Sisters Spaces

Needs, challenges and services

for women
who use drugs
in South Africa

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Colophon:

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Introduction

Drug use, drug policies and drug interventions have historically been narrated and evaluated through men's experiences. Drug-related research, services, guidelines, and training remain overwhelmingly gender-neutral or male-focused. In most drug-related services, including harm reduction, males make up much of the clientele and services provided are generally tailored to men. Both gender-neutral and male-focused services often perpetuate the "invisibility" of women. Consequently, there is a lack of data on the specific needs and challenges faced by women who use drugs when trying to access care.

A mass of gender-specific obstacles exist for women who use drugs within the care system. Compounded stigma may intersect with gender-based, intimate partner violence and moral assumptions about women and motherhood. State-based violence such as police brutality, punitive medical interventions, and the threat of having parental rights removed due to drug use may also be frequently experienced and act as an obstacle. These can be intensified by race, class, and the criminalization of homelessness and sex work. Besides, services not tailored for women may be perceived as unfriendly towards this population, as they may not have appropriately trained staff nor guarantee the safety and confidentiality of women who use drugs.

Gender inequalities are a persistent reality in services assisting the population who use drugs, and situated strategies are needed to address the gender gap. The present assessment, thus, takes a person-centered approach and focusses on the needs and experiences of women who use drugs' to identify the barriers and enablers related to access to services which cater to their needs. It provides a detailed assessment of the experiences of women who use drugs and their harm reduction providers in five cities in South Africa - Cape Town, Durban, Ekurhuleni, Port Elisabeth, and Pretoria – including, when possible, previous studies from other locations. The assessment also contains the perspectives of staff from services - such as food provision, shelter, gender-based violence support, and projects to generate skills and income - which were perceived by women as fundamentally needed, but oftentimes very difficult to access.

Building upon prior studies, in-depth interviews, and focus group discussions, the present assessment provides a detailed representation of the current needs of and challenges faced by women who use drugs in South Africa. It taps into the web of existing services directed towards and accessed by women, to focus on what has been hindering their access to basic human needs and specialized care. This rich information serves as a basis for recommendations on strategies and interventions to help closing the gender gap in services needed by women who use drugs.

Context

Women and gender inequality

Women have faced intense discrimination throughout history and across nations, from lacking legal rights and independence from their husbands to being thought to have inferior brains and bodies. Although gender inequality has declined in the last 70 years, the equal participation of women in society, even in the countries with the smallest gender gap, is still yet to come. At the current pace, it is estimated that it will take, on average, more than a century to close the gender gap worldwide (approximately 135 years worldwide and in Sub-Saharan Africa) (1). Political empowerment represents the largest gap worldwide, followed by economic participation and opportunity. The last one, more specifically, may take two and a half centuries to close – the gender pay gap remains a reality with salaries for women on average being lower than that of men for no other reason than gender.

In South Africa, economic participation and opportunity represents the highest form of gender gap. Even though this is one of the countries with lowest gender gap in the Sub-Saharan region, South African women still face several challenges to have full access to their rights. Several aspects of gender inequality have been exacerbated by the COVID-19 pandemic. More women lost their jobs in comparison to men, and violence against women raised by 30% in some countries. In South Africa, both the frequency and severity of violence increased, including sexual violence against women, with the most common perpetrator being the intimate partner (2). Research in the country has shown that women with violent or controlling male partners are at increased risk, for instance, of HIV infection (3). Such challenges are compounded by and severely increased for women who are not white, who use drugs, or have a lower economic status.

Intersectionality

Besides gender, other individual characteristics such as race, economic class, and drug use play a role in how people encounter the world and live their lives. These characteristics "intersect" with one another and overlap, shaping life experiences and possibilities (4). The lived experiences of violence and discrimination of a black woman will differ from those of a white woman. Experiences of cisgender women will be distinctive from transgender or queer woman, as well for those women who use drugs. Structures of law and society can be intrinsically racist, sexist, and discriminatory of certain practices such as drug use or sex work.

Women who use drugs

Worldwide, women who use drugs are vastly underserved within health and social services and programs, despite facing increased risks. They are consistently reported to have less access to harm reduction services and to be at higher risk of HIV and hepatitis C infection than men who use drugs (5). They are also more likely than men to be "second on the needle", as they tend to inject after and be injected by a male partner (6). Moreover, stigma and discrimination hits women who use drugs in stronger ways than their male counterparts. Due to traditional cultural and moral values women who use drugs are often judged "not quite the kind of women they are supposed to be". This triggers discriminatory attitudes towards women, influencing their access to care services, income-generation opportunities, safety, and general wellbeing.

Services for women who use drugs

To date, worldwide, many existing policies and services do not cater for women who use drugs' needs. Drug-related services, guidelines, and drug policy itself are often gender-neutral or male-focused. Most harm reduction services are primarily occupied by men and tailored to men, leading women who use drugs needs to be unacknowledged and unaddressed (7). Mixed-sex or mixed-gender spaces may be (perceived as) threatening to women: women may face harassment from male clients, may be required to attend services in the presence of their abusers, or risk losing parental rights when registering for a drug-related service. Pregnant women and women with children may have their children removed or be prosecuted for child abuse for drug use alone.

Services specifically designed for the needs of women who use drugs already exist in different parts of the world, albeit in small numbers, and have shown positive results. This is the case, for instance, for female- only Drug Consumption Rooms (8), NSPs (9), or shelters for women who use drugs (10). Female-only and female-focused services can increase feelings of safety, promote access and adherence, and offer more suitable responses to gender-based violence and issues related to pregnant and parenting women. However, such types of services still do not exist in South Africa.

Women who use drugs in South Africa

A systematic review from 2017 has estimated that around 76,000 people injected drugs in South Africa, and between 16% and 23% of these are women (11). Heroin is the primary drug injected in the country, although people also inject stimulants such as cocaine, methcathinone and methamphetamine. The same substances are also used non-injected, but precise estimates on use are still unavailable (12). Anecdotal data, however, points that injecting may not be the main mode of drug use in South Africa, and that focus on this is shortsighted. Lack of data on non-injecting drug use may also represent a similar bias. Prevalence of HIV among people who inject drugs in the country is estimated to be more than double the adult general population (46.4%). No estimate is available for HIV prevalence among women who inject drugs (13) .

Some women who use drugs in South Africa engage in transactional sex, and this add risks to their health and safety considering a context of gender-based economic disparities and high prevalence of violence in sexual relationships (14). South African studies have shown that transactional sex is often motivated by basic survival and sustenance needs, although it can also be used to get access to opportunities in areas where women have these severely circumscribed, such as in employment and education (as the case of young female students engaging in transactional sex) (15). Transactional sex has been associated with increased risk for HIV, substance use, and associated with increased risk of rape and physical violence from clients (16,17). All aspects of sex work are criminalized in South Africa, meaning that both the selling and buying of sex are illegal. Criminalization puts women at risk of law enforcement intervention and punishment, besides triggering discriminatory and judgmental attitudes and driving them away from care.

Criminalization of people who use drugs also has a particularly severe impact on South African women. Women who use drugs report continuous harassment, physical and sexual violence, and invasive searches from law enforcement officers (18). Criminalization of drugs and sex work may lead women who use drugs to face criminal

charges and be incarcerated. While in prison, women have no (or very inadequate) access to Opiate Agonist Therapy (OAT), overdose prevention or other harm reduction commodities. Women in South African prisons have reported dehumanizing and punitive attitudes, including hindered access to basic health care based on discriminatory attitudes of prison staff against drug use (18).

Previous studies in the country have called attention to the difficulties of health systems in responding to women who use drug's needs. Women who use drugs are "not on the agenda" of health policy and planning, and services end up being unresponsive to the multiple needs of the population (19). A few assessments with women who use drugs (12,20) call attention to some of their unmet needs, but a more in-depth view, also considering the perspective of service providers, is necessary to understand the challenges of this population in South Africa.

The assessment

The present assessment focused on the needs of women who use drugs and services (potentially) catering for these needs in five South African cities: Cape Town, Durban, Ekurhuleni, Port Elisabeth, and Pretoria but also included previous data from Johannesburg and Nelson Mandela Bay. The assessment was composed of two interconnected phases.

First phase

In the first phase of the assessment, the focus was:

- to build a detailed understanding of the needs and challenges of women who use drugs assisted by harm reduction programs in the five cities
- to map the female-focused services currently being provided by harm reduction programs (and closely connected partner services) and frequented by women who use drugs
- to provide recommendations on new services and possible programmatic development to better cater to women's needs.

Mainline conducted in-depth interviews with 13 women who use drugs and 15 staff from harm reduction programs currently assisting these women. While women were interviewed face to face by local assistants, staff were interviewed online. Interviews with women intended to map their current needs, the services they frequent, and eventual challenges to access these or other services catering for their needs. We also asked women what makes a service friendly to them and to what extent they feel they are meaningfully included in the services that are currently available or accessed. Data from prior in person focus group discussions (FGD), kindly provided by ANOVA, was incorporated into our assessment. The FGDs aimed to gain further insight on the needs of women who inject drugs (WWID) and the possible services to be included in their currently programs.

Interviews with both staff of harm reduction services addressed the existing services focused on women who use drugs and how service workers viewed the needs and challenges of this population. We also inquired about other services they may partner with and/or refer women to and about the qualities making services friendly and accessible to women. The in-depth interviews prepared for this assignment were inspired by the Community Monitoring Tool for Gender-Responsive Harm Reduction Services for Women who use Drugs made from INPUD (21).

Tables 1 and 2 show an overview of the interviewees. Women who use drugs (Table 1) were between 24 and 57 years of age, and most had a relatively long history of drug use (between 3 and 24 years). They used different illicit substances, the most common being heroin, crystal meth, crack cocaine and cannabis. They mainly injected or smoked these substances. All interviewees were current clients of harm reduction programs, and most had visited the program in the last week. The 33 women partaking in the different FGDs done before this assignment were enrolled in programs dedicated to people who inject drugs.

Overall, all the harm reduction staff (Table 2) directly involved in female-specific activities were female. Mostly, these are social workers and psychosocial counsellors, and all had more than one year of experience working with women who use drugs in their current position.

Table 1: Women who use drugs

WWUD	Data from	N	Organization	Age	Type drugs	Uses for	Program
Cape Town	ANOVA FGD	8	TB/HIV Care	na	WWID only	na	na
Durban	ANOVA FGD	10	TB/HIV Care	na	WWID only	na	na
Ekurhuleni	ANOVA FGD + this assessment	8 + 2	Tintswalo home-based care	39-57 +na	Chrystal meth(s/i) + kat + WWID only	3-7 years na	na
Port Elizabeth	this assessment	3	TB/HIV Care	24-39 years	heroin (i), crystal meth (i/s), mandrax (s), cannabis (s))	7-15 years	last week/ day before
Pretoria	this assessment	8	FPD (Harmless)	33-43 years	heroin (i/s), crystal meth (i/s), crack (s), cocaine(sn), cannabis (s), khat	8-24 years	last week/ day before/ last month
Nelson Mandela Bay	ANOVA FGD	7	TB/HIV Care	na	WWID only	na	na
Johannesburg	ANOVA FGD	5	ANOVA	na	WWID only	na	na
This assessment		13					
Total		36					

Table 2: Harm reduction staff

Staff	Organization	N	Function	Gender	Experience with WWUD
Cape Town	TB/HIV Care	2	social worker and psychosocial counsellour	Females	1 to 3 years
Durban	TB/HIV Care	4	social worker, psychosocial counsellours	Females	1 to 4 years
Ekurhuleni	ANOVA	2	social worker, (field) management	Females	n/a
Port Elizabeth	TB/HIV Care	3	social worker, outreach worker, (field) management	Females	3 to 7 years
Pretoria	FPD (Harmless)	4	outreach worker, (field) management, social worker	Females	1 to 4 years
Total		15			

The interviews were voice recorded with the permission of participants, anonymized, transcribed, and analyzed with a qualitative data analysis software (Atlas.ti). The summaries of the FGDs from ANOVA were also analyzed. This primary data was compared to two previously published assessments with women who use drugs in South Africa:

- A 2017 consultation held with 78 women who use drugs in Pretoria (16 women), Cape Town and Durban (15 women each) and Johannesburg (32 women) in 2017 (20), and
- A 2019 report investigating the experiences of women who use drugs with access to harm reduction and health services in Durban (12).

Second phase

Overall results from the first phase showed that, although harm reduction services areperceived by stakeholders as welcoming and essential in catering for several needs of women who use drugs, they are still far from securing fundamental rights for women who use drugs. Basic needs such as nutrition, shelter, protection from violence and a basic income, are not sufficiently met for women who use drugs in South Africa. Therefore, the second phase of this assessment focused on mapping the availability of services in these fields in the same five cities.

Thirty-four in-depth interviews were conducted with staff from shelters, food distribution services, skills, and income-generating projects, as well as programs for gender-based and intimate partner violence (see table 4). These corre-

sponded to 28 different services, as some catered for more than one type of need and staff from different departments within the same organization/service where interviewed.

The following pages describe, first, the main needs and challenges of women who use drugs in South Africa. These come from the results of the interviews with women who use drugs and harm reduction staff (first phase). After that, we present a description of existing services offering aid needed by women who use drugs, along with an assessment of how accessible they are for women and the links they have with harm reduction services. These come from the results of the interviews with the staff from food provision, shelter, gender-based violence and skills development and income generation services and programs.

Table 3: Stakeholders from shelters, skills development, GBV and food provision services

City	Shelter	GBV	Nutrition	Skills development	Total
Cape Town	4	1	1	3	9
Durban	2	3	2	2	9
Ekurhuleni	1	-	1	1	3
Port Elizabeth	2	3	1	3	9
Pretoria	2	1	1	-	4
Total	11	8	6	9	34

Recruitment of interviewees was done via an initial list of services and harm reduction program staff that was gathered through mutual contacts. Online research efforts and snowball sampling were used to further supplement the list. Originally, the target sample was set at 40 interviews, two staff per field per city. This proved to be difficult to achieve given the high-level of non-response after repeated contact attempts. This low response rate was possibly influenced by the effects of the COVID-19 pandemic and periods of political unrest happening in the country at the time of the assessment.

Like the first phase, the interviews were voice recorded with the permission of participants, anonymized, transcribed, and analyzed with a qualitative data analysis software (Atlas.ti).

Needs and challenges of women who use drugs

Women who use drugs in South Africa face several challenges in their daily lives and when searching for care. Even though all women interviewed for this assessment are current clients of harm reduction programs, their needs are still far from being met. While some of these needs could be partially satisfied by adjusting these harm reduction services and activities, others refer to basic human needs beyond what a harm reduction program alone can provide.

The needs and challenges of women found during this assessment are described below and are composed of women's testimonies and the perceptions of staff working with them. Although, in general, opinions of staff and clients did not differ much, these are distinguished along with the text. Whenever possible or relevant, reported experiences and thoughts are also differentiated by city.

Discrimination when accessing public health care

At least 10 out of 13 women who use drugs interviewed for this assignment reported being discriminated against and mistreated when trying to access the public health system. Experiences of discrimination were also brought up in all five focus group discussions. Women reported experiencing stigma and discrimination against them on account of their drug use, engagement in sex work and situation of homelessness. They also felt targeted by offensive behaviors from public health care staff and, in some cases, reported being explicitly refused care.

In *Ekurhuleni, Johannesburg, Pretoria, and Port Elisabeth*, women reported being discriminated against for using drugs and not showering. Women find it difficult to go to public health clinics when they, for instance, have sexually transmitted infections or another health problem, as health care workers chase them away because they are "dirty". Women from Durban and Nelson Mandela Bay also complained about government staff being rude and judgmental towards them and reported being called names by health care workers, whom they feel do not respect them. Consequently, these women testified to either delay searching for health care as much as possible or decide no longer to access public clinics and hospitals.

> *I'm not going there. I'm full of sores and all these spikes and things. No, I'm not going there. In the [harm reduction] organization, it's easier because they know what you're going through. But at the hospital, the government, they don't know anything about you. They say, "are you rotting?" Things like that, and it's wrong. You can't just tell someone, "You're rotting", not knowing what made her rot anyway (Port Elisabeth, female client 3 [1]).*

> *Especially us who use drugs, they can even call us names; tell us we are stinking. They are treating us like animals, not like human beings. You are not in that situation because you like it. You are in that situation because you are trapped […]. Instead of them sitting you down, talk to you maybe in privacy, they will just shout at you in front of people. Tell you to get off, tell you bad things, and sometimes for us to go to the clinic, we don't, because we know that we'll get bad treatment if we go there. That's why sometimes we're sick, but we just sit, we don't take medicines or anything. Some will get sicker until*

we must go to the hospital, but you find that maybe by that time it's too late. (Pretoria, female client 2)

Women from Ekurhuleni, Nelson Mandela Bay and Johannesburg have also described being refused services based on discriminatory behavior from government staff. They narrated having been refused emergency services by ambulances, being turned back by security guards at clinic or hospital's doors and having clinics place condoms in plastic bags outside the service to take, but not allowing them inside. Some women also reported being refused contraceptives or denied the right to choose which contraception to use, as well being restricted from terminating a pregnancy. Women from Durban reported being unable to receive help from certain hospitals and clinics, as these directly refer them to services assisting people experiencing homelessness instead, where they might not have the types of services they were searching for or be suitable for women who use drugs.

Another severe breach of human rights reported by women in Pretoria relates to care workers be suspicious of and belittling women in cases of rape, using a supposed engagement with sex work as a reason to doubt a rape report.

> *I got a friend who was raped, and then when she went there to tell the doctor what happened, the nurses were like, "Are you not a sex worker?" They were harassing the lady with so many ugly words that she left the place without even getting help. (Pretoria, female client 1).*

In Cape Town, on the other hand, most women referred to experience good service from government health care facilities. Yet, some did perceive that they were not provided with the same quality of health care as the general population, and their cases were not treated with the same urgency.

Due to the unfair treatment many women receive from public health care, most request for harm reduction programs to offer such services instead: Sexual and Reproductive Health Rights (SRHR), food, shelter, gender-based violence, and others. They feel like harm reduction services are the only place where they are accepted, respected, and welcomed.

> *Sometimes nurses are like, "You're 30, but you are on ARV? You're sleeping around with men, carelessly". They will judge you. Sometimes you think, "Must I really go fetch those meds?" No man, I don't want stress in the queue. After the queue it's insults, after the insults, it's the judgments… This [harm reduction] organization makes it easier for us; it brings the medication to us. Sometimes they keep it for us in the centre, they count the pills for you for the week […] you feel more at home, you feel like you're with your sisters. You can talk about everything, no one's judging nobody […] If they had more medication for us here, it would be better to come here than to the hospitals and clinics (Porth Elisabeth, female client 11)*

[1] All the quotes were anonymized by giving interviewees a unique code. For women who use drugs, the code was female client and a number. For staff, the type of service they work for (harm reduction, shelter, GBV, nutrition, or skills development) and a number. In all cases, the city of the respondent is also mentioned.

> *At the government clinics, they don't treat us right because we are using drugs. They treat us like thieves; they see us as a threat. Even if you go to the clinic, they don't assist you with anything […]. We have no way to complain. We come back to [harm reduction program], even if we need other health assistance, we go to them, because they are the only people that can understand us. (Pretoria, female client 4)*

Legal barriers and law enforcement harassment

Besides perpetuating stigma and discrimination, criminalization of drug use and sex work adds legal and policy-related barriers that hinder access to fundamental human rights for women. The criminalization of drug use impacts accessibility to and obstructs the provision of harm reduction services. Law enforcement, for instance, may confiscate drug paraphernalia materials provided by harm reduction programs or deliberately target people who access these programs. In Cape Town and Pretoria, women recount moments where their needles were taken from them, a common occurrence also among males.

Women also reported specific gender-based harassment from law enforcement officials. In Cape Town, women mentioned having male officials searching them after requesting for a female official to complete the search. They also experienced being searched in public, asked to drop underwear/pants, and searched in the breast area. Moreover, women described being uncomfortably watched by security when trying to bathe or wash their clothes at the river and being instructed to use the bathroom with the door open while the security stands and observes.

A previous assessment on barriers to reducing harms among women who use drugs in Durban (12) found similar stigmatizing and violating experiences related to law enforcement. In the study, women recounted being treated like animals and called 'paras'—shorthand for parasites by law enforcement workers. They reported that police frequently dismissed their complaints and violations of their rights, besides subjecting women to searches, confiscations (of harm reduction material and medication) and detention based on their identities as people who use drugs.

> *The challenge that I see now is the SAPS [South African Police Service]. They don't understand the life we live as addicts because they fight with us most of the time. If they find you with syringes, they think maybe Harm Reduction is promoting drug use. Or they don't even know that there are places like Harm Reduction. So if you can come up with something that could help us with the police, especially, they can believe us. Because if you tell them 'I got this from this organization', they think we are lying. (Pretoria, female client 1)*

Other practices and laws have even more profound and debilitating impacts on women. Criminalization of sex work, in addition to the outlawing of drug use, negatively affects women's access to rights. Women, for instance, described having their reports of physical and sexual violence ignored by the police, who conflated rape and violence with sex work. Women in Durban, Cape Town, Pretoria, and Port Elisabeth reported being restricted from opening sexual and physical violence cases in the police station; they felt they were not being taken seriously and met with laughter, even if the officer had witnessed them being a victim.

> *No, they [police] don't help because they claim that sex work is a crime. When you go there, they don't listen to your story. They're just going to make a joke out of you. Then they say, "No, there's nothing we can do. We can't open a case. Who are we going to arrest?" (Pretoria, female client 4).*

> *As a prostitute walking in the streets, you can't call the police station and tell them the client raped you. The last time I tried it, they said to me that, "If they paid you were you going to come here? Because they didn't pay you, now you're filled with tears? Bullshit, just get out of here. We've got better things to do." (Port Elisabeth, female client 11).*

A 2017 assessment made with the input of 78 women who use drugs from Pretoria, Cape Town, Durban and Johannesburg, entitled "Were You Really Raped or Did You Just Not Get Paid?", reflects the same violent behavior from law enforcement authorities (20). These negative experiences with law enforcement dissuade women from reporting crimes against them and leaves them isolated in a place of suffering from violence and without any type of support. Additionally, law enforcement officials may reenact violence against women in even more brutal ways. In the group of Johannesburg, some women described being arrested by police and taken to a field where the officers raped them. Similar reports of sexual violence perpetrated by law enforcement officials were found in the 2017 assessment.

Besides directly breaching the fundamental rights of women who use drugs, the attitudes of law enforcement also create challenges for harm reduction staff when assisting women. Staff reported feeling they lack alternatives to guarantee the respect of women's rights.

> *When they get abused or beaten, we're like, "Go to the police station!" And then they say, "The police station? They secondary victimize us". Then what do we do? Then we're stuck because our project doesn't go further with legal issues. We end at the psychosocial or health sector. I think we also need that side of the project whereby we are legally helping them. (Pretoria, harm reduction staff 12)*

Besides, corruption within the police force may further hinder the manner that harm reduction staff protect the women they are helping. Several women who engage in sex work are exploited and/or abused by their pimps, even when working inside of brothels. Corruption, however, may personally endanger staff and organizations trying to report those cases.

> *Unfortunately, corruption in law enforcement makes things a bit tougher. Some of these [sex work] houses, the police do visit them. But because some of those police are on the payroll of the pimps, it's difficult for you to go and report. As an organization, we are only providing support in terms of health. Now, if we must go to the police to report, and then the same police will go to the pimps and say, "It's these guys who are reporting you." You know already where we are sitting, and as an individual, you can get gunned down … and you also put the organization into jeopardy or conflict. (Durban, harm reduction staff 6)*

Gender-based violence

Perhaps the major challenge for women who use drugs in South Africa is gender-based violence and intimate partner violence. Structural violence against women was mentioned by virtually all staff and women who use drugs interviewed for this report and in previous as-

sessments done in the country (12,20). Intimate partner violence, sexual assault and rape, as well as physical, psychological, and economic abuse were narrated as shared experiences of women who use drugs. As previously described, this violence endured by women who use drugs is perpetrated by the state, by other males in and outside the drug-using community, and by the clients or pimps of women who engage in transactional sex.

Women are in the most vulnerable conditions due to the intersection of their varied identities and contexts where their most basic human rights are violated - such as homelessness, engagement in sex work, and substance use. Women who use drugs and experience homelessness reported being robbed more often than their male counterparts. They are perceived as more fragile and less able to defend themselves and thus are a specific target of theft and rape.

> *I was abused maybe a month back. One guy attacked me in the middle of the night. They just came from nowhere and attacked me because they thought maybe I had drugs in my pocket and money. They wanted to search me, and they couldn't find anything. Then they beat me and took my phone. (Pretoria, female client 7)*

> *It is not safe for a girl to be sleeping outside. Guys take advantage of you. You smoked, you're high, goofed. You just submit to anything, like a man who comes in with a knife and say that "if you don't fuck me, I'll do this". We have the strength to fight, but because you're afraid that -I'm in the streets and in the bushes in the park, who's going to hear me if I try screaming? (Port Elisabeth, female client 11)*

Experiences of state-perpetuated violence and discrimination as described in the previous sections hinder women's trust in public services. They may lead them to accept situations of extreme violence and violation of human rights as a given. Women may shut themselves off from asking for help in fear of further judgment and violence, ultimately believing that nothing can be done to change their situation.

> *The bridge is not a safe place. I was staying with a dude about three-four years ago, and then he got arrested. I was left alone now there. I would go out, steal or get my money on the streets. When I came back, they would take that money from me. I put my money inside my bottom power to hide there so that if they come and touch me, they can't feel anything. I remember this guy…He stuck his finger in my bottom power to go and get my money because he knew we ladies put our money there. He beat me to a pulp, bent me over, and found his way into my bottom power, and took my money. […] And if you have a boyfriend, they will beat you. If you didn't go to the streets to go and get money or come back and you don't have money, it's a problem. […]*
>
> *Interviewer: Can't you do anything about it?*
>
> *What are you going to do? You go to the police station and say what? Because the minute you enter, "Hey, hey, hey. Out. Out, out, out. Go and sort your problems out." We don't get any help whatsoever, whatsoever. (Pretoria, female client 8)*

Structural violence against women is also heightened by the stigma and discrimination surrounding drug use. Women explained that their drug use is often exploited by men who tend to profit from a woman's dependency on drugs to exploit and mistreat them sexually. When a woman needs assistance with injecting or is ex-

periencing heavy withdrawal symptoms, males would often offer to assist them in exchange for sex. As the women are in a position of vulnerability, they may experience abuse from males in several ways in situations like these.

When women who use drugs engage in transactional sex, the risks of suffering from abuse and violation of rights are even higher. The impact of the illegality of sex work is worsened by the structural violence against women and general discrimination towards people who use drugs. Several women who are currently clients of harm reduction programs partaking in this assignment engage in sex work to provide for themselves, either voluntarily or forced by their partners and suffer from violence from both sides.

> *Most of them are sex workers, and they get raped by their clients on the street. A person would pick them up in the streets, and then they force themselves upon them or some promise to pay after they are done with whatever service they agreed upon, but then they don't pay. They end up beating them up and throwing them, for example, out of the moving car just because they're not paying […] If the partner knows that the lady is a sex worker, so they'll bully them into going to work even if they don't want to just because they need to do drugs. They need their next fix. If they don't want to, they beat them up. (Port Elisabeth, harm reduction staff 11)*

Female sex workers who use drugs are also more likely to work in unsafe conditions (e.g., street-level sex work) than their colleagues who do not use drugs. As a result, they are then more likely to have higher-risk sex and experience violence, making them more vulnerable to blood-borne infections and a wide range of sexually transmitted infections (22–24). Moreover, punitive regulations related to drug use and engagement in the sex industry may reduce women's ability to access harm reduction and other types of care services (12). Some houses in which women work or some of their pimps may intentionally maintain a woman's dependence on drugs to further profit from them. They may boycott women's intentions to reach a service or even their attempts to bring information and positive change.

> *When you are approaching, when you're trying to help, now you're against those who wanted to keep the girl on drugs because their purpose is that she must be on drugs so that they can continue making money on her, you see. For a person like this, every time that you're trying something, it's always going to bounce back because the sooner they're done with you, whenever they go back, there is a different conversation that takes place. There is no supporting system (Durban, harm reduction staff 6)*

Intimate partner violence

To protect themselves from experiences of violence, women may choose to have a male partner to defend them on the streets. Frequently, however, the same "protectors" will abuse and take advantage of women physically, psychologically, sexually, and economically. Intimate partner violence is another challenge, mentioned both by harm reduction staff and their female clients, and one of the most common forms of violence against women in general. It includes physical, sexual, and emotional abuse and controlling behaviours by an intimate partner, such as isolating a person from family and friends, monitoring their movement, and restricting access to financial resources, employment, education, or medical care (25). Some of these perpetrators, are also clients of harm reduction programs the women frequent.

> *We find that women are vulnerable, primarily those who are living on the street. Because of the dangers they face daily, she might find a boyfriend who will keep her safe and protect her. Once they are protected, that boyfriend can have power over her where they are going to abuse and exploit them. They might say, "Go and make money." They depend on men because they don't have shelter, they must support their addiction. They will have to resort to going back to those abusive boyfriends. (Ekurhuleni, harm reduction staff 7)*

> *When you depend on someone to give you a place to stay and food to eat, even if that person abuses you, you'll sometimes just stay because you're being fed; you have a roof over your head. Many of these women have left their family homes because, in our communities, there is a lot of stigma against substance users. So they come to town and start living in a group where it's easier because they're all substance users. No one will judge the other. You've been living there for five years. Your boyfriend starts abusing you, where will you go? You won't go back home. (Pretoria, harm reduction staff 15).*

> *In most of those cases, in the relationships, you find a gap in the trust. The male partners do not trust them, they'd accompany them [to group sessions], and they'd control them. For the incentives they get from the groups, they'd be bullied into handing over the money. […] Sometimes, you find that their partners beat them because they didn't see them at home where they had left them... (Durban, harm reduction staff 4)*

Several individual, societal and relationship factors are associated with a woman's increased likelihood of experiencing violence by her partner. Gender-inequitable social norms, poverty and low socio-economic status of women are important factors contributing to that. Previous exposure to violence and abuse or sexual abuse during childhood are also decisive factors (25). Several of these are present in the lives of the women who use drugs assisted by harm reduction programs.

The high rates of intimate partner violence experienced by women who use drugs negatively affects their lives in several ways, including physical damage, mental health problems, negative consequences to their sexual and reproductive health, harmful drug use, self-harm, and difficulties in adhering to care (3,25).

> *We see a lot of females don't stick to the program. I was always asking myself, "Why are they not coming as much as the guys are?" we then found out that maybe sometimes she can't come because there's the partner that says, "No, you can't go." Women are very restricted within their relationships, their roles of where you can go and what you can't do. There's also that thing of, again, empowering them to say, "Hey, this is your life. You need to take action." It's complicated to say to someone you need to act when they rely on them for survival. For most of the women that we see, they need a man to keep them against the elements, to survive on the streets. Sometimes you'd find that the woman is adhering to the methadone program, but then she can't even drink her OST properly because when she collects it, he doesn't collect his, then he takes her medication. (Pretoria, harm reduction staff 14)*

> *At times, you find out that the lady can't even come to take their medication because they fear their partner, what they might do to them if they found out their status. Or if they found out that they've been coming to meetings here (Port Elisabeth, harm reduction staff 11)*

Harm reduction staff generally realize that intimate partner violence may be tough to overcome. What might be interpreted as a woman's inaction may be the result from a calculated assessment about how to protect herself (and eventually her children). Women may stay in violent relationships for several reasons, including fear of retaliation, lack of alternative means of economic support, concern for their children, lack of support from family and friends, and love and the hope that the partner will change (25). Working with victims of violence requires special skills, yet, harm reduction staff, in general, is not trained or professionally educated to handle such complex and sensitive issues.

> *It's very difficult because these relationships are ride or die. You can have 100 sessions to tell this person, "Hey, this person is not good for you." She's going to come back and tell you, "I can see that [this] doesn't work. I can see he's not okay, but I love him." (Pretoria, harm reduction staff 14)*

Lack of privacy and confidentiality

Lack of privacy and confidentiality was mentioned as a challenge both by women who use drugs and staff working with them. Fear of breach in confidentiality can lead women to avoid talking about sensitive issues they need help with, such as gender-based or intimate partner violence, STIs or HIV status. It can also discourage women from frequenting services for fear of being identified as a person who has HIV, uses drugs, or as someone who is a victim of violence.

Women from Cape Town explained that they do not feel their privacy is respected when interacting with mobile outreach units, making them hesitant to access these services. Since many clients are always around the car, they find it challenging to find a private space to talk about more sensitive issues. For example, women mentioned their fear of having to fill a form where they would have to disclose their HIV status or of going to pick up their medication as they did not want to be identified as HIV or TB positive. In Pretoria, women referred to a similar anxiety about lack of privacy when getting HIV medication or tests results.

In Durban, staff noticed that during satellite groups done in open spaces (in areas far away from the service), it was difficult to guarantee the client's privacy since people passed by and sometimes would stop to listen to the conversation. In Pretoria, both staff and women who use drugs mentioned that some women fear to open about their experiences and problems in group activities promoted by the service because of possible breach of confidentiality by other participants.

> *They talk about gossip among each other. One of the ladies said, we were talking about HIV and AIDS, "No, I can't tell you guys anything, because the minute you tell people that, it becomes a community thing, so no, no, no, no, no." (Pretoria, harm reduction staff 14)*

> *Most of the time, when we come, we just sit on this side. Others, you'll see them sitting that side. We are not close. We are not together. The others, if we talk, they take our stuff, our privacy. When they see you on the street, they say, "You see that lady? At the [program], she was talking this and this and this"… (Pretoria, female client 2)*

Harm reduction staff also feel that confidentiality is crucial and should be addressed with women at the services. Especially due to peer work, they think that clients may fear that their stories can be shared with others. Staff suggested that this could be addressed with information, education, and communication—for harm reduction staff as well as for women who use drugs accessing the services.

> *I think in training we should emphasize confidentiality. Because women are very sensitive, they like to keep things to themselves; they don't like the world to know what they go through without saying anything. We must assure them that whatever they say to us, whatever they discuss, is not going to go out there, and the whole world will know that: "You are a sex worker, you are injecting, you are whatnot". […] Especially because most of the staff we work with is people who are used to them, they're like buddies. So, they feel like, "If he knows about me, then he's going to tell the others." (Pretoria, harm reduction staff 12)*

Especially regarding violence, women may fear that their testimonies reach their perpetrators, either via staff or other women partaking in a group activity. Ultimately, if a service cannot assure privacy and confidentiality, it can encourage the behavior of avoiding care, which can further push women who use drugs into isolated, hidden, and unsafe spaces.

Family relations and stigma

WWUD from Durban, Cape Town, Pretoria and Porth Elisabeth explicitly mentioned that stigma towards drug use is worse for women. They see a general perception that, while it is okay for men to use and inject drugs, for women, it is not. Women described to be discriminated against by society in general, establishments in the vicinity of harm reduction services they frequent, and by the drug-using community. This stigma faced by women who use drugs is also clear to the staff of harm reduction programs.

Stigma against women who use drugs was mentioned to be especially present their families of origin. Several women have left their families due to their drug use or are now in a position where they are blocked from returning. Some women left rural areas to search for employment or because they were promised a job that would allow them to support their families, just to end up being tricked or manipulated into the sex industry. Others also left their home due to repeated abuse inflicted on them by members of their family, such as child sexual assault or intimate partner violence.

> *When I opened up and told my mom about the incident between my uncle and me, it was just horrible. She's my mom; I forgave her. I love her, but she should have acted better. She should have stood by me as a daughter, but she made me feel I'm the one to blame. I was only eight. How can I seduce a 50-year-old man at the age of eight? She suggested it stays a family secret. That's her brother we're talking about. I must dare not ever even utter this to anyone else. I had to deal with it alone. (Port Elisabeth, female client 11)*

> *Rape is one of the biggest challenges and trauma from childhood because when you have sessions or when you engage with women, they will tell you that one of the biggest reasons they left home and are homeless is because of trauma, childhood trauma, most of them rape. They were raped, and then they end up on the street,*

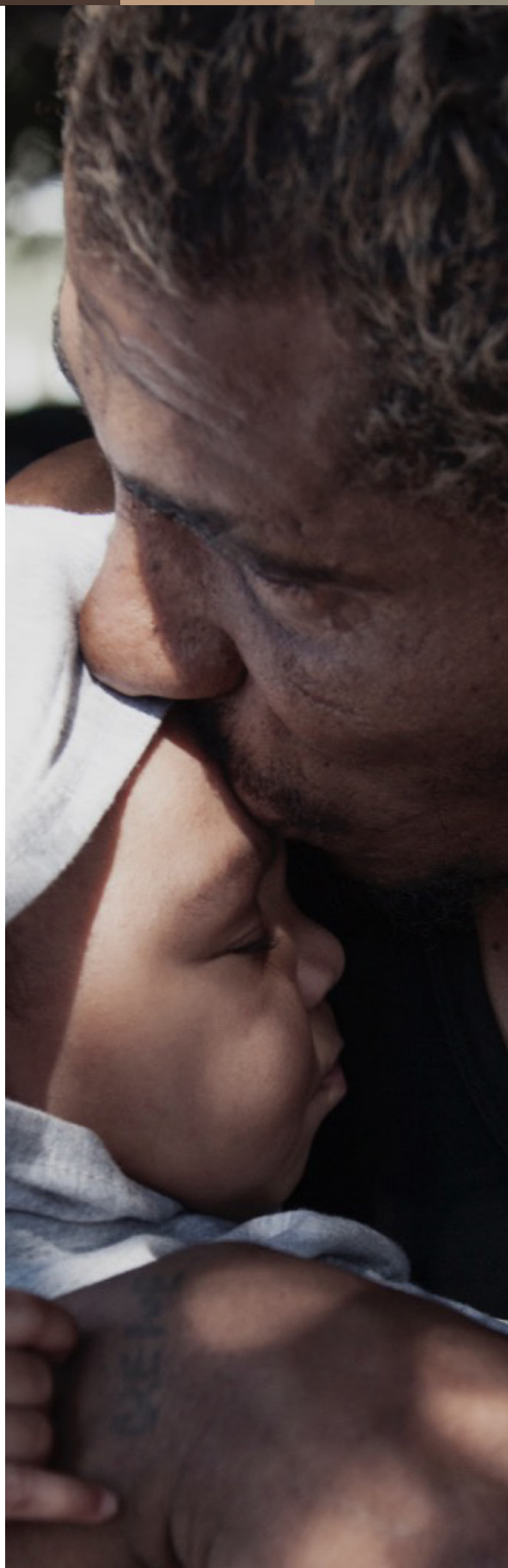
running away from such perpetrators from home. (Durban, harm reduction staff 3)

At the same time, harm reduction staff mentioned the desire of working towards a goal of family reintegration. To them, bringing women closer to their families of origin and assuring their families could support them was seen as a chance for women to leave the streets. Staff saw a (re)united and happy family as a possibility that would make women feel loved and protected.

> *It would be nice to organize a family day, where they would have a picnic with their families, their children, provide drinks and snacks in the process of building those relations back at home. […] Even if it's an activity, walking down memory lane when they were still kids, what are the best memories that the parent remembers about the child? What are the best memories that the child remembers when they were back at home? Things that they can motivate them, give them the hope that they're still loved. It's not that their families have given up on them. (Durban, harm reduction staff 4)*

A few women also mentioned the desire of being reunited with their parents and would like to have help to achieve that.

> *Some of us can't of go back home. They have chased us away at home because of things we had done while smoking drugs. You find that now you are clean, you no longer smoke drugs, but you are still on the street because you can't go home. No one can go with you to your parents and ask for forgiveness and tell them that you've changed, you're no longer smoking drugs, you understand? If you have a social*



worker, at least she can monitor you; she can take you home, sit with your parents down, talk to them and tell them that you have changed (Pretoria, female client 2)

Nevertheless, staff also describe that even when some female clients eventually stopped using drugs and managed to get accepted back to their family of origin, this was not without significant challenges and was sometimes unsustainable.

> *… she changed her life, then she moved back home, and her kids were happy to see her because remember there's always that maternal-- They're happy that she's back. They gave her a little room. When the kids came back from school, they started going to her in the room outside, and then granny didn't like this. It was a problem with granny to say, " now she is trying to change these kids against me." It became an issue where she ended up moving back out of the house because it was a fight for the affection of the children between the two of them. (Pretoria, harm reduction staff 14)*

Parental rights and motherhood

Stigma towards women who use drugs is even more acute concerning women who are pregnant or have children. Laws designating drug use as criteria for loss of child custody can further legitimate discrimination and discourage women from accessing services. The threat of children being taken from them 'for their own protection' remains a constant fear and barrier to women accessing harm reduction services (24). According to staff, the general strategy at Child Welfare in South Africa is that parenting rights are to be removed if the parent uses drugs. The Children's Act declares that social workers must look out for the child's wellbeing, while making the generalization that a parent who uses drugs will not be able to make the right decisions, and thus, unable to care for the child.

An added difficulty relates to the functioning of the child welfare and benefit systems. In South Africa, children from vulnerable families can get a welfare grant of about 350 Rands (the SASA grant). To get this benefit, the mother must get a card and verify their fingerprints. However, it may happen that some women who are dependent on drugs get the money and "disappear" for a while, leaving the children for the family to take care of. This puts extra economic strains on the family, who then prefer to forcibly remove parental rights and place the children into foster care. With foster care, the family member assigned gets a slightly higher amount than the 350 Rands for the children grant. They also have a court order that impedes the mother from coming in and taking the child. While this option may make it easier for the family to handle the situation, it deprives women from their right to be a mother to their children.

In Nelson Mandela Bay, women described it as extremely challenging to live without and not see their children. Women from Pretoria mentioned the importance of being able to rely on harm reduction programs to help them care for their children, to retain their parental rights. Women partaking in the group in Durban mentioned that those having children and living on the street should be assisted, as this is difficult to take care of a child while using drugs and experiencing homelessness.

> *We run away with our children from our homes. We start from the streets. It's not easy to give any social worker a child because they could take your child, and then they will never make follow-ups for you. As an addict, they know you*

will never follow them because it's difficult, financially it's difficult. The situation that you are in, it's not simple for you to follow them. If it's [harm reduction program], I know I will feel free if they can take my child because I know they will follow me. I'll be able to access my child. It's what I want because it's not that I give away with my child just because I don't want him or neglected him. It's just because of the life they are living (Pretoria, female client 6)

Staff from Durban, Cape Town and Pretoria perceived the need to have childcare services (or a child-friendly space) for their clients who have kids so that women could partake in groups and appointments without having to mind their children at the same time. The program in Durban investigated the possibility of having daycare within the harm reduction service but noticed that it would be virtually impossible given the current regulations in South Africa. A childcare center needs to be registered at the Department of Social Development. Since harm reduction programs are spaces involving people who use drugs, it can be very challenging to get permission to also register for the care of children. Another possibility identified by harm reduction staff is to develop partnerships with existing child-minding centers. Yet, the situation of women's homelessness and the working hours of regular child-minding centers may not be conducive for catering to women's needs. Women may need a safe space where they can receive support to be with their children, and at the same time, be able to restructure their lives with work activities and health care. Shelters focused on women who use drugs and experience violence exist in other parts of the world and have successfully supported women who use drugs with children (10).

Given the current lack of support, most of the female clients of harm reduction programs with children have left them with their families of origin. These women rarely see their kids, and when they do, staff described that as a complex and emotionally triggering arrangement.

> *Because they're on the streets, they can't have access to their kids. Even if they want to meet the child, sometimes we would arrange meetings with the family and bring the child over because families don't trust them around kids, especially users. Sometimes, families feel like if they take the child to the mother, it's going to disturb the routine of the child because now, obviously, the child will see the mother, get used to being with the mother, and then the mother will be back on the streets again. It's also saving the child from the emotional pain of looking at mom like that. Even the client themselves, some of them don't feel comfortable seeing their kids under that state. They say, "No, I don't feel comfortable because what am I teaching my child when they see me like so dirty using drugs?". (Port Elisabeth, ham reduction staff 9)*

Women from Nelson Mandela Bay and Johannesburg requested assistance to help them see their children and become more present in their lives. They described that after years of separation, they needed to learn how to reconnect and communicate with their children. Women also felt that when their family's expectations are too stringent, their family loses hope and suggest parental skills programs that could teach them how to relate with their children.

Self-stigma

Experiences of stigma and discrimination on account of being female, homeless, a person who uses drugs, or a sex worker are often internalized; this can result in low self-esteem and self-worth, creating a feeling of being undeserving of being healthy and negatively influencing women's health-seeking behavior (26). The 2017 assessment with women who use drugs in Pretoria, Cape Town, Durban, and Johannesburg (20)

found that negative self-image was common. Negative self-beliefs are reinforced by repeated acts of violence and harassment, leading women to disregard themselves, their health, and their well-being. Both self-stigma, negative experiences and expected discrimination led to decreased access to health care and an increased isolating behavior, putting women even more in danger of further violence and harm. Similar findings were reported in the current assessment.

> *In clinics and hospitals sometimes, you need to take off your clothes for a checkup, and then you're like, "Oh God, I injected heroin in my arms I'm full of checkmarks, I wonder what she is going to say now when I take off my top. Oh, God." It makes it difficult; I'm not going there. (Port Elisabeth, female client 11)*

Internalized discrimination may also push women who use drugs to have relationships only with a partner who also uses drugs, fearing not being understood or accepted by someone who does not use drugs. Self-stigma can also lead women to take discriminatory, humiliating, and violent behavior as expected or "deserved". Moreover, women may buy into expectations that they should be the caregivers, accommodating and subordinating their needs to those of men, which may serve as a barrier to prioritizing their own health and wellbeing (27). As noticed by harm reduction staff, self-stigma triggers some women to remain in abusive relationships, even when they have conquered a more stable life.

> *When the males quit [drugs] for real, and the girl doesn't want to quit, he generally leaves her. But I've seen with the girls that when they quit, they find work, and they do well, instead of leaving this person, they will support his habits.*

> *I had a client in an abusive relationship, she was doing well, had a good job, but she kept him. I was like, "But why are you still keeping him. You're always complaining about him?"[she answered] "Because who's going to take me now at this point, with my history?" The self-esteem in females is very low. In the end, it is a reason for accepting violence. Also, the thing of, "He took care of me when I was in the streets. I would have died if it wasn't for him." (Pretoria, harm reduction staff 14)*

Lack of nutrition, clothing, and hygiene

Women from all cities partaking in this assessment reported little to no access to services providing nutrition, clothing, shower facilities, and hygiene products. Also, in the evaluation made in four South African cities in 2017, women who use drugs lacked these essential commodities (20). Some women mentioned that one of their biggest challenges is not having a standard place to bathe, leading to poor self-care and hygiene. Certain items, like toiletries and sanitary pads, are currently provided by some harm reduction programs. When available, the provision is much appreciated by the female clients, yet the current provision remains insufficient to cater for women's needs either by being offered irregularly or by having a lack of supplies.

> *We need cosmetics to be clean and bathe, like maybe toothpaste, roll-on and toothbrush, facewash, and even soap to wash our own clothes because we don't have many clothes. I have two pairs of jeans so that when I take off this one, I can wash another one. So that we can be clean even on the streets so that people mustn't treat us like garbage because people call us names because we are dirty. We need clothes so that we can change. (Pretoria, female client 2)*

Sanitary pads were also highly appreciated by women from several cities. Some harm reduction programs are currently distributing them, but it does not fulfill the unmet needs as the frequency is not sufficient, the available choices of sanitary products is not in line with their personal context, and because they lack private spaces to clean themselves while living on the streets.

> *As much as we try to give them once a month, there's not enough stock (Port Elisabeth, harm reduction staff 9).*

> *The females are always looking for pads and things like that. We even had a focus group to see what we could cater for them. They wanted more disposables than reusable. Because they don't have water to wash reusable pads on the street, and then it stains and things like that. (Cape Town, harm reduction 2)*

Women from Cape Town, Durban, Nelson Mandela Bay and Pretoria suggested that food, clothing, blankets, and hygiene packs (with toiletries, underpants, and sanitary pads) be given as an incentive to participate in harm reduction services, such as outreach and female-focused workshops. Staff agrees that these benefits are essential and must be provided to improve interest and adherence to harm reduction services.

> *I think they're thinking, "I'm going to spend the whole day there. First, I'm not getting something to eat, and then I will spend four hours there. That means my hustle for the day is gone." There's always some incentive that we think as users we should get to be in a particular place for a certain number of hours. Otherwise, we'll see that as not beneficial to us. Currently, with our DIC, we don't have a lot of things, so that's why I think the ladies are not coming. We don't have washing powder for them to do their laundry. We don't have a meal for them. (Pretoria, harm reduction staff 13)*

Harm reduction staff from Durban, Pretoria and Port Elisabeth mentioned that offering nutrition to women once they come to the service can improve adherence to different types of health treatments. For example, by providing food to women who use drugs, this can help them handle the side effects of heavy medications (such as for HIV/TB/hepatitis) which sometimes need to be taken with food. To be able to be at the harm reduction service without having to search for nutrition somewhere else is an important aspect for women who use drugs, as it reduces the number of places they need to attend. Some of the programs, however, currently miss the funds to offer that benefit.

> *Some of the women will tell us, " Sister, I just need maybe two fat cakes, or three fat cakes, so that I'll be able to swallow this medication." Most especially TB treatment. It makes them sick when they didn't have anything like a foundation on their stomach. (Port Elisabeth, harm reduction staff 10)*

> *What I've discovered is in terms of having meals for clients, that's one of the biggest challenges because clients will say: "We'll come, but we'll even get food and all of that?" ... (Durban, harm reduction staff 3)*

> *We were offering food on Monday, Wednesday, and Friday, but because now there are no more [donor] funds, there's no food. […] We used to get a lot of people that we're adhering to their medication. It was very helpful. Because they had no reason not to take their medicines because sometimes, they say, "I did not take my medication because I was hungry. I didn't have money to get food." Even if they do get money, they will prioritize the drug more than food. It's a given. At least, if they're getting the food for free, it's beneficial for them (Port Elisabeth, harm reduction staff 9)*

Providing nutrition may not seem, at first sight, a goal of a harm reduction program. However, it has been shown that food in a harm reduction service dedicated to females increases their engagement, helps them feel supported, and mediates the impacts of poverty that these women face (8).

Lack of shelter

Female clients at and staff of harm reduction services both requested the availability of shelters for women who use drugs. Participants made a similar request on the 2017 assessment (20).

> *We must add even shelters; too many ladies, most of us are sleeping on the streets. We don't have blankets in the first place and where we are sleeping is not safe. I think if you add a shelter for us where it's going to be only women's where there won't be men, we can at least be safe because on the street we are on the risk, we can get sick, we can get raped, we can get all these problems because we are on the streets. If you get us shelter, I know that all the women will be safe (Pretoria, female client 2).*

The scarcity of shelters seems to be a reality for people experiencing homelessness in general. Harm reduction staff trying to place clients into shelters mention that these clients are often denied due to a lack of space. Even if there are vacancies, there is a lack of equipment and resources such as mattresses and blankets. Shelters are even rarer for women who are victims of violence, and access gets further complicated when women who have experienced GBV are using illicit substances. Most shelters have strict rules that are difficult for women to comply with in order to join and stay in the service. These requirements may be related to obliging abstinence and enrollment in a drug treatment program, having a valid ID, or to lacking the understanding that even those enrolled into OST may need some special arrangements to make sure they can keep accessing their treatment while in the shelter.

> *They are not supposed to use on the premises. Once they are caught using on the premises, they're chased away. Secondly, they're not supposed to come to the premises intoxicate; they must be sober. If they are not sober, then it's an issue for the shelters. It's a bit of a challenge. It's only people that are currently on the methadone program that they agree to take to the shelters. Also, we put our head on the block for them making sure that we tell them, "You stick to the rules because if you don't, they'll chase you out". Once they chase somebody out, it's difficult for us to re-refer that person again (Durban, harm reduction staff 5)*

> *Again, it is difficult to work with clients who are using heroin because you can't just remove them without medication like your methadone or your OST Programs and move them into a shelter. What you find is, immediately after we place them there, the following day, they are*

gone because of withdrawals and all of that. (Durban, harm reduction staff 3).

Shelters may also have a fee the client needs to pay to enter. Even though the cost may be low (around 30-50 rand), the amount may be too high for women. Some harm reduction programs had a specific budget to support clients going to shelters in the past, but it is no longer possible due to funding changes.

In this context of scarcity, when placing clients into services, harm reduction staff must prioritize and focus on the most vulnerable out of a population which is in great need across the board. These can be, for instance, those women who suffer from violence and are currently pregnant. Recognizing the low success rate in securing shelter, most staff mentioned relying on the strategy of tracking down women's families of origin with the end goal of reuniting the client with their family.

Finally, even those clients who could secure a place in a shelter report to find it challenging to cope with the regulations and overall stigma around their identities. They may hide their drug treatment or visits to a harm reduction facility in fear of discrimination or being expelled from the service.

> *I stay in a shelter for women victims of violence. If I have to come here [harm reduction service], they start to ask, "Where are you going, to do what?" You must register; you must sign when you're going out. Luckily, today, I decided to come for an interview here—and I had to go for my treatment, so that's how I asked. Sometimes they find challenges to put it in the way, and I don't want to give them that picture in which I'm a smoker. If they know that I'm a smoker, they won't feel comfortable being with me around them inside the yard. Even myself, I won't be*

comfortable. You know how painful it is when you come, sitting with people like this, they start putting their things away. Those are the things that I don't want. (Pretoria, female client 3)

Unemployment and lack of (formal) skills

Women's most basic human needs such as nutrition, hygiene, shelter, and safety are often not met due to economic poverty. Unemployment and lack of income are major challenges for the South African women who use drugs who partook in this assessment. In the 2017 assessment, many WWUD referred to resorting to begging, working as a sex worker, or, in a few extreme cases, engaging in acts of petty crime to attain essential items (20). Participation in sex work was a common way that these women could secure an income. Nevertheless, the criminalization of sex work paired with gender-based and intimate partner violence pushed these women back to experiences of profound disrespect of their rights.

It is tough to hustle in the streets; we do not have the muscles to carry things to the scraps as men do. So, for us to make sure we have a drug to smoke, we do sex work. Sex work is the highest source of income and yet a tough one because we live in the streets and there is no water to bath. We must sleep with different men in that condition. And as we are heroin smokers, men do not have any respect for us. Once they get the sex, they call us names and they get rid of us like dogs. At times they take us to distant places where people cannot see them, and once they ejaculate, they spit on us like we are dogs and call us names (Johannesburg, female client FGD).

Moreover, staff described that racism intersects with stigma for sex work and drug use to create even more challenges for black women, who may be less valued in transactional sex when compared to white women.

Amongst black males, sleeping with a white woman is still considered … there's still that-- She's going to get a little bit more-- She can be able to get someone who's going to take care of her better than what he would with a black woman. There's still that whole thing of-- To also accept that no, they don't get treated the same. Even when they are prostituting, the price is not the same. Black women, people are doing sex for five Rands…. (Pretoria, harm reduction staff 14)

Both women who use drugs and the harm reduction staff working with them mentioned that the lack of skills and formal education hinders women from finding healthier and more sustainable ways of assuring income. Women partaking in the groups in Nelson Mandela Bay and Johannesburg asked to be assisted with finding a job and to be given short courses to improve their skills. Women from Pretoria and Port Elisabeth also asked for skills development, educational opportunities, and aiding in securing employment.

They say knowledge is power so accessing skills development it will be great for some of us. (Pretoria, female client 1)

We need activities, skills. They can teach us work like handwork, anything so that we can be independent. We can work for ourselves. There are many activities they can teach us. I if can get

some of these skills like this. It will be better if they can offer us so that we can stand for ourselves. (Pretoria, female client 6)

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For me, I have criminal records. Obviously, being employed for me is going to be a hard thing. It's not something that's just going to come easily. If I had certain skills […] even just a little bit like business ideas and business classes, even if I want to start selling something […] I'm sure, sister, if I'm doing something now that is generating income for me. I'm waking up in the morning, I'm doing something besides stealing or selling myself, I'm going to feel proud of it. (Pretoria, female client 8)

Staff from Durban, Pretoria, Port Elisabeth also mentioned the importance of skills development workshops for women who use drugs to help generate income and facilitate their formal education. Those working in harm reduction services also indicated that dependent drug use is often associated with line of work, especially for women engaging in sex work. Finding alternative income generation methods can help women leave a context where they are vulnerable to violence, reduce the harms of their drug use, and empower them to become economically independent.

It is crucial to choose skills that both attend to women's needs and are pragmatic in terms of their possibilities and environment. In that sense, many staff pointed at hairdressing and beadwork as two areas in which women declared to have interest and, at the same time, do not require a higher degree of formal education – which most do not have.

[2] Also called grade 12, the last year in high school.

“

Most of them, they don't have matric [2]. Some of them have never even been to high school. Some who went up to primary school don't even know how to write correctly. They want to learn computer skills…(Port Elisabeth, harm reduction staff 9)

“

There's not enough offer of interesting skills. Once you get into the system of you didn't finish your matric, you dropped out of school, everybody thinks that people want to grow a garden. They don't want to grow a vegetable garden; they don't want to sew bags. People want the skills that they want because it's attractive to them and that is fair. We're all different... Then there's baking. Most of the ladies we have had don't even have cooking skills because the person has been in and out. She doesn't want to do that. What most of them like is beauty. This whole beauty thing of doing hair, doing nails, because they've been doing it. Even when they were down and out in the streets, they were still trying somehow to get their hair done, to get your nails done. (Pretoria, harm reduction staff 14)

Skills development workshops are currently happening in a few harm reduction programs partaking this assessment and are highly appreciated by the clients. These services are mentioned in the section “existing services and networks”.

Centralized services and lack of transport

Women, in general, did not mention having challenges when accessing harm reduction services, where they felt welcomed and were thankful for the provisions they received. The location of services, nonetheless, represented

a barrier for some. In Pretoria and Port Elisabeth, women mentioned that accessing harm reduction services was challenging due to not having services in the areas where they live/stay and lacking transportation to get to the regions serviced. Also, Nelson Mandela Bay participants mentioned being unable to afford transport to the Drop-in Center, which was located too far away. Women from Cape Town added that some live further away from where the outreach team is located, making it harder for them to receive enough needles for the week. Staff from Pretoria, Port Elisabeth and Durban also recognize the challenge and mentioned that they no longer have financial support to reimburse clients' transportation, which restricts access for those living far away from the premises.

Moreover, female clients pointed out that there are still many women who use drugs are who are not being reached. Women from Durban and Cape Town mentioned several areas wherein the outreach team is absent, but where is a great need for women who use and inject drugs. Women have asked for transportation support and decentralized services so that those living in remote areas can also access harm reduction.

> *There's no [harm reduction program] where I come from, so sometimes I will miss my appointment because I don't have money for transport. […] Where I come from, especially with women, I would appreciate it a lot if you could at least reach out to those hidden women in the location. Not only focus here on the cities (Pretoria, female client 1)*

To cope with the distance gap, teams from Port Elisabeth and Durban have tried to bring female-specific groups and activities to the areas where women are far away from the service. Although groups seemed to work, it was difficult to overcome challenges like distance, timing, logistics for carrying mobile tents, and guaranteeing safety and privacy for staff and clients.

> *Sometimes it's time because those spaces are pretty far. Perhaps it is an hour drive to those places, and by the time you get there, maybe the clients are not there, or they've been waiting, because we also have other things that we need to do. […] If you wait for the client, it affects the service delivery because you also need to go to other sites and continue the work. The team drove for an hour to get there. They can't leave the social worker alone to render services; they wait for her […] It's also a matter of finding a not dangerous place, mainly because our social workers are females, so they are places where they don't go. (Port Elisabeth, harm reduction staff 9)*

> *We end requesting an Uber's to make sure that we get to the place and come back. Sometimes you must carry things like a gazebo and chairs and stuff, but because we don't have a mobile car, it's not possible. If maybe we would have a mobile clinic with consulting rooms so that we can also have a private professional, space with our clients, and mobile, so that we can move it to wherever we need to go at that moment. Because you find that sometimes when you must do counselling sessions in an open space, it's difficult for you to gain rapport with the client. (Durban, harm reduction staff 5)*

Transportation was also mentioned as a problem to reach public health clinics and hospitals.

Lack of programs for non-injecting drug use

The assessment in five South African cities in 2017 identified the lack of harm reduction services for individuals who did not inject substances. Little information on safe drug use was available for those who used crack cocaine or methamphetamines, and no harm reduction supplies specific to these drugs were distributed (20). Four years later, despite some activities dedicated to the harm reduction of stimulant use, the lack of attention to non-opioid drugs and non-injecting drug use seems to remain.

In Cape Town, staff mentioned having distributed harm reduction kits for people who use stimulants in the past. They contained vitamins, water, oil, and bubble gum and were popular among women who use stimulants. The program no longer has these kits, and staff noticed that it created difficulties in assisting those primarily using stimulant substances. In Port Elisabeth, staff mentioned that only condoms and lubricants are distributed to women smoking crystal meth since other services are solely focused on those injecting their drugs. Staff from Durban and Pretoria also feel that they cannot properly assist individuals who are not injecting. They fear that this imbalance may lead women to switch to injecting drug use to access the benefits offered. Worryingly, they have already seen this happening.

> *We don't have hygiene packs or COVID packs for them as our funder is only catering for injectors, so if they're not injectors, it becomes a bit of a problem because now it puts them at a disadvantage. It brings up that mentality that somehow "are you guys suggesting that I start injecting so I can be able to get all these benefits?" (Durban, harm reduction staff 4)*

> *I think the project was made like that to assist injecting drug users. […] And especially now that there are incentives, women will be like, "Oh, so only the injecting women are the ones that are getting services like incentives," so I'm going to stop smoking and inject, then I'll get services", which is-- it's not what we want! (Pretoria, harm reduction staff 9)*

Women who smoke their drugs also mentioned that programs should not forget about them and should inform them about services which are not restricted to those injecting their drugs. As they usually see outreach work distributing needles, many think that help is there only for those injecting. At the same time, services such as HIV testing and counselling or referrals to other SRHR services may be available for everyone, independent of the type of substance or route of administration.

> *For some of us smokers, we only know that you guys help with the drug habit. We're not aware of your clinic, of all the services we can find here. Because when they [outreach] come, they come to change the syringes most of the time. (Pretoria, female client 3)*

Existing services and networks

Harm reduction

Services offered to WWUD

Harm reduction programs in South Africa currently offer several services to their female clients, although some are gender neutral and not female-specific. Below are the services mentioned by female clients and the staff of harm reduction services when assessing services for women.

NSP, OST, DIC and outreach work

All harm reduction programs partaking in this assessment conduct outreach work and have needle and syringe programs (NSP). Several women mentioned getting their syringes from programs like this and have subsequently learned how to inject safely. Some participants had specific requests in terms of material, e.g., tourniquets with a belt and small syringes, as they believed it would fit better their smaller arms and veins (in comparison to men). Programs in Durban, Cape Town and Pretoria also have a drop-in center. In Pretoria and Durban, Opioid Agonist Treatment (OAT) is provided in collaboration with other organizations, but provision is not enough even in these places, and several female clients have requested more availabilities to access to OAT.

However, the programs are generally gender-neutral and not designed to assist women who use drugs; there is an exception for some specific female-only activities and, in a few cases, female-only service hours (as explained in the following sub-sections). Although most harm reduction staff interviewed recognize that women have specific needs distinct from their male counterparts, the general idea is that harm reduction programs need to be there for everyone, without being exclusive or gender specific. Harm reduction staff often sees the lower rates of participation for females as related to the lack of certain benefits, not to the lack of designated spaces for women. Those who do work in female-specific activities believe that services that cater to solely women are needed, even if their organization is meant to assist all genders and sexes [3].

> *There aren't any specific hours at the DIC for women or for male. Everyone just pops in. (Durban, harm reduction staff 2)*

> *I'm battling to get the ladies to come to our DIC. For some reason, I'm really battling. The guys do access the service, but I'm not sure why the ladies-- I try preaching this as much as I can to say that this is where you come just for personal hygiene. We've got showers. It's a mission to get the ladies to access this service even though they're quite aware. One of the reasons why I think they're not attending is, for example, one of the benefits of attending a drop-in center is that you'll get a meal, and we currently don't*

[3] When talking about female-specific or female-only activities and services, we mean people who identify with the female gender, not necessarily people born with the female sex. A few staff mentioned the harsher conditions for trans sex workers, the higher rate of violence due to the even more compounded identities when being trans, or the experiences of trans men and women being assisted in the services. In one or two cases, staff mentioned transgender women being assisted in female-only groups or spaces.

have that. […]so that's why I think the ladies are not coming. We don't have washing powder for them to do their laundries. We don't have a meal for them. We're not giving out anything on the DIC. (Pretoria, harm reduction staff 13)

SRHR services

Services attending to sexual and reproductive health (SHRH) were offered by most harm reduction programs partaking this assessment. These include condom distribution, contraception and family planning, tuberculosis screening, testing and treatment for HIV and other STI's, sometimes access to PEP and PrEP, as well as psychosocial counselling for mental health and addiction. These services (except for family planning) are often offered for both male and female clients without distinction. Nevertheless, female clients, especially those engaging in sex work, seem to access these types of health services relatively more often than their male counterparts, despite being the minority.

Most often they access STIs medications because, you see, even the negotiation of condoms becomes a challenge for them. Also, when they're high, it becomes difficult for them to use condoms and all those things. The chances of them not just becoming HIV positive but having all vaginal infections may pop up more often. That's one of the things that they try to access most. (Durban, harm reduction staff 5)

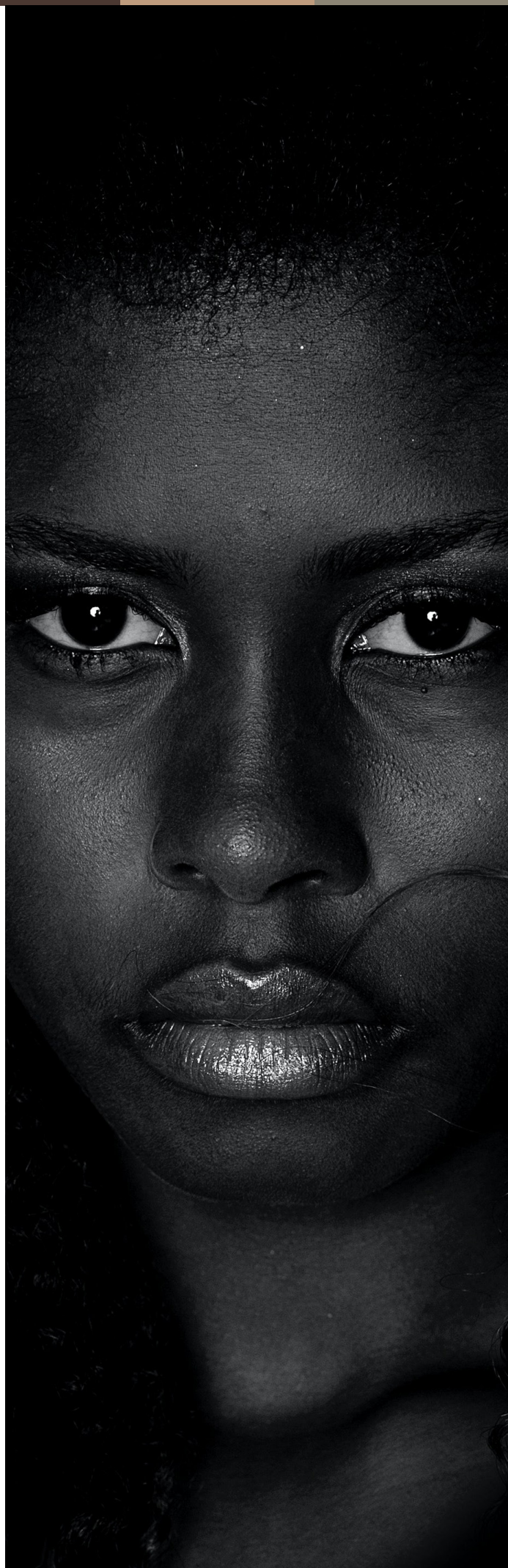
Female clients appreciate the services, especially the fact that several services can be accessed under one roof. As explained later (and in the needs and challenges section), women have a strong preference for accessing SHRH and other services at harm reduction programs instead of public clinics.

There is a lot of things happening here. When I entered, I found that they also do like HIV testing and counseling, putting into treatment, only to find out, I was positive. I was starting to default because of me using drugs, I never got a chance to go take my medication. By the time I got into this yard, I found the good services that they've got combining everything. It was amazing for me. Those are the services that you're getting here. Good services, so far. (Pretoria, female client 3).

For pap smears, termination of pregnancy (TOP) and other services, programs mostly refer clients to public health clinics and hospitals. Both staff and women mentioned the desire for pap smears to be offered by harm reduction programs as well. A few clients also asked programs to offer prevention of mother-to-child transmission (PMCT) for women of reproductive age living with or at risk of HIV, which would help maintain the health of the mother and stop their infants from acquiring HIV.

Female only hours

One way of offering women more targeted services and attention is to offer female-only hours at services commonly provided in a gender-neutral base. Harm reduction programs in Pretoria and Cape Town offered female-only hours in their drop-in centers, usually around the hours the female-only groups occur. The main reason was to allow women to use the showers without having men around. Staff perceived that woman felt more comfortable in female-only spaces and cherished that as their "own space". Female clients also appreciated the dedicated space and reiterated that they feel comfortable showering while men are not around.



> *We are not comfortable when we're sharing with men, because sometimes I can get into the shower and then I'm naked. A guy can come in without knowing that there is somebody there. He can barge in, and then you can see it's going to make a problem. (Pretoria, female client 4)*

Female-only spaces can help women to feel more at ease and can aid in to building trusting relationships with staff and other women by being open about their problems and needs. Previous research has shown that women may feel or be threatened by men in mixed-sex or mixed-gender spaces, and their past negative experiences related to gender based violence may hinder them from frequenting mixed spaces (8) Women from places where female-only hours do not exist requested such space. The request for female-only hours was also made by participants of previous assessments in South Africa (20). The need was acknowledged by harm reduction staff working in programs where this is currently unavailable.

> *The clients have called for that previously, but due to staffing and the resources, it's a challenge. It's something that I think could be very beneficial for our clients, especially women who use drugs. (Durban, harm reduction staff 3)*

> *I think in terms of the privacy of females to have their own time is needed so that they can be able to say, "I need pads. I've got this." Without having males around to hear or them feeling like they can't ask for such things. In terms of privacy, it would benefit them to have it [female only-hours] (Port Elisabeth, harm reduction staff 9).*

In Cape Town and Port Elisabeth, staff also mentioned having organized one-off events focusing on women, such as a gathering where women could get new clothes and make up or a group visit to the swimming pool or the beach. A few clients from Pretoria also showed interest in having these types of events dedicated to women.

Distribution of sanitary pads and other female-related items

Several harm reductions programs that partook in this assessment provide sanitary pads and other products to clients, such as make-up items and toiletries. Nevertheless, these services are normally not long-lasting or regular due to a lack of supplies and funding. In the places where this provision is currently not being offered or is insufficient, clients have requested it, such as in Durban, Nelson Mandela Bay, and Cape Town.

Sanitary pads, especially, are highly needed and appreciated by clients. Nevertheless, not always the pads available meet the needs of women experiencing homelessness; besides, clients mentioned the need for underwear as well, not only pads.

> *Currently, we do have pads, but they are those reusable pads. […] We do give them obviously, it's what we have, but ideally, you would want to have a pad where you can just use it and throw it away. If you're in the streets, where are you going to wash that hygienically? (Port Elisabeth, harm reduction staff 9)*

Female-only support groups

Providing psychosocial counselling groups for women has been a way for harm reduction programs to support female empowerment. These groups currently exist in Durban, Cape Town, Pretoria, Ekurhuleni, and Port Elisabeth. The groups occur once or twice a week (once a month in Ekurhuleni) and are coordinated by a social worker and/or psychosocial counsellor. When the organization also has a drop-in center (DIC), they may restrict male access to their center while the group is running or in the hour preceding the group, so that women can use the shower and other facilities without having men around.

Several themes related to being a woman who uses drugs were discussed in these groups, such as: sexual and reproductive health, STIs, family and children, reducing harms of drug use, safety in homelessness, navigating sex work, skills development and employability, financial management, and gender-based and intimate partner violence. These support groups have also been used to inform women of their rights, such as how to report a case of sexual assault or abuse, or how to proceed if they get arrested for sex work. In some cases, these support groups have the capacity to offer food and refreshments, and those that have the budget can sometimes offer toiletries, cosmetics, sanitary products, secondhand clothes, and transportation reimbursement.

The female-only support groups are highly appreciated by the women who partook in this assessment. The groups function as a safe space for women to talk about their experiences and needs, while providing room for them to realize that they are not the only ones experiencing these challenging circumstances. A similar appreciation for the groups was mentioned by the women who partook in the previous assessment in Cape Town, Pretoria, Johannesburg, and Durban (20). Having a shared space with other women also seems to increase a feeling of "sisterhood", where women feel supported and care for each other. As mentioned earlier, assuring confidentiality is crucial for sisterhood to take place.

> *They make us feel so safe, and it's great to know that you're not alone in your struggle. There are people who care […] Girls can find places like these where they can feel safe talking about problems, the heavy burdens on their shoulders, and many women are trapped in this closet. They feel ashamed to talk, and maybe you were raped, your father raped you and such things. Then you think, what will she think of me if I tell her that my dad raped me, and my brother was sticking a gun up my private part? We learnt that here, we meet different people, such great people that you will think that your problems are worse, but you will be surprised seeing that they are going through bigger things than yours, and yet talk about it proudly, confidently, without shame, without hiding a word. So it empowers you and give you the sort of, if she can talk about that, what was my shame? Being raped by my dad, if she can say about 20 guys who formed a line and raped her, what about me being raped by my dad? (Port Elisabeth, female client 11)*

In the focus group discussions done by ANOVA, clients asked for the continuation of female-only discussion groups or, if not existent yet, offered by harm reduction programs in their areas. What participants mostly appreciated was the possibility of sharing their experiences and the challenges they face daily. Women also enjoyed the chance to use the space to talk about something different than drugs, such as their day-to-day life, health, families, and the future. They also appreciated learning and be reminded that they need to stand up for themselves, take control of their lives, and be determined in bringing about change in their lives.

The staff noticed that women are more comfortable talking about sensitive issues, such as gender-based and intimate partner violence, within the presence of women-only.

> *Most of the time, the women aren't free enough to express themselves. Fear of being judged by the partner, fear of exposing your relationship during your partner's presence. When we have the groups specifically for females, it helps them to open more, to be able to relate more to other female stories (Port Elisabeth, harm reduction staff 11)*

> *It gives them a floor to express themselves without the fear of their partners having to know this is how they feel about them or are revealing the secrets of what happens behind closed doors. When they have sexual-related infections, they're able to bring those things up and talk about it. Whereas if the partner is present, they will not bring such things up because the partners will want to know, "Where did you get it?" They won't understand that you don't have to have sex to get it. In such groups, they're able to bring everything up to par; their histories, what they've gone through, their past relationships, what they've learned from them, and what is currently working for them or not in their current relationships; and everything else that is happening in their lives, their fears, their aspirations. In female-only groups, they can be themselves in totality. (Durban, harm reduction staff 4)*

Psychosocial support and individual counselling

Several programs also offer one-on-one counselling sessions for women. Sometimes, a client cannot share specific experiences and problems in the group but can voice out concerns or talk about their personal stories during individual sessions. Individual sessions can also be dedicated to following up on issues brought in a group session, wherein counsellors aim to gain additional details to provide more specific sup-

port. This support usually involves linking clients to other facilities that can provide the services they need—be those related to gender-based or intimate partner violence, methadone provision, shelter, getting an ID or helping to (re)connect with their families of origin and children.

Despite the support given, a gap remains in terms of more in-depth support for victims of violence. Staff and clients seem to mostly understand mental health as relating to more severe forms of suffering such as psychosis, hallucinations, or depression only, instead of more broadly related to self-knowledge and wellbeing. At the same time, cultural beliefs around mental health problems and gender roles may impose further challenges for women to get support when they need it. Women lack support to handle the traumas they have accumulated with time, which may trigger some to repeat violent situations and deprivation of rights.

> *People still need a lot of education on that. Specifically, within the Black community, many cultural issues tend to be placed when a woman is going through something. The first diagnosis would be that the person is bewitched. There is a definite need for mental health services, especially with women, and it would be great to have this inside our programs. […] somebody like a psychiatrist or psychologist that people can debrief with, get medication and support if needed. In South Africa, currently, gender-based violence is quite rife… There's a lot of traumatic experience that our ladies go through. The essential human rights ladies are not aware of that. They think that sometimes-- and culturally as well, we believe that sometimes we should enable the guy and you should be the breadwinner of the relationship. That comes with a lot of trauma and mental health issues. (Pretoria, harm reduction staff 13)*

Skills development

Some harm reduction programs included in this assessment provide various types of skills development workshops for women to help to generate income. These workshops depend on the availability of courses that can be offered, and as much as possible, what is relevant and appealing to women. For example, some workshops were related to bid work (Durban), cooking lessons (Nelson Mandela Bay), and beauty (Cape Town). In Ekurhuleni, there are programs that aid in the development of various trade skills related to baking, sewing, domestic work, early childhood development certifications, or courses to work in daycare centers.

In Durban especially, these workshops were also directed to educate women on the possibilities of opening their own business. They also assist women with budgeting and financial management, so that they can immediately apply the profits they make into growing their business.

> *You'd find that most of the members, they know how to do hairdressing, but they don't know how to start the business. There's a common idea that you'd have to have your own salon to be able to start a business. With a business such as hairdressing and in our environment, you don't even have to have that space. If you have a chair and you can get clients, you get one person even if it's a group member, you do their hair and you use them to advertise your business. You'll attract customers in that way. Because in our country, we don't mind sitting on the street and having our hair done, as long as the person can do the hair. We try and show them those opportunities that they need to shift from finding resources that they don't have and utilize what they have now to kick start their business (Durban, harm reduction staff 4)*

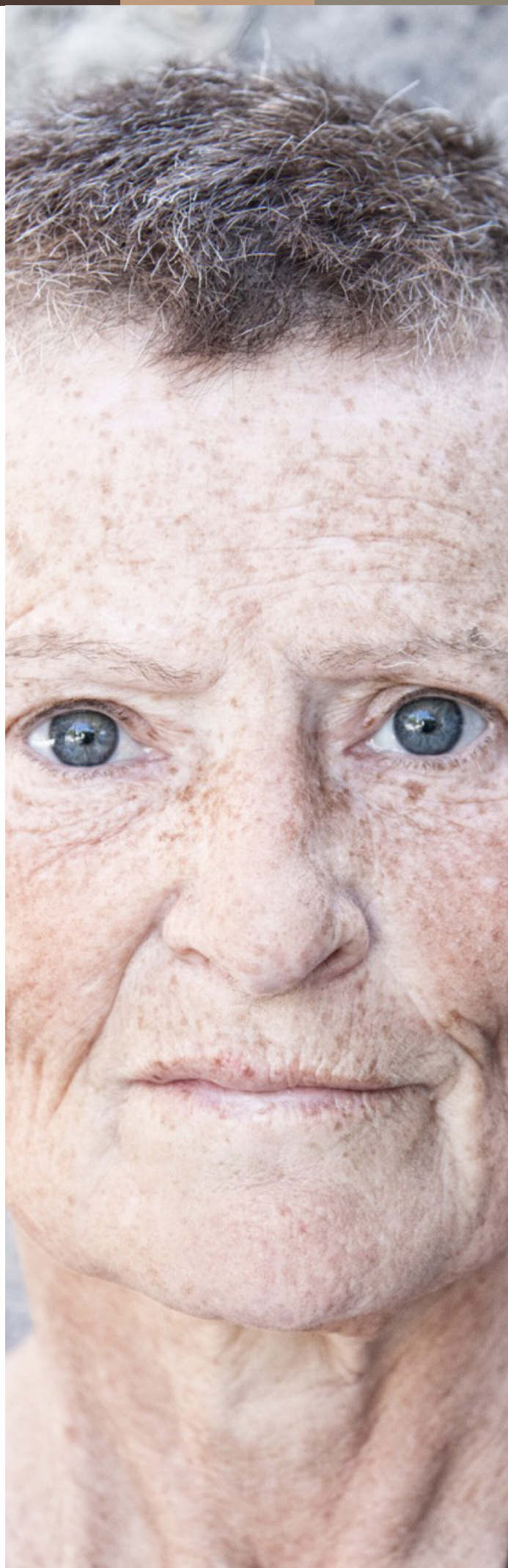
Staff from Pretoria mentioned they would like to partner with organizations offering skills development to promote the empowerment of women. Skills development could be potentially coupled with a scheme that could foster the placement and reintegration of women into the workforce via partnerships with businesses and services. Another type of skills appreciated by the clients relates to opportunities for active involvement and leadership.

> *Today, I'm proud I can stand up in front of 100 people and tell them my story, without shame, without feeling small or whatever. I learned to be a public speaker. I even tell people that I'm HIV positive and I'm not ashamed to tell them that I'm on ARVs and the importance of using ARVs and it's so great. I don't know, I've got so much that I can say but I really, really appreciate the organization, and I think they've been doing so good for us (Port Elisabeth, female client 11).*

Accessibility

Harm reduction services were, in general, considered to be accessible and welcoming by women who use drugs who partook in this assessment. This was mentioned throughout the interviews and in the focus groups. Participants evaluated harm reduction programs and their staff in a positive manner, and commonly referred to feeling accepted, valued, and being able to access services without issue. Similar results were found in the previous assessment in Durban (12).

> *I do feel very comfortable. When first I met them, we were in the street. They invite me to the facility. I was dirty, I was nervous, but they made me feel free. They welcomed me. They didn't care how things were (Pretoria, female client 6)*



> *I was mixed up. I lost it. I was just thinking of an easy way to kill myself. Believe me when I tell you that meeting these people of this place was the greatest thing that has ever happened to me. Because ever since I joined this organization, I've learned to understand that there are uphills and downhills in life. Not every day can be Christmas. We must, as women, believe and know that we are unique in our image, and drug addictions are not the end of the world. Drug addiction and prostitution do not mean that you're out of the society or you cannot be a better person. (Port Elisabeth, female client 10)*

Women, in general, did not report stigma or discrimination from harm reduction service providers, with only three exceptions mentioned by clients from Pretoria and Port Elisabeth. In Pretoria, one client had a misunderstanding with one staff member where she felt she was not helped in the way she expected to be while printing her CV. Another felt that male staff prioritized male clients, leaving women unattended for longer periods. In Port Elisabeth, clients perceived one staff member as rude and releasing their own stress onto clients during work.

Staff from harm reduction programs also had the general perception that their clients did not have any impediments while accessing the programs, specifically due to outreach efforts and other decentralized activities, as well as the development of trust and respect forged with the female clients.

Nevertheless, as mentioned in the Needs and Challenges section, some factors can interfere with women's access to harm reduction services. The lack of money for transportation was a common issue mentioned by women who use drugs and harm reduction staff. Cases of intimate partner violence in which male partners prohibit women's access to programs was also an aspect noted by the women. Finally, according to some participants from the current assessment and the one from Durban (12), law enforcement targeting possession of drug use instruments or drug-related medication such as Opiate Agonist Treatment (OAT) also discouraged women who use drugs from going to harm reduction services in fear of repression and punishment.

While some current clients are satisfied with the services and their accessibility, several women who use drugs remain unassisted. In the focus group discussions (ANOVA), participants were asked to mention if and where harm reduction teams could find women who use drugs in need of services. In all groups, participants recalled several areas where women do not have access to services. These were in neighborhoods where programs do not work (in specific streets, parks, markets, traffic lights, or residential households) and places where sex work happens (street-based, brothels, or motels). There is, thus, a need for upscaling current harm reduction services for women, especially outreach efforts.

Network and referrals

For the services not available at the harm reduction programs, staff refers clients to other equipment. However, counting on a referral network can be quite challenging, both due to stigma related to drug use and lack of resources and vacancies to assist all those who need it.

The stigma and discrimination women feel when accessing public health care bring challenges to harm reduction staff when trying to build partnerships and refer women to SRHR services or other health-related services they need. In all cities where we interviewed staff, a common observation was that simply referring clients to a government clinic or hospital usually does not guarantee their access to care. Women who use drugs' experiences with stigma and the fear of punishment pushes them away from these services.

> *Some clients won't go to the government hospital because they get so stigmatized and humiliated by the nurses or any other health worker. So, they don't do Pap smears, or breast cancer screenings, because those services are only available there. And there, the treatment is not so good as compared to us, who are dealing with PWID clients. We are more understanding, while the government hospitals deal with the general populations (Port Elisabeth, harm reduction staff 9).*

Women who use drugs from all cities also complained about queues in public health clinics, saying that the wait is too long, sometimes close to a full day, before being assisted. Unsustainable waiting times and discrimination were mentioned as important reasons for avoiding treatment from public health clinics. Women also sometimes want to avoid long waiting times due to the prospect of stigma and discrimination, going into withdrawal while waiting in line, and losing time that they would have spent working to make money.

Harm reduction workers recognize that staff at government facilities need sensitization training to help them understand the population better and accommodate their specific needs. In some cases, staff in harm reduction services try to avoid stigma by alternatively inviting workers from other services to the harm reduction program instead of referring the clients to other spaces that may be less accommodating or pleasant. This could work as a bridge between the different spheres of help—such as harm reduction, public health, and gender-based violence support; those not working at harm reduction services would then be able to learn more about women who use drugs and harm reduction principles while clients remain in an environment where they feel safe and respected. One program, for instance, invites staff from gender-based violence services to counsel women who use drugs in the female-only support groups. The evaluation is that this is working well.

If there are enough resources, harm reduction staff may accompany clients to their appointments in public health clinics, at least to the first appointments. The participants from Ekurhuleni who spoke about this felt that this is successful in encouraging women to go to clinics and helping them feel safe; however, it is time-consuming thus not possible frequently or doable for every client.

> *When we accompany them to the clinic, everything is smooth sailing because we already have that relationship with the nurses. When they see us with them, they can assist them. When they go by themselves, that's where the problem is because they are being discriminated […]. You find out that once they experienced that, their chances of going back to the clinic are very minimal. When we go with them, they help them very nicely, and the results are very successful (Ekurhuleni, harm reduction staff 8).*

Offering more services within harm reduction services, rather than referring clients to external organizations, is preferred by harm reduction staff and has also been requested by women who use drugs. Their perspective is that this would increase access rates and help mitigate possible experiences of stigma and discrimination while searching for care. Similar perceptions were also described for services such as shelter, food provision, gender-based violence, and skills development. Due to their specificities, these will be dealt with in more detail in the following sections. They will also consider the input and vision from the staff of these organizations.

Shelters

Services offered

Shelters provide a space for sleeping, showering, and eating meals. In general, the shelter services that partook in the assessment were offered for free, some with the expectation of chore-based contributions from clients. Although, it was noted that there are other shelter locations in some cities, often governmentally - run, that charge fees to those who wish to sleep there. Important to note that some shelters have a limited period that residents are allowed to stay. Some shelters also offered programs for skills development, income generation, primary health care, and referrals to more complex health and social care needs. Those focusing on women victims of violence usually provided gender-based violence related services such as individual and group counselling and legal support. Worth mentioning that in rural areas of South Africa even less shelters offer gender specific services. Except for two shelters dedicated to women, services that provided shelter that partook in this assessment were male-only, or mixed-gender but with separated spaces. In the shelter that offered space for women, there were very few women making use of the service. Those assisting both male and female clients usually provided females with separate rooms and toilets, along with specific toiletries such as tampons and sanitary products. When asked to reason about the lower rate of female clients, staff generally indicated they believe there are more males experiencing homelessness than females. However, in some cases it was noted that there are more factors that can hinder a woman from coming to make use of the shelter services, such as being restricted by a partner or a pimp. Moreover, many shelters do not accept women with children.

Accessibility

Within the shelters included in this assessment, access is granted by referral from another service or, in a smaller scale, via the shelter's outreach program. Organizations with outreach efforts, staff found being able to directly get in touch with women who use drugs, especially those engaging in sex work, to be more effective. However, there issue of safety for outreach staff was brought up, which in some cases prevented staff from going to specific places where sex work or drug use occurs or influenced services to scale-down their outreach efforts due to lack of people willing to do it.

Referrals to these shelters were mostly done by the Department of Social Development, other harm reduction services, or members of the church. In the case of gender-based violence shelters, the police and the community also were entities referring women to different services.

Some staff were asked to recount the process that a client must go through once arriving at a shelter. Often, it begins with an assessment of the client and checking the criteria for enrollment. These criteria vary between services, but in general clients should be currently homeless, and may need to have an ID. The most significant bottleneck for women and other people who use drugs is the common expectation that people should be abstinent from drugs to be allowed into the service. Generally, clients are warned that drug use is prohibited on the premises and may need to sign a code of conduct committing to abstain from drug use. If a client discloses that they use drugs, they are often directly referred to an abstinence-focused drug treatment program or an addiction care center. The idea is that once clients are detoxed and in recovery, they can return to the shelter or to a service and receive the help they initially came for. In some cases, if a client does refrains from disclosing their drug use but is discovered to be

using later, strict measures may be applied to enforce abstinence policies.

> *Usually what happens is if a client comes in and we know that they have a history of substance abuse especially within the last two years, then we recommend that they join either the matrix program or if they have the means they can go to the Cape Town Drug Counselling Center or any other substance abuse program. If they refuse, then we do perform random drug testing on-site, and when a client tests positive on whatever substance it is, then they receive a disciplinary warning. […] if a client receives three of those warnings and they still refuse assistance of getting into a rehabilitation program, then often the client is then no longer allowed to be at the [shelter]. (Cape Town, shelter staff 1)*

Requirements like these may reflect and explain some of the difficulties women who use drugs mentioned to have in accessing shelters. Similar stringent rules also applied for women engaging in sex work and women who are victims of violence.

> *If we know that you're on drugs we don't take you, we try to organize rehab for you. From there, then you can come straight to the shelter. If you are in [shelter] and you're practicing sex work, it won't work again because now it will be like a hostel. If you come in, you must stop those things, we are not trained on how to deal with those things (Pretoria, shelter staff 10).*

During the hard lockdown in the COVID-19 pandemic, safe spaces were erected around the country to house those that were street based. Nevertheless, there has been controversy amongst people who use drugs who accessed these shelters, with incidents of rape and abuse being reported in Cape Town. Moreover, as access to methadone was not allowed in most of these safe spaces, many people who use opioids experienced withdrawals and impromptu detox.

Individuals working at shelters who were included in this assessment often believed that women (and people) who use drugs must be serviced by staff who are specialized in drug dependency and viewed themselves and their organization as unable to deal with people currently using substances. This combined with the belief that drug dependency should be "cured" and that individuals should be entirely abstinent to be able to use shelter services may create an environment where women who use drugs are left out from services.

When compared to women (and people) who do not use drugs, shelter staff sometimes saw women who use drugs as less cooperative or more difficult to work with.

> *You see, people who are drug dependents generally don't want to co-operate with our programs, and they generally don't want to participate in the activities because they might be on a high or they might need the drugs at that point so it's more disruptive in an organization such as ours, to also then have such people in the organization. We tend to stay away from that. (Durban, shelter staff 6)*

In some cases, it was indicated that on account of traumatic experiences and living as a homeless person, some women were unreceptive to help and at times acting as an aggressor in a service environment.

The behavior of using drugs, as well as engagement in sex work, was often seen as an indicator of a lack of desire or commitment to change.

The continuation of drug use was also viewed by some as endangering for others in a shelter, who could potentially be at different stages of recovery; it was seen that having one individual who is not abstinent may encourage others to relapse or make them feel unsafe in an environment if drug use was allowed.

> *… we do not take people that are on drugs because it's a small facility and people on drugs, get withdrawal symptoms. […] it's not nice. It's a communal sleeping hall and at night, two o'clock in the morning, those guys are up because they need the next fix, and they're not allowed to use any drugs on-premises. What makes it difficult working with them is the fact that they do not want to change (Ekurhuleni, shelter staff 7).*

> *…we work with clients who are at different levels of recovery. Someone new might be coming in and they are at the height of their drug use. Someone else is trying to get off and is weaning themselves off the drugs. Someone else is now in a recovery program and has maintained sobriety for a long period of time. We also need to think about those clients who are actively participating within their recovery and try to minimize the triggers that could be surrounding them (Cape Town, shelter staff 3).*

From the eleven shelter providers that partook in this assessment, only one indicated that they accept women currently using drugs and to refer them to harm reduction organizations, with the end goal of helping them to get out of the drugs.

> *We do not exclude people because they're on drugs because it is also part of our role to try and assist people to be out of drugs. If somebody is on drugs, we work with [NSP outreach service]. We work with [OST service] where they can be enrolled into methadone… They deal with harm reduction, so, when a person is on drugs, we take them there to assist them to be out of drugs. We also work with the Department of Social Development to try and get them space into a rehab center. (Durban, shelter staff 5)*

Another shelter working exclusively with young women, explicitly referred that most of their clients currently engage in sex work. They acknowledged that these women need shelter services during the day, given their evening work, and offer a day drop-in center with showers and meals. A shelter for daytime, however, is still not in place. Finally, a further difficulty for women who use drugs to access shelters is that even the facilities dedicated to females usually do not accept children, except for the shelters dedicated to victims of violence (where they face other barriers due to their drug use).

Links with harm reduction services

Only two shelter staff mentioned to currently have (or have had in the past) a referral link to local harm reduction services, namely a needle and syringe program and a program offering opiate substitution treatment. All other shelters that had a referral mechanism to drug-related services, were in contact with rehab programs or other forms of (mostly inpatient) centers focused on drug abstinence.

Gender-based violence

Services offered

A few GBV service providers who were interviewed in this assignment provide temporary shelter as a safe house for women suffering from violence. In these spaces women can also receive food and clothing, psychosocial and legal support, and support for their children. Other services may offer outreach, individual and group counselling, helpline (toll-free number), self-defense classes, workshops dedicated to fostering creativity or skills development, provision of hygiene items such as pads and toiletries, and help with documentation such as ID. One of the services interviewed also offered psychosocial workshops and therapy for perpetrators of intimate partner violence.

Accessibility

Like shelters, access to services providing gender-based violence support is mostly granted by referral from another care service, police or directly from the community. Also, like shelters, although such services are highly needed by women who use drugs, the set criteria may seriously hinder accessibility for this population. Many services providing support to women who have experienced gender-based or intimate partner violence referred that, to be able to enroll in the services provided, women need to be abstinent from drugs.

> *… our focus is victims of domestic violence, not people who need rehabilitation or who are dependent on drugs. Is very difficult for our organization to stay focused when we have a diversion in services such as that, which requires an organization that's more focused on drugs.*

> *[…] I think the drug dependency needs to be addressed first before you can address the domestic violence. (Durban, GBV staff 6)*

Abstinence is required especially in shelters dedicated to women who suffered from violence, but the abstinence approach may also be binding for other types of services such as individual or group counselling. Women are often warned that drug use will not be tolerated and frequenting a service under effect of substances prohibited. This is seen as potentially disruptive and obstructive to the personal healing process of others. Staff from abstinence based GBV services referred to difficulties working with women who use drugs and pointed at the lack of available free of charge in-patient drug treatment as a problem.

A few GBV service providers who partook in this assessment work with the population of women engaging in sex work and/or who use drugs via outreach efforts and counselling; these services acknowledged that setting high threshold criteria is undesirable if one wants to reach this population. Staff from these services also call attention to the need of having female-only activities and services, where women can feel safe and have their privacy respected.

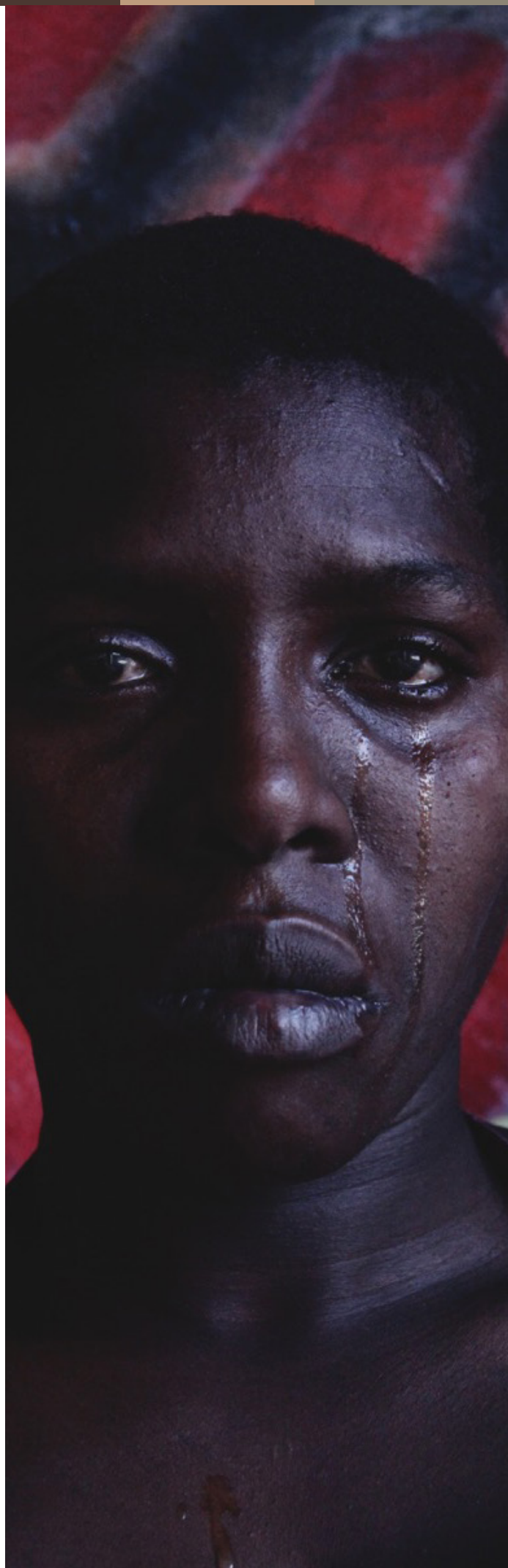
> *The only real request we have is that you show up and that you meet me halfway. [...] I never tell them that they need to be clean because it's a process that everyone needs to go through. If I'm going to start putting a stop strip before they even start, then it's making me just as judgmental as the next person. My understanding is that they first need to start the process and see that it works, and feel comfortable and trusting enough… (Cape Town, GVB staff 1)*

Even the staff working in services that currently assist women who use drugs feel that the abstinence-based approach hinders how women access services, especially housing.

> *Our big dream is to have our own property where our girls will be accepted and will be cared for in a way that is healing and healthy for them. There are safe houses throughout the city for women and other NGOs who are supposed to be helping with gender-based violence and things like that but we just really battle to find … there is nowhere that will take our ladies in the situation that they're in, which is sex worker, drug-addicted, and often homeless. We always get told that our ladies don't meet the criteria for the safe houses. It's incredibly frustrating for us. (Durban, GVB staff 4)*

Other problematic points include the paperwork needed for women victims of violence to be enrolled in services (e.g interim order and/or other paperwork). Finally, service staff working with women who use drugs and engage in sex work point out that there is a prominent need for specialized psychosocial care. When interacting with stakeholders who are not familiar with the sex work field, women can feel uncomfortable when attending mental health or psychosocial services. Besides, those who have children usually end up losing parental rights for lack of a place to support them in raising their kids.

> *The moms are not coping because they're living in a brothel, which is basically a derelict house that's been taken over by drug lords. She's in there and everybody is smoking crack. She's got her newborn child in there, but there's nowhere for her to go, so it's either that or she sleeps outside with her newborn child. These women are not bad mothers, they're some of the most*



fierce and strongest mothers I've ever met in my life. DSD takes their babies away from them because of the physical situation that they're in. We just are so tired of seeing that happen... (Durban, GVB staff 3)

Those working with women who use drugs and engage in sex work point to the double stigma the population suffers. They also mention that most of their clients engage in sex work to provide for their families and children and suffer from prejudice and misconceptions from the general population and other service providers.

Links with harm reduction services

Roughly half of the GVB staff that were interviewed mentioned having a referral link to local harm reduction services, usually outreach needle and syringe programs or opiate substitution treatment. These programs and their employees tended to have a similar understanding around drug use and sex work as the staff from harm reduction programs who were spoken to in the previous assessment. They were usually less judgmental and more accepting of low threshold rules when compared to GBV staff who were not linked to harm reduction programs and were committed to support women who use drugs and/or those engaging in sex work.

Would always go to [harm reduction service] social workers, just because we know that those people are in the line of work that they're in because they genuinely love and care for these women. They genuinely understand them in the same manner that we do… (Durban, GVB staff 4)

Virtually all interviewees would appreciate to gain knowledge around women who use drugs and harm reduction, even those already working with this population.

Nutrition

Services offered

Nutrition providers who partook in this assessment generally focus on the population of people experiencing homelessness, and some also assist foreign nationals and refugees in this situation. Part of the nutrition providers are religious; others are charitable organizations born out of people's commitment to help those in more vulnerable situations. Most of these services provide meals in a fixed space and operate during fixed days/times, but in a few cases, meals were provided to schools or via a mobile unit. Besides food, some also provide showers, counselling, skills development workshops, and referrals to other facilities. One service also provided primary health care via a satellite center.

These organizations are mostly staffed by volunteers or peer workers and stay functional from various donations. During the COVID-19 pandemic, food provision services were especially affected, as several staff mentioned that the service had to close during lockdown periods and/or had to reduce service provision due to loss of donations.

Accessibility

Services offering nutrition are relatively low threshold in comparison to the other services investigated for this assessment. In general, there are no requirements for people to access the service other than being homeless (or in a situation of social vulnerability) and being respectful of staff and other service users while waiting for

food. Since client interactions with the service are very brief, the fact that someone uses drug or is currently intoxicated has less effect on service provision.

> *Yes, everyone's welcomed. If you start to misbehave, then we will escort you out. We've served many drunk, homeless people, or many that are on drugs. […] You can be as drunk as you want, provided you stand in the queue, you wait your turn, you don't cause any problems, we'll give you a bowl of food. (Cape Town, food provider staff 1)*

> *We don't make any of our services conditional because we want to provide the service. It would be wonderful if people did want to change their lives, but often, they don't and often they can't. (Durban, food provider staff 4)*

In fact, some of the staff providing nutrition services referred to suffer from discrimination from society in general towards their work and the population they assist. Providing food for people experiencing homelessness can be perceived as enabling people to stay in the streets.

> *For me, it's about allowing the homeless people to live their homeless life with dignity because, like I said, they're not going to go off the streets. People say, "Yes, but you shouldn't feed them. You enable them." Quite to the contrary, if you don't provide a meal, you're going to have starving, aggressive, desperate homeless people on the street because not feeding them is not going to drive them away. It's just going to make them more desperate. (Cape Town, food provider staff 1)*

Nevertheless, a potential challenge regarding access for women who use drugs is that most services providing nutrition operate on a gender-neutral basis and are mostly frequented by men. Most staff estimations were that around 90-95% of clients are male. Some staff believe, in general, that the reason for disparity is a lower number of women experiencing homelessness.

> *All our services are available to anybody who can benefit from them. […] Among the work we do with the homeless, we see a lot more men than women just because there are a lot more homeless men than women. Our services are responsive to the needs that we encounter... (Durban, food provider staff 3)*

One interviewed staff acknowledged that women, especially those engaging in sex work, may not feel comfortable to stay in a line among male clients. Another mentioned that women engaging in sex work may be either sleeping or working during the times where food is provided.

When referring to women frequenting the service, staff usually mentioned a few specific cases of women who are regulars in the service, usually coming with their children. In these cases, staff mostly perceived interactions between male and female clients to be respectful. Most services had a rule that women are served first. Staff mentioned to see more women and children only in special days such as Christmas or Easter, when the services are broadened to include a special meal and perhaps also provision of clothing, blankets, or other goods.

This gender blindness, unfortunately, is not specific for services providing nutrition in South Africa. A previous study in the country has already called attention to the fact that very few services are sensitive to the needs of young women who use drugs. Most available social and health care

services adopt a 'one-size-fits-all approach' that provide men and women with the same services. When faced with questions about specific services for women, service providers and planners shared concerns that additional efforts to reach underserved women would create an additional demand for services that they would not have the capacity to take on. Besides lack of resources, the pervasive gender inequality in South African society was mentioned as reason why women who use drugs are not on the agenda; women lack influence and are seen through the relationships they have with men, as either wives, mothers or daughters (19).

Links with harm reduction services

Except from one food provider partnering with a needle exchange program and one who previously worked with an OST program, none of the other interviewees worked with harm reduction services in their cities. Most also did not know about harm reduction. When mentioning other partnering services, staff referred to shelters, primary health care providers, or rehab centers. Those partnering with rehab did notice the limitations of such approach with the population of people who use drugs and who are homeless. They referred to see, in practice, that people often relapse into dependent drug use once they come out of drug treatment and go back to the streets, since the reasons leading them to dependent drug use—for example, lack of access to work and shelter—have not been solved. One participant also mentioned to know organizations who are specifically working with women who are homeless. Nevertheless, they do not work together due to having a conflicting approach.

> *They're often women-run, which is excellent. They tend often, to be fair, to be run by white middle-class women who are looking to save often poor Black women who are living in town and therefore don't necessarily start from a position of shared life experience or shared language. They often tend to be religiously motivated, which we are as well as organization, but within that quite a strong, "Let me save you from your drugs. Let me save you from your prostitution," rhetoric which we don't. […] Our view is always, "For as long as somebody wants to take the drugs and wants to be a sex worker, let's at least make sure that nothing else kills them." (Durban, food provider staff 4).*

None of the interviewed staff mentioned to have been trained on how to assist women who use drugs or on harm reduction in general. According to them, many of their colleagues are also not trained in social work in general since there are several volunteers in the field. A few of them mentioned that such training would be desirable.

> *I think most of us, we're scared when it comes to needles. As part of the sensitizing, we could be trained in these things so that we may know, "Okay, this is how it works. It isn't as scary as we perceive it to be." I think in that line, we really do need training so that we are not afraid when you see them walking into the office. I think one of the things that can happen is that you can have a pre-judgmental attitude if you're not aware of things, but when you are more informed, you're more likely to be patient and respond accordingly. (Pretoria, food provider staff 6)*

Skills development and income generation

Services offered to WWUD

Organizations providing skills development or income generation programs focus on trying to improve the economic situation and/or the employability of the people they assist. The organizations partaking this assessment offer a diversity of training opportunities such as computer skills, forklift driving, cashier, welding, agriculture, beauty therapy, hairdressing, nails styling. They also have programs in which people go door-to-door or establish a street tend to sell secondhand books, beadwork, or other products made by them or donated. Some programs involved also an informal, green-based car wash or waste management. Other programs connect people with certain skills to companies in need of such skills. Some also offer work readiness programs, and psychosocial support. Specially those focused on women or people experiencing homelessness provide gender-based violence workshops, occupational therapy, and integration with housing first. Those working with economically vulnerable populations usually also provide food during workshops.

Most of the organizations providing skills development or income generation also provide different types of services where people can access courses to develop their skills. These can be drop-in centers, outreach work, housing, legal support, food provision, or other types of workshops. Clients may also get referred by other services. Especially those integrating a variety of services seemed to be reaching people who use drugs and who are in situations of socio-economic vulnerability.

> *We had about 30 guys that were in and out of the court so-called chronic homeless. Individuals that have been on the streets for years, if not decades, and who almost always have a severe substance use problem or mental health issue. We would interview them and say, " If we start doing something, what is it that you need?" They said they need an opportunity to fix their lives and that requires a job. They didn't want social workers or soup kitchens and all the other things that were around, they said they needed a chance to take control over their lives. We started a pilot providing work and psychosocial support, and it worked extremely well. This was in 2015 and we now have 80 people in full-time rehabilitative or supported work opportunities combined with psychosocial support and housing first. We only work with those that have active addictions … (Cape Town, skills staff 1)*

To fulfil skill development workshops, some organizations receive funding from the national or local government, while others partner with businesses to get funding. These could be manufacturers of hair products or energy drink companies, for example. COVID-19 pandemic also affected the work of some organizations providing skills development, as they had to decrease the number of participants per group/workshop or move most of its work to an online format.

Accessibility

Even though economic empowerment is a fundamental need of women and other people who use drugs, their access to these services is severely restricted. The main reasons for this are the strict criteria most services have in terms of substance use, as well as their gender-neutral or male-focused positions. Like staff from services providing shelters or nutrition, many of their colleagues providing skills development believe that the reason why programs are frequented mostly by men is that women would have less

need of such services. In their perspective, less women are homeless when compared to men, and women would often find other ways to assure their livelihood (such as being supported by a man and/or engaging in sex work). They may perceive women as uninterested in programs or as coming only to accompany their male partner. Women may also be perceived as more violent and difficult to deal with than men.

> *I think there is a higher percentage of males on the street in Durban. If truth be told, I think women can find their way to making some form of income on the streets. Not all do, but some can. That's why you see maybe lesser numbers of women on the streets. All the women-- and I'm trying to just be general, but I think it's true. All the women that have come onto the programs have come via a male partner that's been in the program, and then they've joined because of seeing the male partner, either getting some money or just wanting to be in the same space as the other (Durban, skills staff 4).*

> *We do not have any women currently because as you know when it comes to housing, you must divide, so that either men or women, you can't do both […] There's a higher percentage of male homelessness than there's female. Unfortunately, we only have had one house and we found that there were more men that were needing the service than females, so that's why we went towards the male. (Cape Town, skills staff 3).*

> *…the women that come to our program, because they've been on the streets for very long, they're tough as nails and sometimes quite violent that they've internalized having to obviously protect themselves. The trauma scent can be quite hard to work with […] when we started our supportive housing programs, the women have caused much more trouble than men. We've had to exit them because of continued violence and two have left because it just became so uncomfortable for them. We have less men that we've ended up in these situations. I think in some ways it links to the sexual violence and early age trauma, like being raped by family members is very typical for our female clients. Because it has never been unpacked, that translates into very difficult behaviors that continue playing out and making transitioned to something else harder. (Cape Town, skills development staff 1)*

When acknowledging that gender imbalance in programs might hinder women's participation, staff may still understand that services do not have a responsibility in this imbalance. They may perceive services as only passively receiving recipients rather than being able to direct or frame the demand coming to them, as well as the behavior of clients within the facilities.

> *I think the one barrier may be the imbalance, the gender imbalance, and therefore, say, you're expecting women to hold their own, not just on the street, but now on the speed in a program that's predominantly men as well. They don't get very much respect from trying to hold their own in a way, in a gender-biased environment. The gender bias comes from recipients of the program, I think, rather than from the program itself. (Durban, skills staff 4).*

With a few exceptions, most services providing skills development partaking this assessment understand drug use as hindering skills development and income generation. For some of them, drug use is unacceptable and potentially dangerous to others, making impossible to successfully engage in work.

> *Basically, to be part of the program, the one thing is that you cannot be under the influence of any substance when working. You would be a risk to yourself or anyone else. For instance, someone that was using substances, there's always the element of substance-induced psychosis. If the person is actively psychotic, they clearly cannot work, as well as, when someone's highly traumatized, they also can't work because the reaction to work, they become harmful. They can be harmful to themselves and others. (Cape Town, skills staff 2)*

> *Basically, if anybody seems to be under the influence of any form of substance, they will be tested. (Cape Town, skills staff 3)*

For others, substance use is undesirable, but people will not necessarily be impeded from partaking the service because of their use. The end goal of these service providers is still that clients become abstinent, but they will have a certain level of tolerance and patience until the clients gets to this point.

> *..our main objective is for them to abstain from it. Addiction is not an overnight thing. By giving them the opportunity to see the light at the end of the tunnel now, they start to understand. If somebody's caring for them, not using them, eventually, will automatically make them to abstain from drugs, but we'll have to break it very, very gently […] make them to wake up and say, "You know what? If I want to be successful, I cannot take drugs […] We're not going to say, "Because you did drug, we'll just throw you back on the street." I'm there to accommodate them. (Durban, skills staff 5)*

Finally, some skill development services which were focusing on women, were not focusing on a population with higher levels of social vulnerability:

> *We have our social media platforms. We reach out through that, because you know we're living in a technological world that is changing every second, so we thought social media is the best to take out everything that we're doing out there to people so that they know about us. We have engagements on Facebook, on LinkedIn, we have our Instagram, and our twitter.*
>
> *interviewer: And for people who may not have access to a phone or social media?*
>
> *They could come to our center or maybe give us a call back. We'll call them, or they can write us a message, or send a WhatsApp text (Ekurhuleni, skills staff 6)*

Links with harm reduction services

Only two of the nine staff providing skills development and income generation services mentioned to be in contact or working with a harm reduction program. These were related to having clients frequenting an OAT center or referring clients to these places. In one case, the facility had a few clients trained to perform surveys with other people who use drugs.

Recommendations & discussions

The following recommendations derive from the results of phase 1 and 2 of the present assignment and are framed primarily towards donors and policy makers.

Support decriminalization

1. Support the decriminalization of drug use

Criminalization of people who use drugs severely impacts women who use drugs. Treating drug use as a crime triggers judgmental and discriminatory attitudes against women in the community in general. It also gives room to discrimination within services, such as public health and social care facilities, where women could have their needs met. The criminalization of drug use influences accessibility and can obstruct the provision of harm reduction services. Besides, prohibitionist laws also hinder women's access to their families and their right to be mothers and contribute to increased harassment and violence from law enforcement officers (18). Decriminalizing drug use is crucial to improve women's access to care and fundamental human rights.

2. Support the decriminalization of sex work

Several women who use drugs being assisted by harm reduction programs engage in sex work to provide for themselves and their families. Criminalizing sex work greatly increase their vulnerability to violence and health problems, particularly STIs and HIV. Considering sex work a crime also hinders women's ability to report abuse or violence they suffer while working. Women mentioned to often have their reports of sexual abuse dismissed by law enforcement officials on the basis that they -women- are the ones committing a crime. Decriminalizing sex work can contribute to sex workers being safer, besides reducing levels of gender-based violence and improving (public) health.

Secure safe spaces for women who use drugs

Lack of focus on developing and implementing gender-specific interventions represents missed opportunities for improved health outcomes for women who use drugs. There are several ways in which services can secure safe spaces for women:

3. Fund harm reduction services specific to women who use drugs

Harm reduction equipment targeting women only have shown that the absence of unwanted men's attention and violence can improve access and adherence, providing women with a feeling of safety and having a non-threatening space (8,24,28). Women only services have also been successful in recognizing women's agency, responding to gender-based violence, and addressing legal and emotional issues related to pregnant and parenting women who use drugs (8,10). Potential female-only services to be added are shelters for women who use drugs and suffer from violence (including space for their children), women's only Needle Syringe Programs, Drop-in Centers, Drug Consumption Rooms, and Opiate Agonist Treatment.

4. Promote female-only hours in existing mixed services

Providing specific hours for females in services that are currently run on a gender-neutral or male-focused basis can be relatively easily implemented in existing services and not necessarily require hiring extra staff. Women may feel threatened in mixed gender spaces and may miss the privacy necessary to discuss challenges related to gender based and intimate partner violence, sex work, or sexually infectious diseases, for instance. Female-only hours can be provided in services such as Drop-in Centers (DIC), Opiate Agonist Treatment (OAT), shelters, skills development workshops and income generation programs. By targeting females only during a certain time, service can help provide a safe space, and better focus on catering women's specific needs. Having a dedicated space may help women feel welcomed and frequent available services in higher numbers.

5. Fund female-targeted outreach

As mentioned by several respondents of this assignment, many women who use drugs and are in vulnerable situations are not being reached by services that could cater for their needs. Some of the services providing shelter, nutrition, skills development, or gender-based violence support interviewed for this assessment mentioned to work with outreach work. These, in general, had a better reach of women who use drugs than the ones providing office-based only services.
Specific outreach work targeting females, possibly with female peers, may help to engage more women who use drugs in existing services. Participants explicitly mentioned that women who use drugs could help locate and access new clients, encouraging other women who are afraid to access services.

6. Support and scale up female-only psychosocial support

Most female clients being assisted by harm reduction programs frequent female-focused groups and/or individual counselling with social workers. This support is highly appreciated by women, and functions as a safe space to share experiences, needs, challenges, and build a feeling of "sisterhood", where women feel supported and care for each other. Many of the women who use drugs interviewed for this report, as well as other female clients of the staff interviewed, faced, and continue to be confronted with deeply traumatic experiences, many of such, involving a male figure. Female-only spaces can help women to feel more at ease and can aid in to building trusting relationships with staff and other women by being open about their problems and needs. Such spaces enable these women to share and resignify these experiences, promoting healing and empowerment.

7. Upscale harm reduction services, especially in rural communities.

There are a growing number of women and people who use drugs in rural settings and little to no services available to them. At the same time, stigma and discrimination might be even higher in rural settings when compared to the bigger scale cities included in the present assessment. Outreach services could be an ideal starting point for women who use drugs living in rural areas.

Promote gender equality in programs and services

Based on the recognition that gender equality and equity are linked to human rights, fairness and social justice for women and men.

8. Hire female staff and peers

Peer workers have knowledge and expertise from lived experience and may have increased capacity for empathy and a lack of judgement related to women's contexts. Besides, women who use drugs tend to be more hidden than men and may congregate in different spaces. Women may open more easily about gender specific or sexual issues with other women rather than with a man, as it was mentioned by several respondents in this assessment. If a service is willing to contribute to reduction of gender inequality, an excellent way to start is by having a balanced number of males and females, including representatives of the LBTQI+ population.

9. Promote non-discrimination and respect in supported programs

Staff can discuss discrimination and gender roles in current service activities. An open discussion is essential to understand the gender roles and inequalities in communities of people who use drugs and within the services and programs. Ultimately, all service users must be fairly treated regardless of age, sex, sexual orientation, gender identity, ethnicity, religion, class, occupation, and drug use status (6).

10. Foster the discussion of gender based and intimate partner violence with male clients of harm reduction programs

Women who use drugs frequently suffer from gender based or intimate partner violence which is enacted by their male partners or members of the drug using community, many of them also clients of harm reduction programs. Yet even though harm reduction services reach high numbers of male users, no work is currently done with male clients to raise awareness around violence against women. Harm reduction staff have often close contact and trustworthy relationships with clients and may be in a good position for creating a safe environment to discuss issues related to different forms of masculinities, fatherhood, and violence in intimate relations with women.

Fund support for women suffering from gender-based and intimate partner violence

11. Foster the discussion of gender based and intimate partner violence with male clients of harm reduction programs

Women who use drugs frequently suffer from gender based or intimate partner violence which is enacted by their male partners or members of the drug using community, many of them also clients of harm reduction programs. Yet even though harm reduction services reach high numbers of male users, no work is currently done with male clients to raise awareness around violence against

women. Harm reduction staff have often close contact and trustworthy relationships with clients and may be in a good position for creating a safe environment to discuss issues related to different forms of masculinities, fatherhood, and violence in intimate relations with women.

12. Fund the provision of mental health and gender-based violence support services for women who use drugs

South African women who use drugs suffer from all sorts of gender based and intimate partner violence, greatly affecting their physical, economic, and mental wellbeing. Yet, most services focusing on gender based and intimate partner violence are not open to assist women who are currently using drugs. Investing in sensitization of these services can be a long-term strategy to try to assure that the current network of services can cater for the needs of women who use drugs. The current situation, nonetheless, asks for urgent responses, given the dramatic and inhumane situation in which many women encounter themselves. Funding the provision of gender based and intimate partner violence support inside harm reduction services, along with mental health support for women who use drugs can be a good short-term solution. It will not only allow women to start a trajectory of self-care, but also create the opportunity to test and demonstrate the effectiveness of such programs, opening space for more sustainable solutions in the medium and long terms.

13. Fund the provision of paralegal work (legal support) to WWUD

Due to the criminalization of drug use and sex work, women who use drugs in South Africa may face several legal challenges. Legal support can help women to address their needs regarding gender-based and intimate partner violence, sex work, and parenting rights. Ideally, harm reduction programs can provide paralegal services by having specialized workers in their staffing. Alternatively, if such services are provided by other organizations, programs can develop referral mechanisms and properly link women who use drugs to them. All harm reduction staffs, including outreach workers, must be informed about organizations providing legal support and have at least basic information on what women can do and where they can go when suffering from rape and other forms of violence.

14. Support the documentation of women's rights violations

Providing comprehensive legal services may not always be possible. To ensure that victims and other vulnerable individuals are protected, proper documentation of all cases and professional gathering of evidence should be done for later follow-up and advocacy (2).

Meaningfully involve WWUD

Foster the meaningful involvement of women who use drugs in all aspects of programs, policies and services influencing their lives. This includes – but it is not limited to - the design, planning, monitoring, and delivery of harm reduction services.

15. Foster Community Advisory Groups (CAGs) with women

CAGs should consult women about service delivery quality and possible additions in services to improve their lives. Such spaces should also look at providing workshops to assist women in building up their participatory skills, empowering them beyond a consultation level (20). They can help to promote, respect, and enforce the human rights of women, including the right to adequate health information, reproductive rights, non-coercive services, and humanizing treatment.

16. Support the organization of networks of women who use drugs

The South African Network of People Who Use Drugs (SANPUD) already has a few local representatives of women who use drugs in different cities in the country. These network, however, seem to be still unknown to most of the female clients of the harm reduction programs interviewed in this assessment. Supporting the growth of these and other networks can help develop and increase the reach of these networks. This can lead to increased empowerment and education of women to actively engage in the defense of their rights.

Foster women's empowerment and independence

17. Fund workshops for skills development and income generation

Being economically dependent is a major risk for women. As described in this assessment, several women who use drugs engage in risky practices and are exploited by men who promise to offer protection, shelter, and food. They may not have formal education or other skills that could help find employment and generate income in other ways than transactional sex. Developing skills and learning other ways to generate income can help women to become independent and be less vulnerable. Research in South Africa has shown, for instance, that interventions combining microfinance with gender-equality training can be effective at reducing levels of intimate partner violence (29). Women who can provide economically for themselves and their children can be in a better position to negotiate with their partners, and to secure their safety. Several services currently providing skills development, however, have a high threshold for women who use drugs, having abstinence as a criterion for enrollment. Providing skills development workshops inside existing harm reduction programs already frequented by women can be a way of increasing their access. Skill development workshops should consider the desires of women as well as the types of businesses that can be carried forward in a certain environment. They can also include education around budgeting, financial management, and how to start and manage a busines.

18. Fund nutrition in harm reduction services

Several women lack basic nutrition and, yet few seem to be accessing services that provide nutrition. As staff from harm reduction and other services mentioned, providing food can be essential to engage women in services, assuring they will have enough energy to focus on activities and enough strength to cope with strong medications and treatments. Besides, nutrition packages are particularly important for women who are pregnant and women who have children and are caregivers in their families.

19. Legally support and empower women who have children

Due to the criminalization of drugs and sex work, many women who use drugs are deprived from their right to motherhood. They may also not have the specific knowledge required to navigate the complex legal system in search of more proximity with their children. Lawyers and paralegal workers working from harm reduction programs can help these women to acknowledge, understand, and secure their rights. Moreover, some women may have difficulty bonding with their children, even when they express the desire of having the kids close to them. Kids may have stayed in shelters or with other family members for a long time, and the relationship must be rebuilt. A safe space where trained staff can help women navigate this emotional maze can be crucial for them to rebuild mother-child connections and their own autonomy as mothers. This includes providing a basic level of childcare at harm reduction services, allowing for women to access care whilst their children are safe and being supervised. A good practice example is the program Attitude in Brazil (10).

Support low-threshold and accessible services

20. Provide transportation incentives

Providing a bus ticket or money to reimburse for transportation as an incentive for partaking in groups and other activities can increase women's access to care. Some women might not have the resources to pay for transportation, and other can use the incentive to provide for other immediate needs.

21. Support a harm reduction approach in services for women

Women should not be required to be abstinent or to enroll into abstinence-based drug treatments (rehabilitation or detox) when frequenting essential services. They should also not be required to abandon their current work (e.g., transactional sex) or to leave children unattended to be able to engage in activities. Women should be aware of all existing facilities providing for their needs and allowed to engage in services from a low-threshold approach.

22. Fund integrated harm reduction services for women who use drugs

Due to the unfair treatment that women receive from other care services, many requested for harm reduction programs to offer such services instead: sexual and reproductive health rights, gender-based and intimate partner violence support, shelter, skills development, income generation, among others. Staff from harm reduction services have both lived experience and acquired knowledge on how to approach people who use drugs and may better un-

derstand and cater for the needs of women who use drugs. Women who use drugs felt accepted, respected, and welcomed in these services and mention to engage with care provided by a harm reduction program more easily. One-stop-shop services have shown to be very effective in catering for the complex needs of people who use drugs and increasing their access and retention to care. Good examples of this are specific shelters for women who use drugs and their children operating from a harm reduction perspective (10) .

Invest in inter-organizational partnerships

23. Support the development of partnerships between harm reduction and other essential services

Harm Reduction services alone cannot cater for all needs of women who use drugs. Women need and can profit from a series of other benefits provided by services focusing on sex work, gender based and intimate partner violence, nutrition, housing, skills development, income generation, and sexual and reproductive health rights, to name a few. Developing partnerships and formal mechanisms of referral with these services can help guarantee that more women who use drugs will have access to their basic rights. This might require engaging in sensitization around harm reduction and the specific needs of women who use drugs with staff from such services, as well as an initial mapping of services available in the territory. Moreover, it may require frequent contact and advocacy with services, and potentially a staff dedicated to such activities, as, for instance, an advocacy officer.

24. Support the building and dissemination of information about services for women (who use drugs)

Often women in need do not reach out to available services simply for not knowing they exist. They might be located far from where Drop-in centers they frequent are or far from spaces visited by the outreach team. Besides, while sometimes high-level management or social workers may have an overview of the care network in a specific territory, this information usually does not travel down to those performing outreach work, and consequently, do not reach most clients. Likewise, outreach workers may hear about important services women know of, or cannot reach, but do not have as their function to build up a network and referral mechanism with such services. Supporting harm reduction services in building, maintaining, and disseminating a network map with useful services for women who use drugs can help increase the demand for and access to services. Such maps can contain not only the location and types of services provided, but also criteria for access, opening hours, and potentially a specific contact person. The information should be widely circulated among all staff from harm reduction services, and a shorter (pocketable) version could be given to clients as well.

25. Foster the sensitization of staff from essential services for women who use drugs

Women partaking this assessment described being refused services based on discriminatory and/or abstinence-based behavior from social and health care staff, specially from public health clinics and hospitals, but also from shelters and gender-based violence services. Professionals of non-harm reduction services, on the other hand, felt they did not have enough/specific knowledge to

approach women who use drugs. Many had denigrating views around drug use, based on myths and unscientific ideas. To improve women's access to care, these professionals must be provided with basic education around drug use, harm reduction and gender. They should be encouraged to treat women with dignity, compassion, patience and in a non-stigmatizing way. By (better) understanding drug use, gender issues, and harm reduction, staff might be able welcome women who use drugs in their daily activities and cater for their needs. Such professionals include – but are not limited to- staff providing shelters, gender-based violence support, nutrition, skills development, and income generation. Faith-based leaders, especially in rural communities, are also key actors, as they are often the first point of contact for the family and partners of women who use drugs. Finally, community-based health care and peer workers are often the first to become aware of substance dependance in a community and are usually approached to assist due to their proximity to the community.

26. Support the sensitization of law enforcement workers

Women and harm reduction staff partaking this assessment reported a series of human rights infringements committed by law enforcement officials in South Africa. The apprehension of drug-using materials given by harm reduction programs and intentionally targeting of people who access these programs where common behaviors from officials towards both male and females. Moreover, women also reported to suffer from specific gender-based harassment and violence from law enforcement officials. Examples included being searched by male officers, being asked to drop underwear/pants in public, and being watched when trying to bathe at the river. Women also reported having their reports of physical and sexual violence ignored by the police, and experienced being laughed at in police stations when trying to file a rape complaint. These negative experiences with law enforcement dissuade women from reporting crimes against them and leaves women suffering from violence even more isolated and without any type of support. Regardless the fact that drug use and sex work are currently criminalized in South Africa, police officials must treat all citizens with respect and dignity and must be aware of the consequences of such actions for the wellbeing of women who use drugs and the reach of services assisting them.

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