EXPLORING THE EXPERIENCES OF WOMEN INJECTING NYAOPE RESIDING IN THE CITY OF TSHWANE MUNICIPALITY, GAUTENG

by

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DECLARATION

Declaration of independent work:

I declare that **EXPLORING THE EXPERIENCES OF WOMEN INJECTING NYAOPE RESIDING IN THE CITY OF TSHWANE MUNICIPALITY, GAUTENG** is my own work and that all the sources that I have used or quoted have been indicated and acknowledge by means of complete references. I further declare that I submitted the dissertation to originality checking software and that it falls within the accepted requirements for originality. I further declare that I have not previously submitted this work, or part of it, for examination at UNISA for another qualification or at any other higher education institution.

Lefoka Moganki Hendrick

Signature:

Date: 02/09/2019

DEDICATION

There are many people who contributed to the person I am today and without them, I doubt I would have achieved this milestone. It is therefore my desire to dedicate this study to:

- My Parents: Chiraka and Tebogo Lefoka; kea leboga Papa le Mama
- To those I consider special group of people: my clients; people who use drugs. I hope this will be your voice.
- To my siblings: Abuti Pule Lefoka, Itumeleng Lefoka and Kgadi Lefoka. You are the best siblings anyone can ask for.
- My beautiful wife and my children: Mologadi my wife kea Leboga, and Lethabo le Tshegofatso my children, this is a culture I wish you to follow. A culture of education and excellence.
- My Pastors: Pastor Machitela and Pastor Nonga. May the good God bless you.
- To Participant 11. The participant died after a week of interview. Your contribution to this study is acknowledged even in your absence. May your soul rest in peace.
- Finally, to my mentees. It is possible.

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ABSTRACT

The purpose of the study was to explore the experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng. The study was conducted at COSUP sites namely; Soshanguve, Pretoria CBD, Sunnyside, Mamelodi, Eersterust, and Attridgeville. The study focused on females who have a history of injecting nyaope, accessing substance use related services at a registered service provider within City of Tshwane Municipality, Gauteng.

Research design of the study was exploratory, which is basically used to explore a new topic or learn more about phenomenon where little is known. The research approach was purely qualitative methodology. This permitted the researcher to deeply explore the lived experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng. A qualitative in-depth interview method was used to collect data from 24 participants who took part in the study.

Questions of the interview were semi-structured, in-depth one-on-one interviews and were used to explore the lived experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng.

The findings of the study revealed that females who are injecting nyaope, are at risk of contracting HIV and other blood-borne infections. The stigma that is perpetuated by families, intimate partners, communities, health care professionals, and police officers is creating a hostile environment for female nyaope injectors; which increases the risk of contracting HIV and other blood-borne infections. Harm reduction services have the potential to address the needs of female nyaope injectors if fully implemented.

It can be concluded that there is a need for substance abuse service providers to implement comprehensive harm reduction services to curb HIV prevalence amongst female nyaope injectors.

KEY TERMS

Nyaope, HIV, Female nyaope injectors, Harm reduction, NSP, People who inject Drugs, City of Tshwane Municipality, Substance Abuse, Experiences, Exploration.

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
COSUP	Community Oriented Substance Use Programme
CoT	City of Tshwane Municipality
DSD	Department of Social Development
GCWA	Global Coalition on Females and AIDS
HIV	Human Immunodeficiency Virus
HTS	HIV testing services
IDU	Injecting Drug Use
NDARC	National Drug and Alcohol Research Centre
NPO	Non-Profit Organisation
NSP	Needle and syringe programmes
OST	Opioid substitution therapy
PrEP	Pre-exposure prophylaxis
PWID	People Who Inject Drugs
SANAC	South African National Aids Council
STI	Sexual transmitted infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNISA	University of South Africa
UNODC	United Nation Office on Drug and Crime
WHO	World Health Organisation

DEFINITION OF KEY CONCEPTS

- **Experience:** Things that have happened to you that influence the way you think and behave (Oxford Dictionary, 2015:524).
- **Female nyaope injectors**: In this study, female nyaope injectors refers to any women between the ages of 18–35 with a history of injecting nyaope for non-medical use and accessing substance abuse or related services.
- **Harm reduction**: “Harm reduction refers to policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop” (International Harm reduction association https://www.hri.global).
- **Needs**: What one requires because it is essential or very important (Oxford Dictionary, 2015:1002). In this study, the needs refer to what is necessary for people who inject drugs to live a healthy, stable and safe life with low risk of contracting HIV.
- **Nyaope**: Nyaope is a relatively new designer drug which is commonly used in many Black townships in South Africa. The full composition of nyaope is generally not known, although most agree that heroin is the main ingredient, and rumors of the inclusion of ARVs have been documented (Mokwena, 2015:138).
- **People who inject drugs**: People who inject drugs refers to people who inject non-medically sanctioned psychotropic (or psychoactive) substances (WHO, 2015:3).
- **Recovery:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. (SAMHSA’s WORKING DEFINITION OF RECOVERY). In this study, recovery means the process through which a female nyaope injector has taken a step to stop using nyaope through a professional intervention.

- **Risk:** To do what might get you into an unpleasant situation (Oxford Dictionary, 2015:1298). In this study, risk means the probability of contracting HIV.

TABLE OF CONTENTS

1. CHAPTER ONE

Orientation of the Study

1.1 Introduction

A significant decrease in HIV prevalence and mortality were observed from 2009 to 2013 globally; mostly within sub-Saharan Africa. However, a decrease in HIV prevalence amongst people who inject drugs (**PWID**), more especially female nyaope injectors, has not been good (Springer, Larney, Alam-mehrjerdi, Altice, Metzger and Shoptaw, 2016:2). It is estimated that females account for 27% of all people who inject drugs in South Africa, and 19,4% of female nyaope injectors are HIV infected (Springer et al, 2016:6). HIV prevalence, among drug injectors, is normally exceedingly higher than it is among the adult population; with people who inject drugs accounting 28 times higher prevalence (UNAIDS, 2014:2). Global HIV prevalence for all ages has decreased by 25% from 2010–2017. However, HIV infection amongst people who inject drugs has risen (UNAIDS, 2019:2). The prevalence of HIV infection amongst people who inject drugs seems to have risen over the previous years; from 1,2% in 2011, to 1,4% in 2017 (UNAIDS, 2019:11).

This research explored the experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng. The drug injecting practice has brought together the field of substance use with that of HIV prevention. Injecting heroin is becoming an increasing trend in most regions of South Africa (Weich, 2017:26). Sharing of needles for injecting drugs contributes to the spread of HIV and other blood-borne viruses (Degenhardt, Peacock, Colledge, Leung, Grebely, Vickerman, Stone, Cunningham, Trickey, Dumchev, Lynskey, Griffiths, Mattick, Hickman and Larney, 2017:1192). Nyaope is a novel fashionable drug that is normally used in many townships in South Africa. The full make-up of nyaope is not known, even though most researchers concur that heroin is the main component, with rumors of the inclusion of ARVs having been documented (Mokwena, 2015:138).

Females are not exempt, as active members of the society, they are also participating in drug use. It is reported that substance abuse in our society is rampant, and data has suggested that the statistics of female drug users is fast approaching that of male users (Bahramnejad, Rabani-Bavojdan, Rabani-Bavojdan, Kaviani, 2015:156).

Consequently, it is critical to understand the experiences of female nyaope injectors, so that we can mitigate factors that contribute to HIV prevalence within their population.

The City of Tshwane has an HIV prevalence that is marginally lower than the national average, however, not significantly (Shisana, Rehle, Simbayi, Zuma, Jooste, Zungu, Labadarios, Onoya, 2014:46). It is of great importance that the City of Tshwane Municipality and South African National Department of Health address HIV prevention amongst key population, more especially female nyaope injectors, if it is determined to improve the HIV prevalence.

Some of the female nyaope injectors participate in transactional sex to sustain their drug use habit. Asher, Hahn, Couture, Maher, and Page (2013:6) argue that due to the considerably higher rates of transactional sex work by people who inject drugs (**PWID**), combined with poor condom use, females are at a higher risk than males. In Tanzania, women who inject drugs reported low condom use, as many as 12 times the number of sexual partners as their male counterparts.

Female nyaope injectors are hardly the focus of research, and as a result, their injecting practices are poorly understood (UNAIDS 2014:4 & El-Bassel and Strathdee, 2016:3). The experience of female nyaope injectors are not well documented as it is a neglected field. The need to explore the experiences of female nyaope injectors was long overdue.

1.2 Background of the problem

Nyaope injection has brought the focuses of HIV prevention and substance abuse together. It has called for an integrative approach. According to Dada (2013:21), there are not enough substance use interventions and integrated HIV services that focus particularly on Injecting Drug Users (**IDU**) in South Africa.

Observing the risky behaviour of people who inject drugs, specifically female nyaope injectors, demands attention by researchers. Despite a slow increase of heroin use over the previous 10 years, research on injecting drugs in South Africa remains limited (Dada, 2013:8). There is limited research on the drug injection practice, yet the number of people who inject increases daily. This poses a risk in addressing HIV prevalence.

The drug injection practice is linked with social and health harms such as hepatitis and other infections, specifically, HIV (Dada, 2013:19). Needle sharing is problematic. Dada (2013:20) reports a study where 89% of people who inject drugs shared needles in the past 30 days, 6% had been paid for sex, and 1% never used condoms. Sharing needles increases the risk of contracting HIV. Contracting HIV through using used injecting equipment is six times more likely to result in infection than contraction through unprotected sexual intercourse (WHO, 2015:8).

Female nyaope injectors have considerably diverse needs and have higher risks of infections and violence than male injectors. A focus on female nyaope injectors is imperative for several reasons, including;

- Their higher death rates;
- Increased chances of experiencing injection-related problems;
- Higher rates of the Immuno-deficiency virus (**HIV**); and
- Elevated injection and sexually risky behaviour (Robert, Mathews and Degenhard, 2010:8).

It is important that the research study focuses on female population of drugs users in the City of Tshwane Municipality.

The effects of drug use are more severe in females than in males. They are associated with problems such as economic hardship, greater drug dependence, health risks, as well as involvement in HIV-related high-risk behaviour (Jamshidimanesh, Mousavi, Merghati-Khoei, Emamian, Keramat, 2016:158). It is therefore necessary to understand the experiences of female nyaope injectors so that we are able to address their needs and influence policy making with regards to HIV prevention.

1.3 Rationale of the study

HIV prevention amongst people who inject drugs is an important strategy in reducing HIV infections and related deaths. United Nations Office on Drugs and Crime (**UNODC**) reported that sharing of injecting equipment is one of the main drivers of HIV transmission amongst people who inject drugs (UNODC, 2019:19).

Studies conducted in a number of countries have indicated a significantly higher prevalence of HIV amongst females who use drugs than their male counterparts. Some countries have reported incidences of HIV amongst females who use drugs to

be as high as 85%, compared to rates of up to 65% amongst all people who use drugs in the worst affected countries (GCWA, 2011:3).

Women who use drugs face multiple individual, social, and structural factors that fuel their vulnerability to HIV and other blood-borne infections (El-bassel, Wechsberg and Shaw, 2012:2 & Azima, Bontell, Steffanie and Strathdee,2015:17). A study conducted in South Africa has highlighted that women who use drugs suffer human rights abuses at all levels (UNODC, 2019:21).

There is less literature on the experiences of women who inject drugs in South Africa. In 2018, UNODC funded a consultation in major cities in South Africa; Pretoria, Cape Town and Johannesburg, to get a better understanding of the lived experiences of women who use drugs (UNODC, 2019:3). The study included women who inject drugs and those who do not inject drugs in their sample.

The researcher is of the view that studying the experiences of women who inject drugs will assist in understandings their lived experiences, needs, challenges, risks, coping strategies, and their vulnerabilities. The research findings will enable practitioners and policy makers to utilise context based research findings instead of relying on international literature.

Reducing HIV incidences by improving HIV prevention and treatment for PWID is an urgent international priority; as identified by several high level initiatives, including the Global Fund to Fight AIDS, Tuberculosis and Malaria and the UNAIDS 90-90-90 targets. These initiatives are aimed at substantially scaling up access to, and the effect of, HIV treatment by 2020 (DeBeck, Cheng, Montaner, Beyrer, Elliott, Sherman, Wood and Baral, 2017:358).

1.4 Problem statement

For those who started using nyaope, there is little hope as many who are seen going to rehabilitation centers return to their community and use nyaope again. In their study, Mokoena and Huma (2014:360) discovered that those who went to inpatient treatment centers stated that the programme did not benefit them at all, and that almost all of them continued using nyaope a few days after being discharged.

The researcher has observed that more people are transitioning from smoking to injecting nyaope. Those who inject do not have access to clean needles, as a result,

they share. The practice of sharing injections exposes the users to HIV and other blood-borne diseases. Females are not left out; they are also part of those communities which inject themselves with nyaope.

Female nyaope injectors have significantly diverse necessities and experience increased risks of infections and violence than men who inject drugs. A study focusing on females who inject drugs is overdue, and it needs the attention of all stakeholders. It is therefore important to explore the experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng.

1.5 Significant of the study

The study is expected to enlighten the City of Tshwane Municipality; Gauteng Department of Social Development; substance abuse service providers; and concerned stakeholders about the experiences of female nyaope injectors. The study will add to literature in the field of drug injecting. The study will provide practical strategies in order to mitigate the incidences of HIV amongst female nyaope injectors as well as address the challenges they experience in their daily lives.

1.6 Research purpose

The purpose of the study is to explore the experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng. Furthermore, it is to gain an accurate and deep understanding of factors contributing to females injecting nyaope and how they can be aided to reduce the risks associated with nyaope injection.

1.7 Research objective

De Vos, Strydom, Fouche, and Delport (2011:94) describe research objective as more precise, measurable and more speedily attainable conception of such a "plan to do or achieve". The research objectives are specific little steps the researcher has taken in order to achieve the research goal.

The research objectives were as follow:

- To identify factors contributing to females injecting nyaope;
- To explore the experiences of female nyaope injectors; and
- To explore strategies to mitigate or reduce HIV prevalence amongst female nyaope injectors.

1.8 Research question

Research question is described as the main emphasis of the research in question form, integrating the important ideas that seek to investigate or explain the main concepts of the research (Maggie, 2013:26). The following research questions will be addressed.

- What are the factors contributing to females injecting nyaope?
- What are the experiences of female nyaope injectors?
- What are the services/programmes that can reduce the HIV prevalence amongst female nyaope injectors?

1.9 Scope of the study

The study focused on female nyaope injectors residing in City of Tshwane Municipality, Gauteng. 24 research participants aged between 19–35 years old residing in City of Tshwane Municipality were interviewed.

1.10 Theoretical foundation of the study

Social Ecological Model and Health Belief Model were utilised to understand the experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng. These models were considered as they are able to examine environmental circumstances that affect health and wellbeing, as well as health behaviours by concentrating on the beliefs and attitudes of females who have a history of injecting nyaope.

1.11 Research process

A qualitative and exploratory research was followed in this study. Purposive sampling was employed to select 15 participants from females who were still injecting nyaope and 9 from females who recovering from injecting nyaope. The participants were between the ages of 19–35 and reside in the City of Tshwane Municipality. An in-depth, semi-structured interview was employed for data collection on 24 research participants. Field undertaken notes were also kept by the researcher to record some of his own perceptions and observations. Data was analysed using six phases as identified by Braun and Clarks (2006) in Jensen and Laurie (2016:609-610).

The research methodology will be explained in more details in chapter three of this study.

1.12 Outline of the dissertation

Chapter 1: Overview of the Study

This section presents the research title, introduction, and background of study, rationale of the study, research problem, significant of the study, research purpose, objectives and research questions, definition of key concepts, scope of research, theoretical foundation of study, research process, research outline and summary.

Chapter 2: Literature Review and theoretical frame work

This chapter will present the theoretical framework which guides the study and relevant literature related to female nyaope injectors.

Chapter 3: Research Methodology and Design

This chapter will present the research methodology and provides detailed research approach, research design, data collection, data analysis, measures to ensure trustworthiness, and ethical consideration.

Chapter 4: Data Collection and Findings

This chapter will present the interpreted data as research findings from the interviews conducted.

Chapter 5: Conclusion and Recommendations

This chapter will present the conclusion and recommendations of the study based on said findings.

1.13 Summary

This chapter has outlined the background of the study, research rationale, problem statement, significance of the study, research purpose, research objectives and question, definition of key concepts, theoretical foundation of the study, research process, outline of the dissertation, and summary. The next chapter will present the literature review on experiences of female nyaope injectors, as well as the theoretical framework.

2. CHAPTER TWO

Literature Review

2.1 Introduction

This section reviews different literature on the female drug injecting phenomenon and their vulnerability to contracting HIV. A literature review gives a chance for the researcher to classify, evaluate and combine current body of scientific work produced by researchers (Booth, Papaioannou and Sutton. 2012:2). Like all other research, most original research is seen as an extension of what has previously been learnt about a particular topic. Literature review is the way we learn what is already known and unknown on the specific topic (Babbie, 2010:506).

2.2 South African HIV epidemic

South African HIV prevalence has escalated from an estimated 4,25 million in 2002 to 7,52 million by 2018. Almost one in five of South African females in their child-bearing ages (15–49 years) is HIV positive. HIV prevalence amongst youth aged 15–24 has decreased from 6,7% in 2002 to 5,5% in 2018. It is estimated that 19% of adults between the ages of 15–49 years are living with HIV. The total number of people living with is projected at about 7,52 million in 2018 (StatsSA, 2018:7).

2.3 Female nyaope injectors and HIV

It is a general knowledge that alcohol and other drugs are known to have a direct and indirect impact in increasing the risk of HIV transmission. This take place directly through sharing of used injecting equipment, and indirectly, as alcohol and other drugs can decrease inhibitions and impair decision making. As a result this influences risky sexual encounters such as having multiple sexual partners and increased length of sexual encounters (Parry, Carney and Williams, 2017:111).

Significant decreases in HIV prevalence and mortality were observed from 2009–2013 globally; mostly within sub-Saharan Africa. However, decreases in HIV prevalence amongst people who inject drugs, more especially female nyaope injectors, has not been good (Springer et al, 2016:2).

Worldwide, the statistics of people who inject drugs is about 16 million, of whom, three million are projected to be HIV-infected (Azim et al, 2015:16). It is estimated that

females account for 27% of all people who inject drugs in South Africa, and 19,4% of female nyaope injectors are HIV infected (Springer et al, 2016:6).

Different studies have stressed that people who inject drugs are at higher risk of contracting HIV. People who inject drugs do not have equal risk of contracting HIV. Female drug injectors are at higher risk of contracting HIV. There are several reasons why female nyaope injectors may have a higher risk of contracting HIV infections as compared to man who inject drugs. Females may struggle in accessing sterile injection equipment. They may experience extreme stigma when they seek treatment for substance use. As mentioned above, female nyaope injectors are quite likely to have a male injector as a sexual partner. There are also substantial gender inequalities in many countries that may add to increased HIV risk for females in general (Des Jarlais, Freelemyer, Modi, and Arasteh, 2013:2).

- Their higher death rates;
- Increased chance of experiencing injection-related problems;
- Increased rates of HIV; and
- Elevated injection and sexual risk behaviour (Robert et al, 2010:8).

The effects of drug use are more severe in females than in males and are associated with problems such as economic hardship, greater drug dependence, health risks and involvement in HIV-related, high-risk behaviour (Jamshidimanesh, Mousavi, Merghati-Khoei, Emamian and Keramat, 2016:158).

Female nyaope injectors are more likely to participate in drug and sexual risks than males who inject drugs due to severe discrimination and cultural stigma perpetuated on them (Marottaa, Gilberta, Terlikbayevab, Wua and El-Bassela, 2018:97). Female nyaope injectors tend to be dependent on drugs faster than their male counterpart, inject more frequently per day, have intimate partners who inject, contract and die from HIV/AIDS, and have severe combined risks. This is partly because most of them engage in sex work to raise money for drugs (Khuat, Morrow, Nguyen and Armstrong, 2015:1). The mean age of first drug injection by female nyaope injectors is 19,5 years, and mean number of injection used is normally twice per day. Drug injecting is most widespread during late adolescence and early to mid-adulthood; overlapping with a woman’s reproductive years (Uusküla, Raag, Vorobjov, and Des Jarlais, 2018:3).

2.4 Use and challenges of nyaope in South Africa

Nyaope is a drug preferred by many drug users in townships, especially in Gauteng. It is reported that hundreds of nyaope users are dying in the City of Tshwane from Nyaope overdose, some as young as 9 years old (Masombuka, 2013:29). Heroin is the main ingredient in nyaope (Mokwena, 2015:138). The use of nyaope and its effects on the lives of those who use drugs, their communities, their families and the country has been most covered by media. There is as assumption that nyaope can be the worse drug in South Africa. Those who use nyaope are identified easily by their poor personal hygiene, their slowness of movement and their half-dazed looks.

In townships, they are often labelled to as “nyaopers” and are known for committing petty crimes in order to maintain their habit. The author believes “nyaopers” as a name is derogative and perpetuates stigmatisation on people who inject drugs (Mokwena, 2016:138). The stigmatisation contributes to people distancing themselves from individuals who use drugs and are afraid of those with drug use problems, viewing them as dangerous (Paquettea, Syvertsenc and Pollinia, 2018:3).

Nyaope was declared an illegal drug when the amendments (amendment of schedule 1 and 2) to the Drug Trafficking Act of 1992 (Act 140/1992) were signed in 2014. Before 2014, there were no laws to regulate new narcotics created by modifying the chemical structure of certain substances, or finding chemicals with entirely different chemical structures that produced similar effects. Nyaope was easily accessible in the communities, drug dealers sold it freely without fear of being arrested (Mokwena, 2016:138 & Dintwe, 2017:160).

The use of nyaope presents an immense social and health problem and affects users, families and their community. The problem of nyaope is worsened by being easily accessible in townships where black people mostly live. Furthermore, being fairly cheap and therefore, enticing large numbers of unemployed youth who are mostly poorly educated, with poor employment opportunities, and fewer opportunities for rehabilitation (Mokwena and Huma, 2014:360).

Nyaope is a concoction of low quality heroin smoked with dagga or injected. The abuse nyaope, in South Africa, has escalated in recent years mainly amongst young African and Coloured males. This influences users to resort to crime, losing their jobs and

dropping out of schools. Nyaope users are mostly from poor backgrounds, they often resort to criminal activities to finance their drug habit. Females are not left out, they are also using nyaope. Heroin is an addictive drug and the presence of ARVs makes nyaope an even more addictive drug mixture which can cause violent stomach cramps. Users experience extreme difficulties when attempting to stop using nyaope on their own (Mthembi, Mwenesongole and Cole, 2018:115-116 & Mokwena, 2016:138 & Meel and Essop, 2018:588).

Nyaope use is consequently a major problem, followed by HIV epidemic in South Africa. Studies regarding the prevalent abuse of nyaope in South Africa, has shown that nyaope abuse has led to the growth of drug abuse and crimes statistics (Monyakane, 2018:2).

The use of nyaope is reported to make the users feel ecstatic and excited. Continuous use is linked with the development of tolerance and dependence. Users will start to use increasingly greater and more frequent amounts of the drug to achieve the same effect. When nyaope users are dependent on nyaope, they will experience withdrawal syndrome in the form of physical pain if they do not use nyaope (Mokwena, 2016:138).

Even though nyaope was known to be smoked, users are transitioning to injecting. This practice of injecting is likely to contribute to an increase in health cases including transmission of HIV and endocarditis. Endocarditis due to injecting drugs contributes to morbidity and mortality in young male population (Meel and Essop, 2018:585-588). This implies that females who inject nyaope have a likelihood of having heart attacks.

Pregnant women who use nyaope compromise their health and that of their unborn babies. Using nyaope while pregnant has harmful effects to unborn babies (Mthembi et al, 2018:115-116). Drug use amongst pregnant females may add in numerous pregnancy complications, such as neonatal abstinence syndrome, low birth weight, and premature birth. Neonatal abstinence syndrome mainly refers to heroin withdrawal syndrome, which is experienced by infants born to females who continue to use heroine during pregnancy (UNODC, 2018:21).

According to Dintwe (2017:162), nyaope is a multi-faceted challenge, its addiction is caused by a variety of factors. Nyaope addiction needs a multi-faceted approach; it poses unique challenges for the police and other law enforcement agencies. It

therefore calls for an integrative approach to address nyaope challenges in the communities. The challenges cannot be addressed without engaging the users to shed light concerning their challenges, coping resources, experience, risks, needs and hopes.

2.5 Risky behaviour of females drug injectors

HIV amongst people who inject drugs is unjustly higher compared to the general population; sharing injecting equipment is one of the elements contributing to high HIV incidence. People who inject drugs are also at risk of HIV transmission through unprotected sex, which is predisposed by links to sex work, transactional sex and drug-related effects. Several social and structural factors contribute to the increased HIV burden amongst people who inject drugs. For example, the criminalisation of drug use contributes to stigmatisation of people who use drugs, which makes it difficult for people who inject drugs to access health services (Scheibe, Shelly, Lambert, Schneider, Basson, Medeiros, Padayachee, Savva and Hausler, 2017:2).

2.5.1 Sexual risk by female nyaope injectors

Female nyaope injectors engage in transactional sex, sex work, sharing of injections and poor condom use, increasing the risk of contracting HIV. If female nyaope injectors address their risky behaviour, it will reduce the risk of contracting HIV and reduce financial burden on the stat; which comes with supplying ARVs and related services to HIV positive people.

2.5.1.1 Transactional sex

Females are more likely to engage in transactional sex and sex work as compared to their male counterparts (Scheibe, Howell, Muller, Katumba, Langen, Artz and Marks, 2016a:113). Females who use drugs and engage in sex work are more likely to share used injections and other injecting equipment amongst themselves and their clients. (Azima et al (2015:17) further argue that females who use drugs engage in unprotected sex with their clients, as well as their intimate partners, and have higher rates of sexual transmitted infections (**STI**). They are also at risk of experiencing sexual violence and incarceration.

A study conducted in Tanzania, highlighted that female who use drugs have reported condom inconsistency and multiple sexual partners as compared to men (Asher et al, 2013:6). Due to the significantly higher rates of transactional sex and sex work by females who inject drugs and coupled with poor condom use, HIV risks are higher for them as compared with their male counterparts.

2.5.1.2 Poor condom use

Majority of the females who use drugs are often incapable of discussing safe sex with their intimate partners. Sexual risk-taking may be linked with the feelings of trust in a relationship, or they may be culturally entrenched in the gendered distribution of power. Endeavours to discuss condom use with an intimate partner can consequently result in violence, isolation and exclusion if taken as an unwanted challenge to fidelity and privilege within the relationship (GCWA, 2011:5). This implies that culture and believes have a negative impact in terms of intimate relationships between females who are using nyaope and their partners.

There are different factors that contributes to poor condom use. Haddad, Tang, Krashin, Ng'ambi, Tweya, Samala, Chiwoko, Chaweza, Hosseinipour, Lathrop, Jamieson and Phiri4 (2018:44) argue that low utilisation of condoms has been associated with cost, religious ideology, alcohol or drug use, younger sexual debut, poor knowledge of HIV/AIDS, beliefs of diminished sexual pleasure and male emotional fulfilment, disbelief in prevention efficacy, distrust in relationships, and gender inequality.

2.5.1.3 Sex work

It is reported that most female sex workers use drugs. For some of them, drug dependency has contributed in starting to work as sex workers. Others may have started to use drugs to cope or numb the challenging routines linked with sex work (Strathdee, West, Reed, Moazan, Azim and Dolan, 2015:2). Sex workers in South African have mostly been unnoticed and underserved by health and social services. From 2010, efforts have focused on improving health care services for sex workers. Studies in South Africa suggest that the prevalence rate among female sex workers varieties from 40–88%, considerably higher than the 14,4% prevalence among adult females in the general population. Sex workers in South Africa are susceptible to a

variety of factors that predispose them to HIV and other blood-borne infections (SANAC, 2016:13-18). More attention is required in order to address the challenges of female nyaope injectors who work as sex workers.

2.5.2 Impact of sharing injection

Females are also injecting drugs, it is reported that 87% of female started to inject with heroin (Scheibe, Makapela, Brown, dos Santos, Hariga, Virk, Bekker, Lyan, Fee, Molnar, Bocai, Eligh, and Lehtovuor, 2016b:110).HIV contact through using used injecting equipment is six times more probable to transmit infection than contact through unprotected vaginal intercourse (WHO, 2015:8). This implies that chances of contracting HIV through use of contaminated injecting equipment is very likely.

Female nyaope injectors are vulnerable and are at high risk of contracting HIV. In South Africa, is it projected that HIV prevalence amongst people who inject drugs is 12,4% (Scheibe et al, 2016b:108). People who inject drugs are severely affected by HIV. Prelude analyses of the 2013 Global AIDS Response Progress Reporting (**GARPR**) data projects that people who inject drugs account for 30% of new HIV infections outside of sub-Saharan Africa (UNAIDS, 2014:3).

Neglecting people who inject drugs, especially female nyaope injectors, through HIV prevention programmes, is tantamount to wasting money through HIV promotions and compromising efforts toward vision 90-90-90 and ending HIV by 20130.

2.6 Vulnerabilities of female nyaope injectors

Females who use drugs, regardless of whether they are injecting or not, experience numerous issues which increases their vulnerability to HIV. These includes: concomitant sex work, STIs, viral hepatitis, mental health problems, reproductive health issues, stigma, child care, violence, and lack of access to health services; including for HIV prevention, care and treatment (Azima et al, 2015:17).

2.6.1 Biological factors

Females are more biologically susceptible to sexual transmission of HIV than males. Such vulnerabilities, when joint with the particular risks experienced by females who use drugs, worsen their risk of HIV infection even further (GCWA, 2011:3 & UNODC, 2018:6). A female, as a receptive partner, has a greater risk of heterosexual HIV

transmission through vaginal or anal sex than a male insertive partner, although risk differs depending on the context and setting (Larney et al, 2015:7).

The physiological risk of contracting HIV is higher for females than males because females have a more mucosal surface area exposed to pathogens and infectious fluids for longer periods during sexual intercourse, and they are likely to face increased tissue injury. Exposure of a larger area of vaginal epithelium during sex, transmission of a larger volume of genital fluids from male to female ,and a higher viral load in semen, are cited as possible reasons for this discrepancy (Ramjee and Daniels, 2013:2). Female specific clinical manifestations, such as gynaecological infections and precancerous lesions in the vagina and cervix, places females at a biological disadvantage (Rodrigo and Rajapakse, 2010:9).

2.6.2 Gender inequality

The social construction of the purpose of gender, as it relates to social standards and disparities, describes and shapes risk in the context of relationships between men and women. Studies on HIV prevention has argued that gender inequality and the subsequent power differential found in relationships between males and females are contributing factors in heterosexual HIV transmission and unequal rates of HIV among females (Morrisa, Montgomery, Bricenoa, Evansa, Andrewc, Pagec and Hahna, 2018:2).

There is a consensus that females' lower social status can leave them vulnerable to infections from males, due to principles of masculinity linked with risk-taking and sexual conquest (Turmen, 2003:412). Cultural norms and values disempower females to discuss safer sex with their intimate partners, which increases their vulnerability to contracting HIV. Females reported that the fear of losing their intimate partners affects their decision making as it relates to safe sex; leaving the decision to practice safe sex to their partners (Jamshidimanesh et al, 2016:163).

2.6.3 Intimate partner violence

Intimate partner violence (**IPV**)has been reported as a substantial facilitator to HIV transmission risk among females who use drugs, and is also more prevalent amongst female nyaope injectors compared with females in the general population (Stoicescu, Cluver, Spreckelsen, Casale, Sudewo and Irwanto, 2018:308)

It is further argued that females who use and inject drugs experience high proportion of IPV such as physical assaults, sexual coercion, and rape. Females who are exposed to IPV may be unwilling to refuse sex with a condom for fear of provoking further violence (Larney et al, 2015:8). A refusal to use a partner's used injecting equipment can expose females at a higher risk of IPV, which will further increase their risk of HIV infection.

Such violence is often supported by cultural concepts whereby the male partner is free to exert power and control. Sexual duress is one of the forms of IPV, most strongly associated with the risk of HIV transmission. The risk of HIV amongst females who have experienced violence may be up to three times higher than those who have not. Eventually, the helplessness effects of IPV can result in a greater struggle for females in discussing safer sex practices to reduce their risk of acquiring HIV (GCWA, 2011:6).

In situations where intimate partner is responsible for buying drugs for the female, there is often the anticipation that the female will have sex with them in exchange, which points to a gender power inequality that is deepened by drug use and places the female drug user in high risk of contracting HIV infection. In these situations, a female's denial to have sex, or her attempts to discuss condom use, may trigger further violence (UNODC, 2018:17). In order to protect female nyaope injectors, the South African government, through the parliamentary processes, has to create bills and laws that are aimed to protect the vulnerable females drug users. This is discusses further in Section 5.4.

Females' intimate relationships with their male partners who also use drugs are complex and lively. Females work to maintain their drug habits and that of their intimate partners. A study of female nyaope injectors who sell sex in Canada established that the males control females' lives through a process of building trust, supplying and controlling the supply of drugs, gaining control of their sex work environment, and transactions with their clients. Sexual and physical violence against female nyaope injectors is prevalent and the experience and the threat of violence serves to subdue them further (Azima et al, 2015:17). IPV affects females' influence and ability to discuss the conditions of sexual intercourse, especially condom use (Turmen, 2003:413).

2.6.4 Cultural factors

Culturally entrenched power disparities that exist between men and women across the world often leaves women susceptible to increased stigma, abuse, violence and coercion (GCWA, 2011:3). Cultural expectations of masculinity applauds men to accept the patriarchal attitude that wives, partners and daughters are their belongings, and most husbands expect or demand their conjugal 'rights' (Ramjee and Daniels, 2013:2).

The stigma that is experienced by female nyaope users is intense as compared to that which is experienced by male counterparts because of gender-based stereotypes that hold females to different values. Drug use by females is seen as breaking their traditional role in society as mothers and caretakers. Increased stigma is also linked with homelessness to females who use drugs, which causes them to stay deep-rooted within drug-using networks. As a result, they spend less time with people who do not use drugs that could be potential sources of help for treatment and care (UNODC, 2018:20).

It is reported that women who use and inject drugs are fewer than men, and they account for 20% of the worldwide estimate of people who inject drugs. In terms of risks, females who use drugs are more vulnerable than males to HIV and other blood-borne infections. This is not only for biological reasons, but also because of gender power disparities. For example, being incapable to discuss condom use, being injected after an intimate male partner has injected himself with the same needle, and being involved in sex work. (UNODC, 2018:20).

Cultural customs make it tough for females to acknowledge their drug problem and leave their homes and families to undergo substance related treatment. Since many females who use drugs also live with a partner or other family members using drugs, relationship issues and the role of drug use within the relationship remain the key issue in females seeking support for drug treatment (UNODC, 2018:22). Societal customs that supress females and build imbalanced power relationships further strengthen injection sharing and drug-related norms in intimate partnerships (Marottaa et al, 2018:103).

2.6.5 Economic factor

While financial deficiency does not contribute to drug use alone, various factors linked with family, interpersonal instability, high prevalence of mental health disorders and low school completion rates, result in a situation where a lack of social and economic resources make females more vulnerable to using drugs. (UNODC, 2018:20).

Female nyaope injectors typically depend on male partners for drugs and injections, contributing to high drug and equipment sharing (Des Jarlais et al, 2012:2). Many females are forced to participate in sex work to finance their own or their partner's drug use, which may put them at dual risk of HIV infection through unsafe sex as well as unsafe injections (Azima et al, 2015:17).

Financial gender inequality stimulates IPV in relationships, lessens females' power in sexual discussions with male partners, and intensify their susceptibility to HIV. Unfavourable socioeconomic conditions can lead females to practice sex work, consequently elevating their HIV risk (El-Bassel and Strathdee, 2016:6). Female nyaope injectors often face gender and power inequalities Mburu, Ayon, Tsai, Ndimbii, Wang, Strathdee and Seeley (2018:2). Poor socio-economic circumstance can limit development, educational opportunities, access to health care services and employment creating a favourable setting for HIV spread (Rodrigo and Rajapakse, 2009:10).

Globally, females who use drugs experience high unemployment rates due to the stigma and discrimination. These females have slight prospects of accessing the job market and become financially dependent. Most of the females continue to be poor and depend on their intimate partners for food and shelter. These financial limitations reduces their access to educational or occupational training, banking and asset accumulation, as well as property ownership. Financial gender inequality also promotes IPV in relationships, reducing females' power in sexual discussions with male intimate partners, and ultimately elevates their susceptibility to HIV (El-Bassel and Strathdee, 2016:6).

Poor economic position has been linked with earlier sexual debut, inconsistent condom use, having multiple sex partners, increased chances that the first sex act is non-consensual, and a greater probability of having had transactional sex or physically

forced sex. Many females opt to engage in transactional sex to finance their lives (Ramjee and Daniels, 2013:3).

Poor economic standing predisposes females to multiple risk factors that increase their likelihood to contracting HIV. Efforts to empower females economically should be prioritised in order to address HIV infections especially among the younger females as they are the ones affected most by HIV. This is discusses further in Section 5.4.

2.6.6 Social factors

Significant others play a role in encouraging females to inject drugs. Females are more likely to start injecting drugs with an intimate partner and are likely to have that partner inject them (El-Bassel and Strathdee, 2016:5, Larney et al, 2015:7). Females who are in an intimate relationship with a drug user have been shown to be significantly linked with a female's initiation and continuation of drug use. They are also likely to request the male partner to inject them, contributing to their higher susceptibility (UNODC, 2018:18, & GCWA, 2011:6).

Tuchman (2015:6) discovered in her study that most females were initiated into drug injecting by their fellow females, rather than a male sexual partner. This is contrary to most literature which states that male intimate partners initiate females to injecting drug use. Societal determinants of gender inequality such as socio-economic conditions, gender norms, ethnicity, and religion can increase the risk of HIV (GCWA, 2011:3).

Females who use drugs may be excluded from family support structures, and those who are not financially independent or lack employment prospects may be more probable to participate in sex work, elevating their sexual HIV risk and drawing extra stigma linked with sex work (Larney et al, 2015:7).

Female nyaope injectors who try to care for their offspring, while living with the substance abuse related stigma, face another layer of complexity with their family members. Females who use drugs may also have responsibilities as caregivers; consequently, their drug use unpleasantly disturbs their families, in particular, children. Such adverse childhood experiences can be transgenerational and impart the risks of substance use to the children of females with drug use disorders (UNODC, 2018:6).

Children are emotionally and financially dependent on their parents, harmful parental drug use, especially by the mother in societies where they have the role of caregiver, can affect the children adversely in the long term (UNODC, 2018:22).

2.6.7 Conduct of law enforcers

El-Bassel and Strathdee (2016:6) suggest that females who use drugs may be ill-treated by police officers. Police officers may use violent policing on female nyaope injectors; including arresting females for buying or carrying sterile injections, pestering at needle exchange programs or drug treatment clinics, soliciting bribes to avoid arrest, sexual abuse and violence, or planting drugs on females. Studies of females globally have established a strong association between substance use and police sexual misconduct, coercion, or rape. Females do not report police abuses due to fears of imprisonment or other punitive penalties for themselves and their families.

Criminalisation of drug use increases the likelihood of police targeting drug injectors. This adds to increased rates of drug offence sentences amongst people who inject drugs. The criminalisation of drug use, mainly in public spaces, has also led to police targeting drug and HIV treatment locations for arrests and detention of people who inject drugs (Marottaa et al, 2018:97). Growing literature of research has proposed that violent policing, such as crackdowns, has not decreased drug use and has instead led to serious public health consequences, including high HIV infection epidemics amongst people who inject drugs. For example, the fear caused by intensive policing on people who inject drugs may cause people who inject drugs to hideaway into remote or hidden settings and avoid needle exchange services that can help protect them from HIV infection (Hayashi, Small, Csete, Hattirat and Kerr, 2013:1).

Studies have further suggested that criminalisation of drug use pushes pregnant females to hide their drug use from healthcare providers, restricting them from accessing harm reduction and HIV prevention services (El-Bassel and Strathdee, 2016:5).

The percentage of females convicted for drug related crimes is high as compared with that of males. Once released from correctional centre, females experience the combined stigma of their gender and their status as ex-offenders. They continue to experience difficulties such as discrimination when accessing social services and

health care services. They also experience social isolation, leaving them to continue living in conditions of social and economic disadvantage and inequality (UNODC, 2018:7).

It is understood that injecting drugs in public spaces may lead to drug crime convictions for females who inject drugs. This is because law enforcement pays greater attention on drug user status for female nyaope injectors compared to male injectors. Injecting in public locations is also strongly linked with hasty injections due to fear of police contact and harassment. This then exuberates female nyaope injectors to ignore hygienic and safe injection practices (Marottaa et al, 2018:103).

According to a research titled *'Experiences with Policing among People Who Inject Drugs in Bangkok, Thailand' (*Hayashi et al, 2013:5-7), it was discovered that people who inject drugs experience abuse at the hands of the police. Police falsely accuse them, planted evidence on them, or coerced them into admitting to a crime that they did not commit. Despite having experienced abuse and corruption from the police, participants showed an unwillingness to open criminal cases against the police or seek justice. Some participants indicated that they felt helpless and were discouraged by the police officers' disregard for their rights. The findings indicate that police exploitation and other police misconduct have further led to people who inject drugs' vulnerability to drug-related harm.

Some participants reported that they try to avoid police and do so by refraining from going into public spaces where they could be exposed to police scrutiny. This intervention by the police often obstructed females who inject drugs access to health care. The violent policing undermines justice and intrudes important health services. This is violating the right to the highest attainable standard of health enshrined in the International Covenant on Economic, Social and Cultural Rights (Article 12) (Hayashi et al, 2013:7).

South African key populations indicated numerous types of abuse committed by police officers. Key populations were defined by the United Nations Joint Programme on HIV and AIDS as social groupings that are among the most likely to be exposed to HIV, and who are negatively affected by punitive laws and stigmatising policies which people who inject drugs are classified to (Scheibe et al, 2016a:1).

2.6.8 Mental health challenges

People who inject drugs face elevated levels of mental health challenges such as depression, psychosis, as well as anxiety and personality disorders. It is understood that mental health conditions leads to drug use (UNODC, 2015a:13). Females are more likely, than males, to name trauma or stressors such as relationship problems, environmental stress and family problems as grounds for their initiation or continuation of substance use (UNODC, 2018:9).

Increased vulnerability adds to a mix of mood and anxiety disorders, particularly post-traumatic stress disorder, and is linked with substance use amongst females. Some studies suggest that females may be more likely to start using drug as a way of self-medicating for mental health issues, such as depression, anxiety, and posttraumatic stress disorder. These are often a result of trauma, abuse, and violence (Pinkham, Myers and Stoicescu, 2012:3).

2.6.9 Stigma and discrimination challenges

Stigmatisation and discrimination on females who use drugs increases the probability of practicing high risk behaviours, which then increases chances of contracting HIV and other blood-borne virus (**BBV**) transmission. The stigma attached to females' drug use can result in them being forcibly removed from their homes, ostracised by family, friends and the community large, and having their children removed from their custody. This happens regardless of whether or not their parenting skills are compromised by the use of drugs (GCWA, 2011:2-3). Females who use drugs are stigmatised worse than males due to traditional stereotypes that hold females to different expectations and roles of females as mothers, partners and caretakers (El-Bassel and Strathdee, 2016:5 & Khuat et al, 2015:1).

Current evidence suggests that female nyaope injectors construct self-stigmatised identities to an extant where it becomes difficult to have important relationships; assuming that they do not deserve to be loved. The internalisation of the stigma is associated with low self-esteem. Apart from being ashamed of themselves, female nyaope injectors consistently witness negative attitudes from their communities and families. This stigma is influenced by moral judgement. Apart from the stigma which is perpetuated on them by the communities, they experience regular stigmatisation in

healthcare settings. Regardless of its source, stigmatisation of females who inject drugs seems to result in isolation and exclusion through prejudiced social processes and institutional practices. Different forms of stigmatisation of female nyaope injectors are an influential barrier to their access and utilisation of health care services (Mburu et al, 2018:3-5). Stigma perpetuated on females who inject drugs does more harm than the drug itself.

Drug use and injecting practice attracts deep levels of stigma. People who use drugs may encounter condemnation by their families and communities and discrimination in a variety of settings such as health care settings. Social exclusion, stigmatisation, and discrimination may fuel HIV risk and dent HIV prevention and treatment (Larney et al, 2015:6). Females who use drugs are deprived social support, such as child-care, due to stigma held by their families and friends (El-Bassel and Strathdee, 2016:5).

In many communities, drug use, both in general and among females, is severely stigmatised. This results in females who use drugs hiding themselves more than males who use drugs (UNODC, 2018:22).

2.7 HIV prevention strategies among female nyaope injectors: Harm reduction services

Regardless of the acknowledgement of the effects of drug use on HIV transmission, there are inadequate HIV harm-reduction services in South African. Based on the connection between HIV risk behaviour and drug use, it can be justified that strengthening efforts to offer integrated HIV harm-reduction and substance abuse treatment services should be prioritised. Although the drafting of South Africa's Third National Drug Master Plan (2013-2017) gave eminence to the necessity of addressing drug abuse as part of comprehensive HIV prevention efforts, programmes targeting people who use drugs, with a sole purpose of addressing drug use and sexual risk behaviour in South Africa, are scarce (Parry et al, 2017:112).

Females experience substantial systemic, structural, social, cultural and personal obstacles in accessing treatment for drug use. At a structural level, the most important barriers include lack of child-care services and negative attitudes towards mothers and pregnant females with a substance use condition (UNODC, 2018:22). Female nyaope

injectors are a subpopulation that is deserted from HIV prevention and substance abuse treatment strategies for people who inject drugs (Marottaa et al, 2018:102).

Stigmatisation and discrimination perpetuated on people who inject drugs makes it hard for them to access health care services. Several studies indicates that, when female nyaope injectors are living with HIV and are pregnant, they face ample obstacles accessing services to assist their infants from acquiring HIV infection (UNAIDS, 2014:10). A comprehensive package of harm reduction was endorsed for all people who inject drugs in order to lessen social and health harms related to injecting drugs (Mburu et al, 2018:1).

The Southern African HIV Clinicians Society (**SAHCS**) released a statement on the 3rd of June 2019 pledging their support for harm reduction. In the statement, they reported that they supports evidence-based law and policy-making. They believe that South Africa will not reach its, nor international, HIV or viral hepatitis reduction and treatment targets or related public health goals if it does not decriminalise drug use (SAHCS, 2019).

Intervention guidelines includes are discussed in the section that follows.

2.7.1 Harm reduction services package

A technical guide for people who inject drugs was designed by WHO, UNODC and UNAIDS; it was named *harm reduction* (UNDOC, 2017:63). Intervention guidelines contains, needle and syringe programmes (**NSPs**), opioid substitution therapy (**OST**), prevention, vaccination, diagnosis and treatment of viral hepatitis B and C, and community distribution of naloxone for prevention and treatment of opioid overdose to name the few. Implementation of a harm reduction approach is cost effective and beneficial for the health outcomes of people who use drugs, their families and the communities in which they live (UNAIDS, 2014:13).

2.7.1.1 Needle and syringe programmes (NSPs)

The first needle exchange programme in South Africa was established in Cape Town in 2012, focusing on men who have sex with men. In 2015, this service was provided by a different service provider and was accessible to a wider range of people who

inject drugs. In the same year, needle and syringe services were established in Durban and Pretoria (Scheibe et al, 2019:2).

The use of drugs in South Africa is criminalised, but no laws prohibit the acquisition or provision of injecting equipment, therefore, the provision of needle exchange programmes is not outlawed. HIV is efficiently spread through the use of contaminated injecting equipment and can spread rapidly within PWID networks. Provision of injecting equipment can reduce the HIV transmission among females who inject drugs drastically (Scheibe et al 2017:2)

The facilitation of access to sterile needles and injecting equipment through NSPs has proven to be effectively in decreasing the risk of contracting HIV and other blood-borne infections. NSPs provide sterile needles in order to discourage the use of contaminated needles and injecting equipment. NSPs have confirmed to produce outcomes and are cost-effective, and have not been shown to promote drug use or injecting.

NSPs should attract people who inject drugs to other crucial services like health and social services, which they might be unwilling to use. NSPs are implemented by people who have a history of injecting drugs. As peers, they are able to appeal to people who inject drugs to access harm reduction services.

Characteristics of NSPs are that they:

- are harm reduction-oriented, make minimal demands on the injector;
- offer a range of free products;
- are not punitive (do not adhere to strict exchange policy);
- does not stop injectors from giving other injectors needles;
- provide other services by qualified staff, for example, psychosocial service or medical services;
- provide needle disposal services;
- provide overdose management;
- train drug injectors on safe injecting; and
- are integrated with other services (UNODC, 2017:62-63).

2.7.1.2 Opioid substitution therapy (OST) and other evidence-based drug-dependence treatment

The first South African government-funded OST was implemented in Western Cape and has demonstrated modest success, in terms of completion and retention rates, and further argues for a move to increase availability of and accessibility to OSTs for management of opioid use disorder (Michie, Hoosain and Macharia. 2017:542).

OST aims to alleviate the symptoms of opioid withdrawal, reduce cravings, and the opioid response through receptor coverage. Over 40 years of research has shown that OST saves lives, improves retention in healthcare and treatment, reduces illicit heroin use, reduces interactions with the criminal justice system reduces HIV risk, and improves health and quality of life. (Scheibe, Marks, Shelly, Gerardy, Domingo and Hugo, 2018:800).

OST has shown to be the greatest effective drug-dependence treatment for preventing HIV among people who injecting drugs and are addicted to opioids. OST is a safe and cost effective medical opioids treatment. OST improves ARV and TB treatment adherence for diagnosed people (UNODC, 2017:66-72).

2.7.1.3 HIV testing services

The HIV testing services (**HTS**) are initial entry into HIV prevention services. They are important to caring and sustaining treatment for people living with HIV. Integrating counselling with knowledge of one's HIV status and HIV testing services can assist people with regards to harm reduction services in order to prevent HIV transmission.

The HIV testing services must be part of a cohesive programme. This must address HIV prevention, care and treatment. The HIV testing services should adhere to the "Five C" principles namely; Consent, Confidentiality, Counselling, Correct test results and Connection to follow-up services (UNODC, 2017:72-74).

2.7.1.4 The antiretroviral therapy (ART) regarding people living with HIV

Expanding accessibility to HIV testing and ART is critical, both to reducing levels of AIDS mortality, and to reducing HIV incidence. This is therefore the focus of the UNAIDS 2020 targets, which aim to achieve a 90% rate of diagnosis in people living

with HIV, a 90% rate of ART coverage in HIV-diagnosed individuals and a 90% rate of virological suppression in patients on ART (Johnson, Dorrington and Moolla, 2017:2).

There is significant decrease of HIV related illness and death as a result to increased availability and access to ARV. Recent improvements in HIV treatment, combined with promotion for increased availability of cost-effective drugs, have resulted in massive enhancements in the value of life of people living with HIV globally. Conversely, global levels of treatment provision have improved significantly over the last years. The accessibility of ARV amongst people who inject drugs is still very poor, with a global average of less than 10%. South Africa has the largest ART program in the world, with more than 3,4 million HIV-infected individuals accessing ARV drugs. The ARV programme continues to grow with the removal of CD4+ count thresholds as a criterion for ART initiation (Moorhouse, Maartens, Venter, Moosa, Steegen, Jamaloodien, Fox and Conradie, 2018:73-74).

According to WHO guidelines, it is recommended that people living with HIV must commence with ART regardless of their clinical stage and CD4 count. This must include people living with HIV who inject drugs. (UNODC, 2017: 75-76).

2.7.1.5 Treatment and prevention of sexually transmitted infections

Sexually transmitted infections (**STIs**) are infections caused by bacteria, viruses and parasites that are transferred mainly via sexual contact, be it vaginal, anal, oral or in some instances via non-sexual means, that is, by means of blood or blood products. The high level of STIs in South Africa can be attributed to a large number of factors including low socio-economic conditions, social stigma, gender inequalities, inability to access adequate health care systems and lack of preventative programmes (Van Eyk, 2016:12).

South Africa has some of the highest rates of STIs in the world, the government views them as a major public health problem. In 2007, the South African government introduced its first national strategic plan for HIV and STIs; its latest plan for 2017–2022 includes STI interventions and targets (Kularatne, Niit, Rowley, Kufa-ChakezhaID, PetersID, Taylor, Johnson and Korenromp, 2018:2).

The delivery of elementary HIV and STI clinical services is a crucial part of a comprehensive package of services for people who inject drugs. Intervention

strategies should aim to improve STI care-seeking behaviour as a community standard. People who inject drugs, together with their intimate partners, should have knowledge of STI symptoms and be encouraged to undergo STI screening regularly (UNODC, 2017:76-77).

2.7.1.6 The reproductive and sexual health

Women's sexual and reproductive health and wellbeing is dependent on a complex factors of socioeconomic and healthcare. Two decades after the advent of democracy, South Africa remains a highly unequal society socio-economically. Black South Africans continue to be economically disadvantaged, with females most disadvantaged. On average, women are 30% poorer than men. South African women's sexual and reproductive health and rights (**SRHR**) in the context of new legislation, policies and programmes in the second decade of democracy include; contraception and fertility planning, abortion, maternal health, HIV, cervical and breast cancer, and sexual violence (Cooper, Harries, Moodley, Constant, Hodes, Mathews, Morroni and Hoffman, 2016:79-80).

People who inject drugs have similar needs for a variety of sexual and reproductive health services. These needs are often not available for females who inject drugs. Accessibility and availability of family planning and contraceptives for females who inject drugs is important and part of their basic rights. The right to access to health care services, which includes sexual and reproductive health care, is enshrined in South African Constitution. This implies that female nyaope injectors have equal rights to reproductive and sexual health as supported by the constitution (Constitution of SA, 1996:11).

Drug use may influence a female's menstrual cycle. This may lead to irregular menstruation. Female nyaope injectors should be knowledgeable that this does not stop them from becoming pregnant. They need contraceptives if they do not wish to fall pregnant (UNODC, 2017:78-81). Intensified efforts are needed to reach and provide services to women who inject drugs, and to ensure that these services are inclusive of their sexual and reproductive health needs (Scheibe et al, 2019:8).

2.7.1.7 Effective condom distribution for people who inject drugs and their intimate partner

Condom distribution, promotion and social marketing represent a highly cost-effective HIV prevention strategy; given the low cost of condoms and their strong prevention efficacy (Ashmore and Henwood, 2015:1). Condoms have been endorsed as an HIV prevention strategy. This has been effectively applied since the mid-1980s and remain a very effective tool in prevention of sexual transmission (UNODC, 2017:81-82).

2.7.1.8 Essential information, education and communication

The harm reduction programme comprises change of knowledge, attitudes, beliefs and behaviour. It strives to establish community cohesion. The information, education and communication materials should enhance HIV infection services. The material should use easy to read information to prevent misinterpretation (UNODC, 2017:82-84).

2.7.1.9 The prevention, vaccination, diagnosis and treatment of viral hepatitis B & C

According to Scheibe et al (2019:2) viral hepatitis is accountable for the demises of about 1,34 million people every year globally. This is similar to the annual number of deaths from HIV/AIDS (1,3 million), malaria (0,9 million) and tuberculosis (1,3 million). This statistics are alarming and necessary programmes should be implemented to protect female nyaope injectors from contracting viral hepatitis B and C. HCV, and HIV are major health threats affecting PWID in South Africa. On-going high risk practices are influenced by limited access to OST and needle and syringe services, as well as the social and structural factors affecting PWID. High coverage of OST and needle and syringe services can reduce the risk of HCV infection by 74% (Scheibe et al, 2019:8).

Hepatitis B is avoidable through vaccination, and treatment is effective in retreating liver infection and preventing liver cancer. There is no vaccine for Hepatitis C. Sharing injecting equipment may contribute to Hepatitis C infection. Injecting equipment should be provided to females who inject nyaope to prevent sharing injecting equipment. (UNODC, 2017:84-86).

2.7.1.10 The prevention, diagnosis & treatment of Tuberculosis (TB)

Tuberculosis (**TB**) remains an enormous public health concern globally. South Africa is ranked among the top 10 high TB burden countries with the highest absolute burden of TB, and the second highest rate of TB incidence, respectively. TB is one of the top 10 causes of death worldwide, and has been the leading cause of death from a single infectious agent for the past 5 years, surpassing even that of HIV/AIDS. South Africa had the highest number of HIV-associated TB cases worldwide in 2017, with 59,9% of incident TB cases coinfected with HIV. HIV-positive TB mortality accounted for 71,8% of deaths among TB patients (Padayatchi, Daftary, Naidu, Naidoo and Pai, 2019:2 &Mekebeb, Von Pressentin and Jenkins, 2019:1-2).

There is increasing scientific data linking HIV, injecting drugs and multidrug resistant TB (MDR-TB), mostly in Eastern Europe. PWID diagnosed with MDR-TB, and in specifically HIV-associated MDR-TB, have poor treatment outcomes and high death rates.

All female nyaope injectors who are living with HIV should be screened frequently. WHO four-symptom TB screening algorithm should be utilised. This screening helps establish suitability for treatment of latent TB infection. Programmes aimed at people who inject drugs can offer doorways to early TB detection and timely prevention and treatment of both TB and HIV (UNODC, 2017:86-90). Tuberculosis is curable and can be prevented, therefore all female nyaope injectors should be encouraged to be screened and take their treatment.

2.7.1.11 The distribution of naloxone for prevention and treatment of opioid overdose within the community

With an increasing global problem of opioid use and dependence, the mortality rate from opioid overdose continues to rise; there are more than 100,000 deaths globally per annum. Heroin is the most common drug involved in opioid overdose in much of the world. Naloxone is a well-established essential medicine for the treatment of life-threatening heroin/opioid overdose in emergency medicine. Naloxone administration reverses heroin/opioid overdose within minutes with rapid re-establishment of independent breathing and return of consciousness (Strang, McDonald, Campbell, Degenhardt, Nielsen, Ritter and Dale, 2019:1396).

Naloxone should be readily accessible as part of harm reduction services overdose prevention programme. The accessibility to naloxone must concentrate on:

- Training and capacitation of community members on administration of naloxone. The training should be prioritised. Once community members are trained on the administration of naloxone, naloxone should be readily available in the communities, so as to enable the community to assist in reducing overdose when need arise.
- Community health workers, emergency services, police and general health care practitioners should be equipped to administer naloxone. This is because they are usually the first respondents in health related fatalities.
- Increased access through commercial points of sale, for example community pharmacy and medical general practitioners, will enable easy accessible to naloxone as over the counter medication (UNODC, 2017:91-93).

2.7.1.12 Implementation of psychosocial services

The HIV care services and harm reduction sites must make provision for early detection and management of mental health challenges amongst female nyaope injectors. It is imperative that service providers should be aware of self-stigma which may contribute to social withdrawal, a poor sense of self-worth and an unwillingness to admit or adhere to treatment or other health and social services (UNODC, 2017:93).

2.7.2 Additional services to strengthen components of comprehensive Harm reduction package for female nyaope injectors

In addition to harm reduction interventions discussed in 2.7.1 from (UNODC, 2017:62-93), services purposed to address the needs of female nyaope injectors will be discussed in detail.

2.7.2.1 The provision of reproductive and sexual health needs

People who work with female nyaope injectors need to be knowledgeable about sexual and reproductive health needs of female nyaope injectors. Sexual and reproductive health needs of female nyaope injectors should be; pre-conception support, access to contraception, prevention of mother to child transmission, sexual transmitted infection services and cervical cancer screening. This services should be merged into harm

reduction services and vice versa. Female nyaope injectors are also likely to profit from relaxed and reliable and discreet family planning services. This should include pregnancy tests, counselling support and termination services (UNODC, 2016:31).

2.7.2.2 Prenatal and postnatal care

Harm reduction programme staff must provide support when they coach female nyaope injectors about the potential need for prenatal care and provide them with home pregnancy test kits if possible. It is common for female nyaope injectors to have abnormal periods. Female nyaope injectors may not be aware that they are heavily-pregnant until late into their second or even third trimester. Female nyaope injectors should be empowered with accurate information pertaining to the risk and harms to pregnancies associated with continued drug use. This will improve their ability to take appropriate decisions. The staff should exhibit a non-judgmental attitude at all times to female nyaope injectors (UNODC, 2016:31-33).

2.7.2.3 Provision of gender-based violence and related services

Female nyaope injectors are highly vulnerable to gender-based violence. Gender-based violence refers to physical, mental, emotional and other forms of abuse and harassment. The harm reduction services should assist to identify and respond to Gender-based violence by providing direct support to female nyaope injectors (UNODC, 2016:33-34).

2.7.2.4 Services tailored for PWID who are engaged in sex work

Female nyaope injectors that practice sex work are best aided when harm reduction and sex worker services are diligently connected. Services may be provided through referral or by offering them on-site. Such services can be provided at harm reduction service site, at sex worker project sites or through outreach. Harm reduction personnel should be fully supportive and recognise that sex work is a genuine profession and that it is not their role to critic the correctness of a client’s career choice. Information on safety intervention to avoid violence for sex workers is important and highly pertinent to sex workers who use drugs (UNODC, 2016:35).

2.7.2.5 Provision of parenting supports

Most female nyaope injectors experience stigmatisation and marginalisation from their close and extended families as well as their communities. Female nyaope injectors might not have access to extended family networks where parenting skills can be learnt or where they can be supported. Issues concerning child custody, the law, and domestic violence might be more important for them. Harm reduction services can play an important role in assisting female nyaope injectors overcome many of these challenges. Female nyaope injectors who have limited family support may need additional aided referral to other groups or agencies (UNODC, 2016:35).

2.7.2.6 The benefits of child-care

The provision of elementary child-care services is important in improving service access for female nyaope injectors who have main responsibilities for caring for young children. Trustworthy child-care can be useful in allowing female nyaope injectors to effectively utilise HIV Counselling and Testing (**HCT**) and other counselling and testing services. The Harm reduction services and community-based organisations can further support female nyaope injectors' child-care needs by encouraging substance abuse service providers to offer ongoing child care and education at the site for the duration of the individual's stay (UNODC, 2016:35).

2.7.2.7 Provision of couples counselling

Couples counselling may capacitate female nyaope injectors to implement and follow safer-injecting and safer-sex practices. Couple counselling can also be directed to addressing tensions and imbalances in relationships. This will further assist female nyaope injectors to access harm reduction services if their intimate partner refuses them to participate (UNODC, 2016:36).

2.7.2.8 Legal aid services (relevant to female injector needs)

The harm reduction services offer referrals to reliable and quality legal services.
The legal support is provided by organisations, groups and individual persons who specialise in issues that have direct bearing on female nyaope injectors.
The services should be integrated into a harm reduction site of service provision through paralegal, peer outreach activities, and include legal literacy, addressing

specific issues related to female nyaope injectors and females living with HIV (UNODC, 2016:36).

2.7.2.9 Provision of ancillary services and commodities

Some ancillary services have been revealed to build conducive relationship between harm reduction services and female nyaope injectors. It is highly impossible for harm reduction programme to address all needs directly. It can still provide female nyaope injectors with reasonable options by establishing links with service providers which can assist with provisions of ancillary and commodities services.

The following are among various commodities and ancillary services which can pull females to harm reduction services:

- toiletries;
- free washing facilities;
- food parcels;
- pregnancy test kits;
- condoms (male and female); and
- child-care necessities (UNODC, 2016:36-37).

2.7.2.10 Income generating strategies for female nyaope injectors

Income-generating strategies can help female nyaope injectors achieve some degree of financial independence. Strategies in this area might focus on skill development, microfinance and access to employment, among other things (UNODC, 2016:37).

2.8 Harm reduction services in South Africa

In South Africa, programmes that integrate substance use and HIV prevention services for people who inject drugs are almost non-existence and are mainly offered by non-profit organisation. Subsidised substance abuse treatment services are almost wholly for abstinence-based programmes (Scheibe et al, 2017:2).

2.9 Theoretical framework

The study will used the Social Ecological Model and Health Belief Mode. The models were used as a guide to understand experiences of female nyaope injectors. The Social Ecological Model attempts to scrutinise environmental circumstances that affect

female nyaope injectors' health and wellbeing. The Health Belief Model focus on explaining and predicting the attitudes and beliefs of female nyaope injectors.

2.9.1 Social Ecological Model

Social Ecological Models classifies individuals as rooted within bigger social systems and gives detailed accounts of the interactive characteristics of individuals and environments that influence health outcomes. Social Ecological Models views that multiple levels of influence that exist on female nyaope injectors. It focuses on the social, physical, and cultural facets of an environment that have a collective effect on health. The environment itself is multi-layered, institutions and neighbourhoods are rooted in larger social and economic structures. Establishing sustainable health improvements, therefore, is most effective when all of these factors are targeted concurrently (Golden and Earp, 2012:364).

The Social Ecological Model offers a holistic approach to understanding health-based choices and influences. It foscuses on in-depth examination of personal qualities and environmental situations that affect health and wellbeing of female nyaope injectors (Dunn, Kalich, Henning& Fedrizzi, 2015:7). The Social Ecological Model describes individuals' behaviours using five concepts, namely; intrapersonal, networks/interpersonal, community, organisation and public policy (Baral, Logie, Grosso, Wirtz and Beyrer, 2013:2 & Kumar, Quinn, Kim, Musa, Hilyard and Freimuth. 2012:1). Female nyaope injectors do not act in isolation; they are influenced by different factors. It is important to understand the way female nyaope injectors interact with their communities and environments in order to determine why they do what they do.

2.9.1.1 Intrapersonal factors

The attitude and beliefs are the usual variables measured for the intrapersonal level of influence (Kumar et al, 2012:3). Intrapersonal factors are behavioural or biological features linked with susceptibility to acquire or transmit illness or infection (Baral et al, 2013:2). These features have the ability to influence how female nyaope injectors behave. Age, education level, sexual orientation and economic status are some of the many attributes noted at this interval. Unfavourable socioeconomic circumstances can

contribute to female nyaope injectors entering into sex work. This may increase the risk of contracting HIV (El-Bassel and Strathdee, 2016:6).

The interpersonal factor will be expanded further by utilising health belief model in Section 2.9.2 Health belief model which attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of female nyaope injectors.

2.9.1.2 Interpersonal factors

The interpersonal level indicates social influence from significant others. The relationships and social networks that female nyaope injectors take part in have great potential to influence their behaviour. Families and friends are important influencers at the interpersonal stage of the model. Interactions with other people can offer social support or create obstacles to interpersonal growth that encourages healthy behaviour. Sexual networks are included in interpersonal relationships and have a direct impact on health and health behaviours in multiple ways (Baral et al, 2013:2). Interpersonal relationships have important influences on health behaviours, including consulting a healthcare provider or accessing substance use programme. Female nyaope injectors who believe that family and friends do not want them to access substance use programme or harm reduction services are unlikely to access such services (Kumar et al, 2012:3).

Female nyaope injectors may be left out from family support structures. Those who lack financially, or have less prospects of employment opportunities, may be more likely to participate in sex work, which increases their HIV risk and attracts further stigma linked with sex work (Larney et al, 2015:7). Female nyaope injecting practice attracts extensive levels of stigmatisation. People who use drugs may experience denunciation by their families and communities, as well as discrimination in a variety of settings, including health care settings. Social exclusion, stigmatisation, and discrimination increases HIV risk and dents HIV prevention and treatment (Larney et al, 2015:6).

2.9.1.3 Community environments

Community atmospheres may also encourage health and welfare. It can also be a foundation of stigmatisation for female nyaope injectors. The description of who or what founds a ‘community’ is debated, however, it generally include; network ties,

associations between organisations and group, and geographical regions (Baral et al, 2013:3). Formal or informal social standards that occurs among individuals, groups, or organisations, can reduce or strengthen healthy behaviours. Female nyaope injectors are stigmatised worse than their male counterparts. This is influence by cultural stereotypes that hold females to higher expectations and roles (El-Bassel and Strathdee, 2016:5).

Drug use by female nyaope injectors is perceived as infringing their traditional role in society as mothers and caretakers. Increased stigmatisation is also linked with homelessness of females who use drugs, which results in them to staying extremely deep-rooted within drug using networks and spend less of their time with people who do not use drugs (UNODC, 2018:20).

2.9.1.4 Institutions/Organisations

Institutions include healthcare organisations, stretching from primary care physicians to community health centres. It offer female nyaope injectors substance related and harm reduction services. (Kumar et al, 2012:3). Institutions are influential in the development of behaviour as they often impose behaviour-determining guidelines and boundaries. The organisation have rules, regulations, policies, and informal structures that constrain or promote accessibility of services (Baral et al, 2013:2). The study has explored the role of health workers in creating barriers for female nyaope injectors not to access health services at community health centres.

2.9.1.5 Policy and laws

Policies and laws are initiated at local, national and international levels. They makes up the widest level of the Social Ecological Model. The policies have the prospects to influence large numbers of female nyaope injectors. The policies implemented either promote or demote the community's ability to provide preventive or harm reduction services. Laws make certain practices illegal or legal (Baral et al, 201:3). In this study, the researcher has looked into the conduct of the law enforcers in relation to the role they play in facilitating the high risk behaviour amongst female nyaope injectors.

Nyaope was declared an illegal drug when the amendments (amendment of schedule 1 and 2) to the Drug Trafficking Act of 1992 (Act 140/1992) were signed in 2014 (Mokwena, 2016:138 & Dintwe, 2017:160). This implies that anyone who is using

nyaope will be arrested. According to El-Bassel and Strathdee (2016:6) female nyaope injectors maybe be oppressed by police officers as justification for using drugs. Hostile policing includes arresting females for buying or carrying sterile syringes, harassment at needle exchange programs or drug treatment clinics, asking bribes to avoid arrest, sexual abuse and violence, or planting drugs on females. Studies of females worldwide have found a strong link between substance use and police sexual misconduct, coercion, or rape. Female nyaope injectors fail to report police abuses due to fears of imprisonment or other retaliatory consequences for themselves and their families. This study viewed the conduct of law enforcement officers when dealing with female nyaope injectors.

2.9.2 Health Belief Model

The Health Belief Model is one of the most effective health behaviour-change models that contains of six constructs:

- perceived susceptibility;
- severity;
- benefits;
- barriers,
- cues to action; and
- self-efficacy.

These constructs predict why female nyaope injectors may or may not accept precautionary measures against the disease of interest (Kaba et al, 2017:797). Motivating people to avoid a negative health consequence is a key element.

Perceived susceptibility is the individual's awareness of the chance of contracting a health condition (Tarkang and Zotor, 2015:5). It is about contracting HIV through sharing injections, transactional sex and unprotected sex. The researcher explored why female nyaope injectors overlook the risk of contracting HIV when they share their needles, have unprotected sex, and engage in transactional sex. Essentially, whether female nyaope injectors see themselves as susceptible to contract HIV and other blood-borne infections.

Perceived severity speaks to one's belief of how serious contracting a health condition and its consequences are. The researcher explored how female nyaope injectors perceive the gravity of contracting HIV and its consequences on their lives (Tarkang and Zotor, 2015:5).

Perceived benefits is about ones conviction to implement effective strategies to reduce the risk of contracting HIV or other blood-borne infections (Tarkang and Zotor, 2015:5).

The researcher explored if the female nyaope injectors believe that there are benefits when they practice safer behavior. The safer behavior can be ensured by using a sterile needle every time they inject drugs, and using condoms consistently every time they engage in sex. It is within themselves to develop the strategies which will reduce risks of contracting health conditions.

Female nyaope injectors should acknowledge that there are perceived barriers. Perceived barriers affect people's decisions to take a particular action. The barriers might be societal or structural (Tarkang and Zotor, 2015:5).

Female nyaope injectors should acknowledge that they have the ability to deal with the obstacles, and that they are able to take necessary actions to reduce the risk of contracting infections, despite challenges they encounter.

Cues to action are experiences that inspire a person to take action. Self-efficacy refers to an individual's self-belief in their aptitude to produce required behavioural change (Tarkang and Zotor, 2015:5). Female nyaope injectors should believe in themselves, they should believe that it is within themselves to change their risky behaviour.

3. CHAPTER THREE

Research Design and Methodology

3.1 Introduction

This section will describe research method, research design, population and sample, data collection, data analysis, ethical considerations and actions used in the study.

3.2 Research approach

A qualitative research approach was utilised in this study. The aim of the study was to explore the experiences of female nyaope injectors. A qualitative research method was the most appropriate research paradigm. Qualitative approach methods permit the researcher to study designated issues authentically and in detail as they classify and try to understand the groups of information that arises from data (Blanche et al 2006:46). Qualitative research emphases on describing and understanding the phenomenon rather than explanation or predicting female nyaope injectors' behaviour (De Vos, 2011:64 & Babbie, 2012:53). It was considered appropriate because it affords the researcher an opportunity to explore the experiences of female nyaope injectors. Qualitative research attempts to view the experiences of female nyaope injectors through their own perspective (Babbie, 2012:271).

3.2.1 Characteristics of qualitative research

3.2.1.1 Natural settings

Qualitative researchers gather data in the field and site where participants lives. The participants are not carried into a laboratory, nor do researchers send questionnaires out for participants to complete. The interviews are conducted by means of face-to-face communication. The researcher held the interviews at the Community Oriented Substance Use Programme (**COSUP**), where the participants are accessing substance abuse related services.

3.2.1.2 Researcher as key instrument

Qualitative researchers gather data themselves by means of inspecting documents, observing behaviour or interviewing participants. In this study, the researcher only used interviews for data collection.

3.2.1.3 Multiple sources of data

Qualitative researchers collect numerous forms of data, such as interviews, observations, documents, and audio-visual information, without relying on a single data source. The researcher conducted interviews with 15 females who are current injectors and nine who were recovering from injecting nyaope.

3.2.1.4 Inductive and deductive analysis

Qualitative researchers shape their designs, categories and themes from the bottom up by arranging the data into gradually more abstract units of information. Qualitative researchers keep an emphasis on learning the meanings as articulated by the participants, not the meaning the researcher brings to the research or expressed by literature.

3.2.1.5 Emergent design

The course for qualitative research is developing. This means the beginning phase of the research process cannot be forcefully set. Some or all phases of the process may change after the researcher enters the field.

3.2.1.6 Reflexivity

Qualitative researchers mirror on how their part in the study and their personal background, culture, and experience could possibly for shaping their interpretations. For example, the themes they advance and the meaning they subscribe to data. This will be discussed more in Section 3.9.

3.2.1.7 Holistic account

Qualitative researchers attempt to establish multifaceted pictures of the problem or issue under study (Cresswell, 2014:186).

3.3 Research design

Kumar (2014:122) states that research design is a blueprint, arrangement and plan of enquiry so considered as to find answers to a research question or problem. In this research, the researcher used exploratory, and descriptive research designs.

“Exploratory research is implemented in order to gain awareness into a situation, phenomenon, community or individual” (De Vos et al, 2011:95). Kumar (2014:370) states that exploratory research is implemented when the objective of the study is to explore an area where little is known. The experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng, will be explored in order to gain insight into the phenomenon in study.

Descriptive research was also used in this study. According to De Vos et al (2011:97), descriptive research denotes to more rigorous examination of the phenomenon and their deeper meanings, as a result, leading to thicker description.

3.4 Research methods

3.4.1 Population

Population is described as the entire quantity of cases to be studied (Walliman, 2016:110). The population in this study were females, between the ages of 19–35 who reside in City of Tshwane Municipality, and have a history of injecting nyaope.

3.4.2 Sampling

Due to restricted time, money and human resources, a research sample was drawn from females with a history of injecting nyaope between the ages of 19–35 who reside in City of Tshwane Municipality.

Sampling is described as the course of choosing a few representations from the population to become the basis for approximating or predicting the prevalence of an unknown piece of information, situation or outcome regarding the bigger group of female with history of injecting nyaope. A sample is a subgroup of the population the researcher is interested in (Kumar, 2011:229-230). The research sample was 15 females who are currently injecting nyaope and nine females with a history of injecting nyaope who were between the ages of 19–35 and resided in City of Tshwane Municipality. The total participants which the researcher interviewed were 24.

The researcher used purposive sampling in this study. Purposive sample is chosen based on what the researcher knows about the population and the aim of the study. The researcher exercises judgment or knowledge of a population, and the aims of the research, to select a sample (Maggie, 2013:111).

During recruitment, the researcher was guided by inclusion and exclusion criteria when selecting the research participants. The researcher considered recovering female nyaope injectors and current female nyaope injectors in this study. The researcher initially targeted current female nyaope injectors but included the recovering female nyaope injectors to balance the sample and to maintain high credibility of the results.

Table 1: Details of female nyaope injectors interviewed.

Participant No	Employment status	Age	Ethnicity	Duration of using nyaope	Duration without drugs
1	Unemployed	23	Black	7 years	Currently injecting
2	Unemployed	32	Coloured	4 years	Currently injecting
3	Unemployed	34	Black	5 years	Currently injecting
4	Unemployed	22	Black	4 years	Currently injecting
5	Unemployed	31	Black	5 years	Currently injecting
6	Unemployed	27	Black	6 years	Currently injecting
7	Unemployed	24	Black	8 years	Currently injecting
8	Unemployed	35	Black	13 years	Currently injecting
9	Unemployed	31	Black	11 years	Currently injecting
10	Unemployed	32	Black	12 years	Currently injecting
11	Unemployed	35	Coloured	9 years	Currently injecting
12	Unemployed	32	Coloured	4 years	Currently injecting
13	Unemployed	28	Coloured	1 year	Currently injecting
14	Unemployed	23	Black	4 years	Currently injecting
15	Unemployed	27	Black	9 years	Currently injecting
16	Unemployed	31	Black	6 years	5 Months
17	Unemployed	27	Black	10 years	1 year eight months
18	Unemployed	32	Black	6 Years	8 Months
19	Unemployed	30	Black	9 Years	4 Months
20	Unemployed	35	Black	16 Years	5 Months
21	Unemployed	26	Black	6 Years	6 Years
22	Unemployed	32	Black	15 Years	9 Months
23	Unemployed	31	Black	12 Years	5 Months
24	Unemployed	29	Black	9 Years	11 Months

Twenty-four research participants were considered for this study. All participants were active beneficiaries of COSUP, and they were recruited when they came to access their weekly services at different COSUP sites. The participants were prepared prior about possible inclusion into the study by their site social workers before the researcher recruited them for the study. Risks, benefits and their rights were discussed at length with the participants in the presence of a site social worker before they consented to participate in the study.

3.4.2.1 Inclusion criteria

3.4.2.1.1 Recovering female nyaope injectors.

Recovering female nyaope injectors are females with a history of injecting nyaope, who are initiated on OST for two months or more.

- The participant should be a female who has a history of injecting nyaope and has stopped injecting.
- The participant should reside in City of Tshwane Municipality.
- The participant must be in between the ages of 19–35 years.
- The participant must be linked to an organisation.

3.4.2.1.2 Current female nyaope injectors.

Females who are currently injecting nyaope are those with history of injecting nyaope, who have not received medical treatment or been admitted at an inpatient treatment center, but are undergoing the process to be on treatment or to be referred to an inpatient treatment center.

- The participant must be a female who has history of injecting nyaope.
- The patient must reside in City of Tshwane Municipality.
- The participant must be between the ages of 19–35 years.
- The participants must be linked to an organisation.

3.4.2.2 Exclusion criteria

3.4.2.2.1 Recovering female nyaope injectors.

Recovering female nyaope injectors are females with a history of injecting nyaope, who are OST for more two months or more.

- All male nyaope injectors are excluded from the study.
- A participant who does not have a history of injecting nyaope.
- Participants who have relapsed.
- Participants who reside outside City of Tshwane Municipality.
- Participant who are younger than 19 years or older than 35 years of age.
- Participant who are not linked to linked to an organisation.

3.4.2.2.2 Current female nyaope injectors

Females who are currently injecting nyaope are females with history of injecting nyaope who have not received medical treatment or been admitted at an inpatient treatment center, but are undergoing the process to be on treatment or to be referred to an inpatient treatment center.

- All male participants are excluded.
- Females who does not inject nyaope.
- Participants who reside outside City of Tshwane Municipality.
- Participant who are younger than 19 years or older than 35 years of age.
- Participant who are not linked to an organisation.
- All participants who are under the influence of a substance during the time of the interview.

3.5 Data collection process

Bickman & Rog (2009:27) highlighted five issues which the researcher considered in planning for primary data collection: (1) site selection, (2) authorisation, (3) the data collection process, (4) accessibility and (5) other support needed.

The researcher requested permission to conduct research at COSUP. COSUP was more suitable as it is a harm reduction based organisation and runs OST and NSPs across the City of Tshwane Municipality.

After permission was granted to conduct the research within COSUP sites, the researcher liaised with COSUP Social Work Manager to facilitate entry at all COSUP Sites, namely; (1) Sunnyside, (2) Daspoort Poli Clinic, (3) Mamelodi Regional Hospital, (4) Eersterust Community Health Centre, (5) Laudium Community Health Centre, (6) Tshwane District Hospital, (7) Olievenhoutbosch Ext 23, (8) Sediba Hope Bosman, (9) AttMed Attridgeville, (10) Soshanguve Block V, (11) Block K, (12) M17, and (13) Reliable House Hatfield.

The researcher telephonically contacted the social workers at the thirteen COSUP sites. The social workers agreed to inform potential participants about the study, therefore, the researcher shared informed consent for participants in the study with social workers.

The researcher negotiated dates with the social workers for collection of data. The social workers gave the researcher days which the participants were coming for their weekly services.

The researcher was able to interview 24 research participants, and data reached saturation point. As mentioned, nine recovered injectors and 15 current injectors were interviewed.

Table 2: List of COSUP sites where data was collected and how many participants were interviewed

COSUP Site	Recovered injectors	Current injectors
Soshanguve Block H	2	0
Soshanguve Block V	2	0
Sediba Hope Bosman	0	6
AttMed Attridgeville	1	4
SunnySide	0	1
Eersterust Community Health Centre	0	4
Mamelodi Regional Hospital	4	0

The researcher did not collect data at Daspoort Poli Clinic, Laudium Community Health Centre, Tshwane District Hospital, Olievenhoutbosch Ext 23, Sediba Hope Bosman, Soshanguve M17 and Reliable House Hatfield. The researcher communicated with the social workers about reaching data saturation and apologised for the inconvenience.

The interviews were conducted at COSUP site offices with strict supervision from a site social worker who set in during the data collection session. The participants consented to their site social worker sitting in during interview process.

The researcher used purposive sampling in order to select participants from those identified at COSUP. The researcher was recruiting participants individually as they were coming at COSUP. The researcher gathered data from the 24 participants by means of semi-structured interviews. An interview is described as a verbal conversation in which one person, the interviewer, tries to obtain information from, and

gain an understanding of another person (the interviewee). The interview is an effective tool for bringing about rich data on people's views, attitudes and the meanings that support their lives and behaviour (Gray, 2014:382).

The researcher used in depth, semi-structured interviews as a data gathering method. The in-depth interview is steered through the aid of an interview guide. An interview guide is a written list of questions and topics that need to be addressed in a particular order, but are open ended questions (Bernard, 2013:82-83). The in-depth interview permits for probing of views and opinions where it is required for respondents to expand on their answers (Gray, 2014:385-386). A semi-structured interview is regarded as an effective tool as far as interviewing is concerned. According to Thomas (2017:206), it offers a structure of a list of issues to be covered together with the freedom to follow up points as necessary. All the interview were audio recorded and the interviews were kept safe as to protect the information to maintain confidentiality.

The researcher used qualitative observation. Qualitative observation involves taking field notes on the behaviour and non-verbal communication of the participants (Creswell, 2014:191).

The researcher had initially planned to interview 15 recovering female nyaope injectors and 15 current female nyaope injectors, however, 15 current female nyaope injectors and nine recovered female nyaope injectors were interviewed as mentioned. The reason the researcher did not interview 15 recovering female nyaope injectors was due to data saturation. Kumar (2011:398) denotes that data saturation is the phase in data collection where a researcher is determining very little or no new information from the research participants. The research reached data saturation after the researcher interviewed 24 research participants and then researcher stopped. Saturation was reached after 19th interview, but the researcher continued until the 24th interview.

There were a few challenges that were experienced during data collection. One participant requested money in order to participate in the study. She indicated that she did not have money for drugs and she must go look for money and participating in the study will waste her time, the researcher did not give her money and she left. Two participants were intoxicated during data collection, as a results, they were not considered for inclusion.

The data collection period started on the 1st of July 2019 and came to completion on the 26 July 2019. The researcher interviewed the participants at an environment they were familiar with, and in the presence of their social worker. This was done to assist the participant be at ease since the researcher was a male interviewing vulnerable females. The researcher gave the participants an option to choose a language suitable to them. The participants chose English and Sotho/Sepetori.

Establishing a conducive environment was imperative for the researcher before data collection. The provision of pre-counselling enabled the researcher to establish a rapport before collecting data. All the interviews were audio recorded and transcribed for data analysis

The researcher collected data using Kvale's interviewing guidelines:

- Introduction questions

The interview primarily centred around the experiences of female nyaope injectors. The experiences were explored with guidance by the theoretical framework. Constructs of the Social Ecological Model and Health Belief Models were used to explore the experiences of female nyaope injectors. The researcher used the semi-structured interview guide to conduct the research (Berry,1999 & Krave 1994).

- Follow-up questions

The interview process started with questions aimed at exploring the factors contributing to female nyaope injecting, followed by exploring the experiences of female nyaope injectors and ways in which HIV can be curbed amongst them (Berry,1999 & Krave 1994).

- Probing questions

Using open-ended and probing questions, the researcher was able get the participants to elaborate more of their lived experiences and enable them not to answer 'yes and no'. The researcher observed body language and recorded accordingly. This demanded active listening from the researcher (Berry, 1999 & Krave 1994).

- Specifying questions and direct questions

The researcher was guided by the interview guide; the questions the researcher asked were specific as per the interview guide. The researcher allowed flexibility and did not ask the questions as they appear on the interview guide (Berry,1999 & Krave 1994).

- Indirect questions

The researcher used indirect questions as they often take an open-ended form with the intention to open up the opportunity for the interviewees to elaborate on things that they see as important and meaningful to their life (Berry,1999 & Krave 1994).

- Structuring questions

The researcher used structuring questions. Structuring questions refer to the use of key questions to finish off one part of the interview after exhausting it and opening up another. For example, after exhausting “What influenced you to inject nyaope” the researcher introduced “How did your family react after they discovered you are injecting nyaope”. This enabled the researcher to ask all important questions and not to ask irrelevant questions (Berry,1999 & Krave 1994).

- Silence

The researcher was attentive to the research participant and was willing to tolerate silence when it happened. Silence allows pauses in the interview which can offer the interviewee ample time to reflect, gather their thoughts and energy for more disclosure. Throughout the interview process the, researcher carefully and attentively listened without interruption, allowing participants to express themselves freely (Berry,1999 & Krave 1994).

- Interpreting questions

The researcher used interpretation during data collection. Interpreting questions is similar to some forms of probing questions, to rephrase an interviewee’s answer in order to clarify and interpret rather than to explore new information. This line of questioning allowed the researcher to assist the participants explore more, especially when participants were asked about their risky behaviour as a result to nyaope injecting (Berry,1999 & Krave 1994).

- Throw away questions

The researcher used throw away questions. Throw away questions serve different purposes, including to maintain conducive relationship, to assist with making the participants calm whenever the questions are sensitive. The study was sensitive, it was exploring the lived experience of female nyaope injectors (Berry,1999 & Krave 1994).

3.6 Data analysis

Data analysis is the process of organising, structuring and giving meaning to bulk of collected data (De Vos, 2011:397). Data analysis consist of “reading through your data repeatedly and engaging in activities of breaking the data down (thematising and categorising) and building it up again in one novel way (elaborative and interpreting)” (Blanche et al, 2006:322).

The researcher used six phases as identified by Braun and Clarks (2006) in Jensen and Laurie (2016:609-610) to analyse data.

- Phase 1: The researcher acquainted himself with the data;

All 24 audio interviews were transcribed, after transcribing, the researcher read through the transcripts to familiarised himself with the content of the transcripts. The process of transcribing started immediately after the first interview was conducted; the researcher did not wait until 24 interview were conducted before transcribing.

- Phase 2: The researcher generated initial codes;

The researcher started to generate initial codes. The researcher read through the transcript one-by-one, critically identifying initial codes. The transcripts were coded whilst the researcher was listening to the recording. This allowed the researcher to code many codes which had a potential to form different themes.

- Phase 3: The researcher searched for themes;

The researcher started organising codes linked to each other into potential themes and used a table form to organise the codes and themes orderly.

- Phase 4: The researcher reviewed themes;

The researcher reviewed and polished all the themes. Sub-themes were created to accommodate themes which are in alignment.

- Phase 5: The researcher defined and named the themes; and

This phase started when the researcher was satisfied with the themes and sub-themes identified. It was identified what each theme is about and what aspect of data each theme captures.

- Phase 6: The researcher produced the report.

The researcher started writing up the thematic analysis to be included in chapter four of the dissertation. The researcher strived to provide a concise, coherent, logical, non-repetitive, and interesting account of the experiences of female nyaope injectors. The analysis went beyond description of data and was linked to the research questions.

3.7 Ethical consideration

Social researchers abide to ethical and professional responsibilities in order to conduct themselves in a principled manner (Neuman, 2014:69). According to De Vos et al (2011:115), ethics are described as a set of virtuous principles and values. The ethical procedures serve as principles which the researcher ought to assess their conduct.

3.7.1 Voluntary participation

According to Babbie (2012: 520), social research represents a meddling into people's lives, and it disrupts the subject's steady activities. Researchers should acknowledge the intrusion, and provide all participants with an opportunity to be fully briefed of the study so that they can consent voluntarily knowing what the study entails. According to De Vos et al (2011:116), participation should at all times be voluntary; no one was forced to participate in the research project. The purpose of the research was been explained and all participants were allowed an opportunity to accept or decline participating in the research project. No one was forced or lured with money to

participate in the research study. One participant did not want to participate and the researcher respected her decision.

The researcher distributed consent forms to all participants. The consent forms were written in easy English, free of vocabularies, jargons, and legalese so that the participants can comprehend what was written before they consent to participate.

3.7.2 Prevention of harm to the participants

The social research should, under no circumstances, harm the research participants being studied; irrespective of whether they are volunteering for the study or not (Babbie, 2012:522). De Vos et al (2011:115) denotes that no harm to the participants is an important ethical rule.

The study concentrated on personal experiences of female nyaope injectors, which increased the sensitivity of the study. There was no likelihood of physical harm that could occur to the participants as a direct result of the study. However, the sensitivity of the study on the emotional state of participants was foreseeable and recognised. The researcher prepared to mitigate the emotional harm by conducting pre-counselling with all participants before data was collected to minimise psychological harm. The fact that participants willingly consented to be interviewed minimised the probability of psychological harm. The researcher used social work counselling rooms to conduct the interviews. A debriefing interview followed up after completion of data collection session and participants who consented were referred to a site social worker for further intervention.

3.7.3 Anonymity and confidentiality

Protection of participant's interest, welfare, and the protection of their identity is key in social research. A response may be regarded as unidentified when the researcher cannot identify a given respondent (Babbie, 2012:523). The research participants were provided with an opportunity to choose a nickname for themselves to protect their identity. The researcher also assigned participants numbers to the participants. All information regarding their address, and contact number has been safely stored. The data which was collected by the researcher is protected, only the researcher and authorised members of the university have access to it.

3.7.4 Deceiving participants

Deception is described as misleading participants, purposely misrepresenting facts and concealing information from the participants (De Vos et al, 2011:119). The researcher informed the participants that the study is for MA Social Behavioural Studies at UNISA. The researcher did not deceive the participants in any way or the other. The consent form provided all the information needed.

3.7.5 Debriefing of participants

Debriefings are psychosocial sessions in which participants have an opportunity, after the study, to work through their experiences and its aftermath in order to get their question answered and remove misconception (Babbie, 2012:123). The researcher afforded research participants opportunity to ask any questions they might have had after collection of data. The participants who consented for referral were referred to their site social workers for further counselling.

3.8 Measures to ensure trustworthiness

Polit & Beck (2011:584) denotes that the standard of respectable qualitative research is based on trustworthiness. The trustworthiness is discussed in details using five construct namely; credibility, transferability, dependability and confirm ability and authenticity.

3.8.1 Credibility

According to Kumar (2014:219), credibility contains confirming that the results of qualitative research are credible or authentic from the perspective of the participants in the research. The findings must reflect the experiences of females who are injecting nyaope and females who have recovered from injecting nyaope. This qualitative research has explored the experiences female nyaope injectors who reside in City of Tshwane in order to come up with the possible solutions. The researcher enhanced credibility by:

- Building rapport with the participants: Pre-counselling was conducted with research participants before data collection in order to build rapport.
- Transcript verification: Transcripts were taken to the participants to allow them to read through and confirm the information as other interviews were conducted in

Sepedi (Sepitori) then translated to English. Transcripts were taken back so that the participants can establish if the interview transcript did not lose meaning during translation process.

- Two participants who were under the influence of the substance(s) at the time of the interview were not be considered.

3.8.2 Transferability

Transferability is described as a level to which the results of qualitative research can be generalised or transferred to other contexts of setting (Kumar, 2014:219). The researcher has interviewed multiple participants from different areas within the City of Tshwane Municipality. The researcher has audio taped the interview, observed and explored nonverbal clues during the interview.

3.8.3 Dependability

Dependability is described as whether the same results will be achieved if the same phenomenon is observed twice. Qualitative research promotes flexibility and freedom (Kumar, 2014:219). To improve dependability, De Vos at all (2011:421) state that the researcher should ask whether the research process is logical, well documented and audited. Due to high cost of co-coder, the researcher could not appoint an independent co-coder, rather the supervisor, as an experienced qualitative and mix-method researcher, assisted with co-coding to ensure dependability.

3.8.4 Confirmability

Confirmability is described as the level to which the results can be confirmed or corroborated by other researchers (Kumar, 2014:219). De Vos et al (2011:421) report that confirmability captures the traditional concept of objectivity. Conformability was captured by audio recording the participants which was explored by following up on questions, probing, and not assuming to understand what the researcher did not understand.

3.8.5 Authenticity

Authenticity is described as the extent to which researchers honestly and authentically show a variety of realities. Authenticity emerges in a report when it carries the feeling and tone of participants as they are lived. The experiences of female nyaope injectors

residing in City of Tshwane Municipality will not be changed, it will be taken as the real truth of the problem under investigation (Polit & Beck 2011:585).

3.9 Reflexivity

Reflexivity is described as the capacity of the researcher to stand outside the research process and disapprovingly reflect on the process without influencing the direction of the study. It entails continuous reflection about the researcher's role, personal background, culture and experience, as well as the integrity of the process. (O'Leary, 2004:11& Cresswell, 2014:186). The researcher is passionate about the field of substance abuse and the human rights issues affecting people who use drugs. The researcher approached the study open-mindedly, with the intention to learn the lived experiences of female nyaope injectors.

The researcher acknowledged the potential of influencing the study, however, the importance of objectivity and giving the female nyaope injectors a chance to represent themselves in the study assisted the researcher to be reflexive through the study. The researcher did not collect data at his COSUP site; none of the research participants knew the researcher. No participant knew that the researcher was an employed social worker within COSUP, which had a potential to compel participants to participate in the study. This was achieved by asking the social workers not to disclose information about the researcher.

3.10 Conclusion

This chapter provided an overview of the research approach, research design, population and sample, data collection, data analysis, ethical considerations and measures utilised in this study. The researcher presents and discusses the findings in the following chapter.

4. CHAPTER FOUR

Findings of the Study

4.1 Introduction

The purpose of the research was to explore the experiences of female nyaope injectors residing in City of Tshwane Municipality. Furthermore, it was to gain insight into, and understanding factors contributing to female nyaope users injecting, as well as how they can be assisted to reduce the risks associated with nyaope injecting. This chapter discusses the findings of the research. 13 themes, 46 sub-themes, 3 categories and 3 sub-category were identified. These will be discussed fully in 4.3.

4.2 Profile of participants

Interviews were held with 24 participants accessing harm reduction services at COSUP sites. COSUP has sites across all regions in City of Tshwane Municipality. The researcher recruited and interviewed participants at different COSUP sites, namely; Soshanguve, Pretoria CBD, Sunny Side, Mamelodi, Eersterust, and Attridgeville. Fifteen current injectors and nine recovered injectors were interviewed. Fifteen current injectors were recruited from NSP database and nine recovered injectors were recruited from OST database. Participants chose pseudonyms for themselves. For the purposes of data analysis, a participant's number is used rather than the pseudonyms. The numbers were allocated without following any arrangement or order.

4.3 Research participants

Table 2

Participant No	Employment status	Age	Ethnicity	Duration of using nyaope	Duration without drugs
1	Unemployed	23	Black	7 years	Currently injecting
2	Unemployed	32	Coloured	4 years	Currently injecting
3	Unemployed	34	Black	5 years	Currently injecting
4	Unemployed	22	Black	4 years	Currently injecting
5	Unemployed	31	Black	5 years	Currently injecting
6	Unemployed	27	Black	6 years	Currently injecting
7	Unemployed	24	Black	8 years	Currently injecting
8	Unemployed	35	Black	13 years	Currently injecting
9	Unemployed	31	Black	11 years	Currently injecting
10	Unemployed	32	Black	12 years	Currently injecting
11	Unemployed	35	Coloured	9 years	Currently injecting
12	Unemployed	32	Coloured	4 years	Currently injecting

13	Unemployed	28	Coloured	1 year	Currently injecting
14	Unemployed	23	Black	4 years	Currently injecting
15	Unemployed	27	Black	9 years	Currently injecting
16	Unemployed	31	Black	6 years	5 Months
17	Unemployed	27	Black	10 years	1 year eight months
18	Unemployed	32	Black	6 Years	8 Months
19	Unemployed	30	Black	9 Years	4 Months
20	Unemployed	35	Black	16 Years	5 Months
21	Unemployed	26	Black	6 Years	6 Years
22	Unemployed	32	Black	15 Years	9 Months
23	Unemployed	31	Black	12 Years	5 Months
24	Unemployed	29	Black	9 Years	11 Months

The participants' ages range from 19–35 years, which positions them in their youth. Four coloured and 20 black females were part of the research. All participants were females as the research was purposed to explore the experience of female nyaope injector. The participants were all unemployed at the time of data collection. Majority of them had more than 5 years' history of using nyaope. Those who have recovered had 4 months or more since they have stopped using nyaope.

4.4 Key findings

The following themes were generated after the process of data analysis. The themes are arranged as per the objectives of the study.

4.4.1 Objective 1: Factors contributing to injecting nyaope

This section focuses on the factors contributing to the use and injection of nyaope.

4.4.1.1 Factors contributing to using nyaope

4.4.1.1.1 Intimate partner influence

The motives and underlying reasons that drive women to drug use and addiction are different from those of men. While men are mainly introduced to drug use through their peer and friendship networks, women may start using drugs due to family matters and the influence of their intimate relationships (Zolala, Mahdavian, Haghdoost and Karamouzian, 2016:1). An intimate partner who is using drugs can be influential to their female partner. Female nyaope injectors reported that they were influenced by their boyfriends to use nyaope. One participant indicated that her partner was always away and he did not give her the attention she desired, which led her to using nyaope so that she can spend time with him.

The participants supported the narrative when they said:

Participant 19 “I was trying to please my boyfriend. I loved him, and I wanted him to spend time with me”.

Participant 13 “I was in a relationship with someone using nyaope. I was using Cat at that moment; from Cat he introduced me to nyaope”.

Participant 12 “I first started using nyaope with my boyfriend, smoking zol”.

Intimate male partner influenced the initiation of their female partners’ smoking nyaope. This finding is corroborated by UNODC (2018:18) & GCWA (2011:6) arguing that being in an intimate relationship with a partner who also uses drugs has been revealed to be considerably linked with a female’s commencement into and continuation of drug use. Females who use drugs are probable to have had a male intimate partner who introduce them into drug use. They are also probable to have asked the male partner to inject them. This occurs in a social setting where others are present, and it further contributes to their high vulnerability.

4.4.1.1.2 Peer pressure

Peer pressure and a sense of belonging contributes to nyaope use. A yearning to test and to be part of a social network adds to use of nyaope (Marks, Gumede and Shelly, 2017:5). Peer pressure was quoted as one of the sturdiest predictors of youth behaviour; it influences experimentation of drugs. In a study by Gauteng Department of Community Safety (2014), participants reported that they used nyaope to impress their friends to avoid being stigmatised. However, they became habitual users and were eventually addicted (Charlton, Negota and Mistry, 2019:45). The participants felt they would not be part of the social network if they did not use nyaope. Findings of this research study corroborates with the Department of Community Safety findings. The participants reported that:

Participant 10 “Truly speaking, I was involved [in drug use] because of peer pressure, having friends at school who are smoking and feeling like if you do not do what they do, you are not cool, that is how I got hooked”.

Participant 24 “I was with my friends; we were smoking dagga and they taught me to smoke nyaope”.

Participant 23 “I was with my friends, we began by smoking dagga then this other day our friend came with nyaope for us to try out. That is how I was introduced to nyaope”.

Participant 8 “I was smoking dagga before I got introduced to nyaope; then I had a friend that was smoking nyaope; then I was introduced to nyaope and that was it”.

There is evidence that some of the nyaope users started and consequently became addicted as a result of following what their peers were doing. Dintwe (2017:115) argues that peer pressure is the sturdiest predictor of youth behaviour with enormous influence on young people’s experimentation in drugs during adolescence. One of the reasons is that young people would want to gain admiration and honors amongst their peers. The desire for approval and acceptance by peers and friends can easily influence an individual to be pressured into doing something that he or she would not normally do. This need for acceptance from peers increases the likelyhood of engaging in risky behaviour (Jacobs and Slabbert, 2019:228).

The Department of Basic Education should introduce life-skills programme as part of their Life Orientation curriculum where learners will be capacitated and empowered to handle peer pressure. Implementing such a programme from Grade 7 will enable the learners to handle peer pressure well.

The researcher further observed that the use of dagga amongst friends raises the likelihood of using nyaope. Participants highlighted that they were using dagga before they started using nyaope; it can be assumed that if they were not smoking dagga, chances of using nyaope were less.

4.4.1.1.3 Tricked by friends

Participants indicated that they smoked nyaope without their knowledge. They were tricked by their friends into smoking nyaope because they assumed they were smoking dagga. They only knew they were smoking nyaope when they started experiencing withdrawal syndromes and by then it was too late. They sought-out how to get nyaope on their own to satisfy their withdrawals. This is supported by the following narratives:

Participant 3 “I lived with this guy (who is my neighbour) in a two room [house]. I had borrowed [rented] him the other room so that when I am not there he can guard for me. That guy was smoking nyaope. One day told the guy to prepare the dagga since I was still busy cooking; I will come and smoke. He then prepared the dagga. I was not

paying attention when he was doing it as I was busy. While he was preparing he added nyaope. I am used to preparing mine with a paper from yellow pages book; that guy was preparing it with rizla. I went to his room to smoke; I felt that this dagga is different from the one that I am smoking [on regular occasions] then I asked him why is dagga it tasted different and it made me dizzy. He said this is the one that is good. Then I started to like that one that he prepared instead of the one I prepare myself because but the other one I feel the high same time [compared to the other one which tales time]. By then I was not aware that it is that thing [nyaope]".

Participant 9 "I was associating with people who were attending school, studying together. We competed with one another in terms of academic performance, and I met a wrong turn [bad] friend. This friend was smoking and doing lot of things. They would give me to smoke, indicating that it is only dagga. I was surprised this other morning when I woke up, I started to feel stomach pains, but I did not understand until she came and told me to give her money so that she can buy [nyaope]. After smoking, the pains disappears".

Marks, Gumede and Shelly (2017:5) discovered in their study that some of the nyaope users were uninformed of what drug was being used. A fewer of the users assumed they were smoking dagga, when in fact they were smoking nyaope. They only became conscious when they started experiencing physical withdrawals after stopping their day-to-day use of the drug. This happened after a period of time sufficient to develop a physical dependence. Smoking nyaope turns into a way to cope the pain and discomfort of the withdrawals.

Smoking dagga increases the likelihood of being tricked by friends to smoke nyaope without ones knowledge. The participants could not have been tricked into smoking nyaope by their friends if they were not smoking dagga.

4.4.1.1.4 Losing weight

Participants indicated that they were gaining excessive weight which they were not happy and comfortable with. They started smoking dagga to lose weight but when the progress was not speedily, they started using nyaope. The effects of acute marijuana use on appetite and snacking behaviour are well-known and colloquially described as, "the munchies". However, findings consistently indicate that users of marijuana tend

to have lower body mass indices than nonusers (Sansone, R. A and Sansone, L. A. 2014:50). This is expressed through the following statements:

Participant 18 “For me to start using nyaope was because I wanted to lose weight”.

Participant 16 “I started smoking nyaope because I want to slim, to lose weight”.

Carra and Jaffeb (2012:3) argue that overweight persons are more likely than their slimmer age group to face teasing, discrimination and tense relationships with family. This contributes to an unstable psychological well-being, including depressed moods and poor self-esteem. It can be concluded that the participants did not desire to experience discrimination, as a result, they found themselves applying mechanisms which would enable them to lose weight and keep to their body image.

4.4.1.1.5 Mental health

Participants reported that they started using nyaope due to issues they were facing in life. Some studies propose that females are more likely to indulge in substance use as a way of coping with mental health issues, such as depression, anxiety, and posttraumatic stress disorder that are often the result of trauma, abuse, and violence (Pinkham et al, 2012:3). Females who use drugs reported to have high rates of post-traumatic stress disorder and may also have encountered childhood difficulties such as physical neglect, abuse or sexual abuse (UNDOC. 2018:6). The participants reported that:

Participant 20 “It was when my brother killed my father, it [the murder] has affected me a lot. When I tried to reflect on what happened, it was just too much”.

Participant 21 “My brother had just passed away; I was stressed and I could not sleep. I had a friend that was smoking nyaope; she told me that if I can smoke this (nyaope), I can be able to sleep”.

Participant 15 “I can say that I started to smoke nyaope because of the things that happened in my life. I was adopted and [through that] adoption, my father turned me into his sexual slave. When I spoke with my adoptive mother, she told me that I was lying about it. That is when I was told how they did a favour for me; how they picked me from gutters; how I should be grateful. So they ended up kicking me out, and I stayed on the streets”.

Participant 5 “For me to begin using nyaope was [because of] the situation at home, after my mother passed away”.

Participant 22 “I told him that I am struggling with sleep, it just after my mother passed away. I was struggling with sleep, he then told me that there is a drug called nyaope”.

Different emotional stressors, like the death of a parent and incest by family members has driven the participants to smoke nyaope to ease the pain. There is solid evidence for the role of mental health, particularly depression and post-traumatic stress disorder, in both conserving and enabling associations between substance use, IPV and HIV. Mental health experiences can also play a role in raising females’ drug use, and in constraining their ability to distinguish and navigate risky circumstances (Stoicescu et al, 2018:3326-3328). The experiences of trauma can lead to the development of mental health issues and further increase the risk of drug use (Arpa, 2017:6).

4.4.1.1.6 Counteracting other drugs

The participants started using nyaope to counteract other drugs. Participants were using cocaine, which is a stimulant. The participants reported that they struggled with sleep when they have used the cocaine and they used nyaope to relax their nervous system since nyaope is a downer. Masombuka (2013:44) reports that cocaine can provisionally reduce the need for food and sleep, so users struggle with sleep after using it. Angarita, Emadi, Hodges and Morgan (2016:9) reports that wooziness and tiredness are common side effects of opioid. This is confirmed by the following narratives:

Participant 4 “I was using uppers; I was using cocaine. You know with cocaine, it is like when you want to sleep it is a problem; so I knew that this thing [nyaope], it will down me and help me sleep”.

Participant 2 “I met some people who were smoking that also, but, they told me about the downer. The downer is heroine, it pins you down when you too up [too high]”.

The participants started using nyaope to address restlessness which was prompted by use of stimulant drugs. It was never their intention to be regular users, but to the addictiveness of nyaope, the participants were addicted.

4.4.1.1.7 Curiosity

Curiosity has influenced a participant to smoke nyaope. The participant had a history of using dagga so when people she knew were using nyaope, which she did not have any idea what it was so she was curious. The participant asked to try it and she was hooked. For adolescents, substance use tends to be acquired through experimentation and curiosity, particularly through peers (El Kazdouh, El-Ammari, Bouftini, El Fakir and El Achhab, 2018:1). This is supported by the following narrative:

Participant 1 “The very first time I tried nyaope, I did not know that it was nyaope. I came across some boys from where I come from back at home, they were smoking and I wanted to try what they were smoking, then I tried it”.

4.4.1.2 Factors contributing to injecting nyaope

4.4.1.2.1 Need for intense high

The need to experience an intense high which lasts longer has influenced females to transition from smoking nyaope to injecting it. The transition from smoking dagga to their injecting initiation was centred on their need to increase the effect of the drug and their desire to fit in with the injecting drug use social network (Tuchman, 2015:3). Guise, Horyniak, Melo, McNeill and Werb (2017:8) suggest that many studies described the search for a greater ‘high’ or ‘rush’, potentially available through injecting, as the primary reason linked to injection initiation. An increased high associated with drug injecting was described as developing from engagement in social networks that include people who already inject drugs, where the high is witnessed or encouraged and curiosity generated.

Participants reported that when they inject nyaope, they experience an intense high which lasts for longer as compared to when they have smoked. Smoking nyaope was considered a waste by the participants as it could not give them a desired high and it wears off easily, forcing them to use nyaope too often. The participants alluded that:

Participant 15 “I felt that smoking dagga was not strong like it used to be and when I injected, it stayed longer in the body but zolo was not”.

Participant 8 “I was smoking, but [after] realising that I do not feel that kick that I want, so I went for an injection”.

Participant 4 “Started injecting because smoking it did not do anything anymore”.

Participant 13 “Injecting goes straight to the blood, gives much more high than smoking; after [realising] that I started to inject”.

Participant 2 “You get more high same time you inject it, but to smoke, you have to wait to feel it and you do not feel it more”.

Participant 22 “In my township they give us free packets, so everyone in my township was using a syringe. I was not using a syringe by then, so Makwera (dealer) gives us free two packets every Tuesdays. So the one I… there was two of us, they pair us. The one who I was paired with injects and he forgot that I smoke with dagga. He mixed all of it in water, I told him that today am withdrawing, he is taking chances, I am going to use syringe. That is how I started, I felt the high the whole day, I realised that it saves money, I will not be going back to smoking it; I started using a syringe”.

Participant 10 “When I started to injecting, smoking dagga was not giving me a desired high. I did not feel it after smoking; so a friend told me about the injecting practice. I was told if I inject it remains longer in my body and I will achieve the desired high”.

Participant 18 “The high is fast because it goes straight to the blood, it is not like the one of dagga”.

Participant 24 “The high that I was experiencing was more intense than that of dagga, when injected I got more high”.

Participants indicated that when nyaope is injected, it gives a high faster as compared to smoking. The injector experiences the high immediately after injecting. Drug injecting is regarded as easily to use and an effective manner to use low-purity heroin. The injecting of heroin produces near-rapid analgesic and etatic effects. When heroin is injected, it lasts more hours as compared to when is smoked (Masumbuka, 2013:44).

4.4.1.2.2 Intimate partner

Female nyaope injectors were predisposed by their intimate partners to inject nyaope. Female nyaope injectors are more likely to be in an intimate relationship with a partners who inject drugs. Their relationships with their intimate male partners who

also use drugs are complex and lively (Azima et al, 2015:17). The relationship between female nyaope injectors and their male intimate partners is characterised by violence. Rejection to use a partner's used injecting equipment can position females at a higher risk of IPV, as a result, further increasing their risk of HIV infection (GCWA, 2011:6). The participants reported:

Participant 17 "Because the father of my child, the person I was dating was smoking with zol and ended up injecting, I also ended up injecting".

Participant 1 "My boyfriend influenced me [to inject], sometimes when we do not have money, he was injecting and I was not [injecting]. This other time he said let me allow you to try. Mostly he would say that but I would refuse [to inject] but on that day because we only had one bag, he mixed then that is how I started".

The influence of intimate partners on initiating injecting nyaope should be acknowledged. Such an influence increases the risk of female nyaope injectors contracting HIV and other blood-borne infections. The way the participants reported it reflects powerlessness from the females as the initiator is an intimate partner.

4.4.1.2.3 Curiosity

Female nyaope injectors are not on all occasions inactive in transitioning from smoking to injecting drugs. Often, they have an active role in transitioning. Some participants reported that the transition was their own idea. The participants were curious about injecting but incapable to inject themselves, Tuchman (2015:3). For the participants, as highlighted, curiosity was a contributing factor which influenced them to inject nyaope. The participants reported that:

Participant 23: "I saw people injecting so I became curious".

Participant 16 "I was smoking at Block R and some boys were injecting with one girl but they got the intense high more than us who are smoking with cocktail, then I got curious".

Participant 7 "I was dating my boyfriend who was also a smoker. It happened that this other day we found new needles and we used to see people injecting and we were smoking cocktail. He said to me let us sell this needles then I was like no! Let us not sell them let us try to inject and feel what they feel only for today".

It is not always males who influence females to inject. **Participant 7** influenced her intimate partner to inject nyaope while **Participant 23 and Participant 16** injected because of curiosity after they saw other people injecting.

4.4.1.2.4 Cost effective

Nyaope does not come cheap. Participants indicated that injecting nyaope reduces the cost as you achieve intense highs and it remain in the body for longer. Injection initiation involved crossing boundaries of morality, stigma or risk, where fears or negative social norms are displaced or replaced. Accounts of managing increasing tolerance, economic efficiency and seeking a better high were frequently linked. A recognition of the increased efficiency of injection drug use can occur within social networks of people already injecting. They can encourage this understanding or be a rationale for coercing others into injecting, and thereby, reflect economic pressures generated by poverty, marginalisation, and shifts in drug supply (Guise et al, 2017:8). The participants reported that:

Participant 16 “The problem of cocktail is that, I would smoke the whole day because after an hour I withdraw, then I have to smoke and it becomes costly. But with injecting you can smoke two packets, you can stay the whole day with the desired high until late at night”.

Participant 24 “It was going to be too much costly for me, the more I buy the more money I need to have. It is better for me to inject so that I can have the satisfying high”.

Nyaope costs between R25–R35 per fix. However, it is an increasing cost. Even in the short term, it is high because of the strength of the addiction and the resultant frequent use (Mokwena and Morojele, 2014:376). Injecting nyaope reduces the cost as an injector is able to get an intense high using low quantity of nyaope.

4.4.2 Objective 2: Experiences of female nyaope injectors

4.4.2.1 Risky behaviour

Injecting drug use (**IDU**) is associated with high sexual risk, linking people who inject drugs to the well-established HIV epidemic in Africa. Although most HIV infections in the region occur as a result of unprotected heterosexual sex and mother-to-child transmission, current high-risk trends in IDU, and few services targeted to IDU,

positions this mode of transmission to become a significant threat in a region that is over burdened by HIV. While data available on IDU is scarce, evidence has suggested that PWID engage in high-risk injection and sexual exposures, and have high rates of HIV infection. Low HIV testing uptake and lack of knowledge of the risks associated with injecting drugs may also contribute to the emerging problem (Asher et al, 2013:2). Female nyaope injectors engage in transactional sex, injection sharing and poor condom use which escalate the risk of contracting HIV.

Multiple and concurrent partnerships, low and inconsistent condom use and low levels of male circumcision have been shown to be the key drivers of the epidemic. While HIV risky behaviours are known to be drivers of the spread of HIV, cognitive factors including perceived susceptibility to HIV, perceived monetary or material benefits of having sex for material gain, self-efficacy, and attitudes play a significant role in influencing risky sexual behaviours. Based on the health belief model, an individual's personal belief influences their behaviour (Manjengwa, Mangold, Musekiwa and Kuonza, 2018:2).

4.4.2.1.1 Sexual risk

Females who use drugs are barred from family support structures. Those who lack financially or have poor employment prospects are more likely to be involved in sex work, which increases HIV risk and draws the additional stigma linked with sex work (Larney et al, 2015:6).

4.4.2.1.1.1 Sex work

Females who participate in both the sex work and use of drugs are more likely to share needles and other injection equipment among themselves and their clients, as well as have unprotected sex with their clients and their intimate partners. Many females are pressured to sell sex to finance their own or their partner's drug use, which may put them at dual risk of HIV infection through unsafe sex as well as unsafe injections (Azima et al, 2015:17). Adverse socioeconomic conditions may contribute to females engaging in sex work (El-Bassel and Strathdee, 2016:6). The participants raise money through sex work; which increase their risk of contracting HIV infection. This is supported by the following statement:

“I sell my body - **Participant 2**”. Another one said: “I am hustling through sex work – **Participant 6**”. Recovered participant shared that “At times my boyfriends would give me but they began to complain, so I looked for other options then I became a sex worker, so that I can be able to buy myself drugs - **Participant 24**”.

The participants found themselves becoming sex workers to make money for their next fix, they did not entirely want to depend on their boyfriends for money.

4.4.2.1.1.2 Transactional sex

Female nyaope injectors are more likely to participate in transactional sex compared to their male counterparts (Scheibe et al, 2016b:113). Poor economic standing has been linked with earlier sexual involvement, inconsistent condom use, having multiple intimate partners, increased chances that the first sex act is non-consensual, and a greater likelihood of having had transactional or physically forced sex. Many females choose to engage in transactional sex to finance their live (Ramjee and Daniels, 2013:3). Transactional sex increases the risk of female nyaope injectors to contract HIV. Participating in transactional sex is significantly linked with increased HIV prevalence in females. In a review of this association, across eligible studies, females who have history of participating in transactional sex were, on average, 50% more probable to be living with HIV than females who had never participated in transactional sex (UNAIDS 2018b:7). The participants reported that they participate in transactional sex in order to raise money for their drug use.
The participants reported that:

Participant 10 “Sometimes I sleep with someone for money”.

Participant 15 “Truly speaking even my boyfriend does not know. I have people who I meet secretively and I would give them sex in exchange of money”.

Participant 20 “… like to have a mutual agreement that he would give me money and I have sex with them”.

Participant 8 “Since I started using nyaope I do not have feelings, I do not like to be intimate with men but I do it, even if a man can come with R300 and say sleep with me I will do it because I want to buy drugs. I need that money”.

The need to get the next fix influences female nyaope injectors to engage in transactional sex to raise money when they do not have other options of raising money. This practice increase their risk of contracting HIV and other blood-borne infections. This practice increases the likelihood of female nyaope injectors contractring HIV.

4.4.2.1.1.2.1 Factors contributing to transactional sex

Formson and Hilhorst (2016:8-9) contend that there are three elements that jointly contribute to transactional sex. Firstly, the fortunate economic position of men. It is rooted in their access to well-paid sections of the formal and informal economy, as well as to resources such as housing. The second is masculine dissertations. It places a high worth on men having multiple sexual partners. The third, by contrast, relates to an expression of females' agency: females engaging in transactional sexual relationships not as inert victims but rather in order 'to access power and resources in ways that can both challenge and reproduce patriarchal structures'. Participants reported that:

Participant 1 "I did not have money to buy nyaope so he said you are not fine, you look sick; he knows that I am smoking because he used to see me. Then he said escort me I want to take something in my room then we will come back. I said if you can give me at least R20.00 I will escort you. He then said let us go I will give you, when we got there he said I will give you R100 if you sleep with me, and at that time, I was desperate, so I took it then I slept with him".

Participant 22 "Sleeping with a person whom you do not love, just because you want him to give you money so that you can smoke nyaope. You just tell yourself that you will sleep with him and no one will see us. When you sleep with him, no one will see you, and you sleep with him and he gives you money for nyaope, then it ends there. Even if you do not love that person, you sleep with him so that he can give you money".

Financial factors influence female nyaope injectors to participate in transactional sex. A lack of stable income contributes to females having to resort to begging or other forms of income generation, such as sex work or crime, in order to pay for their daily needs (UNODC, 2017b:32). Transactional sex is a way for drug users to earn an income to finance their high drug consumption. Studies have shown high rates of

transactional sex among IDUs; this behaviour is strongly associated with HIV infection in these populations. In this respect, transactional sex among IDUs increases the risk of spreading HIV to their social networks and the general population (Guimarães, Rodovalho, Fernandes, Silva, de Felipe, Vera, Gregório and Lucchese, 2016:1).

4.4.2.1.1.2.2 Feeling associated with transactional sex

It is not all female nyaope injectors who are proud of engaging in transactional sex. A participant indicated that she resented herself after practicing transactional sex for the first time, however, due to the demand of money to be able to maintain the using habit, she felt powerless and found herself engaging further in transactional sex. **Participant 1,** with tears in her eyes, reported that "I resented myself afterwards, but then I still did it again". She was not proud of engaging in transactional sex but she kept on engaging in it as she struggled for money through socially moral ways.

4.4.2.1.1.2.3 How females are approached for transactional sex

Men are taking advantage of female nyaope injectors. Men are aware that female nyaope injectors are financially struggling and need money to buy nyaope. Some females reported that they are used by men for sex, and are targets of sexual favours, in return for a small amount of money. This further breaks down the psyche of these females, as their bodies are equated to nothing more than a few Rands (UNODC, 2017b:19-21). The Participants reported that:

Participant 16 "… they take advantage to us".

Participant 15 "… they approach me as sex object and ask how much do you sell".

Participant 10 "They had advantage [over me] because I am using drugs, they know that if I give her R50, I will be able to sleep with her".

Participant 12 "Many times guys approach me to have sex with them and I … I do not know if it is in me, I cannot say yes or no. Then they will tell me they will pay me R50 just to sleep with me".

Participant 22 "Some are upfront with you because they know you use nyaope. They will tell you that if you satisfy me, I satisfy you. I give you money and you satisfy me. He is upfront, knowing that you use nyaope; he does not tell you that I love you, he

does not lie to you. He will tell you that I give you R30; their price is R30. He will tell you I give you R30 so that you can buy packet and it ends there".

Participant 19 "When a person comes and offer me money, I would say I do not want that amount; you see how I look, if you can give me at least R300 then I can give you what you want with a condom, then we would have sex".

Some participants like **Participant 19** and **Participant 1** exploited the opportunity by demanding higher amount of money which was able to sustain them for longer. This means some female nyaope injectors decide to be taken advantage of, or rather, they use the unpleasant circumstances for their advantage.

4.4.2.1.1.3 Inconsistent condom use

Females who use drugs are frequently disempowered to discuss safe sex with their intimate partners. Sexual risk-taking may be associated to feelings of trust in a relationship, or they may be culturally entrenched in the gendered distribution of power. Efforts to discuss condom use with an intimate partner can therefore result in violence, isolation, and exclusion if taken as an unwelcome challenge to fidelity and privilege within the relationship (GCWA, 2011:5). Gendered cultural beliefs place an intimate partner above oneself, avoiding conflict, and conserving accord in relationships may add to females' powerlessness to discuss safer sex, even in situations when they feel they are at risk (Stoicescu et al, 2018:3316). The participants reported that:

Participant 16 "We often use it [condom] when I am on my periods… I usually do not tell him to use a condom, he is used to the fact that he is my partner".

Participant 20 "He is positive I never contracted HIV, seems like my blood is strong, and I do not contact HIV".

Participant 6 "Yes we do [have sex] but there were times when we did not use a condom and also sometimes it burst".

Participant 7 "After we went to test and then it came (and found out) we were both clean [HIV negative], we never used a condom and we always go and test like last week when I came from my medical certificate we both got tested again and then I was clean so it is like that".

Participant 10 “The first time when we slept together, we used a condom but as time goes we stopped because we were used to each other”.
Participant 17 “I did think of it [using a condom] but we had been in the relationship for a while now and before I started to inject, we tested on the gazebos that are placed on the streets; we were both negative since then”.

The participants are not consistently using condoms with their intimate partners. The attitude of not using condoms by partners of female nyaope injectors is increasing their risk of contracting HIV. The risk is higher as most of the boyfriends are injecting nyaope themselves, and might be sharing injections with other drug users.

Female nyaope injectors in developing countries have shared that females were more probable to participate in high risk activities in the context of a sexual relationship with an intimate partner (Rahman, Iqbal and Vicknasingam, 2015: 2). This was supported by the following narratives of participants:

Participant 12 “He does not like to use a condom, but it is a long time we have not been sleeping together, (intimate) he is not a person of [not much into] sex”.
Participant 19 “He did not want to use condom. Eish! I loved him; I do not know how to explain this, I loved him”.
Participant 24 “You know when you talk to males about using condoms they do not understand, at times they want to have unprotected sex. I think that we were going to fight maybe he was going to hit me”.
Participant 20 “It is hard to refuse my partner as he would accuse me that I have been sleeping around, why I am refusing? It is difficult because I do refuse at times and suggest condom use, but he does not want to”.

The participants reflected helplessness in negotiating condoms use with their intimate partners. They feel powerless and have left their health in the hands of their intimate partners. Women gave many reasons for not using condoms. Amongst others, it was reported that condoms were perceived to be something that was used at the beginning of a relationship when there was still a lack of trust and commitment. The need to continue using a condom could be seen as a sign of distrust or a lack of real love. Women also wanted to preserve their relationship by pleasing their partner or making sex more enjoyable by not insisting on a condom (Kanda and Mash, 2018:3)

4.4.2.1.2 **Sharing needles**

Societal customs that supress females and generate imbalanced power relationships further strengthen injection sharing in intimate partnerships (Marottaa et al, 2018:103). The participants reported to having injected with a used injection with their intimate partners. Reasons for sharing needles and injecting equipment are complex. Individual factors like knowledge, perceived risk, and perceived sense of control indisputably influences injecting and sharing behaviours (Morris, Andrew, Tan, Maher, Hoff, Darbes and Page, 2019:2). The participants reported that:

Participant 1 “He did not have an injection, actually we had but it blocked, so he asked if he can use mine”.

Participant 10 “I just said because is my boyfriend, I only shared with my boyfriend”.

Females tend to ignore risks in the context of injecting intimate relationship (Morris et al, 2019:5). It is easy for female nyaope injectors to inject with their partners as they perceive sharing with their partner as not risky.

Participants reported to have shared injections within the network of people who inject drugs, especially with intimate partners. They explained that a lack of access to clean injections has contributed to them sharing injections because the withdrawals are unbearable, and at the time when they have to inject, they do not think of the consequences of sharing injection. At that point they indicate that injecting the drug is more important than anything. The participants reported that:

Participant 19 “At that time where was I going to get the injection? Because when I withdraw I get alostro [withdrawals]; it is a very painful thing, it is like having cramps, I cannot do anything by that time. I am experiencing withdrawal, there is nothing else that I can do”.

Participant 21 “My needle was broken and I was experiencing withdrawals, that feeling is unexplainable”.

Participant 23 “Mine was blocked, I was with this other guy who is my ex, he gave me his and he injected me because at that time I was not able to inject myself. I could not find the veins, so I asked that he inject me”.

Participant 2 “Because you cannot wait when you withdraw, you do not think about it”.

Participant 6 “Eish! I was sick and cracking (withdrawing) and I did not have an injection, and also, I did not have money to buy it. I had to borrow”.

Participant 21“It is because when you are experiencing withdrawals you become impatient, for me to go to Dischem and come back and smoke [inject] was too much of administration. So if I can ask from my associate I would ask just to inject then I will go later”.

Participant 5 “Eish! I never thought of that because I was withdrawing, you know when down, eish!”

Participant 5 “When you experience withdrawal you lose your mind, you forget about everything, you forget about sickness, you forget that what you doing will get you in trouble and you will remember after. At that point, you are looking for that high, you inject and get high, then after you realise that sharing a needle increase chances of having AIDS”.

Participant 7 “I will not lie, the first time I was starting to inject, I used to [share needles]; sometimes in location is hard to find a needle. I used to ask if I have alostro and I do not have it [own needle]. Someone borrows me and I give them something then I inject”.

Participant 9 “I was withdrawing and I wanted to inject badly, and this thing that I know this person, I have lived with him for a longer period, and he is safe, he does not have HIV. That is what I was telling myself but I knew I cannot be 100%, because what if he also borrows other injectors”.

Participant 4 “It was difficult to find a needle because when you are going to a pharmacy they would ask do you have a prescription to buy needles”.

Participant 22 “Where I stay needles are scarce and we can use one needle with 10–20 people because they are scarce where I stay”.

Participant 17 “I did not think because I did not know anything about a syringe. I told myself that as long as he has sterilised with water then it is clean.

Participant 24 “I was not thinking about all that, my main concern was to smoke {to inject] and relieve myself from the withdrawal symptoms and be high”.

Participant 19 “Yes, when desperate, one would share and the person giving you a needle wants some remains. He or she is also desperate and experiencing withdrawals, that person would give you a needle (also)”.

Participant 16 “It did happen [sharing needles] that they were scarce. The ones that had it they would borrow; we were not thinking about being sick so we diagnosed a person by looking at him if he is sick or not for as long as we did not see the symptoms. But a coughing person who looks discoloured and sick I would not allow them to borrow me the gun [syringe]”.

Participant 12 “I had to get that nyaope in my system for me not to get sick and where am I going to get a needle now? It was at late night and he is the only one who has a needle. But I had to share that packet with him if I had to use that person’s needle”.

Participant 11 “Eish! I wanted to get something from my friend, because I had nothing to smoke that time, after she injected, she left something for me to inject as well. So when you borrow someone your needle, they must leave something for you”.

Participant 19 “You cannot think about it because I was eager to feel what he or she was feeling and wanted to be high at that moment; nothing goes to mind”.

Participant 7 “You when you have alostro you do not make sense of those things, unless after when you are fine then you get to think about those things like, what if I get sick? What if this?, but it is already done”.

Participant 8 “You know when you are addicted you do not really care, you just want the kick of nyaope, it is because you are already addicted. If you can inject once, tomorrow’s alostro, will only be taken out by injecting so if you do not have an injection you do not really care”.

When female nyaope injectors start experience physical withdraws, their need for the drug surpasses all other concerns, even as they may have knowledge of infection risks (Chakrapani, Newman, Shunmugam and Robert Dubrow, 2011:7). It is key that female nyaope injectors should never run out of needles. Importantly, they have a habit of sharing needles and injecting equipment among friends in their social networks

(Horitavorn, 2008:13). From a moral perspective, giving people needles might seem like promoting needle using practice, but from what the participants have indicated, lack of needles influences sharing and availability of needles will reduce sharing amongst female nyaope injectors.

4.4.2.2 Social interaction

4.4.2.2.1 Family

When most participants start engaging in substance use, they live with their families. When their families learn about their drug use, they react. It is reported that families experience traumatic experiences. Families experience mix feelings which includes fear that their child might die, feeling of disappointment or accountability for the drug dependence, and shame as a result of being stigmatised by the community as a parent who cannot control their children (Masombuka, 2013:99).

4.4.2.2.1.1 Family reaction when they discovered that participants are using nyaope

The families were not happy with the participants when they learnt that they are using nyaope. The families experienced lots of unpleasant emotions; they were shocked, angry, surprised and disappointed when they learnt that participants are using nyaope. Schultz and Alpaslan (2016:100) argue that the initial reaction of the family involves shock when they learn about the drug use of their family member. The shock is joined with feelings of dismayed, rage, frustration, sorrow, disorientation, helplessness, as well as pity and disbelief. The initial shock reaction experienced is not unusual, for when a family discover about the drug use of one of its family members, the family is "thrown into shocked disarray". The participants reported that:

Participant 17 "Yoh! They were angry. It was bad because when they found out that I am smoking and everything I needed, I depended on them, that changed and the way the treated me, was not [it was no longer] the same".

Participant 22 "They would have taken me for an animal. I am forward, or am not scared of things, maybe they would think I want to kill myself or something like that because it is not usual. I hear when they speak about others. Saying she is injecting,

and she is not scared of things, I hear when they talk about others. I was afraid to tell them that I am injecting".

Participant 18 "They were really disappointed, shocked, because I was the brilliant child in the family".

Participant 16 "They were not happy at home, there is no mother that would be happy, there is no parent that can be happy that their children are smoking nyaope".

Participant 13 "Yoh! They disowned me, totally. But from his family I get support and they always encourage me to stop and stuff like that because they knew I never smoked before, and he was the reason that I started to smoke".

Participant 18 "They did not trust me, no one was trusting. Everybody, even my mother; her money … she would always make sure she puts it safe. Everyone who would come home would hold on to their bags, phones are kept safe; like, you are not trusted at home".

Participant 14 "Yoh! They were very angry with me".

Participant 11"They were shocked because I was a sports girl and playing soccer, also running; now I am using drugs. Every time they watch the friends I used to play sports with see what they have become in the media it hurts them, they are sore".

Participant 10 "I have broken their hearts; especially that I am a mother; I have kids. My mother just prayed to God, waiting for a day where I would change my life".

Participant 5 "They were in disbelief, saying no one has smoked nyaope in the family. The people who claim I am using nyaope are crazy, they talk bad things about their children. I always made sure when I was on the streets. I would not be untidy; I would be clean, my partner would give me money and I would buy groceries whenever I am going home. They would be shocked as I do not look like someone who is smoking nyaope. I always make sure I look beautiful, my hair is proper, am wearing proper, plus I like good things".

Participant 7 "They are not feeling good actually, at first I could not even communicate with them, it was like… I do not know how to even explain. It was like I am out of their lives forever, like I do not have a mother, I do not have a brother, I do not have a grandmother, but they are there, they exist".

Participant 9 “They were so angry and their hearts were broken, it contributed to conflicts in the family, it was not nice”.

The families did not expect to see their children using nyaope. When they learnt that they are using, they did not believe it. They got the shock the lives. The family did not only go through shock and disappointment, they tried to show support to some participants. The participants reported that their families reacted by offering support and taking them to centres where they could be rehabilitated when they learnt that they are using nyaope. This is supported by the following narratives:

Participant 14 “They tried everything, first they took me to places where they thought they will help me to stop, even to church and then I came to COSUP. They even came with me here for me not to run. I tell them there by the house that I am coming to COSUP then I first go there” [to use nyaope].

Participant 4 “Oh! My mother was crying and said that I must go to a rehab or she is going to disown me and all those things. Then I went to rehab but I went to rehab to please them, it was not for me. I think that is why it never worked out”.

Participant 19 “She is a parent, no parent wants their child to do wrong things. She tried to take me to rehab and took me to another doctor, they inserted another pill”.

Participant 22 “My mother tried to help me, even before she passed away she went some place for me to get help but before she could, she passed away”

The family extended their hand to help participants when they learnt that they use drugs. This reflects that family is supportive. They sought help for the participants at different institutions.

4.4.2.2.1.2 Family reaction when they discovered participants are injecting nyaope

The families were disappointed at the conduct of the female nyaope injectors when they learnt that they have transitioned from smoking to injecting. The families confuse pure injecting practice with *bluetooth practice* where drug injectors share blood among themselves. The families further associated drug injecting with committing suicide. The practice of sharing blood among drug injectors was first reported in Tanzania in 2005, and is unique to sub-Saharan Africa. It involves injecting heroin, then drawing out as

much as 3 cc of blood into a syringe, and passing the syringe filled with blood to another injector for injecting (Asher et al, 2013:2). This practice is called *bluetooth* by South Africans (www.timeslive.co.za) and *flashblood* by Tanzanians. The participants reported that:

Participant 24 “My mother was worried thinking that I am killing myself saying that I will die very young”.

Participant 16 “Ehh! the one of injecting was the one that made them more furious because I had once missed [injected wrongly] and they saw that I missed and they have heard how many people have died because of the needle they tried to reprimand me about it”.

Participant 14 “Like I told you, the trust in the house and things like that. They did not trust me; if I turn my back they are there, if I do, they are there. When I see their phones, they are gone already because of they are scared of me, they take it”.

Participant 4 “She said I am killing myself and I am so clever, why am I throwing my life away and all those things”.

Participant 21 “Yoh! It became worse, very worse because my mother does not like and does not even want the injection”.

Participant 12 “Like my mother does not treat me like she treats my other brothers and sisters. She treats me far different from the others, like if something is getting lost in the house or something is not there, then they would always say ‘but why must she take things in the house that does not belong to her’. So always when things go missing they say it’s me. Sometimes they will not dish food for me out.

Participant 11 “They are disappointed, I am disappointing them, and they want me to come out the drug”.

Participant 1 “She expressed a lot of concerns; that means you cannot stop because you are even worse than before”.

Participant 7 “Yes, they reacted but not badly they just told me you going to die, we hear now that you are even injecting, do you know that injecting is more dangerous than smoking, now you will be gone”.

Participant 10 “They are not proud about it [the injecting], they said what I am doing now is killing myself. Sometimes when things are lost, I am the first suspect. They undermine me because I am a drug addict”.

Drug use and injection invites extensive stigmatisation. Females who use drugs may encounter rejection from their relations and communities. Female will further face discrimination in a variety of contexts, including health care settings. As a result, females who use and inject drugs may be unwilling to divulge their drug use and be reluctant to access health services, including drug treatment, for fear of stigmatisation. Social barring, stigma, and discrimination contribute to increased HIV risk and weaken HIV prevention and treatment (Larney et al, 2015:6).

4.4.2.2.1.3 Perception of how families would have acted when if discovered the participants inject nyaope

Some of the participants hid their nyaope injecting from their families so their families did not know they transitioned. Due to stigma associated with injecting nyaope, the participants are of the assumption that if their families knew they were injecting nyaope, they would be disappointed at them and might disown them. This is supported by the following statement of the participants:

Participant 5 “Yoh! Yoh! Yoh! Eish, I think that they will give up on me and will tell me that they are paying burial society and they are waiting to collect my dead body. You know how the words of the parents are, once they can tell you to stop they reach a point where they give up”.

Participant 18 “Yoh! They will go crazy. Yoh! You know my mother does not tolerate the injection at all more than dagga, she can even tell me that I should not inject I would rather dagga than injection. Because there has been this misconception of bluetooth they think like that we are experiencing that, a lot of people are saying a lot of things about the injections”.

Participant 7 “They think people who are smoking drugs are not good at all, they are stealers, they are not supposed to be around people, like … I do not think they will ever like me or they will ever feel safe around me. They are going to think maybe I am going to steal or maybe, you know, they will not be comfortable around me anymore”.

4.4.2.2.1.4 Feelings associated with being home

The reaction of family members toward female nyaope injectors often has an emotional effect on them. Female nyaope injectors feel unwanted and not accepted by family members due to drug use. Their “good daughter” image is substituted by the junkie image which they have seen in the media (Horitavorn, 2008:20). The participants did not feel welcomed and comfortable at their homes.

Participant 2 “I do not feel like I am welcomed, that is why I just go because they are always talking about me”.

Participant 14 “I feel like I am a stranger in my own house [home] and now that my mother is not there, and my father is also using but he is not doing it in front of people. People know that he is also smoking, but not nyaope, he is smoking mandrax … so like ... he swears at me [say things like] ‘you nyaope what what, go to the hostel. I never taught you smoke this thing, I told you before spiking and all those things.’ He is always talking like he prevented me from stopping to do this but he never”.

4.4.2.2.1.5 Relationship with children

The participants reported that due to drug use, they were not involved, the way they wished to be, in their children’s lives. They believe their drug use affected their involvement in their children’s lives. Kontautaite, Matyushina-Ocheret, Plotko, Golichenko, Kalvet and Antonova (2018:4) reported that 25 females in their study described the restriction of parental rights because they were drug users or drug dependents. Mothers were not permitted to contribute in any decision-making related to the child’s health and were poorly involved in the life of the child. The findings of the study corroborate the findings of Kontautaite (2018) and partners. The family has taken some responsibilities from female nyaope injectors due to using nyaope. The families are now managing social grants and welfare of the children. The participants reported:

Participant 11 “It was because I was on alcohol and I started using drugs; that is the reason she took her [family took her child away]”.

Participant 16 “My children stays with my mother, even the grant money, my mother has it”.

Participant 18 “He did stop, but now he is doing everything. Like paying for the child’s school fees, the transport, buying the child’s groceries, everything that has to do with the child, he takes care of it”.

Participants are not happy with the state of relationship they have with their children. They expressed that their children do not want to see them using drugs and it is unpleasant for them.

The participants reported that:

Participant 23 “At times I would chase him away, you understand me? But there was a time when he asked me why am I injecting, then I made a promise that I will stop. He found me again injecting and asked if I am still injecting, then I promised him again that I will stop. That is when that thing made me feel bad because this was hurting my child, because when he would find me injecting, he would walk away same time; he would no longer entertain what I am doing, turning away from the things that I am doing”.

Participant 10 “He knows and it affects him because he is old enough, and he understands. He asks my mother, when I am going to stop smoking. It makes feel bad”.

Participant 2 “We do not have a good relationship but he knows I am his mother, he is five years [old] but I do not see him much”.

4.4.2.2.2 Community

4.4.2.2.2.1 Reaction by the community when they learnt that females use nyaope

When families try to tolerate drug-using behaviour, the community makes things worst with their gossip. Gossiping by neighbours about females who use drugs makes family members feel uncomfortable and humiliated. Using drugs brings shame and lost face in the community and among relatives (Horitavorn, 2008:24). Participants reported that:

Participant 23 “They started acting up, others would distance themselves from me, and others would not greet me. There was no more trust in me, even if a person wants

to ask me to run their errands, it becomes difficult because of they might think that I will run away with their money".

Participant 1 "The community, to be honest, once they know you smoke or injection nyaope they start to look down upon you. They do not take you as a person anymore, to them you are just a thing".

Participant 8 "Like everyone sees their child better and I am seen like the worst person".

Participant 4 "They have this perception that if you are using nyaope you are dirty and you will do this thing of recycling and you steal, and so, they are judgmental. That stand-offish thing comes and they are, like no we do not want you here".

Participant 17 "They treated me badly because they were talking behind my back. If anything got lost they would point at me saying I am brining people to come and steal; it was bad".

Participant 9 "Some treat us badly, sometimes when things get stolen, you are the suspect. They look down on you, they treat you badly and when they look at you, they see rubbish".

Participant 15 "They tell their children that they must not come near me or my associates, then there are some whose children are also smoking. When they see me, they wish that I can change and leave the drug and also to becomes a better person".

Some participants reported that instead of the normal discrimination which is perpetuated on females who smoke and inject nyaope, some community members expressed love and encouragement. The participants reported that:

Participant 9 "Some treat me well and others discriminate against me, and undermine me. Others changed, sometimes they treat you well, sometimes they stigmatise".

Participant 3 "They did not discriminate against me that I am smoking nyaope; they were supporting me, they would give me advice, they even offered to buy me drugs when I did not have money because they wanted to be free when I am around them. They did not want to hide their phones when I am around them. They would tell me that they know about nyaope and how people act when they withdraw, they did not

have a problem as such, they only emphasised that they do not want me to steal because of nyaope".

Awareness campaigns should also be directed to the community with the aim of educating them about the effect of their stigmatisation which is perpetuated on female nyaope injectors. It can also help teach them how they can assist females to mitigate risk of contracting HIV and other blood-borne infections.

4.4.2.2.2.2 Community reactions to injecting practice by female nyaope injectors

Female nyaope injectors experience intensive stigma than their male counterparts because their drug use is perceived as breaking the natural roles of females in society, that is, as "mothers, the anchors of their families, and caretakers" (Rahman, Iqbal and Vicknasingam, 2015:1). Once the community learns that particular females have transitioned from smoking to injecting, they increase the level of stigma and discrimination. Studies from India, Mexico, Vietnam, and the UK on stigmatisation within social and healthcare settings have revealed that female nyaope injectors often experience intense stigma and social barring from their communities due to social condemnation of females injecting drug use (Mburu et al, 2018:5). The participants have reported that:

Participant 20 "When I was smoking dagga it was better [the stigma], but after using injection, it became worse".

Participant 24 "Yoh! They treated me badly, very bad. When I was passing by they would say it is that girl who injects nyaope, what kind of a girl is that; people would talk behind and I hear them".

Participant 11 "They have changed and they kept on saying that now I have taken it far and that I will get sick".

Furthermore, like the families of female nyaope injectors, the community equates the practice of injecting nyaope to self-destruction. **Participant 9** reported that "they are saying now they are killing themselves, this is the end, and some are happy, someone said few weeks back, "to inject is better why does she not sniff it". This was corroborated by **Participant 22** when she reported that "when they pass us on the streets and they will say hurtful things about us, they would say we are killing

ourselves, and things like that. But they would not tell us, they would gossip as they walk away".

The stigma has contributed to female nyaope injectors hiding their injecting and exposing themselves to high risk behaviour and lack of access to harm reduction services. **Participant 2** reported that "… it was not easy, because I would go far from the people who really know me, I would smoke where people do not know me". Fear of the community knowing that she injects nyaope drove her away from her community, around people she knows, places she knows, to where she is not known. This could make her meet different drug networks which engage in riskier behaviours than the ones which are in her community.

4.4.2.2.3 Health care institutions

Female nyaope injectors have different experiences regarding health care institutions, which are mostly unpleasant, making it challenging for them to seek health care services when they are in need. Participants shared about the stigma and discrimination they experienced from health practitioners. Stigma and discrimination influences how health practitioners relate with, and spoke to people who inject drugs when they learn about their drug use (Carusone, Guta, Robinson, Tan, Cooper, O'Leary, de Prinse, Cobb, Upshur and Strike, 2019:4).

The intense stigma directed to female nyaope injectors can present an overwhelming obstacle to the opportunity of approaching harm reduction services, drug treatment, HIV treatment, sexual and reproductive health care. More, especially in culturally conventional societies (Pinkham et al, 2012.126). Many females unavoidably found themselves forced by conditions to seek health services, and in those conditions, they tried to hide their identities, so as to avoid being stigmatised or discriminated against by health workers (Mburu et al, 2018:5). Stigma adds to poor mental and physical health and hinders with drug treatment and recovery (El-Bassel, 2015:5).

4.4.2.2.3.1 Barriers accessing health care services

Participants highlighted stigmatisation, withdrawal and poor services at local health institution as a barrier to assessing health care services. They reported that:

Participant 2 "They treat me well, but when I tell them I smoke nyaope they change".

Participant 8 “You do not feel welcomed as long as it is about withdrawals or if the nurses can find out that you are an addict, they do not treat you nice”.

Participant 4 “Some of them become very rude and very stand-offish. Some of them are very judgmental and at times they say things like ‘why must you be even be here because this thing that you are using kills everything, so do not come here to waste our time’. Sometimes they have that attitude, but not everyone”.

Participant 3 “They treat us good at the clinic [Sediba], they are not like our clinics (ordinary clinic) they would insult us. It happens that you arrive at 7.00am, you will leave at 4.00pm or 4.30pm. Since I have been attending the clinic from town [Sediba] I never spent more than 3 hours, even an hour”.

Participant 22 “I feel, if I go to the clinic, people who are at the clinic will look at me, all the attention will come to me, saying there comes nyaopes [nyaope user], what is she doing at the clinic, things like that”.

Participant 5 “Let me tell you, the first time they turned me away for proof of address. I stayed the first day, then the second day, I looked for the proof of address and I did not find it. Third day I went and asked for help, I was fine, then they refused saying I should find proof of address looking at me”.

Female injectors who are vagrant or lack proper documents may face extra difficulties in accessing harm reduction or HIV treatment (El-Bassel, 2015:4). **Participant 5** was turned away several times from the community health centre because she did not have proof of address.

Participants highlighted that stigmatisation by health care practitioners makes them unwelcomed at the clinic. They further alluded that due to time spent at the clinic, it is unbearable to deal with withdrawals. The participants shared the following narratives:

Participant 8 “Yoh! When you smoke and you do not have money you will compromise your appointment. Like you must first hustle before going to the clinic”.

Participant 6 “When I have used drugs, I get strength and I would be able to go to the clinic”.

Participant 24 “It was not easy because every day I had to look for money to be able to smoke. The time I spent going to the clinic was the time that I was supposed to make money in the streets while I am sitting in the clinic”.

Participant 17 “I would smoke first, it would not have been easy because I would be going up and down”.

Stigma has been identified as an essential barrier to care for people who inject drugs, leading to poor health outcomes. PWID were less likely to receive a routine physical examination than the general population (Lan, Lin, Thanh, and Li, 2018:2).

4.4.2.2.3.2 Attending antennal classes

The participants did not visit their clinic in time when they were pregnant. Factors which influenced the participants not to access their health care services disadvantaged them as they did not attend antenatal classes. Females who use drugs normally do not take the non-appearance of menstruation as a sign of pregnancy; other signs of pregnancy had to be seen before they would begin to suspect that they were pregnant. Most females’ pregnancies were accidental because of their irregular periods while taking drugs (Horitavorn, 2008:39). The participants reported that:

Participant 17 “I did not attend to the clinic until the child came. The child came before time but he is fine, healthy and well. I was scared that the child can be disabled or come deformed but I was unable to stop”.

Mokwena (2016:138) argues that health issues pertaining to nyaope use are not extensively known, however, Thomas and Velaphi (2014) reported cases of two neonates who were born to mothers dependent to nyaope. The children presented with growth restriction and other signs of neonatal abstinence syndrome, which the authors attribute to nyaope use. Drug use among females may also result in some pregnancy difficulties, such as neonatal abstinence syndrome, low birth weight and premature birth. Neonatal abstinence syndrome mainly refers to opioid withdrawal experienced by infants born to females who continue to use opioids during pregnancy (UNDOC. 2018:16)

Some female nyaope injectors did not know they were pregnant until quite late, making it more challenging for them to have an opportunity to benefit from a fitting prenatal

care, harm reduction services, drug treatment and other support, or to terminate their pregnancies safely if they so choose (Pinkham et al, 2012:127). This was confirmed by **Participant 19** when she reported that she "was 7 months pregnant" when she discovered her pregnancy. The participants did not know they were pregnant until it is too late to attend antenatal classes at their local clinic. **Participant** 10 reported about her child that "she is also infected with HIV... I went late to the clinic". If she had known in time and attended antenatal classes, the health care practitioners would have assisted the participants to be on medication which would have enabled the child to be born HIV negative.

It is also reported by literature that most health practitioners are not skilled to handle the unique needs of females who use drugs. The unfriendly attitude towards females who use drugs poses a substantial deterrent for females to pursue treatment (Azim et al. 2015:519). It is therefore of importance that health service providers are trained and capacitated to handle the unique needs of female nyaope injectors so that they know what to do when they encounter female nyaope injectors. A study by Mburu and colleagues (2018) has shown that different forms of stigmatisation of female nyaope injectors are an obstacle to their access and use of health services. Facing shame related to one's drug use can contribute to dodging of harm reduction and general healthcare services. Further, the study revealed that poor access to services was facilitated by poor interactions with, or obvious discrimination by health providers (Mburu et al, 2018:5)

4.4.2.2.3.3 Treatment of abscess by female nyaope injectors

Participants have experienced abscess and they treat it differently. Some participants reported that they go to community health care centres while others indicated that they treat them themselves and others do not treat them.

Participant 3 reported that she does not experience abscess even when she has missed, she reported that "I would be surprised when I have missed, you see my hand (showing) I had missed but I cannot show you the wound because I do not see it. This are the marks of injecting. I cannot really show you because when I have missed, I get swollen then it disappears just like that. I do not get open and get discharges like it happens with others. In my case once it gets swollen, I would wear an ankle cap and

my hand will get normal". This was corroborated by **Participant 5** who said "I do miss at times. But I do not get abscess, you see here and here (showing). I have missed yesterday but it is not even painful".

Participant 9, who went to the community health care centre, reported that "I missed on Monday and I immediately went to the hospital following day. That is where I was told that the reason they dealt with it easy was because I came for treatment early. They also showed me an example of a person who does not go to hospital early". **Participant 18** reported that it was embarrassing to go to the clinic but she went and "(the nurse) just looked at me, he was a male nurse. He just looked at me, clicked his tongue and cleaned me then gave me pills. I am sure that he was able to conclude that I am injecting and it was embarrassing". **Participant 12** reported that "when I was using a needle, old needle at that time, I did not know about COSUP, I was using one needle for two weeks because I was using it alone, so I started getting abscess in my hand then my hand started to get dirt, stinking; then I went to Steve Biko (hospital)". The participants, despite the stigmatisation perpetuated on them for injecting drugs, drew courage and visited their community health centres when they experienced abscess.

Some participants indicated that they treated themselves. **Participant 7** reported that "I used to leave it until it becomes yellow itself then, I bust it, then after that I put a Betadine then I bandage it. I have to clean it first then my husband advised me to drink Stameta". **Participant 11** reported that she "was treating it with an olive leaf and bandages".

The stigma perpetuated against female nyaope injectors is doing more damage that the drug itself. Judgmental and moralising views towards drug users are regularly spoken within South African communities, more specifically by health practitioners. This demands specific attention as health care service providers are required to attend medical needs of female nyaope injectors. The attention can be through training health care workers to handle female nyaope injectors. Sensitisation training for health practitioners about key populations has been endorsed to reduce stigmatising attitudes and behaviours towards clients, and therefore reduce HIV transmission and prevalence rates in South Africa. The training is in line with The South African National Strategic Plan for HIV, TB and STIs (2017–2022) states the objective is to "invest in

expanding training and sensitisation programmes to reduce stigma: Programmes to protect those affected by HIV against discrimination and violence and to support access to HIV prevention, treatment, care and support" (Duby, Fong-Jaen, Nkosi, Brown and Scheibe, 2019:2).

Through the sensitisation training, the health workers will be able to handle female nyaope injectors, which will make female nyaope injectors to feel welcomed at the health care centres and not to delay when they experience health issues.

4.4.2.2.4 Police

The police, as law enforcers, are caught violating the law with regards to female nyaope injectors. Instead of protecting the rights of female nyaope injectors, the police are leading in violating their rights. The police indirectly contribute to needle sharing. Carrying clean needles for fear of arrest contributes to needle sharing, which increases the risk of contracting HIV (Chakrapani et al, 2011:4). Scheibe et al (2017:2) reports that drug use is criminalised in South Africa, but no laws ban the buying or providing injecting equipment. The participants reported that police broke and confiscated their needles, and arrested them without charging them in court.

4.4.2.2.4.1 Breaking injections

In order to curb HIV incidence amongst female nyaope injectors, it is important that they should have access to sterile injecting equipment at all time in order to discourage injecting sharing. Females who use drugs report high rates of police abuse (UNAIDS, 2019:14). Appropriating injecting equipment, even in places where needle-syringes are not legally restricted, contributes to female nyaope injectors not carrying their injections (UNAIDS, 2019:36).

Police confiscate and break female nyaope injectors' injections, exposing them to a situation where they must share injections with other injectors. It is extreme disappointing when police confiscate injections which are provided by harm reductions programmes like COSUP with an aim of reducing infections among people who use drugs. **Participant 11** reported that "they did not arrest me, they took my needles and broke them". This was supported by **Participant 10** who reported that "they break them [the needles] and release you and take those who have drugs". **Participant 4**

further added that “they took all of them [the needles], like, I just came from COSUP to exchange and they took all of them”. Police are fighting and unfairly treating female nyaope injectors. Confiscating female nyaope injectors’ needles fuels the sharing of needles among females and the network of people who inject nyaope.

4.4.2.2.4.2 Police arrests

The participants have been arrested by the police without being charged in court. The participants have identified this type of arrest as white door arrest. The researcher is of the view that the police arrest female nyaope injectors as punishment for injecting nyaope. Such a practice violates the rights of female nyaope injectors and destroys the trust and faith the females have in the justice system.

The participants reported that:

Participant 22 “Sometimes the police, when we are at station, when they find us smoking, they take us to holding cells and we remain in the police cell for 48 hours. After 48 hours, we are released through a white door. We do not go to court or magistrate, they just punish us”.

Participant 7 “I was charged but I was out with white door [not charged], it is like you do not get to go to court; they keep you in police station. The day you have to go to court, you stay there in court until people get to court and they are finished after lunch. Mostly they call you guys the ones arrested for drugs and then they make you sign and take finger prints then you can go”.

Participant 10 “They arrested me but later I was out and never went to appear at court, I only got out with a white door. I do not know whether it was a warning or what”.

When the police are dealing with female nyaope injectors, they do not excise respect and do not protect their rights. **Participant 3** recalled the ordeal she suffered when the police arrested her for the second time. She reported that “police approached us, people ran away and I fell down, then I was arrested. The police said I have something stashed down there, I said I do not have anything hidden on me. I tried to explain that I fell as other guys were running away. The female police searched me and stripped me but they did not get anything. They discussed among themselves to take me or leave me and they ended up taking me… people were looking, it would have been

better if they took me inside the van but they insisted that I undress in public they said that they want see, I really did not feel well".

Due to violation of human rights perpetuated by the police on female nyaope injectors, female nyaope injectors do not trust the police. Female nyaope injectors do not report police abuses due to fears of incarceration or other retaliatory penalties for themselves and their families (El-Bassel, 2015:6 & UNDOC, 2017b:23). **Participant 2** reported that "we do not go there, because if we go to the police station, for someone who is injecting drugs, they are not going to take you serious". The treatment female nyaope injectors receive from the police has created an impression on female nyaope injectors that the police are not for them, and they do not deserve justice.

Police are another factor that drives drug users out of their community. The "War on Drugs" brands injecting drug users as criminals characterised by deviance, lack of control, violence, and moral depravity. This eventually builds an environment of violence and discrimination against anyone who uses drugs (Horitavorn, 2008:25).

There is cumulative acknowledgement that the criminalisation of people who use drugs is destructive to human rights and public health objectives. The decriminalisation of drug use and possession has the prospect to lessen obstacles to providing harm reduction services. UNODC is conducting sensitisation training for police officers to assist in addressing the harms that often rise when people who use drugs interacts with the police (Southwella et al, 2019:4).

Dintwe (2017:162) contends that the availability and distribution of nyaope is openly visible and the failure by law enforcement agencies to close ranks with the pushers and drug lords provides a mystery as far as the willingness of law enforcement agencies to deal with nyaope.

The author further argues that law enforcement need to approach nyaope differently because:

- Nyaope is a multi-faceted challenge;
- Nyaope addiction is caused by a variety of factors;
- Nyaope addiction needs a multi-faceted approach; and
- It poses unique challenges for the police and other law enforcement agencies.

4.4.2.3 Raising money

Female nyaope injectors engage in different means to raise money to feed their habit. They do not engage only in sex related risk as highlighted at the sexual risk section.

4.4.2.3.1 Having multiple partners

The participants have highlighted that they are able to generate money through multiple partners. Some of the partners are aware that they are not in normal relationship, rather they are in a transactional sex relationship. Others are of the assumption that they are in relationships, without knowing they are used as cash cows. Multiple partners increase risk of contracting HIV infection.

Participant 10 reported that “I have my people whom I engage in transactional sex with, but he does not know”. **Participant 24** “only one was good to me but the other two, they were not so good to me but I was with them because I wanted money”.

Participant 7 reported that “I used to, because you know, sometimes the other one does not have money, the other one has it, so it is like when that one does not have that one has; they cannot all not have it at the same time. So that was one (way) of finding myself, control my habit because if one did not have I would go to another one; apparently he would have money, then I would smoke and feed my habit”.

Participant 23 said “I used to do it because there was this guy that loved me but he knew that I have a problem of smoking. He used to come to me wanting to have sex with me then I would tell him I cannot, I want money first so that I can be fine because you will also be fine with whatever you want so I also want to be fine, I want money”.

The participants, while having their intimate relationships, established a network of sexual partners whom they slept with for money.

4.4.2.3.2 Stealing

Charlton, Negota and Mistry (2019:47) argue that most of the time nyaope users are unemployed and do not have sufficient resources to maintain their drug using lifestyles. Due to their circumstances, many admit to engaging in crime to feed their habit. The common crimes that were identified include housebreakings, theft, stealing of appliances or steel, robbery, shoplifting, jewellery theft and theft of other household

utensils. Nyaope users further confirm that they would steal whatever they can get their hands on like water faucets, electric cables, copper and aluminium wires. Once they have obtained these items, they will sell them at scrap yards for cash and use the money for their next “hit”. Most participants stated that they prefer to commit minor crimes as these types of crimes require less energy. Participants acknowledge that at times they are involved in criminal activities to raise money to buy drugs. Participants reported that:

Participant 22 “When I did not have money, the first thing that came to my mind was shoplifting so that I can make money to buy nyaope”.

Participant 1 “Eish! You [when I was still back at home] I used to steal from my parents”.

Participant 19 “Searching my mother; I used to search her with the mentality of I took it and there is nothing she can do. But I did not steal from people in the streets”.

Participant 24 “At times we would steal the purses of the clients and phones”.

Participant 2 “Sometimes if have a customer/client I would steal money or phone just to get extra”.

Participant 5 “Currently I sometimes go to the white neighbourhood and ask, others would give me. When they do not give me, I [would] jump the fence, pick up something very fast then run away”.

Participant 7 “I used to do shoplifting, so I used to go to Jubili Mall, that was the time I was in the location”.

Participant 8 “I do shoplifting, and I steal at home”.

Participant 10 “Sometime I make plans. Sometimes I will do things against my values, like stealing, but most of the time I do odds jobs; I do washing for people. That is how I raise money”.

Participant 14 “I remember with my friend we risked. He wanted to steal something from some people, but if they can realise that we are here, it was either one of us will not make it out of there or not. So we must do it as quickly as possible to get out of

the territory, and you know what, the way we planned it, the getaway is quick, here is the house and there is the bush [showing with hands]. It was not a house but a place where they fix cars, so he gave me the one battery and he also took one battery. That was risky, if they catch you, they will hit you badly. Remember the last one they hit so bad that he did not make it after four days in the hospital; he died. They call those people the Maries. All of them they are like this [huge] but they are using cars, you can ask anyone about the Maries".

Participant 15 "House breaking and stealing things like irons. I did that because of my boyfriend. Personally, I have a fear for stealing from someone".

Participant 6 "Searching and stealing from my clients".

The mixture of poor financial backgrounds, joblessness and the addictive nature of nyaope sways drug users to commit crime, mostly petty theft, to finance their habits. The criminal element is influenced by the intense physical withdrawals for nyaope (Mokwena and Huma 2014:358). Communities distressed by nyaope use report crime mostly in the form of stealing of various items, including food, and household items like pots, cutlery and clothes, committed by the users, as they sell the stolen items to obtain money to sustain their habit (Mokwena and Morojele, 2014:380).

4.4.2.3.3 Depending on boyfriend for money

Drug-using females encounter high levels of unemployment due to the discrimination and stigma. Females who inject drugs have insignificant prospects of finding employment and become financially dependent. Many of the females remain poor and depend on their intimate partners for food, shelter and basic necessities (El-Bassel, 2015:6). This is confirmed by the following statements:

Participant 23 "Hmm… mostly things to smoke I would find them from my boyfriend, because my boyfriend is selling nyaope and at times I would get money from my parents".

Participant 1 "I was mostly dependent on him [my boyfriend], he used to be the one who provided most. If he does not have, I would have to go out and make a plan. If I go home, I would beg, and if I do not get anything, I would steal. Sometimes I would … Eish! There were even times when I had to sleep with someone for money".

Participant 5 “Since he [boyfriend] was arrested, I am unable to hustle for myself, so I meet with people who have intentions of making me their girlfriend, but I am not interested in relationships. I get easily irritated since I began injecting, I tend not to have [sexual] feelings for the next person if he tries his luck. I use such for my advantage, he would be surprised next time when he comes to me I would dismiss him, telling him not to even touch me”.

Participants are seen to be dependent on their intimate partner for maintaining of their nyaope use, the dependence fuels the risk of contracting HIV and other blood-borne. In circumstances where females’ intimate partners supply them with drugs, there is often the anticipation that they will have sex in return, which points to a gender power inequality that is strengthened by substance use. In these circumstances, a female’s refutation to have sex or her efforts to discuss condom use may trigger further violence (UNODC, 2018:17). In order to protect female nyaope injectors, the South African government, through the parliamentary processes, have to create bills and laws that are aimed at protecting the vulnerable females.

4.4.2.3.4 Selling personal belongings

Participant 18 shared that she sold her belongings to raise money. She reported that “other things like sex work I do not do, I would rather sell my own belongings”. The deprived socioeconomic environment results in street trading of a variety of items, which is a platform that nyaope users make use of in order to quickly and easily sell items to support their habit (Mokwena and Morojele, 2014:376).

4.4.2.3.5 Working petty jobs

The participants are involved in different petty jobs to raise money to buy their nyaope. Participants reported that:

Participant 3 “I hustle by pushing people’s trollies, the ones who cook mielies”.

Participant 16 “I do go to people’s houses, I am a woman; ‘do not you not have blankets that are dirty?’ So that I can wash them at a negotiable price”.

Participant 21 “I was plaiting people”.

Some of the participants use their hands to raise money for drugs. **Participant 3** further alluded that she stopped engaging in sex work to push trollies. This shows that female nyaope injectors can be self-sufficient in their pursuit to make money when their heart is at it.

4.4.2.4 Nature of intimate relationship

As discussed above, female nyaope injectors are more likely to be in an intimate relationship with a male sex partners who injects drugs. Females' relationships with their intimate partners who also use drugs are multifaceted and lively. Females work to finance their drug habits and that of their intimate partners. A study of female nyaope injectors who practice as sex workers in Canada established that the males take control of the females' lives through a course of building trust, supplying and monitoring the supply of drugs, gaining control of their sex work environment and transactions with their clients. Sexual and physical aggression against female nyaope injectors is common. The experience and the threat of aggression serves to oppress females further. Intimate partners often control decisions on condom use. Poor condom use has been reported by females who use drugs with both clients and their intimate partners (Azima et al, 2015:17). IPV affects females' power and capability to discuss the conditions of sexual intercourse, especially condom use (Turmen, 2003:413).

Some studies have projected that the occurrence of physical and sexual IPV is 3–5 times higher amongst females who use drugs as compared to community-based samples of nondrug-using females (Pinkham et al, 2012:3). Violence has significant negative consequences on physical, mental and behavioural health, as well as sexual and reproductive health and chronic disease. Females who use drugs experience violence at far higher levels than the general population, and from multiple sources (UNODC, 2017b:6).

Physical violence may build an environment of fear and submission that makes it challenging for females who use drugs to discuss safer sex, and for HIV-positive females to reveal their serostatus (El-Bassel and Strathdee, 2016:5). The participants have reported physical abuse and emotional abuse, as abuse which dominate their relationships.

4.4.2.4.1 What participants dislike about their intimate relations with boyfriends

It is widely agreed that injecting drugs is a key driver of the HIV epidemic through risky sexual behaviour and use of contaminated injection tools. A majority of an estimated 3,8 million women and girls who inject drugs globally are at risk of contracting HIV. Among these women who inject drugs, certain psychosocial conditions, including IPV and depression, co-occur within them leading to increased rates of risky sexual behaviour and subsequent HIV transmission (Mwangi, Karanja, Gachohi, Wanjihia, and Ngang'a, 2019:2). The relationships between female nyaope injectors with their boyfriends are not perfect; there are things which participants have highlighted with regards to what they do not like.
The participants said:

Participant 1 "Sometimes he would tell me 'go and steal at your home, your mother has a lot of money', such things".

Participant 2 "That he is smoking, I hope he was not smoking to help me to stop".

Participant 12 "I do not like it when he is stealing from me; that is what I do not like. I do not like a person that steals my things, he must rather ask then I will give because I cannot say no to a person".

Participant 15 "I am staying at his home and he will tell me that I must not forget that without him I am nothing. If it was not for him, I would be on the street. When he does not have anything, I must go and make a plan so that he can smoke; I end up selling my body".

Participant 4 "The fact that we are both using drugs and we have a child on the way".

Participant 24 "The fact that he allows me to go and be a sex worker; he is supposed to protect me. The other thing is that I used to give him money that I get from being a sex worker. He was not giving me good encouragement, all he wanted was money".

The relationship between female nyaope injectors and their boyfriends is complex. The participants have highlighted that they desire support, protection and encouragement from their intimate partners, but they do not get any from them. The

researcher has observed that female nyaope injectors are negatively influenced by their intimate partners. Participants are not happy with dating intimate partners who are using drugs, they wish their intimate partner could stop using so that they can support them stop using drugs. **Participant 24** and **Participant 15** do not enjoy participating in sex work and t wish their intimate partners could assist them financially so that they can stop engaging in sex work.

4.4.2.4.1.1 Emotional abuse

Participant 3 shared that she experiences emotional abuse at the hands of her intimate partners. She reported that “the way he is so impatient, the way he does not trust me because I was a sex worker, he is controlling. Even now that I am here, you might find that he was following me, maybe if I get out I can find him at the gate”. The participant is being stalked and her freedom of movement is restricted by her intimate partner.

Participant 5 reported that “after 6 months of injecting, I began to change, I did not take any medication. He would tell me that when he was touching me, he would feel flesh, but since I started to inject, he feels bones, and that I appear sick”.

The intimate partners were insensitive of the emotional needs of their partners. It appears that they did not care how their partners felt. The emotional abuse inflicted on female nyaope injectors increases their vulnerability as they start to question their self-worth, which then disturbs communication between the partners. Emotional abuse may generate a similar context of supremacy, which fuels females’ likelihood of participating in high risk sexual behaviour. Developing research suggests that emotional violence has comparable damaging impact on females’ health outcomes as physical and sexual forms of IPV (Stoicescu et al, 2018:3308).

The anxiety of others finding out about the diagnosis also depresses people from making contact with health services, community, and family (Horitavorn, 2008:55). HIV positive females who experience IPV are less probable to access HIV care, comply with ART, and engage in HIV prevention and drug treatment services (El-Bassel, 2015:5). **Participant 5** shared that she “did not want him (boyfriend) to know my HIV status”. She had to wait her for boyfriend to be arrested before she was initiated on ARV treatment.

4.4.2.4.1.2 Physical abuse

IPV and HIV infection are key interrelated public health problems worldwide, disproportionately impacting sub-Saharan Africa. Sexual IPV may directly lead to HIV acquisition by forced sex without a condom or an inability to negotiate condom use with an infected, violent partner. Further evidence suggests that men who use violence against their partners are more likely to engage in a range of high risk sexual behaviours, relative to men who are non-violent (Sabri, Wirtz, Ssekasanvu , Nonyane, Nalugoda, Kagaayi, Ssekubugu and Wagman, 2019:1).

Physical abuse is effected with the aim to capture control of female nyaope injectors by their intimate partner. Participants shared how their intimate partners are physical with them. **Participant 6** shared this about her partner: “he assaults me at times”. **Participant 5** said that “my boyfriend would beat me”.

Participant 5 was abducted by her ex-boyfriend after their break up and knowing the she uses nyaope; he did not permit her to smoke dagga, but rather that she can use his nyaope only if she injects it. **Participant 5** reported that “things did not go well for him with his new girlfriend and when he realised my new relationship was going well, he was jealous. He came with his friends and took me by force to Stinkwater… When we got there, I started to withdraw, he told me that if am withdrawing, I will not smoke his money, if I want to use his drugs, I will have to inject. I resisted at first because I did not want to inject because of him, but in the morning, around 3am, I decided that he can inject me because the withdrawals were getting severe”.

4.4.2.4.2 What participants like about their relationships with their boyfriend

Despite the negative experiences female nyaope injectors go through at the hands of their boyfriends, the participants have indicated what they like about their relationship with their intimate partner. The researcher has observed that participants are in an intimate relationship with people who are using drugs. The participants reported:

Participant 12 “We are open with each other and we do things together, there is no hiding things, no! That is what I like about it, we are honest with each other”.

Participant 13 “We have an open relationship; we are like friends, we trust each other and mostly, we do not do things without each other. He would not smoke if I am not

there and I will not smoke if he is not there, so we always do things together we are like *Bonny and Clyde* (laughing)".

Participant 2 "Like, he would give me money to buy stuff, then I do not have to go to the streets".

Participant 4 "We are open with each other, we have an open communication and we trust each other".

Participant 3 "In our relationship, I love that my partner is considerate. This is because since I started dating him, I can see that I can stop using drugs because he gives me advice and he is not impatient with me. He gives me advice and the reason I go home constantly is because of him. To be honest, for me to go home it is because of him; I go home to see the children then he encourage me to stop smoking and to also come here".

Participant 5 "What I loved about my boyfriend is that he took care of me; people used to tell him that your girl is injecting behind your back but he did not take rumours. As long as he has not seen me, he would have never come to me and fight over something that he did not see. He also trusted me even though people were telling him that I am injecting, he would give me about R2 000 for clothes, and what we need in the house. He has a place in Hercules, it is his own place, now it is me who is in charge because he is not there".

Participant 10 "In the beginning, I used to struggle when I had to smoke; I had to go out and engage in bad things. Now he takes the responsibility that I should not lack".

Intimate partners are helpful in the lives of the female nyaope injectors as the responsibility of provision is relegated to them. The participants shared how the burden to hustle was offloaded from them as a result of the presence of their intimate partner in their lives.

4.4.2.5 Value of NSPs

There is evidence that NSPs lessen the possibility of transmitting HIV and other blood-borne diseases by reducing the proportions of sharing injecting equipment among

people who inject drugs. WHO endorses distribution of two hundred needles and syringes per person who injects drugs each year (UNAIDS, 2019:19).

4.4.2.5.1 Access to clean injections

People who inject drugs who cannot access harm reduction services, specifically needle and syringe programmes, are at high risk of contracting HIV and other blood-borne infections. People who use drugs struggle financially, and buying injecting equipment can be a daunting exercise for them. This will contribute to the increased probability of reusing, and sharing contaminated injecting equipment (Scheibe et al, 2019:2-4). The participants have reported that accessibility to clean inject it is a huge challenge for them. They reported that before COSUP was established, they had to buy injections at pharmacies, which was not easy for them as they were discriminated against. Participants further indicated that they used to get injections from those who have been diagnosed with sugar diabetes. Participants reported that:

Participant 1 “He [boyfriend] bought them, he used to go to town to buy rock [cocaine], when he goes to town, he would buy injections”.

Participant 21 “I was buying them”.

Participant 13 “We bought needles at first, but it was still sealed with the water and all and then after that I started to register myself for NSP by COSUP, now I am getting my own NSPs”.

Participant 10 “There was also a place where there was some females who were sugar diabetic, and she was injecting herself. I would always ask from her when I did not have injections”.

Participant 23 “I was buying them, because they sell them, so I was buying them. After that I had the information that at COSUP they distribute injections, I came and took injections”.

Before the participants had access to NSP, participants used to buy needles. A critical question which this study did not ask would have been “Where were you disposing the used needles?” In terms of reducing the risk for people who inject and general population, NSP disposal service is important.

4.4.2.5.2 Safe injection training

Harm reduction services which teach safe injecting have benefitted the participants who have access to their services. The programme provides clean needles and teaches female nyaope injectors on how to inject, where to inject, and where not to inject. People who inject drugs are linked to increased risk of local soft tissue bacterial infections, with subsequent serious risk for aggressive sepsis, pneumonia, and infective endocarditis. Inappropriate cleaning of the skin before injecting has been linked with increased risk of skin abscess leading to severe systemic sepsis (Islam, Piggott, Moriggia, Astemborski, Mehta, Thomas and Kirk, 2019:2). High intensity injection drug use behaviour is a disposing factor for bacterial infections. Reducing injection occurrence had a rapid and substantial benefit in reducing risk for serious bacterial infections even in the absence of complete cessation (Islam et al, 2019:6).

Through harm reduction, participants were empowered to reduce the risk associated with injecting. Peer educators teach safer injecting and refers people with injection-related injuries for treatment (Southwella, Shelly, MacDonald, Verster and Maherd, 2019:3). **Participant 4** reported that “at COSUP they gave us some classes, how to do it the right way, and how to clean the needles the right way as well”. **Participant 2,** who does not have a history of sharing needles and abscess, reported that NSP “is very important, it also help not to miss yourself or to overdose”. **Participant 14,** who reported that she never shared needles accessing harm reduction services from COSUP, said that she “came to COSUP and they told me all about (it) so I started to. Obviously they told me and showed me pictures, and I just told myself the way I started it was wrong because the other person’s needle is not the way to do, it was wrong”.

4.4.2.6 Needs of female nyaope injectors

4.4.2.6.1 Basic needs

The participants desire to have access to basic commodities which are necessary for survival. Participants reflects the challenges female nyaope injectors face when they must buy necessities like toiletries versus buying drugs. **Participant 23** reported that “there were times were I was not able to do what I want at the time I wanted, if I want to get my hair fixed or I want toiletries or pads, it becomes difficult to get those things because at that time I would have R30 then my priority would be to smoke, and I do

not have pads at that time". **Participant 17** reported that she "needed food, needed to bath, needed clothes, I needed to live normal". **Participant 2** agrees with **Participant 17**, she added that "maybe sometimes they can give us food, to get healthy food, medication maybe if we are sick".

Participants highlighted food, medication, toiletries, clothes and taking a bath as their basic needs. These needs can be addressed through establishing drop-in centres. A drop-in centre offers a chance to provide services that address the broader physical and social needs of people who use drugs, beyond harm reduction. This is important because these needs normally go unserved when people who inject drugs face stigmatisation and isolation. People who inject drugs who do not have anywhere to stay are often malnourished. This can seriously worsen any health condition they may have. Where possible, drop-in centre may provide nutrition, showers where vagrant people will maintain their hygiene, comfortable seating area where people who inject drugs can meet, talk and relax in safe environment. Seating areas can also be used for support group sessions, and sleeping space where homeless people who do not have anywhere to go can rest. Where possible, a residence with camp-beds for short sleeps or longer periods of sleep should be made available (UNODC, 2017:123).

People with a history of injecting drug stated that health was not of a concern during periods of active drug injecting, despite a high level of need due to negative attitude of health care practitioner, high demand of their addiction, and fear of potential consequences (Tweed et al, 2018:3). It is important for government to establish health outreach teams that will go to hotspots, and where female nyaope injectors spend their time, in order to reach the females who are greatly in need of health services.

4.4.2.6.2 Financial independence and financial stability

The participants reported that they have dreams. Drug use might have delayed and wasted their time, but they are determined to stop using drugs so that they can focus on improving their lives and that of their families. The participants indicated the need to be financially stable and independent. Injecting drugs has significant health, social, economic and environmental costs on individuals and society. One of the most imperative costs is lost productivity and social functioning. This includes the looking for and staying employed (Richardson, Wood, Li, and Kerr 2010:7 The participants

indicated the need to be financially stable and independent. Social function-ability will enable them to regain self-worth, as it will allow them to contribute positively in their lives and that of their significant others. Having a secure living environment and being financially independent also plays important roles in the ability of people with history of using drugs to sustain their recovery (Stokes et al, 2018:10). The participants reported that:

Participant 21 “It is for me to go to school, to take care of my child, all that he needs to be right”.

Participant 9 “To go back to school and upgrade my studies, get the job and also take care of my kids and family”.

Participant 10 “I want to live them a legacy; I want to be an example to them and even when I see children in the community or a person smoking, I will help. I will also give testimonies about my experiences and I will not allow them to pass where I have passed, for I understand the pain”.

Participant 15 “I am now old and it has been years I have been smoking. If I get help [I will] then find a job and quit this because I am no longer young, I have grown now”.

Participant 5 “What I need is to get help so that I can stop smoking and to get a job”.

Participant 12 “It is that it is so hard to live this drug but my need is to be a mother to my child you understand”.

Participant 9 “To go back to school and upgrade my studies, get the job and also take care of my kids and family”.

Participant 10 “Eish! I am tired to tell the truth, and because I have kids, and my mother is also aging up”.

Participant 18 “To get a job, look after my child, for God to bless me and get married get my own home and my own car”.

Participant 17 “A job and to be able to take care of my child and stop depending [on people] from home”.

Participant 23 “Now my need is to get a job and do things for myself and to go back to school”.

One participant indicated that employers should understand that she is injecting nyaope and they should not use her drug use as a factor not to give her a job. This view will be embraced by females who wish to inject drugs. **Participant 2** reported that “I need a job, which can understand [the place of employment] that I am using nyaope and that I am injecting, because I need to come off the streets; that will help me”.

4.4.2.6.3 Affordable drugs

Nyaope does not come cheap; when tolerance increase, the budget increases. **Participant 1** indicated the need to have affordable drugs. She reported that her need is “to have access to drugs or maybe to have them at the cheaper price. We can buy them for R10, it would be better and to have access to needles. I would really want to have access to drugs”. The affordability of drugs can reduce the economic hardship female nyaope injectors face on daily basis.

4.4.2.6.4 Access to needles

Female nyaope injectors desire access to clean needles, they do not share needles so accessibility to clean needles will assist them. **Participant 8** reported that “my needs are to get needles, at times I do not get them here, and you find that they are out of stock”. **Participant 1** added that “access to clean needles and not be seen as nyaope”. No participant would like to contract HIV or other blood-borne infections. Accessibility of needles will enable participants not to share, use old needles and to assist those who do not have sterile needles.

4.4.2.7 Personal experience

4.4.2.7.1 Initiation to injecting

Significant others plays a role in encouraging females to inject drugs. As mentioned, females are more probable to have their first drug injecting experience with an intimate partner and to have that partner inject them (El-Bassel and Strathdee, 2016:5, Larney et al, 2015:7). This makes female nyaope injectors susceptible to the risk of blood-

borne infection transmission during injection initiation, as they are more probable to be introduced by a male intimate partner, share drug injecting equipment, and be injected after their initiator (Meyers, Scheim, Jain, Sun, Milloy, DeBeck, Hayashi, Garfein and Werb, 2018:1).

Studies suggested that people who already inject may encourage injection initiation and excite none injectors about the benefits of drug injection which is linked to pleasure or cost-efficiency. This advocacy is then linked to providing injection initiation assistance, including administering an individual's first injection. This encouragement by people who already inject could extend to peer pressure and more direct coercion (Guise et al, 2017:5).

Being in an intimate relationship with a drug user has been shown to be considerably linked with a female's commencement into and continuation of drug use. Females who use drugs are more probable to have had a male intimate partner who started them into drug use; they are also likely to ask the male partner to inject them, including in a social setting where others are present, contributing to their elevated vulnerability (UNODC, 2018:18, & GCWA, 2011:6). The participants were initiated to injecting practice by their friends and intimate partners.

The participants reported that:

Participant 11 "I met this other guy who was injecting. He taught to me inject. He just said it is nice, you will enjoy. He even told me that it stays longer in the blood than zolo [dagga]. I just said that spike me and then it continued and it was like that since".

Participant 2 "It was a friend I got to know, I moved to Cape Town and met this friend. He was a white guy; he was injecting and I was smoking so he told me I am going to feel it more. I can feel the nyaope more if I inject because I was complaining to get more high. He injected me, he taught me how to inject".

Females are more probable than males to begin injecting drugs in social setting and sexual relationships. Female nyaope injectors are more likely to have another person inject them, and to be "second on the needle". Because some female nyaope injectors do not know how to self-inject; they rely on someone else to prevent withdrawal (National Institute on Drug Abuse, 2019:3). Guise et al. (2017:5) argue that social connections and networks were reported as fundamental to drug injecting initiation.

Friends, family, intimate partners, acquaintances, gang members, elders and drug dealers were all described as influential.

It is not always where females are injected as if they are completely powerless when it comes to drug injecting. **Participant 15** reported that “I injected myself while I was hiding, I stole my boyfriend’s injection for I always saw him injecting himself and how he does it. He was doing it in front of me. One day, while he was not there, I stole his injection and I got addicted to using injection”. This reflects that some females use their autonomy, and the decision to inject drugs is entirely theirs.

4.4.2.7.2 Period before self-injecting

The participants took different periods of time to inject themselves. With other participants taking only one week and others having taken more than a year without injecting themselves.

The participants reported that:

Participant 2 “Like two months”.

Participant 5 “It took me three weeks”.

Participant 11 “It was about a month”.

Participant 14 “Close to 8 months”.

Participant 21 Three to six months”

Participant 17 “One week”.

The participants conveyed a sturdy sense of individuality and self-sufficiency of their capability to learn how to self-inject. The capability to self-inject also imparted feelings of know-how, independence, self-control, and prevention of harmful, visible scars on her body (Tuchman, 2015:4). It gives females an opportunity to be in charge of when, where and how to inject. The participants preferred someone they trust to inject them instead of self-injecting: “I am frightened of needles, me putting a needle inside myself, but with someone else putting it, is almost like going to a doctor, a doctor putting a needle inside of you it is different than you putting a needle inside yourself - **Participant 13** ”. **Participant 14** corroborated this when she said “I was afraid of miss spike (missing) so I preferred better give to Leroi and let Leroi inject me because he

knows how to do it". The feeling of self-injecting is frightening and prevents some female nyaope injectors from injecting themselves, which puts them at risk of being second on the needle as they depend on other injectors to inject them. Females need help injecting because of their lack of knowledge or deference to an injector due to anxiety or withdrawal (Tuchman, 2015:6).

4.4.2.7.3 Feelings of injecting first time

Female nyaope injectors reported that injecting for the first time was not comfortable. The reasons for injecting outweighed the discomfort of injecting. This is supported by the following narratives:

Participant 1 "From a scale of 1–10 (laughing), I was not comfortable at all [with injecting] because eish! You know when you are not used to needles, it is uncomfortable but as you go along…"

Participant 2 "I was scared (laughing) I was very scared, but the people from needle exchange came, they asked how do I spike; I told them and they said I am doing it wrong so they taught me how to do it and gave us needles".

Participant 4 "It was not very comfortable because of why? It was like yoh! Really? Am I really doing this? [injecting]."

4.4.2.7.4 Self-perception

Female nyaope injectors create self-stigmatised identities in such a manner as to make it difficult to have valuable relationships, accepting that they do not deserve to be loved. The internalisation of the stigma is associated with low self-esteem. Apart from being ashamed of themselves, female nyaope injectors consistently witness negative attitudes from their communities and families. This stigma is influenced by moral judgement. Besides experiencing the stigma in communities, the stigma of injecting drugs was regularly experienced in health-care sites. Regardless of where the stigma comes from, stigmatisation of female nyaope injectors seems to results in separation and exclusion through biased social processes and institutional practices. Self-stigma is steady with other studies which have defined internalised self-stigma among female nyaope injectors, which in turn leads to feelings of embarrassment, low self-esteem, and reduced self-efficacy (Mburu et al, 2018:5). The participants reported:

Participant 8 “I feel like a failure but I do not want to put that mind of a failure to me, I want to fight this thing”.

Participant 11 “I just need to get out of this thing of drugs, it is not nice for a woman to smoke”.

Participant 9 “If I still smoke I can achieve half or few of them. If I must achieve a 100% and am still smoking, I know I will only achieve 15%. But if I stop using drugs, I will be able to achieve 100%”.

Participant 6 “When I look at my life, it is ruined because of the drugs; they have taken over too much in my life that I live under their control now”.

Participant 5 “I notice that people would take advantage, they would judge me saying I am in a line of people who are taking medication (HIV supplements); ‘she is also sick’; it is like people would be scared at me”.

Participant 7 “I was always in the streets smoking, never had time to eat, never had time to bath, like, I was always where smokers are. I was there, not going home sometimes. My parents would even stay months and months not knowing where I was; I was not talking to them; so that was bad”.

4.4.2.7.5 Sexual reproductive health

Female nyaope injectors have rights to be intimate and to sexual reproductive health services. Substance abuse/use service programmes should empower females with knowledge of their sexual reproductive health. This research has shown that some of the participants do not understand issues pertaining to their menstrual cycle; which then disadvantages them. Harm reduction comprehensive packages could help female nyaope injectors improve their sexual and reproductive health, which will end in preventing unintended pregnancies and improving pregnancy outcomes (Pinkham et al, 2012:128). The participants reported that:

Participant 12 “When I use drugs, I do not fall pregnant. I am telling you, but when I do not use drugs and my system is clean I fall pregnant easily”.

Participant 16 “I have inserted a misconception in my mind that the ladies that smoke nyaope hardly get pregnant; we do not know what nyaope does to their system, you understand me?”

Participant 17 “When smoking, the chances of getting pregnant are slim,because one does not go to periods [menstruation cycle]. I did not even know that I was pregnant, I found out when I was 5 months, and on the 7th month I delivered”.

Participant 23 “I did not have a regular menstrual period. Even now I have not gone on the periods. What I know is that when smoking nyaope as a woman, it becomes difficult to go on the menstrual cycle. Even when you get clean, it takes time for the system to go back to normal and be on periods; it can take close to 4–5 months to be on periods”.

Participant 6 “I lastly saw them (period) last year”.

Sexual and reproductive health care services, which encompasses contraception, should be looked at as a vital part of harm reduction, comprehensive prevention, and care for HIV among female nyaope injectors. For the programmes to make a desired impact, they should offer free, integrated needle exchange, drug treatment and non-stigmatising sexual and reproductive health advice, and parenting assistance (Uuskülal et al, 2018:7). These programmes will be able to attract and reach out to female nyaope injectors (Azim et al. 2015:518). Harm reduction services have established individualised services for females which offer a conducive space and specialised services, such as sexual and reproductive health and pregnancy, neonatal and child-care support (Southwella et al, 2019:4).

4.4.2.8 Life after stopping drug use

4.4.2.8.1 Feeling associated with stopping drug use

Participants reported the use of nyaope as stressful; since they have stopped using drugs they have peace. The participants reported that:

Participant 16 “I do not wake up with stress. I wake up free and normal like other people. Back then it was stressful, I had to wake up each morning and look for money”.

Participant 23 “One does not have stress about to get money to smoke; life of smoking nyaope is very problematic. Like, it is very stressful, you can be afraid to wake up in the morning when you think that where are you going to get money to smoke; while others sell their body to in order to get money to smoke, others steal. Life as a nyaope addict is hard, it is not fun at all”.

Participant 20 “It is good, I even gained weight now. I like the fact that I can be home for the whole day and watch TV. The other thing that I want is to work and have my own properties”.

Participant 24 “I’m no longer smoking, I am clean now. I also keep myself busy by getting skills from POPUP. I am staying at home now, I do not go out a lot, I no longer smoke”.

Participant 17 “I no longer ask for R1 from people. I am leaving like a normal person, even people from the community praise me. My child is also happy even at home”.

Participant 19 “It is nice, I would ask for money, she gives me. All my requests … ‘mom can you please come with pizza’, then she comes with it. She no longer locks the bedrooms, now I do not have problems. I no longer wake up in the morning thinking what am I going to smoke, no longer bother me because I do not feel anything, no cramps, nothing”.

The participants concur that life of using nyaope is a life of slavery; it is a life no one can live intentionally. The participants report that their lives have improved since they stopped using drugs. They are more in control of their lives than before, and they enjoy their current life of no drugs.

4.4.2.8.2 Desire to be treated well by family

Participants indicated that after they have stopped using drugs, they wish for their families to treat them with respect and afford them trust which they had before they started using drugs. The participant reported that:

Participant 16 “She can see the difference but she says I must stay clean; she will be satisfied if after a year I am still clean. That is when she can be assured”.

Participant 24 “Family has changed, they are not treating me as bad as they used to”.

Participant 17 “My mother is happy and the community is happy, things are back to normal. I live like a person that is not smoking”.

A family member’s nyaope addiction has a negative emotional impact on the entire family. It disturbs the functionality of the family. The family, as a unit, becomes tangled in a course of physical and emotional disinterest, and individual members become socially detached from each other (Schultz and Alpaslan 2016:90). When a member of a substance-using family stops using drugs, the family reorganises and restores its peace.

4.4.2.8.3 Treatment by community

Community members have mixed emotions and do not treat females who have stopped injecting nyaope the same. Some wish them luck on their new journey, while other are counting the days for before they relapse.

The participants reported that:

Participant 23 “Now it is fine because they can see there are changes and like … They support me and tell me to be how I am now [clean], they will say ‘the ***participant 23*** that we know is now back so please keep doing that and keep it up”.

Participant 20 “They are wishing me well, telling me to take care of my mother’s house. Others are telling me they are proud of me because people who smoke nyaope sell their belongings”.

Participant 22 “Now they are trying to accept me, they do not treat me like nyaopes (nyaope user), they talk to me nicely. They say I have done well by stopping what I was doing and they treat me well”.

Participant 19 “They would usually say there is no way I am going to last, I am going to go back”.

Participant 17 “I could say fine, but I can also say they are jealous. They would say we only give her a month, soon she will be back to smoking things like that. But it is not everyone, others congratulate me and encourage me to take my other friends (to COSUP)”.

4.4.2.8.4 Managing intimate partner relationships

Intimate relationship influenced some of the participants to start using and injecting nyaope. Participants adjusted their relationships with their partners. One participant has terminated the relationship, while another one changed where she spends time with her intimate partner. The participants acknowledge that their partners have influence and they can trigger them to use again.

The participants reported that:

Participant 23 “Currently, no, I do not have a boyfriend because I realised that continuing a relationship with him will take me back because I went to rehab then came back to him. I went to rehab again then came back to him, I tried being clean and when he is my life; it becomes hard to be clean because there is too much temptations”.

Participant 16 “Now that he is still smoking, I made a decision not to go to his home anymore, if he wants to come, he has to come at home to see us”.

Self-control, which extends to avoiding triggers such as friends who use drugs, places where drugs are sold, are some of the strategies important for maintaining abstinence throughout the recovery journey (Stokes et al, 2018:9). The participants identified their intimate partners as triggers and have instituted plans by separating in the case of **Participant 23** and avoiding to see visit the partner at his place in the case of **Participant 16**. It is not easy for **Participant 16** to separate from her partner as children are involved.

4.4.3 Objective 3: Strategies aimed at curbing HIV prevalence among female Injector

4.4.3.1 Health intervention

A **health intervention** is an act performed for, with or on behalf of a person or a population, whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions. (www.who.int/classifications/ichi/en/). The participants identified NSP, condom distribution, accessibility to PrEP, and HIV testing and counselling as health interventions which can be used to curb HIV among female nyaope injectors.

4.4.3.1.1 Needle and exchange programme

Female nyaope injectors are pressured by lack of accessibility to sterile injections to engage in sharing injections. This fuels their vulnerability of contracting HIV and other blood-borne infections. Programmes that offer disinfected injecting equipment through NSPs are highly effective in decreasing transmissions of HIV and other blood-borne infections (UNODC, 2017:62). Females who are recovering from injecting nyaope acknowledge the worth of NSP in their lives. The following statements support the augment:

Participant 10 “The service of providing injections is a good programme, it must continue”.

Participant 18 “The idea for them to come here and give needles, I think it was a brilliant idea”.

Participant 13 “NSP is important for the people that are smoking. I think the NSP is very important and now that COSUP is offering it, it is something good because some people really struggle to get NSPs”.

Lack of accessibility to injections can influence females who are injecting nyaope to share among themselves or with other injectors.

Barbour, McQuade and Brown (2017:2-3) argue that needle exchange programme has been shown to decrease risky behaviour and to provide a critical link to care for PWID, who may receive all or most of their services through their needle exchange programme. These valuable benefits occur without any known downsides, as NSPs often reduce syringe waste found in the community, decrease needle stick injuries, and have no negative impacts on crime or amount of drug use. Despite these impressive outcomes, NSPs remain politically contentious, largely due to significant social stigma against injection drug use and fears about legitimising drug injection or generating syringe waste. This is supported by the following narratives:

Participant 1 “Actually, to prevent the spread of HIV I would suggest maybe giving them needles”.

Participant 9 “We should not share injections, and get equipment that is clean”.

Participant 12 “What I would like to say is that they must not use these needles together because many of my friends passed on using needles together and did not know if the person is HIV [positive] and so on”.

The participants further empathised that NSPs should be accessible to people who need it the most. Instead of providing the programme in offices, the programme should go to where female nyaope injectors are. **Participant 3** highlighted that service providers should follow the footprint of condom distribution service providers.

The participants reported that:

Participant 4 “There should be more places that provide clean needles”.

Participant 2 “People [female nyaope injectors] cannot always go there at the place where the needle exchange is, then they [NSP service providers] should go to more places”.

Participant 19 “I would suggest that the needles be distributed to them. The same way they distribute condoms, they should give needles the same way”.

NSPs should provide enough injections to enable users so that they do not borrow from other users. The programme can use vending machines, outreach teams, and pharmacies to guarantee that injecting equipment is easily reached and accessible in satisfactory amounts to prevent the need to share and reuse needles and syringes (Southwella et al, 2019:3). This is supported by the following narratives:

Participant 3 “What I think we really need is the accessibility of injections and quantity, because most of us do not use the injections the same way. Some use less, others use more”.

Since female nyaope injectors inject every day, it is important that the NSP is available daily. The participants reported that:

Participant 23 “Injections to be available to everyone at whatever time, there should not be a particular day that a person gets injections, like, when a person needs an injection, they must get it”.

Participant 16 “If they can get needles each and every day”.

Participant 24 “To give them the injections … giving them needles. Everyone should use their syringe. I think that to be helpful to reduce HIV”.

NSPs come with controversy; mainly fuelled by the notion of whether a person who uses drugs should be seen as a criminal or a patient, and whether it is ethical or lawful to provide a person using drugs the means to inject. This assumption is usually held by opponents of NSPs who greatly support drug treatment programmes that are based on abstinence and ‘‘drug-free’’ treatment for addiction. NSPs have demonstrated to be a cost effective way of curbing HIV in other low income settings (Derrick and Clark, 2013:139-140). The researcher argues that NSPs are necessary to curb HIV prevalence and other blood-borne infections, its accessibility will benefit the health state of female nyaope injectors.

4.4.3.1.2 Condom distribution

Females who inject drugs are more probable to practice transactional sex and sex work as compared to males who inject drugs (Scheibe et al, 2016b:113). Most of participants who engage in transactional sex, do not use condoms consistently with their intimate partners. Female nyaope injectors are more probable to practice high sexual risk as a result of the severe discrimination and cultural stigmatisation attached to injecting drug use (Marottaa et al, 2018:97). The participants reported that:

Participant 17 “She must not be shot [lack] of condoms”.

Participant 24 “They can be helped with condoms”.

Participant 15 “Help them by giving them condoms”.

Participant 21 “By giving them condoms”.

Irrespective of a person's HIV status knowledge or ART compliance level, it is projected that the accurate and constant use of condoms decreases the risk of sexual transmission of HIV infection by seventy percent in heterosexual couples. Condom supply interventions have, for many years, been a backbone of public health HIV prevention efforts (Malekinejad, Parriott, Blodgett, Horvath, Shrestha, Hutchinson, Volberding and Kahn, 2017:2).

The participants acknowledge the self-determination of female nyaope injectors to choose to participate in sex work or transactional sex. Risks linked with sex work and

transactional sex can be lowered or reduced by the introduction and correct use of condoms during sexual intercourse. Distribution of condoms goes with the use of the condom. The participants said:

Participant 24 “We can distribute condoms to them, and encourage condom use”.

Participant 16 “Those who hustle by going to Rooival [informal brothel], at least they should have condoms”.

Participant 2 “Sometimes girls come to me and ask for condoms; there is not always condoms everywhere. They want to use condoms but they are not everywhere like in the shops. They should put condoms more around the place”.

Participant 9 “Let them be advised to always have condoms for safety. I cannot say let them be stopped because that is how they are able to get money to buy drugs. All in all, let them be advised to always have condoms with them in order to prevent themselves from getting sickness”.

Participant 6 “They must bring them to us, we always have them”.

Condom distribution should be intensified, and female nyaope injectors should have access to condoms. The distribution should reach female nyaope injectors where they are.

4.4.3.1.3 Pre-exposure prophylaxis (PrEP)

PrEP is a biomedical strategy, which offers supplementary HIV prevention options beyond traditional programmes like condoms for individuals at risk. PrEP comes in form of a pill that is taken daily to prevent HIV infection (Walters, Reilly, Neaigus and Braunstein, 2017:2). PrEP was made available only to people who are HIV negative, who are at a higher risk of contracting HIV (DOH, 2016:4).

The price of PrEP is substantially lower than offering antiretroviral therapy to an infected person for the period of their lifetime. In countries where HIV PrEP is available, including South Africa, awareness of and access to it is low among female nyaope injectors. (National Institute on Drug Abuse, 2019:3). In South Africa, sex workers were amongst the first group of people to be eligible for PrEP initiation in June 2016. They were followed by men who have sex with other men in April 2018. The implementation for adolescent girls and young females was initiated at selected government clinics

(EHPSA, 2018:3). PrEP is imperative for female nyaope injectors because it has the ability to empower them to protect themselves from HIV infection (Walters, Reilly, Neaigus and Braunstein, 2017:2).

The participants highlighted that the introduction of PrEP to female nyaope injectors is long overdue and its accessibility to them will assist in curbing HIV. Participants report that:

Participant 23 “Like, this injection should be available to everyone, for as long as you are negative, it should be available. The one that helps you not to be positive when you are negative at all even if you are being intimate. I do not know what they call it (referring to PrEP)”.

Participant 19 “Is there no pill that they get, like, when a person is raped which they provide in hospital for one not to be infected?”

The researcher argues that female nyaope injectors should have been afforded an opportunity to be initiated on PrEP in 2016 when PrEP was made available to sex workers. Female nyaope injectors are vulnerable. Firstly, they are females; secondly they engage in risky sexual behaviour; thirdly they inject nyaope. Fourthly, due to inaccessibility of injections, female nyaope injectors find themselves in a very dire situation where no one is willing to understand and assist them. Female nyaope injectors should have been prioritised with sex workers by the Department of Health.

PrEP has conceivable worth in the social and sexual networks of people who inject drugs where the prevalence of HIV is high. PrEP will escalate its HIV prevention prospects when it is introduced in a way that supplements and reinforces existing harm reduction and health promotion activities (Coleman and McLean, 2016:2-4).

4.4.3.1.4 HIV Counselling and Testing

HCT is the first step for multiple interventions for HIV prevention and care. HCT serves as an entry point for HIV prevention services that include prevention; such as access to condoms, and prevention counselling for HIV-positives. In addition, HCT links HIV diagnosed people into care and ART. At an individual level, it is associated with reduced mortality and extended life expectancy. At a population level, it is associated with reduced HIV incidence. Ensuring universal and equitable access to HCT services still remains a challenge for many sub-Saharan countries including South Africa. In

South Africa, HCT usage is lower among adolescents, the elderly, and men. Furthermore, some groups at higher risk for HIV infection, including men who have sex with men, young women, and possibly other groups, may be less likely to receive HCT (Mabuto, Latka, Kuwane, Churchyard, Charalambous and Hoffmann, 2014:1).

Risks encountered by PWID are compounded by a lack of HIV testing uptake. HIV testing not only informs serostatus, letting individuals make conscious choices to protect themselves, their partners, and their children, pre- and post-test counselling, it also provides HIV education and individualised risk reduction counselling; even for people who are not infected with HIV(Asher et al, 2013:2).

Female nyaope injectors are active members of the community. They are active in transmitting and also contracting HIV. Overlooking them might make 90-90-90 plan only a dream which will never be realised. Instantaneous HIV diagnosis, proper link to care, early treatment, retention in care, and sustained viral suppression are all important in reducing morbidity and mortality from HIV, (Mburu et al, 2018:2).

This is supported by the following participant:

Participant 13 “I think by going out to the community doing all this, like open the test [centres] where everyone is free; like where they smoke, like smoking zone or something like that, maybe to go there and to offer them for test”.

When female nyaope injectors are diagnosed, retained in ART and a have suppressed viral load, it motivate them to protect themselves against re-infection. People who test for HIV must go to substance abuse hotspots where they will recruit female nyaope injectors to test.

HIV testing in City of Tshwane needs to be extensively promoted more and made available in places accessed by vulnerable people, like female nyaope injectors. HIV testing services must go to where to people are, rather than for people to come to where services are (Dos Santos, Trautmann and Kools, 2011:10).

4.4.3.2 Economic Intervention

4.4.3.2.1 Employment opportunities

South African National Treasury (2019:3) reports that South Africa’s current economic trajectory is unsustainable: economic growth has stagnated, unemployment is rising,

and inequality remains high. The government should urgently implement a series of reforms that can boost South Africa's growth in the short term, while also creating the conditions for higher long-term sustainable growth. These growth reforms should promote economic transformation, support labour-intensive growth, and create a globally competitive economy.

Female nyaope injectors are not immune to the lack of employment as they are part of the society in general. According to Stats, SA (2019:7) there are 6,7 million unemployed persons in South Africa. Female nyaope injectors are affected by unemployment. This facilitates their dependence on their intimate partners which fuels injecting equipment sharing (Des Jarlais et al, 2012:2).

This is supported by the following narrative statements

Participant 3 "As females, we are unemployed, if we can get the opportunity to work for ourselves, I believe HIV among females who inject will decrease, because some of us when we are broke we depend on other users. For example, someone can come without an injection and ask you for your injection; knowing that she or he will leave something for you, you will give them an injection. At that point, I do not know if the person is sick or not. That is how we get infected".

Many females who inject drugs are pressured to sell sex to finance their own and their partner's drug use. Poor prospects of unemployment add to dual risk of contracting HIV infection, through unprotected sex and engaging in sharing needles (Azima et al, 2015:17).

Participant 5 "It is painful to think that, if now you want R100, you need to sleep with five people. But if one has a part time job that would give them R100 in a day it would be much better".

Participant 9 "Females should be hired for part time jobs, it is painful to stay the whole day without using".

Poor socioeconomic status can act as an obstacle to educational prospects, opportunity to approach health care and employment, generating conducive environment for HIV incidence (Rajapakse, 2009:10).

Participant 20 “At times, people who smoke should be kept busy; maybe if they can find work and do odd jobs, even if it is domestic work”.

Participants are of the view that if they are able to find work, working will disturb their routine of using drugs which will decrease the risk of contracting HIV and other blood-borne infections.

4.4.3.3 Educational intervention

The females reported support groups and awareness education as key interventions that can assist in empowering female nyaope injectors to take informed decision which will influence their decisions to protect themselves against HIV infection.

4.4.3.3.1 Support groups

Forming peer support groups of female nyaope injectors is critical to neutralise the self-stigma. It can also reinforce females’ communication skills which assist them in their relationships. This will help them to access social and health services (Mburu et al, 2018:6). HIV programs use support groups as an opportunity for health care workers to provide information to people living with HIV. Both WHO and the US President’s Emergency Plan for AIDS Relief promote peer support groups facilitated by trained people living with HIV to address the special needs of fellow people living with HIV and their partners. Such groups serve the purpose of sharing experiences, encouraging disclosure, reducing stigma and discrimination, improving self-esteem, enhancing patients’ coping skills and psychosocial functioning, and supporting medication adherence and improved retention in HIV care (Bateganya, Amanyeiwe, Roxo and Dong, 2015:368).

The participants acknowledge that support groups will empower them to engage in safe injecting and other behaviours which will reduce their risk of contracting HIV. They further emphasised that the support groups must be conducted within communities. This means they must be assessable to all the female nyaope injectors.

The participants reported that:

Participant 10 “There must be programmes, were females will come together and be taught about the dangers of using drugs, sexual abstinence, and encourage those who are HIV positive to live a healthy life”.

Participant 14 “Get the ladies together and let us talk and listen to each other”.

Participant 13 “Support groups so that they can lean more because other people do not really understand what HIV is. I think through support groups, which must be within the community, we will learn”.

Participant 8 “They can have lessons every month, which will remind them now and then about safe injecting”.

Participant 4 “There should be more support groups”.

Support groups for women who use drugs were also brought forward by participants in the UNODC (2017b) study, with an excessive of importance placed on the importance of these groups being for WWUD. The environment of these support groups should promote relationship-building amongst the participants, as well as provide tools on how best to better one’s view of self and one’s surroundings (UNODC, 2017b:47).

Support groups are a vital service and resource that brings together people affected by a related issues so they can discover solutions to overcome shared issues. It provides space where members will feel supported by others who have related understandings. By joining support groups, people appreciate that they are not alone in their condition (Fanelli and Moyo, 2008:1& WHO, 2017:9). Price and Davey (2008:4) argue that a support group is a safe place to discuss topics that can assist group members to function better.

4.4.3.3.2 Awareness presentations

It is critical for mass media to play a positive role in preventing substance abuse amongst the communities by ensuring that appropriate messages are communicated. This can be done by educating the communities about the risks of sharing needles and safe injecting. It can further share with the communities about available substance abuse intervention programs that are found within different cities or areas (Charlton, Negota and Mistry, 2019:52). This statement is supported by the narrative of participants:

Participant 7 “Spread the information, informing the female nyaope injectors not to share needles”.

Participant 23 “Go to the people who are smoking and educate them about possibilities of contacting infections when sharing needles”.

Participant 9 “There should be campaigns to the hot spots where they meet to smoke. Maybe the campaigns must be once or twice in a week and give people who inject the injections”.

Participant 18 “Even on the television, if they can make a programme or something or documentary to show the risk of woman to be easily infected from HIV when coming to using injections”.

The participants alluded that hope is not lost and efforts must be strengthened to curb HIV prevalence. The participants indicated that awareness campaigns should be conducted and they should go to the hotspots. They should go where female nyaope injectors meet to use their drugs. They further indicated that as campaigns are presented, service providers should take injections with them to give females who are injecting nyaope. The awareness should use all sorts of platforms; including television. Television programmes can target audiences. They can target people who are injecting and teach them about safe injecting and help the community understand complexities of injecting and aim at reducing the stigmatisation against female nyaope injectors.

To eradicate social stigma within our different communities, awareness programmes on stigma must teach the community about the harmful effects of stigmatising attitudes towards female nyaope injectors. The media must teach about the benefits of harm reduction in improving social functioning and health of female nyaope injectors. Media must educate the community and local leadership to understand that drug use is an indication of social glitches that confront female nyaope injectors, rather than an issue of simple individual choice that abstinence and prohibition can solve (Mburu et al, 2018:6).

Harm reduction capacitation for media personnel, police officers, wider community, and policy makers will help establish supportive setting for harm reduction programmes (UNODC, 2017:108).

The researcher’s recommendations will be discussed in Chapter 5 where key findings of the study will also be outlined.

4.5 Conclusion

This chapter presented profile of participants, table of research participants and key findings which are categorised using the three research objectives. Participants' views where expressed regarding what influences them to inject nyaope, their experiences, and the strategies to curb HIV incident among female nyaope injectors. The next chapter draws an overall conclusion of the study to make recommendations.

5. CHAPTER FIVE

Conclusions and Recommendations

5.1 Introduction

The purpose of this study was to explore the experiences of female nyaope injectors residing in City of Tshwane Municipality. Furthermore, it was to gain insight into, and understanding, factors contributing to females injecting nyaope, and how they can be assisted to reduce the risks associated with nyaope injection.

To realise this purpose, a qualitative research methodology was chosen based on the literature and the applicability of Social Ecological Model and Health Belief Model. This chapter provides a summary of key findings, limitations, formulated recommendations, and possible future research.

5.2 Summary of key findings

The findings were presented based on the formulated research objectives. The goal of formulating the research objectives was to enable the researcher to address the research purpose fully.

The objectives of the study were:

- To identify factors contributing to females injecting nyaope;
- To explore the experiences of female nyaope injectors; and
- To develop strategies to mitigate or reduce the HIV prevalence amongst female nyaope injectors

5.2.1 Objective 1: Factors contributing to females injecting nyaope

Two themes; namely factors contributing to use and injecting of nyaope, and experiences of female nyaope injectors, were identified. It was imperative to understand factors that contribute to the use of nyaope before understanding the factors that contribute to injecting transition.

5.2.1.1 Factors contributing to using nyaope

The participants reported multiple factors that have contributed to them using nyaope. Intimate partner influence, peer pressure, tricked by friends, a need to lose weight,

mental health issues, curiosity and counteracting other drugs contributed towards their drugs use.

Firstly, an intimate partner who is using drugs can be influential to their female partner. Female nyaope injectors reported that they were influenced by their boyfriends to use nyaope. One participant indicated that her partner was always away and he did not give her the attention she desired; which led her to using nyaope so that she can spend time with him.

Secondly, peer pressure and a sense of belonging contributes to nyaope use. Peer pressure is mentioned as one of the strongest predictors of youth behaviour, and influences experimentation of drugs. Using dagga increased the likelihood for female nyaope injectors to succumb to peer pressure. Participants have highlighted that they were using dagga before they started using nyaope. It can therefore be assumed that if they were not smoking dagga, chances of using nyaope would have been less.

The Department of Basic Education should introduce life-skills programmes as part of their Life Orientation curriculum where learners will be capacitated and empowered to handle peer pressure. Implementing such a programme from Grade 7 will enable the learners to handle peer pressure well.

Thirdly, participants indicated that they used nyaope without their knowledge. They were tricked by their friends into smoking nyaope; they assumed they were smoking dagga. They only knew they were smoking nyaope when they started to experience withdrawal syndrome. By the time they experienced withdrawals, it was too late; they sought out how to get nyaope on their own to satisfy their withdrawals.

Fourthly, some participants indicated they were gaining excessive weight which they were not happy and comfortable with. They started smoking dagga to lose weight but when the progress was not speedily, they started using nyaope.

Fifthly, participants reported that they started using nyaope due to unpleasant issues they were facing in life. Different emotional stresses like the death of a parent and incest by family member has driven the participants to smoke nyaope to ease the pain

Sixthly, participants started using nyaope to counteract other drugs. Participants were using cocaine, which is a stimulant. The participants reported that they struggled with sleep when they have used the cocaine and they used nyaope to relax their nervous

system since nyaope is a downer. Masombuka (2013:44) reports that cocaine can provisionally reduce the need for food and sleep, so users struggle with sleep after using it. Angarita, Emadi, Hodges and Morgan (2016:9) reports that wooziness and tiredness are common side effects of opioid.

Seventhly, curiosity influenced participants to smoke nyaope. **Participant 1** had history of using dagga, and when people she knew were using nyaope (which she did not have an idea about), she was curious. The participant asked to try it and she was hooked.

5.2.1.2 Factors contributing to injecting nyaope

Firstly, participants highlighted the need for intense highs, influence of intimate partner and curiosity as factors which contributed to injecting nyaope. This study has shown that some of female nyaope injectors are actively involved in the decision to transition from smoking nyaope to injecting. Some participants reported that their initiation to injecting was their own choice due to curiosity of injecting nyaope, but not knowing how to self-inject (Tuchman, 2015:3).

Secondly, curiosity had its way with the participants. Participants indicated that when nyaope is injected, it gives a high faster as compared to the cocktail route of smoking. The injector experiences the high immediately after injecting. Drug injecting is considered as the easy to use and potent manner to use low-purity heroin. Injecting nyaope lasts more hours as compared to traditional route of smoking it (Masumbuka, 2013:44).

Participant 7 influenced her male intimate partner to inject due to curiosity. This statement goes contrary with the literature highlighted that female nyaope injectors were influenced by their partners to inject drugs. Some participants like **Participant 1**, **Participant 17** and **Participant 5** shared how their intimate partners influenced them to inject nyaope.

5.2.2 Objective 2: Experiences of female nyaope injectors

5.2.2.1 Risky behaviour

Female nyaope injectors engage in risky behaviour which increases their chances of contracting HIV and other blood-borne infections. Sexual risk, and needle sharing is a

norm which must be addressed in order to help female nyaope injectors. They may be barred from family support structures. Those who struggle financially or have low prospects of employment, are probable to participate in sex work, which increases HIV risk and draws the additional stigma linked with sex work (Larney et al, 2015:6).

Females practicing sex work and use of drugs are more probable to share needles and other injection equipment amongst themselves and their clients, as well as have unprotected sex with their clients and their intimate partners. Many females are coerced to sell sex to finance their own or their partner's drug use; which elevates their risk of HIV infection through unsafe sex (Azima et al, 2015:17& Arpa, 2017:8). Some participants raise money through sex work due to adverse socioeconomic conditions; this increases their HIV risk (El-Bassel and Strathdee, 2016:6).

Female nyaope injectors are more probable to participate in transactional sex compared to their male counterparts (Scheibe et al, 2016b:113). Poor economic standing has been linked with earlier sexual involvement, inconsistent condom use, having multiple intimate partners, increased chances that the first sex act is non-consensual, and a greater probability of having had transactional or physically forced sex. Most females choose to participate in transactional sex to finance their lives (Ramjee and Daniels, 2013:3). Transactional sex increases the risk of female nyaope injectors contracting HIV. The participants reported that they take part in transactional sex to raise money for their drug use. The need to get the next fix influences female nyaope injectors to participate in transactional sex to raise money when they do not have other options of raising money. This practice increases their risk of contracting HIV and other blood-borne infections.

It is not all female nyaope injectors who are proud of engaging in transactional sex. One participant indicated that she resented herself after engaging in transactional sex for the first time, however, due to the demand of money to be able to maintain the using habit, she felt powerless and found herself engaging further in transactional sex. She was not proud of engaging in transactional sex but she kept doing it as she struggled for money through socially moral way.

Participants felt that men were taking advantage of female nyaope injectors. Men are aware that female nyaope injectors are struggling financially and need money to buy nyaope. Some females reported that they are used by men for sex, and are targets of

sexual favours, in return for a small amount of money. This further breaks down the psyche of these females, as their bodies are equated to nothing more than a few Rands (UNODC, 2017b:19-21).

Most females who use drugs are often disempowered to discuss safe sex practices with their intimate partners. Sexual risk-taking may be associated to feelings of trust in a relationship, or they may be culturally entrenched in the gendered distribution of power. Efforts to discuss condom use with an intimate partner can therefore result in aggression, isolation and exclusion if taken as an unwelcomed challenge to fidelity and privilege within the relationship (GCWA, 2011:5). Gendered cultural beliefs places upkeep of an intimate partner above oneself, avoiding conflict, and conserving harmony in relationships. This contributes to females' powerlessness to discuss safer sex, even in situations when they feel they are at risk (Stoicescu et al, 2018:3316).

Participants were not consistently using condom with their intimate partners. The attitude of not using condoms with their partners is increasing the risk of them contracting HIV. The risk is higher as most of their boyfriends are injecting nyaope themselves, and might be sharing injections with other drug users. The participants reflected helplessness in negotiating condom use with their intimate partners. They feel powerless and have left their health in their intimate partners' hands.

Societal customs that supress females and generate imbalanced power relations further strengthen injection sharing in intimate partnerships (Marottaa et al 2018:103). The participants reported to having injected with used injections with their intimate partners. The reasons for sharing injecting equipment are multifaceted. Individual factors like knowledge, perceived risk, and a perceived sense of control indisputably influences injecting and sharing behaviours (Morris et al, 2019:2).

Participants reported to have shared injections within the network of people who inject drugs, especially with intimate partners. Female nyaope injectors explained that a lack of access to clean injections contributed to them sharing injections because the withdrawals were unbearable, and at the time when they have to inject, they do not think of the consequences of sharing injections. At that point, they indicated that injecting the drug is more important than anything.

5.2.2.2 Social interaction

The theme of social interaction firstly explored the interaction with the family. The participants shared how they interacted with their families when they started using drugs. The participants shared about their families' support when they discovered that they use nyaope; how they reacted when they learnt that they use nyaope; how they reacted when they discovered that participants have transitioned from smoking to injecting; as well as perceptions of how family could have reacted if they knew they are injecting nyaope and how it felt to be at home.

Most participants live with their families when they start engaging in substance. When their families learn about their drug use, they react. It is reported that families experience traumatic experiences. Families experience mixed feelings which includes a fear that their child might die, feeling of disappointment or accountability for the dependence, and humiliation as a result of being stigmatised by the community as a parent who cannot control their children (Masombuka, 2013:99).

Families extended offered to assist participants when they learnt that participants were using drugs. This reflected the supportive nature of the families. They reacted by offering support and taking them to centres where they could be rehabilitated.

Some participants indicated that their families were not happy with them when they learnt that they were using nyaope. The families experienced lot of unpleasant emotions, they were shocked, angry, surprised and disappointed when they learnt that participants use nyaope. Schultz and Alpaslan (2016:100) argue that the initial reaction of the family involves shock when they learn about their family member's drug use. The shock is joined with feelings of dismay, rage, frustration, unhappiness, disorientation, helplessness, as well as disappointment and shock. The initial surprise reaction experienced is not unusual, for when a family learns about the drug use of its family members, the family is thrown into shocked and disarray. The families did not expect to see their children using nyaope. When they learnt that they are using, they did not believe it. They got the shock of their lives. The family felt that the participants were killing themselves through injecting nyaope.

The participants reported that it got worse when their families discovered that they had transitioned to injecting. The families assumed that the participants were practicing

Bluetooth. Drug use and injection invites extensive stigmatisation. Females who use drugs may encounter rejection from their relations and communities and discrimination in a variety of contexts, including health-sites. As a result, they may be unwilling to divulge their drug use and be reluctant to access health services, including drug treatment, for fear of discrimination. Social exclusion, stigmatisation, and discrimination elevates the HIV risk and weakens HIV prevention and treatment (Larney et al, 2015:6).

Some participants hid their drug injection from their families; their families did not know they transitioned. Due to stigma associated with injecting nyaope, the participants were of the assumption that if their families knew they were injecting nyaope, they would be disappointed in them and might disown them.

The participants reported that it was not nice to be at home. They felt unwanted and not accepted by family members due to drug use. Their “good daughter” image is substituted by the junkie image which they have seen in the media (Horitavorn, 2008:20).

The participants reported that due to drug use, they were not involved, the way they wished to be, in their children’s lives. They believe their drug use affected their involvement in their children’s lives. The findings of the study corroborates the findings of Kontautaite (2018) and partners who reported that 25 females in their study described that mothers were not permitted to contribute in any decision-making related to their child’s life, and were poorly involved in the child’s life. The families of female nyaope injectors who had children have taken some responsibilities them due to their use of nyaope. The families are now managing social grants and welfare of the children.

Social interaction explored the interaction with the community. The community, like family, instigates the stigmatisation of female nyaope injectors. Participants reported mixed statements with regards to the community reacting to their use of nyaope. Some participants reported that instead of the normal discrimination which is perpetuated on females who smoke and inject nyaope, some community members expressed love and encouragement. It is reported that the community makes things worst by their gossip. Gossiping by neighbours about females who use drugs makes family members

feel uncomfortable and humiliated. Using drugs brings shame and lost face in the community and amongst relatives (Horitavorn, 2008:24).

Once the community learns that particular females have transitioned from smoking to injecting, they increase the level of stigma and discrimination. Like the families of female nyaope injectors, the community equates the practice of injecting nyaope to self-destruction.

The stigma contributed to female nyaope injectors hiding their injecting, and exposing themselves to high risk behaviour and lack of access to harm reduction services. Fear of the community knowing that they inject nyaope drives female nyaope injectors away from their communities, around people and places they knows, to where they are not known. This could make them meet different drug networks which engages in riskier behaviours than the ones in their community.

Social interaction also explored the interaction with health settings, with emphasis to health workers. Through this theme, participants shared the difficulties of accessing health care services; which has a negative bearing on them when they are pregnant, and on how they deal with abscess.

Female nyaope injectors have different experiences regarding health care institutions (most are unpleasant experiences) that makes it difficult for them to seek health care services when they are in need. Participants spoke about the stigma they felt and the discrimination they experienced from clinicians. The intense stigma directed to female nyaope injectors can present an overwhelming obstacle to the opportunity of approaching harm reduction services, drug treatment, HIV treatment, sexual and reproductive health care. More, especially in culturally conventional societies (Pinkham et al, 2012.126).

Participants highlighted that stigmatisation by health care practitioners makes them unwelcomed at the clinic. They further alluded that due to time spent at the clinic, it is unbearable to deal with withdrawals. This made it difficult for them to access health care services.

One of the implication of stigma perpetuated on female nyaope injectors was when they were visiting clinics when they were pregnant. The participants did not visit their clinic in time when they were pregnant. Factors which influenced the participants not

accessing health care services disadvantaged them as they did not attend antenatal classes. Females who use drugs normally do not take the non-appearance of menstruation as a sign of pregnancy; other signs of pregnancy had to be seen before they would begin to suspect that they were pregnant. Most females' pregnancies were accidental because of their irregular periods while taking drugs (Horitavorn, 2008:39).

This is confirmed by **Participant 19** when she reported that she was already 7 months pregnant when she discovered. The participants did not know they were pregnant until it was too late to attend antenatal classes at their local clinic. **Participant 10** reported that her child was infected with HIV because she went to the clinic late. If she had known in time and attended antenatal classes, the health care practitioners would have assisted her to be on medication which would have enabled the child to be born HIV negative.

The participants reported that in their injecting practice, they miss and get abscess. It was noted that participants deal with the abscess differently. Some participants treat themselves and others visit the clinic, but they reported that it is not comfortable to do so due to stigmatisation.

The stigma perpetuated against female nyaope injectors is doing more damage that the drug itself. Judgmental and moralising views towards drug users are regularly expressed within South African communities; more specifically by health practitioners, which is worrisome and demands urgent attention. Sensitisation training for health care professionals would capacitate the health care participants to handle the female nyaope injectors without stigmatising them.

Finally, social interaction explored the interaction with the police; the law enforcement. The police are caught violating the law with regard to female nyaope injectors. Instead of protecting their rights, the police led in violating their rights. The police indirectly contribute to needle sharing. Carrying clean needles for fear of arrest contributes to needle sharing, which increases the risk of contracting HIV (Chakrapani et al, 2011:4). Scheibe et al (2017:2) reports that drug use is criminalised in South Africa, but no laws ban the buying or providing injecting equipment. The participants reported that police broke and confiscated their needles, and arrested them without charging them in court. Police confiscate and break female nyaope injectors' injections, exposing them to a situation where they must share injections with other injectors. It is extreme

disappointing when police confiscate injections which are provided by harm reductions programmes like COSUP with an aim of reducing infections among people who use drugs.

The participants have a history of police arrest. The participants have been arrested by the police without being charged in court. They indicated that the police arrested them to punish them. They also identified this type of arrest as white door arrest.

5.2.2.3 Raising money

Female nyaope injectors engage in different means to raise money to feed their habit. They do not only engage in sex related risk, as highlighted at the sexual risk section, the participants also indicated that they raise money through multiple partners, intimate partners, stealing and engaging in transactional sex.

The participants established a network of sexual partners whom they slept with for money. They highlighted that they were able to generate money through multiple partners. They also acknowledged that at times, they are involved in criminal activities to raise money to buy drugs. Shoplifting, stealing from the community and customers, for those who sell sex, came out tops.

Some participants sell their belongings, while others engage in petty jobs to raise money to feed their habits. **Participant 3** alluded that she stopped engaging in sex work to push trollies. This shows that female nyaope injectors can be self-sufficient in their pursuit to make money when their heart is at it.

Some participants, like **Participant 19** and **Participant 1,** exploited the opportunity by demanding higher amount of money which was able to sustain them for longer. This means some female nyaope injectors decide to be taken advantage of, or rather, they use the unpleasant circumstances to their advantage.

5.2.2.4 Nature of intimate relationship

Female nyaope injectors' have multifaceted and lively relationships with their intimate partners who also use drugs (Azima, 2015:17). The participants highlighted that they desire support, protection and encouragement from their intimate partners, but they do not get any from them. Participants are not happy with dating intimate partners who

use drugs, they wish their intimate partner were not using drugs to enable them to stop through their support.

The participants also highlighted that they experienced emotional and physical abuse at the hands of their intimate partners. Their intimate partners are verbally abusive and also stalked the participants. One participant does not have freedom as she is always being watched; what she does, with whom and where. The emotional abuse inflicted on female nyaope injectors increases their vulnerability as they start to question their self-worth and disturbs communication between the partners. Emotional abuse may generate a comparable context of dominance and control, which increases females' probability of participating in risky sexual behaviours. Developing research suggests that emotional abuse has comparable damaging impact on females' health outcomes to physical and sexual forms IPV (Stoicescu et al, 2018:3308).

Verbal abuse contributed to **Participant 5** not accessing HIV treatment when she tested HIV positive. The participant reported that she had to wait for her partner to be arrested before she could be initiated on ARV treatment. This is supported by Horitavorn (2008:55) when they argued that the anxiety of others finding out about the diagnosis also depresses people from making contact with health services, community, and family

Physical abuse is effected with the aim to capture control of female nyaope injectors by their intimate partner. The participants shared how their intimate partners are physical with them. Some studies have projected that the occurrence of physical and sexual IPV is three to five times higher amongst females who use drugs as compared to community-based samples of nondrug-using females (Pinkham et al, 2012:3).

Despite the negative experiences female nyaope injectors go through at the hands of their boyfriends, the participants have indicated that which they like about their relationship with their intimate partner. The researcher has observed that participants are in an intimate relationship with people who are using drugs. The participants reported that they have an open relationship with their partners. They do things together, their partners provide for them, and are considerate.

Intimate partners who are not using drugs could not continue dating females who are using drugs, immediately they learnt that their partners were using drugs, they called off the relationship.

5.2.2.5 Value of NSPs

Accessibility and harm reduction education on safe injecting have been rated by the participants as important in reducing risks.

There is evidence that NSPs lessen the possibility of transmitting HIV and other blood-borne diseases by reducing the proportions of sharing injecting equipment among people who inject drugs. WHO endorses distributing 200 needles and syringes per person who injects drugs each year (UNAIDS, 2019:19).

The participants reported that accessibility to clean injections is a huge challenge for them. They added that before COSUP was established, they had to buy injections at pharmacies, which was not easy for them as they were discriminated against. Participants further indicated that they used to get injections from those who have been diagnosed with sugar diabetes.

Harm reduction services, which teach safe injecting, have benefitted the participants who have access their services. The programme provided clean needles and capacitate female nyaope injectors on how to inject, where to inject, and where not to inject. People who use drugs struggle financially, buying injecting equipment can be a daunting exercise for them. This will contribute to the elevated probability of reusing, and sharing contaminated injecting equipment (Scheibe et al, 2019:2-4).

Female nyaope injectors were trained on safe injecting when they were accessing NSPs programme. People who inject drugs are linked to increased risk of local soft tissue bacterial infections, with subsequent serious risk for invasive sepsis, pneumonia, and infective endocarditis. Inappropriate cleaning of the skin before injecting has been linked with increased risk of skin abscess, leading to severe systemic sepsis (Islam et al, 2019:2). High intensity injection drug use behaviour is a disposing factor for bacterial infections. Reducing injection occurrence had rapid and substantial benefit in reducing risk for serious bacterial infections even in the absence of complete cessation (Islam et al, 2019:6). Educating female nyaope injectors on safe injecting has assisted them to be empowered to inject and prevent contracting HIV.

5.2.2.6 Needs of female nyaope injectors

The participants desire to have access to basic commodities which are necessary for survival. Participants reflected the challenges female nyaope injectors face when they must buy necessities like toiletries versus buying drugs. **Participant 23** reported that "there were times were I was not able to do what I want at the time I wanted. If I want to get my hair fixed or I want toiletries or pads, it becomes difficult to get those things because at that time I would have R30, then my priority would be to smoke, and I do not have pads at that time". **Participant 17** reported that she "needed food, needed to bath, needed clothes, I needed to live normal". **Participant 2** agrees with **Participant 17**, she added that "maybe sometimes they can give us food, to get healthy foods, medication maybe if we are sick".

Participants highlighted food, medication, toiletries, clothes and taking a bath as their basic needs. These needs can be addressed through establishing drop-in centres. A drop-in centre offers a chance to provide services that address the broader physical and social needs of people who use drugs, beyond harm reduction. This is important because these needs normally go unserved when people who inject drugs face stigmatisation and isolation. People who inject drugs who do not have anywhere to stay are often malnourished. This can seriously worsen any health condition they may have. Where possible, drop-in centre may provide nutrition, showers where vagrant people will maintain their hygiene, comfortable seating area where people who inject drugs can meet, talk and relax in safe environment. Seating areas can also be used for support group sessions, and sleeping space where homeless people who do not have anywhere to go can rest. Where possible, a residence with camp-beds for short sleeps or longer periods of sleep should be made available (UNODC, 2017:123).

People with a history of injecting drug stated that health was not of a concern during periods of active drug injecting, despite a high level of need due to negative attitude of health care practitioner, high demand of their addiction, and fear of potential consequences (Tweed et al, 2018:3). It is important for government to establish health outreach teams that will go to hotspots, and where female nyaope injectors spend their time, in order to reach the females who are greatly in need of health services.

The participants reported that they have dreams. Drug use may have delayed and wasted their time, but they are determined to stop using drugs so that they can focus on improving their lives and that of their families. The participants indicated the need to be financially stable and independent. Social function-ability will enable them to regain self-worth, as it will allow them to contribute positively in their lives and that of their significant others. Having a secure living environment and being financially independent also plays important roles in the ability of people with history of using drugs to sustain their recovery (Stokes et al, 2018:10).

One participant indicated that employers should understand that she is injecting nyaope and should not use her drug use as a factor not to give her a job. This view will be embraced by females who wish to inject drugs.

It is not everyone who wishes to stop using drugs; service providers should never assume everyone's desire to stop using drugs. Nyaope does not come cheap; when tolerance increase, the budget increases. One participant indicated the need to have affordable drugs. The affordability of drugs can reduce the economic hardship female nyaope injectors face on a daily basis.

Female nyaope injectors desire access to clean needles; they do not want to share needles so accessibility to clean needles will assist them. No participant would like to contract HIV or other blood-borne infections. Accessibility to needles enable participants not to share, use old needles and to assist those who do not have sterile needles.

5.2.2.7 Personal experience

The participants went through different experiences which had a potential to change how they conduct themselves in relation to the risky behavior associated with nyaope injecting.

Female nyaope injectors were encouraged by their intimate partners and social network to start injecting nyaope. Socialising with people who inject drugs contributes to the probability that one will transition to injecting drugs. Intimate partners played an active role in encouraging females to inject drugs. Females are more probable to experience their injecting initiation with an intimate partner and to have that partner initiating them (El-Bassel and Strathdee, 2016:5, & Larney et al, 2015:7).

Female nyaope injectors took different periods of time to be able to inject themselves, with other participants taking only one week and others taking more than a year without injecting themselves. Others reported that they cannot inject themselves even after more than year of injecting nyaope. Relying on other people to inject poses a serious risk of contracting HIV as females are often the second injectors.

When females inject themselves, they are able to show independence and autonomy as they will inject at their time and wherever they are. The capability to self-inject also imparted feelings of competence, independence, control of oneself, and prevention of harmful, visible scars on her body (Tuchman, 2015:4). Participants who have not been able to inject themselves for a longer period preferred to be injected by someone they trust instead of self-injecting. Participants highlighted fear of self-injecting and lack of self-trust to perform the injecting.

The participants reported that the first time of injecting was not a comfortable exercise to engage in. They were motivated by the benefits of injecting as the benefits outweigh the feeling of the discomfort they experienced.

As a result of using and injecting nyaope, they create self-stigmatised identities in such a way as to make it difficult to have valuable relationships, accepting that they do not deserve to be loved. The internalisation of the stigma is associated with low self-esteem. Apart from being ashamed of themselves, female nyaope injectors consistently witness negative attitudes from their communities and families. This stigma is influenced by moral judgement. Besides experiencing the stigma in communities, the stigmatisation of injecting drugs was regularly encountered in health institutions. Regardless of where the stigma comes from, it seems to result in separation and social exclusion through biased social processes and institutional practices. Self-stigma is steady with other studies which have defined internalised self-stigma among female nyaope injectors. This in turn leads to feelings of embarrassment, low self-esteem, and reduced self-efficacy (Mburu et al, 2018:5).

Females who use and inject drugs have rights to access sexual and reproductive health services timeously. The research has shown that some of the participants do not understand issues pertaining to their menstrual cycle, which disadvantages them. The participants reported that when they use drugs, they do not fall pregnant. This was based on their experiences of not seeing their menstrual cycle often. Such

assumptions can lead female nyaope injectors not paying attention, falling pregnant, and only realising late that they are pregnant and do not have the option of abortion. For example **Participant 17** only knew of her pregnancy when she was 5 months in. Substance abuse programmes should work with harm reduction programmes. Harm reduction comprehensive packages could help female nyaope injectors better manage their sexual and reproductive health, therefore preventing unplanned pregnancies and improving pregnancy outcomes, including through improved access to prevention of vertical transmission of HIV (Pinkham et al, 2012:128).

5.2.2.8 Life after stopping drug use

The participants highlighted adjustments they experienced, as well as desires to experience after stopping the use drugs. The challenges of waking up in the morning to raise money for fix was a thing of the past. The participants concur that a life of using nyaope is a life of slavery; it is a life no one can live intentionally. The participants reported that their life has improved since they stopped using drugs. They are in control of their lives more than before and enjoy their current life of not using drugs.

Community members have mixed emotions and do not treat females who have stopped injecting nyaope the same. Some wish them luck on their new journey, while others count days before they relapse.

Families are caught in between trusting the participants or not. Participants wish for their families to trust them like before they started using drugs. Some participants indicated that their families are happy, while others indicated that their families have put them on probation.

Participants identified self-control which extends to avoiding triggers such as; friends who use drugs, places where drugs are sold. These are some of the strategies important for maintaining abstinence throughout the recovery journey (Stokes et al, 2018:9). The participants identified their intimate partners as triggers and have instituted plans by separating in the case of **Participant 23** and avoiding visiting the partner at his place in the case of **Participant 16**. It is not easy for **Participant 16** to separate from her partner as children are involved.

5.2.3 Objective 3: Interventions to mitigate or reduce the HIV prevalence among female nyaope injectors

The participants reported that to curb HIV prevalence among female nyaope injectors, the following intervention must be implemented as matter of urgency:

- NSPs;
- Availability of condoms to female nyaope injectors;
- Accessibility of PrEP to female nyaope injectors;
- Role of HIV testing;
- Scarcity work opportunities in South Africa; and
- Educational intervention will curb HIV prevalence among female nyaope injectors

Female nyaope injectors are pressured by lack of accessibility to sterile injections to engage in sharing injections. This fuels their vulnerability of contracting HIV and other blood-borne infections. Programmes that offer disinfected injecting equipment through NSPs are highly effective in decreasing transmissions of HIV and other blood-borne infections (UNODC, 2017:62). The participants acknowledge the value of NSPs in curbing HIV among female nyaope injectors. They further reported that a lack of accessibility to injections can influence them to share among themselves or with other injectors.

NSPs should provide enough injections to enable users not to borrow from other users. The programme can use vending machines, outreach teams, and pharmacies to guarantee that injecting equipment is easily available and accessible in satisfactory amounts to prevent the need to share and reuse needles and syringes (Southwella et al, 2019:3).

NSPs come with controversy; mainly fuelled by the notion of whether a person who uses drugs should be seen as a criminal or a patient, and whether it is ethical or lawful to provide a person using drugs the means to inject. This assumption is usually held by opponents of NSPs who greatly support drug treatment programmes that are based on abstinence and ‘‘drug-free’’ treatment for addiction. NSPs have demonstrated to be a cost effective way of curbing HIV in other low income settings (Derrick and Clark, 2013:139-140). The researcher argues that NSPs are necessary to curb HIV

prevalence and other blood-borne infections, its accessibility will benefit the health state of female nyaope injectors.

Females are more likely to participate in transactional sex and sex work as compared to males who inject drugs (Scheibe et al, 2016b:113). Most of participants who engage in sex do not use condoms consistently with their intimate partners. The participants acknowledge self-determination of females who are injecting nyaope to choose to participate in sex work or transactional sex. Risks related with sex work or transactional sex can be lowered or reduced by the introduction and correct use of condoms during sexual intercourse.

The participants highlighted that the introduction of PrEP to females who are injecting nyaope is long overdue and its accessibility to female nyaope injectors will assist in curbing HIV. PrEP is a biomedical strategy, which offers supplementary HIV prevention options beyond traditional programmes like condoms for individuals at risk. PrEP comes in form of a pill that is taken every day to prevent HIV infection (Walters, Reilly, Neaigus and Braunstein, 2017:2).

PrEP has conceivable worth in the social and sexual networks of people who inject drugs where the prevalence of HIV is high. PrEP will appreciate its HIV prevention prospects when it is introduced in a way that supplements and reinforces existing harm reduction and health promotion activities (Coleman and McLean, 2016:2-4).

Female nyaope injectors are active members of the community. They are active in transmitting and also contracting HIV. Overlooking them might make 90-90-90 plan only a dream which will never be realised. Instantaneous HIV diagnosis, proper link to care, early treatment, retention in care, and sustained viral suppression are all important in reducing morbidity and mortality from HIV, (Mburu et al, 2018:2).

For HIV testing to be effective, it should reach out to where female nyaope injectors are. This is corroborated by (Dos Santos et al, 2011:10) when reporting that HIV testing in Pretoria need to be more extensively promoted and made available in places accessed by vulnerable people, like female nyaope injectors. HIV testing services must go to where to people are, rather than for people to come to where services are.

Female nyaope injectors are not immune to the lack of employment as they are part of the society in general. According to Stats, SA (2019:7) there are 6,7 million

unemployed persons in South Africa. Female nyaope injectors are affected by unemployment. This facilitates their dependence on their intimate partners which fuels injecting equipment sharing (Des Jarlais et al, 2012:2). Participants are of the view that if they are able to find work, working will disturb their routine of using drugs which will reduce the risk of contracting HIV and other blood-borne infections.

Many females are coerced to sell sex to finance their own and their partner's drug use. Unemployment contributes to risk of contracting HIV infection through unprotected sex (Azima et al, 2015:17).

They reported support groups and awareness education as key interventions that can assist in empowering them take informed decision which will influence their decisions to protect themselves against HIV infection.

Forming peer support groups of female nyaope injectors is critical to neutralise the self-stigma. It can also reinforce females' communication skills which assist them in their relationships. This will help them to access social and health services (Mburu et al, 2018:6). The participants acknowledge that support groups will empower the females to engage in safe injecting and other behaviours which will reduce their risk of contracting HIV. They further emphasise that the support groups must be conducted within communities

The participants further added that awareness programmes, through different communication channels to teach different people the risks of injecting drugs, will assist with curbing HIV infection. It is essential for mass media to play a positive role in preventing substance abuse amongst the communities by ensuring that appropriate messages are communicated. This can be done by educating the communities about risk of sharing needles and safe injecting. It can further inform the communities about available substance abuse intervention programs that are found within different cities or areas (Charlton, Negota and Mistry, 2019:52).

5.3 Limitations of the study

The study had the following limitations:

- Only participants who were accessing service at selected COSUP sites were recruited. Females with history of injecting nyaope, who were accessing

services at other organisations and those who were not aligned to any organisation, were not recruited to be part of the study. Not everyone had equal opportunity to be recruited for the study.

- The research employed qualitative research design, the findings cannot be generalised to all female nyaope injectors.
- Some females could not participate in the study because the researcher could not give them incentive for the time they spent. If drugs were legal in South Africa, the researcher could have bought few packets for each participants so that they could participate in the study. The researcher lost an opportunity to listen to their lived experience because he could not give them money for drugs.
- Few studies were conducted on people who inject drugs within the South African context; only one study on female nyaope injectors in South Africa was conducted by UNODC. The researcher depended on international research for literature. More studies on people who inject drugs should be conducted to understand the South African drug injecting context better, instead of understanding South African drug injecting context using international research.

5.4 Recommendations

The researcher would like to make the following recommendations based on the research findings:

- South African Police Service should be part of the solution of curbing HIV among female nyaope injectors by not confiscating the needles used by female nyaope injectors. By confiscating needles from female nyaope injectors, they are indirectly facilitating injections sharing. The female nyaope injectors indicated that when they experience withdraws, what is important to them is to inject, it is not important if the injection is sterile or was used by someone; they will use it. Therefore, it is important for female nyaope injectors to always have needles in their possession if we desire them not to share injections.
- Due to the high level of stigma experienced by female nyaope injectors, it is imperative that community based organisations that offer substance abuse related services should conduct stigmatisation sensitisation workshops as part of their programmes for the community members.

- Department of Health, and Department of Social Development, should jointly provide NSP services at their clinics and service points to enable easy access of free sterile needles.
- Stigmatisation perpetuated by health care professionals should be addressed by including a module on harm reduction in their training syllabus. Stigmatisation perpetuated by health workers contributes immensely to female nyaope injectors not visiting their health care centers.
- Turnaround time at the community health centers should be improved to enable current injectors to access health related services. When female nyaope injectors spend a long time without using drugs, they experience withdrawals that are unbearable. If turnaround time is shortened, the female nyaope injectors will visit the community health centers and will not leave before they are assisted.
- Ward based support groups should be established to support female nyaope injectors; among other things, they should address self-stigmatisation. The ward based support group should also provide support to the family members who are affected by substance use.
- Female nyaope injectors should be afforded opportunities to partake in economic activities.
- Drop-in centres should be established for female nyaope injectors; these centre should offer harm reduction services. The Drop-in-centres will attract female nyaope injectors to the sites and they will benefit from other health services and bathing facilities more especially for those who are homeless.

The researcher has the following recommendations for policy and practice:

- Department of Health, and Department of Social Development, should jointly implement harm reduction service as documented by United Nations Office on Drugs and Crime.
- The provisioning of PrEP should be implemented for female nyaope injectors to enable them to remain HIV negative. They should not be discriminated against.

The researcher recommends decriminalisation of drugs. The criminalisation of drugs fuels stigmatisation and discrimination against people who inject and use drugs. Criminalisation of drug use places PWID in precarious legal situations and estimates suggest that 56–90% of PWID will be incarcerated at some stage during their life. International agencies and programmes such as UNAIDS and UNODC identify criminalisation and punitive laws as a primary reason why the level of decline in HIV incidence and mortality taking place globally is not being observed in PWID (DeBeckn et al, 2017:358). Criminalisation of drug use has a negative effect on HIV prevention and treatment. This negative effect is particularly evident in relation to decreased needle and syringe distribution, increased syringe sharing, and an increased burden of HIV among PWID (DeBeckn et al, 2017:369). SAHCS released a statement on the 3rd of June 2019 supporting the decriminalisation; they reported that they support evidence-based law and policy-making and that they believe that South Africa will not reach its, nor international, HIV or viral hepatitis reduction and treatment targets or related public health goals if it does not decriminalise drug use (SAHCS, 2019).

5.5 Suggestions for further research

This was a qualitative explorative research; based on what the researcher uncovered during the study, it is suggested that more research in the following areas should be conducted:

- Large scale quantitative research on the experience of female nyaope injectors; which will recruit participants from different organisations, and those who are not aligned with any organisation.
- The researcher recruited participants at COSUP Sediba; the participants indicated that they are homeless. The researcher picked up that the experiences of female nyaope injectors who are homeless and those who live with their families are different. Those who lives with their families have access to bathing facility, while those who are homeless do not have privilege of bathing facilities. Therefore, a qualitative study which will separate female nyaope injectors who are homeless and those who stay with their families will provide better understanding of the lived experience of each group of female nyaope injectors.

- Research aimed at evaluating whether current substance services available address the needs of female nyaope injectors.

5.6 Conclusion

This study explored the lived experiences of 24 female nyaope injectors. The exploration has brought an awareness of the challenges the female nyaope injectors face on a daily basis, and how comprehensive harm reduction can benefit them and reduce the risks they encounter daily. South African government, through legislation, should endorse comprehensive harm reduction service for females who inject and use drugs in order to lower risks of contracting HIV and other blood-borne infections. Stigmatisation, in all levels, including health care centers, police and community, should be eradicated.

This chapter discussed summary of key findings, limitations, formulated recommendations, and possible future research.

6. LIST OF SOURCES

Angarita. G. A, Emadi. N, Hodges. S and Morgan. P. T. 2016. Sleep abnormalities associated with alcohol, cannabis, cocaine, and opiate use: a comprehensive review. Available at https://www.ncbi.nlm.nih.gov/pubmed/27117064 Accessed (12/08/2019).

Arpa. S. 2017. Females who use drugs: Issues, needs, responses, challenges and implications for policy and practice. Available at http://www.emcdda.europa.eu/system/files/attachments/6235/EuropeanResponsesGuide2017_BackgroundPaper-Females-who-use-drugs.pdf Accessed (12/08/2019).

Asher, A. Hahn, J. Couture, M. Maher, K and Page, K. 2013. People who Inject Drugs, HIV Risk, and HIV Testing Uptake in Sub-Saharan Africa. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3800507/ Accessed (17/12/2018).

Ashmore, J and Henwood, R. 2015. Choice or no choice? The need for better branded public sector condoms in South Africa. Available at https://www.ajol.info › index.php › sajhivm › article › download Accessed (08/01/2020).

Azima, T. Bontell, I. Steffanie A. Strathdee, S.A. 2015. Females, drugs and HIV. Available at https://www.ncbi.nlm.nih.gov/pubmed/25277726 Accessed (11/11/2018).

Babbie, E. 2010. *The practice of Social Research*. Belmont, CA: Thompson Wadsworth.

Babbie, E. 2012. The practice of Social Science. Oxford University Press: Southern Africa (pty) Ltd.

Bahramnejad A, Rabani-Bavojdan M, Rabani-Bavojdan M, Kaviani N. The Value of Perfectionism in Predicting Coping Strategies in Drug-User Females. Addict Health 2015; 7(3-4): 157-63.

Baral. S, Logie.C.H, Grosso.A, Wirtz.A.L and Beyrer.C. 2013. Modified Social Ecological Model: a tool to guide the assessment of the risks and risk contexts of HIV epidemics. Available at http://www.biomedcentral.com/1471-2458/13/482 Accessed: (11/10/2018).

Barbour, K. McQuade, M and Brown, B. 2017. Students as effective harm reductionists and needle exchange organizers. Available at

https://substanceabusepolicy.biomedcentral.com/articles/10.1186/s13011-017-0099-0 Accessed (10/01/2020).

Bateganya, M. H. Amanyeiwe, U. Roxo, U and Dong, M. 2015. Impact of Support Groups for People Living With HIV on Clinical Outcomes: A Systematic Review of the Literature. Available at file:///C:/Users/User/Downloads/cdc_37462_DS2%20(1).pdf Accessed (10/01/2020).

Bernard, H.R. 2013. Social Research Methods: Qualitative and Quantitative Approaches. 2nd Edition. SAGE Publication, Inc.

Berry, R. S. 1999. Collecting data by in-depth interviewing. Available at www.leeds.ac.uk › educol › documents Accessed (10/01/2020).

Bickman, L. & J.Rog, D. 2009. Applied Social Research Methods. Second edition, USA, SAGE Publication.

Blanche M T, Durrheim K, and Painter D.2006.Research in practice: Applied methods for the social science.2nd edition. Cape Town: UCT press (pty) Ltd.

Booth. A, Papaioannou. D and Sutton. A. 2012. SYSTEMATIC APPROACHES to a SUCCESSFUL LITERATURE REVIEW. SAGE Publication Ltd. London.

Carusone. S. C, Guta. A, Robinson. S, Tan. D. H, Cooper. C, O'Leary. B, de Prinse. K, Cobb. G, Upshur. R and Strike. C. 2019. "Maybe if I stop the drugs, then maybe they'd care?"—hospital care experiences of people who use drugs". Available at https://www.ncbi.nlm.nih.gov/pubmed/30760261 Accessed 12/08/2019). (

Chakrapani. V, Newman. P. A, Shunmugam. M and Robert Dubrow. R. 2011. Social-structural contexts of needle and syringe sharing behaviours of HIV-positive injecting drug users in Manipur, India: a mixed methods investigation. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3120658/ Accessed (12/08/2019).

Charlton .R.W, Negota. A and Mistry. D. 2019. An exploration into Nyaope users and interventions to curb drug abuse in Gauteng, South Africa. Available at www.ijhssi.org/papers/vol8(1)/Version-2/D0801021425.pdf
Accessed (12/08/2019).

Coleman. R. L and McLean. S. 2016. Commentary: the value of PrEP for people who inject drugs. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5071747/ Accessed (12/08/2019).

Constitution of the Republic of South Africa. 1996. Available at www.justice.gov.za/legislation/constitution/SAConstitution-web-eng.pdf Accessed (12/08/2019).

Cooper, D. Harries, J. Moodley, J. Constant, D. Hodes, R. Mathews, C. Morroni, C. and Hoffman, M. 2016. Coming of age? Women's sexual and reproductive health after twentyone years of democracy in South Africa. Available at https://doi.org/10.1016/j.rhm.2016.11.010 Accessed (10/01/20202).

Cresswell, John W. (2014) Research Design. Qualitative, Quantitative and Mixed Methods Approaches. 4th edition. Lincoln: Sage Publication.

Dada, S. 2013. SUBSTANCE ABUSE & DRUG INJECTION TRENDS IN SOUTH AFRICA. EMCDDA 13th ANNUAL TDI MEETING LISBON. MRC Available at http://www.emcdda.europa.eu/attachements.cfm/att_230539_EN_08.%20S.%20Dada%20-%20Injection%20Trends%20in%20South%20Africa.pdf Accessed (17/12/2018).

De Beck, K. Cheng, T. Montaner, J. S. Beyrer, C. Elliott, R. Sherman, S. Wood, E and Baral, S. 2017. HIV and the criminalisation of drug use among people who inject drugs: a systematic review. Available at https://www.hivlawandpolicy.org/sites/default/files/DeBeck_HIV%20and%20the%20criminalization%20of%20PWID.pdf Accessed (11/01/2020).

Degenhardt. L, Peacock. A, Colledge. S, Leung. J, Grebely. J, Vickerman. P, Stone. J, Cunningham. E.B, Trickey. A, Dumchev. K, Lynskey. M, Griffiths. P, Mattick. R.P, Hickman. M and Larney. S (2017) Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. Available at https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30375-3/abstract Accessed (07/09/2018).

Derrick. S and Clark. N. C. 2013. NEED FOR NEEDLE AND SYRINGE PROGRAMMES IN AFRICA. Available at https://www.ajol.info/index.php/ajdas/article/view/103582 Accessed (12/08/2019).

Des Jarlais, D.C. Feelemyer,J.P. Modi,S.N. Arasteh,K. and Hagan, H. 2013. Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3501794/pdf/APM2012-269123.pdf Accessed (11/11/2018).

De Vos, AS. Strydom, H. Fouche', CB & Delport, CSL. 2011. Research at grassroots: For the social science and human service professions.4th edition. Pretoria: Van Schaik.

Dintwe, S (2017) UNDERSTANDING THE PROFILE OF A *NYAOPE* ADDICT AND ITS CONNOTATIONS FOR LAW ENFORCEMENT AGENCIES Available at https://journals.co.za/content/journal/10520/EJC-8a28d2dc6 Accessed (16/12/2018).

Dos Santos. M, Trautmann. F and Kools. J. 2011. Rapid assessment response (RAR) study: drug use and health risk - Pretoria, South Africa. Available at

www.ncbi.nlm.nih.gov/pubmed/21631928 Accessed (12/08/2019).

Duby. Z, Fong-Jaen. F, Nkosi. B, Brown. B and Scheibe. A. 2019. 'We must treat them like all the other people': Evaluating the Integrated Key Populations Sensitivity Training Programme for Healthcare Workers in South Africa. Available at https://www.researchgate.net/publication/332754288 Accessed (09/08/2019).

Dunn. R.L, Kalich .K.A, Henning. M.J and Fedrizzi. R. 2015. Engaging Field-Based Professionals in a Qualitative Assessment of Barriers and Positive Contributors to Breastfeeding Using the Social Ecological Model. https://www.ncbi.nlm.nih.gov/pubmed/24740721. Accessed (13/10/2018).

El-Bassel. N and Strathdee. S.A (2016) Females who use or inject drugs: an action agenda for females-specific, multilevel and combination HIV prevention and research. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4932853/ Accessed 07/09/2018).

El Kazdouh, H. El-Ammari, A. Bouftini, S. El Fakir, S. and El Achhab, Y. 2018. Adolescents, parents and teachers' perceptions of risk and protective factors of substance use in Moroccan adolescents: a qualitative study. Available at https://substanceabusepolicy.biomedcentral.com/track/pdf/10.1186/s13011-018-0169-y Accessed (10/01/2020).

Fanelli. C. W and Moyo. A. R (2008) Guidelines for Establishing and Operating Successful Support Groups for People Living with HIV. Available at https://www.crs.org/sites/default/files/tools.../guidelines-for-support-groups-hiv.pdf Accessed (12/08/2019).

Global Coalition on Females and AIDS (GCWA). 2011. Females who use drugs, harm reduction and HIV. Available http://idhdp.com/media/1114/brief-females-drugs-hiv-harm-final.pdf Accessed (17/12/2018).

Golden, S. D and Earp, J. L. 2012. Social Ecological Approaches to Individuals and Their Contexts: Twenty Years of *Health Education & Behaviour* Health Promotion Interventions. Available at https://journals.sagepub.com/doi/pdf/10.1177/1090198111418634 Accessed (12/08/2019).

Gray, D.E 2014. Doing Research in the Real World. 3rd Edition. London, SAGE Publication.

Guimarães, R. A. Rodovalho, A. G. Fernandes, I. L. Silva, G. C. de Felipe, R. L. Vera, I. Gregório, V. D and Lucchese, R. 2016. Transactional Sex among Noninjecting Illicit Drug Users: Implications for HIV Transmission. Available at https://www.researchgate.net/publication/307181034_Transactional_Sex_among_Noninjecting_Illicit_Drug_Users_Implications_for_HIV_Transmission Accessed (10/01/2020).

Guise, A. Horyniak, D. Melo, J. McNeill, R and Werb, D. 2017. The experience of initiating injection drug use and its social context: A qualitative systematic review and thematic synthesis. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5673537/pdf/nihms895006.pdf Accessed (10/01/2020).

Haddad, L. B. Tang, J. H. Krashin, J. Ng'ambi, W. Tweya, H. Samala, B. Chiwoko, J. Chaweza, T. Hosseinipour, M. C. Lathrop, E. Jamieson, D. J. and Phiri4, S. 2018. Factors associated with condom use among men and women living with HIV in Lilongwe, Malawi: a crosssectional study. Available at https://srh.bmj.com/content/44/1/1.2 Accessed (10/01/2020).

Hayashi, K. Small, W. Csete, J. Hattirat, S and Kerr, T. 2013. Experiences with Policing among People Who Inject Drugs in Bangkok, Thailand: A Qualitative Study Available https://www.ncbi.nlm.nih.gov/pubmed/24339753 Accessed (16/12/2018).

Horitavorn. N. 2008. Life Beyond The Norm: Voice of females injecting drug users. Available at www.hivpolicy.org/Library/HPP001738.pdf Accessed (12/08/2019).

Islam. S, Piggott. D. A, Moriggia. A, Astemborski. J, Mehta. S. H, Thomas. D.H and Kirk. G. D. 2019. Reducing injection intensity is associated with decreased risk for invasive bacterial infection among high-frequency injection drug users. Available at https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-019-0312-8 Accessed (12/08/2019).

Jacobs, T and Slabbert, I. 2019. Factors that could contribute to substance misuse and criminal activity amongst adolescents: an ecological perspective. Available at www.scielo.org.za › pdf. Accessed (10/01/2020).

Jamshidimanesh M, Mousavi SA, Merghati-Khoei E, Emamian MH, Keramat A. 2016. Sexual Risk Behaviours Constructed in Iranian Females' Life with Substance Use Disorders: A New Implication of Human Ecological Theory. Available at. https://www.ncbi.nlm.nih.gov/pubmed/28496954 Accessed (17/12/2018).

Jansen, E.A and Laurie, C. 2016. Doing Real Research: A practical guide to social research. London. SAGE Publications Ltd.

Johnson, L. F. Dorrington, R. E and Moolla, H. 2017. Progress towards the 2020 targets for HIV diagnosis and antiretroviral treatment in South Africa. Available at https://www.ajol.info › index.php › sajhivm › article › download Accessed (08/01/2020).

Kaba, Z. Khamisa, N &Tshuma, N. 2017.Age-group differences in risk perception of non-communicable diseases amongst adult in Dieploot township Johannesburg,

South Africa: Cross sectional study based on the Health Belief Model. Available at http://www.samj.org.za/index.php/samj/article/view/12044 Accessed (15/09/2018).

Kanda, L and Mash, R. 2018. Reasons for inconsistent condom use by young adults in Mahalapye, Botswana. Available at http://www.scielo.org.za/pdf/phcfm/v10n1/22.pdf Accessed (10/01/2020).

Khuat, O. TH. Morrow, M. Nguyen, T. NN and Armstrong, G. 2015. Social context, diversity and risk among female nyaope injectors in Vietnam: descriptive findings from a cross-sectional survey. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4608123/ Accessed (18/11/2018).

Kontautaite. A, Matyushina-Ocheret. D, Plotko. M, Golichenko. M, Kalvet. M and Antonova. L. 2018. Study of human rights violations faced by females who use drugs in Estonia. Available at https://www.ncbi.nlm.nih.gov/pubmed/30400951 Accessed (12/08/2019).

Kularatne, R. S. Niit, R. Rowley, J. Kufa-ChakezhaID, T. PetersID, R.P. H. Taylor, M. M. Johnson, L. F. and Korenromp, E. L. 2018. Adult gonorrhea, chlamydia and syphilis prevalence, incidence, treatment and syndromic case reporting in South Africa: Estimates using the Spectrum-STI model, 1990-2017. Available at https://journals.plos.org/plosone/article/file?type=printable&id=10.1371/journal.pone.0205863 Accessed (10/01/2020).

Kumar, R. 2011.Research methodology: A step-by-step guide for beginners. 3rd edition. London: Sage Ltd

Kumar, R (2014) Research Methodology: A step by step guide for a beginner.4th Edition. London: Sage Publications

Kumar, S. Quinn, S. S. Kim, K. H. Musa, D. Hilyard, K. M and Freimuth, V. S. 2012. The Social Ecological Model as a Framework for Determinants of 2009 H1N1 Influenza Vaccine Uptake in the US. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3916095/ Accessed (12/08/2019).

Kvale, S. 1994. Ten standard Objections to Qualitative Research Interviews. Aavailable at https://www.sfu.ca › ~palys › Kvale-TenStandardObjectionsToQualIntervie Accessed (10/01/2020).

Lan, C. Lin, C. Thanh, D. C and Li, L. 2018. Drug-related stigma and access to care among people who inject drugs in Vietnam. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5794669/ Accessed (10/01/2020).

Larney, S. Mathers, M.M. Poteat, D.T. Kamarulzaman, and Louisa Degenhardt, L. 2015. Global Epidemiology of HIV Among Females and Girls Who Use or Inject Drugs: Current Knowledge and Limitations of Existing Data. Available at https://www.ncbi.nlm.nih.gov/pubmed/25978476 Accessed (11/11/2018).

Mabuto, T. Latka, M. H. Kuwane, B. Churchyard, G. J. Charalambous, S. and Hoffmann, C. J. 2014. Four Models of HIV Counselling and Testing: Utilization and Test Results in South Africa. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4094499/pdf/pone.0102267.pdf Accessed (10/01/2020).

Maggie, W (2013). Social Research Methods. 3rd edition. Melbourne, Australia Oxford University Press

Manjengwa, P.G. Mangold, K. Musekiwa, A and Kuonza, L.R. 2018. Cognitive and behavioural determinants of multiple sexual partnerships and condom use in South Africa: Results of a national survey. Available at https://sahivsoc.org/Files/document%20(1).pdf Accessed (10/01/2020).

Mekebeb, M. B. Von Pressentin, K and Jenkins, K. S. 2019. Institutional tuberculosis infection control in a rural sub-district in South Africa: A quality improvement study. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6620558/pdf/PHCFM-11-1971.pdf Accessed (10/01/2020).

Malekinejad. M, Parriott. A, Blodgett. J. C, Horvath. H, Shrestha. R. K, Hutchinson. A. B, Volberding. P and Kahn. J. G. 2017. Effectiveness of community-based condom distribution interventions to prevent HIV in the United States: A systematic review and meta-analysis. https://doi.org/10.1371/journal.pone.0180718 Accessed (2/08/2019).

Mampolokeng Mathuso Mary-Elizabeth Monyakane 2018. A Rehabilitative South African Criminal Law Response to Nyaope, Drug Addiction: - A Recommendation for Health Oriented Nyaope Drug Weaning. Available on https://crimsonpublishers.com/rpn/pdf/RPN.000554.pdf Accessed (16/12/2018).

Marottaa, P. L, Gilberta, L. Terlikbayevab, A. Wua, E and El-Bassela, N. 2018. Differences by sex in associations between injection drug risks and drug crime conviction among people who inject drugs in Almaty, Kazakhstan. Available at https://www.ncbi.nlm.nih.gov/pubmed/30219718 Accessed (16/12/2018).

Marks. M, Gumede. S and Shelly. S (2017) Drugs are the solution not the problem: Exploring drug use rationales and the need for harm reduction practices South Africa introduction. Available at https://www.researchgate.net/publication/325858204 Accessed (21/07/2019).

Masombuka, J. 2013. CHILDREN'S ADDICTION TO THE DRUG "*NYAOPE*" IN SOSHANGUVE TOWNSHIP: PARENTS' EXPERIENCES AND SUPPORT NEEDS. Dissertation for the degree of MASTERS OF SOCIAL WORK: UNIVERSITY OF SOUTH AFRICA.

Mburu. G, Ayon. S, Tsai. A.C, Ndimbii. J, Wang. B, Strathdee. S and Seeley. J. (2018) Who has ever loved a drug addict? It's a lie. They think a 'teja' is as bad person": multiple stigmas faced by female nyaope injectors in coastal Kenya. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5970466/ Accessed (07/09/2018).

Meel, R. and Essop, M. R. 2018. Striking increase in the incidence of infective endocarditis associated with recreational drug abuse in urban South Africa. Available at https://www.ncbi.nlm.nih.gov/pubmed/30004347 Accessed (16/12/2018).

Meyers. S.A, Scheim. A, Jain. S, Sun. X, Milloy. M.J, DeBeck. K, Hayashi. K, Garfein. R. S and Werb. D. 2018. Gender differences in the provision of injection initiation assistance: a comparison of three North American settings. Available at https://doi.org/10.1186/s12954-018-0270-6 Accessed (21/07/2019).

Michie, A.G. Hoosain,S. and M Macharia, M. 2017. Report on the first government-funded opioid substitution programme for heroin users in the Western Cape Province, South Africa. Available at http://www.scielo.org.za/pdf/samj/v107n6/21.pdf Accessed (7/1/2020).

Mokwena, K. 2015. "Consider our plight": A cry for help from Nyaope users. Available at https://www.sciencedirect.com/science/article/pii/S1025984815000241 Accessed (17/12/2018).

Mokwena, K. E. & Huma, M. (2014). Experiences of 'nyaope' users in three provinces of South Africa. Available at journals.ub.bw/index.php/pula/article/view/360/261 Accessed (17/12/2018).

Mokwena. K and Morojele. N. 2014. Unemployment and unfavourable social environment as contributory factors to *nyaope* use in three provinces of South Africa. Available at https://www.semanticscholar.org/paper/Unemployment-and-unfavourable-social-environment-as-Mokwena Morojele/4e0f9039ed08fcbf2ab602e4f72a7d10f6d5065c Accessed (12/08/2019).

Moorhouse, M. Maartens, G. Venter, W. D. F. Moosa, M. Steegen, K. Jamaloodien, K. Fox, M. P and Conradie, F. 2018. Third-Line Antiretroviral Therapy Program in the South African Public Sector: Cohort Description and Virological Outcomes. Available at www.heroza.org › uploads › 2018/12 › 2018-Moorhouse-JAIDS-Third-line Accessed (08/01/2020).

Morrisa, M.D. Montgomery, M.E. Bricenoa, A. Evansa, J. L. Andrewc, E.W. Pagec, K and Hahna, J. A. 2018. A Study of Sexual Relationship Power among Young Female nyaope injectors and Their Sexual Partners. Available at https://www.tandfonline.com/doi/abs/10.1080/10826084.2017.1404105 Accessed (12/11/2018).

Moses H. Bateganya. M. H, Amanyeiwe. U, Roxo. U and Dong. M (2015) Impact of Support Groups for People Living With HIV on Clinical Outcomes: A Systematic Review of the Literature. Available https://www.ncbi.nlm.nih.gov/pubmed/25768876 Accessed (12/08/2019).

Mthembi, P. M. Mwenesongole, E. M and Cole, M. D. 2018. Chemical profiling of the street cocktail drug 'nyaope' in South Africa using GC–MS I: Stability studies of components of 'nyaope' in organic solvents. Available at https://www.ncbi.nlm.nih.gov/pubmed/30296627 Accessed (18/11/2018).

Mwangi.C, Karanja. S, Gachohi. J, Wanjihia.V and Ngang. Z (2019) Depression, injecting drug use, and risky sexual behaviour syndemic among female nyaope injectors in Kenya: a cross-sectional survey. Available https://www.ncbi.nlm.nih.gov/pubmed/31146748 Accessed (12/08/2019).

National Institute on Drug Abuse (NIDA). 2019. FEMALE NYAOPE INJECTORS: OVERLOOKED, YET VISIBLE. Available at https://www.iasociety.org/Web/.../2019__IAS__Brief__Females_who_inject_drugs.pd Accessed (12/08/2019).

Neuman, W.L. 2014. Social Research Methods: Qualitative and Quantitative Approaches. 7th Edition. Pearson Education Limited, London

Oxford Advanced Learners Dictionary: International Students Edition. 2015

Padayatchi, N. Daftary, A. Naidu, N. Naidoo, K and Pai, M. 2019. Tuberculosis: treatment failure, or failure to treat? Lessons from India and South Africa. Available at https://gh.bmj.com/content/bmjgh/4/1/e001097.full.pdf Accessed (10/01/2020).

Parry, C. D. H. Carney, P and Williams, P. P. 2017. Reducing substance use and risky sexual behaviour among drug users in Durban, South Africa: Assessing the impact of community-level risk-reduction interventions. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5639608/ Accessed (16/12/2018).

Paquettea, C.E. Syvertsenc, J.L. and Pollinia, R.A. 2018. Stigma at Every Turn: Health Services Experiences among People Who Inject Drugs. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5994194/pdf/nihms966056.pdf Accessed (06/01/2020).

Pinkham, S. Myers, B. and Stoicescu, C. 2012. Developing effective harm reduction services for female nyaope injectors. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3501794/pdf/APM2012-269123.pdf Accessed (11/11/2018).

Polit, DF. & Beck, CT.2008. *Nursing Research, generating and assessing evidence for Nursing*, 8thedns, Philadelphia: Lippincott Williams & Wilkins.

Price. C and Davey. H. 2008. HEPATITIS C, PEER SUPPORT GROUP MANUAL: For people living with hepatitis C or hepatitis C – HIV co-infection, family and friends affected by HCV, and staff of AIDS services organisation and community health centre. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5622540/ Accessed (12/08/2019).

Rahman. F, Lall. P, Iqbal. S and Vicknasingam. B. 2015. Pain, instability, and familial discord: a qualitative study into females who use drugs in Malaysia. Available at https://www.ncbi.nlm.nih.gov/pubmed/26542117 Accessed (12/08/2019).

Ramjee, G and Daniels, B. 2013. Females and HIV in Sub-Saharan Africa. Available at https://www.ncbi.nlm.nih.gov/pubmed/24330537 Accessed (12/11/2018).

Richardson. L, Wood. E, Li. K, and Thomas Kerr. T. 2010. FACTORS ASSOCIATED WITH EMPLOYMENT AMONG A COHORT OF INJECTION DRUG USERS. Available https://www.ncbi.nlm.nih.gov/pubmed/20565522 Accessed (12/08/2019).

Roberts. A, Mathers. B, Degenhardt. L. 2010. Female nyaope injectors: A review of their risks, experiences and needs. National Drug and Alcohol Research Centre (NDARC)

73, Rodrigo, C and Rajapakse, S. 2010. HIV, poverty and females. Available https://www.ncbi.nlm.nih.gov/pubmed/24037044 Accessed on (16/12/2018).

Sabri, B. Wirtz, A.L. Ssekasanvu , J. Nonyane, B.A.S. Nalugoda, F. Kagaayi, J. Ssekubugu, R and Wagman, J. A. 2019. Intimate partner violence, HIV and sexually transmitted infections in fishing, trading and agrarian communities in Rakai, Uganda. Available at https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6909-8 Accessed (11/01/2020).

SAMHSA's WORKING DEFINITION OF RECOVERY. Available at https://ncbi.nih.gov>books Accessed (08/08/2019).

SANAC. South African National Aids Council. The South African National Sex Worker HIV Plan 2016/2019, Pretoria, South Africa: 2016. Available https://sanac.org.za/wp-content/uploads/2019/02/SANAC14lowspreads.pdf Accessed (12/08/2019).

Sansone, R. A and Sansone, L. A. 2014. Marijuana and Body Weight. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4204468/pdf/icns_11_7-8_50.pdf accessed (10/01/2020).

South African National Treasury (SANT). 2019. Economic transformation, inclusive growth, and competitiveness: Towards an Economic Strategy for South Africa. Available at

http://www.treasury.gov.za/comm_media/press/2019/Towards%20an%20Economic%20Strategy%20for%20SA.pdf Accessed (10/01/2020).

Scheibe. A, Howell. S, Müller. A, Katumba. M, Langen. B, Artz. L and

Marks. M. 2016a. Finding solid ground: law enforcement, key populations and their health and rights in South Africa. Available at http://www.jiasociety.org/index.php/jias/article/view/20872 Accessed (08/08/2019).

Scheibe, A. Makapela, D. Brown, B. dos Santos, M. Hariga, H. Virk, F. Bekker, L. Lyan, O. Fee, N. Molnar,M. Bocai, A. Eligh, J. & Lehtovuori, R.2016b HIV prevalence and risk among people who inject drugs in five South African cities. Available https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5463380/ Accessed (17/12/2018).

Scheibe, A. Shelly, S. Lambert, A. Schneider, A. Basson, R. Medeiros, N. Padayachee, K. Savva, H and Hausler, H. 2017.Using a programmatic mapping approach to plan for HIV prevention and harm reduction interventions for people who inject drugs in three South African cities. Available https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5463380/ Accessed (17/12/2018).

Scheibe, A. Marks, M. Shelly, S. Gerardy, T. Domingo, A.K. Hugo, J. 2018. Developing an advocacy agenda for increasing access to opioid substitution therapy as part of comprehensive services for people who use drugs in South Africa. Available at https://repository.up.ac.za/bitstream/handle/2263/67240/Scheibe_Developing_2018.pdf?sequence=1&isAllowed=y Accessed (08/01/2020).

Scheibe. A, Young. K, Moses. L, Basson. R.L, Versfeld. A, Spearman. C. W, Sonderup. M. W, Prabdial-Sing. N, Manamela. J, Puren. A. J, Rebe. K and Hausler. H. 2019. Understanding hepatitis B, hepatitis C and HIV among people who inject drugs in South Africa: findings from a three-city cross-sectional survey. Available at https://doi.org/10.1186/s12954-019-0298-2 Accessed (21/07/2019).

Schultz. P and Alpaslan. A. H. 2016. OUR BROTHERS' KEEPERS: SIBLINGS ABUSING CHEMICAL SUBSTANCES LIVING WITH NON-USING SIBLINGS. Available at http://socialwork.journals.ac.za/pub Accessed (01/08/2019).

Southwella. M, Shelly. S, MacDonald. V, Verster. A, and Maherd. L. 2019. Transforming lives and empowering communities: evidence, harm reduction and a holistic approach to people who use drugs. Available

https://www.ncbi.nlm.nih.gov/pubmed/31219890 Accessed (12/08/2019).

Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D, Onoya, D et al. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town, HSRC Press.

Southern African HIV Clinicians Society (SAHCS) 3 June 2019. Available at https://sahivsoc.org › Files Accessed (10/01/2020).

Springer. S.A , MD, Sarah Larney, Zahra Alam-mehrjerdi, Frederick L. Altice, MD, David Metzger and Steven Shoptaw (2016) Drug Treatment as HIV Prevention Among Females and Girls Who Inject Drugs From a Global Perspective: Progress, Gaps, and Future Directions. Available https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4443704/ Accessed (07/09/2018).

Stats SA (2018). Mid-year population estimates. P0302. Pretoria.

Stoicescu, C. Cluver, L. D. Spreckelsen, T. Casale, M. Sudewo, A. G and Irwanto. 2018. Intimate Partner Violence and HIV Sexual Risk Behaviour Among Female nyaope injectors in Indonesia: A Respondent-Driven Sampling Study. Available https://www.ncbi.nlm.nih.gov/pubmed/29948336 Accessed (12/11/2018).

Stokes. M, Schultz. P and Assim Alpaslan. A. 2018. Narrating the journey of sustained recovery from substance use disorder. Available at https://doi.org/10.1186/s13011-018-0167-0 Accessed (02/08/2019).

Strang, J. McDonald, R. Campbell, G. Degenhardt, L. Nielsen, S. Ritter, A and Dale, O. 2019. Take-Home Naloxone for the Emergency Interim Management of Opioid Overdose: The Public Health Application of an Emergency Medicine. Available at https://link.springer.com/content/pdf/10.1007%2Fs40265-019-01154-5.pdf Accessed (10/01/2020).

Strathdee. S. A, West. B. S, Reed. E, Moazan. B, Azim. T and Dolan. K. 2015. Substance Use and HIV Among Female Sex Workers and Female Prisoners: Risk Environments and Implications for Prevention, Treatment, and Policies. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4493865/ Accessed (12/08/2019).

Tarkang, E. E and Zotor, F. B. 2015. Application of the Health Belief Model (HBM) in HIV Prevention: A Literature Review. Available www.sciencepublishinggroup.com/journal/.../j.cajph.20150101.11 Accessed (06/01/2019).

Thomas, G. 2017. HOW TO DO YOUR RESEARCH PROJECT: A GUIDE FOR STUDENTS. 3rd Edition. SAGE Publications. London.

Tuchman. E (2015) Females' injection drug practices in their own words: a qualitative study. Available https://harmreductionjournal.biomedcentral.com/articles/10.1186/s12954-015-0041-6 (Accessed 07/09/208).

Turmen, T. 2003. Gender and HIV/AIDS. Available https://www.ncbi.nlm.nih.gov/pubmed/14499987 Accessed (12/11/2018).

Tweed. E. J, Rodgers. M, Priyadarshi, S and Crighton. E. 2018. "Taking away the chaos": a health needs assessment for people who inject drugs in public places in Glasgow, Scotland. Available at https://doi.org/10.1186/s12889-018-5718-9 Accessed (02/08/2019).

UNAIDS. 2014. GAP REPORT: People Who Inject Drugs. Available www.unaids.org/sites/default/files/media_asset/05_Peoplewhoinjectdrugs.pdf Accessed (17/12/2018).

UNAIDS 2018. Transactional sex and HIV risk: from analysis to action. Available https://www.unaids.org/sites/default/files/media.../transactional-sex-and-hiv-risk_en.pdf Accessed (12/08/2019).

UNAIDS. 2019. Health, Rights and Drugs: Harm reduction, decriminalisation and zero discrimination for people who use drugs. Available www.unaids.org/en/resources/documents/2019/JC2954_UNAIDS_drugs_report_2019 Accessed (12/08/2019).

UNODC. 2015. Rapid situation assessment and response: HIV and drug use, especially injecting drug use, among females in Namibia.

UNODC. 2016. Addressing the specific needs of female nyaope injectors: Practical guide for service providers on gender-responsive HIV services.

United Nations Office on Drugs and Crime, International Network of People Who Use Drugs, Joint United Nations Programme on HIV/AIDS, United Nations Development Programme, United Nations Population Fund, World Health Organisation, United States Agency for International Development. 2017. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime.

UNODC. 2017b. Were you really raped, or did you just not get paid? A NEEDS ASSESSMENT OF FEMALES WHO USEDRUGS IN FOUR CITIES IN SOUTH AFRICA

UNODC. 2018. World Drug Report 2018. Available https://www.unodc.org/wdr2018/prelaunch/WDR18_Booklet_1_EXSUM.pdf Accessed (17/12/2018).

UNDOC. 2018b. FEMALES AND DRUGSFEMALES: Drug use, drug supply and their consequences.

Uusküla, A. Raag, M. Vorobjov, S and Des Jarlais, D.2018. Another frontier for harm reduction: contraceptive needs of females who inject drugs in Estonia, a cross-sectional study. Available at https://doi.org/10.1186/s12954-018-0215-0 Accessed (06/12/2018).

Van Eyk, A. D. 2016. The treatment of sexually transmitted infections. Available at https://www.ajol.info › index.php › safp › article › download Accessed (10/01/2020).

Walliman, N (2016). Social Research Methods. 2nd Edition. SAGE Publications Ltd.

Weich. L (2017) Guideline: South African Guidelines for the management of Opioid use disorders (Part 1). Available www.pntonline.co.za/index.php/PNT/article/download/911/1517 Accessed (07/09/2018).

Walters. S. M, Reilly. K. H, Neaigus. A and Braunstein. S. 2017. Awareness of pre-exposure prophylaxis (PrEP) among female nyaope injectors in NYC: the importance of networks and syringe exchange programs for HIV prevention. Available https://www.ncbi.nlm.nih.gov/pubmed/28662716 Accessed (12/08/2019).

WHO (2015). Technical brief on HIV and young people who inject. Geneva, Switzerland. Available www.unaids.org/sites/default/files/media_asset/2015_young_people_drugs_en.pdf Accessed (17/12/2018).

WHO. 2017. Creating peer support groups in mental health and related areas: WHO Quality Rights training to act, unite and empower for mental health. Available at http://www.who.int/mental_health/policy/quality_rights/en/ Accessed (08/08/2019).

WHO. International Classification of Health Interventions (ICHI). Available at https://www.who.int/classifications/ichi/en/. Accessed (10/01/2020).

www.timeslive.co.za/local/2017/02/01/Bluetoothshock-Nyaope-drug-addicts-share-blood-to-get-high1 Accessed (10/01/2020)

7. APPENDIX A-H

A: INFORMED CONSENT FOR PARTICIPATING IN THE STUDY

Research topic: Exploring the experiences of female nyaope injectors residing in the City of Tshwane Municipality, Gauteng

Dear Prospective Participant,

You are invited to participate in a research study conducted by Moganki Hendrick Lefoka in fulfilment of a MA (Social Behavioural Studies in HIV/AIDS), in the Department of Sociology, University of South Africa. The focus of the study is to explore and describe the experiences of female nyaope injectors.

Your participation will involve an interview, which will be tape-recorded. The reason for recording the interview is that the researcher would be able to transcribe and analyze the data in depth, which will result in more detailed data for the purpose of this study. There will also be follow-up questions during the interviews. The University of South Africa had granted the research ethical approval, which means the study will comply with the code of ethics of scientific research on human participants.

There are no physical risks involved in conducting the research. Although there might be some topics that will be discussed during the interview that might be sensitive to the participant or that may cause emotional discomfort. This will be noted by the researcher and the necessary precautions will be applied in order to avoid any harm. Pre-counselling will be offered before the actual interview.

Your participation in this research study would contribute towards understanding the experiences of female nyaope injectors. The findings may contribute towards substance abuse programmes which address the needs of female nyaope injectors. The study does not involve monetary compensation for participating.

Your name and personal details will not be mentioned within this study, you will be referred to by a nickname in order to protect personal information about yourself. Hard copies of your answers will be stored by the researcher for a period of five years in a locked cupboard at UNISA for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard

copies will be shredded and electronic copies will be permanently deleted from the hard driver of the computer through the use of a relevant software programme.

Your participation in this research study is voluntary. This means that you have the right to choose whether you want to partake within this study or not, and that you may withdraw your consent to participate at any stage during the interview process. You will not be penalised in any way if you decide that you no longer want to participate or withdraw in the interview process. If you agree to participate in this study, you will be given a pre-counselling and this information sheet to keep, and you will be asked to sign a written consent form.

If you have any questions or concerns regarding the interview process and the study or if any problems arise from this study- please feel free to contact:

The researcher: Moganki Hendrick Lefoka

Cell No: 078 820 7941 or email address: 44043120@mylfe.unisa.ac.za

Research Supervisor: Dr. T.R Netangaheni

Mobile Number: 076 189 5087 or email address:

Coordinator of the Health Sciences Ethics Committee from Department of Sociology: Prof Derik Gelderblom

Landline Number: 012 429 6486

gelded@unisa.ac.za

Thank you for taking time to read this information sheet and for participating in this study.

Thank you, Kea leboga.

Moganki Hendrick Lefoka

B: CONSENT TO PARTICIPATE IN THIS STUDY

I, _____ (participant name), confirm that I have been informed by the researcher, Mr. M.H Lefoka about nature, procedure, potential benefits and anticipated inconvenience of participation.

I have received, read (or had explained to me) and understood the study as explained in the information sheet. I have had sufficient opportunity to ask questions and am prepared to participate in the study. I understand that my participation is voluntary and that I am free to withdraw at any time without penalty.

I am aware that the findings of this study will be processed into a research report, journal publications and/or conference proceedings, but that my participation will be kept confidential unless otherwise specified.

I may, at any stage without prejudice, withdraw my consent and participation in this study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in this study

I have received a signed copy of the informed consent agreement.

Participant Name & Surname…… (Please print)

Participant Signature……Date……

Researcher's Name & Surname: …… (Please print)

Researcher's signature……..Date……

C: LETTER TO ORGANISATION(S)

Mr. M.H Lefoka

186 Block HH

Soshanguve

0152

Centre Manager

COSUP

Dear Sir/Madam

My name is Moganki Hendrick Lefoka. I have registered for MA (Social Behavioural Studies in HIV/AIDS), Department of Sociology, University of South Africa. I hereby cordially apply for permission to conduct my research at your organisation, which has been selected as a suitable research site as it meet both sampling profile and the research topics core variables in respect of nyaope injecting.

My research topic is titled, “Exploring the experiences of female nyaope injectors residing in the City of Tshwane Municipality”. The fieldwork aspect of my study entails the identification and selection of:

- 15 Female nyaope injectors
- 15 Female recovering nyaope injectors

The sampled of participants will participate in 45 minutes long face-to-face interview session at your centre/offices. The data collection instrumentation includes an audio recorder and an interview guide. All rights relating to research participants in the study will be thoroughly explained to the participants and strictly maintained by the researcher. I will also provide details of my academic supervisor for reporting of any unprofessional conduct on the part of the researcher.

All the findings will be formally documented, and preliminary report will be presented to you; after which a feedback session will be held with the research participants to

check whether or not the study results reflects their written or oral input. The researcher will provide one copy to your organisation for its institutional memory and appreciation of your client's involvement in this exegetic exercise.

Should you have any questions or concerns regarding the interview process and the study or if any problems arise from this study- please feel free to contact the researcher, Moganki Hendrick Lefoka at 078 820 7941, or email me 44043120@mylfe.unisa.ac.za.

Your response in the above regard is highly appreciated and any further clarification will be honestly responded to by the researcher.

Thanking you in anticipation.

Regards

Mr. Moganki Hendrick Lefoka

D: INTERVIEW GUIDE

D.1: FEMALES WHO ARE STILL INJECTING NYAOPE

BACKGROUND INFORMATION

This section of the interview guide refers to the background or biographical information will allow us to compare groups of participants.

Once again, you are assured that your response will remain anonymous. Your cooperation is appreciated. The researcher will spend plus / minus 45 minutes with the participant during the interview.

Gender……

Age…….

Ethnicity……

Duration using nyaope……..

INTERVIEW QUESTIONS

1. How did you start to use nyaope?

2. What influenced you to inject nyaope?

3. Who helped you inject the first time you injected

4. How did your family react after they discovered you are injecting nyaope?

5. How did your community treat you as a nyaope female injector?

6. How often did you visit community health centre/Clinic?

7. What are your experiences with the police?

8. Have you ever engaged in risky behaviour due to injecting nyaope practice?

9. What were your needs as a female who injects drugs?

10. What suggestion do you have about how HIV prevalence can be reduced amongst female nyaope injectors?

This is the end of the interview.

Thank you for participating in the study your time is highly appreciated

D.2 RECOVERING FEMALE NYAOPE INJECTORS

BACKGROUND INFORMATION

This section of the interview guide refers to the background or biographical information will allow us to compare groups of participants.

Once again, you are assured that your response will remain anonymous. Your cooperation is appreciated. The researcher will spend plus / minus 45 minutes with the participant during the interview.

Gender……

Age…….

Ethnicity……

Duration without using nyaope……..

INTERVIEW QUESTIONS

1. How did you start to use nyaope?

2. What influenced you to inject nyaope?

3. Who helped you inject the first time you injected

4. How did your family react after they discovered you are injecting nyaope?

5. How did your community treat you as a nyaope female injector?

6. How often did you visit community health centre/Clinic?

7. What are your experiences with the police?

8. Have you ever engaged in risky behaviour due to injecting nyaope practice?

9. What were your needs as a female who injects drugs?

10. What suggestion do you have about how HIV prevalence can be reduced amongst female nyaope injectors?

11. How is life without ejecting nyaope?

This is the end of the interview.

Thank you for participating in the study your time is highly appreciated

E: COSUP PERMISSION LETTER

Faculty of Health Sciences
Dept of Family Medicine
P O Box 667
Pretoria 0001
Republic of South Africa
Tel. 012-356 3298
Fax 354-1317

University of Pretoria

Dear Sir/Madam

RE: Permission letter to conduct research at COSUP sites

This letter serves to confirm that **Mr Moganki Hendrik Lefoka** has been given permission to conduct research on our COSUP sites, on the study topic titled: **Exploring the experiences of female nyaope injectors residing in City of Tshwane Municipality**

Thanking you in advance

Prof JFM Hugo
Head of Department
17 May 2019

F: ETHICAL CLEARANCE CERTIFICATE

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

NHREC Registration # : Rec-240816-052

CREC Reference # 2019-CHS - 0246

Student No : 44043120

Decision:
Ethics Approval from 01 April 2019 to 31 March 2022

Researcher(s): Moganki Hendrick Lefoka

Supervisor(s): Dr.T.R Netangaheni
Department Sociology
Email: robert.netangahe@gmail.com
Cell: 076 189 5087

Exploring the experiences of female nyaope injectors residing in City of Tshwane Municipality, Gauteng

Qualifications Applied: Masters

College of Human Science ethics committee hereby acknowledge your application for Research Ethics Certificate; approval is granted for three years on condition that the researcher should submit annual progress report.

The **Chair of College of Human Sciences Research Ethics Committee Reviewed the High Risk Application** on the **12 April 2019** in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.
The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.

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PO Box 392 UNISA 0003 South Africa
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www.unisa.ac.za

2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the Department of Psychology Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.
5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No field work activities may continue after the expiry date **(31 March 2022).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

The reference number **2019-CHS-0246** *should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature :

Dr Suryakanthie Chetty
Deputy Chair : CREC
E-mail: chetts@unisa.ac.za
Tel: (012) 429-6267

Signature :

Professor A Phillips
Executive Dean : CHS
E-mail: Phillap@unisa.ac.za
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G: EDITOR'S REPORT

To whom it may concern

Good Day

I have edited Mr Moganki Hendrick Lefoka's dissertation titled "Exploring the experiences of female nyaope injectors residing in the City of Tshwane Municipality, Gauteng".

I used the accepted language in South Africa, which is UK English (not US). While editing, attention to detail was paid and I looked for most of the standard things: grammar, sentence structure, punctuation, capitalisation, spelling, word choice, organisation and paragraphing. Additionally, I have checked it for relevant aspects of consistency in terms of style, format, redundancy and most importantly, clarity. This is a very well written document which meets all the requirements on the editors' checklist and can be published to the public.

Regards,

Editor: Praise Magidi

Qualification: BA Languages Degree

Obtained from: University of Pretoria (in 2012)

Years of experience: Five years

Praise Magidi 16/01/2020

H: TRANSCRIPT

Researcher: Thank you for agreeing to participate in this study, as I have indicated, this study is for my Masters. The information which will be collected here, will be kept confidential. For the purpose of record keeping, I will use your nickname.

Participant 1: Yes.

Researcher: Tell me Participant 1 how did you start to use Nyaope?

Participant 1: The very first time I tried Nyaope I did not know that it was Nyaope I came across some boys from where I come from back at home, they were smoking then I wanted to try what they were smoking, then I tried it. It passed a few months before I tried it again, when I saw them after then I was hooked I think for some months then I quite then again around 2017 December I saw my ex-boyfriend he wanted me to give him money because I had money at that time, because I knew what he was smoking and I knew what he wanted to use the money for, when he asked for R20 I asked him what he wants the money for, but I was asking while knowing then I just said let us go and smoke actually I was bored, you see?

Researcher: Yes.

Participant 1: Then we went and smoked.

Researcher: You said you started using with some boys from home?

Participant 1: Yes.

Researcher: What was your relationship with those boys?

Participant 1: Actually there was no relationship it was just people I know around.

Researcher: Awesome, were you smoking something before you smoked Nyaope, what were you smoking?

Participant 1: I used to smoke cigarette and weed but by the time I was, let me say, before I smoked Nyaope I had already quite smoking weed I was smoking cigarette.

Researcher: Cigarette only?

Participant 1: Yes.

Researcher: Ok, when did you start smoking Nyaope because here you said 2017 December?

Participant 1: Yes, I smoked for the very first time…

Researcher: When was that?

Participant 1: 2012.

Researcher: 2012.

Participant 1: Yes.

Researcher: And for how long?

Participant 1: Maybe for a couple of months then I quit, then I relapsed again in 2017 until now.

Researcher: So you, 2012 you started using…

Participant 1: Then I stopped in the same year.

Researcher: Same year, then you started using again in 2017 up until now?

Participant 1: Yes.

Researcher: Ok, so with injecting when did you start to inject?

Participant 1: I think it was around January last year.

Researcher: January 2018?

Participant 1: Yes.

Researcher: What influenced you to inject?

Participant 1: My boyfriend because sometimes when we do not have money, he was injecting and I was not

Researcher: Not injecting, hmm.

Participant 1: … this other time he said let me allow you to try, because mostly he would say that but I would refuse but on that day because we only had one bag, then he mixed then that is how I started.

Researcher: So you used his injection?

Participant 1: No he had …

Researcher: Clean!

Participant 1: … it was my own because at that time I thought it was a matter of concern to use your own, like I did not know I hadn't really known much about the whole injection thing, I thought maybe it is a matter of safety because I thought everyone uses their own injection like they do in clinics use it once then throw it away it is only then that I have learnt that you can reuse the injection.

Researcher: Ok, so you used a clean needle the first time you injected?

Participant 1: Yes.

Researcher: Where did you get that needle?

Participant 1: He bought them, he used to go to town to buy rock when he goes to town he would buy injections.

Researcher: In your life since you started to inject have you shared any needle before?

Participant 1: Yes I have shared a needle.

Researcher: Whom did you share with?

Participant 1: My Boyfriend.

Researcher: You shared with your boyfriend, how many times roughly if you could recall?

Participant 1: I think 5 times.

Researcher: So many times?

Participant 1: Yes.

Researcher: When was the last time you shared?

Participant 1: A few weeks back when I was back at home, I think two weeks back.

Researcher: When you were back home, what contributed for you to share when you were back at home?

Participant 1: He did not have an injection, actually we had but it blocked, so he asked if he can use mine.

Researcher: accessibility was the issue there, at which you did not have access to clean needles that is why he used yours?

Participant 1: Yes.

Researcher: Ok, by the time you started to share needles with him did you think of contracting the like of HIV and Hepatitis?

Participant 1: Actually to be honest with him because he is my boyfriend and I used to sleep with him I did not see the need.

Researcher: As a need, what you are saying is that you have never shared with someone outside your relationships.

Participant 1: Yes, only my boyfriend.

Researcher: Only your boyfriend, the first time you injected who helped you to inject?

Participant 1: He injected me.

Researcher: He injected you?

Participant 1: Yes.

Researcher: How comfortable were you?

Participant 1: (Laughing) from the scale of 1-10 I was uncomfortable at all because eish you know when you are not used to needles it is uncomfortable but as you go along …

Researcher: You get used to it?

Participant 1: Yes.

Researcher: But now, the first time you injected what made you not to turn back and say ‘no let us not inject’?

Participant 1: Actually after he injected me the feeling I felt it was quite pleasant that is what made me to even continue.

Researcher: To continue, how do you raise money to buy drugs?

Participant 1: That is a struggle.

Researcher: Struggle, how do you struggle/hustle?

Participant 1: Eish you know back at home I used to steal from my parents when I was back at home, my boyfriend mostly is the one who would try but before I could afford it because I was in school and I had allowance. My parents would give me money so I could afford it until I stopped school that is when things became much tougher…

Researcher: Much tough yes.

Participant 1:… I was mostly dependent on him he used to be the one who provided most if he does not have I would have to go out and make a plan, if I go home I would beg and if I do not get anything I would steal sometimes I would, eish there were even times when I had to sleep with someone for money.

Researcher: For money. Ok currently you are dating, are you seeing someone currently?

Participant 1: Yes.

Researcher: How is your relationship with him, or how many boyfriends do you have?

Participant 1: I have one.

Researcher: You have one boyfriend, how is the relationship with him?

Participant 1: It is fine besides the drugs we fight a lot about drugs.

Researcher: What do you fight about?

Participant 1: Sometimes he would rob me like even though we are both feeling the same way he would be selfish then he would take more then give me less, make me take water just dilute water, those are the things we fight mostly about.

Researcher: What do you love about your relationship with him?

Participant 1: I can be myself around him.

Researcher: And what do not you like in your relationship with him?

Participant 1: I hate that we both smoking.

Researcher: That you are both smoking, and what else?

Participant 1: I can say that he is a bad influence but love him

Researcher: He is a bad influence how, because of drugs?

Participant 1: Yes and he can tell me sometimes, he would push me and say ‘baby go home go ask your mother’ you see?

Researcher: Yes.

Participant 1: sometimes he would tell me go and steal at your home your mother has a lot of money, such things.

Researcher: And you do not like things like those?

Participant 1: Yes.

Researcher: And what else do not you like about your relationship?

Participant 1: (Laughing) the fact that sometimes I have to lie about where I got the money if I have money I lie.

Researcher: You lie to whom?

Participant 1: To him, if I did not get it in a way I know is comfortable.

Researcher: Like engaging in sex work and stuff?

Participant 1: Yes if I slept with someone in exchange for money.

Researcher: You are not comfortable to discuss, he is not aware that at times you have to sleep with people to make money.

Participant 1: No he is not.

Researcher: Ok, have he expressed himself about how he would feel if it happens?

Participant 1: Yoh, a lot of times, because he used to tell me like he used to say I mustn't be like maybe So and So, because they sleep with people for money. People can know that I am doing that they will look down on him and me also, he would say things like that, when he said that it hurts because I know like, eish it feels like bad you know?

Researcher: Hmm (nodding), so initially you said you do not usually you were comfortable using the same needle with your boyfriend because you sleep with him?

Participant 1: Yes.

Researcher: have you discussed the issue of condom use with your boyfriend?

Participant 1: Not really, like in the first early stage of our relationship I used to ask him for protection and he was from jail so I did not know, but as time went on …

Researcher: What changed because initially you asking what changed that?

Participant 1: To be honest I do not know, I guess we got too comfortable.

Researcher: With each other?

Participant 1: Yes.

Researcher: But how comfortable are you to discuss condom use with him?

Participant 1: Actually I wouldn't be scared maybe if I were to tell him about condoms maybe he would think that I am cheating.

Researcher: He would think you are cheating?

Participant 1: Yes, but I would not be uncomfortable.

Researcher: How did your family react when they discovered that you are injecting?

Participant 1: Eish they did not like it especially my mother, she was really angry, they were pissed off I think.

Researcher: Ok, they knew that you were using Nyaope?

Participant 1: Yes.

Researcher: But after transitioning from smoking Nyaope to injecting, how did they look or how did the reaction change towards you?

Participant 1: Actually my mom when she discovered that I am injecting and I lied to her, I was telling her that I am trying to quite but to think at that same period I was, I had recently told her she has discovered the needles, she expressed a lot of concerns, that it means you cannot stop because you are even worse than before.

Researcher: What about your community, how did they react when they learnt that you are injecting?

Participant 1: The community to be honest once they know you start to smoke Nyaope, injection or not they start to look down upon you. They do not take you as a person anymore to them you are just a thing.

Researcher: Just a thing! How did that make you feel?

Participant 1: Bad but what could I have done? I was already in that situation.

Researcher: When was the last time you visited a health care clinic?

Participant 1: Around March if I am not mistaken.

Researcher: What were you doing there?

Participant 1: I took my baby for clinic then when I was there I just, because my boyfriend had borrowed someone the injection, so I was concerned. I wanted to check HIV.

Researcher: Have you ever, do you have any history of abscess?

Participant 1: What is abscess?

Researcher: When you miss and then you get swollen….

Participant 1: Oh yes

Researcher: How many times did it happen?

Participant 1: Twice I think.

Researcher: Twice,

Participant 1: But before even if I missed I did not become swollen but when I put pressure on it that is when it becomes… it has been twice.

Researcher: Ok, let us talk about this twice. It happened the first time, how did you deal with it?

Participant 1: I can say self-medication.

Researcher: Self-medication, so what made you not to go to clinic?

Participant 1: I was embarrassed.

Researcher: You were embarrassed?

Participant 1: Yes.

Researcher: Ok, the second time?

Participant 1: Still I did not go to clinic.

Researcher: You self-serviced yourself?

Participant 1: Yes.

Researcher: Ok.

Participant 1: I just let it heal.

Researcher: Just to ask, as a woman, are you on any prevention method?

Participant 1: Currently no.

Researcher: How would you make sure you do not get pregnant because as you were saying you do not use condom with your boyfriend?

Participant 1: When I know my weeks like this week I am ovulating, I do not sleep with him.

Researcher: You do not sleep with him? Ok.

Participant 1: and you know normally my boyfriend and I since we both into Nyaope, sex is not a priority.

Researcher: Is not a priority?

Participant 1: We only have sex sometimes.

Researcher: Sometimes?

Participant 1: Yes.

Researcher: So what is your experience with the police?

Participant 1: The?

Researcher: The police, your experience with the police, have you ever had any encounter with them?

Participant 1: No, but from what I have seen they used to arrest people with a needles.

Researcher: So they will arrest you if you if they find you with a needle?

Participant 1: As far as I know for drugs, but I have never been in that situation or arrested.

Researcher: Have you engaged any activity, risky activity or behaviour due to injecting, due to the need to use drugs?

Participant 1: Not that I can remember but I can say when I use my injection because I do not know who else injected with my injections

Researcher: But now have you engaged in any risky behaviour due to drugs?

Participant 1: Yes.

Researcher: What were those risky behaviours?

Participant 1: Like sleeping with someone, especially when you sleep with someone you do not have a relationship with and you do not know that person, maybe they can kill you or what that is mine.

Researcher: Sleeping with someone and what else?

Participant 1: Stealing.

Researcher: Stealing from the family or from community members?

Participant 1: From family and the community, but I myself I do not steal around, I only steal at home because I am a girl, I cannot even jump but from what I have seen around people can go and steal from someone and they can be beaten by the community.

Researcher: So, when you said that at times you sleep with people for money, how does that happen, where do you get those people and how do they approach you?

Participant 1: Actually the very first guy I slept with it was someone I know you see? Someone I know from the community.

Researcher: Ok, hmm.

Participant 1: He saw that I was not fine, I was shaking so I went by the shops to buy cigarette because I did not have money to buy the (Nyaope), he said you are not fine you look sick, he knows (that I am smoking) because they used to see, then he said escort me I want to take something in my room then we will come back then I said if you can give me at least R20.00 I will escort you. He then said let us go I will give you, when we got there he said I will give you R100. If you sleep with me and at that time I was desperate so I took it then I slept with him.

Researcher: Did sex with that guy happen once or he came for more?

Participant 1: Yes, he did but then it got annoying because I resented myself afterwards, but then I still did it again I think around three times but the last time I got so aggressive I started insulting him because when I think about it, it just eish (silent). Then the other guy actually this one is an older person so, he is also from around he used to propose to me. The first time I met him he proposed me I just saw an

opportunity that this person will give me money, he used to give me R200.00 every time I see him, when I ask him he would always give me. This other time he said I must come to his place but then I did not know he was staying then he directed me and I was scared because I know his children and his wife but he called me to another place that is when we slept.

Researcher: So now as a woman who inject drugs, what are your needs?

Participant 1: My needs?

Researcher: Yes.

Participant 1: Ok, I to have access to drugs.

Researcher: To have access to drugs!

Participant 1: Or maybe the cheaper price we can buy them for R10.00 it would be better and to have access to needles but at this stage I am trying to quite I want to go to rehab.

Researcher: You are saying if like those are your needs too, but because you want to quit rehab is also on the list.

Participant 1: Yes because right now I am currently within that process that is why I came here, but let us say I was not in the process of wanting to quite I would really want to have access to drugs, access to clean needles and stigma of being seen as Nyaope and for people to respect us.

Researcher: For people to respect you?

Participant 1: Yes.

Researcher: Now I need you to help me with suggestions, if it was CAP HIV incidents or cases amongst woman who use drugs, what do we need to do?

Participant 1: Can you please repeat the question.

Researcher: If we must CAP the HIV incidents. If we must stop new cases of HIV incidents on females who use drugs or woman who inject drugs basically what do we need to do?

Participant 1: Actually to prevent the spread of HIV I would suggest maybe giving them needles.

Researcher: Giving them needles and what else?

Participant 1: … to use on their own because some the ones I have here around Pretoria they are sex workers encourage them to use protection at all times and but obviously you cannot give them drugs but I would suggest if it was possible to make it possible for them to have drugs at least like two dose a day, morning and in the night just to sleep.

Researcher: in the absence of any questions I would like to thank you for giving me this opportunity to have an interview with you, like I promised this information will remain as confidential as possible and your name will not be used on any document but for record keeping and administration we will stick to your nickname which is Participant 1.

Participant 1: Yes.

Researcher: Miss Participant 1 thank you again for providing me with this opportunity thank you.

Participant 1: Thank you