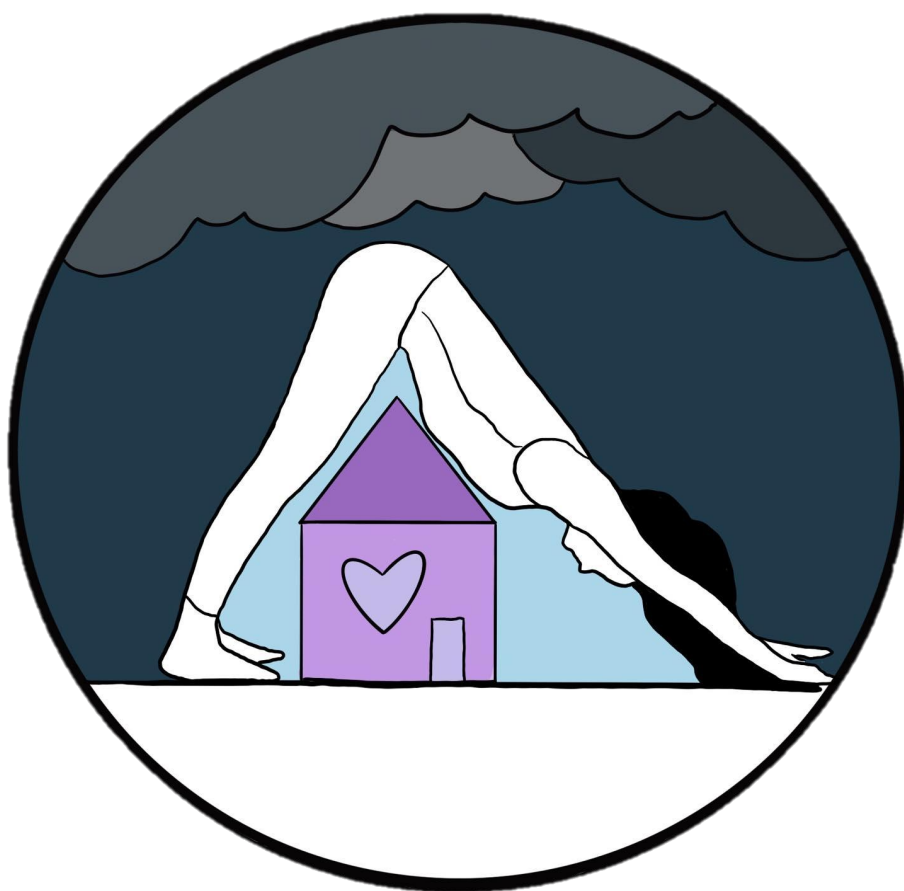


# Addressing Inclusion of Women who Use Drugs in Shelters

## Facilitator Guide



## Foreword

Women and gender diverse people who use drugs experiencing violence and/or homelessness, often face very restricted access to shelters. Commonly, women's shelters apply a "zero tolerance" policy with respect to drug use and to refer people who use drugs to other services (which usually don't exist, so people remain at risk of violence and unstable housing). Those who desperately need shelter and non-judgmental support are turned away at a time when they are most at risk. Many shelters feel they do not have the staff expertise to serve this population, without examining ways to overcome such concerns.

This workshop aims to provide a space for addressing such barriers to improve capacity for shelters to accommodate women and gender diverse people who use drugs. It is designed to provide information for shelters' managers, policy makers and staff to:

- Raise awareness among management of shelters and other relevant policy makers on the need to lower thresholds to meet the needs of women in all their diversity by accommodating clients who use drugs.
- Provide management of shelters with insights and practical tools to lower thresholds to shelter access for clients who use drugs, while policy makers will gain insight on how to adjust policies to support improved access to shelters for those in need.

It is recognised that, in some contexts, supplementary Sexual Orientation, Gender Identity and Expression, and Sex Characteristics (SOGIESC) and other related capacity building will be needed to better enable inclusion for two spirited, trans, nonbinary and gender diverse people in shelters. This toolkit touches on key considerations while especially addressing barriers to inclusion for people who use drugs.

## Acknowledgements

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## Facilitator Guidance

The facilitators for this workshop should be experienced in leading workshops and facilitating group discussion using methods such as role play, debate, brainstorming and group work. The facilitator should read the notes for each module in order to prepare the debates and questions, adapt content to local context and be able to provide correct local information about referral pathway services.

The workshop content is not intended to lay blame or cause distress, rather its aim is to raise awareness of counter-productive issues pertaining to stigma and discrimination together with exclusionary rules and practices, to provide opportunity for discussion on issues which are often otherwise left unaddressed. Content includes practical advice for shelters staff on including clients who use drugs in a respectful, non-judgemental manner.

The workshop toolkit as a complete package has been designed to be used as is, but also designed to be flexible so that trainers can adapt/select module components to suit national/local context. Sessions are designed for workshop groups of 15 participants.

Each module includes details on material required and the preparation needed before running the workshop, including documents to read and guidelines or national frameworks to be aware of.

## Facilitator Tips

### ***Respect experience***

Adults bring a wealth of expertise to your workshops. During participant recruitment stages, if you can, ask participants what specific experience they have in addressing the needs of clients who use drugs. Assess what they know and don't know, and cater your training to fill knowledge gaps.

Participants will respond positively to well-prepared sessions that cover relevant information—ie issues that can be applied to their work. They will be thinking: *“Teach me what I need to know, and why it's applicable to my job.”* Make sure your communication during the workshop will help participants to understand the benefits of your sessions and how they can help them grow personally or professionally.

### ***Seek participation***

Participants want to share their knowledge. So let them. Elicit responses that draw out their expertise, such as, *“Tell us about how you've handled a difficult situation at your shelter”* or *“Share a positive experience you've had with clients.”* Effective workshops recognise that adults often learn collectively from each other. These kinds of conversations break down barriers to learning and motivate participants because they feel they're included as part of the workshop.

Adult learners also like to feel involved in the learning process. As a facilitator, sending handouts and/or agendas ahead of time to your participants about what will be covered in your workshop can help participants to prepare any questions or other topics they would like to see covered.

### ***Build a friendly environment***

Adult learners value a friendly environment, so from the outset, the facilitator needs to build rapport with participants by setting an open, responsive tone. That means showing concern for each participant, understanding the variety of their responsibilities, and knowing that everyone is motivated differently and comes with accumulated stories of achievements.

### ***Offer affirmation***

Beyond that, the facilitator can offer positive reinforcement. Some adult learners bring fear to their training, or they show inflexibility. By sharing affirmation, the facilitator encourages learning. Say things like, *“Thank you for sharing your expertise/your concern”*; *“That was a valuable insight”*; *“I’m sure everyone learned something from what you’ve just said.”*

### List of workshop modules:

<b>Module 1</b>	<b>Welcome and introduction Session 1</b>
<b>Module 2</b>	<b>Addressing stereotypes and fears</b>
<b>Module 3</b>	<b>Stigma and discrimination</b>
<b>Module 4</b>	<b>Shelters and harm reduction</b>
<b>Module 5</b>	<b>Conclusion</b>
<b>Module 6</b>	<b>Welcome and introduction Session 2</b>
<b>Module 7</b>	<b>Overview of modules</b>
<b>Module 8</b>	<b>Policy barriers</b>
<b>Module 9</b>	<b>Tools to include women who use drugs in shelters</b>
<b>Module 10</b>	<b>Action planning</b>
<b>Module 11</b>	<b>Conclusion</b>

### **Planning the Workshop**

It is recommended that you read through the entire facilitators guide in preparation for the workshop.

#### **Important links:**

[Powerpoints](#) (Modules: 1,3,4,5,8,9)

[Handouts and evaluation.](#)

[Policy and procedures](#)

Consider the following tips:

- The content of each session can be adjusted to suit the level of experience of the participants in each setting.
- If presenting the workshop virtually, you can use zoom and propose to do a test with the participants a few days before the workshop to explain functions (chat, webcam, virtual rooms). Make sure that all the participants have an individual computer (or phone), with good internet connection, a microphone and a webcam.
- At the beginning of the training, ask participants if they have received the handouts (to be sent 3 days before workshop planned date). As a last resort, you can insert a copy of handouts in the chat box.
- Avoid reading out PPT slides (refer instead to trainer notes).
- Watch the clock carefully to not to exceed time allocated.

### Session preparation instructions:

Module 1	Insert WHRIN address of website in the chat box.
Module 2	Draw gender symbols on a flipchart sheets before workshop as instructed in this guide ( <i>see handout 2.1</i> ). Keep resulting post-its and flipchart for reference in module 7.
Module 3	Prepare the small papers to distribute to participants for this module as instructed in the handout 3.1. Keep resulting post-its and flipchart for reference in module 7.
Module 4	Before the training, read the specific <a href="#">related interviews</a> on pages 4, 17, 21 and 28 (relating to slide 5 in PPT presentation). Also prepare a list of existing gender-based violence services in trainee location/s Facilitator to prepare a list/map of existing harm reduction services in trainee location/s. Keep resulting post-its and flipchart for reference in module 7.
Module 7	Prepare outputs (post-it papers and flipchart sheets) from modules 2-4
Module 8	Before starting this module, the facilitator needs to be aware of the national laws, frameworks, protocols and regulations, and have some general knowledge about shelter policies in their country As further preparation for the workshop, see the WHRIN <a href="#">shelter services policy and procedures</a> for shelter operations.
Module 9	Facilitator to be pre-informed about Naloxone status within the country before starting the workshop (finding out whether it is legal, if it's available, who can access it, where it can be prescribed or administered, and who provides training it its use and/or for rescue breathing)
Module 10	Copies of the table to be used for group work to be drawn on flipchart sheets in the handout 10.1. Make sure time is left to fill evaluation forms ( <i>11.1</i> ) together.

# Session 1 Agenda

Time	Module	Materials required
09:00 – 09:45	<b>Module 1 Welcome and introduction 45 min</b> <ul style="list-style-type: none"> <li>Workshop overview</li> <li>Context</li> </ul>	Computer/projector/screen/speakers PPT slides from 2 to 7 Flipchart
09:45 – 10:15	<b>Module 2 Addressing stereotypes and fears 30 min</b> <ul style="list-style-type: none"> <li>Identifying stereotypes and fears associated with inclusion of clients who use drugs in shelters</li> </ul>	Computer/projector/screen/speakers Flipchart Handout 2.1
10:15 – 11:00	<b>Module 3 Stigma and discrimination 45 min</b> <ul style="list-style-type: none"> <li>Experience of stigma by women in all their diversity who use drugs</li> <li>Our roles in stigma and discrimination</li> </ul>	Computer/projector/screen/speakers PPT slides from 2 to 4 Flipchart Handout 3.1 WUD and stereotypes
11:00 – 11:15	<b>Break 15 min</b>	
11:15 – 12:15	<b>Module 4 Shelters and harm reduction 60 min</b> <ul style="list-style-type: none"> <li>Gendered harms caused by drug prohibition</li> <li>Harm reduction approaches in shelters</li> </ul>	Computer/projector/screen/speakers PPT slides from 2 to 5 Flipchart Handout 4.1
12:15 – 13:00	<b>Module 5 Conclusion 45 min</b> <ul style="list-style-type: none"> <li>The ‘inclusivity imperative’ with shelter access</li> </ul>	PPT slides 2 and 3

## Session One Details

Half day/4 hours interactive workshop

## Workshop objective

To raise awareness among management of women’s shelters and other relevant policy makers on the need to lower thresholds to meet the needs of women in all their diversity by accommodating clients who use drugs

## Number of participants

15 participants maximum

# Module 1, Session 1

## Introduction and overview

### Aims

Facilitators and participants get to know each other.

Participants understand the goals of the workshop.

All is set for a smooth running of the workshop.

### Materials

- Computer/laptop
- Projector
- Projection screen
- Speakers
- PPT slides
- Flipchart with sheets
- Felt pens
- Registration sheet
- Name tags

### Proceedings

45 Minutes

- Welcome participants, introduce facilitator(s) and topic and circulate registration sheet (*if virtual, record present participants*) (5 min)
- Ask participants to introduce themselves (name, some background related to shelter experience and maybe what are their history in working with women including trans women who use drugs (20 min)
- Introduce WHRIN and the origin of the work engaged for women and gender diverse people who use drugs to access shelters. (6 min)

The Women and Harm Reduction International Network (WHRIN) is a global platform with the goal to improve the availability, quality, relevance and accessibility of health, social and legal services for women who use drugs. WHRIN research on responses to COVID lockdown conditions for women who use drugs in 2021 confirmed gender based violence and homelessness were both exacerbated, while shelters generally exclude women who use drugs. This finding informed a proposal supported by a Robert Carr Fund COVID short term grant to support expansion of access to shelter facilities for women who use drugs. WHRIN has accordingly researched, developed and tested this workshop toolkit.

The toolkit has been built, informed by literature review to reflect good practice responses to various barriers to access to shelters for clients who use drugs. The toolkit provides evidence to support policy and practice reform required for emergency or domestic violence accommodation services to be inclusive for women and non-binary people who use drugs.



- Introduce yourself and your background in the project and/or in harm reduction. (2 min)
- Explain the goal of the workshop and give an overview of the workshop (2 min)
- Establish ground rules (respect for each other's opinions, listening to each other, phones off or on silent, feel free to ask questions – or keep them for afterwards, etc) (2 min)
- Present slides 2 to 7 to give an overview of the situation of women including trans women who use drugs and the harms caused by punitive policies and laws. (8 min)

## Facilitator Prompts

### Slide 2

Read the question and present it as a general question to start the workshop and to help participants to start thinking about the discrimination that puts women including trans women who use drugs at risk.

*Should women who use drugs be excluded from crisis shelter accommodation?*

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### Slide 3

Read the quote which illustrates staff experience working in a shelter accepting women who use drugs. Then read the quote from South Africa.

*"We know what she's about, we're not afraid. We know how to work with her, that she's using substances. We're not going to get freaked out and we know what to expect. It was awesome! We worked as a team".\**

Quote from staff working in women's shelter which accepts clients who use drugs

*"We can't get shelter and facilities because they have too many rules for us [drug users]"*  
*"Open something like a shelter that is cheap but only for us female users like how they have shelters for only boys"\*\*\**

\*Jude Bopp, Saying Yes Effective Practices in Sheltering Abused Women with Mental Health and Addiction Issues, YWCA Canada, 2014

\*\*\*"Were you really raped or did you just not get paid?", Needs Assessment of Women who Use Drugs in Four Cities in South Africa, UNODC, 2019

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### Slide 4

Read the quote highlighting this concern for all stakeholders and policy makers.

*"Services should be open to all women and appropriately tailored to the diverse needs of those seeking support"*

Quote from UN Women site, Virtual Knowledge Centre to End Violence against Women and Girls, "Shelters"

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## Slide 5

Show that the slide summarises what is happening to women who use drugs as a consequence of punitive drug policy. When explaining that clients who use drugs are more at risk of gender based violence than other clients, stress that women who use drugs and trans women are exposed to high levels of a range of violence inflicted by intimate partners and family members as well as from law enforcement officers and the health sector.

- Global estimates indicate that 1/3 of people who use drugs are women
- Women who use drugs (WUD), especially those experiencing GBV, are at higher risk of HIV and hepatitis C transmission than men who use drugs
- WUD have less access to harm reduction services
- WUD experience more GBV than women who do not use drugs (estimated 5-24 times more)

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## Slide 6

Explain that women and trans women who use drugs face barriers to accessing a wide variety of social services and to participating in public life. Barriers include those mitigating availability and affordability of childcare, fear of losing child custody, fear of prosecution, limited transportation, lack of health insurance or 'requisite' paperwork, controlling relationships, and resistance from family. These barriers are supported by gender norms that judge women more harshly than men when considering drug use.

- Availability and affordability of childcare, fear of losing custody, fear of prosecution, transportation, health insurance, controlling relationships, resistance from family etc.
- Some clients experience internalized stigma and shame.

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## Slide 7

Present CEDAW as the international convention specifying the rights of women. The convention is signed by 155 countries to provide safe environments for women in all aspects of life. Explain that many international guidelines underline the necessity for states to ensure safety and freedom of women and non-binary people, to protect and assure equality of rights - inclusive of those who use drugs.

- CEDAW: sets up an agenda for national action to end gendered discrimination against all women including those who use drugs \*
- Failure to reach stigma and discrimination, criminalization and gender equality targets will prevent the world from achieving essential milestones \*\*
- Women, including those who use drugs, have the right to enjoy human rights and fundamental freedoms on a non-discriminatory basis in all fields of life\*\*\*
- To reach the goal of substantive equality it is essential to start with what it takes for the most vulnerable among us to thrive \*\*\*\*

\*As Convention on the Elimination of All Forms of Discrimination Against Women

\*\*Global Anti-Stigma for 2020

\*\*\*International Guidelines on Human Rights and Drug Policy, OHCHR/WHO/UNODC/UNAIDS/UNHCR

\*\*\*\*Report of the Special Representative on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Thabang Mofokeng, Human Rights Council 17th session, 2022

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## Module 2, Session 1

### Addressing stereotypes and fears

#### Aim

To explore and address preconceived ideas (stereotypes) and fears leading to shelter exclusion for women in all their diversity who use drugs

#### Materials

- Computer/projector/screen/speakers
- Post-it papers in 2 different colours
- Flipchart sheets (at least 2) to stick on the post-it papers
- Flipchart sheet with drawing of a man/male symbol
- Flipchart sheet with drawing of a woman/female symbol
- Flipchart sheet with a symbol for third gender, for example one of the following symbols (*see handout 2.1*)



Transgender (androgynous)



Other/undefined gender



Intersex and genderfluid/  
gender non-conforming

**Online version:** Ask participants to look at **handout 2.1** for this module and have paper and pen ready.

#### Proceedings

30 Minutes

##### 1. Introduction (5 min)

Explain that we all carry our ideas and fears, especially of things and people unknown to us, made worse if we have heard negative things (stereotyping) about particular people or issues or if we have had negative experiences. It is normal to have such ideas and fears and we shouldn't be afraid to express them, because talking about them and understanding where they come from are important steps towards overcoming our fears. This workshop aims to offer a safe space to open up about ideas, worries and fears and to see if we can overcome them together. This means we will not judge anybody for their opinion or expression thereof.

##### 2. Our ideas and fears around gender diversity and drug use (10 min)

Distribute post-it papers in two different colours among participants; make sure everybody has at least one post-it in each colour. Ask participants to write down on one colour (for example on the green post-it) which words come to mind when thinking about women including trans women who use drugs. This can be, quite literally, starting with what people who use drugs look like (according to participants). Also ask participants to write down descriptions or synonyms/names (stereotypes) associated with women who use drugs. They can use as many post-it papers as they want.

Then ask them to write on the other colour (for example on the blue post-it) how do they think women who use drugs would behave in the shelter, how would this be different from the behaviour of their current clients, and what (if any) risks they would bring to the shelter? Or, in other words, what would be the perceived challenges if they would open up the shelter to clients who use drugs?

Ask participants to stick their post-it papers on the flipchart sheets; one sheet for the images/labels (green papers) and the other one for the fears/challenges (blue papers). Cluster them, looking for similarities or patterns and read them out loud.

**Online version:** ask participants to have paper and pen ready and draw 2 columns (instead of having 2 post-it colours). Proceed the same method as described above but instead of sticking the post-its onto the flipchart, ask them to read their notes out.

Keep resulting post-its and flipchart for reference in module 7.

### 3. Gender roles and expectations (10 min)

The goal of this exercise is to understand gender stereotypes and how they can be harmful. Present the flipchart sheets with the drawings of a male (symbol) and a female (symbol) and explain that we probably have all learned that there are two genders or sexes and that each of those has assigned their own “appropriate” characteristics and behaviours. Ask participants to express “typical” characteristics and behaviours of men and of women and write them down on the corresponding sheet. Make sure everybody gets an opportunity to speak. If it doesn’t come up spontaneously, ask participants if drug use (including alcohol) would fit male or female behaviour, and which words they would associate to male drug use and female drug use together with specificities and differences attached to sex.

Then ask participants if they feel comfortable with those assigned characteristics. Or has anybody ever felt their freedom to express their identity has been limited by constructed characteristics? Give an example from your own life (e.g. *“as a woman I am expected to have kids and to become a perfect mother model, but I prefer and choose not”*). Allow three or four participants to share their own examples and use those to question the mainstream ideas about gender roles and gender expectations. You can also ask participants if they think the drawing/symbols you used are appropriate and why they are or are not.

Present a third sheet with a symbol for a “third” gender and ask participants which characteristics and behaviours would suit this gender. After enough suggestions, ask them if they think there should be any limitations in gendered characteristics and gendered behaviour or if it should be left completely free and up to each individual to decide on their own characteristics and behaviour. Where should those limitations be and who should decide?

You can ask why gender stereotypes are harmful for everyone, and then propose some of the definitions below in relation to stereotypes when looking at social norms and health:

- Health: the right of everyone to the enjoyment of the highest attainable standard of physical and mental health is universal. Having highlighted how sex-role stereotypes and sexual stereotypes often curb sexual expression and reproductive freedom, including by forcing women to continue with unwanted pregnancies, we can see that gender stereotyping creates marginalisation and other harms

- Stereotyping of roles fuels norms that are based on the belief that the freedom of women, especially with regard to sexual identity, should be curtailed and regulated. Where gender norms are transgressed, people are often punished severely with adverse health outcomes and violations of their right to health. For example, State control over women's lives in forcing women to continue unwanted or unplanned pregnancies
- Providing all women and non-binary people with knowledge and skills relating to sexual and reproductive health rights with related education and information, enhances their freedom to make informed health-related decisions and promotes equal participation in society

**Online version:** Ask participants to look at the symbols in their **handout 2.1** for this module and have paper and pen ready to take notes. Proceed the same for the exercise as detailed above.

#### 4. Wrap up / conclusion (5 min)

Check if participants have questions or doubts

Summarise the module in a few sentences, drawing out the most important messages:

- It is normal to have fixed ideas or fears about certain things or people unknown to us. But it is good to realise that those are not universal truths. Uncovering them and reflecting on where they come from may open up our spirits to new understandings and personal growth
- Rediscovering or moving our own boundaries can thus help us to become more understanding and therefore more effective in our work, to grow as professionals with more skills and experience

## Module 3, Session 1

### Stigma and Discrimination

#### Aim

To explore how stigma and discrimination affect women including trans women who use drugs and to become more aware of our own roles in facilitating or preventing discrimination and stigmatisation at work

#### Materials

- Computer/projector/screen/speakers
- Flipchart
- Handout 3.1
- PPT slides
- A space large enough for participants to stand in a line shoulder to shoulder and take up to twelve steps forward
- Small papers (or messages for each participant in virtual workshop) with the following identities written on them:

1. Single mother injecting drugs and working in sex industry
2. Successful male lawyer who secretly injects drugs
3. Sex working young man
4. Young woman living with HIV
5. Pregnant injecting drug user, unemployed, partner unemployed
6. Cannabis smoking successful business man
7. Alcoholic female diplomat
8. Trans-woman who is a doctor
9. Woman homeless, unemployed injecting drugs
10. Male dentist who is a tobacco smoker
11. Actress injecting heroin
12. Successful journalist snorts cocaine on weekends
13. Housewife with large Valium habit
14. Male arsonist – doesn't take drugs or alcohol, employed as firefighter
15. Male politician vegan in public, cruel to animals in private

#### Proceedings

45 Minutes

##### 1. Introduce the module (5 min)

Ask participants if they know what stigma is and what discrimination is. Explain the differences and the relation between the two.

Slides 2 to 4 with definitions of stigma and discrimination. First, ask participants if they can explain stigma and discrimination definitions, and then go through the slides and explain that stigma and discrimination are both direct consequences of our preconceived ideas and fears, most of which we received from our families, peers, media and social media.

## Slide 2

- Stigma is considered to be an opinion or judgement held by individuals or society
- If these judgements are acted upon, these actions may be considered to be discriminatory

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## Slide 3

### Elements

- Labelling of differences
- Stereotyping of those labelled
- Categorising/separation (us and them)
- Status loss, and unequal outcomes
- Enabled by power relations

### Functions

- To keep people away
- To keep people out
- To keep people down

3

## Slide 4

- Discrimination is the physical and mental, visible or tangible response to stigma
- Micro-aggressions; everyday 'slights' and 'innuendos' .
- Discrimination can be intentional or unintentional; and it may occur at an individual or systemic level\*.
- It may include direct actions or more subtle aspects of rules, practices and procedures that limit or prevent access to opportunities, benefits, or advantages that are available to others\*\*.

\* AIVL Training "Putting together the puzzle": Stigma, discrimination and injecting drug use  
\*\*Extract from the 523's Glossary of Terms, the 523's community centre for LGBTQ2S, Toronto

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Preconceived ideas can also come from laws and politics. For example, most drug policies in the world are not based on science or evidence, nor on wellbeing, public health or human rights, but rather on political interests, moral judgement and racism. Those policies cause harms to people who use drugs in general, and specifically to women, including trans-women who use drugs. Because of the expectations from society at large, both trans women and cis-women who use drugs face even more stigma and discrimination than men who use drugs. Explain also that stigma is used to make some groups the scapegoats and the ones from whom problems come: this is often politically developed with a purpose, and well described by many sociologists.

This module will explore how stigma and discrimination affect trans- and cis-women who use drugs. Remind participants that internalised stigma affects many but not all people who use drugs. Make sure participants know what “cis” means; explain that this describes a person whose gender identity corresponds to their sex assigned at birth.

## 2. Experiencing stigma and discrimination (20 min)

Randomly assign the above identities to participants by handing out the small papers. Ask them to keep their identity to themselves for now. Explain that each participant is to assume the identity and circumstances of their role consistently throughout the activity.

Ask everyone to stand in a line with their backs against a wall and explain that the aim is to see how far across the room your identity can reach. Participants can take a small step forward if they can answer 'yes' to your question or statement and remain where they are if their answer is 'no'.

**Questions and statements:**

1. Do you (does your identity) have easy access to a computer and an Internet connection to send an email?
2. I would be safe, and not run the risk of being fired, if there were a test for illicit drugs at work today
3. Would you trust the police to help you if you have a problem?
4. My parents are very proud of me
5. Will you be sure to be treated in a correct (friendly) way if you would visit a health clinic to get treatment for a sexually transmitted infection (STI) today?
6. It is unlikely that I will be subject to violence in my lifetime
7. When you go out for a drink with your friends, will you be sure to be left alone by the police?
8. My children will not be taken away from me by relatives or a social welfare / childcare institution
9. Do you have a safe place to sleep tonight?
10. My self-esteem is good; I have a positive image of myself
11. Are you a man?
12. I have strong social network that will support me whenever I need it

Ask those left towards the back of the room to announce their identity and share on how it felt to be left behind.

Ask the group to return to their seats. Once seated, ask the group for comments on the disparity they just experienced. Enquire what would need to change for those left behind to move forward?

**Online version:** Using private messages, assign one of the above identities to each participant. You will read statements and ask participants to write 1 point each time they can answer 'yes'. Then at the end of the exercise, you ask each participant to read out their identity and give the score they have reached. Ask those who got 0 or very few points how they feel to be left behind. Then ask the group for comments on the disparity they just experienced. Enquire what would need to change for those left behind to move forward?

### 3. Personal values and professionalism (15 min)

Ask participants to have a look at the post-it of the second module (the ones on which images /stereotypes were written down - the green ones).

**Online version:** Participants will need to refer to the 2 column paper they used and filled during module 2. Give them half a minute, then ask the group what they think about the words.

- Can they trace back within themselves where some of their ideas about gender and drug use come from?
- What has shaped those ideas (school, peers, church, parents, (social) media, work environment)?
- As a professional, how do you think those images/stereotypes influence your work? (if participants don't know, some examples could include: "*a drug user has inappropriate or disruptive behaviour*", or "*a woman who uses drugs can't be a good mother*", or "*drug users are stealing everything*"...).
- Can you think of a situation in your work where certain images or ideas you have may have had a negative impact on your work or on a professional trusted relationship with a client?



Explain that because of our preconceived ideas, we are likely to discriminate against or stigmatise people, even if not intended, either by what we say, how we act, or by the rules we design and implement for others. These can make others feel upset and exhausted and tend to stand in the way of effective support for the people we intend to help.

Keep resulting post-its and flipchart for reference in module 7 and 8.

#### 4. Wrap-up and conclusion (5 min)

Check if participants have questions or doubts.

Summarise the module in a few lines, providing key messages:

- Professionals have personal values that can be stigmatising to the persons they are working with. Being a professional means recognising the stigma and prejudices we can feel and being able to put these images and stereotypes aside to accept people as they are.
- Language and the way we talk to people matters. In our work, respect and trust are necessary to build confidence and constructive relations.
- Ask participants if they can all give one word that made an impact on them or one word they will not express the same anymore.

#### Module 3 Stigma and discrimination

Additional reading and training material in **handout 3.1**

## Module 4, Session 1

### Shelters and Harm Reduction

#### Aim

To introduce harm reduction approaches and principles and how they can be integrated in shelters.

#### Materials

- Computer/projector/screen/speakers
- PPT slides
- Flipchart
- Handout 4.1
- Facilitator to prepare a list/map of existing harm reduction services in the city/adapted to each context
- To prepare a list of existing gender-based violence services

Before the training, read the specific related interviews on pages 4, 17, 21 and 28 (*relating to slide 5*)

#### Proceedings

60 Minutes

##### 1. Introduce the module (5 min)

Introduce the title of this module and ask participants if they know about 'harm reduction' and if so, can they explain what it is. Tell them we will take a deeper dive into this, but first we'll look at how someone's gender places them in society when using drugs, and how our shelter(s) currently (generally) deal with drug use.

##### 2. Gendered harms of drug prohibition (10 min)

Ask one or two participants to briefly present on why women's shelters exist and which needs they address.

Provide a short history of the global drug policies (War on Drugs):

*When president Nixon announced the War on Drugs in 1968, this had little to do with drugs. The goal of this war was not to fight or control drugs, but to disrupt communities of black people and communities who were protesting against the Vietnam war. Drug prohibition was inspired by political, racist (post-colonial) interests that have a gendered impact in practice. Since then, both drugs and the people using them have been stigmatised and criminalised all around the world, leading to full prisons, clogged justice systems, militarising police, violence, preventable deaths and health problems. Increasingly, women are bearing the brunt of this. Women are being incarcerated in rapidly increasing numbers for producing, trafficking or consuming drugs and they are often the targets of violence. Add the intersecting stigma around gender and sexual identities to this and it is easy to see the levels of discrimination, violence and abuse that trans women who use drugs face.*

Link this discussion to the previous contributions on the needs of women that shelters are addressing.

Ask if there are any questions or thoughts participants wish to share after hearing this and if so, allow a few minutes for a conversation.

### 3. Where does our shelter stand? (25 min)

Separate the group into 3 or 4 sub-groups (aim for 4 people per group) and ask them to write down how their shelter(s) currently approach drug use and gender diversity.

- Drug use – do shelters currently refuse or evict clients who are (suspected of) using drugs? How do they deal with the possession of drugs or drug use equipment in the shelter? Do they tend to solve issues related to drugs directly with clients, or do they involve the police...?
- Gender - do shelters accept trans women and people whose gender identity is different from their biological sex? If so, are there specific rules for them? Or are they referred elsewhere?

Also ask groups to reflect on where those approaches come from; what is the reason for their implementation?

Give them 12 minutes for this, and ask the group to identify one person who will report back in plenary then ask them to stick their paper on the wall/share back with the group.

Keep resulting post-its and flipchart for reference in module 7.

**Online version:** each rapporteur will explain orally what was written and expressed by the sub-group.

Ask each group to present (2 minutes each), thank participants for their efforts.

### 4. Harm reduction package and approach (15 min)

Present slides 2 to 5.

#### Slide 2

Give a short overview of the harm reduction package and the broader harm reduction approach (that includes advocating for decriminalisation and the importance of social support networks).

☐ Needle and syringe programmes (NSPs)  
☐ Opioid agonist therapy (OAT) and other evidence-based drug dependence treatment  
☐ HIV testing and counselling  
☐ Antiretroviral therapy  
☐ Prevention and treatment of STIs  
☐ Condom programmes  
☐ Targeted information, education and communication  
☐ Prevention, vaccination, diagnosis and treatment for viral hepatitis  
☐ Prevention, diagnosis and treatment of TB

*Increasing consensus that community naloxone distribution and SRHR (including GBV services) should be added to these essential elements*

2

#### Slide 3

Give a general definition of harm reduction and if there is time you can first ask participants how would they define harm reduction with their own words and then give the definition and see if it's clear for all attendees.

*People have the right to be safe even if they are not ready or willing to abstain from drug use.*

*Harm reduction involves giving people who use drugs evidence-based choices that can help to protect health.*

3

#### Slide 4

Continue to detail and explain what harm reduction means in terms of values and principles for actions.

- Non-discriminatory and unrationed
- Not restricted by criteria such as sex/gender, employment status, past imprisonment, drug use status or pregnancy status
- Gender mainstreaming
- Informed consent without coercion
- Confidentiality
- Respect

*The UN system has endorsed harm reduction as an effective response to drug use.*

4

You can give more complete information, including:

- ✓ Not restricted by criteria such as sex/gender, employment status and profession (including sex work), criminal justice history (including imprisonment), drug use status or pregnancy status.
- ✓ Gender mainstreaming—based on the recognition that gender equality and equity are linked to human rights, fairness and social justice for all.
- ✓ Informed consent without coercion—through providing a full range of options to enable clients to make decisions and respecting their autonomy in doing so.
- ✓ Confidentiality—respecting and safeguarding the privacy and autonomy of clients.
- ✓ Respect—treating each client with respect and dignity.

You can also explain that harm reduction is recognised by international bodies and stakeholders.

#### Slide 5

Provide practical examples to welcome and support women who use drugs in all their diversity, (adding some details you will have read in the preparatory phase of the workshop). Refer here to the case study from Slovenia (**handout 4.1**) as an example.

- 
- Women Nest, Nairobi–3 shelters accomodation for women who use drugs
  - Sister Space, Vancouver – women only safe injecting room
  - MdM Myanmar, Kachin state – meaningful engagement of women
  - Club Eney, Kyiv –addressing GBV

5

## 5. Wrap up/conclusion (5 min)

Check if participants have questions or doubts.

Summarise the module in a few lines, providing key messages:

- Drug prohibition disproportionately harms women including trans women who use drugs through incarceration, violence from law enforcement and by creating a culture of violence against criminalised people. Harm reduction, if integrated, can reduce harms and bring benefits for clients while boosting the utility and professionalism of the shelter.
- Harm reduction helps towards giving back confidence to people in managing their own lives. Shelters can also bring effective changes in people's lives when most in need and work to reduce violence and inequalities for women, whether cis- or trans women. Harm reduction integration helps crisis shelters to address the needs of women in all their diversity, while also improving the professionalism of shelter policies and staff skills.
- Harm reduction facilitates respect for people's lives and their choices while offering tools to support clients who use drugs.

For more information on good practice in harm reduction programming for women (*see **handout 4.2***)

# Module 5, Session 1

## Conclusion of Session One

### Aims

To check in with participants on where they stand now in relation to clients who use drugs  
To repeat the most important messages  
To receive feedback on the workshop

### Materials

- Post-it papers from module 2
- PPT slides

### Proceedings

30 minutes

Announce the end of session one with a brief summary of the modules (using the core messages in the conclusion of each module) (5 min)

1. Go back to the post-it papers from module 2 with challenges opening the shelters for women who use drugs in all their diversity (the blues ones) and ask if people still feel the same, or if some may have changed their minds after what they've learned today. If so, what has changed? (10 min)
2. The 'inclusivity imperative' with shelter access; present slides 2 and 3 and explain what inclusivity for all women means. Ask participants if this definition is clear and how it can be integrated into their practices. Encourage participants to express thoughts and give some time for exchanges. (5 min)

### Slide 2

- Allow clients to make choices about their drug use while ensuring the shelter remains safe and comfortable for everyone.
- Accept the goals and decisions of the clients using the shelter
- Each client has the right to be in control of their own life
- Empowerment is a matter of trust and respect

- All women and gender diverse people in need deserve access to GBV support and shelter inclusion, including those who use drugs

- Inclusive means accepting women as they are, regardless of their drug use status and life-style

## Session 2 Agenda

Time	Module	Materials required
09:00 - 09:45	<b>Module 6 Welcome and introduction 45 min</b> <ul style="list-style-type: none"> <li>• Workshop overview</li> </ul>	Computer/projector/screen/ speakers Flipchart
09:45 - 10:15	<b>Module 7 Overview of session one 30 min</b> <ul style="list-style-type: none"> <li>• Addressing fears</li> <li>• Stigma and discrimination</li> <li>• Shelters and harm reduction</li> </ul>	Computer/projector/screen/ speakers Flipchart
10:15 - 11:10	<b>Module 8 Policy barriers 55 min</b> <ul style="list-style-type: none"> <li>• Identifying policy and other barriers for women who use drugs access to shelters</li> </ul>	Computer/projector/screen/ speakers PPT slides from 2 to 6 Flipchart Handout 8.1
11:10 - 11:20	Break 10 min	
11:20 -12:05	<b>Module 9 Tools to include women who use drugs in shelters 45 min</b> <ul style="list-style-type: none"> <li>• Promoting and facilitating safer drug use</li> <li>• Opioid overdose management (incl. first aid and Naloxone)</li> </ul>	Computer/projector/screen/ speakers PPT slides from 2 to 14 Flipchart Handouts 9.1 – 9.9 Naloxone/1 page evidence-based Sharps containers Safe consumption rooms Bleach Rescue breathing training/visuals
12:05 -13:00	<b>Module 10 Action planning 55 MIN</b> Concrete actions to allow internal policies changes	Computer/projector/screen/speakers Flipchart Handout 10.1
13:00 -13:30	<b>Module 11 Conclusion 30 MIN</b> Workshop evaluation and closing	Evaluation form 11.1

Session Two Details  
Half day/4 hours

### Workshop objective

To provide management of shelters with insights and practical tools to lower thresholds to shelter access for clients who use drugs. Policy makers will gain insight on how to adjust policies to support improved access to shelters for women who use drugs.

### Number of participants

15 participants maximum

## Module 6, Session 2

### Welcome and Introduction

#### Aims

Facilitators and participants get to know each other (if not session one and two same day workshop).

Participants understand the goals of the workshop.

All is set for a smooth running of session two.

#### Materials

- Computer/projector/screen/speakers
- Flipchart

#### Proceedings

45 minutes

(NB: 1 and 2 apply if not running session two on the same day as session one)

1. Welcome participants, introduce facilitator(s) and topic and circulate registration sheet (or note down participants present) (5 min)
2. Ask participants to introduce themselves (name, some background related to shelter and maybe what are their experiences with clients who use drugs (30 min)
3. Explain the goal of the workshop and give an overview of the workshop (5 min)
4. Establish ground rules (respect for each other and opinions, listening to each other, phones off or on silent, feel free to ask questions – or keep them for afterwards, etc) (5 min)



# Module 7, Session 2

## Overview of session one

### Aim

To give a general view of the issues addressed in session one.

### Materials

- Computer/projector/screen/
- speakers
- Flipchart

Products (post-it papers and flipchart sheets) from modules 2-4; on the walls or virtual whiteboard so participants can have a look at them before coming in and/or during the break

### Proceedings

30 minutes

#### 1. Introduction (3 min)

Before considering practical aspects for improving shelter accessibility for clients who use drugs, provide a summary of the main components of session one:

#### 2. Summary of module 2 - Addressing fears (8 min)

Remind participants that the first module of the workshop was about addressing our preconceived ideas and fears in relation to drug use and gender diversity. Invite someone to give a short summary of module Thank the person, and if they have not covered all key points below, add:

- The second module covered stereotypes and fears correlated to drug use and gender diversity. Participants were asked to consider their assumptions when interacting with someone using drugs or a person whose gender identity doesn't match their sex assigned at birth.
- We discussed how society, in various ways, transmits expectations about how men should look and behave and how women should look and behave – and that the use of drugs is not considered 'good' behaviour, especially for women. We tried to unpack those expectations and discussed "deviations" from those fixed roles and how much we should leave behind, for people to be enabled to express their gender and drug use identities.

The main conclusions of the first module were that:

- People carry fears and personal ideas about others. While this is quite normal, we need to be aware of biases and ask ourselves where they come from and if they are valid. This helps us to grow as a person and as a professional.
- To move your own boundaries and discover new approaches helps to build a better understanding of and communication with your clients and thus be more effective in your everyday work.

Ask if there are any questions before moving on.

#### 3. Summary of module 3 - Stigma and discrimination (8 min)

Invite one of the participants to give 2 words that for them reflect what they learned or what was important to them during the second module. Ask if other participants have questions or want to react to the words. Then give a summary of module 3:

This module explored the feeling of being stigmatised and discriminated against through a game where some of us felt left behind with fewer opportunities in life. Participants reflected on the origins of their own preconceived ideas that can be stigmatising, even if not intentionally. We discussed how the expression of such ideas, through language, exclusion policies, attitude or body language can potentially influence our work in a negative way.

The main conclusions of this module were that:

- Being a professional means recognising the stigma and prejudice we carry with us and being able to put these aside to accept people as they are.
- In our work, respect and trust are necessary to build confidence and meaningful provider-client relations in order to achieve quality outcomes

Ask if there are any questions before moving on.

#### 4. Summary of module 4 - Shelters and harm reduction (8 min)

Ask one of the participants to give a summary of the 4<sup>th</sup> module. Thank the person and if they have not covered all key points below, add:

- This module started by exploring drug prohibition and how it impacts people's lives. We learned that drug prohibition in practice has little to do with drugs, but more to do with political interests, racism and the control of certain communities. We learned that women and non-binary people are relatively more and differently affected by drug prohibition because of socio-economic inequities and gendered social expectations. For trans women who use drugs, already facing stigma and violence because of their gender identity, the impacts are particularly severe.
- Participants presented on how their shelters approach drug use and gender diversity and where these approaches come from. We then looked at harm reduction as an alternative approach to better support trans women and other women who use drugs.

The conclusions of this module were that:

- Drug prohibition disproportionately harms women who use drugs (hyper-incarceration, gender-based violence, including intimate partner violence and violence from law enforcement, loss of child custody etc);
- Harm reduction, if integrated in shelters, can bring various benefits:
  - Facilitating respect for people's lives and their choices
  - Giving back confidence to clients
  - Bringing safer options to clients' lives and reducing gender inequalities
  - Improving professionalism in shelters policies and staff by serving women in all their diversity

#### 5. Conclusion (3 min)

Ask if participants have remaining questions or doubts.

## Module 8, Session 2

### Policy barriers

#### Aim

To explore how shelter policies and (sub-)national laws or regulations limit shelter access for clients who use drugs

#### Materials

- Computer/projector/screen/
- speakers
- PPT slides
- Flipchart
- Handout 8.1

Before starting this module, the facilitator needs to be aware of the national laws, frameworks, protocols and regulations, and have some general knowledge about shelter policies in their country.

As preparation for the workshop, read the WHRIN [shelter services policy and procedures](#) for an example of inclusive shelter functioning.

#### Proceedings

55 minutes

##### 1. Introduce the module (5 min)

Explain that, now that we have reflected on stereotypes, stigma and harm reduction approaches, we would like to have a renewed look at the shelters where we work and how shelter policies can (unintentionally) impose barriers for clients who use drugs. Some of those policies may be based on government rules, regulations, laws and frameworks. While we can adapt our own (shelter) policies, we may still need to deal with existing legislation. In this module we want to discuss how to approach government regulation issues, while in the next module we will go deeper into shelter policies and practices.

##### 2. Group work: Shelter policies (20 min)

Separate the group into 3 or 4 sub-groups (aim for 4 people per group) and ask them to list the barriers to inclusion of clients who use drugs in their shelters, based on their policies and also on their daily practices.

Refer to the exercise “where does our shelter stand” from module three. Whereas in that module the question focussed on the point of view of shelter staff and management, this time we are asking participants to look at their shelter through the eyes of their potential new clients who use drugs.

Ask participants to consider their current policies, daily practices, behaviour, shelter lay-out, activities, and so on from that point of view and consider what are potential barriers for clients who use drugs. (In case groups are lacking ideas, you can propose some directions to think about as below, as shelter managers will know perfectly their rules or procedures in place):

- Strict rules in place in timing allocated to leave the shelter and curfew in place at night: can it be more flexible?
- Can the length of stay be adapted to each client's situation?
- Can referrals or links to harm reduction services be improved, strengthened and reinforced?

- Ask each group to write their answers down on a flip chart.

After 10 minutes, invite participants back in plenary and ask each group to present their answers in 2 minutes. Thank each group for their work.

### 3. Group work: Policies or regulations imposed by government (20 min)

Ask participants to stay in the same groups and look again at what they have just written down. Ask them to imagine they have decided to change some of their policies and practices to better accommodate and serve clients who use drugs.

It is likely that some policies or practices are there to mirror national laws or regulations. Which are the policies that participants think they cannot change? And what can they do about this?

If they say that nothing can be done, ask them if they would be in a position to ask for exemption to certain laws/regulations, if they could advocate to change those rules, or if they could decide to not adhere to those rules.

If they say one of those options may be possible, ask them to think about how this could be done (what would be the process, the risks, possible positive and negative consequences, how long would it take, which agencies to approach etc). Ask participants to write down their answers.

After 10 minutes ask them to come back to the plenary and present their work in 2 minutes. Thank each group for their work.

### 4. International examples and guides (5 min)

Present slides 2 to 6 with examples of how shelters elsewhere have managed to adapt their policies and practices to include clients who use drugs.

#### Slide 2

What shelters need in practice to adapt their policies and on which areas to focus. Highlight the possibility of requesting exemptions and specific authorisations that will allow reforms.

Providing clients who use drugs with access to injecting equipment in the shelter is a key step. Consider that the meaningful involvement of clients in the life and functioning of the shelter will bring more comfort for all and ensure messages and information are delivered effectively.

- Approach drug use as a public health issue and adjust internal shelters policies to be non-punitive and safety oriented
- Seek exemptions and MoUs as needed
- Organise access to harm reduction supplies
- Involve clients in the functioning of shelters (discussions, creation of formal committees, problem solving)

Examples of shelters which changed their policies to give access to clients who use drugs to their facilities. Participants can refer to the module 4 case study of the shelter in Slovenia (*see handout 4.1*).

### Slide 3

- Assessment: WUD have no safe place to go when facing violence
- Target group: women who use drugs who are experiencing violence
- Abstinence is not required, use of drugs and alcohol in the house still is forbidden. Any illicit drugs brought to the house are placed in special lockers
- Results: Stigma safe house has strongly contributed to the decrease of risky drug use, delinquency, homelessness and the possibility of returning to violent relationships\*

\* [EN | Stigma \(drustvo-stigma.si\)](#), Safe House for Female Illegal Drug Users – Victims of Violence

3

### Slide 4

- Shelter for women including trans women who use drugs, focusing on those who are threatened by violence and are mothers or pregnant
- Shelter rules are few: no fighting, no stealing, no sex, no consumption of illicit drugs or alcohol inside the house
- Clients can leave the house, upon agreement with their case managers: to visit family, have a date, work, study, go to a care service, drug treatment, or to use drugs.
- A lawyer works part-time in the house to support regaining custody or to prevent loss of child custody
- Results: Having a place to stay helps to manage more controlled drug use. Clients positive about having a safe space and being able to take responsibilities. Housing helps clients with opportunities for income generation and to increase self-care.\*

\* Rignon I R., Breeksema J, Woods S., « Speed limits, harm reduction for people who use stimulants », pp 48-58, Mainline

4

### Slide 5

The example from the City of Toronto which has established standards for shelters to be trans-inclusive. You can explain this is a recommendation which provides an example to be followed by all shelters.

- Development of a more formal Advisory Committee of people from the trans community, including trans women, or a similar entity to monitor and assess the range of services available (or not) to trans women and whether these services adequately meet the needs of trans women
- Imperative that ALL shelters comply with Toronto Shelter Standards which state that shelters must support transsexual/ transgender (TG/TS) and intersexed people in accessing services in the gender that the individual identifies with to best preserve safety and dignity\*

\*Sakamoto L, Ricciardi J, Plyler J, Wood N, Chapra A, Chin M, Allan B, Cameron R & Nunes M, *Coming Together: Homeless Women, Housing and Social Support*, Wellesley Institute, May 2010

5

### Slide 6

Presenting the policy and procedure guidelines developed by WHRIN for shelters operating in Kenya, Nigeria and Ukraine. Also present existing guidelines and distribute hard copies to read at home.

- Shelter services for specific group: all those who identify as women, who are drug users and experiencing or feel threatened by violence and/or are experiencing homelessness
- A policy designed to promote autonomy with very low threshold criteria
- Safety plans provided
- Increase collaboration with harm reduction service providers to improve referral linkages

6

We can see that working on a national framework for shelters to accept WUD and to propose guidelines to integrate harm reduction practice includes:

- Access to harm reduction supplies
- Harm reduction training and support for staff
- Approach drug use as a public health issue and adjust internal shelters policies to be non-punitive for drug use and safety oriented
- Involve the residents in the functioning of shelters (discussions, creation of formal committee)
- Engaging in technical working groups with governments supports advocacy and awareness actions for community to access services
- Propose specific slots/allocations for clients who use drugs for gender-based violence support response
- Creating separate shelters for clients who use drugs can, depending on approach and context, result in more stigma – each context should reflect needs expressed by clients.

#### 5. Wrap up/conclusion (5 min)

Check if participants have questions or doubts.

Summarise the module in a few lines, providing key messages:

- We've seen that some of our policies and daily practices intentionally or unintentionally exclude clients who use drugs like (mention those that were mentioned as most important from the group work).
- We've started thinking about how we can change this, like for example (mention some of the examples presented by the groups).

#### Module 8 Policy barriers

Further information on decriminalisation and drug policy (*see handout 8.1*).

## Module 9, Session 2

### Tools to enable inclusion of clients who use drugs in shelters

#### Aims

To provide practical tools to facilitate shelter access to clients who use drugs  
To acquaint participants with Naloxone

#### Materials

- Computer/projector/screen/speakers
- PPT slides
- Flipchart
- Handouts 9.1 – 9.9

Trainer to be pre-informed about Naloxone status within the country before starting the workshop (finding out whether it is legal, if it's available, who can access it; where it can be prescribed or administered; where to access instruction for use of Naloxone)

#### Proceedings

45 minutes

##### 1. Introduction (5 min)

Explain that, having touched on policies that restrict or exclude clients who use drugs, we now want to look at what can be done at your shelter(s) to create a more welcoming environment for clients who use drugs without heavily increasing resources and making radical changes. This requires some adjustments that can be made within the existing premises, and especially adoption of an open-minded attitude with knowledge and capacity among shelter staff regarding gender diversity, drug use and harm reduction.

##### 2. What can we do? (20 min)

Ask people to go back to their groups from the previous module to look at the barriers they listed. They had focussed on issues that are difficult to change because of government regulations.

Now ask them to write down on a flip chart what can be done to facilitate the inclusion of clients who use drugs in their shelter, without breaking the rules or requiring lots of advocacy.

Changes can be proposed in the lay-out and use of the premises, knowledge, attitude and behaviour of staff, shelter rules, information for current clients, external communication, adding services, collaboration with partners or expansion of referral networks, etc. Explain that details on how to implement the change are not yet needed, because we will work on that in the next module. In this exercise we mostly want participants to brainstorm and list all the things they think can be changed relatively easily.

If the group doesn't have ideas or seems reluctant to identify some possibilities, prepare in advance a list with anticipated answers that you can suggest to the group.

For example:

- “*Drug users are thieves and unreliable/don’t respect rules*” – you can reflect on what was seen in Module 3 about stigma and discrimination, and when someone is rejected and subject to discrimination it can make the individual less cooperative, unfriendly or defensive. Shelters generally have systems for addressing difficult behaviours and staff need to understand that drug use does not, in itself, cause problem behaviour.
- “*Drug users are violent*” – you can answer that violence is not caused by drug use however clients who use drugs experience greater rates of violence than most. A climate of confidence and trust is critical – as is generally well understood in trauma informed GBV services and shelter programmes.
- “*Drug users can face withdrawal*” – you can propose that reinforced partnership with harm reduction services will facilitate access to opiate substitution therapy and medical services when needed, and allowing drug users to leave the shelter when they need will also prevent this situation.
- “*Drug users lack of hygiene*” – this is a myth best addressed by providing a shower with soap.

Give the groups 8 minutes for this work, then ask them to present in 1 minute. (Keep resulting notes for use in module 10)

Thank each group and after the last presentation, show slides 2 and 3, presenting language guides around drug use and around gender diversity. Ask if they have questions or comments. Repeat to participants that language and words matter.

## Slide 2

What to say	What not to say
People/person who use(s) drugs	Drug user; drug abuser; druggo; druggies; drug fiend; acronyms (PWUD, etc.)
People/person who inject drugs	Injector; junkie; smackhead; injecting drug user; meth-head; acronyms (PWID, IDU, etc.)
People/person who smoke drugs	Pothead; chuffer; meth-head, crackhead
People/person with drug dependence	Addict; drug addict; drug abuser; problem(atic) drug user; misuser; substance abuser*; person who is addicted
Client/s; service user/s	Patient
People/person who has used drugs	Clean; sober; drug-free; ex user; in recovery; maintaining recovery; ex-alcoholic

2

## Slide 3

Cisgender: A term used to describe people whose gender is the same as what was presumed for them at birth (male or female).

What to say	What not to say
Trans and gender diverse, transgender, trans person	Trans*, transgendered, transgenderism, tranny, pre-op/ post-op, sex & gender diverse.
Men, women and non-binary people	Men, women and trans
Woman, woman with a trans experience, trans woman	Transwoman (as in tallwoman instead of tall woman)
Think: “Would I ask a cisgender person this?”	“Have you had the surgery?” / “Tell me more about your genitals?” / “What is your real name?”

3

Inform participants that both guides are included in the **handouts 9.8 and 9.9** and it can be a good support to become more familiar with the terms which are inclusive and respectful.



### 3. Safer use and Naloxone (15 min)

Introduce safer drug use; one or more groups may have touched upon (allowing or restricting) drug use in the shelter; use this as a bridge to introduce safer drug use.

Ask participants what safer drug use means for them. Remind them that if people who use drugs living in their shelter have no place where they can use drugs, they are very likely to use in public spaces, or at best in the house of a friend or a dealer. Walk them through the risks of using in public spaces, by asking questions (addressing overdose, police harassment/violence/abuse, violence from other people, discarded equipment etc). Carefully assess the willingness of the group to consider allowing drug use in the shelter and ask them what they think needs to be in place for this to happen.

Present slides 4 show what can be done, such as (unofficially) allowing consumption in parts of the shelter (room, toilet, garden or yard), promoting keeping an eye on each other when using, stocking Naloxone, and providing lockers to keep drugs and using gear safe. Direct participants also to examples and guidance in **handouts 9.3 and 9.4**.

#### Slide 4

- Allow consumption in one specific place: it can be a room (eg personal clients room), bathroom, toilets, basement or in the vicinity of the shelter (yard, garden)
- Support peer supervision – promoting a safe practice “not to use alone”
- Provide safe equipment and disposal facilities in the shelter
- Have naloxone on site (and train clients on how to use it)
- Learn rescue breathing
- Provide lockers to each client to keep drugs/alcohol

4

#### Slide 5

Seattle - tiny houses where drugs are allowed

A steady supply of sterile needles/syringes and disposal containers organised around the village



5

#### Slide 6

- Only one shelter accepting women who use drugs!
- Linkage with harm reduction services to provide sterile injecting material and access to opiate agonist therapy
- Linkages with social services \*

\* Rigoni R., "Sisters Spaces - Needs, challenges, and services for women who use drugs in South Africa" Mainline, 2021

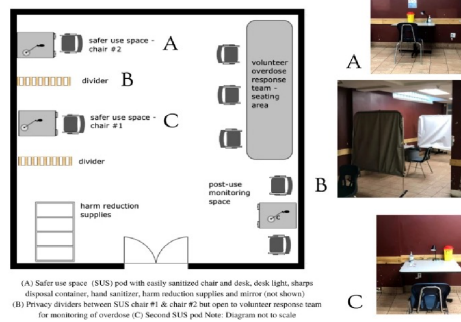
6

## Slide 7



7

## Slide 8



8

Present slides 9 and 10 with examples of safe disposal units in toilets/bathrooms and discuss this possibility for their shelters. Since participants may feel this is far from their reality, keep it light and casual (don't go into details, but direct them to more background in **handouts 9.5, 9.6 and 9.7**), and remind participants that it also seemed challenging at the start in the shelters you have described.

## Slide 9



9

## Slide 10



10

If harm reduction programmes, including needle and syringe programmes and safe consumption rooms exist in the vicinity of the shelter, advise linking up with those programmes for drug using clients to have access to safe equipment and to other relevant information and support.

Suggest participants can even consider obtaining such equipment from harm reduction services to provide to their shelter clients directly.

If needle and syringe programmes (NSP) are not available, shelters may still provide sterile water (boiled tap water) and aluminium foil (beware of quality; some have poisonous oils on them) and stress that drug use equipment should never be shared and ideally also not re-used.

Buying syringes from the pharmacy for shelter residents may also be possible. If not, as a very last resort, shelter residents who inject drugs can be offered bleach to sterilise their injecting materials. This is last resort as not guaranteed to eliminate the transmission of HIV and viral hepatitis, but is much better than sharing needles and syringes that have not been bleached. Standard bleach for cleaning bathrooms can be used.

Ask participants if they have heard about Naloxone and its use.

Present slide 11 to briefly explain signs of overdose, then present slides 12 and 13 to briefly introduce what Naloxone is and how it works. Explain that Naloxone is an antidote to opioid overdose.

#### Slide 11

- Unresponsive or unconscious individuals
- Not breathing or slow/shallow respirations
- Snoring, gurgling, or choking sounds (due to partial upper airway obstruction)
- Blue lips and/or nail beds
- Heart rate slows or stops
- Pinpoint pupils
- Pale and clammy skin
- Vomiting

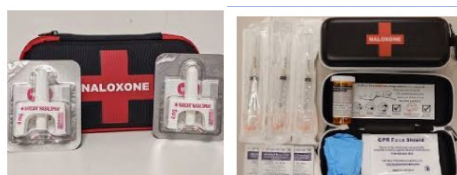
11

#### Slide 12

- Naloxone is the antidote to opioid overdose
- It ties to opioid receptors to block the effects of opioids
- Naloxone helps to restore normal breathing
- Naloxone has no effect if given to someone with has had no opioids
- Naloxone should be given if someone is showing signs of an opioid overdose

12

**Slide 13** With photos on slide 13 you can explain that Naloxone can be administered in 2 forms, nasal spray and/or injection. If Naloxone is available in your country, you can upgrade photos from the slide and show what is used.



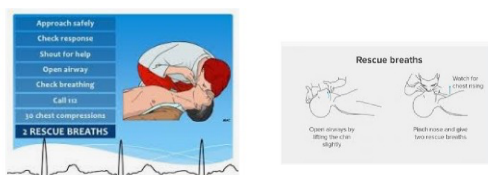
13

Refer to **handout 9.1** for more information and encourage participants to review the simple, [quick training available on-line](#).

If Naloxone is available outside clinical settings (or is expected to become available soon - explore whether they could apply for an exemption to have Naloxone onsite), explain that instruction to administer Naloxone is available and inform participants who can provide Naloxone training for them.

Then ask them if they are familiar with first aid training for managing opioid overdose.

**Slide 14** Present slide 14 on rescue breathing, and inform them about how they can arrange training on this topic (*see also handout 9.2*)



14

#### 4. Wrap up and conclusion (5 min)

Check if participants have questions or doubts.

Summarise the module in a few lines, providing key messages:

- Inclusion of clients who use drugs can be achieved with the addition of simple tools: (mention some of the examples presented by the groups)
- For more complex and/or longer term changes, repeat which organisations are available to train and support participants (probably your own organisation is one of them or even the main / only one).

To complete what we have seen briefly during the workshop, you can refer to the table below to clearly understand the difference between a stimulant and a depressant drug.

Drugs	Effects
Stimulants: Cocaine/Crack, MDMA/ecstasy, amphetamines (speed, ice, crystal), tobacco, caffeine, ATS, Ritaline	Speeding up bodily functions, increasing heart rate and raising blood pressure (speed up the central nervous system)
Depressants: all opioids as morphine, heroin, opium, Fentanyl, codeine, oxycodone, methadone and buprenorphine And alcohol, benzodiazepines (as Valium)	Slowing down bodily functions, feeling relaxed and calm (slow down the central nervous system)

## Module 10, Session 2

### Action planning for concrete change

#### Aim

To work on action plans that will support the inclusion of clients who use drugs in shelters

#### Materials

- Computer/projector/screen/speakers
- Flipchart
- Handout 10.1

Copies of the **handout 10.1** table to be used for group work, to be copied on flipchart sheets.

**Online version:** Ask participants to refer to **handout 10.1** for the table they will use during group exercise 3.

#### Proceedings

65 minutes

##### 1. Introduce the module (3 min)

Explain that changes can be introduced starting from a guiding plan or framework. Plans are needed to implement changes as smoothly as possible, but also to provide concrete tools for staff to improve their work. Changes can't be made in one day, this is a journey and some external support or resources might be necessary. This module explores how plan for change.

##### 2. Visioning exercise (10 min)

Ask everyone to shut their eyes and image a point in the future:

*1 year from now at an international shelters awards ceremony where they are presented with a medal for achievement. The welfare minister asks you to mount the stage and then tells the world about why it is that your shelter has been chosen for this award.*

*Keep your eyes closed and listen the words of the minister*

(give them a full minute of silence for this).

Then another minute to write down what the minister said. Then ask 2-3 participants to read out the words

##### 3. Group work: design a plan for change (45 min)

Explain that the objective of the exercise is to identify short-term and medium-term actions to improve inclusion of clients who use drugs in shelters.

Ask participants to form three groups. (Policy makers could rotate between groups, spending 10-15 minutes in each group, in order to have a minimal understanding of the wishes and ideas of different groups).

The first part of the group work is to list desired changes in the table that has been distributed to each group, or which can be found in **handout 10.1**. Participants can use their list of changes from the group work from module 9 (and draw inspiration from the work of other groups), or add other changes they want to work on.

Ask them to think of realistic changes they can achieve in the short to medium term. If there are too many desired changes listed, ask groups to prioritise and only work on two achievable and impactful changes. Make sure each group has included plans for desired culture, language, and attitude changes within the shelter, since this will be the basis for all other change.

In the first column groups should list steps to prepare and implement each of the changes. Ask groups to write detailed, specific and realistic steps to avoid getting stuck along the way.

Then ask participants to list persons and organisations that are needed to implement or support each change. It is likely they will list people and institutions who are not present today, such as other members of staff or management, volunteers and partner organisations, the current shelter clients, government authorities, influential members of the neighbouring community etc. Highlight that it may be important to engage these stakeholders for sustainable change.

Remind participants also to list people and organisations who can help with, for example training or mentoring, by brokering other important relations, by providing services to your new clients that you cannot provide.

Participants should assign a person responsible to coordinate the change process. The person they appoint needs to have the authority to enable change.

Then, in the final column, ask groups to design an estimated timeline for each change as an approximate period for each step, or a date for each milestone. Make sure there is more than just a deadline for the change to be implemented.

As facilitator, you need to move around each group regularly, to ask if the instructions are clear, if they have questions/doubts, and to see they don't get stuck or forget important things.

After 30 minutes, invite participants back to plenary and ask each group to present their work in 3 minutes (using their flipchart table or chat in zoom).

Take a few minutes to discuss each plan with the wider group. If you see gaps, make suggestions or ask groups to think about how to troubleshoot things they haven't specified. Explain that, since issues of drug use and gender diversity may be new, networking with and learning from harm reduction and other organisations are important.

Thank each group for their work.

Desired change (see **handout 10.1**)

#### 4. Wrap up and conclusion (7 min)

Check if participants have questions or doubts.

Summarise the module in a few lines, providing key messages:

- You have made important first steps by discussing your ideas and hopes and by starting this table that can be the basis of your change pathway. Some changes will take time if you need to convince people to engage, find allies and design new service elements.
- Shelters are stronger if they connect with different partners who can bring their knowledge but also practical tools or measures.
- The work you have achieved today is a first step that needs to be continued. We trust that shelter managers will follow up on changes with staff and continue this critical work.



## Module 11, Session 2

### Closing and conclusion of the practical workshop

#### Aims

To check in with participants on where they stand now in relation to clients who use drugs accessing shelters

To check if they now see practical solutions to overcome barriers to inclusion

To repeat the most important messages from the workshop

To receive feedback on the workshop

#### Materials

Evaluation form (*handout 11.1*)

#### Proceedings

30 minutes

1. Announce the end of the workshop, and summarise the 3 modules (using the core messages in the conclusion of each module) (5 min)
2. Go back to the action planning tables prepared during module 10 and check if participants feel they have enough tools to start making changes in shelter policies, set-up and daily practices.

If yes, ask what kind of changes they think can happen now. If no, ask what obstacles they see and what they need to overcome them. (10 min)

3. What comes after the action plan?

If the plan is sufficiently detailed and clear, the next step can be to present it to the rest of the management and staff of the shelter. If (parts of) the plan still need to be developed and discussed, what they prepared today can be the base for further development. (5 min)

4. Ask all participants for feedback, distribute evaluation forms (*handout 11.1*) and request everyone to fill and return them.
5. Thank everybody and close the session. (10 min)