges and opportunities this presents.

Table 1.1

Roles of police (briefly)	
<ul style="list-style-type: none"> • To maintain public order and safety • To identify problems and prevent them from becoming more serious crimes or problems for individuals, the community, police or governments • To uphold/enforce the law • To protect the community from violent crime and harm • To detect and investigate crime • To be fair and just • To prosecute suspects/offenders at court • To prevent anti-social behaviour 	<ul style="list-style-type: none"> • To provide assistance to and support victims of crime • To gather information and intelligence • To investigate, disrupt or stop organised crime • To protect human rights • To mediate or help resolve community conflicts or disputes • To support vulnerable people (e.g. people who are homeless, have mental ill-health) • To uphold the human rights of all people (e.g. elderly, children, women, ethnic minorities, lesbian, gay, bisexual, transgender people and other intersectional identities, people in police custody and other closed settings)
Gender-specific roles of police (women and girls)	
<ul style="list-style-type: none"> • Preventing and investigating crimes that specifically target women • Investigating: <ul style="list-style-type: none"> • Domestic/intimate partner violence • Sexual assault and rape • Harassment • Stalking • Human/sex trafficking 	<ul style="list-style-type: none"> • Responding to female suspects and offenders • Ensuring policing services and responses are gender-sensitive, i.e., ensuring women police are always present for interactions with female survivors, victims, witnesses and suspects • In criminalised environments, women who use illicit drugs and sex workers • “Honour” based violence/killings • Infanticide • Child marriage • Child abuse and rape

1.2 International frameworks for gender-responsive HIV prevention for policing and law enforcement

Time: 15 minutes

- Ask participants which international, regional or national legal frameworks they are aware of that place obligations on nation states which relate to women and policing/criminal justice. Facilitators should familiarise themselves with the particular country context they are delivering the training in for regional and national legal frameworks.
- Collect a few answers.
- Refer to slide and provide overview of frameworks.
- Draw participants attention to the Code of Conduct for Law Enforcement Officials and discuss what is included in their agencies Code of Conduct. Ask participants how they make use of their Code of Conduct at work, if at all?

Box 1.1: International instruments and resolutions relevant to gender and policing⁷⁷

- United Nations Security Council Resolution 1325 (2000) on women, peace and security, which, “Urges Member States to ensure increased representation of women at all decision-making levels in national, regional and international institutions and mechanisms for the prevention, management, and resolution of conflict” (operative paragraph 1).
- Universal Declaration of Human Rights (1948): refers to the entitlement of each individual to enjoy their rights and freedoms “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (Art. 2). Article 7 stipulates that “All are equal before the law and are entitled without any discrimination to equal protection of the law.”
- International Covenant on Civil and Political Rights (1966): states that “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (Art. 26).
- Convention on the Elimination of All Forms of Discrimination against Women (1979): all people, regardless of gender, are entitled without discrimination to equal protection of the law.
- Beijing Declaration and Platform for Action (1995): an ambitious agenda for gender equality focused on 12 areas of change, including ending violence against women and girls.
- Code of Conduct for Law Enforcement Officials, UN General Assembly Resolution 34/169 (1979) and UN Guidelines for the Effective Implementation of the Code of Conduct for Law Enforcement Officials: all persons have the right to liberty, personal security and freedom of expression. Law enforcement agencies should be representative of, and responsive and accountable to, the community as a whole. Law enforcement should uphold international human rights standards, and their actions should be open to public scrutiny.
- UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985): treat all victims of crime with compassion and respect and protect them from retaliation or further violence. Conduct investigations in ways that do not further degrade those who have experienced violence and provide specialist care for women, including by informing them of support services.

- Ask participants what their understanding is of the United Nations Sustainable Development Goals (SDGs), and how they relate to gender, HIV and policing?
- Provide a brief overview and refer participants to Handout 1.2.
- Explain that these SDG goals and targets can also relate to women in closed settings (e.g. police custody, prisons etc) because access to health services, non-discrimination and justice also apply for incarcerated or detained people

⁷⁷ Adapted from DCAF, OSCE/ODIHR, UN Women 2019. p. 12.

Table 1.2: Sustainable Development Goals and targets relevant to health, gender and policing

Goal	Targets
GOAL 3: Ensure healthy lives and promote wellbeing of all individuals irrespective of age	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
	3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
	3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
GOAL 5: Achieve gender equality and empower all women and girls	5.1 End all forms of discrimination against all women and girls everywhere
	5.2 Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
	5.5 Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life
	5.C Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels
GOAL 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	16.1 Significantly reduce all forms of violence and related death rates everywhere
	16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children
	16.3 Promote the rule of law at the national and international levels and ensure equal access to justice for all
	16.6 Develop effective, accountable and transparent institutions at all levels
	16.7 Ensure responsive, inclusive, participatory and representative decision making at all levels
	16.10 Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements
	16.B Promote and enforce non-discriminatory laws and policies for sustainable development

1.3 Important principles and methods underpinning the gender-responsive harm reduction policing

Time: 10 minutes

Provide an overview of the following:

- **Evidence-based policing:** emphasises using research evidence to underpin policing efforts and crime prevention effectiveness.
- **Gender mainstreaming:** refers to an overarching gender lens that cuts across all policing and law enforcement strategies and functions
- **Sex-disaggregated data:** informs understanding of the needs of women in the community, as well as the internal human resources (women police) to be able to respond effectively.

- **Human rights:** the human rights of individuals must be promoted, respected and enforced, including the right to health.

1.4 Gender-responsive harm reduction policing: connecting theory and practice

Time: 15 minutes

- Facilitators can refer to the introduction of the training guide for more details on the policing models.
- Inform participants that gender-responsive policing and harm reduction policing combines policing models that are already in use by police across the globe and include some of the methods and practices they described in the previous exercise.
- Refer participants to the description of gender-responsive harm reduction policing below and present Figure 1:

Box 1.2: Gender-responsive harm reduction policing

Gender-responsive harm reduction policing describes an approach where police and law enforcement officers draw on their knowledge of the benefits of harm reduction interventions in the context of policing and actively analyse, assess and determine what action, if any, they should take, while taking into account the specific needs and realities of a person’s gender identity (and other intersectional identities) and power differentials in the context of HIV prevention.



Figure 1. Gender-responsive HIV prevention and selected policing models

- Ask participants which policing models they have heard of and to give a brief description about the aims of the model. Invite other participants to complement explanations given.
- Explain and reinforce that the responses given above are already well-recognised approaches in policing. The importance of outlining these policing models is to highlight that many of the concepts underpinning gender-responsive harm reduction policing are already in use by police and law enforcement officers and the aims of the training are consistent with their role in public safety.
- Summarise using the descriptions below.
- Ask the participants which models they think are the most relevant to gender-responsive HIV prevention and consider rotating the nodes on the figure according to their feedback with the most relevant at the top (clockwise).
- Explain that these approaches encourage policing practices that are effective in protecting the whole community by considering the different (and sometimes competing) needs or desires of individuals through consultation, engaging and empowering community members' involvement in problem-solving and explaining justifications for actions and responses to promote transparency and accountability.

1.5. Understanding key aspects of the policing models for gender-responsive harm reduction

Time: 20 minutes

- Divide participants into 4-6 groups
- Give each group the prepared paper cut outs from Annex 2, ensuring each group has a full set of each policing model.
- Ask each group to identify the correct name, aims and examples of the policing models so they have three pieces of paper for each model:
 - Strategy/model name
 - Aims
 - Example methods
- Inform the groups that they have 20 minutes to correctly group the policing models
- After 20 minutes has elapsed, it is time for participants to report the results back to the group.
- Invite each group and their nominated speaker to present their results. Invite other groups to contribute more ideas, ask questions or seek clarifications about the similarities and differences of the policing models.

Table 1.3: Facilitator’s guide for monitoring and discussion for group activity

Strategies that inform gender-responsive harm reduction policing		
Strategy name	Aims	Example methods
Harm reduction policing	To apply policing approaches which contribute to supporting effective public health approaches to HIV prevention	<ul style="list-style-type: none"> • Engaging with harm reduction service providers to understand the impacts of specific policing practices on their ability to operate to optimum capacity • Ensuring peer and outreach workers can provide HIV prevention services without interference • Refer people from key affected populations (e.g. WID, FSWs) to health, housing and social services instead of arrest and prosecution

<p>Problem-oriented policing</p>	<p>To systematically identify and explore underlying causes of problems and develop a response to measure the effectiveness of a targeted policing strategy</p>	<ul style="list-style-type: none"> • Using the SARA problem-solving model (scan, analyse, respond and assess) to systematically determine whether or how to: <ul style="list-style-type: none"> • eliminate or reduce a problem • reduce harm created by a problem • develop more effective responses to the problem, or • remove the problem from the police mandate
<p>Community policing</p>	<p>To involve the community in the co-production of community safety</p>	<ul style="list-style-type: none"> • Listening, responding and engaging with community concerns • Mobilising communities e.g., community groups, advisory committees, partnerships • Co-production of identifying, negotiating and achieving priorities • Decentralised decision-making • Problem solving; local problems, local solutions • Being proactive and accessible to the community through foot patrol, bicycles, door-to-door visits, • Community newsletters, sharing information • Education projects, capacity building, target hardening • Outcome measures, ie. community satisfaction, quality of life indicators, fear of crime
<p>Third-party policing/ partnership policing/ relationship policing</p>	<p>To prevent and control crime through utilising third-parties or multi-agency collaborations to address public safety and security.</p>	<ul style="list-style-type: none"> • Persuading or coercing organisations or non-offending persons to take responsibility for preventing or reducing crime and addressing quality of life issues e.g. business or property owners, health and building inspectors, parents etc. • Uses legal, criminal, civil and regulatory rules and laws • Collaborating with third parties, e.g. government and non-government agencies, communities, businesses etc. • Multi-agency collaborations • Formalising partnerships though e.g. Memorandums of Understanding, Standard Operating Procedures, committees etc.
<p>Gendered policing</p>	<p>To provide gender-sensitive policing services and access to justice for women</p>	<ul style="list-style-type: none"> • Ensuring mechanisms to report crime or safety issues to police are gender-sensitive • Collecting, analysing and sharing sex-disaggregated data • Training and deploying women and gender non-conforming police to respond to women's needs • Examining connections with and impacts of gender-based violence
<p>Trauma-informed policing</p>	<p>To build awareness that recent or childhood trauma can lead to physical and mental ill health, including substance use or risky behaviours</p>	<ul style="list-style-type: none"> • Training police to recognise signs of trauma (e.g. hypervigilance, disengagement, aggression, hostility, trembling, memory gaps, and more) • Training police to respond to individuals they engage with by asking, "What has happened to you?" instead of "What is wrong with you?" • Ensuring contact with the criminal justice system does not further harm or re-traumatise vulnerable people • Ensuring police provide referrals to support services

Restorative justice	To restore victims, offenders and affected communities through community-based responses to injustice	<ul style="list-style-type: none"> • Empowering victims, offenders and affected communities • Ensuring opportunities for healing and forgiveness • Enabling people to take responsibility • Respectful dialogue • Community caring
Procedural justice	To engender public support and cooperation for policing through demonstrating procedural fairness	<ul style="list-style-type: none"> • Treating people with dignity, courtesy and respect • Listening to the community • Fairness • Transparency behind decision-making
Reassurance policing	To reassure the public they are safe	<ul style="list-style-type: none"> • Being known and familiar to the community • Being accessible and approachable • Being visible • Communicating with and providing information about community safety to local communities

1.6 Conclusion and reflection

Time: 5 minutes

- Re-state the learning objectives
- Summarise the key messages of this module and explain how it links to the forthcoming modules

In this module we have explored gender equality, using a gender perspective and discussed in broad terms the approach of gender-responsive harm reduction policing.

The approaches we have discussed can contribute to ensuring policing practices are effective in protecting the whole community by considering the different (and sometimes competing) needs or desires of individuals through consultation, engaging and empowering community members' involvement in problem-solving and explaining justifications for actions and responses to promote transparency and accountability.

Policing models such as community policing, problem-oriented policing and partnership policing are already in use (as participants have likely described during the activities, even if not recognised by name.)

Therefore, these are legitimate approaches to policing which we will discuss more in the forthcoming modules with respect to more specific scenarios to outline the police role in protecting public health, and specifically women at-risk of HIV in this case.



FURTHER READING:

Beckett, Katherine (2015). The Uses and Abuses of Police Discretion: Toward Harm Reduction Policing. *Harvard Law & Policy Review*. Vol 10.

El-Bassel, N., & Strathdee, S. A. (2015). Women Who Use or Inject Drugs: An Action Agenda for Women-Specific, Multilevel, and Combination HIV Prevention and Research. *Journal of Acquired Immune Deficiency Syndromes* (1999), 69 Suppl 2(Suppl 2), S182–S190. doi.org/10.1097/QAI.0000000000000628

International AIDS Society. (2019). Reducing harm: Police as partners in preventing HIV, promoting public health and protecting the human rights of people who use drugs.

Natarajan, M., & Babu, D. (2020). Women police stations: have they fulfilled their promise?, *Police Practice and Research*. doi.org/10.1080/15614263.2020.1809827

Ritterbusch, Amy E, Pinzon Niño, Eliana Lizeth, Reyes Páez, Ricardo Antonio, Pardo Triana, Julie, Jaime Peña, Daniela, & Correa-Salazar, Catalina. (2020). 'I feel safer in the streets than at home': Rethinking harm reduction for women in the urban margins. *Global Public Health*, 15(10), 1479–1495. doi.org/10.1080/17441692.2020.1751234

Restorative Justice/Harm Reduction Pilot Project: Participatory Program Evaluation on Ontario HIV Treatment Network website. Ontario. Accessed 22 September 2020.

Schneiders ML and Weissman A. (2016). Determining barriers to creating an enabling environment in Cambodia: results from a baseline study with key populations and police. *Journal of the International AIDS Society*. 19(Suppl 3) :20878.

Sherman, L. W. (1998). *Evidence-Based Policing*. Police Foundation. Washington.

Tyler, T. R. (2006). *Why people obey the law*. New Haven, CT: Yale University Press.

Tyler, T. & Fagan, J. (2008). Legitimacy And Cooperation: Why Do People Help the Police Fight Crime in Their Communities? 6 *Ohio State Journal of Criminal Law* 231-275.

Vera Institute of Justice (2015). *Building trust through trauma-informed policing*.

Wood, George, Tyler, Tom R, & Papachristos, Andrew V. (2020). Procedural justice training reduces police use of force and complaints against officers. *Proceedings of the National Academy of Sciences - PNAS*, 117(18), 9815–9821. doi.org/10.1073/pnas.1920671117

Handout 1.1

Definitions

Gender equality: refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality does not mean that women and men will become the same but that women's and men's rights, responsibilities and opportunities will not depend on whether they are born male or female.

Gender equity: Gender equity refers to specific measures that are designed to redress historical inequalities between men and women. There are many examples of gender equity and they apply across all sectors. Examples include taking steps to ensure girls and boys and women and men have equal access to health and education opportunities, designating temporary special measures to bring women into decision-making arenas and employment, and/or designing processes to ensure women can safely participate in economic life.

Gender perspective: The term 'gender perspective' is a way of seeing or analyzing which looks at the impact of gender on people's opportunities, social roles and interactions. This way of seeing is what enables one to carry out gender analysis and subsequently to mainstream a gender perspective into any proposed program, policy or organization.

Source: UN Women

Handout 1.2

Box 1.1: International instruments and resolutions relevant to gender and policing⁷⁸

- *Universal Declaration of Human Rights (1948)*: refers to the entitlement of each individual to enjoy their rights and freedoms “without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (Art. 2). Article 7 stipulates that “All are equal before the law and are entitled without any discrimination to equal protection of the law.”
- *International Covenant on Civil and Political Rights (1966)*: states that “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status” (Art. 26).
- *Convention on the Elimination of All Forms of Discrimination against Women (1979)*: all people, regardless of gender, are entitled without discrimination to equal protection of the law.
- *Beijing Declaration and Platform for Action (1995)*: an ambitious agenda for gender equality focused on 12 areas of change, including ending violence against women and girls.
- *Code of Conduct for Law Enforcement Officials, UN General Assembly Resolution 34/169 (1979) and UN Guidelines for the Effective Implementation of the Code of Conduct for Law Enforcement Officials*: all persons have the right to liberty, personal security and freedom of expression. Law enforcement agencies should be representative of, and responsive and accountable to, the community as a whole. Law enforcement should uphold international human rights standards, and their actions should be open to public scrutiny.
- *UN Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power (1985)*: treat all victims of crime with compassion and respect and protect them from retaliation or further violence. Conduct investigations in ways that do not further degrade those who have experienced violence and provide specialist care for women, including by informing them of support services.

78 Adapted from DCAF, OSCE/ODIHR, UN Women 2019. p. 12.

Table 1.2: Sustainable Development Goals and targets relevant to policing, gender and health

Goal	Targets
GOAL 3: Ensure healthy lives and promote wellbeing of all individuals irrespective of age	3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
	3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
	3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
	3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
GOAL 5: Achieve gender equality and empower all women and girls	5.1 End all forms of discrimination against all women and girls everywhere
	5.2 Eliminate all forms of violence against women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
	5.5 Ensure women’s full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life
	5.C Adopt and strengthen sound policies and enforceable legislation for the promotion of gender equality and the empowerment of all women and girls at all levels
GOAL 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	16.1 Significantly reduce all forms of violence and related death rates everywhere
	16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children
	16.3 Promote the rule of law at the national and international levels and ensure equal access to justice for all
	16.6 Develop effective, accountable and transparent institutions at all levels
	16.7 Ensure responsive, inclusive, participatory and representative decision making at all levels
	16.10 Ensure public access to information and protect fundamental freedoms, in accordance with national legislation and international agreements
	16.B Promote and enforce non-discriminatory laws and policies for sustainable development

Handout 1.3

Overview of policing models currently in use which support gender-responsive harm reduction policing

Box 1.2: Gender-responsive harm reduction policing

Gender-responsive harm reduction policing describes an approach where police and law enforcement officers draw on their knowledge of the benefits of harm reduction interventions to prevent HIV in the context of policing and actively analyse, assess and determine what action, if any, they should take, while taking into account the specific needs and realities of a person's gender identity (and other intersectional identities).



Figure 1. Gender-responsive HIV prevention and selected policing models

Handout 1.4

Policing models that underpin gender-responsive harm reduction policing

Harm reduction policing Harm reduction policing seeks to reduce the negative impacts of criminalisation of some behaviours on a wide range of public health and social outcomes. This is achieved through empowering police officers with knowledge and awareness of harm reduction approaches alongside improved understanding of decision-making processes underpinned by an ethics of care, so that police can actively apply approaches that will contribute to reducing harms associated with criminalised behaviours (e.g. drug use, sex work).

Problem-oriented policing (POP) draws greater attention to the end product of policing efforts in order to assess their effectiveness. It encourages police to systematically “identify and appropriately address the underlying factors which make some locations crime ‘hot spots’ and which lead to repeated calls for assistance”, or systematically plan a response to a particular issue of concern.

Community policing involves the participation of the community in co-producing community safety and contributing to determining shared objectives, how police services are delivered and identifying local priorities.

Third-party policing/partnership policing/relationship policing. Third-party policing is where police have the legal authority to partner with or coerce third parties to regulate or intervene in circumstances to produce an outcome. While partnership policing has similarities to third-party policing, it can differ in the extent of formalisation and potential for coercion. Partnerships may be formalised through Memorandums of Understanding, written protocols and other structured forms of engagement which embeds accountability mechanisms, rather than through legislation.

Gendered policing enables women officers to be deployed to provide policing services to their own gender and promotes using a gender lens across all other approaches.

Trauma-informed policing recognises that police come into contact with people who may be vulnerable as a result of recent or past trauma and that police responses must prevent further harm, as well as connect people to appropriate services and supports.

Restorative justice is a community-based response to injustice that is based on principles of non-domination and empowerment. It focuses on restoring victims, offenders and affected communities through healing, responsibility, respectful dialogue, moral learning, community caring and forgiveness.

Procedural justice refers to the perception or demonstration of fairness in policing encounters with the public. Where police demonstrate they are listening to the community, explaining police policies and practices during encounters with the community, and treating people with dignity, courtesy and respect, they are more likely to engender co-operation and support.

Reassurance policing includes reassuring the public they were safe through being visible, accessible and familiar in local neighbourhoods.

MODULE 2:

Gender-responsive harm reduction for women who inject drugs

Module Overview:

This module explains what gender-responsive harm reduction is, and why it is important for police officers to understand it.

Sub-Sections

Module 2 is divided into three parts, as follows:

Part 1: Why does gender matter when working with people who inject drugs?

Part 2: Women who inject drugs and sell sex: gender-specific vulnerabilities and needs.

Part 3: What is gender-responsive harm reduction?

Module Aim:

- To strengthen participants' understanding of the gender-specific challenges that women who inject drugs face, and what gender-responsive harm reduction services are.

Learning Objectives:

In this module, participants will:

- Reflect on biases against women who inject drugs, and preconceived notions that society in general, and police officers in particular, tend to have about women who use drugs
- Have a fundamental understanding of the stigma and discrimination the women who use drugs experience.
- Learn about the gender-specific vulnerabilities and needs that women who inject drugs have.
- Understand how drug use and sex work intersect for women who inject drugs.
- Learn what gender-responsive harm reduction services are.

Required material: flip charts, markers, projector, computer, internet connection (to stream video)

Part 1: Why does gender matter when working with people who inject drugs?

Overview: A guided participatory discussion on gender and injection drug use

Learning Objectives:

In this part, participants will:

- Reflect on biases against women who inject drugs, and preconceived notions that society in general, and police officers in particular, tend to have about women who use drugs
- Have a fundamental understanding of the stigma and discrimination that women who use drugs experience.

Required material: One flip chart, markers.

Time: 35 minutes

	Content	Time	Method/action	Handouts/aids
2.1	Self-reflection	10'	Quiet self-reflection	Handout 2.1: self-reflection questions
2.2	Participatory discussion on gender and harm reduction	20'	Guided discussion using a Powerpoint to pose questions	Flip chart and markers
2.3	Conclusion and reflection	5'	Plenary discussion	

USEFUL LEARNING MATERIALS AND RESOURCES:

Women and Harm Reduction International Network (WHRIN) website <https://whrin.site/>



Facilitator Instructions:

2.1 Self-reflection exercise

- Introduce the focus of the module.
- Explain that we all have biases.
- Explain that the purpose of the exercise is for each participant to reflect on their own biases. Emphasize that the exercise is for self-reflection only and that participants will not be asked to share their observations about their own biases.
- Ask participants to be direct and honest in their answers
- Tell the participants that they have 10 minutes to complete the exercise and ask them to keep their answers so that they can look at them later.

- Distribute Handout 2.1

HANDOUT 2.1

Self-Reflection Questions: How do I feel about women who inject drugs?

1. What are some of my own attitudes about women who inject drugs? What kind of people do I think they are?
2. When I see a woman injecting drugs, do I think about her any differently than when I see a man injecting drugs? What differences are there? Why do I think there are these differences?
3. If I see a pregnant woman injecting drugs, what do I think about her? Why do I think that?
4. If I see a woman who has small children, injecting drugs, what do I think of her? Do I have some idea about the kind of person she is? Why do I think that?
5. What do I think about sex workers who inject drugs?
6. I know that some sex workers also inject drugs. What is the main reason?
7. When I see that a sex worker has been beaten violently, what do I think the reason is? Why do I think that is the reason?

2.2 Participatory discussion on gender and harm reduction

Some things for the facilitator to keep in mind:

- Some people may have no idea what gender means.
- Some people may believe they understand what gender means, but in fact they do not.
- Some people may have very strong feelings about gender, either believing it is an important concept or believing it is not important.
- Even after a trainer explains what gender means, people have preconceptions which they are not willing or able to let go.
- Some people may get angry when the topic of gender is discussed.

The importance of facilitator attitude when discussing gender:

- The attitude of the facilitator is very important.
- Try not to “preach”.
- Allow participants to think through the concept for themselves.
- Give participants time to think about, and if they feel comfortable, to share experiences in which they dealt with gender-specific issues.
- Some participants may think they have never encountered a gender-specific problem, but may later realise that they have.
- Do not get impatient or irritated if participants do not understand or agree on gender.

Remember:

- As the facilitator, remember that you yourself may not have always understood what gender means
- We ALL have things to learn about gender
- Always be respectful, even when you do not agree with someone's opinion
- Listen

Facilitator Instructions:

- In this section, the facilitator will use a series of slides to pose questions.
- Invite a participant to volunteer to write down the group's answers to each question on the flip chart.
- For each question, ask a different participant to volunteer.
- After participants have answered the question, the facilitator will go to the next slide showing the sample answers.
- Congratulate participants when their answers coincide with the sample answers on the slide.
- Ask participants if they agree with the sample answers.

Table 2.1

Questions	Sample Answers
<p>QUESTION 1: What does gender mean to you?</p>	<ul style="list-style-type: none"> • Socially constructed- women are more dependent on men and there are lot of expectations of women-example- women should do all the domestic work • Women have lower social status than men, producing unequal power relations. For example, women have lower status in families, communities and society • Women have less access to and control over resources and they have less of a say in decision-making than men.
<p>QUESTION 2: What are gender stereotypes?</p>	<ul style="list-style-type: none"> • Women are weaker than men, physically, but also mentally and psychologically • Women should be “feminine” • Women are emotional • Women should wear make-up and look pretty • Women should smile and not look angry or sulk • A good woman should be married • A good woman is chaste and faithful • A women should cover her body properly when she goes outside (but a man need not) • A woman who does not act or dress properly is asking to be harassed • Women are sexually passive, men are not
<p>QUESTION 3: What are gender roles?</p>	<ul style="list-style-type: none"> • Women should do all domestic work • A woman should work in the house and not go out to work • A woman should not make more money than her husband • Women should be responsible for childcare • A woman should take care of her family members • A woman should listen more and speak less • A woman is good at jobs like being a secretary, but not good at being the boss • Generally speaking, the work that women do is not at important as the work that men do

<p>QUESTION 4:</p> <hr/> <p>Why does gender matter in health?</p>	<ul style="list-style-type: none"> • Gender stereotypes and roles have led to a systematic devaluing and neglect of women’s health • Health services for women may be less developed • Women may be less able to go to health services • Expectations of chastity may make it difficult for women to access STI services • Women have less control over money and may not have the money to pay for health services • When women are sick, their families may be less willing to pay for health care • Women are expected to be caregivers and may have less access to caregiving for themselves when they are sick
<p>QUESTION 5:</p> <hr/> <p>Why does gender matter for harm reduction services?</p>	<ul style="list-style-type: none"> • Families may be less supportive of their female members, so women have less money to go to rehab or access abortion services • Gender stereotypes make it more difficult for women to go to services • Women who inject drugs might have more diverse needs than men who inject drugs • Women may be more concerned about confidentiality than men so male-dominated services may not suit women
<p>QUESTION 6:</p> <hr/> <p>Do you think there are gender issues in your workplace?</p>	<ul style="list-style-type: none"> • Discuss!

2.3 Conclusion and reflections

Here are some common questions and issues that tend to come up when training on gender:

- Violence is violence. What does it matter if it is gender-based violence or not? Men also experience violence after all. I think we should talk about this.
- I think that women also beat up men. Why should we focus on violence against women?
- Men have a lot of stress at work because they are expected to provide money for their families. This should be recognised and appreciated.
- Due to stress from work and women’s nagging, it is understandable that a man may hit his wife.
- A wife should always be ready to have sex with her husband. It is not acceptable for a wife to refuse.

Part 2: Women who inject drugs and sell sex: specific needs and vulnerabilities

Module Overview: A presentation and video

Learning Objectives:

- Learn about the gender-specific vulnerabilities and needs that women who inject drugs have.
- Understand how drug use and sex work intersect for women who inject drugs.

Required material: computer, projector, internet, handouts

Time: 55 minutes

	Content	Time	Method/action	Handouts/aids
2.4	Presentation on gender-specific needs	20'	PPT	
2.4	Video Balka https://www.youtube.com/watch?v=Z79QGaEqsDM	30'	Video	Computer, projector, internet
2.3	Conclusion and reflection	5'	Plenary discussion	Handout 2.2 Discussion Questions

Facilitator Instructions:

- Use a PPT to introduce gender-specific vulnerabilities and needs.
- Facilitators may need to tailor the presentation of data to the specific audience.
- The sections below detail background information for PPT content for facilitators to consider.

Data

- In all countries of Asia, there are women who inject drugs. As far back as 2002, women injection drug users had been documented in India, Nepal, Pakistan, Bangladesh, Indonesia, Vietnam, Thailand, Sri Lanka, Philippines, Taiwan, Japan and Malaysia.⁷⁹ A year 2000 Rapid Assessment Survey in 14 urban sites across India found that about 8% of drug users were women. Women constituted between 10% and 20% of drug users in Hyderabad, Imphal, Dimapur, Mumbai, Thiruvavthapuram and Goa.⁸⁰ In Manipur, UNODC estimated that approximately 7% of PWID were women in 2006.⁸¹ The numbers of women who use drugs are increasing as is women's representation as a percentage of people who use drugs; the 2020 World Drug Report reports that approximately one third of people who use drugs, are women.⁸² And HRI reports that women account for one fifth of the global estimated number of people who inject drugs.
- In most countries, there are more men who inject drugs⁸³ than women. However, the percentage of people who inject drugs who are women is growing. In Vietnam, a study found that the proportion of PWID who were women increased from 15 to 30% between 1999 and 2004.⁸⁴

79 Reid and Costigan 2002.

80 UNODC ROSA 2002.

81 Chandrasekaran et al 2006.

82 UNODC. World Drug Report 2020, available at <https://wdr.unodc.org/wdr2020/>

83 HRI 2018.

84 Detels 2004.

- There are significantly higher HIV infection rates among women who inject drugs, compared to men who inject drugs. Studies in nine EU countries showed that the average HIV prevalence was more than 50% higher among women who inject drugs than it was among their male counterparts.⁸⁵ A study in Kazakhstan found that WID were 2.5 times more likely to be HIV positive than men who inject drugs.⁸⁶

Gender-specific stigma

- In general, there is greater social stigma around women using drugs than around men. For this reason women are more likely to hide their drug use.
- Parents and siblings are often less supportive of a female family member using drugs than of a man. Therefore a woman drug user may get less family support than a man and may be more likely to hide her drug use from her family.
- Gender-specific stigma about drug use decreases women's access to harm reduction and other health services. More than men, women fear people finding out that they use drugs, and this makes some women avoid drop-in-centres⁸⁷ and dislike and avoid buying injecting equipment.⁸⁸

Violence

Rates of violence against women (VAW) are universally high

- The most common form of violence experienced by women globally is violence inflicted by an intimate partner.
- Global studies suggest that half of all women who die from homicide are killed by their current or former husbands or partners.
- In one study, 55% to 95% of women who had been physically abused by their partners never contacted the police or other services for help.
- Domestic violence makes it difficult for women to access services and can lead to an increase in risky behaviors.

VAW is higher among women who use drugs

At least one in three women is beaten, coerced into sex or otherwise abused by an intimate partner in the course of her lifetime. Among women who use drugs, the rates are much higher.⁸⁹

- These include rape and gang rape during sex work, intimate partner violence and marital rape, and assault within their own drug using community.

EXAMPLES OF DRUG USE AND VIOLENCE AGAINST WOMEN – VOICES OF WOMEN

“I am a drug user – no one will take me seriously.”

“I cannot go to the doctor. If the doctor finds I am a drug user, he will report me to the police.”

“Everyone knows that I am a sex worker. They will say that I deserve what I got.”

85 European Monitoring Centre for Drugs and Drug Addiction 2006.

86 Bronzan et al 2004.

87 Burns 2009.

88 Hunter and Judd 1998.

89 See, for example, Stoicescu et. al. 2018.

- Women who use drugs may experience violence in their homes. They most often report being beaten by fathers, brothers, and uncles, because of drug use. Fear of domestic violence hinders access to HIV prevention and harm reduction services
- Women who use drugs may experience violence from their husband or sexual partner. Some report violence from partners when their partner is high. Others report violence when they themselves decide to quit drugs.

EXAMPLE: *“I wanted to go to the drug treatment center, but my husband objected. He got angry and hit me. He told me that I should start injecting instead. I refused. I was smoking at the time. But he continued to pressure me and after some time I agreed. Now I inject”.*

- Low social and economic status of women coupled with gender inequality, social norms, and men’s power over women’s sexuality contribute to HIV vulnerability and men’s violence against women in South Asia.⁹⁰

Narender stabbed his wife to death because she refused to give him money for smack. Married for 20 years they had two sons...when she refused to give the money he caught her by the hair, stabbed her three times on her neck...⁹¹

VAW is under-reported, but especially so for women who use drugs

Harsh drug policies make women drug users vulnerable to assault, including sexual assault, from police officers.

- Women drug users may be reluctant to access medical or legal services in the event of sexual assault, and this may be especially the case if they are engaged in sex work.
- Women who use drugs often have limited access to police protections and may be fearful of being arrested on drug charges, if they seek police protection from violence.

Gender-specific injection risks

Women who inject drugs tend to have riskier injection behaviours than men who inject drugs.

- Women tend to share injecting equipment more frequently than men, and when women are injecting in a group that includes both men and women, women tend to be “last on the needle.”⁹²
- Many women who inject drugs have husbands or intimate partners who also inject drugs. Women drug users may choose to share needles with their husband or intimate partner as a symbol of trust in the context of their relationship. A woman may also be reluctant to ask her male partner to use sterile injecting equipment because this implies a lack of trust between them.⁹³

90 Kumar and Sharma 2008; Gupta 2002.

91 Extracted from The Hindu, January 2, 2001, reported in Resource Module for Trainers, Centre for Harm Reduction, MacFarlane Burnet Institute 2006. p. 165.

92 Eurasian Harm Reduction Network website.

93 MacFarlane Burnet Institute 2006. p. 170.

- Women are more likely than men to be injected by someone else rather than injecting themselves. Women who share needles in the context of an intimate relationship often (but not always) report having their partner inject them.⁹⁴ Being injected by another person is associated with higher risk of HIV infection (due to higher likelihood of sharing contaminated equipment).
- Women tend to have smaller veins than men and may be more likely to require assistance injecting. In the context of a marriage or other intimate relationship, a woman being injected by her male partner may be part of their relationship.
- Women injectors tend to have significantly weaker access to harm reduction services that can teach safe self-injection.

CASE STUDY

“I started using drugs with my first husband. He was the initiator and he convinced me. I married him and only later found out that he had started using. At first, we had a lot of fights, then I thought that I was going to freak out. So I shot up for the first time. He injected me so that I wouldn’t bug him anymore and we wouldn’t get into fights, and I liked it.” OSF Study, Ukraine

Women who Inject Drugs and Sexual Risks

Women who inject drugs are at risk of sexual transmission of HIV. But in many countries, awareness of sexual risk among women who inject drugs remains low and condom use, particularly in marriage, is also low. Even when women are aware of the risk of sexual transmission of HIV, condoms are rarely used in marriage and women have little power to negotiate condom use with their husband or intimate partner.

The main issues are:

- Women who inject drugs tend to have poor access to important sexual health services, notably STI diagnosis and treatment.
- Women who inject drugs may be reluctant to access STI services if there are requirements to register.
- A study of women drug users at two treatment centres supported by Family Health International in Dhaka, Bangladesh, found that over 50% of the women were positive for syphilis.⁹⁵ A sex worker project in Sonagachi found that women drug users may be especially reluctant to access STI services if there are requirements to register with government health services, as they may fear being identified as a drug user.⁹⁶
- Women lack the power to successfully negotiate condom use with their intimate partner. Women who use drugs may not be in a position to choose whether or not to use a condom in their intimate relationships.⁹⁷

94 Eurasian Harm Reduction Network website.

95 The test used confirmatory testing at intake. Kumar and Sharma 2008.

96 Kumar, Suresh. pers. comm. February 2010.

97 Eurasian Harm Reduction Network website.

LOW CONDOM NEGOTIATION POWER

“Even if I say he will not use. He will ask ‘am I a loafer going after other woman?’
Even if I tell about injecting drugs and condom use he will not use”⁹⁸

- In domestic violence situations, it may not be possible to request a condom be used. Low social and economic status of women coupled with gender inequality and men’s power over women’s sexuality contributes to men’s violence against women in South Asia.⁹⁹
- Women’s economic dependence on men increases their vulnerability to HIV by constraining their ability to avoid risky sex and negotiate safer sex.¹⁰⁰

Reproductive Health

- Women who use drugs may experience a lack of control over their reproductive choices, and may not be in a position to choose whether or not to use a condom.
- Women drug users may be apprehensive about accessing pre and post-natal care.
- Women who use drugs face a range of SRHR barriers. Among these are limited access to contraceptives (research shows that more than 69% of women who inject drugs do not use contraceptive services due to system barriers)¹⁰¹ leading to high rates of unintended pregnancy and abortion;¹⁰² limited access to appropriate ante- and post-natal care and related to this; poor access to antiretroviral therapy (ART) and prevention of vertical HIV transmission services.¹⁰³
- Women who are HIV+ may be especially apprehensive about attending pre-natal services
- A woman who uses drugs can be pressured to abort. This is particularly the case when she is HIV+.

WOMEN AND DRUG USE: EXPERIENCE IN REPRODUCTIVE HEALTH SERVICES

“When I became pregnant, I went to the AIDS Center to discuss my pregnancy with the doctor. I am HIV+. The doctor told me to abort. He said my baby would not be born healthy. He told me that I would not live long enough to care for my baby. I answered that I intended to have my baby. So he did a medical exam. He told me that the fetus was already dead, and that for safety reasons I should have a uterine scrape. I did not believe him. I borrowed some money from my parents and went to a private doctor. He told me my baby was fine. Now I only go to the doctor’s office to pick up my ARVs. I never want to go there.”

Drug Use and Sex Work

Background

- Women who use drugs may also be selling sex to make money to buy drugs or directly in exchange for drugs. Women drug users may be selling sex to support themselves, their children, and/or their partner.

98 Kumar, Suresh. 2003. Formative Research Chennai.

99 Kumar, Suresh. 2003. Formative Research Chennai.

100 Kumar, Suresh. 2003. Formative Research Chennai.

101 Uganda Harm Reduction Network 2019.

102 UNODC 2014.

103 Frontline AIDS 2020.

- Research has found that about half of women who inject drugs in Asia also sell sex.¹⁰⁴
- A study of women drug users in Manipur found that 80% of the respondents reported having sex with non-regular partners and two-thirds reported having had sex in exchange for money or drugs.¹⁰⁵ Another study of women drug users in Manipur found that more than half of all respondents reported that they had engaged in sex work for money to purchase drugs (56%), some had exchanged sex more directly for drugs (11%) or gifts (5%).¹⁰⁶ A study of women who use or inject in Morocco found that 95% did sex work (n=52), primarily for money to buy drugs and to support their children.¹⁰⁷
- Studies in Asia have found that some FSWs use drugs. In China, a study of female sex workers in Guangxi found that 80% used drugs.¹⁰⁸ In some parts of Vietnam, studies have found that 50% of women who inject drugs are engaged in sex work—both drug using women who sell sex and sex workers who use drugs.¹⁰⁹ One study in Manipur, found that 19% of female sex workers (and 11% of the clients) self-reported injecting drugs in the previous year.¹¹⁰
- Women who both sell sex and inject drugs have some of the highest rates of HIV infection and sex workers who inject drugs tend to have significantly higher HIV infection rates than those who do not. A study in Manipur found that HIV infection rates among women who both inject drugs and sell sex were 9.4 times higher than among FSWs who do not inject drugs.¹¹¹

Vulnerabilities among women who inject drugs and sell sex:

- Women drug users who exchange sex for drugs may not identify themselves as sex workers, and it may therefore be difficult to provide them with services related to their sex work. One study in the US found that up to 70% of women injectors who exchanged sex for drugs did not self-identify as sex workers.¹¹²
- Violence is one of the primary issues facing sex workers around the world. During the first national sex workers meeting in Bangladesh in 2017, the theme of the conference was violence, chosen by sex workers from around the country because it is the worst issue they face. Violence may take many forms: sex workers worldwide are subjected to physical, sexual, and emotional violence. Perpetrators may include intimate partners, police and military (the State), family, vigilantes, and society. Violence against sex workers (VASW) can occur at work, in the home, or in public.¹¹³
- Women who inject drugs may be forced into sex: Studies in South Asia have found that many women drug users report being forced by their boyfriends or husbands to sell sex in order to supply their male partners with money for drugs.¹¹⁴ A study in Manipur found that 10% of respondents reported being forced into sex either by a boyfriend or another partner.¹¹⁵ Women drug users who are in this situation may have particular difficulties accessing drug treatment—such as detoxification or rehabilitation services—because husbands may depend on their wife’s income from sex work for their drug money, and may therefore not want their wife to enter treatment—and stop sex work.
- Some brothel owners or pimps may introduce women to drug use.
- Women who use drugs and sell sex tend to have low rates of condom use and so are vulnerable to getting infected with HIV by sexual transmission. A study of women who inject drugs in Manipur found

104 Reported in Resource Module for Trainers, Centre for Harm Reduction, MacFarlane Burnet Institute 2006. p. 168

105 Panda et al 2001.

106 Oinam 2008.

107 Burns 2007.

108 Reported in Resource Module for Trainers, Centre for Harm Reduction, MacFarlane Burnet Institute 2006. p. 166

109 Reid and Costigan 2002.

110 NACO 2001.

111 Agarwal et al 1999.

112 Rothenburg et al 2000.

113 The Asia-Pacific Network of Sex Workers 2019.

114 Kumar and Sharma 2008.

115 Oinam 2008.

that only 21% reported regular condom use with a boyfriend or partner, and less than 10% reported regular condom use in sex work.¹¹⁶

- Some women who use drugs and are also sex workers have reported riskier sex as the length of time during which they use drugs increases: Women who have been using drugs and selling sex for longer periods of time report they are less likely to use a condom with clients. Women who have been using drugs and selling sex for extended periods of time tend to report more clients and less condom use.¹¹⁷
- Female sex workers who use drugs may experience stigma about their drug use from non-drug-using FSWs. Some sex workers report a hierarchical divide between sex workers who use drugs and those who do not. Injecting drugs may be highly stigmatised in sex worker communities, and in brothels, injecting drugs may be discouraged or forbidden. Perceptions in brothels and among clients that FSWs who inject drugs are at high risk of HIV and other STIs can have a detrimental effect on brothel business, and this can lead to FSWs who inject drugs being rejected from their places of work. This can lead FSWs who use and inject drugs to hide their drug use as much as possible. And conversely, women who inject drugs and sell sex might be ostracised by other women who inject drugs and don't sell sex
- Women who inject drugs and also trade sex for money or drugs may be more likely to share injecting equipment than WID who do not do sex work.¹¹⁸ Importantly, drug use does not cause a person to sell sex and vice versa.

HIV-related services

- Women drug users have concerns that testing positive for HIV could subject them to stigma of gender, drug use, and a positive HIV status, and they may therefore be especially apprehensive about getting a test for HIV.
- Women who sell sex may be especially worried about getting an HIV test because a positive result can impact their ability to work.
- Women drug users may experience heightened difficulties accessing ARV, including the double stigma of being female and using drugs; heightened stigma if they are sex workers; particular reluctance to register and concerns about confidentiality.
- Women report difficulties meeting costs more often than men. Although HIV testing may be free of charge, transportation costs may be prohibitive, women with childcare responsibilities may not have the time to attend, and fees are often imposed for confirmatory tests and for CD4 and viral load counts.

Facilitator Instructions

Show a video about women who inject drugs.

Suggested videos:

Balka, available

www.youtube.com/watch?v=Z79QGaEqsDM

Video on Afghani women who inject drugs, available

www.youtube.com/watch?v=B0hP1nXkHuE

116 Oinam 2008.

117 Burns 2007.

118 Allan 1994; Ditmore 2013.

Part 3: What is gender-responsive harm reduction?

Module Overview:

A presentation introducing gender-responsive harm reduction and a discussion about women and drug use based on a video – Bevel Up.

Learning Objective:

In this module, participants will:

- Learn what gender-responsive harm reduction services are.

Required material: computer, projector, flipchart, markers

Time: 90 minutes

	Content	Time	Method/action	Handouts/aids
2.7	Presentation	15'	PPT	
2.8	Group Work: Role Plays	45'	Small group work	Handout Flip chart and markers
2.9	Video and discussion: Bevel Up www.nfb.ca/film/bevel_up_drugs_users_and_outreach_nursing/	30'	Watch video and use guiding questions	

USEFUL LEARNING MATERIALS AND RESOURCES:

UNODC (2014) Policy Brief: Women who Inject Drugs and HIV” Addressing Specific Needs.

UNODC and INPUD (2016) Addressing the specific needs of women who inject drugs: Practical guide for service providers on gender-responsive HIV services.



Facilitator Instructions:

2.7 Provide a presentation using the following information:

UNODC, INPUD and WHRIN have identified the following key interventions as part of the package of services to be provided to women who inject drugs:

1. Harm reduction components	2. Interventions responding to the needs of women who inject drugs	3. Key implementation considerations
<p>Needle and syringe programmes (NSPs)</p> <p>Opioid substitution therapy (OST) and other evidence-based drug dependence treatment</p> <p>HIV testing and counselling (HTC)</p> <p>Antiretroviral therapy (ART)</p> <p>Prevention and treatment of sexually transmitted infections (STIs)</p> <p>Condom programmes for people who inject drugs and their sexual partners</p> <p>Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners</p> <p>Prevention, vaccination, diagnosis and treatment for viral hepatitis</p> <p>Prevention, diagnosis and treatment of tuberculosis (TB)</p>	<p>Sexual and reproductive health, including services for STIs and prevention of mother-to-child transmission (PMTCT)</p> <p>Maternal and child health</p> <p>Gender-specific peer education and support</p> <p>Gender-based violence-related services</p> <p>Services tailored for women who inject drugs who are also engaged in sex work</p> <p>Provision of female condoms</p> <p>Parenting support</p> <p>Child care</p> <p>Couples counselling (aimed at ensuring that the responsibility for reducing HIV and health risks is equally shared between both partners)</p> <p>IEC that is specifically relevant to women who inject drugs (including safer injecting and safer sex techniques)</p> <p>Legal aid (attuned to be accessible and relevant to the needs of women who inject drugs)</p> <p>Provision of psychosocial and ancillary services and commodities</p> <p>Income-generation interventions for women who inject drugs</p>	<p>Service delivery and integration</p> <p>Discreet and accessible service locations</p> <p>Women-only spaces and/or times at drop-in centres or separate venues</p> <p>Specific outreach for women who inject drugs</p> <p>Collaboration and cross-referral with programmes addressing sex work and HIV</p> <p>Secondary needle and syringe distribution*</p> <p>Addressing stigma and discrimination</p> <p>Advocacy for improved services and the elimination of policy, legal and social obstacles</p> <p>Resourcing</p> <p>Data</p> <p>Participatory planning, implementation and evaluation</p> <p><i>NOTE: Where interventions listed in columns 1 and 2 of this chart cannot be included on-site, strong referral linkages should be developed with relevant service providers as available.</i></p>

Source: UNODC (2014). Policy Brief: Women who Inject Drugs and HIV: Addressing Specific Needs.

Existing harm reduction services may not be female-friendly.

- Many harm reduction services have primarily male clients and male service providers. Some women drug users may not be comfortable interacting with male service providers and some women have experienced harassment or assault from male service providers and male drug users.
- Women drug users also have gender-specific reproductive health, pregnancy, childcare, and experience with gender-based violence such as sexual assault.
- Many harm reduction services do not provide the gender-specific services that women require and may therefore be unattractive to women. Women drug users may also feel uneasy about coming to a drop-in centre or speaking with a male outreach worker.

Gaps for sex workers

- FSWs who are known to be injecting drugs tend to have less earning power than other FSWs they are thus very motivated to hide their drug use from clients and from the FSW community. This makes it difficult for them to access harm reduction and other drug related services.
- There is significant overlap between women drug user and sex worker communities, but sex worker interventions often do not offer drug-related services, and harm reduction services tend not to provide support for sex workers. This makes it difficult for women who use drugs and sell sex to access all the services they require.

Good Practices

- Ideally, harm reduction and sex worker interventions should be closely linked, either through a referral service or by offering on-site services: harm reduction services at sex worker project sites and sex worker services at harm reduction sites. In practice, there is little documented evidence of services that comprehensively address the needs of women who sell sex and inject drugs, in low resource settings.

GOOD PRACTICE

Sites providing services to sex workers don't always include harm reduction services, and harm reduction services may not be equipped to fully address the needs of women – including sex workers – who use drugs. So, in addition to encouraging and supporting sex worker services to provide harm reduction commodities, it is also important to offer harm reduction services through referral by SRHR/HIV service providers or outreach services; harm reduction service sites (such as drop-in centres); or through outreach to brothels and street-based locations frequented by sex workers.¹¹⁹

Making harm reduction services women-friendly

- Provide women-friendly outreach kits that can include tampons, sanitary pads, and female-specific literature, supplies for children, along with needles, syringes, male and female condoms.
- Offer secondary needle and syringe services (extra needles and syringes for women to pass on to others) on-site and via outreach is a good way to reach women as well.
- Have a female doctor available and a gynaecologist
- Offer childcare on-site
- Provide referral services to female-specific services such as gender-based violence counselling, pre- and post-natal care, child health care, and women's shelters.
- Outreach services can also work with women who inject drugs to support women's negotiation skills to engage in safer drug use and safer sex.
- Home visits via outreach can also provide opportunities to reach out to female care-givers.
- Offer services that specifically address women's vulnerability to parenteral HIV infection including simple instructions on safe-injection techniques offered to women in a gender-sensitive manner. Because women are less likely than men to access services that provide information on safe injecting

119 UNODC, INPUD & LEAHN 2016.

and teach safe injection, it is especially important for service providers to offer safe-injection instruction when women do access services.

- Opportunities to instruct women on safe-injection include: via outreach, during home-visits, at women-only drop-in-centres, in women-only spaces or time/s within drop-in centres
- Discuss the gender-specific obstacles women face to safe-injection, such as opposition from an intimate partner and lack of direct access to sterile injection equipment, in the context of women's support groups, female outreach and female-safe spaces.
- Provide simple instruction on safe injection to women.

Examples of Good Practice

- A woman-only drop-in centre: The Social Awareness Service Organisation (SASO) in Imphal, Manipur, India, established a drop-in centre (DIC) specifically for women in 2006. Many of the DIC's clients were women drug users who also sell sex.¹²⁰ The DIC had women staff, a woman doctor—who was particularly welcomed by clients, provides referral to women-specific services, offers recreational activities including TV, newspapers and women's magazines, and space for socializing. Women have space to bathe and make-up kits are provided. Women received standard harm reduction services including needles and syringes, health check-ups and medicines, clinic-based detoxification, overdose management and medicine, counselling. In addition, the DIC provides a number of gender-specific services for women such as referrals to reproductive health services, antenatal care and PMTCT/HIV-related care, as well as support groups for WLHIV, women IDU, SWs, and adolescent girls. The DIC has links to two rehabilitation centres that were persuaded to accept women.¹²¹
- Providing services for women at a drop-in centre that is primarily attended by men: Drop-in Centres that are already operational and service mainly male drug users can improve female attendance in a number of ways: by providing special times for women only, such as a "ladies night," by providing a separate room for counselling services for women with a female counsellor, by including women on staff, by offering women-only support groups, and by providing on-site gender-specific services for women as described above.
- Female peer outreach workers and meaningful engagement: WID and WUD should be engaged at all points of service delivery, from design, to implementation to monitoring. Outreach is a critical component of any service designed for WID. The key is to meet them where they are—i.e. meet them in the places where they feel safe and comfortable, in their own environment. In some countries there is a belief that peers should not do outreach because this work puts peers at risk of relapse. Peer outreach—WID or former WID for accessing WID clients—is the most effective way to reach vulnerable populations and especially effective for the most hidden and vulnerable populations. In addition, employing peers as outreach workers empowers outreach workers themselves by providing an income-generating opportunity. Peer outreach workers accessing WID should be supported: Legalizing or formalizing the status of outreach workers can give them authority when working with clients and protect them and their clients in cases where they may be approached by police.
- At one project in New Zealand, a "Prostitutes Collective," run for and by sex workers, operates full needle and syringe services at numerous drop in centres around the country. The collective works as an integral part of national NSP and sexual health networks.¹²²
- In Canada, a "street nurse" program Associated with Vancouver Coastal Health and a project called Sheway provides drug-related HIV services via outreach. Street nurses effectively access WID/FSWs and FSW/WID—although the project's target group is much broader—providing both drug-related

120 HIV/AIDS Alliance in India 2007.

121 HIV/AIDS Alliance in India 2007.

122 Jenkins 2006. p. 172.

and sex work-related services.¹²³ Services are provided in the outreach setting, and via referral to Sheway—a one-stop shop that provides the range of services for women drug users.¹²⁴

- In Dar es Salaam, SALVAGE, a sister organization of the Tanzania Network for People who Use Drugs (TaNPUD), provides buckets, soap and food with other hygiene materials to women who use drugs, along with needles and syringes and face masks during the Covid – 19 pandemic.¹²⁵
- The Metzineres initiative, launched in 2017 in Barcelona, represents a promising model for how harm-reduction programs can provide essential services and support to women and gender non-conforming drug users who have survived situations of violence. Because access barriers and other institutional gaps mean that women and gender non-conforming people who use drugs often do not enter the local health or social services system, the Metzineres project aims to provide services such as shelter, food, counseling, and a needle exchange program. The project has been recognized as a model for harm-reduction practices both within Spain and internationally.¹²⁶

2.8 Role Plays

Divide the participants into groups of 3-5 people each. Provide the following case studies and ask the participants to prepare a role play. Give the groups 20 minutes to prepare their role play. Instruct them to make their role play maximum 5 minutes.

ROLE PLAY 1: (HANDOUT 2.2)

Reshma is a 24 year old woman who has been smoking heroin for 3 years. She has a daughter who is 2 years old. Reshma started smoking with her husband, who works in construction and is often away from home for long periods of time. About one year ago, Reshma's parents discovered she is smoking heroin and her father was very angry. She has had no contact with her parents since that time. Recently Reshma has been feeling sick. She would like to go see a doctor, but she is afraid that if she goes to the hospital, the doctor may find out she is a drug user and report her to the police.

1. What advice would you give to Reshma about going to see the doctor?
2. How would you advise Reshma about her drug use? Who can she see to help her with her drug use?
3. What questions would you ask Reshma to help her care for her daughter?
4. How would you advise Reshma about her fear of being reported to the police?
5. Please develop a short skit in which Reshma goes to see a doctor. What questions would the doctor ask Reshma? How would Reshma react?

123 Wild, N. 2008. Bevel Up: A Documentary Film About Drugs, Users, and Outreach Nursing.

124 Thumath et al 2008.

125 UNAIDS 2020b.

126 WOLA 2019.

ROLE PLAY 2: (HANDOUT 2.3)

Sandya is a 28 year old sex worker. She is married to a man who injects drugs and she has been using drugs for 6 years. She began using heroin with her husband. At first she smoked, but 2 years ago the price of drugs increased and Sandya's husband taught her to inject, as it is cheaper. Sandya has only injected together with her husband. When drugs got more expensive, Sandya's husband could no longer afford drugs for both of them, and Sandya began doing sex work on the side. Recently, Sandya has begun to feel ill very often. She would like to go see the doctor, but is worried the doctor will find out about her drug use and/or sex work. Sandya has never heard of HIV.

1. What questions would you ask Sandya?
2. What advice would you give Sandya?
3. To which services would you direct Sandya?
4. What kinds of support do you think Sandya needs?
5. Please devise a short skit in which Sandya goes for an HIV test. What questions would the doctor ask Sandya? How would Sandya respond?

ROLE PLAY 3: (HANDOUT 2.4)

Aisha is 18 years old, comes from a poor family, and plans to get married soon. Her parents have already arranged her marriage to a man from a wealthy family, and the wedding is due to take place in 2 months time. Aisha's friend recently told her that her fiancé injects drugs. Aisha's parents found out, and they want her to go through with the wedding plans. The marriage plans have already been publicly announced.

1. What advice would you give Aisha and her parents?
2. To which services would you direct Aisha and her fiancé?
3. Please devise a short skit in which Aisha goes to a harm reduction drop in center and meets with a counsellor. What questions would she ask the counsellor? How would the counsellor respond?

ROLE PLAY 4: (HANDOUT 2.5)

Rashida is 31 years old and has 3 children. Recently her husband died, and at that time Rashida found out that he injected drugs and was HIV-positive. Rashida's in-laws found out that their son died of AIDS-related complications and they blamed Rashida for bringing HIV into the family. They have thrown her out of the house, but are keeping the children. Rashida's own parents have refused to take her back. Rashida is now staying at a shelter. She misses her children very much and is also afraid that she may be HIV-positive herself. Recently she was arrested for drug possession and spent a week in jail. After getting out of jail, the shelter refused to allow Rashida to stay there.

1. What advice would you give Rashida?
2. To which medical services would you direct her?
3. What other services does Rashida need?
4. Please devise a short skit in which Rashida goes to talk to the staff at the shelter.

ROLE PLAY 5: (HANDOUT 2.6)

Radha is a 26-year old mother of two sons. She comes from a middle-class family, is a home-maker and does not work outside the house. Radha has never taken drugs, but she has recently discovered that her husband injects drugs. She found out when a friend of his told her. Radha also recently found out that she is pregnant. She has heard that injecting drugs may be at risk of HIV infection and she is very worried that she may be infected and that this could put her baby at risk of HIV infection.

1. What medical services would you advise Radha to attend?
2. What advice would you give her about talking to a doctor?
3. What advice would you give her about talking to her husband?
4. Besides medical services, where else can Radha go for help?
5. Please develop a short skit in which Radha goes to see a doctor. What questions would the doctor ask Radha? How would Radha respond?

2.9 Video and discussion: Bevel Up

- The video has a range of detailed resources and guides that facilitators can draw from to address specific themes depending on the audience needs.



Source: Bevel Up - Drugs, Users and Outreach Nursing
www.nfb.ca/film/bevel-up-drugs-users-and-outreach-nursing/

FURTHER READING:

Gupta, GR. 2002. How men's power over women fuels the HIV epidemic. *British Medical Journal*, 324, pp. 183-184.

Kumar and Sharma. 2008. Women and Substance Use in India and Bangladesh, *Substance Use & Misuse*, 43, pp. 1062-1077.

NSWP & INPUD. (2015). Sex workers who use drugs: Experiences, perspectives, needs and rights, ensuring a joint approach. Briefing paper. The Global Network of Sex Work Projects (NSWP) The International Network of People who Use Drugs (INPUD).

Youth Rise (nd). Ain't I a woman? Recognizing and protecting the rights of young women affected by HIV & drug use.



Handout 2.1

Self-Reflection Questions: How do I feel about women who inject drugs?

1. What are some of my own attitudes about women who inject drugs? What kind of people do I think they are?
2. When I see a woman injecting drugs, do I think about her any differently than when I see a man injecting drugs? What differences are there? Why do I think there are these differences?
3. If I see a pregnant woman injecting drugs, what do I think about her? Why do I think that?
4. If I see a woman who has small children, injecting drugs, what do I think of her? Do I have some idea about the kind of person she is? Why do I think that?
5. What do I think about sex workers who inject drugs?
6. I know that sex workers also inject drugs. What is the main reason?
7. When I see that a sex worker has been beaten violently, what do I think the reason is? Why do I think that is the reason?

Handouts 2.2-6

ROLE PLAY 1: (HANDOUT 2.2)

Reshma is a 24 year old woman who has been smoking heroin for 3 years. She has a daughter who is 2 years old. Reshma started smoking with her husband, who works in construction and is often away from home for long periods of time. About one year ago, Reshma's parents discovered she is smoking heroin and her father was very angry. She has had no contact with her parents since that time. Recently Reshma has been feeling sick. She would like to go see a doctor, but she is afraid that if she goes to the hospital, the doctor may find out she is a drug user and report her to the police.

1. What advice would you give to Reshma about going to see the doctor?
2. How would you advise Reshma about her drug use? Who can she see to help her with her drug use?
3. What questions would you ask Reshma to help her care for her daughter?
4. How would you advise Reshma about her fear of being reported to the police?
5. Please develop a short skit in which Reshma goes to see a doctor. What questions would the doctor ask Reshma? How would Reshma react?

ROLE PLAY 2: (HANDOUT 2.3)

Sandya is a 28 year old sex worker. She is married to a man who injects drugs and she has been using drugs for 6 years. She began using drugs with her husband. At first she smoked, but 2 years ago the price of drugs increased and Sandya's husband taught her to inject, as it is cheaper. Sandya has only injected together with her husband. When drugs got more expensive, Sandya's husband could no longer afford drugs for both of them, and Sandya began doing sex work on the side. Recently, Sandya has begun to feel ill very often. She would like to go see the doctor, but is worried the doctor will find out about her drug use and/or sex work. Sandya has never heard of HIV.

1. What questions would you ask Sandya?
2. What advice would you give Sandya?
3. To which services would you direct Sandya?
4. What kinds of support do you think Sandya needs?
5. Please devise a short skit in which Sandya goes for an HIV test. What questions would the doctor ask Sandya? How would Sandya respond?

ROLE PLAY 3: (HANDOUT 2.4)

Aisha is 18 years old, comes from a poor family, and plans to get married soon. Her parents have already arranged her marriage to a man from a wealthy family, and the wedding is due to take place in 2 months time. Aisha's friend recently told her that her fiancé injects drugs. Aisha's parents found out, and they want her to go through with the wedding plans. The marriage plans have already been publicly announced.

1. What advice would you give Aisha and her parents?
2. To which services would you direct Aisha and her fiancé?
3. Please devise a short skit in which Aisha goes to a harm reduction drop in center and meets with a counsellor. What questions would she ask the counsellor? How would the counsellor respond?

ROLE PLAY 4: (HANDOUT 2.5)

Rashida is 31 years old and has 3 children. Recently her husband died, and at that time Rashida found out that he injected drugs and was HIV-positive. Rashida's in-laws found out that their son died of AIDS-related complications and they blamed Rashida for bringing HIV into the family. They have thrown her out of the house, but are keeping the children. Rashida's own parents have refused to take her back. Rashida is now staying at a shelter. She misses her children very much and is also afraid that she may be HIV-positive herself. Recently she was arrested for drug possession and spent a week in jail. After getting out of jail, the shelter refused to allow Rashida to stay there.

1. What advice would you give Rashida?
2. To which medical services would you direct her?
3. What other services does Rashida need?
4. Please devise a short skit in which Rashida goes to talk to the staff at the shelter.

ROLE PLAY 5: (HANDOUT 2.6)

Radha is a 26-year old mother of two sons. She comes from a middle-class family, is a home-maker and does not work outside the house. Radha has never taken drugs, but she has recently discovered that her husband injects drugs. She found out when a friend of his told her. Radha also recently found out that she is pregnant. She has heard that injecting drugs may be at risk of HIV infection and she is very worried that she may be infected and that this could put her baby at risk of HIV infection.

1. What medical services would you advise Radha to attend?
2. What advice would you give her about talking to a doctor?
3. What advice would you give her about talking to her husband?
4. Besides medical services, where else can Radha go for help?
5. Please develop a short skit in which Radha goes to see a doctor. What questions would the doctor ask Radha? How would Radha respond?

MODULE 3:

Families and sexual partners of women who inject drugs

Module Overview:

This module will introduce participants to the family life of women who use drugs and of the wives of men who use drugs

Module Aim:

- This module will introduce participants to the main challenges women who inject drugs face in their families and the vulnerabilities of women who are married to men who inject drugs

Learning Objectives:

In this module, participants will:

- Gain a broad understanding of the family lives of women who inject drugs.
- Understand how male drug use impacts their wives/partners.
- Learn what kinds of challenges parents who use drugs face and what support they need.

Required material: One flip chart, markers.

Time: 90 minutes

	Content	Time	Method/action	Handouts/aids
3.1	Presentation	15'	PPT	
3.2	Group Work	30'	Small group discussion	Handout 3.1
3.3	Video and discussion	40'	Video and questions	
3.4	Plenary discussion and conclusion	5'	Participants' concluding observations and free discussion	

USEFUL LEARNING MATERIALS AND RESOURCES

Naizindagi (2008). *The Hidden Truth: A study of HIV vulnerability, risk factors and prevalence among men injecting drugs and their wives*, March 2008.



Facilitator Instructions

3.1 Presentation

Marriage and Safe Sex

- In Asian contexts, most people who inject drugs are men and most are married. In India, for example, 43% of people who inject drugs are married or with regular sex partners, according to the National Integrated Biological and Behavioural Surveillance (IBBS) 2014-15.
- Research in India and Pakistan¹²⁷ has found that the majority of HIV-positive men who inject drugs are in discordant marriages—meaning the husband is HIV-positive and the wife is HIV-negative. Men who inject drugs may access HIV testing services and learn their HIV status, but be reluctant to disclose their status to their spouse. In addition, expansion of HIV testing in antenatal settings means that a growing number of wives of men who inject drugs may be accessing HIV testing and learn their status prior to their husband being tested. Preventing HIV transmission to the wives of men who inject drugs and supporting safe sexual practices in marriage thus requires support for disclosure of HIV status in couples affected by drug use, particularly in South Asia.
- A study of men who inject drugs and their sex partners in Chennai found that condoms were not perceived as an important means to protect against HIV, and were used for family planning or during menstruation.¹²⁸
- There is low awareness about sexual transmission in families affected by drug use. Condoms are rarely used. Also, there is a beliefs that condoms are used only with sex workers, and this limits condom use in the context of marriage.

A study in Chennai found that men who inject drugs did not believe they needed to use a condom to keep their wife safe from HIV infection. One man who injects drugs and participated in this study reported: *“Why should I use condom with my wife? She is a good woman.”*¹²⁹

- Wives may wish to request a condom be used but fear that making this request will imply infidelity, and that they may therefore lose their partner.
- A study in Pakistan found that more than 20% of the wives and 30% of the men were not comfortable asking their spouse to use a condom. The main reason given for this by both men and women was that the partner would mistrust the spouse and would become upset.¹³⁰
- A study in Chennai found that many women married to men who inject drugs had unprotected sex with

127 Naizindagi, *The Hidden Truth*. 2008.

128 SAHAI. 2006. Cited in Kumar and Sharma 2008.

129 Kumar, Suresh. 2003. *Formative Research Chennai*.

130 Naizindagi 2008.

their husbands to demonstrate intimacy and trust in the relationship.¹³¹

- Wives may be selling sex to generate income to pay for their husband's drugs and/or to support their families as their husband's income declines. Widows may engage in sex work in order to generate income to look after their families and children.

Family and women's access to services

- A woman's male intimate partner or spouse may oppose her attending harm reduction services: In some cases, her partner may want to hide her drug use and he may attend services, such as needle and syringe programs, himself—bringing supplies back home for his female partner. This practice—while it does serve the useful purpose of providing critical supplies to women drug users—also means that women can be cut off from direct access to services, weakening women's access to and understanding of key HIV messages, as well as to counselling and other important HIV-related services.

Stigma and abuse in families

- Women who inject drugs tend to report poorer relationships with their parents and siblings, than do men who inject drugs.
- The wives of men who inject drugs face significant stigma and discrimination from the general community. Many of them are widowed. Apart from health services, they are urgently in need of support for mental health and living.
- Women who use drugs, may be experiencing physical and psychological abuse from close male relatives--usually spouses, partners and sons, and are increasingly having to take on the responsibility of family breadwinner following the illness and death of drug using partners.

Key HIV-related issues

- Women who are married¹³² to men who inject drugs, are at risk of sexual transmission of HIV.
 - A study in Manipur found that 45% of the wives of HIV+ men who inject drugs were infected with HIV.¹³³
 - A community-based study in Chennai found that 16% of the regular sex partners of HIV+ men who inject drugs, tested HIV+.¹³⁴
 - A Chennai study of men who inject drugs and their regular sex partners also found that 25% of couples were discordant and only the men were positive, and 5% were HIV+ concordant.¹³⁵
- Women are more likely than men to experience negative consequences, such as violence, when they disclose their HIV status: In a Kolkota study, 16.6 % of women reported negative outcomes following disclosure of their HIV-positive status, compared to 11.5 % of men.¹³⁶ Another study found that women particularly feared accusations of infidelity, abandonment, discrimination and violence, and that between 3.5 % and 14.6 % of women reported experiencing a violent reaction from a partner following disclosure.¹³⁷ A study from Lusaka, Zambia, showed that many people expressed worries about

131 SAHAI. 2006. Cited in Kumar and Sharma 2008.

132 'Married' is used here instead of 'partners' or other descriptions, particularly for the South Asian context.

133 Panda et al 2000.

134 Panda et al. 2005.

135 Communication with Suresh Kumar.

136 Taraphdar et al 2007.

137 Medley et al 2004.

sharing HIV test results, such as being ashamed of being HIV positive or of having gone for a test; those who were seronegative said that even going for a test would make their partner suspicious, and some said that they feared blame, abandonment or abuse if their partner found out they were HIV positive. Women more commonly expressed these concerns.¹³⁸ In Zimbabwe, informing husbands was also found to be a major problem for most people with HIV.¹³⁹ The main reasons for non-disclosure were relatively good health and emotional status, denial of diagnosis, fear of rejection, limited knowledge of and belief in strategies to “live positively with HIV,” unacceptability of condoms and safer sex, and women’s economic dependency and lack of power in sexual situations.

- Growing availability of provider-initiated HIV testing in antenatal settings means that the wives of men who inject drugs may be more likely to be tested before their husband: Women who test positive in the antenatal setting may be especially apprehensive to disclose their status to their husband for fear of rejection at an especially vulnerable time—when they are pregnant. In a small study from the Western Cape in South Africa less than 50% of HIV positive women tested in ante-natal care were able to disclose their HIV status to anyone and only a minority of those who did disclose, discussed it with their partner.¹⁴⁰ In a MTCT programme in Botswana, disclosure to partners has also been reported as being low and very few men were either tested together with their wives or agreed to test at a later date.¹⁴¹
- The desire to have children together with limited or no access to modern technologies that allow discordant couples to safely conceive children discourages disclosure (and condom use) in marriage: For some couples, the need to have children may be seen as a greater priority than preventing HIV transmission. Thus HIV positive women may risk HIV transmission to an HIV negative partner or an HIV negative women may risk acquiring HIV transmission from an HIV positive partner.¹⁴² Social beliefs that HIV-positive women should not conceive children or are not capable of caring for a child, also discourage disclosure among women who want to have children. Advanced technologies such as sperm-washing and invitro-fertilization, that allow for safe conception in discordant or HIV-positive couples, are not widely available in low resource settings. Similarly, technologies for assessing viral load counts—key to supporting safe conception in discordant or HIV-positive couples—are not widely available in low-resource settings.

Parenting

- Women who inject drugs may experience pressure to give up their children
- They may choose to give up a child due to lack of resources, homelessness, or unwillingness to care for the child.
- They may encounter financial difficulties to support their children
- They may have difficulty finding care for their children. This is particularly the case if their child is HIV+ because caregivers and nurseries may refuse to accept an HIV+ child.
- They may be engaged in custody battles for their children.
- Their husband or their in-laws may take their child.
- In many countries, women presenting to drug treatment services will often have their children taken away or placed in state custody. This often has little or nothing to do with the quality of their parenting. Rather it is based on stereotypes about drug users in general—that they are unfit parents.

138 Baggaley et al 1997.

139 Meursing and Sibindi 1995.

140 Sixaxhe 2000.

141 Mazhani et al 2000.

142 UNAIDS 2001.

Losing Custody of Children¹⁴³

I am divorced and I had two children. The first is my husband's. My husband was a very bad man. He often beat me and I couldn't stand it. I was desperate and I wanted to get divorced. But he did not agree. It was because his mother, my mother-in-law, wanted to keep my daughter. I didn't want this, but I could not stand the beatings from my husband. So I said OK, and my mother-in-law took my daughter...I miss her a lot...

I have two children. My son—my husband is his father. Now we are divorced. My father took my son and brought him to a shelter for street children, in Tangier. My daughter—my boyfriend is her father. I did not want to tell my family I had her, and I told them that the baby died. In reality, I gave her to a family in Tangier. In that family, they only had boys, and they wanted.

- In many countries maternal drug use (but not paternal drug use) is legal grounds for loss of child custody.
- In the United States, pregnant women who use drugs have been prosecuted under child and fetal abuse laws.¹⁴⁴
- Punitive drug laws lead women to avoid services for fear of losing their children. This increases women's and children's health risks and the likelihood of poor maternal outcomes in pregnant drug using women.
- Women who lose custody of their children experience profound and enduring adverse effects¹⁴⁵ and relapse¹⁴⁶ and overdose rates among women who lose their children are extremely high.¹⁴⁷
- Women drug users with teenage or adult children may have concerns about their children using drugs.

USEFUL LEARNING MATERIALS AND RESOURCES

Australian National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn. 2006 March. www.health.nsw.gov.au/pubs/2006/ncg_druguse.html



3.2 Group Work

Facilitator Instructions:

Divide the participants into three groups. Read out the case study. Then ask each group to consider the questions for their group. Give them 10 minutes to prepare their answers. Then ask each group to present their answers in under 5 minutes. Lead a short concluding discussion.

¹⁴³ Burns 2007.

¹⁴⁴ WHRIN and INWUD 2012.

¹⁴⁵ Harp and Oser 2018; (The) Global Coalition on Women and AIDS 2012.

¹⁴⁶ Thumath et al 2020.

¹⁴⁷ https://www.cbc.ca/listen/live-radio/1-91/clip/15809658?fbclid=IwAR1FhQS_fNhMIWwxv84M-Mcuae8_ZYsVSDEnUkef_1zWSAwuYb2ohHHIMLBI

HANDOUT 3.1**CASE STUDY:**

Maria is married to a man, Rajeev, who injects drugs and they have 2 small children. Rajeev often gets angry and sometimes he beats Maria, or send her out to do sex work to get money to buy more drugs. Maria has also started using drugs but she would like to stop. She has heard about a new methadone program and she would like to start, but she is worried that if people find out she uses drugs, her children may be taken away. One day things are really bad for Maria at home, and she decides that she will go to the methadone program.

QUESTIONS FOR GROUP 1:

Imagine that you are Maria. What will be your main concerns about going to the methadone program? What will you say to the staff at the methadone program when you arrive? What are you hoping the methadone program will do for you?

QUESTIONS FOR GROUP 2:

Imagine that you are an outreach worker and you have been assigned to contact Maria's husband and get his support for Maria to start the methadone program. What will you say to Rajeev? What do you think Rajeev's reaction will be? How can you convince Rajeev that Maria should start the methadone program?

QUESTIONS FOR GROUP 3:

Imagine that you are a law enforcement officer who works in the area where Maria lives. You have found out that Maria and her husband do drugs, and you also know that Maria wants to stop and has gone to the methadone program. What will you do? What is the best way you can support Maria?

3.3 Video

Video and discussion: Bevel Up https://www.nfb.ca/film/bevel_up_drugs_users_and_outreach_nursing/

Facilitator instructions:

Prepare in advance by watching the documentary on YouTube. Select a section of the video that you think will work best for your participants. Consult the accompanying study guide and select a few discussion questions. You can also stop the video after several scenes and ask the participants a series of discussion questions, such as:

1. What do you see happening in this scene?
2. In your view, did the service provider handle the situation well? What were the strengths of the service provider's approach? What could the service provider have done differently?
3. What parts of this scene are useful for your work? Why?

3.4 Plenary discussion and conclusion

Ask the participants to reflect on what they have learned in this module and how they could apply it to their work. Tell them that in the next module, they will work on applying what they have learned.

Handout 3.1

HANDOUT 3.1

CASE STUDY:

Maria is married to a man, Rajeev, who injects drugs and they have 2 small children. Rajeev often gets angry and sometimes he beats Maria, or send her out to do sex work to get money to by more drugs. Maria has also started using drugs but she would like to stop. She has heard about a new methadone program and she would like to start, but she is worried that if people find out she uses drugs, her children may be taken away. One day things are really bad for Maria at home, and she decides that she will go to the methadone program.

QUESTIONS FOR GROUP 1:

Imagine that you are Maria. What will be your main concerns about going to the methadone program? What will you say to the staff at the methadone program when you arrive? What are you hoping the methadone program will do for you?

QUESTIONS FOR GROUP 2:

Imagine that you are an outreach worker and you have been assigned to contact Maria's husband and get his support for Maria to start the methadone program. What will you say to Rajeev? What do you think Rajeev's reaction will be? How can you convince Rajeev that Maria should start the methadone program?

QUESTIONS FOR GROUP 3:

Imagine that you are a law enforcement officer who works in the area where Maria lives. You have found out that Maria and her husband do drugs, and you also know that Maria wants to stop and has gone to the methadone program. What will you do? What is the best way you can support Maria?

MODULE 4:

Policing and gender-responsive harm reduction

Module Overview:

Policing can significantly influence people's access to and uptake of harm reduction services for HIV prevention. Nonetheless, there can be competing incentives for police whereby they may receive recognition or advance their careers for demonstrating competence in regard to 'crime control' through enforcing laws that criminalise behaviours, such as drug use and sex work.

Crucially, policing agencies are increasingly recognising the detrimental effects and costs to the community for pursuing a law enforcement response, where alternative, health-oriented approaches are more effective in securing community safety and wellbeing.

This module includes videos of police describing their support for harm reduction approaches and ethical police interactions with women and people at-risk of HIV infection. Peer-to-peer learning is a powerful strategy for educating police about harm reduction. Similarly, presentations by people with direct experience of using or delivering harm reduction services are central to encouraging direct engagement with policing and de-mystifying any negative preconceptions police may have about the necessity and efficacy of the services. This also sets the scene for a site visit in a forthcoming module – time permitting in the specific training course.

In this module, participants will learn specific approaches, practices, procedures and strategies for gender-responsive harm reduction policing relevant to frontline officers, as well as middle and senior management who are responsible for supervising, mentoring and guiding street-level police.

Module Aim:

Learning Objectives:

By the end of this session the participants will be able to:

- Understand the importance of gender-responsive harm reduction approaches from the perspective of someone with lived experience, a peer or outreach worker or service provider.
- Identify policing practices that hinder or impede the effective operation of harm reduction services for women
- Identify policing practices that facilitate or support the effective operation of harm reduction services for women
- Explore any contradictions, challenges or barriers for police to implement harm reduction approaches, and how to overcome them.

Required material: Videos from links provided below, handouts, any requirements from guest speaker/s

Note regarding inviting a guest speaker/s:

- It is advised that facilitators invite a guest speaker who is a peer or outreach worker, or service provider. It may be appropriate to invite a woman who is an active drug user involved in a national or local PUD/PWIDs network, IF their health and safety can be assured.¹⁴⁸
- If there is a local police officer (serving or retired) who has worked collaboratively with women's harm reduction services, it may be worthwhile inviting them to co-present, if appropriate.

Important facilitator Instructions:

The videos, speakers and case studies in this session aim to stimulate participatory discussions that draw out important strategies, processes and practices for gender-responsive harm reduction approaches for policing and law enforcement. The facilitator should familiarise themselves with the information in Handout 4.1 prior to the session and use it to pose questions and encourage participant-led identification of good practices. The Handout (4.1) can be shared with participants at the end of the discussion for consolidation of learning and as a reference.

Time: 90 minutes

	Content	Time	Method/action	Handouts/aids
4.1	Introduction	10'		
4.2	Videos (1 & 2) of police supporting harm reduction	20'	Video & discussion	Videos from YouTube/ computer & screen
4.3	Guest speaker	40'	Presentation & questions	(Check with speaker)
4.4	Case studies & examples of gender-responsive harm reduction policing	15'	Questions & discussion with guest speaker	
4.5	Conclusion and discussion	5'	Plenary discussion	4.1

USEFUL LEARNING MATERIALS AND RESOURCES:

Monaghan, G., & Bewely-Taylor, D. (2013) Police support for harm reduction policies and practices towards people who inject drugs. Modernising Drug Law Enforcement Report 1. International Drug Policy Consortium.

New South Wales Police Force. 2013. The Needle & Syringe Program: Guidelines for Police. Sydney.

Resourcing Health and Education in the Sex Industry. Ugly Mugs Program, Victoria, Australia. <https://sexworker.org.au/sex-workers/ugly-mugs/>

Sharma, M. and Chaterjee, A. (2012), Partnering with law enforcement to deliver good public health: the experience of the HIV/AIDS Asia Regional Program, *Harm Reduction Journal*, 9:24.

148 For more specific information, see Canadian HIV/AIDS Legal Network 2006, "Consulting with people who use drugs: do's and don'ts", pp. 15-17.

Tenni et al. (2015). Arresting HIV: Fostering Partnerships between Sex Workers and Police to Reduce HIV Risk and Promote Professionalization within Policing Institutions: A Realist Review. *PloS one*, 10(10), e0134900. <https://doi.org/10.1371/journal.pone.0134900>

UNODC. (2014). Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs.

- **Module 4:** Risk and Vulnerability: Policing Key Populations and Protecting Human Rights
- **Module 6b:** What can law enforcement officials do in a drug overdose situation?
- **Module 7:** Law enforcement and the use of discretion, drug diversion programmes and the role of ethical frameworks

Novelty Football Match, Nigeria (2019). See video link in WHRIN report on '16 Days of Action to Eliminate Violence Against Women Who Use Drugs 2019'. <https://whrin.site/campaign/16-days-of-action-to-eliminate-violence-against-women-who-use-drugs-2019/>

See 'Case study: EHRN's Women Against Violence Campaign' cited in UNODC, INPUD & LEAHN (2016). Addressing the specific needs of women who inject drugs: Practical guide for service providers on gender-responsive HIV services. United Nations Office on Drugs & Crime, International Network of People who Use Drugs and Law Enforcement & HIV Network. Vienna. p. 33.

4.1 Introduction

Time: 10 minutes

- Introduce the focus of the module.
- Share the slide with the quote below with participants.
- Ask participants if they have been in any similar scenarios where they have decided not to arrest or investigate someone for drug use? can describe other ways that policing practices can facilitate or support the effective operation of harm reduction services for women. Discuss.

Box 4.1: Example of police supporting women who use drugs in Uganda¹⁴⁹

One day, a lady called Mutuli came to my office and said that she wanted to quit heroin use, but that she could not. I went with her to the Ugandan Harm Reduction Network and explained her needs to them. I explained how many times we had arrested her, the many times she has been to hospital, but she was failing. They told me about methadone, and opioid substitution therapy, which we did not have. To address this, we have been involved in planning the opioid substitution therapy pilot project.

Commissioner Zarugaba Tinka Ignatius National Police, Kampala, Uganda

4.2 Short videos of police officers supporting harm reduction

Time: 20 minutes

Video 1: (Duration 1:14 minutes).

- Introduce video of retired Police Colonel Gulsara Alieva, Kyrgyzstan, who called on her colleagues – law enforcement representatives – to stop police violence against women who use drugs on the International Day for the Elimination of Violence against Women (November 25).



**Video: Call of Gulsara Alieva, retired police colonel, to her colleagues:
LET'S STOP VIOLENCE!**

Box 4.2: Text of statement by Gulsara Alieva

Dear colleagues,

My name is Gulsara Alieva. I am a retired police colonel and a member of the Law Enforcement and HIV Network. On the International Day for the Elimination of Violence against Women, I would like to draw your attention to the fact that, unfortunately, there are violence cases involving law enforcement as well, such as violence against vulnerable populations. There are examples of forced HIV testing or frivolous arrests of women using drugs. In this regard, I urge you all to express a decided "NO" to this malpractice.

To watch the video statement, please visit the following link:

www.youtube.com/watch?v=hqzUO8yYo8M

Video 2: (Duration: 11 minutes).

- Introduce video with a number of Country Focal Points from the Law Enforcement & HIV Network (LEAHN) sharing their support of harm reduction programs.¹⁵⁰



Video: HIV and harm reduction: policing key populations (Law Enforcement & HIV Network) 2014
www.youtube.com/watch?v=KzeBIYVRIYw

- Example discussion points:
 - Ask participants what they would do if they saw a colleague using violence against a woman? Would they intervene? If so, what would they say or do? (Note: this may be a difficult topic for officers to discuss openly. While it is useful to ask for direct experiences, it may be useful to discuss the issue as a hypothetical scenario).
 - Ask participants what they think about the police in Ghana carrying condoms on duty to give to sex workers? Could participants adopt this approach in their own country?
 - Observe the time allocation here and inform participants that the group discussion can continue following the guest speaker's presentation and the case studies.

4.3 Introduce guest speaker

Time: 40 minutes

- Ensure that you have briefed the guest speaker about the aims of the module and particular areas to address for the participants.
- Introduce the guest speaker as an expert in their field, whether that is being an effective peer or outreach worker, or service provider.
- Remind participants to be respectful while the guest is speaking and to ask questions in an appropriate professional manner.
- Inform participants the guest will speak for 30 minutes (if they prefer), then they will have 30 minutes for discussion and questions.
- Invite the participants to reflect on the guest speakers presentation and ask:
 - What did they learn that surprised them the most?

¹⁵⁰ Law Enforcement & HIV Network (LEAHN) leahn.org
www.youtube.com/watch?v=KzeBIYVRIYw

- Do they feel differently about the issues raised than they did before the presentation?
- What might they do differently with respect to their responses to women who use drugs in the future?

4.3 Case studies and examples of gender-responsive harm reduction policing

Time: 15 minutes

- Invite some participants from the group to read out the following case studies and discuss with the group. Invite input from the guest speaker, if available.
- Using Handout 4.1 as a reference, pose questions to participants to explore their thinking about the benefits or limitations of the approaches in the case studies while reinforcing key practices suited to the ranks and positions of participants. Note that the emphasis here is on operational practices that support and endorse harm reduction, although some institutional considerations may be mentioned (e.g. recruit level curriculum changes).

CASE STUDY 1:¹⁵¹

The Service Workers In Group Foundation (SWING) was established in 2004 to promote and protect the health, human rights and dignity of sex workers.

From its initial focus on the issues that affect male and transgender sex workers, SWING has expanded its coverage over the past 10 years to include programmes and projects for sex workers of all genders and sexual orientations.

SWING currently operates drop-in centres in Bangkok, Pattaya and Koh Samui, all of which provide a range of educational and health-related services to sex workers.

SWING's core services include: a comprehensive outreach programme with health promotion workshops and activities on HIV/AIDS and sexual health delivered within sex industry workplaces, as well as a Non-Formal Education Programme, which enables sex workers to attain a high school certification.

Each police cadet is matched with a SWING staff member who is their "buddy" for the duration of the three week training.

SWING staff members are responsible for mentoring their police cadet buddy, familiarising cadets with SWING's operations and educating cadets about the issues affecting sex workers.



The photograph above depicts police cadets and their SWING staff buddies upon the cadets' successful graduation of the Police Cadet Community Involvement Program.

151 As published in HIV Australia 2013.

SWING recognises that sex workers routinely face stigma, discrimination and human rights violations, such as harassment and violence, and have found it difficult to report such incidents to the police.

In order to improve relations between police and male and transgender sex workers, SWING piloted an innovative and acclaimed project that involved collaborative work with the Thai Police Force to deliver a comprehensive sensitivity training programme for police cadets.

Since its launch in 2005, the internship programme has successfully challenged many of the attitudes of police cadets, and has resulted in an increased recognition and understanding of the issues that affect sex workers.

CASE STUDY 2:

Resourcing health and Education (RhED)¹⁵² and the St Kilda Police Station: partnerships between police and sex worker support organisations

The beach-side inner-city Melbourne (Australia) suburb of St Kilda has long been an area where street-based sex workers are highly visible. Street sex work is criminalised and women who engage in street-based sex work often inject drugs, too.

Over many decades, officers from the St Kilda Police Station have collaborated with health and social services which provide support to local sex workers. This collaboration has resulted in police adopting harm reduction approaches to policing sex work even though it is criminalised, including:

1. During their patrols, police do not target street-based sex workers; however, they may approach them to enquire if they need support or referrals to harm reduction services.
2. Frontline police are encouraged by supervisors to use discretion and not enforce laws or make arrests of sex workers for minor offences.
3. Police do not confiscate condoms or used needles and syringes from sex workers.
4. In circumstances where a sex worker is investigated or charged with an offence, police often liaise directly with their case workers (with permission) to ensure legal obligations are met (e.g. attending court).
5. The relationship between police, sex workers and their case workers has resulted in a practice where police can explain legal processes to case workers who then ensure sex workers are fully informed and understand their rights and legal obligations. Police supervisors assign an investigator to the case who will treat the sex worker sensitively and with respect. Case workers monitor the situation and report any complaints to senior police managers for investigation.
6. A Steering Committee was established in 2020 with police officers, RhED staff, sex workers and other stakeholders to explore the decriminalisation of sex work in Victoria.

¹⁵² RhED. Ugly Mugs Program, Victoria, Australia. <https://sexworker.org.au/sex-workers/ugly-mugs/>

Challenges

While there have been many advances towards improving policing and criminal justice responses to sex work in a the criminalised environment, challenges remain, including:

- Difficulty changing the mindsets of some officers who stigmatise sex workers, particularly if they also use illicit drugs.
- Few police have been trained to provide a trauma-informed response to sex workers/women who inject or use drugs.
- Staff turnover: police officers and case workers can change which disrupts the stability of relationships and the need to continuously work to build trust.
- Resource intensive: liaison and collaboration can require significant investment of time. Limited personnel can impact the scope and consistency of collaboration.
- Police officers from jurisdictions outside St Kilda Police Station may not be aware of the discretionary practices of local police and may enforce legislation that criminalises street-based sex work, therefore, disrupting trust developed between local police and harm reduction and other social services.

The screenshot shows the RhED website header with the logo (a red umbrella over the text 'RhED') and a navigation menu for 'RhED Programs'. The main content area features a dark background with a red banner that reads 'Ugly Mugs'. Below the banner, the text states: 'Violence against sex workers is a crime.' It then describes the Ugly Mugs program as a violence prevention tool for sex workers to share information for safety. It mentions the program's origin in St Kilda in 1988 and its global success. A link to an online reporting form is provided, along with contact information for the RhED team member at 1800 458 752.

The screenshot shows the RhED website header with the logo and 'RhED Programs' navigation. The main content area features a dark background with a red banner that reads 'Arrest Referral Program'. Below the banner, the text describes the Arrest Referral Program (ARP) as a support and advocacy service for individuals charged with drug-related offenses who have linkages with the City of Port Phillip. It notes that ARP partners with the Courts, Victoria Police, Correctional Services, health, community, and legal services using a harm minimisation framework and offers access to free legal advice.

4.5 Conclusion and reflection

Time: 10 minutes

- Re-state the learning objectives
- Summarise the key messages and case studies in this module and explain how it links to the forthcoming modules

In this module we have heard first hand about the impacts and benefits of specific police responses with respect to gender-responsive HIV prevention.

It is important to recognise that police constantly make decisions about the nature of their engagement with women who use drugs and the services that support them. In some cases, actively deciding to facilitate referring women to housing, social and support services is the most appropriate way to decrease harm in both the short and long term.

FURTHER READING:

Hayashi, Kanna, Ti, Lianping, Fairbairn, Nadia, Kaplan, Karyn, Suwannawong, Paisan, Wood, Evan, & Kerr, Thomas. (2013). Drug-related harm among people who inject drugs in Thailand: summary findings from the Mitsampan Community Research Project. *Harm Reduction Journal*, 10(1), 21–21. <https://doi.org/10.1186/1477-7517-10-21>

Alliance India. (2018). WINGS of hope for Women who use drugs (WUDs). www.allianceindia.org/wings-hope-women-use-drugs-wuds-2/

Logie, C. H., Lacombe-Duncan, A., Kenny, K. S., Levermore, K., Jones, N., Marshall, A., & Newman, P. A. (2017). Associations between Police Harassment and HIV Vulnerabilities among Men Who Have Sex with Men and Transgender Women in Jamaica. *Health and human rights*, 19(2), 147–154.

Lunze, K., Raj, A., Cheng, D. M., Quinn, E. K., Lunze, F. I., Liebschutz, J. M., Briden, C., Walley, A. Y., Blokhina, E., Krupitsky, E., & Samet, J. H. (2016). Sexual violence from police and HIV risk behaviours among HIV-positive women who inject drugs in St. Petersburg, Russia - a mixed methods study. *Journal of the International AIDS Society*, 19(4 Suppl 3), 20877. <https://doi.org/10.7448/IAS.19.4.20877>

Ratliff, E.A., McCurdy, S.A., Mbwambo, J.K.J., Lambdin, B.H., Voets, A., Pont, S., Maruyama, H., & Kilonzo, G.P. (2013) "An Overview of HIV Prevention Interventions for People Who Inject Drugs in Tanzania", *Advances in Preventive Medicine*, vol. 2013, Article ID 183187, 6 pages <https://doi.org/10.1155/2013/183187>



Handout 4.1

Gender-responsive harm reduction for policing	
Interacting with women who inject drugs and who may also sell sex	<ul style="list-style-type: none"> • Harm reduction interventions encourage women who inject drugs to use sterile needles and syringes, or not to share the needle with others. Therefore, police should not confiscate clean or used needles and syringes from women who inject drugs and dispose of them or use them as evidence for prosecution of drug offences. • All women, and especially sex workers, should have access to condoms and be encouraged to use them. Police should not confiscate condoms from sex workers and they should not be used as evidence to prosecute women for 'prostitution' in criminalised environments. • In some countries, police officers carry condoms with them to give to sex workers to encourage safe sex or have them available in police stations. (This also encourages police officers to have safe sex). • Police should engage with women who use drugs using a trauma-informed response by asking, for example, "What has happened to you?" instead of "What is wrong with you?" • Police should report unethical and illegal conduct to supervisors or independent bodies for investigation: <ul style="list-style-type: none"> • It is illegal and a breach of human rights to demand bribes or sex from women in exchange for fair treatment. • It is illegal and in contravention of police ethics and Codes of Conduct to use violence against women.
Providing referrals to women who inject drugs for social supports, gender-based violence prevention, gender-sensitive harm reduction services and parenting supports	<ul style="list-style-type: none"> • Have a referral list in a prominent place at the police station, available on police employee intranet and a pocket-size version to facilitate timely referrals for women to relevant, targeted services. • Women who use drugs may not report or under-report domestic or intimate partner violence due to fear of being charged for drug use, rather than receiving protection from violence. Police officers can use a problem-oriented policing approach towards prioritising gender-based violence harms over minor matters of illicit drug use and document the reasons for their decision based on harm reduction policing approaches.
Diverting women who inject drugs away from the criminal justice system and incarceration	<ul style="list-style-type: none"> • Police should consider formal or informal diversions/warnings for women who commit minor and non-violent crimes (e.g. personal drug use and possession) based on ethical principles relating to reducing harm to individuals, families and communities. • Detaining women who have young children should be avoided as much as possible (Refer to Bangkok Rules - Module 5). • If a woman is to be held in police custody or detained in a police cell, they should ensure the cell is segregated from men, is clean and hygienic, and that suitable health and medical care is available.
Police patrol and activities near harm reduction services	<ul style="list-style-type: none"> • Police should be aware of the location of harm reduction services in and around their jurisdiction so they can make informed and ethical decisions about conducting police activities and operations in their vicinity. Police should avoid patrolling near harm reduction services so as not to deter clients from accessing them for fear of interference, discrimination or arrest by police. • In the event police have concerns about criminal activity in or near harm reduction services, police should consider contacting the service (where operationally appropriate) prior to conducting searches or investigations at the premises.

<p>Responses to non-fatal drug overdoses</p>	<ul style="list-style-type: none"> • It is imperative that people who use drugs and their networks feel confident to seek health and life-saving support without fear of being arrested or investigated for illicit drug use at a later time. • In an emergency situation where a person has overdosed on drugs, an ambulance or medical help should be called immediately. Where an overdose is non-fatal, the persons' health and wellbeing is the primary and only concern. Police should not be informed or called to the scene. • If an overdose is fatal, police should be called to investigate on behalf of a coroner. • Police should support the procurement and provision of naloxone to the PUD/PWIDs community, outreach workers and harm reduction services, as well as for officers to carry.
<p>Building positive working relationships between police and harm reduction services</p>	<ul style="list-style-type: none"> • Police and harm reduction services should establish formal lines of communication • Develop a Memorandum of Understanding between police and harm reduction services • Adopt Standard Operating Procedures to ensure all parties understand proper processes • Share information about the roles and responsibilities of police, harm reduction services staff and support workers • Host regular meetings to share concerns or raise any issues, especially in the planning stages of establishing a new harm reduction service • Establish rules regarding information sharing that are legal, ethical and respect client confidentiality • Where appropriate, offer internships to police officers to participate in harm reduction service provision or support services to sensitise police to the issues facing women who inject drugs or sex workers (see SWING case study) • Establish gender-sensitive mechanisms for reporting violence against sex workers (see Ugly Mugs case study)
<p>Building trust between police, women who inject drugs and harm reduction services</p>	<ul style="list-style-type: none"> • Establish a police focal point who is able to have an ongoing relationship with harm reduction services • Reduce stigmatising and discriminatory attitudes and behaviour among police towards women who use drugs by: <ul style="list-style-type: none"> • Inviting women who inject drugs/sex workers or their network representatives to deliver presentations to police about their experiences and importance of harm reduction services (where it is safe to do so) • Police can participate in or volunteer for preparing or delivering free food for women who inject drugs alongside harm reduction or social services • Host joint recreational activities e.g. sport, meals, or jointly host events for international days (e.g. International Day Against Drug Abuse and Illicit Trafficking, World AIDS Day) so all parties can get to know each other outside of their usual roles, hierarchies or positions • See the short video on the Novelty Football Match between female police officers and young women who use drugs in Nigeria in the WHRIN 2019 report (see Useful learning materials section). • Participate in community events with equal representation and presentations by police leaders and women who inject drugs, outreach workers or harm reduction providers
<p>Establish an effective complaint system</p>	<ul style="list-style-type: none"> • Work with services to set up a complaint system that is mutually agreed on and continually assess its accountability mechanisms and effectiveness • Establish open communication with local legal services to ensure legal protections for women who inject drugs are upheld

<p>Building public support for harm reduction services</p>	<ul style="list-style-type: none"> • Reassure the community that harm reduction services are legal and have the support of police because they contribute to public health and safety. • Explain to the community that harm reduction services aim to prevent the spread of HIV and other blood borne viruses in the community, as well as provide support for people who inject drugs or sex workers to get health and social supports. • Explain how gender shapes the nature of police responses to crime, health and safety issues in the context of harm reduction • Explain that harm reduction services also collect used needles from public places and dispose of them safely. If a needle cleanup hotline is available, police should provide this to community members to facilitate the rapid collection and disposal of used needles.
<p>Recruit, train and deploy women police for gender-responsive policing</p>	<ul style="list-style-type: none"> • Women police and gender non-conforming officers should be deployed to interact with women who inject drugs, and if necessary, to collect evidence from women (e.g. physical evidence or victim/witness testimony). • Ensure female officers are trained, well equipped and available to respond to the needs of women and families. If there are fewer than 30% women in your police agency, more should be recruited. • Especially in traditional societies, assign women police as focal points for female survivors/victims of crime and witnesses, and establish women’s desks for gender-responsive mechanisms for reporting crimes.
<p>Continuous training and professional development in the context of gender-responsive policing, human rights and HIV prevention</p>	<ul style="list-style-type: none"> • Ensure national-level recruitment and in-service training addressing human rights, gender-responsive HIV prevention services, as well as the intersections of gender-based violence and HIV risk. • Station or unit-based training and mentoring is also recommended, especially where harm reduction services are located nearby. • Ensure officers are educated about ethics and integrity, including skills for preventing and intervening in inappropriate or illegal practices of colleagues.

MODULE 5:

Gender, HIV and closed settings

Module Overview:

This module will cover the basic principles on women in closed settings.

Module Aim:

This model will introduce participants to the gender-specific vulnerabilities and needs that women experience in closed settings and explain the best ways to address those needs.

Learning Objectives:

By the end of this session the participants will be able to:

- Identify the gender-specific vulnerabilities of women in closed settings
- Recognise good practices for women in closed settings

Required material: computer, projector.

Time: 90 minutes

	Content	Time	Method/action	Handouts/aids
5.1	Presentation	20'	PPT	
5.2	An interactive experience to help people understand the circumstances of women who end up in prison for drugs: www.caligtangan.com/	10'	Group activity	
5.3	Video: Orange is the New Black	45'	Group activity	Computer, projector, internet
5.4	Discussion and closing	15'	Plenary presentation	

USEFUL LEARNING MATERIALS AND RESOURCES:

Penal Reform International. (n.d.). Gender-sensitive approach to non-custodial sentences. (Various resources) www.penalreform.org/tools/gender-sensitive-approach-to-non-custodial-sentences/?fbclid=IwAR1zj3PLK6DKUwYmw-AkhhUjHbKPVPAD0TQARG7R6qwFFSiOLRU3tpKBipY

UNODC. (2010). United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules). Resolution 65/229.

UNODC & UNAIDS. (2008) Women and HIV in Prison Settings.

UNODC, ILO, UNDP, WHO, UNAIDS, UNFPA, and UN Women policy brief *HIV Prevention, Treatment, Care and Support in Prisons and Other Closed Settings: A Comprehensive Package of Interventions*.

The Global Fund. (2020). Technical Brief: Addressing HIV and TB in Prisons, Pre-Trial Detention and Other Closed Settings.

Facilitator Instructions:**7.1 Presentation**

Women in prison are at a higher risk of HIV and TB than men in prison and women in the community. The same challenges that lead to women becoming incarcerated are often those that lead to increased HIV infection risks, including punitive laws on sex work and drug use. Their situation is exacerbated by stigma, gender-based violence, inequality, and discrimination. Not only are HIV prevention and care services often poor in prisons, but women's specific health needs, including access to SRH services, are frequently neglected.

~The Global Fund. (2020). Technical Brief: Addressing HIV and TB in Prisons, Pre-Trial Detention and Other Closed Settings.

Deliver a presentation on women's gender-specific vulnerabilities and needs in closed settings, using the following background information:

Women in closed settings have gender-specific vulnerabilities and needs

- Worldwide, women are more often imprisoned for drug offences than for any other crime.¹⁵³
 - Drug couriers frequently use women to carry or smuggle drugs
 - A study in the US found that one in three incarcerated women said they committed an offense in order to get money for drugs.¹⁵⁴
 - A study of female prisoners in the EU found that they are more likely to inject than male prisoners.¹⁵⁵
- Women entering the prison system tend to have poorer health than men.

153 Thailand Institute of Justice 2014.

154 Wolf AM et al. 2007.

155 European Monitoring Center for Drugs and Drug Addiction. Annual Report 2004: the state of the drugs problem in the EU and Norway.

- Many women did not receive adequate health care before incarceration.
- Women tend to have higher levels of mental disorders and depression and levels of self-harm and suicide among women in prison are markedly higher than among men.
- Many women have a history of family violence, sexual assault, adolescent pregnancy, and malnutrition.
- Women are at greater risk of entering prison with an STI such as Chlamydia, gonorrhoea and syphilis, and with HIV.
- For many women entering the prison system, this may be the first time in their life to have access to health care, social support and counselling.¹⁵⁶

Women's gender-specific risks in closed settings

- Women in closed settings are vulnerable to sexual HIV transmission through unprotected sex with male guards, sex work, survival sex, and rape
- Incarcerated women drug users are vulnerable to coercion from prison staff, and report trading sex (unprotected) for drugs.

“An effective system of prison inspection and oversight carried out by an independent body that includes a confidential complaints system is essential in preventing violence and abuse within the prison.”¹⁵⁷

- Because there are comparatively few women's prisons, women convicted of a wide range of offences are often imprisoned together. Because of this, the overall regime for women tends to be dictated by the maximum-security requirements of the few high-risk prisoners. This also impacts underage girls, who may be imprisoned together with adult offenders who have serious long-term criminal histories.
- In addition, the small number of prisons for women often means that women are imprisoned far away from homes and family, making visitation difficult and disrupting family ties.
- Prisons for women are significantly less likely to offer harm reduction services than do prisons for men.
- Imprisonment far from home seriously challenges women's resettlement after release.
- Women prisoners tend to be transferred more frequently than men, disrupting continuity of care.

Children

- Women are generally the primary care-givers for children and when mothers are imprisoned, the impact on children, families and community can be severe.
- In many countries, babies born in prison stay with their mother and young children may accompany their mothers into prison.
- Some prisons have special units for mothers and babies. In others, babies live in prisons with no special provisions from the state.

¹⁵⁶ Noting that in some closed settings (e.g. some prisons, compulsory treatment and 'rehabilitation' centres) these services may not only be unavailable, but the conditions may breach human rights and cause further harm.

¹⁵⁷ Penal Reform International 2007.

- The age of children permitted to stay in prison with their mothers varies. In Europe, 3 years of age is the common limit.
- Imprisonment far from home disrupts a mother's ties with her children outside the prison. Research has shown that maintaining ties with children reduces the chances of a woman prisoner offending upon release.
- In some countries, mothers are temporarily separated (visits stopped) from the children as punishment. This practice strongly affect a woman's physical and mental health and also punishes the child.

Best Practices

1. Health

- Safety and privacy of women should be protected:
- Male officers should not be allowed to perform certain tasks such as pat searching.
- Sex involving staff and prisoners should be prohibited under all circumstances.
- Women who have been sexually assaulted should have access to post-exposure prophylaxis.
- Women in prison should be able to see a doctor without the presence of prison operational staff, because women are less likely to report possible violence and abuse in prison in the presence of operational staff.

2. Self-Harm

- In some prisons, self-harm and attempts at suicide are penalized. Because women are more vulnerable, self-harm is more prevalent among women prisoners, and this practice disproportionately impacts women and exacerbates their mental distress.
- Recommendations:
 - 1. First-night watches
 - 2. Aftercare upon release
 - 3. Post a suicide prevention coordinator in each women's prison

3. Sexual and reproductive health (SRH)

- Subject to the wishes of the woman prisoner, conjugal visits should be available.
- Many prisons fail to deal with women's menstruation. Prisons should provide sanitary napkins, private bathing and washing facilities, proper disposal. In some prisons, sanitary napkins are only available as part of medical supplies and may be withheld as punishment.
- Pregnant women should not be incarcerated except for absolutely compelling reasons.
- Pregnant inmates require a nutritious diet, timely and regular meals, regular exercise, access to obstetric and gynaecological support.
- Delivery in a hospital is the best option.
- The use of shackling during labour should be banned.
- Male non-health care providers must not be present when women are in labour or delivering.

4. Caring for Infants

- Breastfeeding women require appropriate food.
- Meals should be provided regularly and on a flexible schedule.
- Mothers and babies require health checks.
- Where replacement feeding is acceptable, feasible, affordable, sustainable and safe, HIV-positive women should avoid breastfeeding.
- Where replacement feeding is not possible, WHO guidelines recommend exclusive breastfeeding for the first six months with ARV!
- In some prisons, women are discouraged from breastfeeding because this is perceived to interfere with prison routines. This practice should be discontinued.

5. Children

- Consideration of the child's health and well-being should come first.
- Alternatives to incarceration should be considered.
- Facilities should always have good nutrition, decent playing areas and, where appropriate, kindergarten facilities.

6. Key Services

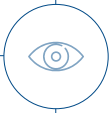
- Regular gynaecological examinations
- STI diagnosis and treatment is critical. Asymptomatic STIs such as Chlamydia enhance HIV transmission.
- Voluntary testing of HIV.
- ARVs and PMTCT. Women in closed settings generally do not have access to ARV.
- Harm reduction services are important for women too, including NSP and OST. Women's prisons rarely have harm reduction services. Little study has focused on women sharing needles in prisons, although women do report needle sharing.
- Care during pregnancy in appropriate accommodations
- Care for children including those born to HIV-positive mothers
- Family planning and counselling services
- Condoms and other contraceptives during detention and prior to parole periods or release

7. Preparing for Release

- Women need access to programmes to prepare them for release, such as life-skills, parenting and health care.¹⁵⁸
- Need for collaboration between prison and civil authorities
- Gender-specific concerns should be addressed: regaining custody of children, housing for newly released women with children, safety from family members who may see the woman as "damaged goods." (Some women have been murdered by family members after release from prison).
- Women particularly need overdose prevention support.

158 UNODC 2016, pp 51-57.

UNITED NATIONAL BEST PRACTICE RECOMMENDATIONS FOR WOMEN INMATES



- Every prison that is required to house women should have a written policy showing that prison practices are gender sensitive and that prison staff have undergone gender training.
- In every prison that houses women there should be an appropriate male-female ratio in prison staff.
- Prisons should be equipped to meet women's special health care needs including STI, pregnancy, PMTCT, childcare, mental distress, and rape-crisis support.
- Female nurses and doctors should attend to women prisoners' health needs. Where this is not possible, male physicians should be chaperoned by having another woman present during health examinations.
- Efforts should be made to protect personal and family relationships including relationships with children in and outside of the prison.
- Non-governmental organizations have an important role to play both inside and outside the prison in supporting family contacts, in preparing women for release, and in supporting women post-release.

5.2. Interactive Activity

- An interactive experience to help people understand the circumstances of women who end up in prison for drugs: www.caligtangan.com/

5.3 Video

Watch an episode of orange is the new black (episode to be identified) and convene a short group discussion using the following guiding questions:

1. What were the main challenges that women prisoners faced in this episode?
2. Did the prison system and staff adequately address those issues?
3. What changes should the prison make to better meet the needs of women prisoners in this episode?

5.4 Wrap up full group discussion

**FURTHER READING:**

Eka Iakobishvili (2012). Cause for Alarm: The Incarceration of Women for Drug Offences in Europe and Central Asia, and the need for Legislative and Sentencing Reform, International Harm Reduction Association.

NoBox Transitions Foundation, Inc., (2019). Women, Incarceration and Drug Policy in the Philippines.

Research reports on women in prison for drug offences in Thailand, Indonesia and the Philippines: <https://idpc.net/policy-advocacy/partnerships/women-incarceration-and-drug-policy-in-south-east-asia>

UNODC. (2008). Handbook for prison managers and policymakers on Women and Imprisonment.

UNODC (2015). Tools and strategies for service providers working with female prisoners.

UNODC. (2014) A handbook for starting and managing needle and syringe programmes in prisons and other closed settings

UNODC (2019) Prevention of Mother-to-Child Transmission of HIV in Prisons: A Technical Guide.

WHO and UNODC. (2011). Women's health in prison, Action guidance and checklists to review current policies and practices.

WHO (2007) Health in prisons A WHO guide to the essentials in prison health

MODULE 6:

Problem-solving, building partnerships and developing a gender-responsive plan for harm reduction policing

Module Overview:

Police have a role in enforcing the law, however, they have a much wider mandate to prevent crime, reduce harm and create a safe environment for the whole community. Police must be skilled at analysing and evaluating information about community concerns or crimes and determining what, if any, immediate action is required, as well as identifying longer term strategies to reduce or remove the underlying causes of the 'problems'. Prevention is more effective than enforcement.

Police worldwide have been adopting a Problem-Oriented Policing approach to address complex recurring problems, including domestic violence, sexual assault, gang and gun violence, and traffic injuries and fatalities. Even in environments that criminalise people who use illicit drugs or engage in sex work, police have a wide range of strategies and tactics to deploy to prevent ongoing harm to individuals and communities. Nonetheless, this requires police to be skilled at problem identification, analysis, response and assessment, as well as ethical decision-making.

This module provides an opportunity for participants to develop their knowledge and skills with respect to Problem-Oriented Policing at the intersection of law enforcement and public health. This approach highlights the importance of undertaking focused action-research which they can also apply to other policing concerns they may face in their work.

Module Aim:

To ensure police and law enforcement officers have the knowledge, skills and tools to apply problem solving strategies, including by building partnerships to support gender-responsive HIV prevention interventions.

Learning Objectives:

By the end of this session the participants will be able to:

- Identify the benefits of gender-responsive harm reduction policing and law enforcement
- Understand and apply the SARA problem-solving method of Problem-Oriented Policing (POP) in the context of gender-responsive harm reduction

- Describe how a range of policing models can be applied to support the effective operation of HIV prevention services for women who use drugs
- Develop a gender-responsive policing plan to support HIV prevention

Required material: butcher’s paper, markers or pens

Time: 2 x 90 minutes (180 minutes)

	Content	Time	Method/action	Handouts/aids
6.1	Introduction	15'	PPT	
6.2	Benefits of gender-responsive policing and law enforcement	45'	Group discussion	
6.3	Developing a problem-oriented policing plan for gender-responsive HIV prevention	60'	Group activity	6.1, 6.2
6.4	Plan presentations	50'	Group activity	
6.5	Conclusions and evaluations	10'	Plenary discussion	

USEFUL LEARNING MATERIALS AND RESOURCES:



Goldstein, H. (2001). “Problem-Oriented Policing in a Nutshell.” Document presented at the 2001 International Problem-Oriented Policing Conference, San Diego, Dec. 7.

Scott, M., & Clarke, R. (2020). *Problem-oriented policing: successful case studies*. Routledge. New York.

Scott, Michael S. 2015. *Identifying and Defining Policing Problems. Problem- Oriented Guides for Police, Problem-Solving Tools* No. 13. Washington, DC: Office of Community Oriented Policing Services.

Thomson, N. et al. (2016). From conflict to partnership: growing collaboration between police and NGOs in countries with concentrated epidemics among key populations. *Journal of the International AIDS Society*, 19(4 Suppl 3), 20939–n/a. doi.org/10.7448/IAS.19.4.20939

UNAIDS. (2018). Gender Assessment Tool: Towards a Gender-Transformative HIV Response.

UNODC. (2014). Training Manual for Law Enforcement Officials on HIV Service Provision for People Who Inject Drugs.

Module 2: Occupational Health and Safety: HIV and Hepatitis.

Module 8: Creating multi-sectoral partnerships to more effectively work with key populations to enhance the national HIV/AIDS response

Facilitator Instructions:

6.1 Introduction

Time: 15 minutes

- Introduce the focus of the module and learning objectives, noting it is a double session.

6.2 Benefits of gender-responsive policing and law enforcement

Time: 45 minutes

- This exercise is to consolidate what participants have learned with respect to gender-responsiveness, HIV prevention, harm reduction approaches and policing strategies and models, in preparation for the group activity.
- Split a flip chart or board into three columns. Add the headings “Individual women”, “Community” and “Police organisation”. Draw a line through the middle and label the top section “Impacts/advantages” and the bottom section “Challenges”.
- Referring to the policing models discussed in previous exercises, ask the participants what are the benefits of gender-responsive and harm reduction policing according to the three columns. Prompts may include:
 - *How might your organisation benefit from being seen as more approachable and trustworthy by women who inject drugs?*
 - *What impact could deploying women police to respond to the needs of women who have experienced gender-based violence, i.e., from an intimate or non-intimate partner?*
- Complement and/or summarise with the ideas in the table below.
- To consolidate participants’ learning, ask them to identify the policing models which underpin the impacts/advantages of gender-responsive policing (note there can be more than one and overlap).

Table 6.1

INDIVIDUALS	COMMUNITY	POLICE ORGANISATION
BENEFITS OF GENDER-RESPONSIVE HARM REDUCTION POLICING		
<ul style="list-style-type: none"> • Reduced blood borne viruses (BBVs), HIV and STIs <i>(Harm reduction policing)</i> • Increased feelings of safety and being supported among women reporting sexual and gender-based violence to police <i>(Harm reduction policing, gendered policing, trauma-informed policing)</i> • Increased confidence and sense of empowerment among women who feel they are treated fairly, with dignity and can contribute to solutions that support themselves and others <i>(Procedural and restorative justice)</i> • Increased access to health, family and social support services due to principles of non-judgement and non-discrimination <i>(Harm reduction policing/ restorative justice)</i> • Human rights are protected <i>(Harm reduction policing/ procedural justice)</i> 	<ul style="list-style-type: none"> • Increased community engagement due to being consulted about local safety and security concerns <i>(Community policing)</i> • Increased community satisfaction due to being informed and understanding reasons for the nature of policing decisions and responses <i>(Reassurance policing)</i> • Increased involvement of and respect for women in decision-making processes with regard to community safety and wellbeing due to being formally included and consulted <i>(Third party policing/partnership policing)</i> • Increased capacity for community-based problem solving through empowering civil society organisations <i>(Community policing, partnership/ relationship policing)</i> • Increased efficiency, effectiveness and satisfaction with the provision of government and non-government funded health and social services. <i>(Harm reduction policing, trauma-informed policing)</i> 	<ul style="list-style-type: none"> • Increased compliance with legislation, policies and codes of conduct which prohibit sex discrimination and require gender-sensitive practices, including ensuring women police conduct searches of women suspects <i>(Gendered policing, procedural justice)</i> • Increased compliance with national and international human rights obligations <i>(Harm reduction policing, procedural justice)</i> • Supports United Nations Sustainable Development Goals 5 (Gender equality) and 16 (Inclusive and just institutions) <i>(Harm reduction policing, gendered policing, partnership policing)</i> • Increased perceptions of legitimacy due to demonstrating fairness and responding to the needs of the whole community, including people who have been marginalised/ stigmatised by police or the community <i>(Harm reduction policing, procedural justice)</i> • More effective crime prevention, control and investigation through increased access to information/intelligence and diverse perspectives <i>(Community policing/ problem-oriented policing)</i> • Increased gender awareness within the police organisation which recognises that women police have a role in providing policing services to their own gender <i>(Gendered policing)</i> • Reduced workload due to transferring or sharing responsibility with other agencies <i>(Third-party policing/partnership policing)</i>

CHALLENGES ASSOCIATED WITH NOT ADOPTING GENDER-RESPONSIVE HARM REDUCTION POLICING

<ul style="list-style-type: none"> • Safety and security needs of women are not addressed • Stigmatized by and discriminated against by police (and others) • Human rights not protected • Limited access to justice • Increase in blood borne viruses (BBVs), HIV and STIs • Access to legal, health and social services is hindered • Entrenched gender inequality • Women are not empowered to make decisions about their own health and wellbeing 	<ul style="list-style-type: none"> • Community environment which tolerates discrimination against women due to observing police abuses and unfair treatment • Women may not feel supported to engage in decision-making processes about community wellbeing and safety • Community-based services for women may be hindered or unable to reach clients 	<ul style="list-style-type: none"> • Distrust in policing and justice system • Complaints about policing practices • Litigation for discrimination/ negligence/ human rights abuses • Negative media coverage of policing • Does not fulfil professional mandate to uphold the law and protect the community • Ineffective at crime prevention, control and investigation • Loss of public confidence and legitimacy due to an inability to meet community expectations • Liability for causing harm to individuals and the community • Loss of community co-operation for crime prevention and intelligence gathering
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- Acknowledge that police already understand and apply some of the policing models and approaches in practice, even though they may have different names for them.
- Reassure participants that the components they have identified are underpinned by policing research, and therefore, are legitimate approaches to policing which they will learn more about in this training.

6.3 Developing a problem-oriented policing plan for gender-responsive HIV prevention

Time: 60 minutes (Note: there will be a coffee break within this session and the group work will continue after the break.)

- Ask participants if they have experience working/collaborating with any harm reduction services (e.g. NSP, OST, outreach services). If yes, ask the participant to describe the nature of the relationship and the extent that it is systematic, formalised or ad hoc.
- Write down any key components (meetings, consultations, standard operating procedures, MoUs).
- Ask the participants if they can identify which policing models these activities or procedures represent. (e.g. community policing, partnership policing, procedural justice).
- Explain to participants that it is their turn to incorporate their knowledge from previous modules and develop a plan for gender-responsive policing for HIV prevention in relation to a scenario they will be given.
- Explain to participants they will have the opportunity to utilise the problem-oriented policing model to develop their plan.

Box 6.1: 10 basic elements of problem-oriented policing¹⁵⁹

Problem-oriented policing is an approach to policing in which (1) discrete pieces of police business (each consisting of a cluster of similar incidents, whether crime or acts of disorder, that the police are expected to handle) are subject to (2) microscopic examination (drawing on the especially honed skills of crime analysts and the accumulated experience of operating field personnel) in hopes that what is freshly learned about each problem will lead to discovering a (3) new and more effective strategy for dealing with it.

Problem-oriented policing places a high value on new responses that are (4) preventive in nature, that are (5) not dependent on the use of the criminal justice system, and that (6) engage other public agencies, the community and the private sector when their involvement has the potential for significantly contributing to the reduction of the problem.

Problem-oriented policing carries a commitment to (7) implementing the new strategy, (8) rigorously evaluating its effectiveness, and, subsequently, (9) reporting the results in ways that will benefit other police agencies and that will ultimately contribute to (10) building a body of knowledge that supports the further professionalization of the police.

- Refer participants to Handout 6.1.
- Ask participants if anyone has used the problem-oriented policing (POP) conceptual model, SARA (Scanning, Analysis, Response, Assessment) before? If yes, ask them to describe their knowledge or experience to the group.
- Summarise the key elements of the SARA Problem-solving Model to the participants.

Box 6.2: The SARA Problem-solving Model¹⁶⁰

A commonly used problem-solving method is the SARA model (Scanning, Analysis, Response and Assessment). The SARA model contains the following elements:

Scanning:

- Identifying recurring problems of concern to the public and the police.
- Identifying the consequences of the problem for the community and the police.
- Prioritizing those problems.
- Developing broad goals.
- Confirming that the problems exist.
- Determining how frequently the problem occurs and how long it has been taking place.
- Selecting problems for closer examination.

¹⁵⁹ Goldstein 2001.

¹⁶⁰ Arizona State University, Center for Problem-Oriented Policing.
<https://popcenter.asu.edu/content/sara-model-1>

Analysis:

- Identifying and understanding the events and conditions that precede and accompany the problem.
- Identifying relevant data to be collected.
- Researching what is known about the problem type.
- Taking inventory of how the problem is currently addressed and the strengths and limitations of the current response.
- Narrowing the scope of the problem as specifically as possible.
- Identifying a variety of resources that may be of assistance in developing a deeper understanding of the problem.
- Developing a working hypothesis about why the problem is occurring.

Response:

- Brainstorming for new interventions.
- Searching for what other communities with similar problems have done.
- Choosing among the alternative interventions.
- Outlining a response plan and identifying responsible parties.
- Stating the specific objectives for the response plan.
- Carrying out the planned activities.

Assessment:

- Determining whether the plan was implemented (a process evaluation).
- Collecting pre- and post-response qualitative and quantitative data.
- Determining whether broad goals and specific objectives were attained.
- Identifying any new strategies needed to augment the original plan.
- Conducting ongoing assessment to ensure continued effectiveness.

- Explain to participants that they will work through each stage of the SARA model with their group to develop a plan to address the scenario (see Handout 6.1).
- Encourage participants to identify which other policing models they will draw upon to develop different stages of the SARA Problem-solving Model (see Handout 1.3 from Module 1).
- Read the following scenarios to all participants.

Table 6.2

SCENARIO 1

Your police station has been receiving complaints that needles and syringes, associated with drug use, have been left on the roadside near the entry to a public park. During the day, the park is used by families and children to exercise and play. You are aware that the area is where street-based sex workers often go to meet clients at night. You remember over-hearing that a needle and syringe program (NSP) opened nearby a few months ago. You find out from your colleagues that the NSP has been approved by the local authorities and senior police officers were informed. However, it appears that no officer from your station has been in direct contact with the NSP. You are concerned that needles and syringes may be harmful to the community and that the NSP will attract more people who use drugs to the area and increase crime. You want to make sure your community is safe, what will you do?

SCENARIO 2

You are driving the police car in an area known for street-based sex work. You and your colleague see three women on the side road. You approach them and ask if they are ok? They seem uncomfortable. You suspect the women are sex workers, but sex work is illegal in your country. You demand the women empty their purses on the ground. You see each of them has a number of unused condoms. You ask the women why they are carrying so many condoms and ask if they are sex workers? One of the women runs away, so you handcuff the other two women. The women admit they are doing sex work because they need money to support their family. You consider charging the women with the crime of 'prostitution' and seizing the condoms as evidence for their prosecution at court. What do you do in this scenario? What can you do to make sure other police have a consistent approach to safeguarding women in these circumstances?

SCENARIO 3

A local lawyer contacts you and asks you to meet them for coffee to discuss some concerns. When you meet the lawyer, they tell you that they have been receiving numerous complaints about male police officers demanding cash bribes from women who use drugs or propositioning them for sex in exchange for not arresting them for minor drug use offences. The lawyer says they have compiled a list of these complaints from women over a two-year period. The survivors/ victims of violence have been reluctant to report the incidents to police because they fear consequences and retaliation. The lawyer indicates the incidents have occurred across the city and is likely to be a widespread problem. As Chief of a major city central police station, what will you do to investigate these accusations that women are being mistreated and exploited?

SCENARIO 4

You are working the night shift and patrol down a laneway where you know people who use drugs and are homeless often sleep. You recognise a woman sitting against the wall as someone you have detained for using drugs in the past. As you approach her, she hides something behind her back. You tell her to show you her hands and she holds out a small wrapped object which she admits to you is a small amount of heroin she was planning to inject. You know that she suffered violence and domestic abuse at home as a child and is estranged from her family. It is illegal to possess heroin and you could arrest her and prosecute her for the offence. Depending on your country context, you may have the option to send her to a detention centre for "treatment" or "detoxification". The woman is not the only person in your area who has ongoing challenges with drug addiction. What can you do to address the needs of the woman and others like her?

- Divide participants into 4-6 groups
- Ensure each group has materials for the task, such as chart/butchers paper, pens and markers. Groups may choose to address each stage of the SARA model on a different page.
- Invite each group to nominate a note taker and a presenter
- Assign one scenario to each group (if more than 4 groups, more than one group can do a scenario) and provide a print out of the relevant scenario to each group (see Annex 3 for scenario handouts 6.2)
- Inform participants they will have 60 minutes to develop their plan and then each group will present their plan to the whole group.
- Ensure participants know they can call on you if they have any questions or clarifications about the activity and offer support and guidance. Proactively encourage the groups to consider which of the policing models they will employ to develop their plan, and how they will incorporate key principles and methods:
 - Evidence-based policing
 - Gender mainstreaming
 - Sex-disaggregated data
 - Human rights-based approaches

6.4 Group presentations

Time: 50 minutes

- After 60 minutes has elapsed, it is time for participants to report back to the group about their plan.
- Invite one group/nominated speaker to present, allowing 5 minutes for presentations and 5 minutes for questions or comments from other participants (estimated for 4 group presentations)
- Prompts to consider during presentations may include:
 - What makes your plan gender-sensitive?
 - Which policing models have you drawn upon to develop your plan?
 - What evidence are you relying on to underpin your decisions?
 - How have you ensured that human rights are protected?

6.5 Conclusion and course evaluation

Time: 10 minutes

- Re-state the learning objectives.
- Summarise the key messages of this module.
- Invite participants to ask any final questions and direct them to resources.
- Invite participants to complete the course evaluation and return to you (Annex 1).

Thank the participants for their time and attention. Acknowledge and thank the contributions and cooperation of guest speakers and people supporting any site visits (if relevant).

In this module we have used the problem-oriented policing framework to develop a gender-responsive plan for police and HIV prevention. The SARA Problem-solving model can be used in other aspects of your work. Please refer to the resources provided for more detailed information.

FURTHER READING:

Drew, J., & Prenzler, T. (2015). *Contemporary Police Practice*. Oxford University Press. Melbourne.

PSI CHAMPION IDU PROJECT. (2012). *Standard Operating Procedures to Improve Community-level Collaboration with Law Enforcement*. Population Services International (PSI).

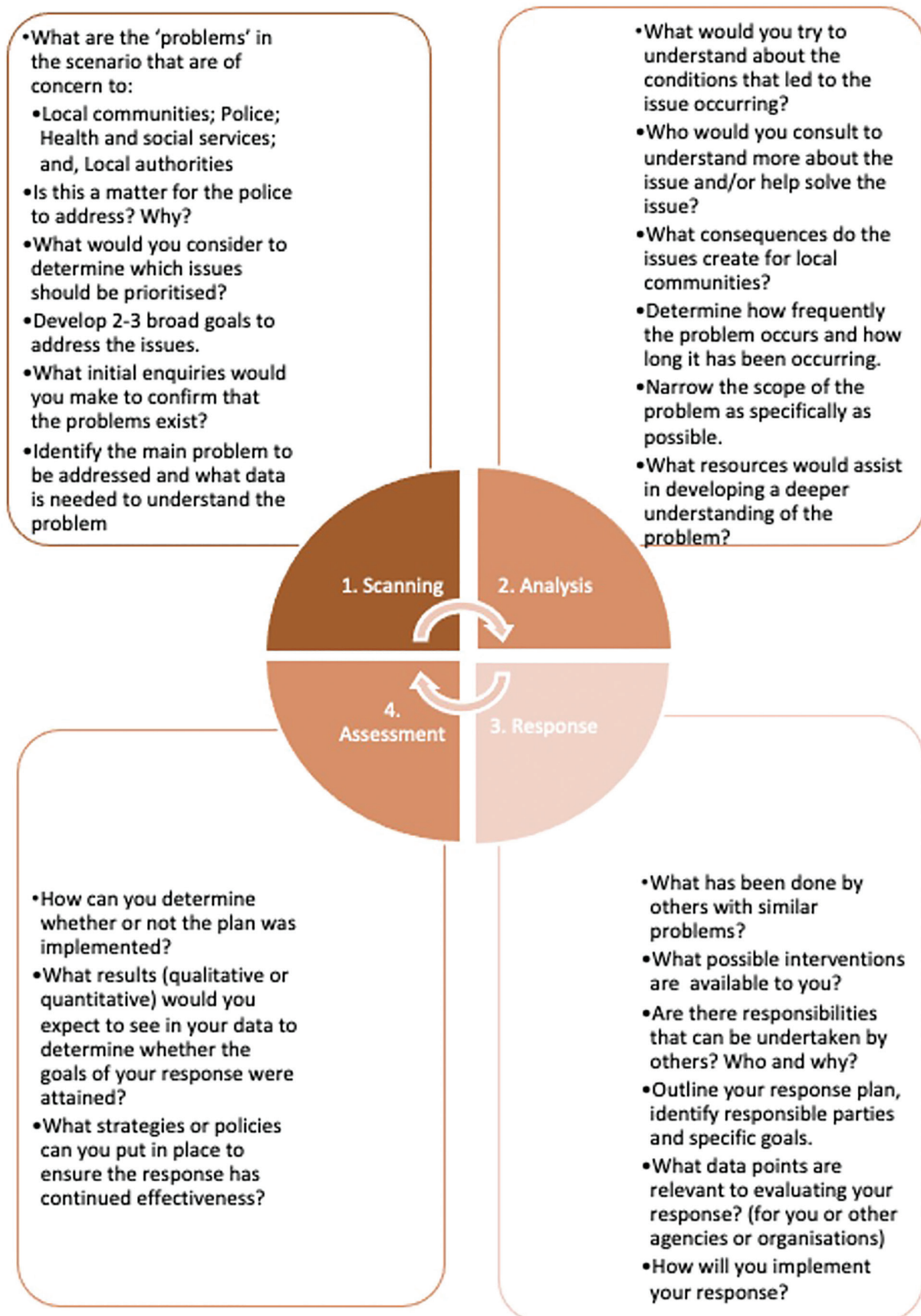
UNODC, INPUD & LEAHN. (2016) *Practical Guide for Civil Society HIV Service Providers Among People Who Use Drugs: Improving Cooperation and Interaction with Law Enforcement Officials*.

Sharma M, Chatterjee A. (2012). Partnering with law enforcement to deliver good public health: the experience of the HIV/AIDS Asia regional program. *Harm Reduction Journal*. 9:24.



Handout 6.1

SARA PROBLEM-SOLVING MODEL



Handout 6.2

SCENARIO 1

Your police station has been receiving complaints that needles and syringes, associated with drug use, have been left on the roadside near the entry to a public park. During the day, the park is used by families and children to exercise and play. You are aware that the area is where street-based sex workers often go to meet clients at night. You remember over-hearing that a needle and syringe program (NSP) opened nearby a few months ago. You find out from your colleagues that the NSP has been approved by the local authorities and senior police officers were informed. However, it appears that no officer from your station has been in direct contact with the NSP. You are concerned that needles and syringes may be harmful to the community and that the NSP will attract more people who use drugs to the area and increase crime. You want to make sure your community is safe, what will you do?

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SCENARIO 3

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SCENARIO 4

You are working the night shift and patrol down a laneway where you know people who use drugs and are homeless often sleep. You recognise a woman sitting against the wall as someone you have detained for using drugs in the past. As you approach her, she hides something behind her back. You tell her to show you her hands and she holds out a small wrapped object which she admits to you is a small amount of heroin she was planning to inject. You know that she suffered violence and domestic abuse at home as a child and is estranged from her family. It is illegal to possess heroin and you could arrest her and prosecute her for the offence. Depending on your country context, you may have the option to send her to a detention centre for "treatment" or "detoxification". The woman is not the only person in your area who has ongoing challenges with drug addiction. What can you do to address the needs of the woman and others like her?

Annexes



Annex 1: Post-training evaluation form

Post-training evaluation

Your feedback is important to us. Please provide your responses below.

	Strongly disagree	Disagree	Undecided	Agree	Strongly agree
The subject of the training is important for my work					
The objectives of the training were clearly explained					
The training exceeded my expectations					
I am happy with the new skills I have developed					

PLEASE WRITE YOUR RESPONSES TO THE FOLLOWING QUESTIONS BELOW

Please have a look back at your answers to the Self-Reflection Questions in Module 2. Have your answers to these questions changed? If so, how?

Which parts or subjects in the workshop were the most useful for you?

What was your favorite group exercise in the workshop?

Do you plan to use the information you learned at this workshop in your own work? How do you plan to do this?

Are there changes you would suggest be made to the workshop? Please give us your suggestions.

In addition to this workshop, what further types of support do you feel would be useful in order to put what you learned into practice at work?

PLEASE CIRCLE YOUR ANSWER

Will you recommend this training to other officers? **YES** **NO**

THANK YOU FOR YOUR PARTICIPATION

Annex 2: Materials for group activity for Module 1

Copy and cut out separately the strategy name, aims and example methods for each group. For example, for four groups be sure to give a complete set to each group. Each group should have 9 x strategy names, 9 x aims and 9 x example methods.

Strategy names x 9: to be cut along the lines and given to each group



Aims x 9: to be cut along the lines and given to each group

To apply policing approaches which contribute to supporting effective public health approaches to HIV prevention

To systematically identify and explore underlying causes of problems and develop a response to measure the effectiveness of a targeted policing strategy

To involve the community in the co-production of community safety

To prevent and control crime through utilising third-parties or multi-agency collaborations to address public safety and security.

To provide gender-sensitive policing services and access to justice for women

To build awareness that recent or childhood trauma can lead to physical and mental ill health, including substance use or risk behaviour

To restore victims, offenders and affected communities through community-based responses to injustice

To engender public support and cooperation for policing through demonstrating procedural fairness

To reassure the public they are safe

Example methods x 9: to be cut along the lines and given to each group

- **Engaging with harm reduction service providers to understand the impacts of specific policing practices on their ability to operate to optimum capacity**
- **Ensuring peer and outreach workers can provide HIV prevention services without interference**
- **Refer people from at-risk populations (e.g. WID, FSWs) to health, housing and social services instead of arrest and prosecution**

- **Using the SARA problem-solving model (scan, analyse, respond and assess) to systematically determine whether or how to:**
 - **eliminate or reduce a problem**
 - **reduce harm created by a problem**
 - **develop more effective responses to the problem, or**
 - **remove the problem from the police mandate**

- **Listening, responding and engaging with community concerns**
- **Mobilising communities e.g., community groups, advisory committees, partnerships**
- **Co-production of identifying, negotiating and achieving priorities**
- **Decentralised decision-making**
- **Problem solving; local problems, local solutions**
- **Being proactive and accessible to the community through foot patrol, bicycles, door-to-door visits,**
- **Community newsletters, sharing information**
- **Education projects, capacity building, target hardening**
- **Outcome measures, ie. community satisfaction, quality of life indicators, fear of crime**

- **Persuading or coercing organisations or non-offending persons to take responsibility for preventing or reducing crime and addressing quality of life issues e.g. business or property owners, health and building inspectors, parents etc.**
- **Uses legal, criminal, civil and regulatory rules and laws**
- **Collaborating with third parties, e.g. government and non-government agencies, communities, businesses etc.**
- **Multi-agency collaborations**
- **Formalising partnerships though e.g. Memorandums of Understanding, Standard Operating Procedures, committees etc.**

- Ensuring mechanisms to report crime or safety issues to police are gender-sensitive
- Collecting, analysing and sharing sex-disaggregated data
- Training and deploying women police to respond to women's needs
- Examining connections with and impacts of gender-based violence

- Training police to recognise signs of trauma (e.g. hypervigilance, disengagement, aggression, hostility, trembling, memory gaps, and more)
- Training police to respond to individuals they engage with by asking, "What has happened to you?" instead of "What is wrong with you?"
- Ensuring contact with the criminal justice system does not further harm or re-traumatise vulnerable people
- Ensuring police provide referrals to support services

- Empowering victims, offenders and affected communities
- Ensuring opportunities for healing and forgiveness
- Enabling people to take responsibility
- Respectful dialogue
- Community caring

- Treating people with dignity, courtesy and respect
- Listening to the community
- Fairness
- Transparency behind decision-making

- Being known and familiar to the community
- Being accessible and approachable
- Being visible
- Communicating with and providing information about community safety to local communities

References and resources

- Agarwal et al. (1999). The prevalence of HIV in female sex workers in Manipur, India. *Journal of Communicable Diseases* 31, pp. 23-28.
- Alderson, M., & Perrone, D. (2019). Procedural Justice and Police Encounters with Homeless Injecting Drug Users. *Criminology, Criminal Justice Law, & Society*. Vol 20, Issue 1, pp. 71–84.
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- HIV/AIDS Alliance India. (2018). WINGS of hope for Women who use drugs (WUDs). www.allianceindia.org/wings-hope-women-use-drugs-wuds-2/
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