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Tools and strategies for service providers working with women who use drugs and spouses of men who use drugs

Country Office Pakistan

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Conducting gender-sensitive outreach to women who use drugs, and family-friendly outreach to the spouses of men who use drugs

Conducting gender-sensitive outreach to women who use drugs, and family-friendly outreach to the spouses of men who use drugs

Women often find it more difficult than men to attend drug-related services. The goal of outreach to women affected by drug use is to contact women who may be reluctant or unable to attend clinic-based services and provide them with gender-sensitive harm reduction and drug treatment services. Outreach is the single most effective method for reaching women drug users and the spouses of male drug users.[1]

Planning for Outreach: Location, timing, and needs

Careful gender-sensitive planning optimises the performance of outreach teams working with women affected by drug use. This includes:

1. Where to conduct outreach: Women who use drugs tend to be more hidden than men, and may congregate in different places than men.

2. When to conduct outreach: The outreach schedule should take women's schedules, and family responsibilities into account.

3. What supplies to bring when conducting outreach. In additional to the harm reduction supplies provided in outreach to men, women may require additional, gender-specific supplies, such as child nutrition supplements or baby clothes.

Before starting outreach activities, it is therefore useful to conduct a simple mapping and needs assessment exercise. This exercise helps outreach workers (ORWs) to determine where and when to meet women drug users and the spouses of male drug users, and what supplies they require.

Outreach team

Outreach should be performed by trained female ORWs, including peers as much as possible. ORWs must have a basic level of training in harm reduction and drug treatment, as well as training on gender-specific needs for women who inject drugs and the spouses of male drug users, including:

- An understanding of gender-specific barriers to accessing and adhering to services, including childcare responsibilities, gender-based violence, relationship power dynamics

[1] Katya Burns, Women, Harm Reduction, and HIV: Key Findings from Azerbaijan, Georgia, Kyrgyzstan, Russia, and Ukraine, International Harm Reduction Development Program, OSI, Oct. 2009. http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/wmhardred20091001.pdf; Hunter, G.M. and A. Judd. 1998. "Women injecting drug users in London: The extent and nature of their contact with drug health services," Drug and Alcohol Review 17:267-276.

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Sample outreach mapping tool		
Information required	**Method to find the required information**	**Resources Needed**
Client location: Where are the clients?	♦ Snowball method: Begin with women who already access services ♦ Through female sex worker (FSW) services ♦ Through male drug users	♦ Human Resources: Outreach workers, ideally peers ♦ Data collection sheet
Client schedule: When to meet clients?	♦ Simple questionnaire asking clients about their daily routines, family and childcare responsibilities	♦ Human Resources: Outreach workers, ideally peers ♦ Questionnaire on client routines
Client supplies need assessment: What supplies fo clients need?	♦ Simple questionnaire asking clients about their needs for supplies such as child-related supplies, of female-specific supples.	♦ Human Resources: Outreach workers, ideally peers ♦ Questionnaire on client supply needs.

- An understanding of the sexual and reproductive health needs of women who use drugs
- An understanding of the care-giving responsibilities among the spouses of male drug users.

Outreach teams should consist of minimum two ORWs should meet at the DIC to plan outreach activities for the day. ORWs should never conduct outreach activities alone. Meeting time should be set at least one hour prior to the start of outreach activities. ORWs should have their own identification badges and mobile phones with them at all times.

Preparing for outreach

Once the place, time and supply needs of clients have been determined, and the outreach teams have been formed and trained, ORWs should take a number of steps before beginning their work with women drug users and the spouses of male drug users:

1. Identify gatekeepers: Before starting any outreach activities, ORWs should identify gatekeepers (pimps, partners, husbands, and so on) whose permission may be required in order to safely access women drug users. All

gatekeepers should be approached and provide permission for outreach to women before outreach activities can be conducted. For the spouses of male drug users in particular, it may be effective to obtain the permission of the husband or other male family members in order to provide home-based outreach.

2. Identity cards: Female outreach workers should be provided with formal identification in order to avoid or minimise problems with law enforcement, and agreements should be in place with the police regarding outreach worker activities before any outreach workers begin their work.

3. Outreach Schedule: ORWs should have an outreach schedule that indicates the times outreach work will take place, where outreach work will take place, and which outreach workers/teams will conduct outreach. Drop-in Centers (DICs) to which ORWs are attached should have an up-to-date copy of the schedule.

4. Outreach planning meeting: ORWs should meet everyday before setting out to conduct outreach activities, to plan outreach activities for the day. The meeting time should be set at least one hour prior to the start of outreach activities.

Outreach supplies

ORWs should prepare packages for female-friendly outreach, to include regular harm reduction supplies such as needles and syringes, condoms, medical supplies for abscess management etc., and also female-specific supplies. When providing needles and syringes for women who inject drugs, it is especially important for ORWs to provide for secondary exchange—extra needles and syringes for women to distribute amongst themselves. ORWs should not limit the number of needles and syringes provided. It is also important to provide women drug users with the correct gage needle to suit their needs. Women have smaller veins than men, and may therefore require thinner needles. When possible, rapid HIV testing services should also be provided.
Female-friendly supplies may include:

- Food/nutrition packages—These are particularly important for women who are pregnant and women who are caregivers in their families and responsible for food preparation in the home
- Women-specific literature, such as information about primary health care, pregnancy, childcare, menopause, and gender-based violence. Literature should be appropriate to the local literacy level and include pictures to explain the issues to women who have limited literacy
- Menstrual pads (if available)
- Diapers
- Children's clothing and toys that women can take home with them
- Female condoms (if available)
- Take home rapid pregnancy test kits (if available).

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Documenting outreach activities

As with all outreach work, female outreach workers should document their access to women and collect key information, using a female-specific form. ORWs should bring a registration document with them to record their outreach activities including a unique identifier code for each women they reach, which supplies were provided, any health conditions, and any referrals made.

Sample female client registration					
Client's unique identifier code	**Date**	**Age**	**Marital status**	**DU/IDU/spouse of male drug user**	**Service client requested**
ABC					
XYZ					

Sample check for tracking female client access to supplies
Client's unique identifier code
Date client accessed
NSP provided? Number of needles and syringes provided?
Child-related supplies provided?
Nutritional package provided?
Female-specific supplies provided?
Pregnancy test provided?
Rapid HIV test provided?

Establishing a referral network for women who use drugs

Establishing a referral network for women who use drugs

Building a strong referral network is critical to providing the full range of services that women drug users and the spouses of male drug users require. Referrals can be provided either via ORWs or through a drop-in center.

Checklist of services that women affected by drug use may require:

- HIV conselling and testing (HCT)
- Antiretroviral treatment (ART)
- Antenatal care
- Prevention of mother to child transmission (PMTCT)
- Drug treatment including during pregnancy
- STI testing and treatment
- Gender-based violence counselling and support
- Parenting classes and childcare support services.

Mapping

A simple mapping exercise can identify specific service provision sites that are able and willing to provide the required services (such as STI diagnosis and treatment, counselling, reproductive health, paediatric care etc). The mapping exercise identifies both client-centered needs and appropriate service providers.

Steps that harm reduction service providers should take to build a referral network

1. Visit the offices of providers and speak with doctors, social service providers etc. to identify those willing and able to work with clients (mapping exercise).

2. Obtain a commitment from specific service providers (individual people) to provide services to clients. These will become "trusted" or "friendly" service providers. If possible, select specific regular times when clients can receive services.

3. It may be useful to sign a "contract" or "letter of agreement" between the DIC and the trusted service provider, describing the exact terms of the agreement. This could include the name of the service provider, the clinic or office where the service provider works, the

Sample mapping exercise for client referrals		
Client need assessment: What services do clients need?	♦ Simple questionnaire asking about clients' needs	Human Resources: ♦ Outreach workers, ideally peers ♦ Questionnaire including questions on client physical and mental health needs, such as questions on sexual and reproductive health, any experience of violence, children and childcare
Location of services: Where are the service providers who can support clients with services that cannot be provided on-site or by ORWs?	♦ Based on expressed client needs, develop a list of service providers, such as antenatal care, sexual and reproductive health, rape crisis centres, housing services, childcare etc ♦ Administer a questionnaire to service providers to identify those with the capacity and willingness to provide services to clients.	♦ Questionnaire to identify which service providers are able to provide services to clients ♦ Map of area: Mark out areas where clients and appropriate service providers are located. Mark public transportation routes. Select location that is convenient to clients' location, appropriate service providers, and public transportation.

days and hours during which the service provider has agreed to provide services to clients. If possible, subsidise or fully cover the expenses for clients to access referral services.

4. Develop a referral slip mechanism to facilitate client access to services outside the DIC and to assist harm reduction service providers to track client access to services. Referral slips should be provided to clients. Clients present the referral slip when they attend services outside the DIC. These slips are retained by service providers and should be retained and collected by DIC staff or ORWs, and used to track client access, identify which services are most accessible and which are least, and develop programmatic strategies to further strengthen the referral system.

5. Provide regular and on-going education for service providers outside the DIC, including both trusted providers and other medical professionals or social

service providers. Education can be in the form of educational materials and pamphlets, or short talks or seminars. Peers educators should be trained and prepared to lead these educational sessions. Important service providers and topics to cover include:

- STI clinics—education on women and drug use
- Pregnancy services—education on drug use and pregnancy, PMTCT for women who use drugs, drug interactions ART and OST
- HIV services—education on women and drug use
- Drug treatment—education on women and drug treatment.

The goals of educating service providers are:

- To improve their capacity to work with women who use drugs, to decrease stigma and discrimination about drug use, and to increase the access of women who use drugs to the range of services they require
- Provide on-going capacity building for service providers outside the DIC supports the referral network's sustainability
- Monitor client access to and attendance at referral services
- Use the referral slips to regularly monitor client attendance at referral services and identify any gaps or barriers to accessing particular services
- Regularly monitor client satisfaction with referral services during outreach or at a DIC.

Addressing gender-based violence among women who use drugs

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Addressing gender-based violence among women who use drugs

Women who use drugs and the spouses of men who use drugs may experience gender-based violence (GBV) from their husbands, from male family members, from sex work clients, and from police. Gender-based violence directly impacts women's health, increases women's vulnerability to HIV, and can also pose a barrier to women accessing health services, including harm reduction services. For example, a woman's husband may opposed her attending NSP or accessing drug treatment/opioid substitution treatment, and may use physical violence or the threat of physical violence to deter her. For these reasons, harm reduction service providers who work with women who use drugs and the spouses of male drug users should be trained to identify cases of GBV and be prepared to provide violence mitigation services and care for women who have experienced or are experiencing violence.

Key Steps to address GBV among women affected by drug use

Training

- Ensure that a DIC-based counsellor has the training required to recognise GBV risk factors in women, knows how to ask women about GBV in a sensitive manner, and can provide professional support and referral
- Ensure that ORWs have the skills necessary to provide basic counselling on GBV.

Check list of questions to ask about GBV

- Have you had any problems with violence? in your home? At work?
- Do you have a safe place to go if you are experiencing violence?
- Have you ever gone to see a doctor because you have been hit or beaten in your home or at work?

Supplies

- Have GBV-specific IEC available at all times at DIC and with ORWs
- List of women's shelters with contact information
- Name and contact information for specialised GBV counsellor
- Name and contact information for trusted doctor.

Services

- Provide women with counselling for mental health and depression
- If appropriate, and with the woman's consent, provide couple or family counselling.

Referral

- Refer women who have physical injuries from GBV to trusted medical professionals
- When possible, provide women and their children with access to temporary housing and/or refer them to shelters
- Referral to specialised GBV services (such as a professional counsellor with expertise in GBV)

Key Areas in which GBV impacts women affected by drug use

Needle Springe Programme (NSP)

Partner opposition and gender-based violence can be a significant obstacle to women accessing NSP. Women who experience violence are more likely to have unsafe injection practices. To support women who may be at risk of GBV when attending NSP, service providers should:

- Teach women about the risks of sharing injection equipment
- Provide secondary exchange (extra needles and syringes for women to distribute through their own networks)
- Encourage couple counselling and couple attendance at NSP.

HIV Testing Counselling (HTC)

Women may have concerns about violence when attending HTC, particularly high-risk women who use drugs or the spouses of men who use drugs. These include concerns about the consequences of a positive test, such as the risk of physical violence to herself, loss of livelihood—for example, if she is engaged in sex work a positive test may impact her income, loss of home—if a positive test could result in her being evicted from her home, or loss of her children. To support women at risk of GBV due to attendance at HTC, service providers should work with women to develop concrete strategies to mitigate that risk, through activities such as:

- Support couple counselling and couple HIV testing
- Identify safe places women can stay and provide women with the contact information for safe places
- Provide the telephone number of a person the woman can call if she feels threatened.

Condom use

Gender-based violence, both for women who sell sex and for women who do not, can be an obstacle to negotiating condom use. In

order to encourage safe sex for women who use drugs and the spouses of men who use drugs and are at risk of violence, service providers for women should provide the following:

- Condoms should be easily accessible at DICs and provided via outreach. For DICs attended by both men and women, condoms should be available in women-only spaces such as women's bathrooms or washing areas. Outreach workers should provide condoms to women without limitation on the number supplied
- Provide female condoms (if available)
- Conduct regular condom demonstrations to instruct women on correct condom use
- Support women to practice safe sex with their husband. Women tend to be less likely to use a condom with their husband than with a non-regular or commercial sex partner
- For married women, provide referral to couples counselling if condom use is an issue.

Supporting condom negotiation and treating sexually transmitted infections (STI)

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Supporting condom negotiation and treating sexually transmitted infections (STIs)

Sex work and drug use may overlap among women drug users. The spouses of male drug users are sometimes engaged in sex work in order to earn income for their family or support their husband's drug use expenses. Women who use drugs may sell sex or engage in transactional sex for drugs or money, and female sex workers may use drugs.

There are a number of challenges to encouraging safe sexual practices to among women who sell sex and use drugs or are married to a man who uses drugs:

- Women who use drugs may be less aware about the risk of sexual transmission of HIV, than they are about the risk of HIV transmission by unsafe injection
- They may be unwilling to discuss sex work or attend services designed for sex workers because they may not think of themselves as sex workers
- They may actively hide their drug use in the context of sex work because drug use can adversely impact their income (clients of sex workers may be less willing to pay for sex if a woman is known to use drugs)
- They may face heightened challenges to negotiating condom use during sex work, particularly if they are in withdrawal
- Spouses of men who use drugs may face pressure from their husband to generate income through sex work.

To support women who sell sex and are affected by drug use to practice safe sex, service providers should:

- Be aware that women affected by drug use may be extremely reluctant to discuss sex work
- Ensure that any discussion of sex work between service provider and client is completely private and confidential. At a DIC, this may involve providing a private space for consultation. During outreach, this may mean finding a private space away from other clients in order to discuss sex work issues
- Be prepared to discuss sex work and safe sex in an open and non-judgemental manner
- Provide condoms in discrete packaging
- Be prepared to discuss proper condom use in detail, including in situations where privacy concerns may make it impossible to demonstrate condom use (such as during outreach)
- Provide descriptions of creative and discrete methods for integrating condom use into sex work
- Provide female condoms and explain how to use them.

Safe Sex: condom negotiation in the context of marriage

Practicing safe sex in the context of marriage is one of the most challenging aspects of harm reduction. This issue particularly impacts the spouses of male drug users, as spouses may have very low awareness of sexual risk, may not know that their husband uses drugs and is at risk of HIV, and may have low condom negotiation power. To encourage safe sex for women who are married to men who use drugs, service providers should:

- Provide information about sexual transmission of HIV
- Provide condoms
- Provide female condoms (if available).
- Conduct condom demonstrations to instruct women on correct condom use
- Provide counselling on barriers to safe sex in marriage including issues of trust and communication
- Provide couples counselling
- Teach condom negotiation skills, for example by using a role playing exercise.

Sexually transmitted infections (STIs)

Women who use drugs may not be comfortable attending mainstream STI services, and may be concerned about being identified as a drug user. Some women who use drugs and spouses of men who use drugs, may have limited knowledge about STIs and not realise that they have an STI, even when they are aware of the symptoms. Even if women do realise they have an STI, they may be unwilling to disclose their condition or seek treatment due to stigma surrounding STIs.

Check list of questions to ask about sexual risk behaviour

- Do you feel comfortable using a condom during sexual activity?
- Do you feel comfortable using a condom with your husband/regular partner? (If not, discuss why?)
- If you do not wish to have sex with your husband, can you say no to him?

To address these issues, as much as possible, DICs should provide gynaecological services on-site. If this is not possible, a strong referral system should be established with "trusted doctors" who can reliably provide gynaecological services to women drug users and spouses of male drug users on a regular basis. Service providers who work with women should:

- Provide STI testing on site or by referral
- Provide STI treatment on site or by referral
- Provide symptomatic STI treatment.

Check list of questions to ask about STIs

- Have you experienced white discharge or uncomfortable itching?
- Have you ever been tested for STIs?

Supporting pregnant women who use drugs

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Supporting pregnant women who use drugs

Using drugs during pregnancy is perhaps one of the most stigmatised and poorly understood aspects of women drug users' lives. This is the time when women who use drugs are most in need of high-quality, informed, compassionate care from healthcare providers, yet are least likely to receive it. To support pregnant women who use drugs, harm reduction service providers should pursue the following strategies:

Educate

Educate ORWs and DIC staff: ORWs and DIC staff may themselves be poorly informed about drug use and pregnancy. Training on pregnancy and drug use should be provided for both ORWs and DIC staff to enable them to provide accurate information and empower women to make safe client-oriented choices, free of the intense stigma that surrounds drug use during pregnancy.

Educate antenatal medical professionals: Medical professionals who provide health care services to pregnant women may have little or no accurate information about the impact of drug use on pregnancy and may have highly stigmatising attitudes towards women who use drugs during pregnancy. Trained harm reduction service providers, in tandem with “friendly” doctors, should provide educational materials and training to antenatal service providers.

Educate women drug users: Women who use drugs and are pregnant often lack accurate information on drug use and pregnancy and may themselves be afraid to seek antenatal care if they are actively using drugs. Harm reduction service providers should provide correct information and support to women who use drugs and are pregnant.

Support access to health services for pregnant women who use drugs

In addition to antenatal care, pregnant women who use drugs may require a range of health services. Harm reduction service providers can provide support to these key services.

Drug treatment: Evidence-based drug treatment—opioid substitution therapy (OST) with methadone or buprenorphine—produces the best pregnancy outcomes for women who use drugs. Service providers should be aware, however, that some women who use drugs may opt for abstinence-based approaches

Antenatal care education requirement checklist on pregnancy and drug use		
Target audience	**Skills required**	**Actions to take**
ORWs and DIC staff	• Understanding of stigma associated with drug use during pregnancy • Understanding of physical impact of drug use on pregnancy • Understanding of appropriate drug treatment options during pregnancy	• Organise a training for ORWs and DIC staff on pregnancy and drug use • Develop culturally appropriate IEC materials for both antenatal care providers and women who use drugs • Train ORWs and DIC staff on empowerment strategies for pregnancy women who use drugs • Develop training materials on pregnancy and drug use • Train DIC staff and ORWs to deliver training to antenatal care providers Identify trained "trusted" antenatal care providers and establish a system of referral to those providers • Deliver trainings to antenatal care providers • Provide on-going support and mentoring to antenatal care providers
Antenatal care providers	• A compassionate and stigma-free method of supporting pregnant women who use drugs • Understanding of physical impact of drug use on pregnancy	• Work with harm reduction service providers and trained medical professionals to arrange training of antenatal care medical staff on pregnancy and drug use • Make IEC on drug use and pregnancy available to antenatal care providers and women attending antenatal care • As needed, develop further IEC materials
Pregnant women who use drugs	• Understanding of appropriate drug treatment options during pregnancy • Understanding of physical impact of drug use on pregnancy • Understanding of appropriate drug treatment options during pregnancy • An informed and empowered approach to confronting stigma associated with drug use during pregnancy.	• Work with harm reduction service providers on empowerment skills to combat stigma • Provide feedback to ORWs and DIC staff on experiences accessing antenatal care.

to drug use during pregnancy, and should be prepared to provide information about safe detoxification during pregnancy. To support drug treatment for pregnancy women who use drugs, service providers should take the following steps:

- Inform women about the impact of OST on pregnancy
- Provide women with information of where and how to access OST
- As needed, accompany women to OST services
- Develop IEC and training materials for drug treatment service providers on drug treatment during pregnancy
- As needed, provide training and mentoring for drug treatment service providers on treatment pregnant women
- Support pregnant women who use drugs to adhere to drug treatment
- Respect women's right to chose abstinence approaches to drug treatment during pregnancy, provide women with information about the impact of abstinence during pregnancy, and support women to adhere to abstinence-based treatment during pregnancy.

HIV Testing and conselling (HTC)

- Women who use drugs are at high risk of HIV and should be offered HTC at least twice during their pregnancy
- Provide women with information about where and when to access HTC services
- As needed, accompany women to HTC services
- Explain PMTCT options to women.

Prevention to mother to child transmission (PMTCT)

- Pregnant women who use drugs and are living with HIV require access to PMTCT
- As early as possible in pregnancy, inform women who use drugs about mother-to-child transmission and PMTCT
- Provide women with information about where and when to access PMTCT services
- Support women to adhere to PMTCT through regular follow-up
- Provide PMTCT service providers with IEC, training and mentoring support on drug use.

Support access to health services post-partum

After delivery, new mothers who use drugs require access to a range of services. Harm reduction service providers can:

- Support access and adherence to ART for mothers post-partum: Under current WHO guidelines, women who accessed PMTCT during pregnancy or

at delivery should continue to receive ART for life

- Support access to HIV testing for newborns and infants
- Inform women living with HIV about the risks and benefits of breastfeeding.
- Provide consistent follow up with women after delivery through home visits and mother and child health checks
- Inform and educate drug treatment providers on offering treatment for neonatal abstinence syndrome
- Inform women about neonatal abstinence syndrome.

Checklist of materials and supplies for harm reduction service providers working with pregnant women who use drugs

- Home pregnancy tests to identify pregnancy as early as possible
- Culturally appropriate IEC materials
- Condoms—Pregnant women who use drugs or are married to men who use drugs should continue to use condoms during pregnancy to either protect against HIV infection in the case they are HIV-negative, or prevent re-infection in the case they are HIV-positive
- Referral materials to antenatal care and other appropriate service
- Form to document service provider access to clients and client access and adherence to services.

Providing effective support for children and parents affected by drug use

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Providing effective support for children and parents affected by drug use

Mothers who use drugs

Women who use drugs may lack confidence in parenting and may have limited parenting skills. Women with small children may find it difficult to attend harm reduction services because of childcare responsibilities. In order to support women with children to parent and to attend harm reduction services, service providers can take the following steps:

Fathers who use drugs

Fathers who use drugs may have limited parenting skills and lack confidence in their ability to support their family. To support men who use drugs to parent, harm reduction service providers can take the following steps:

- Encourage men to attend parenting classes together with their wife
- Offer home-based parenting skills coaching
- Integrate questions about family into outreach activities (ask men about their families and whether or not they have children)
- Provide men with basic coaching and support on parenting via outreach.

Women caregivers

Women who use drugs and the spouses of male drug users may be caring for their husbands and for other family members who have health care needs associated with drug use, HIV, or other drug-related illnesses. In order to best support women who are caregivers in their families, harm reduction service providers can take the following steps:

- Provide information, instruction and support on treating common illnesses in the home
- Provide instruction on home-based abscess management
- Provide information about convenient and appropriate medical services, including location, phone number, and name of a trusted doctor
- Provide information about HIV transmission including unsafe injection behaviours and the importance of NSP for family members who may be injecting drugs
- Provide information about drug treatment including OST, and the location of OST sites, if available
- Provide information about overdose, instruction on overdose prevention, and naloxone (if available). Provide information on how to treat overdose

where naloxone is not available, dispel myths about overdose treatment, help with access to timely qualified medical/social support in the case of overdose (such as a list of doctors and contact information)

- Support the development of support networks for women caregivers by, for example, establishing a caregiver support group at a DIC or other convenient location identified by women caregivers.

Simple guide to supporting mothers who use drugs		
Goal	**Strategy**	**Required Actions**
Build mothers' parenting skills	• Offer parenting classes at the DIC, led by a childcare specialist who has knowledge of drug use and who ideally is a peer	• Recruit a childcare professional or, ideally, train a female peer to provide parenting instruction • In consultation with female DIC clients, set a regular time to provide parenting classes at the DIC • Identify an appropriate private space at the DIC for parenting classes and post a notice at the DIC indicating the time and place of parenting classes
Support and encourage mothers who use drugs to attend harm reduction services as needed	• Provide a child-friendly environment at the DIC by making space for children on-site	• Recruit an appropriate childcare professional to provide on-site childcare, or ideally, train peers to provide childcare at the DIC • Identify a private space (separate room) for childcare. If it is not possible to provide on-site childcare during all opening hours of the DIC, set hours at the DIC during which childcare will be available. Consult women clients on the most appropriate hours to select • Make the childcare space child-friendly by making it safe (no sharp objects), and providing toys
Support maternal and child health	• Offer child-friendly health services such as infant and child health check-ups, support with childhood vaccinations, information and support on paediatric HIV testing and treatment (if needed), and nutritional support for infant and mother.	• Provide mothers with information on young child health needs such as vaccinations • Recruit and hire a paediatrician with the capacity to work with mothers who use drugs • Provide a private space for paediatric health checks • In consultation with mothers, set specific regular times at which mothers can bring their children for health checks at the DIC • If it is not possible to provide paediatric health checks on-site, develop a referral to a trusted paediatrician • Provide infant and young child nutritional health packets at the DIC or via outreach.

Supporting HIV testing, treatment, and care and support for women who use drugs

7

Supporting HIV testing, treatment, and care and support for women who use drugs

Testing

Women who use drugs may be reluctant to attend HIV testing services because they may face stigma and discrimination related both to their drug use and to their gender. These women require access to accurate information about HIV testing services and support from harm reduction service providers to attend these services. (For additional information refer to the tool for "supporting pregnant women who use drugs" and the tool for "establishing a referral network for women who use drugs").

In addition to providing on-site HTC at DICs and referral to HTC services, harm reduction service providers can also explore a range of testing modalities that may improve women drug users' access to HTC, including:

- Provide rapid-testing via outreach or at DICs
- Provide rapid HTC in community settings
- Provide rapid home-based testing [2]
- Provide rapid testing in mobile units.

Enrolment in care and treatment

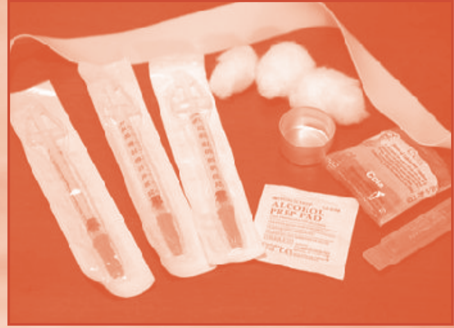
Women drug users who test positive for HIV require may support to access appropriate care. Key care services include:

- Services that determine eligibility for ART, and
- Services that support registration and retention in care.

[2] General modalities outlined in the following article, without discussion of HTC for people who use drugs. Ahonkhai et al. Improving HIV Outcomes in Resource Limited Settings: the importance of quality indicators, BMC Health Services Research 2012, 12:427 http://www.biomedcentral.com/1472-6963/12/427, p.8

Tool for linking women drug users living with HIV to HIV care & support and treatment services			
Goal	**Challenges**	**Strategies**	**Actions**
Registration with care & support services	• Women may be not have formal identification documents • Women may be unwilling to provide identification	• Support women to get identification papers • Work with women and care & support service providers to safeguard privacy and confidentiality	• Explain to women how to obtain identity documents and accompany them to government offices • Provide information and training as needed to care & support service providers on the specific vulnerabilities of women drug users
Access services to determine eligibility for ART	• Eligibility services such as CD4 and viral load counts may not be locally available • Women may face challenges travelling to access eligibility services	• Support women to travel to locations that provide CD4 and viral load counts	• Identify the most convenient location for obtaining CD4 and viral load counts • Provide women with transportation support and accompaniment as needed to eligibility services
Ensure retention and adherence to care & support services	• Care & support service providers may lack information or stigmatise women drug users • Women who use drugs may not feel comfortable attending care & support services.	• Provide capacity building for care & support service providers • Support women drug users to attend care & support services regularly.	• Provide information and training to care & support service providers on drug use • Accompany women to health check appointments with care & support services • Develop personalised schedules for women drug users and provide regular appointment reminders either in person or via text message.

Tool for linking women drug users living with HIV to HIV care & support and treatment services			
Goal	**Challenges**	**Strategies**	**Actions**
Ensure timely initiation, retention and adherence to ART	• Care & support service providers may be unwilling to provide ART for active drug users despite clinical eligibility • Women drug users may lack information on ART clinical eligibility criteria and the importance of adherence to treatment.	• Build the capacity of care & support service providers to dispel adherence myths about drug users, and to understand proper ART dosing for people on OST • Build ART literacy among women drug users • Provide access to services that support adherence.	• Provide literacy training for care & support service providers on ART for people who use drugs • Develop IEC and provide women with coaching and mentoring on ART literacy • Provide key supportive services to support adherence via outreach, at DICs, or via referral. Key services include: drug treatment, nutrition support, transportation support, and mental health counselling.



Teaching safe injection to women who use drugs

Teaching safe injection to women who use drugs

Women who inject drugs often lack the knowledge and skills to self-inject and therefore tend to rely on others to inject them. Being injected by another person is associated with increased sharing of injection equipment and greater risk of HIV infection. It is therefore very important that harm reduction service providers empower women to practice safe injection by providing them with the skills and resources to safely inject themselves.

To empower women drug users to practice safe injection, harm reduction service providers can take the following steps:

Step 1—Supplies: Ensure that ORWs and DIC staff have gender-appropriate injection supplies in adequate quantities. Women generally have smaller veins than men and tend to require smaller gage needles. Needle gage should be determined in consultation with clients and appropriate quantities of correctly sized needles should be procured for the purposes of providing NSP to women.

Step 2—Training: Train female ORWs and DIC staff to teach safe injection. There is a range of safe self-injection instructional material available. (Refer to UNODC Information Brief on Female Drug Users #8 Preventing Parenteral Transmission (sharing of contaminated injecting equipment) of HIV for Women Who Inject Drugs, for instruction information and a list of resources).

Step 3—Assessment: Assess the capacity of women drug user clients to self-inject and the barriers they face to injecting themselves. Develop a simple questionnaire and conduct an assessment of female clients' capacities and challenges to self-injection.

Step 4—IEC: Develop culturally sensitive women-specific IEC material on safe injection. Use the materials provided in the training on self-injection and the results of the client needs assessment to develop IEC materials that target the challenges that women clients identified.

Step 5—Safe spaces: Based on clients' expressed preferences, identify safe spaces to teach self injection to women-only groups. These teaching sessions should be highly interactive, providing room for women to ask questions, share information, and collectively brainstorm on ways to address barriers to self-injection. Safe spaces may include:

- A private room at a DIC
- A woman's home
- A private room at the clinic of a "friendly" or "trusted" service provider, such as antenatal clinic or HTC service.

Step 6—coaching and support: Provide on-going coaching and support to women on self-injection via outreach and DIC services. ORWs should routinely ask female clients about their injection practices including self-injection and sharing behaviours, and monitor clients for changes in behaviour. Problem areas should be identified early and addressed in a timely manner. Refresher trainings on self-injection may be offered. Self-injection should also be discussed in the context of any female drug user support groups in DIC settings.

Sample Questionnaire

- Do you usually inject yourself or does someone else inject you?
- If someone else injects you, generally speaking who is that person? (a friend, a boyfriend, etc.)
- If you do not inject yourself, why not?
- Have you tried to inject yourself?
- Did you have trouble injecting yourself? If so, what trouble did you have?
- Did anyone ever tell you that you should not inject yourself? If so, who? Did that person provide a reason?
- When injecting, do you use your own equipment or do you share with someone else? If sharing, with whom?
- In what locations do you generally inject/get injected? (on the street, at home)
- Where (on your body) do you usually inject?
- Do you usually inject alone of with others? If with others, with whom? (women, men, friends, boyfriend, family members etc.).

Recognizing, addressing and preventing burnout among service providers who work with women who use drugs

9

Recognizing, addressing and preventing burnout among service providers who work with women who use drugs

Burnout—characterised by physical, behavioural and psychological symptoms—can impact DIC staff and outreach workers at all harm reduction service providers, but women who provide gender-specific services to female drug users and the spouses of male drug users may face additional gender-specific stresses that can accelerate burnout. For this reason, it is especially important for gender-sensitive harm reduction service providers to address burnout in the context of their own organisations in a manner that takes gender-specific stresses into account. Effectively addressing burnout will increase staff satisfaction with their work, improve staff performance, and support optimal program outcomes.

Recognising burnout

Staff burnout can manifest in physical, behavioural and psychological symptoms. Physical symptoms can include increased susceptibility to illness, fatigue, sleeplessness, loss of memory, frequent head-aches, muscle aches etc. Behavioural symptoms can include isolation from family and friends, increased conflicts with co-workers, absenteeism from work, and difficulties controlling anger. Psychological symptoms can include depression, anxiety, hopelessness, and a feeling of not being appreciated.

Gender-specific issues that can accelerate burnout among women who work with female drug users and the spouses of male drug users

Excessively long work hours, lack of "down-time," frequent exposure to traumatic events among clients—such as client death, overdose, or experience of violence—lack of professional development opportunities, and inadequate professional and person support, can lead to burnout among all service providers who work with drug users. Women working with women drug users face additional gender-specific stresses, including:

- Increased exposure to overdose: Overdose is more common among women who use drugs than among men, and service providers whose work focuses on women drug users are likely to experience overdose among clients at higher rates than service providers whose work focuses mainly on male drug users
- Client death: Death rates among

women who use drugs are higher than among male drug users, and service providers working with women are likely to be coping with client death in a more intense manner

- Gender-based violence: Reported levels of gender-based violence among women who use drugs are high, and service providers may be required to recognise and provide support in this area on a regular basis. For female service providers who may themselves have experienced GBV, this can be challenging
- Family stresses among clients: While both male and female drug users experience family problems, women who use drugs and the spouses of men who use drugs face additional challenges which require the support of female service provides. Service providers who work with women drug users may be required to support women caregivers in their homes, assist with childcare issues in the context of drug use, and support women drug users who sell sex in conflicts with sex work clients, pimps, or police. This increases the workload of female service providers and exposes them to additional sources of trauma.

Preventing burnout

Generic burnout prevention strategies: A number of strategies that can address burnout among harm reduction service providers in general can also usefully be applied to women service providers working with women affected by drug use. These include:

- Structural strategies, such as
  - Setting realistic targets by strictly limiting the number of clients for whom each ORW is responsible. For women working with women affected by drug use, the number may be lower than that for harm reduction providers who work primarily with me.
  - Setting realistic work hours
  - Providing appropriate compensation for work
  - Providing adequate holiday time
  - Providing professional development opportunities, such as seminars, lectures or attendance at conferences
  - Providing opportunities for career advancement.

- Supportive strategies, such as
  - Providing professional mentoring of junior staff by more experienced staff members
  - Providing regular team meetings and counselling
  - Establishing mechanisms for staff feedback
  - Offering a counselling hotline for staff.

Gender-specific burnout prevention strategies: Women working with women affected by drug use require access to burnout prevention strategies than can address the specific stresses they encounter in their work. Gender-specific burnout prevention strategies include:

- Provide additional support to female ORWs in the course of their work. Most importantly, female ORWs should always work in groups of two and their training should include risk-mitigation strategies to minimise the risk of sexual assault in the course of their work
- Team meetings and counselling sessions should provide women service providers with the opportunity to address the gender-specific vulnerabilities of their clients—such as GBV—in a supportive environment
- Female service providers should have access to additional one-on-one counselling support on a regular basis
- All services that are available to clients should also be available to female service providers including sexual and reproductive health services, GBV services, and parenting/childcare support.

Monitoring and evaluation for service providers working with women who use drugs

Monitoring and evaluation for service providers working with women who use drugs

Monitoring and evaluation is an important component of all harm reduction services. (For an overview of indicators for harm reduction services, see UNODC Information Brief # 12, M&E framework for projects that are specifically designed to work with female IDU and spouses of male IDU—focus South Asia). In addition to collecting and analysing regular program data related to service provision, services for women who use drugs and the spouses of male drug users should undertake two gender-specific tasks:

- For services that work with both men and women, ensure that all data is sex-disaggregated and conduct a gender analysis to compare male and female access to services,
- Develop gender-specific indicators, collect data on this indicators, analyse the data and use the analysis for program development and improvement.

To support gender-sensitive M&E, service providers should take the following actions:

Step 1: Motivate staff to collect accurate data and conduct data analysis by carefully explaining the benefits of M&E, such as improved program performance and increased competitiveness for future funding.

Step 2: Develop an agreed set of gender-specific indicators that accurately reflect program activities. (For examples of gender-specific indicators, see UNODC Information Brief # 12 M&E framework for projects that are specifically designed to work with female IDU and spouses of male IDU—focus South Asia)

Step 3: Develop standard data collection forms and standard operating procedures for data collection and analysis

Step 4: Provide training on data collection to all service providers including ORWs. Provide regular follow-up mentoring for ORWs and DIC staff on data collection.

Staff data collection training checklist

- Ensure that staff understand data collection forms
- Ensure staff have easy access to forms at all times and include forms in ORWs packets
- Establish a system for staff to enter data into an electronic form (if available) on a daily basis
- Ensure that staff have a basic understanding of data analysis, including denominators, numerators, and coverage.

Step 5: Hire a dedicated M&E staff member, or if that is not possible, designate at least one staff member responsible for overseeing M&E including providing mentoring for staff collecting data and conducting analysis of data.

Step 6: Hold regular weekly staff meetings to share the results of the past week's data analysis and brainstorm on strategies to address any gaps identified.

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