

CHECK

WOMEN WHO
USE DRUGS

2023

“CHECK” is a magazine for people who use drugs, experts and advocates working in the EECA region, and those who want to learn more about the drug policy and harm reduction in the region. It is published by the Eurasian Harm Reduction Association (EHRA).

This issue was developed in partnership with Eurasian Women Network on AIDS (EWNA).



ehra 
EUROPEAN HARM REDUCTION ASSOCIATION

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MY PASSION AND MY PAIN

A colleague from the Eurasian Harm Reduction Association invited me to write an introduction for a magazine about women who use drugs. For many years, this topic has been my passion and my pain. It has stages, shades, and development but does not lose its relevance, unfortunately.

At the age of 16, when my first injection happened, I could not imagine that I would become part of one of the most criminalised, stigmatised, marginalised, discriminated groups of women, vulnerable to various diseases and violence. The beginning of my use fell in the mid-1990s in Donetsk, in the absence of harm reduction and access to information and support. By the age of 20, I already had HIV, hepatitis C, and experience of violence.

We have made great strides in accessing harm reduction services in recent years, especially in the context of HIV prevention. However, women often remain a non-priority and invisible group. The problem of obtaining gender-disaggregated data and the design of programmes that do not meet the needs of women are evidence of this. Sexual and reproductive health services are limited to sanitary napkins and pregnancy tests. In our region, instead of support and treatment, the state offers us criminalisation, drug user registers, and institutional violence on the part of health workers, social services, and the police. We are also forbidden to give birth without providing effective family planning services and constantly encroaching on our motherhood. The patriarchal society tells us that we are the wrong women and mothers.

It does not notice violence against us – it sometimes even justifies it.

Protection from violence and support for survivors have recently appeared on the agenda of networks and organisations in CEECA. A growing number of community activists and women's non-governmental organisations are promoting the protection of women who use drugs from violence. Thanks to them, a growing number of crisis centres and shelters have become sensitive to the problems of violence against our women and have removed from their provisions discriminatory clauses requiring sobriety and the absence of HIV infection. The most effective, I believe, are those that are community led and provide comprehensive support beyond temporary shelter.

I personally consider the narcofeminism movement to be an important event. It is not only about access to services, justice, and protection from violence. It is about our dignity and our voice. I believe in the strength of the community of women who use drugs and its individual activists. My most incredible colleagues are among them.

Always yours,
Sveta Moroz, narcofeminist

Overview OF THE SITUATION IN CEECA

Drug-related policies impact women and men differently, with women being stigmatised to a greater degree than men. Existing gender inequalities often compound this stigma. Despite some positive changes in recent years concerning gender equality and human rights, many women who use drugs are still subjected to discrimination, criminalisation, and structural and intimate violence, which can take shape in many forms, such as physical assault, rape, sexual violence, stalking, harassment, and coercive and controlling behaviour.

06 Women who use drugs are especially vulnerable to gender-based violence from intimate partners and law enforcement personnel and have limited options for support. For example, the rules and procedures of shelters and refugee centres often prohibit the provision of accommodation to women who use drugs, which may include those receiving opioid agonist treatment (OAT). Additionally, women who use drugs are often caught in a vicious circle of drug use and gender-based violence, where the trauma of violence contributes towards increased drug use, and, in turn, escalated drug use and its associated behaviour expose women to a higher risk of violence. EHRA's guide *Help Impossible to Ignore* notes that in the CEECA region, the main problems of women who use drugs and experience gender-based violence are difficulties in processing paperwork and accessing safety, support services, and psychological help, as well as intense stigmatisation of the issue of female drug use and dependence.

Women who use drugs, some of whom sporadically or regularly engage in sex work and have relatively limited access to sexual and reproductive health and rights (SRHR) services, are also at a higher risk of contracting

blood-borne viruses, including HIV. Significant barriers to opioid agonist treatment (OAT), such as unequal coverage between urban and rural areas, repressive drug policies, lack of gender-sensitive staff training and knowledge, and abstinence-based approaches, contribute towards a low OAT uptake among women who use opiates. This impact is amplified by a lack of gender-sensitive drug treatment opportunities, which prevents women from accessing OAT and other harm reduction services, such as needle and syringe programmes (NSP).

2022

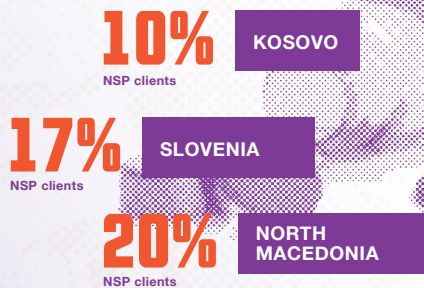
women on OAT program

ARMENIA only 6 women

KYRGYZSTAN 8% women

UKRAINE 15% women

For example, in 2022, Armenia reported only six women receiving OAT, and in Kyrgyzstan and Ukraine, only 8% and 15% of OAT clients were female. The gender balance of clients accessing other harm reduction services is



also disproportional: the percentage of female clients is 10% in Kosovo, 17% in Slovenia, and 20% in North Macedonia.

Women who use drugs face numerous SRHR barriers, such as limited access to contraceptive services, ante- and post-natal care, antiretroviral therapy, and prevention of mother-to-child HIV transmission services. Stigma and discrimination further prevent women who use drugs from accessing SRHR services. Frontline AIDS's resource *Advancing the Sexual and Reproductive Health and Rights of Women Who Use Drugs* is a useful tool for advocates to advance SRHR for women who use drugs.

A few countries in the CEECA region, such as Azerbaijan, Hungary, Estonia, and Kyrgyzstan, have specific pregnancy and childbirth protocols for women who use drugs. A few others (e.g., Moldova and North Macedonia) briefly mention the issue of pregnancy and childbirth in clinical protocols for treatment with OAT medication. Recommendations regarding drug use and pregnancy are comprehensively covered in WHO's *Guidelines for the Identification and Management of Substance Use and Substance Use Disorders in Pregnancy*.

In some countries, such as Armenia, Kazakhstan, Ukraine, Kyrgyzstan, and Moldova, women who use drugs can lose custody of their children due to their drug use. One of the most extreme situations is in Belarus, where children are considered to be in a "socially dangerous situation" if they are parented by a woman who either uses drugs or is on OAT. When the state identifies a child as being in a socially dangerous situation, this is registered in the parent's medical record and passport, and social services can remove the child from the family. On the other hand, several countries, such as Slovakia, Croatia, Slovenia, and the Czech Republic, do not have specific laws on the termination of parental rights in cases of drug use, with drug use alone not being a sufficient reason for deprivation of parental rights.

Women imprisoned for drug-related offences often face specific challenges, such as the increased risk of sexual violence by law enforcement staff, loss of parental rights, lack of access to harm reduction services, and disproportionate penalties in relation to their offences. A high proportion of imprisoned women is in custody for drug-related offences, for example, 40% in Kyrgyzstan, 51% in the Russian Federation, and 68% in Slovenia.

This goes against the *United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders* (the Bangkok Rules), which promote alternatives to custodial sentences for women and highlight the importance of appropriate health care and humane treatment. In many cases, drug-related recidivism is more likely to be prevented by an effective community-based drug treatment than by a custodial sentence, which may intensify the experience of trauma and perpetuate drug use.

The Global State of Harm Reduction 2022 by Harm Reduction International offers a good overview of harm reduction services in prisons in the CEECA region. While many countries (e.g., Albania, the Czech Republic, Estonia, Slovenia, Moldova, and Lithuania) offer OAT, NSP exists in at least one prison only in Armenia, Moldova, Kyrgyzstan, and Tajikistan. On the other hand, in countries with the most restrictive policies, such as the Russian Federation, Uzbekistan, and Belarus, neither OAT nor NSP is available in custodial settings. In some countries, such as Montenegro, Latvia, and Serbia, in-prison OAT is only accessible to people who were on OAT before incarceration, which means that many imprisoned women who could benefit from OAT cannot access it. Several international recommendations have been issued to improve the situation of women who use drugs. For example, in 2021, the UN Committee on the Elimination of Discrimination Against Women (CEDAW) urged Kyrgyzstan to amend a law that provides for the automatic loss of child custody and deprivation of parental rights based on parental drug dependence and to improve access to harm reduction services for women who use drugs. CEDAW also urged the Russian Federation to strengthen measures to ensure the availability of modern contraceptives to all women and girls, including those belonging to disadvantaged and marginalised groups. The UN Committee on Economic, Social, and

“A high proportion of imprisoned women is in custody for drug-related offences, for example, 40% in Kyrgyzstan, 51% in the Russian Federation, and 68% in Slovenia.”

Cultural Rights (CESCR) has issued several recommendations about strengthening harm reduction programmes and removing barriers to accessing drug treatment for women who use drugs. The CESCR recommendations to some countries, such as Uzbekistan and Kazakhstan, also included decriminalising drug possession for personal consumption.

Finally, the *Policy Brief on Women Who Inject Drugs and HIV*, developed by INPUD, UNODC, UN Women, and WHO, advised that harm reduction services should provide adequate staff training, support meaningful involvement of women who use drugs, guarantee personal safety and confidentiality with women-only spaces, and establish strong working linkages with other agencies in the field of reproductive health, legal support, mental health, domestic violence, and maternal and child health. These practices will increase drug treatment uptake among women who use drugs and assist with their reintegration into society.

SISTERHOOD

The material is based on an interview with Lyubov Vorontsova and Alla Bessonova from the Eurasian Women Network on AIDS

ABOUT THE WOMEN'S MOVEMENT, FEMINISM, AND GENDERISM

Alla: When I started in 2006, there were no women's organisations at all. The existing organisations were providing services and HIV prevention. Later, women's organisations began to appear, but rather in relation to new donor priorities, under the project, and still with a focus on services rather than advocacy and other support. What I saw and felt in 2018, when I returned from maternity leave and found myself at the first meeting of future narcofeminists in Berlin, about women's support, sisterhood, safe spaces, advocacy, and promoting women-specific needs and problems in general – it was a revelation, something completely different.

Lyubov: I, like Alla, started working at the national level, and now, looking at that experience inside the country, I think that back then, we united in order to create an organisation, but we did not have common principles and goals that Alla mentioned. We didn't stand for it. This was not our internal principle. Now, we don't need formal units. We can unite to achieve some goal. It works so much better! Many activists have been trained by feminists. Feminism is all about accepting yourself as a woman. Feminism has broadened our perspective and given a different focus on sexual and reproductive rights. If we saw all this earlier through the prism of HIV infection, now it is because I am a woman – not because I have HIV or use drugs or engage in sex work.

Alla: This real sisterhood, women's support, manifested itself and became understandable, became tangible in EWNA, if we are talking about

“Feminism is all about accepting yourself as a woman.”

women's organisations. If we are speaking about the country level, here, the support comes not from the community but from other feminists, and there is a huge difference. How much I was accepted as a narcofeminist and how much I was supported by local feminists is a completely new experience. Feminism is about me; it's about women; it's about my values. Genderism is about money, projects, programmes, and services. And that's why we don't quite understand each other.

ABOUT FEMINISM AND ACTIVISM

Lyubov: I'm trying to remember when I started hanging out with feminists. It must have been 2016–17. I was invited to training, there were women from Kazakhstani feminist initiatives, and for the first time, I heard about feminism. Then, I went to a human rights school, and there were also participants from feminist organisations. I started going to marches. Now, there is the Central Asian Feminist Festival “Femogora”, in which I have been participating for several years, and this is such a different atmosphere. In the community of people living with HIV, I still have not found an understanding of my position. And I know that my friends in the community of women who use drugs have also not found it from either men or women.

Alla: It's like going to psychotherapy. Demolish the entire value system and build a new one. Something like this, probably. It is the work on yourself, on the way you live, like starting physical exercises. It requires effort, resources, and reassessment of values and priorities.

Lyubov: This personal motivation for activism is about understanding yourself and working through internal traumas when you suddenly realise what violence really is. And most often, a woman faces what? She is faced with the fact that she, too, experienced it. She begins the process of working through her own trauma, and this is difficult; for this, you need resources. And subconsciously, I am 100% sure that this is how the protection works. Because if there are no resources, if there is no support around – and more often than not, most of our activists in the HIV service are still in a situation of violence – then we can only make things worse. Where can you get these resources? Where can you get this support? When we create conditions so that any woman can receive help and support in case of violence, it seems to me that then the situation will change; otherwise, you simply won't be able to talk about it. There is very



little attention to this from the point of view of psychological support, and precisely such as sisterhood – just talking in a safe space. Maybe it won't be professional help, but at least no one will judge you for it, and you won't be afraid to say whatever you think.

ABOUT PSYCHOLOGICAL SUPPORT

Lyubov: Unfortunately, most of the cases of violence, stigma, and discrimination occur in the area of sexual and reproductive rights. And therefore, the realisation of sexual and reproductive rights is essential if we want to prevent violence, and it is the key to women's health.

The issue of emotional stress for a woman in our society is very relevant. Well, of course, there can be no physical health without mental health; what kind of treatment and, in general, adherence to any health care services can we talk about if mental health is not in order and support is needed there? We had a supervisor-psychologist during COVID-19, and providing psychological services to women activists became part of our work. We had regional consultations on mental health and conducted training for women activists, where we talked about what these services are, why it is important to implement them, and what tools are available.

When the war in Ukraine started, we realised that our own network had become quiet, and the chat fell silent. We didn't know how to communicate with each other. We didn't know how to talk or how to support each other. This is how Station-14 appeared. We held webinars on peacebuilding, women's role in peacemaking processes, and how we can maintain the idea of peacebuilding, which is valuable in feminism. And secondly, it was just about the sisterhood of feminism in order to return in general to what unites us. We are here because we support each other, and this is our pillar.

Alla: Station-14 is an innovative project that combines psychiatric care and reimbursement of medicines. This is the first practice where a woman first goes to a psychologist, gets a consultation, and can participate in psychotherapy groups. Then, if she has a need, she is redirected to a psychiatrist. The psychiatrist consults her and prescribes medicines, and we reimburse the costs.

Lyubov: I believe in women. And the more I work with women, the more I am convinced that it is women who change this world. Recently, one of the male activists told me: "Why are we talking about women again? This is probably the trend now, fashion." And I replied: "Every year, so many women die from the violence that this is not a trend. The trend is when I want to wear this raincoat today but don't want to tomorrow. And here, I can't choose whether to be a woman or not. I identify as a woman, and I want to be a woman. But I don't have to die for it or live in fear of dying."

For me, female power, unfortunately, does not come from favourable conditions. This strength developed because we live in a harsh environment. I admire women who, despite all this, change not only themselves but the world around them. And I am extremely pleased to be among these women, work with them, and be part of this movement. For me, it's about inspiration.

"...the more I work with women, the more I am convinced that it is women who change this world."

I am *A WOMAN* **SEXUAL AND REPRODUCTIVE HEALTH, Ukraine**

The material was prepared on the basis of an interview
with Natalia Bezeleva, Svitnok, Ukraine

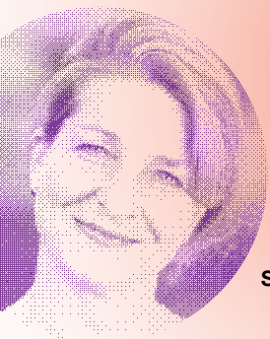


It is no secret that harm reduction or other prevention and care projects are mostly not gender-oriented or are a small component of a larger project. HIV-positive pregnant women receive a simple, standard package of services, the same as what is provided to men. Due to the specific situation of the Donetsk region, large regional medical institutions and laboratory diagnostic centres were located either in Kramatorsk, in the north; or in Mariupol, in the south. Any pregnant woman, wherever she lives, at certain stages of pregnancy had to be examined there, and this was a great difficulty. In 2019–2020, Svitanok, with the support of the French office of Doctors of the World, began

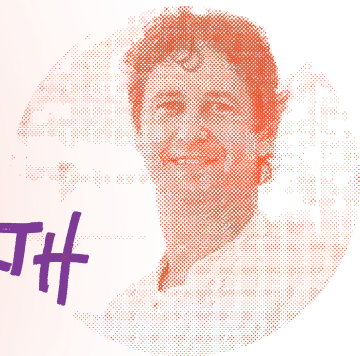
to pay for travel expenses for such visits and provide newborn care products, food, and diapers. In addition, training sessions were held for antenatal clinics and obstetrician–gynaecologists on the management of pregnant women with drug dependence and HIV-positive pregnant women. Training sessions were held with the participation of community leaders and clients. Svitanok bought spirals and paid for the termination of the pregnancy. “Research on sexual and reproductive health shows that women go to the gynaecologist when the level of health damage reaches simply catastrophic proportions. Any kind of family planning activities does not work well. We had

money to buy good spirals, and we had agreements with the regional perinatal centre with specialists, but only 2% of our clients used this service. The most popular service is abortion. And it's not just our clients' problem. This, unfortunately, in principle, is the problem of our women.”

Svitanok became a safe space where women could gather, exchange their stories and ideas, engage in discussions, and feel “close to people like me, where I am understood and where I am safe”.



Pregnancy AND CHILD BIRTH



The article is based on the interview with Dr. med. Jan-Peter Siedentopf, Senior Physician, Head of the Outpatient Clinic for Addiction Disorders and Infections in Pregnancy in Charité – Universitätsmedizin Berlin, Germany

The history of our ambulatory service starts in the early 1970s of the last century. At the time, there was an increase in heroin-using people in Germany. Berlin was a hotspot for drug use due to the high rate of military personnel, and of course, it spread into the German population as well. And then doctors noticed that they had quite a few pregnant drug-using women, especially women that used sex work to finance their drug use. There was no substitution, no OAT in Germany at all, and the doctors came up with an idea to say, “we do not do OAT, but we treat women that need medication; we treat pregnant women to protect the babies”. And this framing was very helpful in getting around legislative problems. But as soon as the baby was there, it was taken away; women had a couple of days in the ward and were then discharged and back on the streets. “We used to take the user woman like an incubator, give her OAT and then take her baby and leave.” It was a really harsh climate for people searching for treatment. Non-pregnant people could not get it at all. In Germany, it took years until OAT was legally allowed.

I have to admit that we don't have a real protocol for using substitution treatment during pregnancy. It's just us doing the work the way we think is best, but it's based on a lot of experience over the years. In medical terms, we only started to get to know that other countries use protocols. Of course, we do have rules. We have fairly strict rules about who is entitled to provide OAT – you need to

“exposing it to a known substance with a known quality and a known dose is far less dangerous...”

have a course in addiction medicine – we have rules for prescribing opiates in general, and we need a special prescription paper. Every doctor can do it, but they have to be registered as a doctor who prescribes opioids. Then, the hospital itself has rules, and so do insurance companies. We have rules about OAT provision, but they do not specifically address pregnancy. No public guidance has been published, but there is a booklet, “Pregnancy and Addiction Help”, that has been around for several years. You can consider it to be a guideline, but there is no legal status to it. It's just our recommendation spread around all over Germany, and many in the German-speaking area follow our recommendations, but it's not compulsory in any way.

The medical part is not so much different to OAT in non-pregnant people, but we always have to consider that there is a baby in the woman's uterus, and this baby is being exposed to OAT. But of course, exposing it to a known substance with a known quality and a known dose is far less dangerous than exposing it to black-market substances that are usually not what they seem to be. We aim to prevent harm for the baby but also, of course, for the mother; OAT reduces the risk of infection, and it reduces the need for money making to support drug use. We have three main substances that are used: methadone/levomethadone, buprenorphine, and morphine. In Germany, we use a lot of levomethadone for pregnancy. Buprenorphine was introduced in 2000. It is our neonatologists' most-preferred OAT substance in pregnancy due to less neonatal withdrawal. And the third substance, slow-release morphine, is a substance we don't like in pregnancy because it will show up as morphine in the mother's milk. During pregnancy, it's fine. But after delivery, a mother on morphine cannot breastfeed. A mother on buprenorphine or methadone can. We can use different substances and see what's best for the patient and what she prefers to take. OAT and perhaps additional treatment of psychiatric disorders empower women just with their medical situation to be more caring to be more present for the baby.

The second is the social aspect which is usually the most important one – housing, social work going onwards after delivery, like having a midwife and social workers visit and check on the baby. There are social services by the state that can check on the baby, but we are working very closely with non-governmental organisations that care for women and do social work. If they are part of the team, the Child Protection Service can say, "OK, we trust you, you're doing your work, we don't have to check". This way, there is control of the living situation of the baby, and on the other side, it keeps government structures as



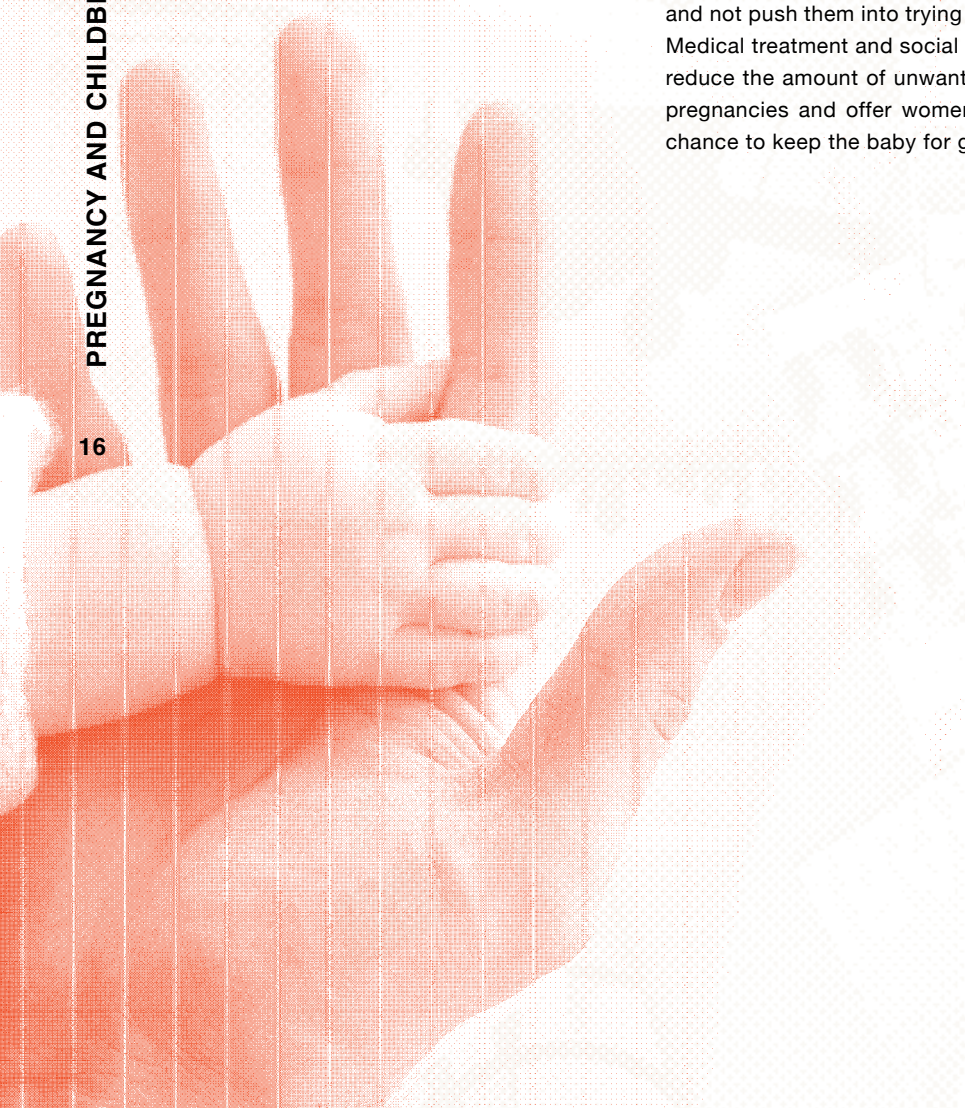
This is a baby of a patient we cared for years ago. Unfortunately, she died later on due to an overdose. The baby in the picture was born here, and she allowed us to use the picture. Looking at it, I am always reminded of her, and she was a patient that was doing very well during pregnancy. At first, she did not want to keep the baby, and during pregnancy, she completely changed her mind, and she was so warm and loving that I think you feel that the baby's feeling well with her. That imagery always reminds me of her and of what our job means; it reminds me of the responsibility we have for our patients, and I think that it is a special population, and we should never forget that – and that it's ongoing. Yeah. Unfortunately, she wasn't in the situation to ask for help from us.

“We need to empower women to have planned pregnancy and motherhood or in a timing where it is in a setting that’s as good as it can be...”

far out as possible because, of course, patients are scared to interact with an official service.

Our team consists of two people: me as a doctor and Manuela Nagel, our social worker, who established a network in Berlin that unites everybody who has expertise or works with pregnancy and OAT. When we meet new patients, we always do it together. Additionally, we have one of those non-government organisations that, twice a week, are in our office, they have their own room, and they do additional counselling on social aspects and can accompany the patient if she needs to go to the child services and so on.

We need to empower women to have planned pregnancy and motherhood or in a timing where it’s in a setting that’s as good as it can be and not push them into trying again and again. Medical treatment and social work, in the end, reduce the amount of unwanted or unplanned pregnancies and offer women a much bigger chance to keep the baby for good.



ADDRESSING **GENDER**-BASED VIOLENCE AND ACCESS TO ABORTION SERVICES

The article is based on the interview with Medea Khmelidze,
Program Manager, Real People Real Vision and Gvantsa Kvinikadze
Gender Researcher, WINGS consultant in Aceso, Georgia

Georgia is one of the countries in the region using the WINGS¹ tool to address gender-based violence among women who use drugs. “WINGS is all about the level of safety. It’s not about street lawyers; it’s how to survive on a daily basis.” When the tool was introduced, selected community members from participating organisations were trained to become social workers. In addition to filling out the questionnaire and building the safety plan with women, community social workers were referring women to mammography, gynaecologists, or places where they could undergo forensic examination in cases of sexual assault.

“After analyzing the data gathered within this work, we decided to provide certain services that were not covered either by the government or the project, for example, a consultation with a gynaecologist, some basic medications that women were prescribed but couldn’t

pay for, and mental health specialists. During the pandemic, we were also able to provide women with some food packages.”

Another service that organisations found resources to provide was abortion. This could include consultation, the pills (it was usually medical abortion, though there have been cases of surgical ones, too), or additional treatment such as the treatment of STIs. Women were free to choose the gynaecologist or ask for a referral. Sometimes, women had part of the money and needed support to cover the rest.

“It’s usually no more than 30 people per year. This is not a service that we need on a daily basis, like syringes or substitution therapy. The need for it, at least in the Georgian context, shows up from time to time – sometimes, it’s more intense; sometimes, the need disappears. But even for one woman, it’s life-changing”.

¹ WINGS (Women Initiating New Goals for Safety) was developed by Dr. Louise Gilbert, Dr. Timothy Hunt, and Dr. Tina Jivatram-Negron of the Social Intervention Group at the Columbia University School of Social Work. When introduced in Kyrgyzstan, sex workers participating in the focus group in sauna in southern Kyrgyzstan in 2013 suggested the name Wings of Hope, and from there on, in the region the project spread under the name “WINGS”. In addition to Kyrgyzstan, “WINGS” work in Georgia, Ukraine, and, since 2022, in Kazakhstan. The cornerstone of the system is to develop a safety plan with the participant. Thanks to that, a woman knows where and whom to call in case of danger or contact in case of violence, how to behave and what to do to reduce the risk of violence or to protect herself and her loved ones as much as possible if it cannot be avoided. In Kyrgyzstan, the tool has been adapted for women who use drugs, sex workers, and LGBTQI, and researchers are currently working with the community on a version of WINGS for users of new psychoactive substances.

SPACES FOR WOMEN WITHIN HARM REDUCTION SERVICES

In Georgia, there are no harm reduction centres specific to women; services are provided for all genders, which is not always safe. To work around it, women's groups are organised after working hours (4–5 PM) or on weekends. There is a separate entrance for women in the opioid substitution clinic, but the space is not divided inside. Statistically, less than 1% of women are on OAT, and up to 7% use needle and syringe programmes, but those women go to service organisations led by women; usually, these organisations are involved not only in activities related to harm reduction but also violence.

“... it’s all about the level of safety. ... it’s how to survive on a daily basis.”







Like most of the organisations in the region, Juventas does not have sustainable services for women, but since 2012, after consultation with clients, Juventas hired a hairdresser to work in the drop-in centre twice a week. “Our hairdresser is a very nice person. She is a good listener, as the girls say. While women are waiting in line or dyeing hair, we sit together, drink coffee, and do counselling, not in a professional sense but just talking in a relaxed and friendly atmosphere.”

Juventas has psychosocial support groups for single parents, mostly mothers, and groups on parenting, family relationships, emotional relationships, and anger management. While parents are in groups, children are with a teacher who helps

them with homework. Or if the children are younger, they do some activities to prepare them for school. Groups are facilitated by psychologists and social workers and are very popular.

“In our experience, it’s easier for women to open up during the women-only group rather than in a mixed one. If they want, they can have one-to-one counselling with an outreach worker, social worker, legal consultant, doctor, or psychologist. If they want, we can form a group, and it will be group work. That is an option that is always open.”

Juventas tried to have a gynaecologist on site, but that was impossible due to the law prohibiting them from providing their medical services outside the medical

institution. The doctor that works in the centre is a neurosurgeon, and he is there to provide basic medical care and shorten the trip from doctor to doctor (in Montenegro, in order to see a specialist, the patient first needs a referral from a family doctor). When he is on call in ER, he calls Juventas clients there to provide services and examinations they need without waiting because otherwise, it would take months.

Several times a year, Juventas provides hygiene packages for women, and when women need pregnancy tests or anything else that can be bought in a pharmacy and they do not have the money, Juventas provides the money for that.

ADDRESSING VIOLENCE AGAINST Women AND GIRLS IN EMERGENCIES

Based on the tools and materials developed by **VOICE**

Since Russia's invasion of Ukraine on February 24, 2022, 12.8 million people have been displaced. Over 5 million have fled the country, and almost 8 million are internally displaced inside Ukraine. In every armed conflict, men's violence against women and girls (VAWG) increases rapidly and stays elevated long

after the fighting stops². VOICE is a feminist organisation working to end violence against women and girls in conflict, crisis, and disaster settings around the world.

Guiding principles addressing VAWG are safety, confidentiality, dignity and self-determination, and non-discrimination.

The survivor-centred approach means:

1. Ensuring the physical SAFETY of the survivor;
2. Guaranteeing CONFIDENTIALITY
3. RESPECTING the wishes, rights, and dignity of the survivor(s) when making any decision on the most appropriate course of action to prevent or respond to an incident of sexual and gender-based violence.

² *Waiting for the Sky to Close: The Unprecedented Crisis Facing Women and Girls Fleeing Ukraine*
<https://voiceamplified.org/waiting-for-the-sky-to-close/#tve-jump-18100ca5b1d>

Using a survivor-centred approach means that you:

- * Validate the person's experience;
- * Seek to empower and restore control;
- * Emphasise strengths;
- * Value the helping relationship;
- * Recognise multiple and intersecting identities.

Assessing risks to women & girls includes:

SAFETY AUDIT: can be part of a *situational assessment and analysis*. It can be used on a regular basis (daily, weekly, etc.) so that changes and new risks can be identified and risk mitigation efforts tracked.

FOCUS GROUP DISCUSSION:

involves a small groups of people (about 10-12) from similar backgrounds (e.g., gender, age, and ethnicity) and help develop a *general sense of the community's perception* of key areas of concern.

SHELTER HOUSE RULES:

Using participatory methods to develop house rules for residents in a shelter is *strongly recommended*.

Here are the main survivor-centred communication tips:

1.

Avoid questions that begin with "why", as such questions can feel like they are placing blame on the survivor.

2.

Do not give advice. 🙅

3.

Instead, just **LISTEN** or, if needed, ask questions such as "Can I tell you about services that are available to support you?" or "How would you like me to support you?"

4.

Validate and normalise: ☺

- * "It is OK to cry/not cry"
- * "It is understandable to feel...."
- * "This is not your fault"
- * "I believe you"

GBV Pocket Guide can be accessed at: <https://bit.ly/43K6ubk>

SHELTER FOR *Women* WHO USE DRUGS AND HAVE EXPERIENCE OF *GENDER* *BASED* VIOLENCE

This material is based on an interview with Neva Faninger, a staff member of Safe Home (Ljubljana, Slovenia)

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Stigma, an organisation based in the Slovenian capital of Ljubljana, is one of the most experienced in our region in integrating support for women survivors of violence into harm reduction programmes. Stigma began implementing harm reduction programmes more than 30 years ago. An important part of their work is a day centre (drop-in centre) for people who use drugs. Safe Home began its work in 2010; it is funded by the state, the city, and a charity lottery. There are seven permanent staff members and two temporary workers. The women who live there are allowed to come and go as they wish from 11 PM to 6 AM. If they are staying over somewhere else, they must inform the staff.

Safe Home is designed for women who use psychoactive substances, including illicit substances and opioid agonist treatment (OAT), and have experienced or are experiencing domestic violence or street violence and need a safe space to address primary and more complex needs. An important rule of Safe Home is that a woman must go there on her own initiative, without anyone forcing her. Safe Home can accommodate eight women. Children are not allowed here. Most clients with children have lost their parental rights, and

their children are in foster care. There are also three apartments provided to Stigma by the municipality as part of a cooperative effort to provide social housing for vulnerable women. These apartments are offered to women who have completed their stay at the Safe Home, stabilised their health, and begun to manage their households and daily lives better.

The Safe Home residents include women recently released from prison. In the absence of adequate mental health support programmes in prisons, women's mental health conditions remain very difficult at the end of their sentence, which is why Stigma tries to support them after their release. According to Neva, education has a crucial impact on women's lives. Since 2008, Stigma has been educating women in prisons. The result is that several women have not returned to the use of illicit substances after their release, avoiding criminal involvement and re-imprisonment.

The organisation does not provide psychotherapeutic services at Safe Home. When the women need psychological support, they are referred to the partner organisation DrogArt; unlike many other therapists, their specialists are not dismissive of people with problematic use. There is also no medical staff

at the Home, so women can go to Stigma's daily centre (drop-in centre), a 20-minute walk away, to get medical help. Substances have a special place in women's lives. According to Neva, 80% of the organisation's female clients have experienced violence from an early age and throughout their lives. For many, illicit substances were a means to get through the trauma and deal with the pain it caused. On the other hand, substance use exacerbates stigma (both external and internal), and stigma leads to powerlessness – women who use illicit substances feel exhausted and do not go to the police and social services. Stigma tries to help with this. According to Neva, in such a situation, it is necessary to provide a woman with the most important things – a place to live and the opportunity to continue her education and find a job.

Despite the deep understanding of the change process within the philosophy of harm reduction, there are rules that Safe Home must follow for legal reasons. For example, women are prohibited from consuming psychoactive substances, including alcohol, while in the Home. In Slovenia, the provision of premises for the use of illicit substances is currently



prohibited by law, from which no exceptions have been provided so far. Therefore, women in the shelter have a special safe to keep their substances and other medications. The shelter provides all harm reduction equipment. For some women, following the rules is too much of a challenge, and they leave. Some turn to shelters that offer more urgent housing. Aggression is also prohibited in the Home, and if a woman behaves aggressively, she may be expelled from the programme. Still, she may try to return a month later.

According to the Home's rules, women can stay there for up to a year and a half. In some cases, however, the length of stay can be extended. "The most important thing is to be patient. It may seem like we know what a woman should do to improve her life, and therefore, our expectations can be too high. We need to learn to leave them at home and remember that against the backdrop of a difficult life situation, even small changes can mean a significant effort for a woman. First and foremost, women need to be given a safe space, support, and acceptance to make such changes possible."



THERAPEUTIC *Community* IN THE Czech Republic

The article is based on the interview with Karel Chodil,
the head of the Therapeutic Community of Karlov



The therapeutic community for women is located around 100 km from Prague. Established in 1999, it is a residential service focusing on two target groups: mothers with children and younger adults and people aged from 16 to 26 years. The community is funded by the state, the Ministry of Labour and Social Affairs, and the city of Prague.

The programme usually lasts 8–12 months. Women can come to the community with children. The maximum number of residents is 9 women and 11 children. The staff team consists of fifteen people: nine therapists with psychotherapeutic training, two education workers taking care of children and their development and educating mothers on parenting, one social worker, and three work therapists, working with mothers and children, showing how to wash their clothes, prepare meals, etc. There is also a psychiatrist that comes once every 2 weeks.

Before entering the community, the person must undergo a detox programme in a hospital. The age limit of children coming to the community with mothers is 6–8 years, depending on the social situation. It is considered unfavourable for school-age children to come to the community, as it is located in an isolated area, and at this age,

friends play an important role in socialisation, but in exceptional circumstances, it can be permitted. Usually, during the mother's stay in the community, older children stay with foster parents or relatives, and visits are allowed after 3 months. Community specialists work with the families of their residents, organising psychotherapy groups once a month.

In the first three months, when a woman needs to go out of the community to see the doctor herself or with the child, she has to ask for permission and will be accompanied by a staff member or peer further along in the programme. After 3–4 months, she can start to go without assistance but still need to explain the reason for leaving. Closer to the end of the programme, women can start looking for a job outside of the community, and they can leave for work every day if they succeed.

If community residents decide to leave, they have 24 hours to change their minds and return. A urine test will be performed upon re-admission. If the person is not back after 24 hours or the urine test comes back positive, they will not be allowed to enter the programme and will be referred to another one. It's possible to re-enter the programme later on, but if the person quits again for the third time, they will not be accepted.

HARM REDUCTION SERVICES IN PRISONS

Based on an interview with Irina Barbiros,
head of the Medical Directorate of the NAP of Moldova

ABOUT NEEDLE AND SYRINGE PROGRAMMES

The estimated number of people who use drugs in prisons in Moldova is 1970 people, and 10% of them are women. Official figures are much lower – about 700 people, of which women account for less than 5%.

Harm reduction programmes in prisons in Moldova appeared in 1999. At first, they were available in a male colony, but then, they quickly spread across all institutions. There is only one women's colony in Moldova, and today, there are 257 women. The harm reduction services available – for both men and women – include needle and syringe programmes.

The exchange and distribution of syringes take place with the help of volunteers from among the convicts. Volunteers – “outreach workers” – receive motivational packages for their work; for women, this package includes sanitary pads. Bedside tables used as syringe exchange points contain syringes of different calibres and condoms. Unfortunately, there are no female condoms. There were talks about this, but so far, they have not been implemented. There are also alcohol wipes, medicines for veins, informational materials, gloves, disinfectants, peroxide, and brilliant green. Services are provided 24/7. That is, a volunteer who works at a syringe exchange point must be available 24/7. It is a little more difficult in pre-trial detention centres because there is no free access, but then the volunteer

has certain hours when he walks around the buildings and exchanges.

As a rule, people who use drugs become volunteers. “A person can be on methadone, be HIV positive, or have a history of drug use. There were cases when a person was an active user. We knew that he was using, but it was possible to work with him. Those who do not have such experience do not last long because they do not understand each other so well. We try to ensure that volunteers work on a peer-to-peer basis.”

“...we are helpless for these patients. They are dying right before our eyes.”

In just a year, 260,000 syringes of all calibres were exchanged in all 15 colonies. In 2021, 85 clients were registered in the women's colony, 11,187 syringes were exchanged, and 2,520 condoms were distributed.

These days, the drug scene is changing, and many are switching to non-injection use. “Pure opiate users are rare. Usually, they are polydrug users. They use both synthetics and opiates, basically everything that comes across. Moreover, when getting into prison, of course,

“These days, the drug scene is changing, and many are switching to non-injection use.”

it is much more expensive to somehow provide yourself with pure opiates. At the moment, we are helpless for these patients. They are dying right before our eyes. Therefore, we are now developing a new protocol for people who use psychostimulants; there will be trainings.”

ABOUT OPIOID SUBSTITUTION TREATMENT

Methadone appeared in the penitentiary system in 2005 and in institutions for women in 2007. At the moment, there are 103 people in the programme, of which 7 are women. “There were 12, but still not as many as we expected, based on the estimated figure.” Buprenorphine has been available since 2019, but there was only one woman on buprenorphine, and she was released. At the moment, there are problems with transferring the patient to the Ministry of Health for further treatment. “Now it’s working by phone, ‘Please see this patient.’ If there would be a single database so that we could transfer all the information electronically, it would be much easier.”

There is a gynaecologist in the women’s colony. Gynaecological examinations are carried out regularly, and screening for cervical cancer and mammography is provided every two years.



Women DEPRIVED OF LIBERTY

Report of the working group on the issue
of discrimination against women in law and in practice

“...punish for them for perceived moral or sexual deviancy. Those stereotypes are far too often enshrined in national laws.”

Women are more likely to be incarcerated for drug-related crimes than men: in 2018, approximately 35 per cent of women in prison worldwide had been convicted of drug crimes, compared to 19 per cent of men. An increasingly punitive approach to the drug problem, adopted by many States with policies of administrative detention of drug users and taking a harsh approach to pretrial detention and post-conviction sentencing of those accused of drug crimes, has been found to have a discriminatory and disproportionate impact on women.

Deprivation of liberty involves human rights violations and has devastating consequences for women’s lives, putting them at risk of torture, violence and abuse, unsafe and unsanitary conditions, lack of access to health services and further marginalization. It cuts women off from educational and economic opportunities, from their families and friends, and from the possibility of making their own choices and directing the course of their lives as they see fit.

Deprivation of liberty is deeply gendered. While there are many forms, they are all tied to causes rooted in discrimination against women. Many forms of deprivation of women’s liberty spring from harmful stereotypes that seek to trap women in subjugation or silence, to punish them for perceived moral

or sexual deviancy, or to smother them with overprotection. Those stereotypes are far too often enshrined in national laws.

Women’s deprivation of liberty is also frequently tied up with violence and conflict, and with poverty, be it through lack of resources or lack of opportunity. Such circumstances trap women, depriving them of choice and often putting them in situations that lead to their confinement.

Those risks are heightened for women who experience intersectional forms of discrimination, such as women with disabilities, indigenous, migrant or older women, women from racial, ethnic, sexual or gender minorities and other marginalized women, all of whom face additional layers of harmful and debilitating stereotypes. They are more exposed to violence, conflict, and economic “unfreedom” than other women.

Addressing women’s deprivation of liberty is thus not a simple matter of reducing incarceration or institutionalization, or outlawing forced confinement in domestic settings. Those steps are necessary, but they are not sufficient. Ensuring that women enjoy liberty to the full extent and in equal measure with men will require the transformation of societies to root out harmful stereotypes and economic and social inequities.

In order to address women’s deprivation of liberty with all of its root causes, States and other stakeholders should:

Reform drug-related policies, laws and practices in line with international human rights standards and take steps to integrate the International Guidelines on Human Rights and Drug Policy into policies that are relevant to women.

Full report: <https://digitallibrary.un.org/record/3814496?ln=en>

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IT OUT!**



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