A close-up, slightly blurred photograph of a woman with dark, curly hair. She is holding a bright yellow flower in her hand. The background is out of focus, showing what appears to be a brick wall. The overall tone is somber and contemplative.

**Were you
really raped,
or did you just
not get paid?**

A NEEDS ASSESSMENT OF WOMEN WHO USE
DRUGS IN FOUR CITIES IN SOUTH AFRICA

Were you really raped, or did you just not get paid?

NEEDS ASSESSMENT OF WOMEN WHO USE DRUGS
IN FOUR CITIES IN SOUTH AFRICA

In this report we hope
to make the realities
real, because numbers
and empiricism may
change minds, but
emotion changes
hearts, and the mind
will usually follow
the heart.

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HarmLess Project

JAB Smart Project

All people featured in images provided their written consent and are aware of the nature and distribution of this report.

ABBREVIATIONS and DEFINITION OF TERMS

ABBREVIATION / ACRONYM	FULL TERM
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
CAG	Community Advisory Group
CANPUD	Cape Network of People Who Use Drugs
COSUP	Community Oriented Substance Use Programme
DIC	Drop-in Centre
DUG	Drug Users of Gauteng
DURPUD	Durban Network of People Who Use Drugs
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
INPUD	International Network of People Who Use Drugs
LEA	Law enforcement agency
NGO	Non-governmental organisation
NSP	Needle and Syringe Programme
OST	Opioid substitution therapy
PWID	People who inject drugs
PWUD	People who use drugs
SANPUD	South African network of people who use drugs
SAPS	South African Police Services
STI	Sexually transmitted infection
TB	Tuberculosis
TMPD	Tshwane metro police department
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WWID	Women Who Inject Drugs
WWUD	Women Who Use Drugs



“I don’t have a partner... I don’t want a boyfriend, it’s trouble. The men make the women work for their drug habits, so I don’t want to use my body to support another person’s habit”

(Fifi, 37, Durban)

EXECUTIVE SUMMARY

“Even when we’re right, we’re wrong”

[Princess, 34, Cape Town]

“Many of the vulnerabilities experienced by women who use drugs illicitly are a compound of those that are experienced by women in general, in addition to those faced by all people who use illegal drugs. Culturally embedded power imbalances that exist between men and women around the world often leave women exposed to increased stigma, abuse, violence and coercion”
(The Global Coalition on Women and AIDS, 2011: 3)

In South African society, we find that such a statement rings true, and being a woman who uses drugs strengthens these imbalances, tipping the scales towards harsh realities for the female drug using community. When unneeded, women are all but invisible, and yet they are expected to be available, with or without consent, when the need arises, as explained by Fifi [37, Durban], “I don’t have a partner... I don’t want a boyfriend; it’s trouble. The men make the women work for their drug habits, so I don’t want to use my body to support another person’s habit”.

In 2018, the United Nations Office on Drugs and Crime (UNODC) supported a consultation in four cities in South Africa; Pretoria, Cape Town, Durban and Johannesburg, so as to get a better understanding of the lived experiences of Women Who Use Drugs (WWUD). These discussions

examined the lived experiences of Women Who Use Drugs (WWUD) in South Africa, particularly the challenges they face, their needs as a community and presented an opportunity to discuss and identify their own solutions to such.

In every consultation the women reported:

1. **Violence, control and extortion** from multiple actors within society, but specifically;
 - a. at the hands of those tasked by the state to protect their rights, such as law enforcement officers and health care providers, as well as
 - b. their intimate and life partners.
2. **Zero accessibility to justice** processes and no consistent recourse against violence, discrimination and the denial of rights at all levels.
3. **Gaps in service delivery** for WWUD, specifically health care, psychosocial support, and safe spaces.
4. **Lack of regard for the needs** of WWUD even from the service providers intended to support them.

Overall, they described an expectation from others to meet an impossible level of accountability in respect of childcare, stability in respect of em-

ployment, mood and acceptability, sexual virtue, responsibility towards partners and children, and gender conformation as defined by a patriarchal community.

The needs identified and solutions brought forward by the community can be combined and fall within seven themes, namely:

1. **Physical needs;** sanitary items, hygiene commodities and clothing.
2. **Harm reduction services;** a call for an increase in the number of needles and syringes currently being distributed in South Africa. With this, a need for more information pertaining to harm reduction, safer injecting and the inclusion of WWUD-specific harm reduction education.
3. **Health care services for WWUD;** in particular, services that directly target the health care needs of these women, or at the very least non-discriminatory services that are welcoming to WWUD, rather than judgemental of them.
4. **Rehabilitation and Opioid Substitution Therapy (OST);** institutions that are economically-viable, evidence-based and responsive to WWUD, incorporating OST on a maintenance level rather than for detox purposes. After-care services are also vital, which incorporate sufficient psychosocial support, housing and skill-development opportunities.
5. **Psychosocial support;** structures and services working on the traumas and lived experiences of WWUD, as well as providing an opportunity for WWUD to build-

up their current view of self – all of which should be made easily accessible, supportive, and non-judgemental, with the primary focus is on the psychological and emotional well-being of WWUD.

6. **Women Who Use Drugs Network;** a network run by the community themselves, for the community, providing a combination of services, but in particular, offering WWUD a platform for voicing their concerns and needs and using this platform as a tool to advocate for WWUD.
7. **Safe Space and Shelters;** the preferential service being WWUD-friendly shelters. However, an additional recommendation was to provide WWUD safe spaces to congregate, relax, and also access ablution services, such as WWUD drop-in centres (DIC).

From these discussions, it became increasingly clear that WWUD are not invested in, and we found there is little to no development of the WWUD community. Factoring in the already patriarchal perceptions of women in South Africa, and combined with drug use, female drug users are not only classed as invisible, but also seen as unfit members of society, and treated as such. “People think that when you are a drug user that you are a no good person meaning that they look down on you” [Shimmer; 43, Cape Town]. .

The series of consultations brought these realities into sharp focus, highlighting the need for decisive action at all levels of society, and the establishment of services that will see and hear the stories that shape the lives of WWUD. Furthermore, the consultations laid bare the failures of society

“If we are going to see real development in the world, then our best investment is women”

on a systemic level even to recognise the plight of the delegates and exposed how there are efforts being made by society to further marginalise and exclude women, both through intent and carelessness.

I hate to sell my body even if I don't want to; maybe I'm sick or tired; it's like a nightmare that won't stop because I face some challenges. You get a client that doesn't want to put a condom and hit you for that as if your life actually depends on that R50, other client they take their money after sex that's what I hate the most take advantage that you smoke you can't even go to the police you become scared because you sell your body. Clients others are cruel they rob me my money, they don't end up paying in full amount R50 they give me R30 telling me that they will give me R20 after sex then they run away or swear at me. You are a prostitute you used to too many dicks why must we pay you R50 its too much and I've got too many needs it's not even enough, so I get terrible experience in selling my body it's too much I'm tired of using my body even if I don't want to or sick I must fuck it's very too much for me. Please help me please I am tired it's too much and painful the money it's not good for me can't even buy important things my needs I have to buy

my wants drugs nyaope one day I'll never forget in my life that guy fucked me three times so badly in my life for R50 I barely even walk talk laugh do things for myself being normal it was like a trauma I could not even forget that thing that bad sex was going on it wasn't nice I hate sex but I'm still doing it for money, and it's not nice [Ginger, 28, Johannesburg].

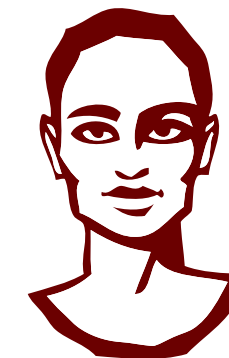
Without a word being spoken, a lack of autonomy was evident: many had no bank accounts, partners and uninvited ‘friends’ disrupted sessions during the consultations, particularly in Cape Town, Durban and Johannesburg, if not directly, then just by their unsettling presence and silently communicated expectations.

However, even with societies’ perceptions and external negative influences looming over the lives of the participants, when given the opportunity to identify solutions to such challenges and life experiences, participants were more than willing to provide. Requests, and at times pleas, for mechanisms of self-empowerment, safe spaces and support-structures dominated discussions, all of which echo Desmond Tutu’s statement, “If we are going to see real development in the world, then our best investment is women”.



COMBAT THIS EVIL

*Preamble to
The Single Convention on Narcotic Drugs*



BACKGROUND

“Combat this evil”

The use of drugs and the pursuit of altered states has been part of the human condition since the beginning of recorded history. From the end of the 18th century the use of certain drugs, by certain people in certain ways has been defined as an ‘evil’.^[1] The ‘demon drug’ and the ‘evil’ drug user have been recurring themes in the public discourse around drugs.^[2] This was further entrenched in the Single Convention on Narcotic Drugs.^[3] It is therefore not surprising that people who use unregulated drugs scheduled under the conventions are heavily stigmatised, excluded, marginalised and often removed from communities through incarceration, or in the name of treatment. Despite clear evidence of the failures and harms linked to prohibition and criminalising people who use drugs (PWUD), and the benefits of harm reduction approaches, the prohibitionist narrative persists, and the war on drugs has become a war on people. While many people

suffer the consequences of prohibition and the war on drugs, the collateral damage is not evenly distributed across all PWUD. Rather, it is already marginalised and economically excluded communities that appear to suffer more than others. This is particularly true for women, and yet the fact that the war on drugs is gendered often goes unrecognised or unacknowledged in the literature.^[4,5]

Women and drugs

Despite some progress towards improving women’s rights, women are held accountable and are controlled in ways that differ from men.^[6] There is an assumption of helplessness and a need to be directed and instructed by a ‘man’.^[7] Simultaneously, there is often an expectation that women should be held accountable to the constructs that establish a set of arbitrary and fluid moral and behavioural standards expected of mothers and wives.^[8] It is therefore not surprising that some

women have historically relied on drugs to fulfil their expected roles. In the 1870s, doctors would inject female patients with morphine,^[9] and opium was the drug of choice for ‘fallen women’ on both sides of the Atlantic.^[9] In more recent times, Benzodiazepines^[10] have served a similar purpose.

Already faced with the reality of navigating the complexities of a patriarchal world, WWUD carry the compounding stigmas of being ‘evil’ women.^[9] WWUD are prejudged to be incapable of being mothers, unfaithful as partners, and unworthy of redemption.^[11] They are rendered invisible, and their role as both participants and victims of drug trafficking and drug use is underestimated and understudied.^[9]

Health

Stigma, lack of visibility and lack of appropriate services are critical factors that lead to the disproportionate health burden WWUD experience compared to men who use drugs. Women have higher rates of mortality, sexual risk behaviours, risky injecting and are more likely to contract blood-borne viruses.^[11,12] While it is known that women have greater biological vulnerabilities to contracting HIV,^[19] contextual factors significantly negatively on the burden of disease women face. Rather than critically examine why resources and systems are failing the needs of WWUD and sex workers, the women themselves are often framed in ways that best describe a contagion.^[11] Women are therefore once again framed as being in need of containment and control. Quantitative

studies dominate the research into the issues of WWUD, and while the numbers are important, it is essential to understand the realities of the lived experiences of these women in order to understand them as complete and complex individuals, living within a broader context that in itself restricts choices. Without this understanding, WWUD will remain an underserved population and marginalised group.

Violence

Violence is “the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either result in or have a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.”^[14]

Violence has significant negative consequences on physical, mental and behavioural health, as well as sexual and reproductive health and chronic disease. WWUD experience violence at far higher levels than the general population, and from multiple sources. WWUD experience higher rates of violence from their partners than women in the general population and women who inject drugs (WWID) were at higher risk of violence compared to non-injecting women.^[16] Intimate partner violence has been directly correlated within a bi-directional relationship with increased HIV risk and risky sexual behaviour.^[13]

Outside of their intimate relationships, WWUD experience violence at multiple levels and in multiple forms. Sexual violence is common, and the perception that sex work and drug use are

inseparable increases the vulnerability for both populations. Violence is inflicted on WWUD by police and the public in general.^[17,18,19] Sex workers face the added burden of violence perpetrated by clients.^[38] When violence is systemic, and law enforcement agencies are perpetrators, WWUD have no safe refuge, and at times, themselves become perpetrators of violence.

Sex work and drugs

There is a presumption that the correlation between dependent use of drugs and sex work is causal.^[20] Despite a lack of data to support a causal link between sex work and drug dependence or drug dependence and sex work, in the recent Jordan case, the Constitutional Court of South Africa referred to such relationship as a “legislative fact”. The South African Law Reform Commission Report (‘the SALRC Report’) on the decriminalisation of sex work also makes similar generalised statements

implying that the relationship between sex work and the use of drugs is causal. In reality, the relationship between sex work, sex, and drug use is complex and nuanced.

WWUD are prejudged to be incapable of being mothers, unfaithful as partners, and unworthy of redemption. They are rendered invisible, and their role as both participants and victims of drug trafficking and drug use is underestimated and understudied.

As noted in a 2015 report by The Global Network of Sex Work Projects (NSWP) and The International Network of People who Use Drugs (INPUD), “sex workers who use drugs are often overlooked, crudely categorised as being within one community or the other. This approach fails to engage with people’s nuanced realities.”

The report continues:

Though some people may sell sex and use drugs, sex work and drug use should not be conflated and causation between the two should not be assumed. These assumptions feed into the stereotyping that both sex workers and people who use drugs experience: people who sell sex are incorrectly generalised as using drugs and having drug dependencies, and people who use drugs are frequently assumed to sell sex, whether they do or not.^[21]

South Africa

Despite claims of increasing levels of drug use in South Africa, there is a paucity of data that can directly answer questions related to the prevalence of drug use and the number of WWUD. The research that has been done has looked mainly at access to health care and confirms many of the findings that are reported in the international literature. Like in the rest of the world, WWUD are rendered invisible,^[22] experience high levels of violence, stigma, social exclusion, and lack of services.^[23,24,25]

The voice of WWUD in South Africa is conspicuous by its absence and needs to be heard in order to ensure that the correct health services, response towards systemic and interpersonal violence and the resources allocated are appropriate, effective and will improve the lives of WWUD. If we fail to address these needs, we are failing all South Africans.

Limitations of existing literature

The literature on WWUD has a number of limitations. One such limitation is that often the experiences of WWUD are observed and reported through the male lens. WWUD are reported on by their male partners and law enforcement agencies dominated by men.

Another limitation is the assumption that peer reviewed literature is somehow unbiased and is always supported by a foundation of empirical research. However, research into the use of drugs, sex work, criminalisation and other topics of moral and political contention is often based on a foundation of ideology and accepted yet is untested or unsupported ‘truths’.^[24,28] Further, to maintain a scientific facade, many researchers avoid humanising their research subjects, limiting and censoring their voices and narratives. The result is a version that ignores nuance and contradiction, focuses on the negatives (violence, negative consequences of drug use and sex work), but describes these events using palatable language, while ignoring the real or perceived benefits of behaviours considered by society to be abhorrent or evil.

It is the structural and endemic violence (supported or even driven by policies based on moral indignation) that should be seen and labelled as ‘abhorrent’. Unless the message conveyed is uncensored, visceral, disturbing, complex and highly uncomfortable, we have probably failed to convey the reality of the lives of many women who have been exposed as using particular drugs in particular ways.

In this report, we hope to make the realities real, because numbers and empiricism may change minds, but emotion changes hearts, and the mind will usually follow the heart.

THE VOICE OF WWUD IN SOUTH AFRICA IS CONSPICUOUS BY ITS ABSENCE AND NEEDS TO BE HEARD IN ORDER TO ENSURE THAT THE CORRECT HEALTH SERVICES, RESPONSE TOWARDS SYSTEMIC AND INTERPERSONAL VIOLENCE AND THE RESOURCES ALLOCATED ARE APPROPRIATE, EFFECTIVE AND WILL IMPROVE THE LIVES OF WWUD. IF WE FAIL TO ADDRESS THESE NEEDS, WE ARE FAILING ALL SOUTH AFRICANS.

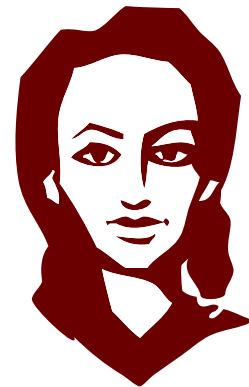


AIMS

This report sets out to develop a deeper understanding of the lived experience of WWUD, their needs and find out from the community of WWUD how to best meet these needs.

A secondary aim was to use this process as a proximal advocacy tool to inform female-specific drug user services, by raising awareness around the lived-experience of WWUD, educating organisations working with female drug users on how best to engage with and assist this community and the highlight importance of WWUD-specific services and their role in redressing the prejudices that impact these women.

We did this through consultations and conversations with WWUD as well as service providers in Cape Town, Pretoria, Johannesburg and Durban.



OBJECTIVES

The objectives of the WWUD consultations were to:

- Offer female drug users a safe, non-judgemental space to share their experiences, challenges, needs and expectations of service delivery in each city
- Identify critical challenges that female drug users experience
- Collate and discuss the above-mentioned challenges and identify how their experiences relate to the literature
- Identify the needs of the female drug using community
- Explore possible solutions to the challenges identified and ways in which to meet the needs of the female drug using community
- Assist facilitation in attaining relevant information from the female drug user



METHOD

- community to inform participants of engagements and conferences related to, and working with the drug using community
- Offer an information sharing session to the community on a topic relevant to their lives.

After doing so, facilitators met with relevant stakeholders and service providers to share the respective city's findings and provide a brief sensitisation training session related to WWUD and how best to work and engage with them.

This report is not to be seen as a quantitative tool, but as qualitative research documenting the lived experiences, and the impact that the identified challenges have on participants' daily lives through the use of purposeful sampling. In addition, it raises the point that female drug users have a voice, as well as solutions to their own challenges, but that they need appropriate platforms to use that voice.

Over a four-week period, four consultation groups were held with 78 women who identified as drug users, in Pretoria (16 women), Cape Town (15 women), Durban (15 women) and Johannesburg (32 women). Each week comprised of a similar formation; two days were allocated to the focus discussion with the community, one day comprised of a round table discussion with service providers and stakeholders in the relevant city, and the final day was used to provide a brief sensitisation session with people who work in the field of harm reduction.

Female Drug Users Consultations

Prior relationships with harm reduction programs in the four cities were used to invite WWUD to the consultation group. Programs that worked with the community were contacted and asked to share the details of the consultations with their community members and these projects also assisted with the collection of identification documents and affidavits from the community and shared these with the consultation facilitators. It was advised that some women might not have identification documents due to their socio-economic status and living conditions. Therefore, participants were given the option to submit an affidavit in place of an identity document if necessary.

WWUD Participant Attendance

	PRETORIA	CAPE TOWN	DURBAN	JOHANNESBURG	TOTALS
No. Participants	16	15	15	32	78
WWID	81%	40%	86%	97%	76%
On OST	6%	20%	7%	19%	13%
Homeless	75%	53%	80%	63%	68%
Experienced partner abuse	69%	93%	87%	75%	81%
NSP Services available	Yes	Yes	No; stopped by the municipality	Yes	3 of 4 cities

It was essential to make the space a comfortable environment for the women, and in all cities, they were given the liberty to leave the room if they felt uncomfortable and/or emotional with a topic that was being discussed, giving them the time to refresh and come back and participate. Psychosocial support and, in Johannesburg, a translator, was made available to the participants, to use if and when needed.





PARTICIPANTS WERE ASKED TO PICK A TOPIC.

IN ALL FOUR CITIES,
THE PARTICIPANTS
CHOSE THE TOPIC OF
**DOMESTIC
VIOLENCE**

WWUD are rendered
invisible, experience high
levels of violence, stigma,
social exclusion, and lack
of services.

Consultations commenced with introductions and participants were asked to pick a topic which they were not familiar with and these topics were then discussed on the afternoon of the second day. The topics of this information session were:

- Pap smears; What, When, How, Why and Where?
- Sexually Transmitted Infections, and Treatment
- Female & Male condoms; Dos and Don'ts When Using Them
- Cervical Cancer
- Pregnancy; Symptoms, Options, Check-ups, Trimesters, Truths about Pregnancy and Drug Use
- Domestic violence; Knowing your Rights, what should be done and What Can Be Done

In all four cities, the participants chose the topic of domestic violence.

In order to afford all participants, the chance to express their challenges without fear of having to raise issues in a larger group, participants were asked to write down any challenges and experiences they had had as WWUD. This was done on coloured paper, with pseudonyms written on the back, and handed in to the facilitator.

The second day consisted of identifying solutions to the needs/challenges identified by the participants on the previous day. These were written on coloured paper and stuck onto the larger sheets of paper which had a list of challenges noted on them. Following this exercise and ensuing discussion, the needs were triangulated. The day ended with an information sharing exercise on domestic violence.

Dissemination of Findings and Sensitisation Meetings

Following consultations with female drug users, an opportunity to share experiences of the two-day consultation with relevant stakeholders, including service providers in the respective cities was created through a round table discussion, and this opportunity was also used to sensitise and build their capacities on selected themes that came up during the consultations. These dissemination and sensitisation sessions took place over two days, immediately following the female drug users’ consultations.

Dissemination and Sensitisation with Harm Reduction Staff Attendance

	PRETORIA	CAPE TOWN	DURBAN	JOHANNESBURG	TOTALS
Dissemination Meeting	14	5	9	4	32
Staff Sensitisation	4	0	9	12	25

In general, these discussions were well received by stakeholders and service providers. However, the importance of hosting a formal dissemination event to share findings was highlighted. The discussions were facilitated by the individuals who facilitated the WWUD consultations, with each city’s findings discussed at length. The challenges, needs and solutions brought forward by the WWUD community in the respective cities were shared with the participants, and all were given the opportunity to ask questions, raise concerns and provide feedback on how solutions could be implemented.

Stakeholders and service providers discussed the services that are provided in their cities, and noted goals and planS to implement specific solutions into their service delivery, such as sharing more female-specific information while working with the WWUD community.

The fourth and final day was a means of sensitising harm reduction staff on ways of working with WWUD, and brainstorm ways that service providers can best utilise the services they already have, to better provide for the WWUD. Sensitisation material from UNODC’s *Addressing the specific needs of women who inject drugs* training handbook was adapted and included the needs raised by the WWUD participants in each city, such as drop in centres (DIC)s and female-specific information into a presentation-style discussion. Focus was paid to the resources that harm reduction programs currently have. The information which was pertinent to the South African harm reduction context was highlighted and discussed at length. This was well received by all.

GOALS OF STAKEHOLDERS AND SERVICE PROVIDERS

PRETORIA

- Increase in information sharing on OST available through COSUP to women who are using opiate based substances.
- Investigate and share female-specific information and education on outreach with Women Who Use Drugs service beneficiaries.
- Formulation of a once-off donations drive, and distribute the items at the monthly Women Who Use Drugs CAG.

CAPE TOWN

- Investigate the probability of having a Women Who Use Drugs DIC day, starting monthly, at the Step Up DIC.
- Promotion of psychosocial services available to the Women Who Use Drugs community at the Step Up DIC.

DURBAN

- Focus on Women Who Use Drugs on outreach:
 - » Provide more female-specific commodities that Step Up currently have, namely sanitary pads.
 - » Provide more female-specific information to the Women Who Use Drugs community on outreach.
 - » Increase the harm reduction and safer injecting education information to the Women Who Use Drugs community on outreach.

JOHANNESBURG

Due to the ending of the funding cycle, no concrete goals were identified. However, participants agreed that they would investigate funding streams that would allow for the inclusion of some of the needs of the Women Who Use Drugs community, such as female-specific commodities and psychosocial services. It was also discussed that stronger referral relationships would be built to assist Women Who Use Drugs with needs that they are not currently able to meet, such as trauma counselling and rehabilitation centres.



FINDINGS

Challenges

Violence

“I’ve been abused in more than one relationship. I would not want to let my kids or anyone else experience such trauma. If it will be of any help I would willing and openly share my experience just so that people can be aware that things/steps can be taken to prevent such humiliation, sadness and unhappiness etc.”

[Kay, 41, Cape Town].

Beyond Physical

A common theme identified during the consultations with WWUD in the four cities, was the low self-worth of these women. The root of such was not defined. However, it was apparent that the lived experiences that WWUD go through play a large part in entrenching such views of self. For the most part, these women have experienced years of abuse, from sexual and emotional exploitation by society or law enforcement to do-

mestic assaults by family and intimate partners, all of which have gradually eroded the spirit of these women. With the constant exposure to these destructive behaviours, be it passive or not, WWUD sink deeper into feelings of hopelessness and self-loathing.

“I have spent 10 years on the street, begging people for money and it’s degrading, but it’s either that or I steal or sell my body”

[Candice, 45, Johannesburg].

Some women who spend their days on the street begging for money have grown used to being ignored or shamed by people who pass them by; *“many people don’t take us like human beings, taking us women like prostitutes. They don’t respect [us]; they call us names like nyaope [heroin] girl or a piece of dirty tissue”* [Nash, 33, Johannesburg].

Some women reported that they are used by men, and are targets of sexual favours, in return for a small amount of money, further breaking down the psyche of these women, as their bodies are



equated to nothing more than a few rands; “boys take advantage of me because I was smoking they knew I always need a fix so for them to give me money I was supposed to have sex with them for [as] little as R20” [Beauty, 30, Johannesburg].

Bystanders to violence who turn women away when attempting to access help, or ignore acts of violence towards these women, entrench the feelings of low-self-worth, offering little support to an already isolated individual. This perpetuation of stigma and discrimination only adds to the negative view of self, as can be seen in a statement made by Lira [35, Pretoria]:

People call you names like nyaope [heroin]. When you coming, they say ‘miss nyaope is coming to steal from us. That means we are not safe in this community because of nyaope.’ People can swear at you because of what we are smoking. And our family turn their back on us. That means we don’t get the respect we deserve anymore. Even our own child he/she don’t respect you anymore he/she don’t see you as mother anymore. If he/she see you he/she calls you nyaope. But I don’t blame them it’s because of what I’m smoking. But I know one day I will change then I will be good mother to my children again.

These acts of emotional and mental violence lower the self-esteem, cementing the belief that they are invisible to others, unimportant or less than human. Adding physical violence only strengthens the already negative view of self, and consequently, decreases the likelihood of WWUD accessing support and other forms of services.

“I ended up in the street because nobody trusted me or wanted me, even my relatives, that’s why

[I] ended up giving up. Sometimes they rape me, some they don’t give me money, they run away, they leave me in the forest, some they beat [me] if I want my money. I almost died”
[Zandile, 24, Johannesburg].

People in uniform

“The trusted men in blue took the little bit of self-esteem I had when he sexually harassed [me]. I have lost trust in the men of peace”
[Fifi, 37, Durban].

When those who agreed to protect women from such forms of abuse - such as law enforcement, social-service providers and even family and friends - become the very people who perpetrate these acts of violence, and with no structures available to counter such negative experiences, dire consequences ensue.

Participants reported that law enforcement played a significant role in the exploitation of women. Horrific stories of assault by law enforcement officers and privately owned security company staff were discussed by participants, and these acts of abuse were not limited to perpetration by male law enforcement officers only. One participant shared her experience of being subjected to a body cavity search by a female police officer, at the back of a police van, on a main road. When relaying her experience, Ruby [47, Cape Town] stated; “stop searching me in public it’s humiliating, even if it’s a female cop.”

A more common experience is the targeting of WWUD for transactional sexual exploitation. An overwhelming number of participants stated that sexual and monetary bribes for release from incarceration are the norm.



WWUD have lost faith in law enforcement systems, viewing them more as enemies and perpetrators of violence and punishment, rather than the protectors of rights.

“I got caught a couple of times by cops and did sexual favours to let me go”

[Sunshine, 48, Cape Town].

WWUD who are arrested or detained for possession of substances, and in some cases, for being in possession of drug using paraphernalia, are given the option of either providing sexual favours to the arresting officers or be taken to the police station for processing.

In some cases, acts of harassment leads to acts of physical violence. One woman relayed her experience of being physically assaulted while asleep by staff members of a private security company hired to safeguard the Durban beaches;

*I live on the street, *crying* in 2015 in Feb, I was sleeping under the trees by the harbour under the coconut, I felt something hit me, I thought a coconut dropped on my head, I opened my eyes, and it was the security beating me there were some men standing there shouting at them saying how can they beat a female like that. I cannot walk anymore because of that incident, and every day these security guards come back there, and nobody can help me. I’m too scared to charge them because they are always there” “I’m now on crutches and disabled*

[Amanda, 37, Durban].

No means of justice

“I was 8 months pregnant; the Blackjacks¹ came to Greyville where I was sleeping. I was urinating under the tree because the baby was heavy on my bladder. The security took a baton

¹ Blackjacks: members of a private security company patrolling Durban beaches.

and beat me with it on my head, I was bleeding. I followed him to the car and told his colleagues what he did to me. They said I was lying and they laughed and drove away. Luckily, my baby was fine”

[Mama H, 26, Durban].

Abuse of power by law enforcement officers is prevalent in all cities. Homeless women, in particular, are at high risk of exploitation. Acts of abuse, bribery, and harassment decrease the likelihood of WWUD reporting such human rights violations to relevant authorities, in fear that, instead of assisting them, the reporting of such behaviour will increase their likelihood of being targeted.

“We have been abused by metro police. Physical[lly] beat[ing] us, taking clothes even my ID. Security they treat [us] badly. We need someone to help us with our problems. When we go to the police station for help they just reject us or laugh at us, not giving us help”

[Queen, 32, Durban].

WWUD have lost faith in law enforcement systems, viewing them more as enemies and perpetrators of violence and punishment, rather than the protectors of rights. In addition, the groups were in strong agreement that even if they do report such acts of violence, little or no recourse shall follow. Adding the element of fear, and the lack of recourse, it is understandable that WWUD feel little support from the law enforcement agencies in South Africa; reinforcing the sense of worthlessness and hopelessness that this community feels.

Some participants report human rights violations to harm reduction service providers in their cit-



**“I have to run after money
then have it taken from me by
force by the man in my life”**

ies. However, all participants unanimously agreed that even this reporting channel is of little use, as no follow-up action is done. Unfortunately, in South Africa, very little paralegal assistance is available to WWUD either in courts or via harm reduction centres. This is primarily due to high legal costs and service providers who are overwhelmed with the reported number of Human Rights Violations.

Domestic Violence

“[Violence] is his thing, I had to ask him if I wanted to use. My husband was the boss”

[Starlight, 43, Durban].

Not uncommon in the lives of WWUD, is the violence they face at the hands of their spouses, partners or family. Most women spoke about having little to no contact with their family members, blaming their drug use as the reason for such. Women relayed stories of being shunned from their family home or choosing to leave their homes, because of their drug use.

“I was humiliated by my own father in front of people I don’t even know, by my uncle’s funeral calling me tikkop”

[Shimmer, 43, Cape Town].

This disassociation from their family left a gap in their support structures, increasing the likelihood of them seeking other forms of support.

WWUD stated that they found themselves in a relationship for a number of reasons, one of which was ironically, ‘for protection’. However, a theme arose where their companion, (the one who was expected to be a protector) frequently became the perpetrator of violence - ranging from physical

and emotional violence to exploitation and coercion. Many women stated that they either were currently in or had been in an abusive relationship. When asked why they felt they were unable to leave or report acts of violence the responses were similar:

Control through money

Participants stated that in most cases, they did not have access, or the means, to manage the finances in the relationship. Any money that was brought into the relationship was held onto by their partner, and he would buy the necessities as he saw fit. Even in cases where the woman was the one who brought in an income, she was still expected to hand all earnings over to her partner, and he would procure the drugs, food and any other necessary items.

“I have to run after money then have it taken from me by force by the man in my life”

[Ruby, 47, Cape Town].

We noticed this pattern in relation to the daily stipends that were given to participants; partners either visited the hotel to collect the money or participants left the venue after the consultations to hand the money over to their partners. When asked why participants did not keep some of their earnings for themselves, we were told that such actions lead to acts of violence and abuse

“Sometimes my boyfriend abuses me emotionally because he supports my habit of drugs. Sometimes he won’t give me money to go smoke even though he knows the pain I’m going through, because he is also a drug user”

[Bisto, 30, Johannesburg].

A sense of loyalty

In addition, participants stated that they could not report acts of violence because *“We love our partners we don’t want to embarrass them”* (open discussion, Johannesburg). This then followed the concept of the fear of the unknown as well as negative repercussions that may ensue; *“[we’re] scared of what will happen...we might end up losing our lives”* (open discussion, Johannesburg), as well as bringing shame to their partner and their family; *“[m]y child was going to hate me if I arrested his father”* [Starlight, 43, Durban].

WWUD are under the impression that they have grown accustomed to their partners’ behaviours and have learnt their ‘red flags’, as well as how best to live with them. Women who are homeless are even more likely to remain in an abusive relationship because they believe they have little place else to go, other than onto the street. *“He was still beating me. After our third child, I left him with the baby. I left him to [go] live on the streets”* [Starlight, 43, Durban].

Women do not want to tarnish the names of their partners, and in some cases, believe they owe their partners for all that they have done for them and will protect their partners as they were once protected.

Lack of support structures, income, safe spaces to go, or psychosocial support to counter the emotional and mental abuse WWUD consistently experience, making it almost impossible for WWUD to leave an abusive relationship. Such elements, in combination with a lack of law enforcement/justice recourse, leave these women questioning whom they can turn to.

WWUD are rendered unseen and unheard,

which is only emphasised by the ever-looming theme of minimal support structures; family, service providers and even amongst selves. With a regular breakdown of the psyche, threats of further violence and nowhere to turn to, recourse seems almost unattainable for WWUD.

Zero recourse

“Being told to go wash my [vagina] by a female cop after telling her you have just been raped”

[Michelle, 42, Durban].

Throughout the consultations, it emerged that participants were more inclined to avoid situations or try not to engage, rather than report incidents of harassment. In addition, participants stated they would rather ignore the perpetrator in question, than retaliate, even if they are aware of their rights, with the hope that this would decrease the likelihood of them experiencing more aggressive forms of harassment. Women would rather be passive, keep quiet or try and escape the situation than engage. This too leads to the lack of willingness to report incidents of violence to the relevant authorities.

“Try to ignore people when they call you names”

[Lira, 35, Pretoria].

Protector or perpetrator

Michelle [42, Durban] made her frustrations clear when describing her attempts at reporting violence to the relevant authorities as *“[n]ot having anyone to turn to at the moment when the abuse against us is taking place and not been believed by the law”*.

Reporting structures are ineffective according to the community, or they barely exist. Circum-



With a regular breakdown of the psyche, threats of further violence and nowhere to turn to, recourse seems almost unattainable for WWUD.

stances such as not having a home to provide an address, or telephone for a contact number in order to receive a case number, play a large part in the unwillingness to report incidents.

Some women shared experiences of disregard by law enforcement when attempting to access the relevant assistance. They are either turned away, laughed at or not believed. In some cases, WWUD are treated with disdain and insulted or ridiculed. *“Even when I had a case, the police made fun of me and laughed at me”* [Starlight, 43, Durban].

As previously mentioned, being “known” drug users or sex workers not only makes them a target of abuse by law enforcement and others but also decreases their likelihood to report abuses, as they expect zero recourse. *“I hate not been able to open a case at a police station because I smoke drugs”* [Nash, 33, Johannesburg].

WWUD require active reporting structures and deserve the opportunity to be heard when they have experienced trauma, but when they feel as if they are disregarded and go unheard, the fear of more damaging consequences outweighs the desire to stand up for themselves.

Inaccessible Services

“I’ve been denied by my government health care centres despite the fact that I’m leaving with HIV”

[Zinhle, 26, Johannesburg].

There is a notable lack of information available to the WWUD communities on where they can seek assistance, be it psychosocial support, reporting human rights violations, or even education of their fundamental human rights. In some instances, the

services themselves are non-existent, but in cases such as health care or ablution facilities, WWUD community members are unaware of where they can go.

Health care Services

When discussing topics on access to health services by WWUD, one needs to acknowledge the socio-economic status of the participants in these consultations. As previously noted, most of the participants were homeless, unemployed and injecting illicit drugs. They have engaged in high-risk behaviours - such as sex work - in order to generate a daily wage. As a result, they are not only at a higher risk of contracting HIV, hepatitis or other sexually transmitted infections (STIs) but are also more likely to experience stigma and discrimination when seeking health care services. This emphasises the need for female drug user-specific health care services and continuous education and sensitisation of primary health care staff who work with WWUD in any health care setting.

Notably, harm reduction services for people who inject drugs (PWID) are available in all the cities that were visited; however, the level of service delivery, as well as the list of services available to the WWUD community, differs from one city to another. In this regard, very few, if any, programmes or institutions offer a comprehensive package of 9 interventions for PWID as described by the UNODC.² This is not an isolated event, as literature has shown that WWUD across the world share the same challenge;

² WHO, UNODC and UNAIDS recommend the following comprehensive package of interventions for injecting drug uses.





“Women who use drugs are more heavily stigmatised, as well as being frequently ignored, invisible, and sidelined in the formation of policy and approaches to harm reduction and service provision”

(Drug User Peace Initiative, a war on women who use drugs INPUD).

In some cities, like Pretoria and Johannesburg, relationships have been built between harm reduction programs and other health care services, offering referral systems and continuity of care to those who may need it. Unfortunately, even with such rapport built, WWUD say they are unlikely to visit a health care facility unless they are accompanied by a harm reduction project staff member.

Hepatitis B virus (HBV) and Hepatitis C virus (HCV) prevention, testing and treatment are barely available, and studies have shown that there is a high prevalence rate of HCV among PWID in South Africa. Testing for HBV and HCV as well as preventative services such as HBV vaccinations and the treatment for WWUD that are HCV positive is non-existent unless accessed through private health care. This too is unattainable for most of the WWUD because they are economically disadvantaged. Treatment for STIs and other sexually related infections are available for sex workers in various parts of South Africa. However, the unwillingness to access such services is also a direct result of negative past experiences.

Self-exclusion

WWUD are unlikely to visit a health care facility, due to previous negative experiences while attempting to access care. There is an expectation

that they will be treated with disdain and judgement, referred to other services, or experience extensive waiting periods before receiving assistance. These are not mere assumptions, but rather previous experiences by community members; *“I once went to a clinic with an STI. When I got there the nurse who attended to me started asking me how I got the STI, and then she started calling me names, and she also called other nurses to come see me because I am a bi*** and I always come with an STI because I’m a prostitute”* [Bisto, 30, Johannesburg].

In addition to this, some women claimed they felt uncomfortable when accessing services that are tailored to PWID. Needle and syringe programs are accessed by WWID. However, other services made available to PWID, such as OST and DICs, are not regularly accessed by the WWUD community, because they feel outnumbered by the sheer magnitude of male drug users who access such services.

The design of health care systems has been discussed many times, with the predominant complaint relating to the time taken to access a service. These long waiting periods, ranging from a few hours to days, impedes on the likelihood of WWUD visiting a health care facility. *“Even if you sort out your fix, you still won’t go to the clinic. I am constantly thinking about the next one”* [Fly, 27, Durban]. A lack of steady income results in women having to resort to begging or other forms of income generation, such as sex work, in order to pay for their daily needs. *“It’s hard for me because it’s not simple getting money to [use] sometimes I even think of selling myself to someone just because I’m hungry and I want to [use]. Like when it’s usually raining there’s no plan so that why*



“[They] have dehumanised us and people know it, that’s why they feel they can look at us like we animals”

I think of selling [myself]” [Thuli, 22, Johannesburg]. As a result, women would choose rather make money to survive the next day and night, instead of treating their health. The importance of one’s health is overshadowed by the need to survive an extra day, and with little to no financial support, they feel as if they have no choice but to satisfy the short-term needs, rather than ‘waste time’ at a health care facility; “I think about how long I have to sit there [clinic] when I could be making money” [Fifi, 37, Durban].

Exclusion through stigma

Participants relayed their experiences when attempting to access health care services. Predominantly, said experiences were tainted by judgement from the service provider.

Certain clinics or health services tend to treat drug users with no respect. For example, if you are on drugs and had an abortion. You already feel bad and hurt because of decisions that are forced on you [and] now the sisters who are supposed to help you, end up judging you.

Their tone of voice or the way they look at you is very cold. There is no compassion just because you on drugs does not mean your heart is made of stone. It’s very easy to pretend you don’t care but at the end of the day we all are still human females, and it’s even worse if you on drugs.

I’ve been subjected to it, and I’ve witnessed it. It’s truly sad when you need help how they just disrespect you.

Everybody has the right to be treated with respect, and it’s their duty or should be, to be professional

[Barbie, 33, Cape Town].

Active denial of services

Zinhle [26, Johannesburg] stated that *“because of being a drug addict [she’s] been denied treatment by government health care centres despite the fact that [she’s] living with HIV”*. The outside appearance of WWUD, employment status and their drug use have been reason enough for health care providers to turn women away without assistance. Whether the reasons for this were justified by staff or not, WWUD are left feeling unassisted and alone, and predominantly unwanted, which only adds to the feelings of hopelessness and further breaks down their already damaged self-esteem. The assumption around being turned away or referred to another facility is that it is due to their drug use, employment (such as sex work) or appearance.

Hereto, when attempting to report incidents to law enforcement, and being turned away, the same emotions are felt. WWUD are frustrated and tired of being denied services, and instead, choose to remain silent, forget the incident, or self-medicate, instead of facing the expected stigma, embarrassment or denial.

In conjunction with the unwillingness to access health care services due to stigma, negative perceptions, and experiences, the availability of health care services for WWUD is minimal. We speak, in particular, of women-centred services; services which are tailored to women, and provide treatment to women, that are non-discriminatory and financially accessible.

Shelter and Safe Spaces

Much like the lack of female-specific health care services, there are no female-specific shelters available to WWUD. Shelters available in these



cities are unwelcoming to these women, and some are unwelcoming to women in general, although this was a perception more than a fact, shared by the community. Noting shelters as unsafe, unsanitary, or actively prohibiting drug use, WWUD resort to sleeping on the street, yet again, exposing them to variables that increase their risks of injury, harassment, and illness. *“Being beaten by the police, being homeless, no shelter, family is far away, selling my body to survive, I got TB and HIV on the street”* [Zama, 21, Durban].

Exclusion through design

Harm Reduction services are predominantly used by male service beneficiaries, and in South Africa, 10-15% of the PWID population are women who inject drugs. As a result, harm reduction services are targeted at men, and minimal women-specific services are available. A general lack of funding for the PWID population results in focus being on necessities such as sterile injecting equipment, wound care and sharps containers, with little funding reserved for women-specific commodities.

DICs that are available, are either a fair distance from where WWUD reside, lack child-care services, do not have designated spaces for WWUD to congregate, or are predominantly targeted to provide a space for PWID in general, with the bulk of the community being male.

Psychosocial Services

Participants stated that some of their challenges are *“not having someone to talk to after experiencing rape”* [Sipho 24, Johannesburg], or other forms of abuse. The need for psychosocial services for WWUD is imperative, as physical and emotional violence is a common experience in the community. However, much like health care


services, such services are rarely accessed, even if they are made available to the community. The reason for such is clear; either WWUD are unaware of where they can access such services, or such services are unreachable due to distance or operating hours. When evaluating the needs of the community, there was a call for psychosocial services, trauma counselling, and even a safe environment where WWUD can share experiences and express themselves; a proper place to go to in cases of emergency. *“If we are raped, physically abused, or even just someone to talk to because we sometimes feel down or depressed or even if we are sick”* [Michelle, 42, Durban]. When discussing this challenge with service providers, many stated that they do provide psychosocial services, but that they were either based at a DIC or not widely promoted to the community.

The Unimportant and Disregarded – a lack of regard for unmet needs

“[They] have dehumanised us and people know it, that’s why they feel they can look at us like we animals”

[Michelle, 42, Durban].

The needs are evident, and despite this being raised with many of the local harm reduction facilities and services, little has been done to assist. When disseminating the findings to service providers in one of the visited cities, it was stated that, as a non-governmental organisation (NGO), they are already aware of the needs brought forward by the community. This then raised the question, that, if they are aware of the needs, why have they not yet been addressed?



Lack of funding is a crucial factor when discussing the inability to provide WWUD with the services they need.

Lack of funding is a crucial factor when discussing the inability to provide WWUD with the services they need. HIV is a targeted virus, and funding is provided to attain the 90-90-90 goal forever looming over the country. Needle and Syringe Programmes (NSPs) are recognised as a proven preventative mechanism for combatting the HIV epidemic, and a frequent target for NGOs providing harm reduction services for PWID is to meet the funder requirements of testing and treatment. As a result, other services that fall outside of the HIV-prevention sphere, that would assist in meeting the needs of this community, are disregarded or provided for as minimally as possible.

However, we cannot distract from the fact that the mere provision of needle and syringes is positively impacting the lives of PWID. Beauty [30, Johannesburg] stated that *“before, I was always in need of needles so to feed my habit it was a must to share one needle [with] as many as we were and in the process, we were infecting one another with HIV”*.

The focus is on HIV, under the guise of improving the quality of life for PWID in South Africa. Unfortunately, providing needle and syringe commodities and conducting HIV tests and treatment is not enough to improve the quality of lives that WWUD currently experience. Participants who disclosed their HIV status, particularly those who were HIV positive, stated that they are unlikely to get treatment for a number of reasons.

Primarily, those who are homeless have had their belongings stolen or confiscated by law enforcement; *“I go to hospital to take our ARVs, Metro police come and take our bags, I tell them my ARVs is there and they say “Fuck off”. So I think that if I go take my ARVs again then the police will just take it again”* [Sne, 26, Durban]. This is a pattern while living on the street. In such circumstances, participants feel that it becomes redundant and borderline pointless to collect one’s medication if it will only be taken from them after a few days/weeks.

Furthermore, in some instances, the process for receiving treatment is a long one, and much like when attempting to access other health care services, participants stated they are unlikely to access HIV treatment services, along with other health care services, due to the extensive time taken to do so; *“I have HIV positive, but I don’t drink treatment but not because of something but because [health care providers] taking time to give me my treatment”* [Felicity, 27, Johannesburg].

HIV testing and treatment, or accompanied referral to health care services for Antiretroviral Therapy (ART) is available in the four cities. However, the demand is higher than can be met by some cities’ programs.



**Community
Recommendations**

In each city, time was taken to discuss the needs and solutions to challenges raised by participants. The recommendations brought forward in this report come directly from the community members who participated, and the findings were unanimous throughout the four cities.

Physical needs

“Everything, getting water, finding a toilet, washing, having clothes to wear, cleaning, eating, seeing with no electricity”
[Shimmer, 43, Cape Town].

Due to prominent elements such as homelessness and unemployment among the

WWUD who were consulted, their most basic human needs are rarely met. Therefore, in order to attain essential items such as food, clothing or money, women may resort to begging, sex work, or - in extreme cases - acts of petty crime. *“Life with drugs is hell since I started smoking I am another person that I don’t understand. I sell my body for drugs. We steal people’s money. My life is in danger I live [on] the street, so we meet with a lot of challenges we get raped some time without condom some of them they are rough. So life is a challenge”* [Precious, 30, Johannesburg]. These methods to procure money for day-to-day living increase the likelihood of them being targeted by law enforcement.

“Life with drugs is hell since I started smoking I am another person that I don’t understand. I sell my body for drugs. We steal people’s money. My life is in danger I live [on] the street, so we meet with a lot of challenges we get raped some time without condom some of them they are rough.”

‘Luxury’ items such as hygiene commodities, sanitary products, birth control and prophylactics are only made available in some cities through harm reduction services. WWUD lack the most essential commodities, such as clothing, running water, healthy food and hygiene items. The reasoning for this, as stated by participants, is that a great deal of their earnings is used to procure their drugs.

Harm reduction services

“Sharing needles is not nice, people that give us needles they help us too much because we not sharing needles”
[open discussion, Durban].

Although sterile injecting equipment is made available in Pretoria, Cape Town and Johannesburg, community members report that the quantity distributed is insufficient to the demand.



**It hurts when we sharing
and using an old needle,
it's sore and painful to get
the needle in.**

In Durban, needle and syringe distribution has been stopped, due to regional politics. The relation between the immense physical ailments presented by the community at the Durban consultation and the prevention of NSP by the city is unclear. However, the cry for NSP to begin again is loud in the community. While holding a discussion in Durban, the following conversation transpired:

- Fifi [37]:** There is a lot of sharing of needles.
- Sne [26]:** Ever since I have shared needles I have infections and sores.
- Mama H [26]:** If you share needles with a person who has HIV it increases the likelihood of acquiring HIV.
- Fifi [37]:** People are fighting over needles – If you don't want to share they become aggressive and become ugly people.
- Sne [26]:** It hurts when we sharing and using an old needle, it's sore and painful to get the needle in.
- Fifi [37]:** People don't want to get HIV tested.
- Sne [26]:** The person does not share their HIV status, and you end up getting HIV because you need to use that needle.

In addition, some of the participants knew very little about harm reduction and ways of injecting safely in order to reduce their risks. Although needle and syringe services are available in three

**“Ever since I have shared
needles I have infections
and sores.”**

of the four cities, the quality of the information and education that is being shared with the community may differ from city to city, and in some cases from area to area. The information gap regarding safer injecting, harm reduction and overdose shows that there is a need for more significant efforts on the service provider's part.

On this same note, there are no harm reduction services for people who are using drugs, rather than injecting. Little information on safe drug use is available for those who use drugs such as crack cocaine or methamphetamines. No commodities are distributed for these drugs. This increases the likelihood of sharing commodities thus increasing the risk of contracting Tuberculosis (TB), HBV and HCV.

Health care services for WWUD

*“Must help us when we are sick, give us
treatment, not to stigmatise us”*
[open discussion, Durban].

Unbiased, non-discriminatory health care services need to be made available to WWUD; “Staff should be trained [in] loyalty, honesty, be chosen on merit” [open discussion, Cape Town]. Health care professionals should be given sensitisation training on how best to work with WWUD and should be encouraged to treat WWUD with dignity, compassion, patience and in a non-stigmatising way. In an open discussion in Durban, one participant stated “[p]lease give us [services] when we coming to clinic, don't ignore us and talk bad and chase us away.”



Mobilising such services and combining them with current harm reduction services, or building strong relationships with current harm reduction facilities that already hold a level of rapport with WWUD, may increase the likelihood of access to such health care services. During an open discussion, it was suggested that health care services be mobilised, and brought to the community, rather than placing at expectation on WWUD to visit the clinic or institution themselves; *“Mobile clinic [for] visiting at our home and bring medication for those [that] are sick and can’t collect for themselves”* [open discussion, Durban].

Treatment for HCV and HBV vaccinations should be made available to those who need it, and funding streams for such should be investigated. ART, STI and other related infection treatment should be available in such circumstances, and the promotion of such services should be done within the community, encouraging WWUD to access the sites as well as promoting the importance of one’s health, and highlighting the needs of adherence to such programs. Harm reduction services who already hold this level of rapport with service users could incorporate such encouragement in their daily service delivery. Education should be done on a ground-roots level with the WWUD community, such as:

- Pregnancy and drug use
- Safer Injecting, harm reduction and overdose information
- Human rights
- Domestic violence

During an open discussion, it was suggested that health care services be mobilised, and brought to the community, rather than placing an expectation on WWUD to visit the clinic or institution themselves.

Rehabilitation and OST

“In government rehab you are not given time in rehab because you have to make space for others”
[open discussion, Johannesburg].

There is an impression that rehabilitation centres have a ‘rotating door’ atmosphere and this leaves women who visit the facility feeling as if they are just a number, further entrenching the already low view of self. However, even with this in mind, when identifying solutions and needs of the community, easier access to rehabilitation services was a dominant discussion point. Participants highlighted the importance of long-term OST being available at such centres, with greater emphasis placed on the individual’s well-being, and the personalisation of care. Centres that provide a constructive, self-empowering atmosphere for WWUD are not easily accessible. Very few centres offer OST, and most provide methadone for detox purposes only; *“[Rehabilitation centres] must provide full medication a perfect one like methadone. We don’t want cramps”* [open discussion, Johannesburg].

There is a perception among some women, especially those in Johannesburg, that going to a re-



“I must go to rehab and leave drugs so that we can stop hurting our friends and family”

habilitation centre will ‘save’ them. Some women believe that rehabilitation will be the cure to their drug use, and is a sure-fire way of bettering their lives; *“I must go to rehab and leave drugs so that we can stop hurting our friends and family”* [open discussion, Johannesburg]. This further highlights a need for the increase in information regarding rehabilitation, particularly noting what rehabilitation centres offer; the pros and cons, the requirements and the process in order to access such facilities. Programs that work with WWUD should also investigate possible centres to which WWUD can be referred to if they would like to access such services.

Support after attending a centre was also a recommendation brought forward by the community; *“I need another way of stopping. I was once in rehab, but when [I] got out, on the same day I went straight to the dealer and started using again”* [open discussion, Johannesburg]. Aftercare services are needed for those who leave a centre, including shelter where necessary and further psychosocial support and life skills; *“My solution is that rehab must have proper medication for us to drink if we would have a place or something to do after rehab it will be better because it won’t be simple to smoke again when you have to do but if you don’t have them is simple for you go back and smoke”* [open discussion, Johannesburg].

Psychosocial support

“When it comes to drugs, there are no friends”
[Ruby, 47, Cape Town].

There is an impression that rehabilitation centres have a ‘rotating door’ atmosphere and this leaves women who visit the facility feeling as if they are just a number, further entrenching the already low view of self.

As aforementioned, WWUD have experienced, and continue to experience trauma on a daily basis. As a result, their view of self is continually being broken down. Very few women claim to have relationships with people with whom they can confide in, nor do they have mechanisms in place to counter such negative experiences. In addition, WWUD do not know of organisations or safe spaces that they can reach out to or visit to access psychosocial services; *“give us a safe space to chat with someone that cares like a crisis centre for users”* [open discussion, Durban]. When assessing the needs of the community, such services were frequently requested. These services would need to be easily-accessible, possibly close to areas where WWUD congregate, non-judgemental and preferably free of charge - all of which could increase service access.

In particular, participants stated that they would like the services of professionals who could listen to them and provide non-judgemental feedback on how to improve themselves. Social workers and psychologists to assist with working through the trauma that these women are facing are also needed by the community. The focus of such engagements should be:



- Building up one's self-worth
- The motivation for change, based on individual
- Coping mechanisms when living on the street as a woman
- Family engagement
- Relationship engagement

Support groups for WWUD were also brought forward by participants, with a great deal of emphasis placed on the importance of these groups being for WWUD, discussing topics related to being a woman who uses drugs; “*we need to talk about this, we need to do this at least once a month as females*” [Tania, 38, Durban]. The environment of these support groups should promote relationship-building amongst the participants, as well as provide tools on how best to better one's view of self and one's surroundings.

WWUD Network

“More women in power with women empowerment as a goal”

[open discussion, Cape Town (Ruby)].

Participants relate strongly to the need for a WWUD network, run by WWUD, for WWUD, capacitating the community and strengthening them. Such a network should focus on the empowerment of WWUD, looking past what they have done, who they are, and what they choose to do with their lives and bodies; “*my challenge is not giving in to cowardice and doing the traditional, socially, acceptable thing which is: hou dji net jou mond! (You just shut up!) Not only am I ethically bound to rebuke the oppression and physical violation of those who are weaker and unable to*

WWUD have experienced, and continue to experience trauma on a daily basis. As a result, their view of self is continually being broken down.

defend themselves but I am also beholden to myself to stand up! Only then can I enter the house of God with no shame” [Fifi, 35, Cape Town].

This network should be a structure that promotes self-love and acceptance, as well as strengthen the community as a whole into a place where a woman doesn't have to say “*I would like to have more female friends*” [Foxy, 32, Cape Town]. In addition, this network of WWUD should be driven by the desire to advocate for drug users and women's rights, and highlight the importance of the community helping, supporting and working with each other, rather than competing.

Such a network should be able to provide a space where women feel comfortable enough to report human rights violations, express themselves, and be open about their challenges and needs; “*I feel training in assertive skills is important. People empowering themselves in their human rights so one knows the law*” [open discussion, Cape Town]. WWUD deserve a space and support structures where they can feel heard, and not ignored, as they have grown used to feeling. With this, it is important to note the importance of recourse for women who have had their rights violated. A network that can assist with the following up of human rights violations, as well as shed light on the perpetrators and hold them accountable for their actions is important to the community;

**“I would like to have
more female friends”**

“Forming awareness where all the human rights abuses committed by enforcement are brought to light. This will, in turn, curb their corruption [and] abuse of power because the media is a good tool to use... Let’s put what is really going on out there” [Shimmer, 43, Cape Town].

WWUD want to feel as if they belong to something, as if their lives have purpose, and be reminded that they are human beings, with rights and needs and that such needs should be met; *“Most of the time I feel all alone, although I’m around people, I can’t open up. I must always be there for others”* [Mary-Jane; 44, Pretoria]. Ways in which to educate the community on such, and to inform the community of their rights, need to be investigated. Workshops and training on such topics should be conducted with the community on a regular basis, much like support groups and access to a social worker or psychologist.

Safe Space and Shelters

***“Government should build more shelters
appropriate for women”***

[open discussion, Johannesburg].

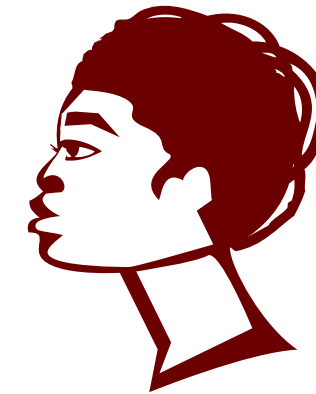
The request for shelters that are freely available to the community was overwhelming. As previously mentioned, community members state that the shelters that are available are either run down or discriminate against them because of their drug use; *“We can’t get shelter and facilities because they have too much rules for us [drug users]”* [open discussion, Johannesburg]. WWUD were also clear that they would like shelters specifically for them as women; *“Open something like a shelter that is cheap but only for us female users like how they have shelters for only boys”* [open discussion,

Durban]. Offering women a safe space to sleep at night, would reduce their likelihood of mid-night harassment from law enforcement and the general population. However, funding for such is lacking, and the process of procuring a building, renovating it and management of such would be considered as a long-term goal, rather than a short or mid-term one.

Alternatively, participants suggested allocating day-time DICs. The goal of which would be to provide a safe space during the day for women with ablution facilities and, if possible, other amenities such as child-care facilities, entertainment and meals; *“sleep/stay and hang out/safe place to inject”* [open discussion, Durban]. Three of the cities visited do have DICs for PWID. However, women shared concerns that these centres are predominantly used by men. Some participants were unaware that such centres existed, while others stated that the location of the centre was too far for them to visit daily, or lacked services such as child-care or meals; services that community members felt were necessary and would increase the likelihood of them accessing the centre.

With this in mind, ideally, programs which already offer PWID-friendly DICs should make these facilities available to WWUD, and, if possible, allocate times that are specifically for WWUD only; *“We will like to have a safe space as women”* [open discussion, Durban]. If such programs can start by opening the DICs to WWUD once a week, focusing on their needs, and then evaluate attendance at regular intervals to assess the demand, they would be able to identify whether providing such services more frequently is necessary.





SUMMARY OF RECOMMENDATIONS

“I would love to see a facility centre that caters for women only. From family problems, women doing drugs, health care, mental health etc... and women staff only, no men!”

[Queen, 55, Cape Town].

Although there were requests for an increase in rehabilitation centres that provide OST on a maintenance level, as well as effective after-care services, one should be wary that increasing access to institutions that are not evidence-based could reinforce the already damaged view of self. Before funnelling funds into systems that preach abstinence, powerlessness, entrench guilt and shame and remind PWUD that their lives are not controlled by themselves, but by external elements, one should investigate alternatives that do have supporting evidence of success. These programs and institutions should focus on the quality of one's life, rather than their period of abstinence, assist in the building up the view of self, rather than adding elements or expectations that can further break them down, and promote a sense of community and support amongst the

drug using community, rather than discriminate and stigmatise depending on the life choices of that individual.

With that, the requests for a centre or safe space for WWUD to congregate was overwhelming. The community is left feeling unwanted and isolated. Providing a space for them to voice their challenges, needs and incorporate their solutions, would be the first step to challenge the corrupt systems that are currently in place.

Regular community advisory groups should be used to consult with the community on how services are improving, and what more can be done to better their lives. Such spaces should also look at providing workshops to assist women in building up their skill-set, in this way empowering the community beyond a consultation level.



“[They] have dehumanised us and people know it, that’s why they feel they can look at us like we animals”

Providing a space for WWUD to voice their challenges, needs and incorporate their solutions, would be the first step to challenge the corrupt systems that are currently in place.

Psychosocial services should be made easily accessible to women; ones that would target the topics mentioned above by Queen, and many other women who participated in the consultations. Where possible, such services should be mobilised and meet the community in areas where they congregate.

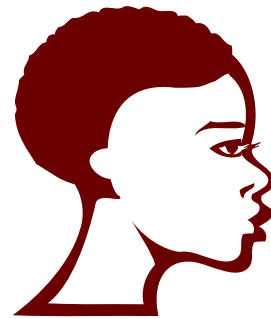
The mobilisation of services should also apply to medical assistance such as HIV testing and counselling, ART, STI screening and treatment, as well as wound care. If such services are provided by programs or institutions that are sensitised to the WWUD community, and rapport is built with the women, the likelihood of services being accessed will increase. In combination with a stance of zero-stigma and discrimination, services being run by women, who are preferably from the community, may make it easier to build such rapport. There should be no cost to the client, and the time taken and waiting periods should be minimal.

According to the community, building services aimed directly at WWUD and explicitly tailored to their needs and wants will increase access.

The reporting, collecting and follow-up on human rights violations is essential to show the community that they are heard. It would be preferable to have this done by members of a WWUD network. The importance of a WWUD network

cannot be stressed enough. It not only provides WWUD with a sense of community, but it also offers women the opportunity to stand up for themselves and can be a way to identify their purpose within society.

Service providers and law enforcement need to be held accountable for their actions and reactions when working with this community, and a means of reporting unfair treatment or discrimination needs to be provided to the community.



CONCLUSION

From the consultations carried out in the four cities, negative self-image appears to be the common perception among the WWUD community. The negative view of self is a common thread among the community. These distorted belief systems are further entrenched by acts of violence and harassment, which only increases the isolating behaviour amongst this community. The less WWUD think of themselves, the more likely they are to disregard their health and well-being and thus decrease their access to health care services, either through expected discrimination, or refusal of services.

When they are victims of crimes, and little recourse follows, their belief that they are “worthless” is further entrenched. When such crimes are at the hands of the people whom they believe are meant to protect them, like law enforcement, intimate partners or friends, WWUD find themselves alone, unsupported and untrusting towards others. Stigma and discrimination based on external appearances or what a woman may choose to do with her body, exacerbate an already tumultuous relationship with the self and once

again this vulnerable key population community are left bereft, with little else but their drugs for comfort.

The lack of positive, female-focused support services such as self-help groups, psychosocial sessions or even a safe space to relax for a few hours, exacerbates an already elevated sense of anxiety and fear, coupled with little knowledge of the emotional tools required to cope – these women then seek escapism through drugs, alcohol and potentially risky behaviours. Stigma and discrimination due to what a woman looks like or what she chooses to do with her body, yet again, entrench low self-worth.

All these contributing factors, without counteractions, leave the community vulnerable to further abuse and merely continues the cycle, adding to the emotional pain, displacement and low-self-worth, these issues break down WWUD until they resemble nothing more than the shadow of who they once were. Instead, they frequently opt for a precarious and at times potentially dangerous existence on the streets.

As strategically focused programs, networks, organisations, service providers and solely by the nature of us as human beings, it is our responsibility to interject and interrupt this cycle of destruction. Emphasis needs to be placed instead

on uplifting, educating, empowering, respecting and mostly hearing the needs and the plights of these women who have exactly the same human rights in society as the rest of us.



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Getting started

The hardest job it seems, is just to make a start.

Even when desire is strong,

This is always the toughest part.

You put off things that should be done.

You wrestle with fear and doubt

But the only way your ship comes in,

Is once you send it out.

The time to do it is always now,

you can't have a doubting heart.

So once the first has begun,

the things you thought you couldn't do

Have already been halfway done.

~Catherine Botha

Poem written by a participant, she asked to have her real name used in this poem



UNODC

United Nations Office on Drugs and Crime