



UNODC

United Nations Office on Drugs and Crime

BRIEFING PAPER

Addressing gender-based violence against women and people of diverse gender identity and expression who use drugs



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Abbreviations

ART	Antiretroviral therapy
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
EVAWUD	Elimination of violence against women who use drugs
GBV	Gender-based violence
HIV	Human immunodeficiency virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
LGBTQI	Lesbian, gay, bisexual, transgender, queer and intersex
OAT	Opioid agonist therapy
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEP	Post-exposure prophylaxis
PIE	Psychologically informed environments
SOGIESC	Sexual orientation, gender identity, gender expression and sex characteristics
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization
WHRIN	Women and Harm Reduction International Network

Definitions of key terms

Advocacy is the process of communication for change, with specific goals directed at individuals and groups that can bring about reforms in policy, law, structures, services and social or cultural environments.

Community-led organizations and networks are those that are led by and for the constituencies they serve. They are self-determining and autonomous entities where the majority of governance, leadership, staff, spokespeople, membership and volunteers reflect and represent the experiences, perspectives and voices of their constituencies, and which have transparent mechanisms of accountability to their constituencies.¹

Community-led responses can be understood as the actions and strategies undertaken by these groups to improve the health and human rights of their constituencies. These responses are informed and implemented by and for communities themselves and the organizations, groups and networks that represent them.¹

Decriminalization: For the purposes of this briefing paper, decriminalization is defined as policies that remove criminal sanctions for personal drug use and minor drug offences. This concept refers to the process through which an offence is reclassified from “criminal” to “non-criminal” through legislative action.²

Gender: Gender can be broadly defined as a multidimensional construct that encompasses gender identity and expression, as well as social and cultural expectations about status, characteristics and behaviour as they are associated with certain sex traits.³

Gender-based violence is violence inflicted upon a person on the basis of their actual or perceived gender that results in – or is likely to result in – sexual, physical, mental or economic harm. Gender-based violence against women is violence directed against a woman because she is a woman, or that disproportionately affects women and gender-diverse people. Gender-based violence can occur in public or in private. It also includes threats of violence, coercion and manipulation.⁴

Gender-responsive describes a policy or programme that considers gender norms, roles and inequalities, with measures taken to actively reduce their harmful effects.⁵

Gender-sensitive concepts and methods of data collection take into account the diversity of various groups of women and men and their specific activities and challenges, and aim to reduce sex and gender bias in data collection, such as the underreporting of violence against women.⁶

HIV harm reduction: For the purposes of this briefing paper, HIV harm reduction services are defined by the interventions included in the Comprehensive Package detailed in the WHO, *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations* (WHO, 2022).

Intersectionality: How intersecting power relations influence social relations across diverse societies, as well as individual experiences in everyday life.⁷

¹ Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations (WHO, 2022).

² International Narcotics Control Board Report 2

³ World Health Organization. Gender and health.

⁴ Adapted from United Nations Declaration on the Elimination of Violence against Women (A/Res/45/104); CEDAW Committee General Recommendation 19; Factsheet: violence against women (WHO, 2021); and Gender-based violence (UNHCR).

⁵ UNOV/UNODC strategy for gender equality and women's empowerment 2022-2026

⁶ UN Statistics Wiki glossary of terms.

⁷ UNODC Issue paper: Organized crime and gender: issues relating to the United Nations Convention against Transnational Organized Crime (2022).

Low-threshold services aim to minimize the barriers a client may face in relation to starting, continuing and re-engaging in opioid agonist therapy.⁸

Opioid agonist therapy (OAT) refers to the prescription of opioid agonist medications with long-lasting effects at an appropriate dose to people with opioid dependence. It is provided under medical supervision and supported by access to evidence-based psychosocial interventions.⁹ OAT is most effective as a maintenance therapy (sometimes referred to as opioid agonist maintenance therapy or OAMT) and should be provided for as long as a person requires it. OAT is the term used for this intervention in this document.^{10,11}

People of diverse gender identity and expression refers to people whose gender identity differs from the sex they were assigned at birth. This includes, but is not limited to, transgender people. Gender identity exists on a spectrum, and people may not identify as completely male or completely female; some people may identify as another, non-binary gender. Across cultures, many other terms are used to describe gender identities and expressions that differ from the sex assigned at birth, in addition to non-binary gender expressions and identities.¹²

Racialize means to identify or categorize a person or group on the basis of their race or ethnicity, with a negative intent or negative consequence.

Women who use drugs refers to women who use narcotic drugs and psychotropic substances for non-medical purposes.

The **10-10-10 targets** of the Global AIDS Strategy 2021–2026 are that by 2025, less than 10 per cent of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services; less than 10 per cent of people living with HIV and key populations experience stigma and discrimination; and less than 10 per cent of women, girls, people living with HIV and key populations experience gender-based inequalities and sexual and gender-based violence.¹³

The **30-80-60 targets** of the Global AIDS Strategy 2021–2016 are that by 2025, 30 per cent of testing and treatment services are delivered by community-led organizations; 80 per cent of service delivery for HIV prevention programmes for key populations are delivered by community-led organizations; and 60 per cent of the programmes supporting the achievement of societal enablers are delivered by key populations (including programmes to reduce/eliminate HIV-related stigma and discrimination, advocacy to promote enabling legal environments, programmes for legal literacy and linkages to legal support, and for the reduction/elimination of gender-based violence). The Global AIDS Strategy also specifies a target that by 2025, **80 per cent of services for women for HIV**, for the reduction/elimination of violence and of HIV-related stigma and discrimination, and women-specific legal literacy services, are delivered by community-led organizations that are women-led.¹³

⁸Principles of drug dependence treatment (UNODC and WHO, 2008).

⁹Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence (WHO, 2009).

¹⁰In much of the existing literature supporting the effectiveness of long-term agonists, they are defined as opioid substitution therapy. Opioid maintenance and methadone/buprenorphine maintenance treatments are other terminologies. The term “OAT” is used in this publication because it reflects the use of an agonist medication, and to indicate that effective treatment involves more than “replacing” or “substituting” an illicit opioid with medication. (Medication-assisted treatment is a more general term that includes all pharmacotherapies approved for the treatment of opioid use disorder.)

¹¹Words matter! Language statement and reference guide (INPUD, 2020).

¹²Adapted from HIV and transgender and other gender-diverse people. Human rights fact sheet series (UNAIDS, 2021).

¹³Global AIDS Strategy 2021-2026 (UNAIDS, 2021).

1. Introduction

In 2022, an estimated 1.3 million people acquired HIV globally, and 46 per cent of all people living with HIV were women and girls [1]. Alarming, the risk of acquiring HIV is 35 times higher among people who inject drugs than among those who do not [2]. Of the world's estimated 296 million people who use drugs, 25–47 per cent are women, depending on the substance and region [3]. Women who inject drugs represent around 19 per cent of the estimated 13.2 million people who inject drugs [3]. There is a strong likelihood that these population size calculations are underestimated, given the marginalization of women who use drugs, the paucity of appropriate services for them, and the resultant data gaps.

There are pronounced and well-documented bidirectional associations between gender-based violence (GBV) and HIV among women who use drugs, sex workers, trans women and young women.¹ These associations are markedly under-addressed in policy and programming [4, 5]. Punitive laws and policies, harmful gender norms and stereotypes, gender inequalities, marginalization, over-incarceration and other barriers to accessing services combine to amplify the risk of HIV transmission among women and people of diverse gender identity and expression who use drugs, and reduce their access to testing and treatment [6, 7, 8, 9, 10].

This briefing paper aims to raise awareness of the scope and scale of GBV experienced by women and people of diverse gender identity and expression who use drugs, and the connection between GBV and the HIV epidemic among them. It highlights practical responses to violence against these populations that can be adopted by providers of harm reduction and allied services. The paper also demonstrates how adopting a gender-responsive approach to drug use benefits women and people of diverse gender identity and expression. The paper begins with a summary of recommendations for policy and government responses.

This briefing paper is also relevant for advocates, human rights defenders, lawmakers, police and other stakeholders who engage with women and people of diverse gender identity and expression. Sample resources and illustrative responses are provided in the annexes.

In this briefing paper, “women and people of diverse gender identity and expression” is sometimes abbreviated to “women” in order to make the text more concise.

¹For statistical purposes, the United Nations defines youth (and hence young women) as those persons between the ages of 15 and 24 years, without prejudice to other definitions by Member States. See [Fact sheet: Definition of youth](#) (United Nations Department of Economic and Social Affairs)

RECOMMENDED RESPONSES TO GENDER-BASED VIOLENCE AGAINST WOMEN AND PEOPLE OF DIVERSE GENDER IDENTITY AND EXPRESSION

Successful prevention of gender-based violence (GBV) requires political commitment, leadership and resource allocation. Here are 10 essential recommendations for policy responses:

- 1** Impose appropriate criminal penalties for GBV [11] – including GBV perpetrated or condoned by the State – without regard for the drug-use status, sexual orientation, gender identity or sex work status of the person who experiences GBV [12].

- 2** Strengthen and implement laws that promote gender equality. Take action to eliminate harmful gender norms and the multiple forms of discrimination faced by women and people of diverse gender identity and expression who use drugs [13].

- 3** Reform punitive and discriminatory laws and policies, which increase risks for both HIV transmission and GBV and create additional barriers to service uptake, including:
 - Laws that criminalize sex work, drug use or possession for personal use [12]
 - Regulations that exclude women who use drugs, including those engaged in sex work, from domestic violence shelters and other safe spaces or from access to housing, or that deprive them of access to childcare or custody of their children [14]
 - Practices that lead to the mistreatment of women who use drugs during obstetric and gynaecological care [15]

- 4** Address social determinants of health, e.g. education, employment, income and work-life balance, social protection, food security, housing and the environment, social inclusion and non-discrimination, structural conflict, and access to affordable, quality health services [16].

- 5** Support the formation and development of community-led networks of women and people of diverse gender identity and expression who use drugs, and engage them meaningfully in local and national planning of GBV responses and policy development [14].

- 6** Prioritize the development of gender-responsive, people-centred, rights-based policies, programmes, including harm reduction, and mechanisms that address violence across the spectrum of service provision and focus on the specific needs and circumstances of women and people of diverse gender identity and expression.

- 7** Invest in the availability and quality of comprehensive essential health, social, police and justice services for victims/survivors of GBV, including the establishment of crisis centres and shelters [17].

- 8** Support multi-sectoral coordination between law enforcement, health, social services, justice institutions and gender equity platforms, relevant technical working groups and human rights organizations [14]. Police, prosecutors and judges must take care to ensure that survivors of violence are not subjected to further harm through arrest, imprisonment and the use of non-custodial sentences [18]

- 9** Provide adequate resources for community-led gender-sensitive monitoring, research, data collection analysis and reporting – with data disaggregated by gender as a primary, overall classification, and by other parameters as applicable. Ensure that community-generated data are used to tailor national responses to GBV and to develop rights-based legal frameworks [19].

- 10** Eliminate harassment and other forms of violence committed or condoned by police or other criminal justice officials against women and people of diverse gender identity and expression, and bolster accountability [14].

2. Background: The causes and consequences of gender-based violence

2.1 ROOT CAUSES OF GENDER-BASED VIOLENCE

Gender-based violence stems from deeply ingrained patriarchal structures and beliefs that fuel unequal power dynamics and continuous attempts to deny women the right to bodily autonomy [4, 7]. (For a definition of GBV, see the Definitions of key terms). Compounding discrimination and violence are fuelled by the intersections between punitive drug policy and gender inequalities.

At least 155 countries have passed laws on violence against women, but challenges remain in enforcing these laws, which inhibit women's access to safety and justice [20]. More work must be done to confront and remove harmful and unequal gender norms, roles and stereotypes and toxic masculinities, as well as to promote gender equality and women's empowerment. This is particularly the case for women and people of diverse gender identity and expression who use drugs, who historically have not been factored into mainstream GBV prevention or service planning. This gap is worsened by the unintended consequences of the implementation of national drug policy frameworks [21], where efforts to control drug supply may be at the expense of public health, human rights and safety [22].

Framing drug use as a “personal failure” has many harmful, stigmatizing and discriminatory effects for people who use drugs [23, 24]. For women, this “failure” is magnified by the gender norms and role inequities imposed upon them.

2.2 GENDER-BASED VIOLENCE AND HIV

While robust data are scarce, available evidence indicates that women who use drugs experience rates of violence up to 24 times higher than violence towards women in the general population [25, 26]. In some countries, women and girls who have been subject to intimate partner violence are 1.5 times more at risk of acquiring HIV than women who have not experienced violence [27, 28]. In addition, women living with HIV are at elevated risk of experiencing violence, particularly if their HIV status is disclosed [27, 29, 30, 31].

There is a stark lack of data on violence specifically against people of diverse gender identity and expression, and even less so in drug-using contexts [10, 32]; however, data that do exist indicate high rates of violence [31, 33]. Stigma and discrimination based on gender identity often intersect with other forms of discrimination such as on the basis of disability, ethnicity or race [34]. Marginalized and racialized women who use drugs experience further layers of discrimination and barriers to accessing essential services.

2.3 UNDERREPORTING OF VIOLENCE

Violence against women and people of diverse gender identity and expression who use drugs is typically underreported, for several reasons:

- Dismissal or blame from institutions such as legal, health, police and social service providers, as well as from family members
- Punitive laws and policies
- Survivors' fear of – and actual experience of – stigma and discrimination
- Survivors' lack of knowledge of their rights
- Fear of being perceived as “offenders”
- Fear of having their children removed from them

The criminalization of both drug use and sex work increases the risk that women who use drugs or who are sex workers (or both) are exposed to abuse by the police or other criminal justice officials [10, 35, 36]. To avoid arrest, deportation or having their children removed by child protection authorities [37, 38], women who use drugs often avoid involving police during incidents of violence or overdose, which in turn increases the risk of violence-related harm as well as fatal overdose.

Police have a combined and often conflicting role as enforcers of laws on the one hand, and as first responders to reports of violence on the other. Women who use drugs generally see law enforcement agents as a threat rather than as protectors, and so are unlikely to rely on police [38]. There have also been reports of police officers as perpetrators of violence and extortion, including demanding sex or other favours in return for avoiding arrest [39]. Even when cases of violence are reported, criminal-justice professionals tend to blame survivors, deeming women who use drugs (especially those who are also sex workers) to be partially responsible for the violence they have suffered [33, 40, 41].

Underreporting of violence by survivors prevents appropriate planning and budgeting for GBV prevention and support programmes. Funding services for GBV survivors, particularly women who use drugs, is not a political priority.

2.4 SEXUAL AND REPRODUCTIVE HEALTH

Women who use drugs may also have reduced access to contraception, owing to negative stereotyping and to the stigmatizing attitudes of some family planning service providers. This can increase the risk of unintended pregnancy and associated negative outcomes such as violence from intimate partners, risks associated with unsafe abortion, and the risk of vertical transmission of HIV, syphilis and the hepatitis B virus. Women who use drugs may be deterred from using sexual and reproductive health (SRH) services for fear of reprisal, rejection and discrimination. If they attend these services, they may not feel safe disclosing their drug use, which can undermine the effectiveness of their treatment. SRH practitioners also often lack knowledge of how to provide effective care to pregnant women who use drugs or who are on opioid agonist therapy (OAT).

Laws that criminalize drug use during pregnancy further deter pregnant women from seeking SRH care and support [42]. Discriminatory and invasive actions against pregnant women and mothers are an infringement of the right to health and the right to be free from torture and other cruel, inhuman or degrading treatment [43, 44]. Such actions impact negatively upon health-seeking practices and can cause interruptions in the provision of care, leading to poor obstetric and neonatal outcomes. In several jurisdictions, pregnant women who use drugs have been coerced into terminating their pregnancies

or are forced to relinquish their children to the State, and are denied information about, and access to, appropriate services [45, 46]. The disrespect and abuse of women who use drugs in prenatal and antenatal services includes unconsented and forceful examinations, un-anaesthetized episiotomy [47], forced or coerced terminations, and other violations of sexual and reproductive rights.

2.5 HARM REDUCTION

The implementation of harm reduction services largely fails to meet the needs of women and people of diverse gender identity and expression who use drugs, particularly those who are subject to violence [48]. Women are rarely involved in planning and delivering harm reduction services, and the services that do exist are scarce and underresourced [49]. Understandably, women experiencing violence, often from male contacts, tend to avoid attending male-centred services, especially where they may meet the perpetrator(s) of violence. Experience of violence acts as a barrier to the uptake and adherence to opioid agonist therapy (OAT), because partners may limit access to OAT services, and requirements to attend a clinic daily to receive OAT can enable stalking by violent partners [33, 50]. An abusive intimate partner may prevent service access. Women in need of HIV services may be constrained by fear that disclosing their serostatus could trigger GBV [50].

2.6 SOCIAL SERVICES

In most jurisdictions, access to welfare services, support or housing is contingent upon abstinence from drug use [51], which in practice contributes to further exposure to violence, trauma, separation from children and housing instability [9, 52, 53]. All these in turn exacerbate HIV-related health risks, including greater risk of HIV transmission, later diagnosis of HIV infection, and delay or disruption in the prescribing of antiretroviral therapy (ART). Additionally, current harm reduction and GBV programmes rarely incorporate services to prevent and address violence against women who use drugs [54].

2.7 IMPRISONMENT

The HIV burden among people in prisons is up to 50 times higher than in the general population [55], and with mandatory prison sentences for even low-level drug trafficking, the incarceration of women has jumped globally by 59 per cent since 2000 [56]. While flexibility is provided in the global drug policy framework for countries to provide alternatives to incarceration, such options are not always available or applied.

Women in detention are also a minority prison population, with unique risk factors and distinct pathways into crime and contact with the criminal justice system [57]. When deprived of liberty, there is increased potential for exposure to violence against women and people of diverse gender identity and expression [38], who are also disproportionately negatively impacted by poor HIV-related service availability, access and quality in closed settings [53]. Women who use drugs are detained for less severe, non-violent crimes, often heavily underpinned by poverty (“crimes of survival”) [58]. GBV is a key pathway to women’s imprisonment. For example, GBV against women is a key cause of indigence and may lead to property-related offences, unpaid fines or sex work-related offences [18]. Punitive approaches to low-level drug trafficking contribute to the overrepresentation of foreign national women in the criminal justice system of many countries.

2.8 HUMANITARIAN CRISES

All forms of violence including GBV are exacerbated in humanitarian crises, which heighten pre-existing gender and socioeconomic inequalities. Women and people of diverse gender identity and expression who use drugs, already disadvantaged by punitive approaches to drug use and its gendered inequalities, experience additional layers of risk and hardship in situations of conflict, natural disaster, displacement and pandemics, further reducing their safety, health and well-being. Discrimination becomes more extreme and harmful during humanitarian crises [59]. Women who use drugs in such contexts also experience greater potential for unsafe sex and drug use practices [60], while at the same time lacking access to life-saving GBV and other SRH services. Where services are offered for GBV survivors in humanitarian settings, access for women who use drugs is likely to be even more limited.

2.9 STRUCTURAL AND INTERSECTIONAL BARRIERS TO HEALTH AND SAFETY

Structural barriers, including intersectional stigma and discrimination and unequal gender norms, perpetuate inequities across the HIV care continuum. Experience of violence among women who use drugs is associated with increased HIV-related mortality, worse treatment outcomes, less access to and retention in ART [6, 61, 62, 63] and lower access to HIV prevention services, HIV testing and harm reduction services [10, 64, 65]. This reality (and the lack of tailored, responsive, cross-sectoral services) has devastating associations with homelessness, precarious and lower socioeconomic status, poor health outcomes, unintended pregnancy, incarceration and social isolation. Recognizing the intersections of multiple inequalities and how these affect women who use drugs can help in understanding the gendered impact of drug policies, and can help inform measures for preventing and addressing the risks of both HIV transmission and GBV [66].

2.10 THE DANGERS OF AN INADEQUATE RESPONSE

Despite the existing international frameworks and guidelines (box 1), many countries continue to criminalize people who use drugs, while offering minimal support for those in need. Furthermore, women and people of diverse gender identity and expression who use drugs are rarely included in policy dialogue about drug use and HIV. Commitments and normative guidance remain mostly on paper, leaving services for women who use drugs primarily as either a research and advocacy activity, or something to be implemented by civil society organizations with limited resources. They are largely not actioned by national governments [51]. Harm reduction programmes rarely provide services for prevention of vertical transmission and other SRH services, and there is a dearth of high-quality, survivor-centred GBV services [9, 67].

The lack of a public health focus in drug policy threatens to invalidate goals for social well-being and to undermine the Sustainable Development Goals and other global commitments. Furthermore, the shortfall of measures to address violence against women who use drugs, particularly in low- and middle-income countries, represents not just a blind spot in the global response to GBV [68], but an urgent public health and human rights crisis.

2.11 INTERNATIONAL POLICY IMPERATIVES

Policy frameworks

A range of policy frameworks exist to guide prevention and response to violence including GBV, for the mitigation of stigma and discrimination, and for ensuring the rights of women and people of diverse gender identity and expression who use drugs (see box 1).

BOX 1. POLICY FRAMEWORKS ON GENDER-BASED VIOLENCE AND DISCRIMINATION

- Universal Declaration of Human Rights (1948) [69]
- Single Convention on Narcotic Drugs of 1953 as amended by the 1972 Protocol (1972) [70]
- International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR) [71]
- International Covenant on Civil and Political Rights (1966) [72]
- Convention on Psychotropic Substances (1971) [73]
- Convention on the Elimination of All Forms of Discrimination against Women (1979) (CEDAW) [74]
- Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) [75]
- Declaration on the Elimination of Violence against Women (1993) [76]
- Beijing Declaration and Platform for Action (1995)^a [77, 78]
- Yogyakarta Principles (2007) (especially Principles 4-11) [79]
- United Nations Rules on the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) (2010)^b [80]
- United Nations updated Model Strategy and Practical Measures on the Elimination of Violence against Women in the Field of Crime Prevention and Criminal Justice (2010) [81]
- General Assembly resolution 65/228: Strengthening crime prevention and criminal justice responses to violence against women (2011) [82]
- Sustainable Development Goals (2015) (especially Goals 3, 5, 10 and 16) [83]
- Commission on Narcotic Drugs resolution 59/5: Mainstreaming a gender perspective in drug-related policies and programmes (2016) [84]
- International Guidelines on Human Rights and Drug Policy (2019) (Section 3.2) [12]
- Commission on the Status of Women resolution 60/2 on women, the girl child and HIV and AIDS (re-affirmed at the Commission's 66th session) (2022) [85]

^aThe Beijing Platform for Action and its subsequent reviews set the basis for women's human rights.

^bThe Bangkok Rules set the minimum standards of health, legal and social support for incarcerated women, including an emphasis on non-custodial alternatives.

The right to health care

There is a need for protocols, training and monitoring on respectful, non-discriminatory, inclusive provision of health care to women and people of diverse gender identity and expression, including in pre- and antenatal settings [86, 87]. The Committee on Economic, Social and Cultural Rights General Comment No. 22 (2016) on the right to sexual and reproductive health for all women, irrespective of drug use status, requires States to refrain from interfering with the right to health, and from applying coercive medical treatments and forced sterilization (article 12 of ICESAR) [88, 89].

The Global AIDS Strategy 2021–2026 includes targets for rights-based social enablers particularly relevant to women who use drugs [90]. These targets are reflected in the General Assembly's 2021 Political Declaration on HIV, wherein countries commit to ensuring that by 2025 less than 10 per cent of countries have restrictive legal and policy frameworks that lead to the denial or limitation of access to services; less than 10 per cent of people living with, at risk of and affected by HIV and key populations experience stigma and discrimination; and less than 10 per cent of women, girls, people living with, at risk of and affected by HIV experience gender-based inequalities and sexual and GBV [91].

Harm reduction

The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) recommend a comprehensive package of essential harm reduction services for people who use drugs (box 2) [92].

BOX 2. COMPREHENSIVE PACKAGE OF HARM REDUCTION SERVICES

PREVENTION OF HIV, VIRAL HEPATITIS AND STIs

- Harm reduction (needle and syringe programmes, opioid agonist maintenance therapy and naloxone for overdose management)
- Condoms and lubricant
- Pre-exposure prophylaxis for HIV*
- Post-exposure prophylaxis for HIV and STIs
- Prevention of vertical transmission of HIV, syphilis and HBV
- Hepatitis B vaccination
- Addressing chemsex

DIAGNOSIS

- HIV testing services
- STI testing
- Hepatitis B and C testing

TREATMENT

- HIV treatment
- Screening, diagnosis, treatment and prevention of HIV associated TB
- STI treatment
- HBV and HCV treatment

* Please note, results of qualitative research found that people who inject drugs prioritize access to harm reduction (needle/syringe programmes, opioid agonist maintenance therapy and naloxone for overdose management) over PrEP.

Source: *Consolidated Guidelines on HIV, Viral Hepatitis and STI Prevention, Diagnosis, Treatment and Care for Key Populations*, WHO 2022.

Additional necessary elements for women and people of diverse gender identity and expression who use drugs include SRH services (e.g., contraception, antenatal, perinatal and maternal care, comprehensive abortion services, infertility treatment and cervical cancer screening and management) [93]. Harm reduction services have been recognized as critical to the effectiveness and quality of HIV responses for all people who use drugs [94].

3. Recommendations to uphold commitments to international human rights frameworks and mechanisms

1 Governments must implement and pursue relevant international goals, conventions and rules (see box 1 above) with attention to ensuring government accountability. Stakeholders should likewise uphold commitments to human rights frameworks which can help prevent violence towards women and provide support pathways for GBV survivors [95].

2 Ensure that the Committee on the Elimination of Discrimination against Women (CEDAW Committee) and other stakeholders are well versed on intersectionality, including drug-use status and sex work, as well as on the evidence base for decriminalization² and harm reduction approaches.

3 Coordinate across the United Nations system – including UNODC, UNAIDS, WHO, United Nations Population Fund (UNFPA), the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), the Office of the United Nations High Commissioner for Human Rights (OHCHR), the CEDAW Committee, the Committee on Economic, Social and Cultural Rights, the offices of relevant rapporteurs and the International Narcotics Control Board – to ensure that efforts to address HIV, drug use and gender are considered together and in ways that always prioritize and never compromise human rights.

²For the purposes of this briefing paper, decriminalization is defined as policies that remove criminal sanctions for personal drug use and minor drug offences. This concept refers to the process through which an offence is reclassified from “criminal” to “non-criminal” through legislative action ([International Narcotics Control Board Report 2022](#)).

4

Governments must enforce the closure of compulsory treatment and rehabilitation facilities,³ in accordance with the joint United Nations statement on compulsory drug detention and rehabilitation [96], as they are noted for human rights violations, including violence towards women who use drugs.

³For the purposes of this briefing paper, compulsory drug treatment and rehabilitation facilities or detention centres are facilities where people who use drugs are confined without their consent, and often without due processes of diagnostic assessment and evidence-based and ethical treatment for substance use disorders ([UNODC, WHO International standards for the treatment of drug use disorders, 2020](#)).

4. Good practice in gender-based violence-related services for women and people of diverse gender identity and expression who use drugs

Integrating and mainstreaming services for GBV prevention and survivor support into harm reduction programming and HIV prevention and treatment programming is likely to improve access [64]. WHO guidelines recommend that health services for GBV survivors be integrated into existing services rather than being stand-alone, especially at the primary health-care level [87]. Likewise, the incorporation of community-led, rights-based harm reduction approaches can complement GBV service provision within facilities.

This section outlines practical examples of approaches for delivering GBV services as part of harm reduction programmes. These approaches should be used as foundations for the design and implementation of services. Examples of such services in action can be found in annex II.

4.1 APPROACHES

Meaningful community involvement

Planning and resourcing strategies must enable the meaningful involvement [97, 98] of women and people of diverse gender identity and expression who use drugs. Their leadership is a foundational element in the design, implementation, monitoring and evaluation of all services. It creates an informed approach to service provision, resulting in improved reach, relevance, effectiveness and efficiency. Meaningful involvement is not only ethically desirable but also indispensable to the development of effective GBV services that address needs and build on individual and collective strengths and lived experiences. Engaging networks or organizations of women who use drugs is key to this. In this approach, they become expert activists rather than “service users”, moving to the centre of learning and teaching [99].

Service integration

All GBV services for women and people of diverse gender identity and expression who use drugs must be built on a clear understanding of systemic inequality, intersectional oppressions, and associated barriers and risks [100]. There is no one model of integrated service delivery for GBV services, but the United Nations promotes coordinated multisectoral approaches based on international standards [17]. Ideally there will be multiple ways for women and people of diverse gender identity and expression to ensure their specific needs are met through flexible and responsive service models and approaches, depending on the context. Models can include one-stop centres that provide health, legal and social services in one place, as well as decentralized approaches that rely on effective referrals and standard operating procedures. A people-centred approach includes standard GBV services, with peer workers, harm reduction providers, health-care providers [87], social workers and legal services providers trained to identify and support survivors.

A key way to improve access is to ensure integration into existing service delivery platforms (especially those closer to communities), rather than stand-alone centres. Where services cannot be included on-site, referral linkages should be developed to reduce access barriers, with referrals based on the needs and wishes of survivors.

To ensure the accessibility, acceptability, applicability, affordability and quality of services, regular monitoring and evaluation by service users and their advocates is required [42, 50]. Community-led monitoring should be applied to facilitate governance and accountability mechanisms for HIV response [101].

Capacity-strengthening

GBV professionals should be skilled at receiving survivors who use drugs with understanding and without judgment. Training and support can be provided to shelter staff, law enforcement officers and other criminal justice professionals and health-care workers to enable the inclusion of people who use drugs and to reform procedures towards greater inclusivity and professionalism.

Approaches that build in first-line support [87], violence awareness and active listening can enhance the relevance and utility of harm reduction services in working with clients experiencing or at risk of violence [102, 103, 104]. Many harm reduction staff will benefit from training on sexual orientation, gender identity, gender expression and sex characteristics (SOGIESC) to improve relevance and client coverage with all service elements.⁴ Harm reduction workers should also be trained to provide first-line support for survivors of GBV. Important communication skills include listening with empathy, communicating without judgment and offering validation. Training should also provide an understanding of violence, relevant laws, knowledge of available referral services, and an intersectional understanding of gender diversity, non-binary and sex worker issues to ensure non-judgmental, informed service provision which upholds client autonomy.

For both shelter staff and harm reduction providers, training should not only focus on what services should be provided, but also address the attitudes and values of service providers towards gender, drug use and violence. Shared learning can be facilitated through cross-organizational training opportunities, staff secondments and site visits.

Workforce development in harm reduction and GBV programmes must include career pathways beyond peer worker roles, while ensuring that gender mainstreaming is reflected in staff recruitment processes.⁵

⁴ See, for example, Hivos SOGIESC tools available at <https://hivos.org/impact-area/gender-equality-diversity-and-inclusion/so-gie-sc-training/>.

⁵ For practical guidance on gender mainstreaming in this context, see related section in *Addressing the specific needs of women who inject drugs: Practical guide for service providers on gender-responsive HIV services* (UNODC, 2016).

Safety planning as part of harm reduction services

Working with clients to support their safety goals and making practical plans based on individual circumstances can help them regain a sense of security by identifying strategies to help mitigate future incidents [105] (for a sample safety plan, see annex I). Safety and the right to self-determination must be at the forefront of an ethical response to any survivor of violence, including persons who use drugs. This requires that all efforts to provide services must respect privacy and confidentiality as the bedrock of service provision and programming [87]. It also means that the client's/survivor's wishes must be respected in taking up or declining services, including referrals.

Building networks and partnerships with community-led organizations of women who use drugs will help ensure effective, peer-led referral pathways and peer engagement in all processes. Harm reduction providers will need to engage with new groups and agencies (violence support providers, sex worker groups, LGBTQI+ agencies and networks, and feminist organizations) to develop intersectional approaches

Psychologically informed environments

Services for survivors of violence should be designed to identify and address immediate, mid- and long-term health, psychosocial, legal and financial needs [38]. These should be fortified by service cultures such as those characterized as psychologically informed environments (PIEs) – safe and welcoming spaces that are non-judgmental, compassionate and responsive to the complex needs of survivors who are women and people of diverse gender identity and expression who use drugs. PIEs provide a framework for reflective, respectful and responsive approaches to providing both harm reduction and GBV services, giving clients choice and control over how and when they engage. Staff training and support revolve around reflective practice (a process of continuous learning from professional experiences) [106] and continuous improvement. While PIEs have been applied primarily in housing contexts, the approach also holds promise for the GBV sector [106, 107].

Women-only safe spaces

Dedicated women-only safe spaces can be made available at drop-in and one-stop centres, while in some cases separate venues may be needed for women to attend services safely [108]. Subject to community consultations, which may identify adjustments, such facilities should in general be inclusive of people of diverse gender identity and expression who use drugs, including those with children. Transgender women should be able to access safe spaces freely.

Data collection and research

Evidence is needed to inform, guide and advocate for effective HIV and GBV programming. Civil society organizations working on the elimination of violence against women have identified lack of data collection as a key “domain of invisibility” that increases exposure to violence and can leave specific needs ignored or unmet [99]. At all levels, therefore, it is critical to collect, analyse, report and use data – and to analyse it from a gender perspective – for planning, resourcing, evaluating and improving services. Harm reduction organizations and governments alike must collect, disaggregate and use data that includes and reflects the experiences of women and people of diverse gender identity who use drugs.

In the interim, it is important to note that lack of data is not an acceptable basis for inaction. Developing and implementing GBV services can take place alongside necessary research and data collection.

Community-designed and -led monitoring and data collection activities can help stakeholders and civil society to ensure comprehensive coverage. For example, services can be evaluated and improved through participatory research into population size estimates and quality of service provision. Documentation

of case studies can inform best practice. Communities of women who use drugs should be included as equal partners in data collection and research. Women who use drugs should lead all stages of the research process, rather than only providing input into research design and data collection [109, 110]. Likewise, they should be meaningfully engaged in the design, implementation and evaluation of services resulting from research and from policy changes.

It is important to create management information systems across sectors for a minimum set of harmonized indicators on those reporting violence. Guidance is available on ethical and safe ways to gather administrative data on GBV from services, including harm reduction services [111].

Advocacy

Groups or networks of women and people of diverse gender identity and expression who use drugs should lead advocacy efforts to reduce violence, including those directed at the wider public. Where such groups or networks do not exist, it is important to advocate for their establishment and development. Service providers can work with groups or networks of women who use drugs to highlight the impacts of violence on their social well-being, health and human rights. Where essential GBV services do not exist, it is critical to advocate for them by engaging with stakeholders including HIV services, financing authorities and policymakers, law enforcement and other relevant service providers.

Advocates should work for an enabling legal environment through the removal of punitive and discriminatory laws and policies, and the introduction and enforcement of protective and enabling legislation and policies that address violence against women and people of diverse gender identity and expression who use drugs, and gender inequalities [112]. Examples of policy reform include:

- Frameworks to ensure that eligibility for safe housing, access to financial support programmes and social protection mechanisms are not contingent on abstinence from drug use or proof of identity [38, 42, 50]
- Revising age of consent laws to improve access to harm reduction, SRH and other services for young women [113]
- Establishing systems to support women who use drugs during pregnancy and parenting, rather than enforcing punitive approaches.

Advocates can also work to secure sustainable funding for organizations of women who use drugs working on prevention and response to GBV, and for GBV services catering to women who use drugs. Advocacy can also promote multisectoral cooperation to incorporate GBV services within the continuum of care for women who use drugs [114].

Engaging with and sensitizing the media can guide journalists towards responsible and quality reporting that avoids sensationalist depictions of drug use that infer that violence is a normal component of drug use.

Challenging harmful gender norms

Harm reduction services can introduce gender mainstreaming and advocacy initiatives to counter sexism, toxic masculinities and other harmful gender norms within their own programmes and among referral network organizations [17, 115, 116].

Addressing stigma and discrimination

It is important to scale up and fund actions to reform public health and law enforcement practices to ensure they support rather than impede addressing GBV, including the removal of discriminatory, arbitrary or violent practices. Training, cross-training, secondments and other support can help referral

network agencies to improve their capacity to work with people who use drugs.⁶ Targeted campaigns and public campaigns addressing social barriers can also be implemented.⁷

All harm reduction workers should be trained to identify and address stigma and discrimination in service delivery against women and people of diverse gender identity and expression who use drugs – including intersecting forms of discrimination such as on the basis of disability, age, ethnicity or race. Harm reduction workers themselves must be free from violence and discrimination in the workplace, and their work as human rights defenders must be protected. Harm reduction programmes must likewise guarantee access to effective accountability mechanisms within their organizational structure [117]. Corresponding programmes for health-care workers and law enforcement agencies should also be instituted or supported.

Ensuring accountability for GBV and related human-rights violations

Holding perpetrators accountable and ensuring the safety of victims/survivors requires meaningful access to justice and comprehensive criminal justice responses to GBV. In addition to advocacy and support for closing legal loopholes and eliminating discriminatory rules and procedures, this requires capacity-building for police, prosecutors, judges and other criminal justice professionals, as well as promoting specialized and coordinated institutional mechanisms. More work is needed on standard operating procedures, coordination bodies and other efforts to increase collaboration among key stakeholders, as well as efforts to enhance legal literacy and access to legal aid and representation for women and people with diverse gender identity and expression, and support for community monitoring. It is also important for harm reduction and GBV services to work with women who use drugs to ensure their access to legal services, complaints mechanisms and related support, as available.

Protective legal and policy approaches to drug use

An enabling legal environment that will efficiently address violence against women and people of diverse gender identity and expression who use drugs can only be achieved through strong political leadership, and the active engagement and leadership of community-led responses that are adequately resourced to advocate for, monitor and implement rights-based responses. It must be ensured that drug policy and law enforcement do not undermine the safety, health and human rights of the victims of violence.

Networks of people who use drugs and harm reduction providers should advocate against punitive laws and promote decriminalization,⁸ along with alternative approaches to addressing drug use. Local and national initiatives can improve relations between law enforcement personnel and women who use drugs, including sex workers, by increasing attention to gender-sensitive policing (e.g., rules, codes of conduct and instructions for police when interacting with women who use drugs to eliminate GBV at the hands of law enforcement; training on the responsibility of law enforcement to respond to GBV for all women; and human rights-based law enforcement practices contributing to accountability and implementation of international standards and norms, including the Bangkok Rules) [80, 118].

A number of countries have initiated or adopted legal reforms to decriminalize minor offences, such as personal consumption of drugs, as well as possession and cultivation of drugs for personal consumption, and have adopted policies to refer people who use drugs to community-based treatment and social services, or impose administrative fines or caution them. These approaches are possible within the

⁶ See, for example, this resource for health workers designed to be delivered by community advocates: [Putting Together the Puzzle: Stigma, Discrimination and Injecting Drug Use. AIVL Training Module for Health Care Professionals and Students \(Women and Harm Reduction International Network, 2013\)](#).

⁷ See, for example, the Elimination of Violence Against Women who Use Drugs campaign: <https://whrin.site/campaigns/>.

⁸ For the purposes of this briefing paper, decriminalization is defined as policies that remove criminal sanctions for personal drug use and minor drug offences. This concept refers to the process through which an offence is reclassified from “criminal” to “non-criminal” through legislative action ([International Narcotics Control Board Report 2022](#)).

framework of the international drug control conventions, which promote health-centred and human rights-compliant responses to drug use and drug use disorders. The unnecessary use of imprisonment for minor drug-related offences is ineffective in reducing recidivism, and aggravates the social, economic and health issues of those involved as well as of their families and communities. It also overburdens criminal justice systems, preventing them from efficiently addressing more serious crime. For minor charges where the woman in contact with the law does not pose a serious or dangerous threat to safety and society, alternatives to prosecution such as case dismissal, depenalization/decriminalization, gender-responsive diversion and treatment programmes, restorative justice and other related alternatives should be considered by police and prosecutors, while upholding respect for the law and the rights of victims [18].

Responding to humanitarian crises

It is possible and necessary to plan for humanitarian crises, despite competing demands, to reduce the harms faced by women and people of diverse gender identity and expression who use drugs. The COVID-19 pandemic and other recent humanitarian emergencies have shown the need for protected harm reduction supply chains, community involvement, low-threshold service access, take-home OAT dosing, emergency shelters and other targeted relief measures. These measures ensure service continuity and ameliorate predictable hardships.

Women who use drugs are expertly placed and possess the requisite leadership skills and knowledge to support and inform inclusivity in responses to crises. Governments should consult with women who use drugs, building on their resilience and strengths, to develop inclusive plans that pre-empt supply, logistical and other obstacles in humanitarian emergencies. International bodies, aid agencies, the United Nations and governments must work with networks of people who use drugs to support service continuity, including for the internally displaced and those seeking shelter at refugee sites [119].

4.2 SERVICES

Addressing gender-based violence in the context of comprehensive sexual and reproductive health and harm reduction services

GBV and harm reduction services should be integrated into SRH services as critical entry points for expanding access to all women [86, 120]. Likewise, SRH services, including GBV services, should be incorporated into harm reduction services.

WHO clinical and policy guidelines for responding to intimate partner violence and sexual violence recommend that survivors be offered first-line support, post-rape care, mental-health care and referrals as needed. Minimum requirements for a systematic protocol to identify and respond to violence include a private space for consultation, standard operating procedures, trained providers to offer first-line support, referrals established and a documentation system [87].

Harm reduction services should be equipped to provide a package of post-violence care on-site. Some clinical elements may require timely assisted referral. In the case of rape or sexual violence, the package should include:

- Emergency contraception
- Access/referral to safe abortion if needed
- Post-exposure prophylaxis (PEP) for HIV
- Confidential HIV testing and counselling

- Prevention and presumptive treatment of sexually transmitted infections (STIs)
- Referral to legal services (including medical examination)
- Referral to or provision of psychosocial support and counselling for both survivor and children/dependents if required

It is critical that GBV prevention and support services, including referral pathways, are attuned to the varied GBV service needs of women who use drugs [42]. Harm reduction services, whether integrated or stand-alone, must be low-threshold (with no appointments needed and short waiting times), confidential, client-centred, discreetly located and physically accessible. Opening hours should be adjusted to reflect client preferences. Mobile services can increase access. Such service delivery adjustments can help women and people of diverse gender identity and expression by increasing control and bodily autonomy, facilitating empowerment and providing an enabling environment for addressing power relations and violence [121].

Effective responses should acknowledge and build on strategies that individuals already use to navigate risk. First-line support should focus on the lived experience of survivors, providing opportunities to link to relevant peer and other support, and upholding non-judgmental, survivor-centred principles. In some cases, the option of assisted referral⁹ has been shown to have a positive impact on service connection [14]. Where such mechanisms are not in place, advocacy for them is required.

The SRH needs of women and people of diverse gender identity and expression who use drugs can also be incorporated into harm reduction services. These include:

- Access to contraception options
- Pregnancy testing
- Comprehensive abortion care [122]
- Antenatal, birthing and postnatal care
- The full range of HIV services including testing, treatment, prevention of vertical transmission of HIV, syphilis and the hepatitis B virus (PMTCT)
- STI case management
- Infertility treatment
- Cervical cancer screening
- Counselling and support

Such services can be incorporated into harm reduction services directly and by establishing linkages with doctors and gynaecologists who are able and willing to provide professional and judgment-free care, and to offer a regular time at service locations. Obstetric services should provide non-punitive, evidence-informed care to all pregnant people. Tailored, adolescent SRH services need to be provided for young women who use drugs to cater for their emerging SRH needs, without limitations to access, i.e. without requirement for parental/guardian consent [93].

Shelters

Harm reduction service providers should coordinate with crisis shelters and housing services to ensure that women and people of diverse gender identity and expression who use drugs and are experiencing violence can access shelters irrespective of drug use status [55, 123]. These services should apply standards as per the United Nations Essential Services package [17]. Ideally shelters will include a safe

⁹Assisted referral means making an appointment on the client's behalf with their informed consent, with the offer of accompanying the client to the GBV or other service location.

consumption space. Examples, such as Hostel Pannekoekendijk in the Netherlands (box 3), support people who use drugs with a range of social, psychological and health support including drug-use equipment and OAT [124].

BOX 3. HOSTEL PANNEKOEKENDIJK

Hostel Pannekoekendijk in Zwolle provides a range of services, including consumption rooms for different substances (e.g. alcohol) and forms of drug use (injecting and smoking). The hostel links closely with other harm reduction service providers as well as local health and social services. Specific SRH support is provided for women as well as for sex workers by two nurses. The hostel also provides assisted housing placements across 27 apartments.

Website: www.tactus.nl/locaties/zwolle-locatie-pannekoekendijk/

Good practice harm reduction approaches in shelters include:

- Harm reduction services in place prior to residents moving into the site to encourage them to adopt or continue safer drug-use practices
- Staff trained on harm reduction, including overdose prevention, recognition and response, as well as the use of naloxone
- Client-centred by including women who use drugs in planning and implementation processes and responding to each person's specific needs
- Harm reduction services designed to meet the varied needs of people living at the shelter, delivered respectfully, non-judgmentally and in a culturally safe way
- Safe spaces for consumption provided in a private location that allows harm reduction staff and peer workers to discreetly support people who use drugs [125] and promptly intervene in case of overdose
- Translation services in countries where there are high levels of migration, or a higher number of migrants who use drugs

Legal aid

Harm reduction services should provide referrals to affordable or free legal services that can assist in addressing violence, family law and child custody issues. These should be provided on-site or through paralegal peer work [126] covering issues specific to women and people of diverse gender identity and expression who use drugs. Cooperation with police and advocacy to remind State institutions of their duties concerning access to legal aid is also crucial,¹⁰ considering that early access to legal aid upon arrest or in the police station can play a significant role in whether a woman remains in pretrial detention or is imprisoned [18].

¹⁰Principles 3 and 10 of the [United Nations principles and guidelines on access to legal aid in criminal justice systems](#) (2013).

Gender-specific peer outreach

Peer outreach can improve uptake of harm reduction services. Peer workers are often uniquely positioned to enhance engagement with women and people of diverse gender identity and expression who use drugs and to increase their access to services. Recruiting women who use drugs with training to provide GBV support can provide a unique service bridge. Peers can often counteract barriers that may otherwise prevent women from seeking support, by increasing trust and a sense of personal safety, enabling navigation of service paths and referrals, and providing a viable context for discussing personal issues, including those relating to GBV.

Other considerations for recruiting peers might include gender identity, age and ethnicity, in order to reflect as closely as possible the varied demographics among people who use drugs. It is important to ensure support and resourcing for this work, including adequate remuneration and workforce development opportunities for peer workers.

Take-home opioid agonist therapy

Take-home OAT dosing has been shown to be a viable method of enhancing treatment access, and it is not associated with diversion of OAT medication or increased risk of opioid overdose [127]. The expansion of take-home OAT as a COVID-19 adaptation was proven to increase the acceptability and uptake of services and should remain in place [128]. It is expected that take-home dosing for women and people of diverse gender identity and expression who use drugs will enhance treatment access, well-being and personal security.

Parenting support

Many parenting women and people of diverse gender identity and expression who use drugs experience family and community isolation, leading to hardships concerning housing, child custody, legal issues or violence. In many settings, the lack of support services for parenting people who use drugs is exacerbated because drug use is used as a justification for removing custodial rights. Harm reduction services can support clients to overcome many of these challenges, directly or through assisted referral to other agencies. Parenting support can attract potential clients to harm reduction services [129].

Sex worker-focused and -led responses

Information on safety strategies to prevent or avoid violence is important and highly relevant to sex workers who use drugs. Support frameworks and mechanisms to prevent potential workplace violence should be implemented. These might include community-led monitoring structures such as “Ugly mug” lists [130], the creation of sex worker-led networks, and coalition-building with law enforcement and social welfare agencies to ensure unfettered and non-discriminatory access to required rights-based services.

It is important that efforts are grounded in and informed by the understanding that sex work is work, and that consensual sex work is clearly differentiated from trafficking in persons and child sexual exploitation, with different support versus referral approaches. All persons, whether consensually providing sexual services or forced or coerced, need their immediate health and protection needs met with human rights-based services. Dialogue with law enforcement officials is critical to prevent extortion and violence by law enforcement officers, and to prevent the use of possession of condoms as evidence of sex work.

Income generation

In some contexts, cost-effective microfinance and community mobilization interventions have reduced economic violence while empowering survivors and improving livelihoods [64, 131]. Direct cash and voucher assistance (CVA) is increasingly being considered as one option to reduce risk and support persons to avoid harmful situations [132, 133]. Such approaches should be grounded in empowering principles and developed with the meaningful participation of the community. Harm reduction programmes may be able to obtain funding for such opportunities by including them in funding proposals and by brokering partnerships with the private sector.

Annexes

I. Safety plan example

The safety plan is a set of measures and strategies that aim to increase the safety of a survivor of GBV. It must be designed by or with the survivor. Each safety plan is unique. Safety involves more than assessing the potential for future assault. It is about increasing space for action: the protection of human dignity, freedom and the right to live a life without violence.

- ✎ Safety planning is an optional process that must only be made with the client's informed consent and collaboration, with support if requested
- ✎ Safety plans should be made available for the client to complete by themselves or with support if requested
- ✎ Referral to appropriate services should be provided, based on the client's stated needs
- ✎ The client's own assessment of their safety and risk levels must be primary
- ✎ The client must be listened to in a confidential and private setting
- ✎ No improbable or unrealistic promises should be made

For more evidence-based detail on how to conduct safety planning, see *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook* (WHO, UN-Women, UNFPA, pp.25-28).

THIS IS YOUR OWN PRIVATE SAFETY PLAN

The following steps are my plan for increasing my safety and preparing for possible further violence. Although I do not have control over the violence committed by perpetrators, I do have a choice about how I respond and how to get myself (and my children) to safety.

- Do you have a safe place to keep this safety plan, at home or with a friend? Do you have a safe place to keep important numbers?

- It is important to practise how you would get out of your house/apartment safely. What doors, windows, lifts, stairwells or fire escapes would you use? Consider which exits would be the safest, and write down below how you would leave.

- If I decide to leave, I will _____
- In order to leave quickly, I can keep my purse/wallet, my identification documents, my phone/phone charger ready and put them (place) _____
- I can tell (name) _____ about violence and ask them to call for help if they hear suspicious noises coming from my home.
 Another person I can tell (name) _____
- I can teach my children how to use the telephone and call for help (police/fire department).
- I can use a code word with my children and/or my friends so they can call for help.
 My code word is _____
- If I have to leave my home, I will go to _____
 (Decide this even if you think it won't be an imminent option.)
- If I can't go to the place above, I can go to _____
- When I suspect my partner/friend/relative/client will be aggressive, I will try to move to a space that is lowest risk, such as _____
- I will use my judgment and intuition. If the situation is very serious, I can give my partner/friend/relative/client what he/she wants to calm them down. I have to protect myself until I am/we are out of danger.

SAFETY WHEN PREPARING TO LEAVE

You may have to leave the residence you share with your partner/friend/relative/client. Leaving must be planned carefully, to increase your safety. A violent partner/friend/relative/client often strikes back if they believe that the person is leaving a relationship/living situation.

▾ I can use some or all of the following safety strategies:

- I will leave money and an extra set of keys with _____ in case I have to leave quickly.
- I will keep copies of important documents (social security cards, birth certificates) or keys at _____
- I will go to the bank and open a savings account by _____, to increase my independence.
- Other things I can do to increase my independence include: _____
- If I use my cell phone, the following month the telephone bill may tell my partner/friend/relative the numbers that I dialed after I left. To keep my calls confidential, I will either use coins at a pay phone or use a calling card for a limited time when I first leave.

▾ Other things I can do to increase my safety

- The local shelter number is _____. I can seek shelter and support by calling.
- I will check with _____ and _____ to see who would be able to let me stay with them or lend me some money.

▾ Other ideas:

- I can leave extra clothes with (or get clothes from) _____
- How often will I sit down and review my safety plan? _____
- I will ask a trusted friend or advocate to help me review my plan. The person I will ask is _____
- I will rehearse my escape plan and practise it (with my children) when it is safe to do so.

SEXUAL SAFETY PLANNING

- ↘ If I'm concerned that a partner/friend/relative/client may insist on engaging in sexual activity that I don't want to do, I can take the following steps to avoid having sex:

1. _____
2. _____
3. _____

- ↘ If I am having sex that I don't want and am concerned that they may hurt me, I can take the following steps to protect myself:

1. _____
2. _____
3. _____

- ↘ I can also do the following things (check all that apply):

- Try to stay physically on top of the person during sexual activities so I can escape if I need to.
- Let the person clearly and calmly know that I don't want to have sex.
- Tell the person I need to go see a family member or friend who is in trouble.
- Have all my important personal belongings and my clothes in one place so I can leave quickly and figure out the easiest way to escape.
- Keep emergency cash or a credit card in my purse to get a taxi or public transport to a safe place.
- Text or call my contacts above to let them know I need a place to go to or ask them to meet me.
- To protect myself from HIV or sexually transmitted infections and pregnancy with the person, I will (describe plan)

✎ I can also do the following (check all that apply):

- I can ask the person to use a condom.
- I can use a female condom.
- I can avoid having vaginal or anal sex.
- I can use other forms of contraception (note: only male and female condoms are effective in preventing HIV or STIs).
- My own strategies can be

✎ If I had unprotected sex and think that I may have been exposed to HIV or think I may be pregnant, I can also (check all that apply):

- See my doctor or emergency-care medical staff within 48 hours and ask them to start me on a dose of antiretroviral medication to prevent getting HIV.
- Get tested for HIV and other STIs.
- Go to the pharmacy to pick up emergency contraception within 5 days after intercourse to prevent pregnancy.

SAFETY PLAN DURING SEX WORK

- When I work, I know the area, and my exit plans are _____
- When I work, I inform this person _____ and this person _____ where I am going and when I expect to be back.
- When I work, I am usually in the company of _____ and _____, and maybe _____
- They can take registration numbers of clients' vehicles, and they know to call _____ if they don't see me coming back.
- When going to work, I have condoms, lube and all material that I need to keep safe.
- When at work, I am dressed for safety (I wear clothes I can keep on me when working and that can't get stuck in car doors; I avoid necklaces and jewellery that is too loose or too tight; and I wear comfortable shoes that are appropriate for running at all times).
- Wherever I work I am aware of escape routes, and I don't let a client get between me and the nearest exit.
- I am a trans sex worker, and I know the area where I am going to work.
- As I know the area, I am clear identifying not identifying to my clients as transgender.
- If I am attacked, I am aware I don't need to be heroic and if I can, I get away safely.
- I can scream or use a whistle to attract the attention of others.
- Other strategies _____

TIPS [134, 135, 136]

- In sex work situations, keep focused on the behaviour of the client, and keep your eyes on your clients and their hands at all times.
- Take your mobile phone, charged and with credit; or a phone card; or some money if you don't have a mobile.
- Have a small amount of cash with you in case you don't make any money or get dumped by a client and you need to use a payphone or get transport home.
- At night, try to work in busy, well-lit areas. Be aware of local policing activities.
- Negotiate price and collect money upfront, and set time limits.
- Do not allow unfamiliar clients to restrain you for any reason, even if this is their fetish.

II. Case studies

Women Nest, Kenya

Women Nest provides a safe space for women who use drugs to report all forms of GBV. The organization works with government facilities as well as other NGOs to support women during the reporting process. Women Nest also runs a GBV intervention programme to challenge women's perceptions of intimate partner violence as normal or an acceptable part of their lives, and to discuss strategies to prevent violence. At the programme's support group meetings, women share experiences, learn about GBV prevention strategies from their peers and access paralegal support. The GBV programme also sensitizes health-care workers on non-stigmatizing strategies for working with women who use drugs who are experiencing violence. The sustainable-livelihood project feeds into GBV prevention by providing a source of income to reduce financial dependence on male partners via the sale of beaded items.

The COVID-19 pandemic escalated GBV against women who use drugs, which resulted in many women becoming homeless. Women who use drugs were at additional risk of physical and sexual violence because curfew laws required all people to be indoors (i.e., with potential perpetrators of GBV). Economic strain due to the lockdown escalated cases of violence. To escape this situation, women sought shelter under bridges, culverts, in bushes and in derelict buildings, where they faced greater risk of rape and acts of physical violence from strangers.

These circumstances prompted Women Nest to establish three safe houses where women could spend the night in safety. The shelters are situated in the informal settlements, within walking distance of major drug-using sites, to increase their accessibility to women, especially at night. Since early 2022 the shelters have been sponsored by WHRIN (Women and Harm Reduction International Network) with renewed emphasis on policy and practices that support client agency and autonomy. Networks of women who use drugs have created a system to identify and refer to the shelter women who use drugs experiencing violence and/or homelessness. To avoid backlash or stalking from male partners, the women keep the location of the safe houses confidential.

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Clinica Wound, Mexico

Extreme violence, fuelled by "machismo" culture and the impacts of male dominance, is among the biggest challenges faced by women who use drugs in Mexico. Women are the ones who suffer the harshest punishments if they are involved either directly or indirectly in drug-related events. The combination of criminalization, stigma, myths and misconceptions around the use of drugs with patriarchal and moralistic social perspectives intensifies the challenges faced by women who use drugs in Mexico.

Clinica Wound conducts open education spaces that are inclusive of the voices of women who use drugs to help demystify assumptions about good versus bad, moral versus immoral and health versus disease; to help promote compassion, dignity, respect for human rights and communities free of violence; to uphold the autonomy of women’s decision-making on issues concerning their bodies, and to debunk the moralism of patriarchal beliefs.

Clinica Wound is led by women, following the principles of liberation medicine and autonomy separate from the State and from patriarchal institutions, centring the needs of women who use drugs. The interventions are simple, treating everyone as equal. Every year, three main community commemorations are held: in March, the displacement of people from their communities in Tijuana; in June, Support don’t Punish, with a focus on the international women’s campaign; and in November the Elimination of Violence Against Women Who Use Drugs (EVAWUD) campaign, with advocacy and activities to remember the lives of women lost in the patriarchal war on drugs, including small street commemorations, rituals, social media, street art and gatherings.

In every space – on the street, in the community, among family and friends, at events and in formal presentations – dangerous and outdated drug policies are challenged, and open safe spaces are created where women share their experiences with service providers, students and volunteers who sit together to advocate for ending societal judgment and misconceptions about drug use. Clinica Wound provides monthly harm reduction services, supplies, needles, syringes, naloxone and women’s toiletries through judgment-free harm reduction approaches. By planting seeds of compassion and respect, strong roots are growing to change the way society looks at women who use drugs.

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Metzineres, Barcelona, Spain

Metzineres welcomes all those who have experienced marginalization by creating safe spaces and places for women and people of diverse gender identity and expression that offer individually focused, compassionate responses to their complex and ever-changing realities. This involves broadening organizational focus beyond the issue of drug use and responding to multifaceted forms of violence and trauma experienced by women who use drugs. These issues must be addressed in tandem to heal and grow. In defining harm reduction, Metzineres understands that the most serious harm that a person receives does not usually come directly from the substance they use but, for example, from lack of employment or housing, as well as from stigma, criminalization and discrimination.

Metzineres has a multidisciplinary team composed of women with lived experience and technical knowledge: a lawyer, a social worker, a psychologist, social educators, nurses, community leaders, a community manager, a designer and researchers. Together the participants have built a model that provides an integral and holistic approach. Its social centre offers a safe space where women can rest, eat something and socialize. They can take a shower, use the washing machine, the computer and Internet connection. They can use their drugs in the consumption rooms and participate in the different workshops or a rich agenda of community activities. Metzineres’ advocacy work, based on realistic data as well as original research, pushes for the rights of women who use drugs, surviving violence and situations of compounded vulnerability to enter the international, national and local political agenda.

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Club Eney, Ukraine

According to UNFPA, in Ukraine 1.1 million women per year experience GBV. Focus group discussions with women who use drugs in Kyiv in 2018 found that all participants reported violence from their partners or family members. They also reported institutional violence, ranging from judgmental treatment and brutality from the police to threats by social workers to revoke their parental custody rights. Women who use drugs are barred from women’s domestic violence shelters. The majority report not accessing other services because of stigma, discrimination and fear of persecution. Over 50 per cent of the focus group participants had also experienced abuse at rehabilitation centres.

While implementing harm reduction projects, Club Eney identified a high prevalence of GBV and the need for GBV prevention services for women who use drugs and sex workers. In 2018, Club Eney began providing gender-sensitive and non-discriminatory GBV prevention services for women from the target populations who have experienced violence. Club Eney was funded by the International Renaissance Foundation for the “Implementation of a Comprehensive Approach by the Communities with Problems of Violence Against Women Who Use Drugs” project. Through this project, Club Eney was able to pilot GBV screening, brief interventions and referrals to a treatment tool, WINGS (Women Initiating New Goals of Safety), among women who use drugs and sex workers in Kyiv. (WINGS is described in further detail at the end of this annex). In 2019, Club Eney conducted WINGS research which confirmed a very high prevalence of GBV among sex workers and women who use drugs, and serious gaps in services for them.

During 2020–2021, with support from the United Nations Trust Fund, WINGS was provided to more than 1,600 survivors of GBV across eight regions of Ukraine. In 2022, the WINGS methodology was adapted for focused HIV testing and treatment for women, to continue providing services in these regions. A shelter for women who use drugs who face GBV was opened with support from WHRIN. The need for a national advocacy campaign to promote the shelter model for women who use drugs is evident. Club Eney has also been an active participant in the EVAWUD campaign initiated by WHRIN in 2019; the organization also works with women’s organizations in nine cities to expand services.

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CAHMA, Canberra, Australia

In 2020, CAHMA participated in WHRIN’s EVAWUD campaign with many activities exclusively designed for women who use drugs, including the Orange Room – a special room within the CAHMA drop-in space designated as a “free from violence safe place”, symbolizing not only a refuge from violence but also a passage to a new life, space for self-exploration, self-expression and positive changes. Women used the room to meditate, relax, rest and self-express in artistic ways (painting, collage, storytelling or knitting orange scarves to wrap trees at the end of the EVAWUD campaign).

A series of activities was organized, including naloxone training, empowerment and self-esteem workshops, afternoon tea, a domestic violence awareness session and collage art therapy. Many of these activities were arranged in partnership with other alcohol or drug/harm reduction services in Canberra. The campaign ended with the “Orange March” and community event, with a barbecue, yarn-bombing trees and a self-defence class organized by community members. The campaign had a

strong presence in social media (on every day of the campaign, calls to action and campaign photos were shared) and in CAHMA’s radio show, “News from The Drug War Front”.

In working with women who use drugs, the following skills are needed: harm reduction knowledge; social justice awareness; empathy, respect and appreciation; good knowledge of identity politics, diversity, feminist theories, strategies of systemic oppression and discrimination; lived experience and use of peer health education models in working with women who use drugs; person-centred approaches, which means that those who work with women who use drugs must control their urge to “fix” them and to impose their own ideas and solutions; the ability to listen to the person, respect their choices and respond in the way that is acceptable to them; and understanding the difference between helping people and empowering them.

Services should create a more welcoming and friendly atmosphere for women who use drugs, with open days for meeting the workers in a less official manner, with more health promotions, workshops and campaigns to raise awareness about the discrimination and marginalization faced by women who use drugs. Services should employ more women, make use of more women’s groups, and provide more programmes targeting specific issues of women who use drugs, more community consultations and platforms for voices of women who use drugs, more programmes around childcare and parents who use drugs, and more programmes to raise awareness of domestic violence.

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SANPUD, South Africa

In South Africa there are significant levels of GBV, with one in five women experiencing physical violence from a partner. Socioeconomic circumstances post-COVID-19 lockdown have driven a further rise in intimate partner violence, and the country is also seeing an increase in femicide, with many of these crimes committed by members of law enforcement services.

SANPUD, together with other women-led organizations, is working to broaden research data to include women who use drugs in rural or hard-to-reach places. SANPUD also provides training, education and support to women who use drugs who are also survivors of gender-based or intimate partner violence. In addition to working with women themselves, SANPUD engages with health-care providers, law enforcement and social services to improve their knowledge around harm reduction and to establish gender-sensitive services for communities of women who use drugs across South Africa.

SANPUD hosts an annual Women’s Day for Health Care, events where women who use drugs can access SRH services away from public health-care clinics and are able to speak openly and without fear of discrimination to health-care professionals who have been sensitized. In 2021, in partnership with WHRIN, SANPUD hosted a FEMALIVE event in Cape Town, with women and men walking to raise awareness for an end to violence against women who use drugs. SANPUD continues to provide health-care commodities, care packs and baby essentials to women who use drugs, many of whom are also victims of daily domestic violence. SANPUD also supports the government legislation introduced in 2020 to protect women and children from abuse and violence. The implementation of this legislation will go a long way to ensuring that cases are successfully prosecuted, that survivors are protected and that there are more effective deterrents in place.

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SisterSpace, Canada

The world's first and only women-only, community-accessible overdose prevention site, SisterSpace is a safe, supported environment where women who use can inject their own drugs, with other women who care about their safety and security. If they choose, they can connect to other services through referrals. The staff recognize that women are the experts in their own situations, and that the decision to make changes in their lives, and what kinds of changes, is theirs alone. SisterSpace is a safe and accessible programme for women who are marginalized and underserved, for example, women engaged in sex work, women who are homeless, Indigenous or racialized, transgender women, and transfeminine individuals. Women express their feeling of safety at SisterSpace, which they attribute to the fact the programme is women-only, the sociable and casual atmosphere, and especially to the peer support workers. Guiding principles include:

- Acknowledging that gender makes a difference
- Creating an environment based on safety, respect and dignity; recognizing that safety equates with consistency and predictability across time
- Developing policies, practices and programmes that are relational and promote healthy connections to children, family, significant others and the community
- Addressing struggles with substance use, trauma and mental wellness through comprehensive, integrated and culturally relevant practices
- Providing women with information and opportunities to improve their socioeconomic conditions
- Establishing a system of comprehensive and collaborative community partnerships with other services

For women who have experienced a lifetime of violence and trauma, it is often their relationship with substances that keeps them going. The goal at SisterSpace is to ensure they have access to health care, good food, safe drugs, help when they want or need it, that they feel valued and valuable; and most of all to keep them alive until they are ready to make different choices.

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YouthRISE, Nigeria

According to YouthRISE Nigeria programme data, at least 25–30 per cent of women who use drugs are current survivors of violence. The violence manifests itself in the forms of intimate partner violence, driven by power imbalances and police brutality linked with the gendered impact of criminalization of people who use drugs. The normalization of violence against women who use drugs makes it difficult for survivors to speak out and access justice.

YouthRISE Nigeria's GBV services provided by YouthRISE Nigeria include counselling, medical support, provision of psychosocial services, PEP, paralegal support and access to justice. Relationships with tertiary centres have been established for cases requiring further management.

Peer-led outreach is one of the most effective approaches in engaging with young women. Meaningful involvement and active participation in designing programmes or advocacy campaigns ensures ownership and active involvement in the implementation process.

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WINGS – implemented in several countries

Women Initiating New Goals for Safety (WINGS) is an evidence-based intervention showing reductions in GBV among women who use drugs [137]. It involves GBV screening, brief interventions and referrals to services. Aiming to strengthen coordinated responses to GBV for women who use drugs and sex workers, in some iterations WINGS has included support for violence crisis shelters to be inclusive of the needs of women who use drugs [10].

The northern India iteration of WINGS found that 75 per cent of participants had experienced violence perpetuated by their partners, neighbours, friends and pimps. Women who participated in WINGS report increased empowerment and ability to identify potentially threatening situations and negotiate safer behaviours and to seek help in the event of violent incidents [91].

The WINGS project in Ukraine, supported by the United Nations Trust Fund to End Violence Against Women, aimed to improve self-confidence and access to essential services for women who use drugs, sex workers, women living with HIV and internally displaced women in four regions. In 2019, WINGS research confirmed a very high prevalence of GBV among sex workers and women who use drugs, as well as serious gaps in services for these women. During 2020 WINGS was applied with over 800 GBV survivors across eight regions of Ukraine. All the women who participated reported a significant increase in their ability to identify and report violence and abuse, one-third of the participants accessed HIV and STI testing, and those who needed it were linked to treatment, care and counselling [138].

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