

# BARRIERS TO HARM REDUCTION AMONG WOMEN WHO USE DRUGS: EXPERIENCES FROM ETHEKWENI (DURBAN), SOUTH AFRICA



This report investigates the experiences of women who use drugs with access to harm reduction and health services in Durban, South Africa. In order to compile these experiences, a series of focus groups with women who use drugs in the city were convened by researchers from the South African Network of People who Use Drugs and Harm Reduction International. The participants were invited to share their experiences of harm reduction services and those factors that can prevent them from accessing them.

Those conversations highlighted a population who are routinely oppressed, criminalised and dehumanised. Despite a clear desire to achieve good health and practice harm reduction, these women were continually blocked from doing so by a law enforcement ecosystem that sees them as undeserving of even basic respect and dignity. We heard how law enforcement officers would prevent women from accessing justice and harm reduction services, and how they would enact harm on them directly through physical, sexual and psychological abuse.

One focus group participant found this behaviour comes from being viewed as ‘animals’ by law enforcement officers. The actions of law enforcement, emboldened by criminalisation and stigmatisation, demonstrate this dehumanisation of women who use drugs. Through the stories they shared, the women built a picture of a law enforcement system that does not value the lives or experiences of women who use drugs. It is one that is happy to ignore and delegitimise their voices, and to dismiss and even commit violations of their human rights.

However, there were also positive stories. A few individual police officers were recognised as approaching women who use drugs with kindness, compassion and decency. Significantly, the women made it clear to us that the staff in harm reduction centres welcomed them with warmth and humanity.



**HARM REDUCTION**  
INTERNATIONAL

## Harm reduction

Harm reduction refers to policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws.<sup>i</sup> It is grounded in justice and human rights. Examples of harm reduction interventions include opioid agonist therapy, needle and syringe programmes, drug consumption rooms, and testing and treatment for HIV, viral hepatitis and other infectious diseases.

The World Health Organisation has outlined a ‘Comprehensive Package’ of harm reduction services for the prevention, treatment and care of HIV among people who inject drugs. The package has been endorsed widely, including by the Joint UN Programme on HIV/AIDS (UNAIDS), the UN Office on Drugs and Crime (UNODC), the UN General Assembly, the UN Commission on Narcotic Drugs, the Global Fund and the President’s Emergency Plan for AIDS Relief (PEPFAR).

The Comprehensive Package, as outlined by WHO<sup>ii</sup>, includes the following interventions:

- Needle and syringe programmes
- Opioid agonist therapy (referred to as opioid substitution therapy)
- HIV testing and counselling
- Antiretroviral therapy for HIV
- Prevention and treatment of sexually transmitted infections
- Condom programmes for people who inject drugs and their partners
- Targeted information and education for people who inject drugs
- Prevention, vaccination, diagnosis and treatment for viral hepatitis
- Prevention, diagnosis and treatment of tuberculosis
- Community distribution of naloxone for treatment of opioid overdose

However, properly understood, harm reduction is linked not only to commodities to address HIV and other infectious diseases. It encompasses a range of social services and conditions, the most fundamental of which is respect for the human rights of people who use drugs. It seeks not only to reduce the harms of drug use itself, but also of drug laws and drug policy. As such, harm reduction also includes the provision of housing, psychosocial support and employment initiatives, as well as advocating for alternatives to criminal sanctions for people who use drugs.

## Harm reduction in South Africa

There are an estimated 76,000 people who inject drugs in South Africa. A recent systematic review has estimated that between 16% and 23% of these people are women. Heroin is the primary drug injected in the country as a whole, though injection of stimulants such as cocaine, methcathinone and methamphetamine has also been documented.<sup>iii</sup> The non-injected use of the same substances is also widely documented, but precise estimates are unavailable.

Drug use remains criminalised in South Africa. No distinction is given in law between possession for personal use or possession of larger amounts for sale or trafficking, according to the Drugs and Drug Trafficking Act (1992). The Act also empowers police to search premises, vehicles and containers for illegal substances without a warrant if they have “reasonable grounds” to suspect an offence has been committed.<sup>iv</sup> The description of what reasonable grounds are is vague in the South African context, thus it is widely exploited by Law Enforcement and people are targeted based on their external appearance, race, location and socio economic status. PWUD do not necessarily need to have substances on them to be arrested and are often detained for possession of ‘drug using equipment’ – such as carrying NSP commodities – which is not illegal for someone who is insulin dependent, or other ‘justified’ health concerns.

HIV in South Africa is a generalised epidemic, with general adult population prevalence standing at 18.8%.<sup>v</sup> Prevalence among people who inject drugs is estimated to be more than double this figure at 46.4%.<sup>vi</sup> This is also more than double the estimated global prevalence among people who inject drugs of 17.8%. Hepatitis C prevalence among people who inject drugs is slightly above the global figure at 54.7%, while hepatitis B prevalence is 5%.<sup>vii</sup> No estimate is available for HIV prevalence among women who inject drugs.

South Africa is one of just four countries in sub-Saharan Africa in which both needle and syringe programmes and opioid agonist therapy are available.<sup>viii</sup> However, the scale of implementation remains small, with just four needle and syringe programmes and 11 sites providing opioid agonist therapy. None of these services are tailored to the needs of women who inject drugs.<sup>ix</sup> No services are available in prisons.

In Durban, the Step Up project has operated since 2015 with the support of TB/HIV Care. It currently provides people who use drugs in the city with information on harm reduction interventions and practices, and linkage to health services. Until 2018, Step Up also providing a needle and syringe programme. However, the local government forced the closure of the programme citing discarded needles and syringes in public spaces. Since then, Step Up, TB/HIV Care and local organisations of people who use drugs have been advocating for the re-opening of this essential service.

### **Methadone shortage – November 2019**

On 28 October 2019, Equity Pharma, a service provider, reported a stock out of methadone. Up until then, there had been no formal communication that a shortage was imminent or when supplies would be available again. It was only on 2 December 2019, when methadone was again available and was dispensed to OAT sites in Cape Town, Johannesburg and Pretoria.

The stock out had negative effects on all clients who were stable on methadone (over 600 people across three cities). The reduction of methadone doses that many people had to manage resulted in withdrawal symptoms as well as psychological distress and destabilizing/ worsening mental health of clients. People who reused heroin were put at risk of poisoning, due to uncertain purity and dose of street-drugs. The crisis resulted in many people re-engaging with the criminal market to access illegal opioids, and with it the risk of arrest and incarceration, as well as many triggers associated with previous high-risk substance use practices and setting back personal goals around less harmful substance use.

Increased injecting frequency, and in particular sharing, increased individual level risk of HIV and HCV transmission and overdose, and also negatively affected some of the HIV and HCV prevention gains the OAT programmes have had over the past 18 months. Therapeutic relationships between prescribers, supports and clients has been negatively affected, and notable effort is required to stabilize clients and up-titrate them onto original doses. All stakeholders and clients are aware of the vulnerability to the methadone supply and potential for future stock outs. The threat and experienced methadone stock out left programmes and patients on OAT with few alternatives; (1) down titrate their methadone and transition to buprenorphine ( $\pm$  naloxone); or (2) down titrate/ stop methadone and resume use of heroin/illicit opioids until the methadone supply was re-established.

### **Ethical medical practice**

Despite having knowledge of the potential disruption in supply, Equity Pharma did not inform anyone of the situation. Equity Pharma did not provide organisations or prescribers with sufficient time to safely down titrate patients and transition them over to Buprenorphine as per clinical guidelines. The lack of transparency and communication from the pharmaceutical company, has resulted in:

- o Negative relationships between clients and the OST providers, undermining their therapeutic relationships and trust.
- o Concerns about potential threats to supply in the future among OST prescribers and programmes, and concerns around the ethical conduct of Equity Pharma.

### **Women and harm reduction**

Researchers from around the world have conducted a considerable amount investigation into the barriers than women face when accessing harm reduction services. This project seeks to add to this pre-existing body of work.

There are an estimated 3.2 million women who inject drugs worldwide, constituting 20% of all people who inject drugs.<sup>x</sup> Accounting for the concealing effects of criminalisation, gender power imbalances and stigma, this number is likely to be an underestimate.<sup>xi</sup> The limited data that is available suggests that women who inject drugs are at greater risk of HIV and viral hepatitis acquisition than men who inject drugs.<sup>xii</sup> This increased vulnerability is a product of a range of environmental, social and individual factors affecting women, which also affect their ability to engage in health promoting services such as harm reduction.

Our review of the literature on women's access to harm reduction found that two themes recurred above all others: criminalisation and stigma. Despite the growing population of incarcerated women, antiretroviral therapy for HIV treatment, opioid agonist therapy and needle and syringe programmes are all more widely available in male prisons (though limited) than in female prisons.<sup>xiii</sup> Men are consistently prioritised for the limited prison health services that exist, due to the larger number of men incarcerated and therefore the greater urgency and cost-effectiveness of providing services to male prisoners.<sup>xiv</sup> In order for harm reduction in prison to be equitably accessible regardless of gender, service provision must be increased in women's prisons.

Women consistently report unsafe injection behaviour in prison in the absence of accessible sterile injecting equipment.<sup>xv</sup> This includes syringe sharing, the use of improvised injection equipment, and the use of bleach as disinfectant.<sup>xvi</sup> Women are well aware of the risks involved, and a study in Canada reported unprompted demands for accessible sterile injecting equipment in prisons from female prisoners.<sup>xvii</sup>

### Structural violence and stigma

Women's access to harm reduction services is hindered by structural violence and stigma that result from patriarchal social norms and attitudes, and which can be compounded by other identities such as race, class and sexuality. With regard to barriers to harm reduction services for women, structural violence is apparent in the greater stigma faced by women who use drugs compared with men.

Entrenched expectations of women are a foundational element of barriers to harm reduction services for women who use drugs. Examples of such expectations include that they should be primary caregivers, accommodating, and subordinate their needs to those of men.<sup>xviii</sup> Qualitative studies have consistently found that women report facing greater stigma based on drug use than men, and that women fear disclosing drug use because of the risk of stigma and social sanctions.<sup>xix</sup> This has direct consequences on the ability and willingness of women to access harm reduction services.

Firstly, it discourages women from accessing services for fear of being identified as a drug user. For example, young women in the United Kingdom report being reluctant to make contact with drug and harm reduction services as doing so risks making their drug use public, and therefore exposes them to stigma.<sup>72</sup> Similarly, women in Kenya report a lack of privacy and confidentiality in harm reduction counselling rooms as a barrier to accessing these services, referring to the risk of drug use being made public.<sup>xx</sup> Research in Australia, Indonesia and Tanzania has produced similar findings.<sup>xxi</sup>

Not only does stigma dissuade women from accessing services, but it also means women who use drugs can be pushed into hidden and unsafe spaces in order to ensure that their drug use is not made public. For

example, a qualitative study in Tanzania found that women were less likely to frequent “drug hang outs” where harm reduction outreach workers operate due to the risk of violence and stigma.<sup>xxii</sup> In Indonesia, women report concealing drug use (including from health professionals) and socially isolating themselves in order to avoid pervasive stigma.<sup>xxiii</sup> In such circumstances, women are more vulnerable to sexual and physical abuse and are less easily accessible to outreach workers.<sup>xxiv</sup>

Female sex workers who use drugs are subject to even greater stigma and are more vulnerable to harmful consequences. These women are more likely to work in less safe conditions (for example street-level sex work and exclusion from brothels) than their colleagues who do not use drugs, and as a result are more likely to experience violence and higher-risk sex.<sup>xxv</sup> Furthermore, in some cases female sex workers face losing clients if their drug use is known, leading to a lack of engagement with harm reduction services.<sup>xxvi</sup> These conditions, combined in many cases with punitive legal and policy environments for people in the sex industry, reduce their ability to access harm reduction services.

Women who use drugs not only experience generalised social stigma, but also direct stigma and discrimination from health professionals, including those involved in providing harm reduction services. As in the wider public, this stigma is more acute for women than men because of wider social expectations about womanhood and the role of women. Women have reported pervasive stigma across the health system in studies conducted around the world, including in Australia, Kenya, South Africa and the United Kingdom.<sup>xxvii</sup> For example, women in Kenya report being served last in conventional health services if their drug use is known, and women in Tanzania report that health workers explicitly discriminate against people presenting with injection-related injuries or conditions.<sup>xxviii</sup>

A systematic review of stigma towards people who use drugs from health professionals found that negative attitudes are pervasive and that they lead people who use drugs avoiding health and harm reduction services.<sup>xxix</sup> Experienced stigma leads to the anticipation of stigma, which discourages people who use drugs – and particularly women who use drugs who face greater stigma – from accessing services. For example, women in South Africa and Tanzania report a reluctance to access

any health service due to experienced stigma, and studies have found that in some cases women are less likely than men to adhere to opioid agonist therapy due to stigma experienced in harm reduction services.<sup>xxx</sup>

Experienced and anticipated stigma can also lead to extreme self-stigmatisation among women, as has been documented in Georgia and the United Kingdom.<sup>xxxi</sup> In these cases, research has found that stigma is internalised as low self-esteem and self-worth, creating a sense of not being deserving of good health and therefore a lack of health-seeking behaviour.<sup>xxxii</sup>

The experience of stigma is particularly acute for women who use drugs and are pregnant or parenting. The proliferation of myths and half-truths (for example, related to fetal health in withdrawal) and the misinterpretation of data around pregnancy and drug use contribute to an environment where women are subjected to misinformation from health professionals and others.<sup>xxxiii</sup> The stigma created by this environment prevents health professionals from engaging meaningfully with women who use drugs, disincentivises women from having open conversations about drug use while pregnant or parenting, and can force women into riskier practices to conceal drug use and/or pregnancy.<sup>xxxiv</sup>

In many services worldwide, outreach workers, who are sometimes people with lived experience of drug use themselves, are introduced into harm reduction services to reduce the effect of stigma and increase service uptake among marginalised populations such as women.

Studies in Kenya, Tanzania and Canada have found that female outreach workers are better positioned to engage with women who use drugs, and women report that their presence in harm reduction services reassures that staff understand the issues they face.<sup>xxxv</sup> Outreach workers are noted, for example in Kenya and Tanzania, to be particularly effective in reaching hidden populations, such as women driven to social isolation by pervasive stigma.<sup>xxxvi</sup> However, the stigma faced by women who use drugs is pervasive, and outreach workers are not immune to stigmatising women. For example, a qualitative study in Indonesia found that women report judgmental attitudes from outreach needle and syringe programme employees.<sup>xxxvii</sup>

## Findings

Many of the themes studied in previous research on women and harm reduction were present in our conversations with women who use drugs in Durban, South Africa. Women reported experiencing profound stigma based on their drug use, most acutely from law enforcement officers. They relate this to a wider sense that through stigma, discrimination and criminalisation they are not respected as human beings. Throughout our conversations, they referred to being treated as ‘animals’, called ‘paras’ as shorthand for parasites, and seen by police and prison staff as ‘frogs’ or ‘cockroaches’.

The words and attitudes have grave consequences. When asked to discuss the factors that stand in their way of accessing harm reduction services, the women we spoke to overwhelmingly focused on the influence of law enforcement. Their lives, they said, are not valued as other human beings. Police dismiss their complaints and violations of their rights. They are detained when they have committed no crime. They are subjected to searches, confiscations and detention based solely on their identities as people who use drugs, which rob them of essential health and harm reduction materials and push them into more hidden spaces.

Besides blocking access to essential services, law enforcement officers also cause them direct physical and psychological harm. They told us of physical, psychological and sexual abuse that has become routine. Examples of violations of basic human rights are frequent over the following pages. Perhaps worst of all, the women have nowhere left to turn when they suffer this abuse. Those who nominally exist to protect and serve are the greatest threat.

A key difference with previous research was that women did not report issues in the harm reduction services themselves. While stigma and discrimination were present in discussions around law enforcement and general health services, explorations of harm reduction services were almost uniformly positive. Despite the violence and arrests they face from law enforcement officers, the women prioritise access to harm reduction materials, particularly sterile injecting equipment, and continue to attend drop-in centres.

The decision to prioritise accessing these services appears at least in part because they provide an

environment in which the women are valued as human beings, in contrast to their experience with law enforcement. The women commonly referred to feel safe, included and valued in Step Up's harm reduction centre. There, they reported being shown compassion and humanity.

### **Dehumanised, devalued**

*"You are a para[site]. There is no use for you."*

*[Reported words of a police officer in Durban, South Africa]*

The extreme stigma experienced by women who use drugs in Durban is exemplified by their reports of interactions with law enforcement officers and prison staff. In those interactions, they frequently report being dehumanised by officers, who refer to people who use drugs as "paras" (short for parasites).

'We are used to being treated like animals,' said one woman of the treatment she and her peers received at the hands of police.

These attitudes have severe consequences on the ability of women to maintain good health and practice harm reduction. Even in cases of emergency, they report police ignoring their needs. One woman shared an experience of witnessing a friend overdose, and the total lack of humanity shown by police.

'The thing that stayed in my mind as long as I remember. The one guy was just out of prison and he injected more than his body could cope with. He overdosed. He was laying there and needed help. I remember a police van came past and I stopped them and said, "Please help me there is a man who has overdosed all I need is a lift to the clinic". They all turned to each other and I remember their faces. They asked if he used whoonga [heroin] and I said yes. They said, "we are not an ambulance" and drove away. That man then later died. Those people were meant to help. He was laying in front of them. I didn't say they were an ambulance, I just saw them and thought, "thank God these people will help." Even if they didn't take him, if they called the ambulance it would come quickly. But nothing.'

In this case, where a man's life was in the balance, law enforcement officers refused to help because of their attitudes towards drugs and people who use them. A man's access to life-saving medical care was prevented by stigma.

The most basic duty of police officers is to enforce the law. However, the experience of the women we spoke to demonstrates that this duty is not applied to people who use drugs. Violations against women who use drugs are met with a blind eye. 'You can't go to the police. They will never help you. Even if someone is hurting you. You can try flag the police car but if they stop, they will listen to the other person and just say, "See what you can do to her" and drive away. This how unsafe you are. [...] They will shake hands with the person who is hurting you.'

For women engaged in sex work and drug use, law enforcement officers are even more contemptuous. Women reported that abuse is explained away as a natural consequence of their work.

One woman reports that a man was abusing her. When the police arrived, she had almost fallen from a high window. 'I saw the man talking to them,' she said. 'So, I thought good, they are making a case. Then I think the man gave [the police] money to bribe. The police then came to me and said, "You can't open a case against this man because you are selling yourself to him. So just go."

When women took their cases directly to the police, they were met with attitudes dehumanising them and delegitimising their experiences. One woman told us, 'I wanted to open a case for rape. I went to the station and the guy at the desk he said loudly to the others, "Hey do you hear what this para is saying? She is saying she is getting raped." They laughed. They said, "Hey come now, we don't have time for this. Go away."

Another woman had a similar experience. When reporting a crime, she was told, 'Hey, you are a para. You stay on the road. We are not going to help you.' 'We don't have the right to report,' she said.

'I think this is very important,' said another woman. 'Even us paras, we go to the police station to report things and we don't have the rights. They just laugh. They don't assist us. We are not a person; they don't take us seriously.'

Whatever we say they just take advantage. When you are a sex worker – everything that you might say they say we deserve it – cos we smoke, and we are sex workers.'

Entrenched stigma against women who use drugs deprives them of access to the most basic protection of the state. Negative experiences with law enforcement dissuade them from reporting crimes against them, increasing their vulnerability to violence and ill health. The attitude of officers also influences the way in which the community at large see the women. As one woman explained, 'I wish [the police] could understand that what they do makes the normal people turn on us. They can do anything to us. The communities then think they can do anything to us. If the police can hurt us, then so can they.' This contributes to a sense among the women that they are alone, that they are separate from society and have no one to turn to when their rights are violated.

'You don't even feel safe. What's the use? If you go to a police station, they don't want to help you. You feel lost. Where do you go?'

### **Arbitrary arrest**

*'They plant us, arrest us for nothing.'*  
[Focus group participant]

The role of the police in reducing women's access to harm reduction and health services is not limited to their inaction. The women we spoke to also reported law enforcement frequently taking active decisions that worsened their circumstances and aggravated the already devastating impact of drug policy on their lives.

Their mere existence is routinely criminalised. Women going about their daily lives are targeted for police searches and arrest. 'Even when we're walking in the streets or under the bridge, they come and catch us,' said one woman. 'They don't find anything, but they take us to the station and say they found rock [crack cocaine] or heroin. Even though they found nothing.'

They commonly told us they had been held in police detention or even prison based on searches that had found no evidence of illegality. One told us, 'They never caught me with anything, but they caught me and locked me up in December. I stayed six months for nothing. For nothing.'

Several women told us about experiences of police

officers planting illegal substances on them as an excuse to arrest them. One woman's story was symptomatic of many: 'I was [arrested] for heroin, but he did not find the heroin on me. He planted it. I went to court and I was detained for a year. He put it on me.'

Again, women engaged in the sex industry were subjected to special treatment, and verbal and physical abuse took on a sexual nature during searches and arrests. 'Even if you did nothing wrong, they can search you. Or arrest you. Especially if you are a sex worker. They say, "you must fuck me because you are selling your pussy."'

When women are convicted of drug offences, the arbitrariness and non-transparency of sentencing adds to the perception that the authorities do not care about their needs. The former female prisoners that participated in our research had been incarcerated for anywhere between seven days and more than a year, despite having been found guilty of similar offences.

Even once sentenced, release patterns can be unpredictable, with the prison system showing little regard for ensuring predictability and managed release schedules. "Yes, it's always different," said one participant. "Sometimes you get a sentence for five months, and you do two months, and then they just stop. They send you home."

### **Confiscation of essential health commodities**

*'They took my ID and my ARV treatment. He said that I must die for all he cares,'*  
[Focus group participant]

Targeted searches of women suspected of drug use frequently resulted in not only the confiscation of the substances themselves, but also of essential health and harm reduction commodities. One woman told us that police once found and destroyed an unused needle that had been obtained from the Step Up needle and syringe programme, while another told us that she had been arrested for carrying needles and kept in police detention overnight.

While the women report that the confiscation of sterile injecting equipment did not dissuade them from accessing the needle and syringe programme while it operated, the closure of Durban's only such programme means that sterile injecting equipment has become considerably less accessible. As one woman said, "We can get another, but

it's far to get it. I pay 10 rands<sup>xxxviii</sup>.” The punitive confiscation of legally obtained commodities for health, which can no longer be easily or freely acquired in the city, represents a severe barrier to women's ability to practice harm reduction and prevent the transmission of HIV and other blood-borne diseases.

Police also confiscate and destroy women's basic life necessities, in another exhibition of the dehumanisation of women who use drugs. “The Metro [local police] came and took my blanket, my clothes, my ID. I don't have my ID and that's hard,” one woman told us. Another told us that the police come almost every day to confiscate her clothes and blankets, while yet another told of how the police had burnt her blankets and clothes while she watched. These reports were frequently associated with physical and sexual abuse of women living on the streets.

Police even confiscate medication. ‘They took my ID and my ARV treatment [for HIV]. I told the Metro guy it was my meds. He said that I must die for all he cares,’ one woman told us.

Another participant had a similar story. When she was arrested, she told the officers she needed to get her HIV medication. ‘They don't care about that,’ she said. ‘They say “Even if you die it's a good thing for society, because you are a para and you smoke. There is no use for you.”

The consequences of confiscating medication can be severe, both directly because of the lack of treatment for health conditions and because of the difficulty in obtaining replacements. ‘The AIDS clinic gives us treatment for three months. Metro took it all. I have to wait now for three months without the medication and I am defaulting. I will be getting sick. I'll go back to the clinic now, but I don't know if they'll give me [replacements].’

Stigma faced inside the health services contributes to the difficulty in getting replacement medications for those that are stolen. As one participant told us, ‘They say, “Now you're wasting your pills. Are you selling them?” You have to explain that the Metro came and took them, but they don't believe you. They think we sell the medication.’ In their conversations with our team, the women felt the need to defend themselves against the stigma they have become used to receiving from health workers. ‘We are good, we take our ARV and TB medication,’ they told us.

The effect of the confiscation and the anticipated stigma is compounded when confiscation of medication disrupts the women's routines in ways that they cannot accommodate. ‘Sometimes I just default because it is not easy for me to get to the clinic. So, I stop drinking it, I stop taking it all. Then I wait until the next date to go back because its far to go, and even then, sometimes they don't give you more.’ The anticipation that they will be stigmatised, that they will not be believed, means that women decide not to attend health and harm reduction services once their medication or commodities have been confiscated.

By confiscating or destroying harm reduction supplies, basic goods and even medication, police officers are putting direct barriers in the way of women obtaining and maintaining good health. The stigma faced in health centres only compounds this problem.

However, with regard to harm reduction equipment, the women were clear. ‘Nothing stops us coming to get syringes. We need them. If you get arrested for theft then you might think, “I'm not going to steal again.” But if you get arrested for needles you will still get needles, because you need them. Having harm reduction equipment is not a crime.’ Several women repeated this sentiment.

While it is positive that unjust law enforcement does not dissuade the interviewed women from accessing this harm reduction service, it is clear that these practices increase the risks woman who use drugs face.”

### **Withholding health and harm reduction services**

*‘They should have methadone. It would save a lot of lives.’*

*[Focus group participant and former female prisoner]*

When women are held in prison or police detention, access to health and harm reduction services is rarely possible. This in part relates to the total absence of harm reduction services in South African prisons: no needle and syringe programme or opioid agonist therapy is available in any detention centre in the country. However, it is exacerbated by the discriminatory and stigmatising attitudes of police and prison staff when dealing with women who use drugs with medical concerns.



Focus group participants reported frequently being told that their illness was a result of their drug use, and that they had brought it on themselves and would therefore not receive any treatment. One woman reported being told, 'You are a para, that's your problem. You were smoking so that's why your stomach is sore. That's why you are in prison!'

'In prison, you have to beg, beg, beg for meds,' one former female prisoner told us. 'Especially if you are a para. They don't want to help or care. They don't give you all the treatment either. They give you sometimes just one [pill] when you need more.'

One woman reported that prison staff denied all responsibility for treating her tuberculosis. 'I told them I need my TB meds, or I will default, but they didn't care. On Tuesday I came back to court and I asked again for my TB meds, because I couldn't breathe properly. They didn't care about that. They said, "This is not our problem. This is the problem of the police who arrested you"'

Several participants told us that it was possible to obtain medication for health problems in prison, but that it was made extremely difficult by prison staff. 'They do give you medication, but only because they have to. Not because they are nice. They know it would be illegal to give it to you, and they know that if you die it will be a problem [for them].'

Another woman had a similar story, and told us that her anti-retroviral medication was taken from her. When she fell ill, she was told it was withdrawal. 'Eventually I collapsed and then only they did something. They got my [HIV] medication for me. Nearly a month of being so sick.'

Even when I was sick, they were still harassing me,' she said. 'They only take action if they see it is serious.' The lives of women who use drugs when they are incarcerated are subordinated to the whims and conveniences of prison staff.

In the latter case, the excuse of prison staff for not treating her was that she was going through withdrawal (known as "arosto" in South Africa). In doing so, they implied that opioid withdrawal is not a health condition that they should be responsible for treating. This is a clear violation of the prisoners' right to health. Opioid agonist therapy is an essential component of harm reduction and part of the World Health Organization

recommended response to HIV for people who inject drugs, and therefore must be provided to women in prison and in the community.

The consequences of not providing opioid agonist therapy in prison are grave. Several women told us that drugs, including opioids, were completely unavailable in women's prisons in South Africa (though they were readily available in men's prisons). With no opioids available, either illegal or prescribed, women dependent on opioids can enter withdrawal when they are held in detention. 'You must suffer. You face the pain until the arosto is out,' one told us. 'Some of the girls kill themselves from the pain. The number of girls who kill themselves is really a lot. One of the girls with us, she hung herself from the pains and no one came. No one would help her. No methadone. They should have methadone or anything to help with the pain. It would save a lot of lives.'

For some, the fear of withdrawal is their greatest concern when being arrested and incarcerated. 'You just don't want the arosto. I don't care about the prison. I don't want to be arrested and have the arosto.'

### **'We are used to being treated like animals':**

#### **Violence and abuse at the hands of law enforcement**

#### **Physical violence**

*'They think we are cockroaches'  
[Focus group participant]*

Law enforcement officers directly harm the health and wellbeing of people who use drugs. The women we spoke to reported commonly being subjected to physical, sexual and psychological violence by police and prison staff.

Often, these attacks were unprovoked by any illegal behaviour. 'When you are sleeping, they come and kick you. Most of us sleep with our faces covered. The cops will laugh and say, "Oh sorry, I thought you were a guy,"' one woman told us. She added, 'Even if I was a guy, what gives you the right?' These types of attack are frequent, happening, 'all over, every day.'

Several women explained that female police officers were the worst offenders. 'Don't think the women will defend or speak up for you,' said one woman. 'The women are the ones to take advantage more. They are the worst. The men [are] a bit better. [...] I was going to court and I bumped a

police officer by mistake,’ said one woman. ‘She took me into a room and said, “Do you want to fight with me?” I tried to explain, and then she sprayed me with pepper spray in my eyes and tried to hit me. I had just bumped her by mistake.’

In all cases, these attacks are a demonstration of the way in which women who use drugs are stigmatised to the point of dehumanisation, and are not considered worthy of basic human rights and dignity. One woman, perhaps more than any other, summed up this attitude: ‘We can just be sitting there, and they come and want to spray insecticide. They think we are cockroaches. They don’t care just because they know you are an addict. They call you anything, they hurl abuse and this and that. Every day there are worse stories.’

‘We are used to being treated like animals,’ said another woman.

The women explained that these attacks not only caused them direct harm and health concerns, but also dissuaded them from accessing other services. ‘I’m scared of the withdrawals,’ said one. ‘But I am more scared of the police because they can hit me.’ This fear, in a context where possession of drug-related medication such as opioid agonist can attract police attention, means that women are less likely to access these harm reduction services.

## Sexual violence and degrading treatment

*‘They make you bend up and down like a frog.’  
[Focus group participant and former prisoner]*

Violence experienced by women who use drugs is frequently sexual in nature. In some cases, this is used as part of an effort to humiliate and degrade them. Again, the women we spoke to emphasised the behaviour of female officers. One woman told us,

‘Mostly it’s the female cops that are the worst abusers against us. Because she knows you’re an addict, she will make you pull up your top and feel your breasts to see what you have. She won’t even take you to the side [for privacy].’

Another woman agreed, ‘The women say such disgraceful words, in front of the men. “Lift up your skirt. You aren’t even wearing a bra.” And they go on.’

‘Don’t worry, you are going to prison, at least you can have a bath.’ They laugh and say, “You’ll look nice after that.”’

According to the [United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders](#) (‘the Bangkok Rules’)<sup>xxxix</sup>, prisoners are entitled to be searched in private by properly trained, respectful staff of their own gender. In the experiences of the women we spoke to, none of these conditions were fulfilled. Searches are not conducted in private, but in groups. ‘There is no privacy – maybe there is eleven of us coming from court. We all stand there and take our clothes off in front of the warden.’

Wardens involved in searches are disrespectful and abusive, and in some cases conduct full body searches in the presence of male colleagues. ‘She will make you reveal yourselves and say all kind of abusive words. “When did you last bath?” She makes funny comments to male colleagues like, “Don’t you want this as your girlfriend?” Every day. Every day.’

These experiences were repeated by several women. ‘The women [wardens] are rude. They say you must bath before you speak to them. They search your butt. They put their gloves on and then they search you and say horrible things about how you smell, or how you look.’

‘They search your pussy even. They make us all stand in a line and bend over. Then they check. They make you bend up and down like a frog to check nothing is inside. If you have something hidden in there, they will pull it out. Everyone can see. There is no privacy.’

This verbal and sexual abuse can also spill into physical abuse. ‘They tease you about your body. You are too skinny or too fat. They say you are too smelly. Something is wrong with you. They chase you to go shower, right now, in cold water. I shower for 15 minutes, they say, “Go back. You still smelly go back again and wash again.” This can take an hour.’

Women who use drugs are also subjected to sexual violence from male law enforcement officers. In these cases, the women reported officers exerted their authority over women to extract sexual acts or money. For example, an officer told one woman, ‘If you don’t like to be arrested, let’s go and book a place and have sex. Then I’ll take you out.’

Other women told us similar stories of being threatened and exploited for sex. When they resist these assaults, they are arrested or beaten. 'It's the norm. We are so used to it. Every week.'

In other cases, officers take advantage when the women are in particularly vulnerable conditions. One woman told us how she was in a police cell before being transferred to prison and was entering opioid withdrawal. An officer approached her and said, 'You must give me a blow job, and I will give you something to smoke.' She agreed, but told us, 'It was just a trick. He only had cigarettes. He could see I was desperate.'

Perhaps most damning is the impunity law enforcement officers enjoy for these serious abuses of human rights and human dignity. Few officers have any interest in defending their rights, and any attempt by the women themselves to introduce accountability is met with increased violence. As one woman told us, 'If they ever find you videoing them – yoh! Then it's another story. They beat you almost to death, and then arrest you.'

One woman summed up the paradox. 'The police are supposed to protect you and assist you, but they abuse us. We get a lot of abuse because we use drugs, and because we can't go anywhere. There is nothing worse than someone hurting you and knowing that you can't get help.'

#### **'You know they are there for you': Positive experiences of humanity and compassion**

*'They give love and care to show that we don't need to be ill-treated.'*  
[Focus group participant]

When we set out on this research project, we did so with a hypothesis that women faced barriers to harm reduction services in part because those services are inadequate for their needs. This was based on evidence and experience from numerous studies around the world (see Introduction). However, our investigation has found that the major barriers highlighted by women who use drugs lie outside the services, in the attitudes of law enforcement officers and prison staff.

When speaking about the harm reduction drop in centre operated by Step Up in Durban, the women were consistently positive. They frequently focused on the

warmth and humanity that they experienced from the centre's staff. 'They give love and care to show that we don't need to be ill-treated,' said one participant. 'They always have that smile and you don't feel shy to go to them. You know they are there for you.'

'We [go to Step Up] to bath and eat, but most importantly to feel safe,' said another woman. The presence of female staff at the centre was clearly emphasised as an important factor in the way women felt about it: 'We can talk here, and get sisterly love.'

Another participant added, 'It does not feel like you're seeing a counsellor. You feel like you are sitting with your mum here.'

Our participants were also keen to highlight those law enforcement officers they saw as trustworthy and just. While they clearly emphasised that these individuals were exceptions, it was notable how much of an impression they had made. Several women mentioned one officer, known only as Smally. 'He is a very fair person,' we were told. 'He is the only policeman I can actually speak to. He is very faithful and good.'

Also noteworthy was the relatively low bar the women set for the kindness of police officers. Of another officer, Mr. Dingaani, one woman told us that, 'If you see him in the street, he will greet. [...] He will spend time and talk to us. He won't sleep with us girls. He doesn't ask for sex for being kind.' That this behaviour, treating the women with basic decency and respect, is so noteworthy to the women, is damning of the behaviour of other officers.

The common thread in the positive experiences shared with us, both with law enforcement officers and harm reduction centre staff, is that they treat the women as human beings. While beyond these cases, our participants shared with us how they were treated like "animals" or "parasites", how they were beaten, abused and degraded, they recognised and emphasised the transformative power of basic human kindness, dignity and compassion. They spoke about harm reduction centres and sympathetic law enforcement as safe havens. These experiences are symbolic of the very minimum these women should expect from society, but are currently the maximum that they receive.

## Endnotes

<sup>i</sup>Harm Reduction International, 2019. *What is harm reduction?* Available online: <https://www.hri.global/what-is-harm-reduction>

<sup>ii</sup> United Nations Office on Drugs and Crime, et al., 2017. *Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions*. Vienna: United Nations Office on Drugs and Crime.

<sup>iii</sup> Degenhardt, L. et al., 2017. 'Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review.' *Lancet Global Health*, 5(12), pp.1192-1207.

<sup>iv</sup> Republic of South Africa, 1992. *Drugs and Drug Trafficking Act*.

<sup>v</sup> UNAIDS, 2019. *UNAIDS Data 2019*. Geneva: Joint United Nations Programme on HIV/AIDS.

<sup>vi</sup> UNAIDS, 2019. *UNAIDS Data 2019*. Geneva: Joint United Nations Programme on HIV/AIDS.

<sup>vii</sup> Scheibe, A. et al., 2017. *Programmatic surveillance of viral hepatitis and HIV co-infection among key populations from seven South African cities: Data to inform unmet need*. South Africa.; TB/HIV Care, 2018. *Viral hepatitis C initiative for key populations in South Africa: Summary Sheet*. Cape Town: TB/HIV Care Association

<sup>viii</sup> Stone, K. & Shirley-Beavan, S., 2018. *The Global State of Harm Reduction 2018*. London: Harm Reduction International.

<sup>ix</sup> Stone, K. & Shirley-Beavan, S., 2018. *The Global State of Harm Reduction 2018*. London: Harm Reduction International.

<sup>x</sup> Degenhardt, L. et al., 2017. 'Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review.' *Lancet Global Health*, 5(12), pp.1192-1207.

<sup>xi</sup> International AIDS Society, 2019. *Women who inject drugs: Overlooked, yet visible*. Geneva: International AIDS Society.

<sup>xii</sup> Des Jarlais D. C. et al., 2012. 'Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas.' *Drug Alcohol Depend* 124(2), pp.95–107.

<sup>xiii</sup> El-Bassel, N. & Strathdee, S. A., 1999. 'Women who use or inject drugs: an action agenda for women-specific, multilevel and combination HIV prevention and research.' *J Acquir Immune Defic Syndr*, 1(69, Suppl 2), pp.182–90; Sander, G. et al., 2019. 'The Global State of Harm Reduction in Prisons.' *J Correct Health Care* 25(2), pp.105–20.

<sup>xiv</sup> Fair, H., 2009. *International review of women's prisons*. London: International Centre for Prison Studies, Kings College London.; Burns, K., 2009. *Women, Harm Reduction and HIV: Key findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*. New York: Open Society Foundations; van der Meulen, E. et al., 2018. 'A legacy of harm: Punitive drug policies and women's carceral experiences in Canada.' *Women Crim Justice*, 28(2), pp.81-99.

<sup>xv</sup> Strathdee, S. A., 1999. 'Substance Use and HIV Among Female Sex Workers and Female Prisoners: Risk Environments and Implications for Prevention, Treatment, and Policies.' *J Acquir Immune Defic Syndr*, 1(69, Suppl 2), pp.110-117; Dolan, K. et al., 1996. 'HIV risk behaviour of IDUs before, during and after imprisonment in New South Wales.' *Addict Res*, 4(2), pp.151-60; Rehman, L. et al., 2004. 'Harm reduction and women in the Canadian national prison system: Policy or practice?' *Women Health*, 40(4), pp.57-73; Dolan, K. et al., 2009. 'Presence of hepatitis C virus in syringes confiscated in prisons in Australia.' *J Gastroenterol Hepatol*, 24(10), pp.1655-7.

<sup>xvi</sup> Strathdee, S. A., 1999. 'Substance Use and HIV Among Female Sex Workers and Female Prisoners: Risk Environments and Implications

for Prevention, Treatment, and Policies.' *J Acquir Immune Defic Syndr*, 1(69, Suppl 2), pp.110-117; Dolan, K. et al., 2009. 'Presence of hepatitis C virus in syringes confiscated in prisons in Australia.' *J Gastroenterol Hepatol*, 24(10), pp.1655-7; Boyd, S. & Faith, K., 1999.

'Women, illegal drugs and prison: Views from Canada.' *Int J Drug Policy*, 10(3), pp.195-207; Boys, A. et al., 2002. 'Drug use and initiation in prison: Results from a national prison survey in England and Wales.' *Addiction*, 97(12), pp.1551-60.

<sup>xvii</sup> Rehman, L. et al., 2004. 'Harm reduction and women in the Canadian national prison system: Policy or practice?' *Women Health*, 40(4), pp.57-73.

<sup>xviii</sup> Medina-Perucha, L. et al., 2019. 'A qualitative study on intersectional stigma and sexual health among women on opioid agonist treatment in England: Implications for research, policy and practice.' *Soc Sci Med*, 1(222), pp.315-22.

<sup>xix</sup> Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43-51; Myers, B. et al., 2016. "'Not on the agenda": A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa.' *Int J Drug Policy*, 30, pp.52-8; Otiashvili, D. et al., 2013. 'Access to treatment for substance-using women in the Republic of Georgia: socio-cultural and structural barriers.' *Int J Drug Policy*, 24(6), pp.566-72.

<sup>xx</sup> Ayon S. et al., 2018. 'Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: role of community-based outreach and drop-in centers.' *AIDS Care*, 30(4), pp.480-7.

<sup>xxi</sup> Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43-51; Spooner, C. et al., 2015. 'Impacts of stigma on HIV risk for women who inject drugs in Java: A qualitative study.' *Int J Drug Policy*, 26(12), pp.1244-50; Copeland, J., 1997. 'A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours.' *J Subst Abuse Treat*, 14(2), pp.183-90; Olsen, A. et al., 2012. 'Positive health beliefs and behaviours in the midst of difficult lives: women who inject drugs.' *Int J Drug Policy*, 23(4), pp.312-8.

<sup>xxii</sup> Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43-51.

<sup>xxiii</sup> Spooner, C. et al., 2015. 'Impacts of stigma on HIV risk for women who inject drugs in Java: A qualitative study.' *Int J Drug Policy*, 26(12), pp.1244-50.

<sup>xxiv</sup> Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters*, 16(31), pp.168-81; Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43-51.

<sup>xxv</sup> Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters*, 16(31), pp.168-81; Azim, T. et al., 2015. 'Women, drugs and HIV.' *Int J Drug Policy*, 26(Suppl 1), pp.16-21; Rusakova, M. et al., 2015. 'Why are sex workers who use substances at risk for HIV?' *The Lancet*, 385(9964), pp.211-2; Deering, K. N., 1999. 'Client demands for unsafe sex: The socio-economic risk environment for HIV among street and off-street sex.' *J Acquired Immune Defic Syndr*, 63(4), pp.522-31; Tran, T. N., 2004. 'Drug use, sexual behaviours and practices among female sex workers in Hanoi, Viet Nam - a qualitative study.' *Int J Drug Policy*, 15(3), pp.189-95; UNAIDS, 2009. *Guidance note on HIV and sex work*. Geneva: Joint United Nations Programme on HIV/AIDS.

<sup>xxvi</sup> Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters*, 16(31), pp.168–81.

<sup>xxvii</sup> Medina-Perucha, L. et al., 2019. 'A qualitative study on intersectional stigma and sexual health among women on opioid agonist treatment in England: Implications for research, policy and practice.' *Soc Sci Med*, 1(222), pp.315–22; Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43–51; Myers, B. et al., 2016. "'Not on the agenda": A qualitative study of influences on health services use among poor young women who use drugs in Cape Town, South Africa.' *Int J Drug Policy*, 30, pp.52–8; Ayon, S. et al., 2018. 'Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: Role of community-based outreach and dorp-in centres.' *AIDS Care*, 30(4), pp.480-7; Copeland, J., 1997. 'A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviours.' *J Subst Abuse Treat*, 14(2), pp.183-90; Khuat, O. T. et al., 2015. 'Social context, diversity and risk among women who inject drugs in Vietnam: Descriptive findings from a cross-sectional survey.' *Harm Reduct J*, 12.

<sup>xxviii</sup> Medina-Perucha, L. et al., 2019. 'A qualitative study on intersectional stigma and sexual health among women on opioid agonist treatment in England: Implications for research, policy and practice.' *Soc Sci Med*, 1(222), pp.315–22; Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43–51; Ayon, S. et al., 2018. 'Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: Role of community-based outreach and dorp-in centres.' *AIDS Care*, 30(4), pp.480-7.

<sup>xxix</sup> Van Boekal, L. C., 2013. 'Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: A systematic review.' *Drug Alcohol Depend*, 131(1-2), pp.23-35.

<sup>xxx</sup> Esmaeli, A. et al., 2018. 'The effect of female sex on hepatitis C incidence among people who inject drugs: Results from the international multicohort InC3 collaboration.' *Clin Infect Dis Off Publ Infect Dis Soc Am*, 66(1), pp.20-8.

<sup>xxxi</sup> Medina-Perucha, L. et al., 2019. 'A qualitative study on intersectional stigma and sexual health among women on opioid agonist treatment in England: Implications for research, policy and practice.' *Soc Sci Med*,

1(222), pp.315–22; Otiashvili, D. et al., 2013. 'Access to treatment for substance-using women in the Republic of

Georgia: Socio-cultural and structural barriers.' *Int J Drug Policy*, 24(6), pp.566-72.

<sup>xxxii</sup> Medina-Perucha, L. et al., 2019. 'A qualitative study on intersectional stigma and sexual health among women on opioid agonist treatment in England: Implications for research, policy and practice.' *Soc Sci Med*, 1(222), pp.315–22; Otiashvili, D. et al., 2013. 'Access to treatment for substance-using women in the Republic of Georgia: Socio-cultural and structural barriers.' *Int J Drug Policy*, 24(6), pp.566-72.

<sup>xxxiii</sup> Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters*, 16(31), pp.168–81.

<sup>xxxiv</sup> Pinkham, S. & Malinowska-Sempruch, K., 2008. 'Women, harm reduction and HIV.' *Reprod Health Matters*, 16(31), pp.168–81; Malinowska-Sempruch, K., 2015. 'What interventions are needed for women and girls who use drugs? A global perspective.' *J Acquir Immune Defic Syndr*, 1(69, Suppl 2), pp.96-97; Burns, K., 2009. *Women, Harm Reduction, and HIV: Key findings from Azerbaijan, Georgia, Kyrgyzstan, Russia and Ukraine*. New York: Open Society Foundations.

<sup>xxxv</sup> Brown, N. L. et al., 2005. 'Developing an effective intervention for IDU women: a harm reduction approach to collaboration.' *AIDS Educ Prev Off Publ Int Soc AIDS Educ*, 17(4), pp.317–33.

<sup>xxxvi</sup> Zamudio-Haas, S., 2016. 'Generating trust: Programmatic strategies to reach women who inject drugs with harm reduction services in Dar es Salaam, Tanzania.' *Int J Drug Policy*, 30, pp.43–5; Ayon, S. et al., 2018. 'Barriers and facilitators of access to HIV, harm reduction and sexual and reproductive health services by women who inject drugs: Role of community-based outreach and dorp-in centres.' *AIDS Care*, 30(4), pp.480-7.

<sup>xxxvii</sup> Spooner, C. et al., 2015. 'Impacts of stigma on HIV risk for women who inject drugs in Java: A qualitative study.' *Int J Drug Policy*, 26(12), pp.1244–50.

<sup>xxxviii</sup> Approximately USD\$0.55

<sup>xxxix</sup> United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders ('the Bangkok Rules') 2011 <https://cdn.penalreform.org/wp-content/uploads/2016/07/BangkokRules-Updated-2016-with-renumbering-SMR.pdf>