

HARM REDUCTION FOR WOMEN IN PRISON



This briefing draws on focus groups and interviews held with women in Durban, South Africa and Barcelona, Spain, and seeks to paint a picture of the barriers women face when accessing harm reduction services in prisons.



Punitive drug policies disproportionately impact women, and drug use and drug offences are a significant contributor to the incarceration of women around the world. In fact, a higher proportion of women than men are imprisoned for drug-related offences.

When women who use drugs are detained, their access to harm reduction services is severely lacking.

The publication of this briefing would not have been possible without the contributions of Angela McBride, Julie McDonnell and Shaun Shelly of the South African Network of People who Use Drugs (SANPUD), and Aura Roig, Joana Canedo, Monica Marginet and Adelaida Lopez of Metzineres. Harm Reduction International would also like to thank all the women who participated in our focus groups and interviews. The cover photograph is credited to SANPUD and all other photographs are attributed to photographers Lorena Ros and Ana Agraz.

| HARM REDUCTION FOR WOMEN IN PRISONS |

Worldwide, only 54 countries provide opioid agonist therapy (OAT) in any prison, and only ten provide needle and syringe programmes (NSP) in any prison.[1] Article 12 of the International Covenant on Economic, Social and Cultural Rights requires states to ensure that all prisoners have access to adequate health services. The United Nations' "Nelson Mandela Rules" on the treatment of prisoners require states to provide equivalent health services in prisons as are available outside. States that do not provide harm reduction services in prisons are in breach of their international obligations.

An estimated 93% of prisoners worldwide are men.[i] Because of this, the needs of female prisoners are commonly marginalised and deprioritised. For example, in Canada, OAT is reportedly implemented to a lesser extent in women's prisons.[ii]

**"Women are made invisible, with the excuse that there are fewer of them – only 4% of the prison population. So, their needs are ignored."
[Former female prisoner, Barcelona, Spain]**



[1] Stone, K. & Shirley-Beavan, S., 2018. The Global State of Harm Reduction 2018. London: Harm Reduction International

Both inside and outside prisons, harm reduction services for women are frequently inadequate. Evidence from around the world demonstrates that women who use drugs are subjected to far greater stigma than their male peers. This impacts their willingness and ability to access harm reduction and other health care services. The intersectional impact of being a woman, a person who uses drugs and being in prison makes the stigmatisation even more acute.

Criminalisation of people who use drugs also has a particularly severe impact on women. Women who use drugs consistently report facing harassment, physical and sexual violence, and invasive searches from law enforcement officers. The highly controlled environment inside prisons can exacerbate this.

Health Services in South African prisons

In South Africa no harm reduction services are available in places of detention. There are 22 prisons in South Africa that provide space for women, housing more than 4,000 women.[2]

While in most cases data on occupancy rates is unavailable, the prison system as a whole is estimated to run at 138% of its capacity, and women's prisons are thought to be significantly more overcrowded.[3] Women in prisons in South Africa have no access to OAT and other harm reduction commodities.

For women who use opioids, the failure of the state to provide OAT in places of detention can lead to women experiencing withdrawal symptoms, known as "arosto" in South Africa. The Special Rapporteur on torture found that the denial of OAT to a person experiencing withdrawal symptoms can amount to inhuman and degrading treatment, or even torture.[iii] One former female prisoner reported 'You must suffer. You face the pain until the arosto is out. Some of the girls kill themselves from the pain.'

Another woman interviewed indicated 'One of the girls hung herself from the pains and no one came. No one would help her. No methadone. They should have methadone or anything to help with the pain. It would save a lot of lives.' Even access to more basic health services is limited. This is particularly true for women who use drugs, who are stigmatised and dehumanised, referred to by prison staff as "paras" (parasites).

'In prison, you have to beg, beg, beg for help or medication. Especially if you are a para. They don't want to help or care.'
[Former female prisoner, Durban, South Africa]

The risks can be also acute in police detention, where the limited prison health services do not reach. "When I was arrested for three days, they didn't care. I told them I need my [tuberculosis] meds or I will default, but they didn't care."

[2] Hopkins, R., 2017. 'This is what life in prison is really like for women in South Africa' Wits Justice Project. Johannesburg: University of the Witwatersrand.

[3] Walmsley, R., 2017. World Female Imprisonment List (4th edition). London: World Prison Brief; Walmsley, R., 2018. World Prison Population List (12th edition). London: World Prison Brief

Opioid Agonist Therapy

The women we spoke to reported fewer barriers to accessing OAT programmes in prison compared to NSPs. Some observed that their experiences in prison were largely similar to those outside. However, severe problems arose around punishments and expulsions from the programme. Women reported that there were often mistakes that led to people being provided incorrect doses of OAT medication (most commonly methadone), and that in these cases methadone was traded among prisoners. One woman described being caught taking someone else's dose in addition to her own.

'After, they caught me taking it, they threw me off the programme for 21 days, no matter what my dose was. I wanted to die, because sometimes you can get heroin [in prison] but sometimes you can't. When they threw me off, I couldn't. It was bad, bad withdrawal. You go around the yard looking for pills, you don't care what, some people might give you some methadone. But 21 days off the programme? No.'

Punitively withholding OAT is inhumane and degrading punishment. The European Court of Human Rights has ruled that withholding this essential medicine in places of detention can constitute torture.[6]

Key UN guidance indicates harm reduction interventions, including NSP, OAT and treatment for HIV, tuberculosis (TB) and hepatitis, should be available without interruption within all parts of the criminal justice system; and emphasises that the use of illegal drugs while on OAT should never be a reason for excluding a client from the programme. [7]

[6] ECHR, 2016. Domestic Authorities Failed to Thoroughly Examine Which Therapy was Appropriate for Long-term Drug Addict in Detention. Strasbourg: European Court of Human Rights.

Dehumanisation and Punitive Attitudes

In both South Africa and Spain, women reported being humiliated, dehumanised and subjected to excessive punishments in prison because of their drug use. Invasive searches are one means by which women are subjected to dehumanising and humiliating treatment. In one prison in Barcelona, "they had a mobile toilet. If you had swallowed something and it came up on the x-ray, they handcuffed you, gave you laxatives and you had to shit in front of the guards.'

Women reported similarly invasive and degrading treatment in South Africa. 'They search you properly, they search your [vagina] even. They make us all stand in a line and bend over. Then they check. They make you bounce up and down like a frog to check nothing is inside. If you have something hidden in there they will pull it out. Everyone can see. There is no privacy.'

By using such extremely humiliating and punitive measures against women who use or transport drugs in this way, prison staff drive women into more hidden spaces and more out of sight practices. They push them away from the formal health and harm reduction services (where they are available). As a result, they increase the harms of drug use and exacerbate the distrust between people who use drugs and prison authorities.

In Barcelona, women reported concern that doctors were overprescribing antipsychotics, benzodiazepines and even OAT. "When I went in, they kept giving me methadone. They are pretty happy to give it to you – there's brutal overmedication. The doctor is indiscriminate."

Women also describe a "culture in the yard" where women would share knowledge of how to acquire prescription drugs from the prison health staff. 'It was "Yeah, ask for this, or "here's what you have to say to get that."'

[7] 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 Organization, United States Agency for International Development. Implementing comprehensive HIV and HCV programmes with people who inject drugs: practical guidance for collaborative interventions. Vienna: United Nations Office on Drugs and Crime; 2017

Women felt they, as women who use drugs, were being medicated so that they presented less of a challenge for the prison staff. 'They want you to be doped as much as possible. I remember they gave me Sinogan, and I couldn't even move. The guard came, and I couldn't even get out of bed. Better for them that way. They cancel you as a person and that's it.'

There are a significant number of overdoses deaths but no access to information of how to prevent it or what to do when it occurs. Naloxone is not available for inmates. Over medication was related to a high number of overdoses and a significant number of deaths. "There was one time when five women died because of overdose, they had mixed heroin with their medication."

"In some cases, guards reversed the heroin overdoses, but because heroin is not allowed in prison, after saving the person, she is sanctioned with penalties."

Recommendations

These recommendations were developed following consultation with women who use drugs, and are derivative of existing standards.

- **Women in prison must have access to adequate health services.**

The International Covenant on Economic, Social and Cultural Rights is clear that access to the highest attainable standard of health care is a human right. This applies equally to those in prison, and the United Nations' Nelson Mandela Rules require states to provide people in place of detention with the same standard of care that is available outside.

- **States must explore alternatives to incarceration for women convicted of low-level drug offences.**

By criminalising women who use drugs, states are prioritising incarceration over health and wellbeing. Decriminalising drug use would reduce the stigma faced by people who use drugs, reduce barriers to access health and harm reduction services, and be a more cost-effective way approach to drug use. It is recommended by the United Nations and the World Health Organisation.[v]

- **Opioid agonist therapy must be available inside prisons.**

Opioid agonist therapy saves lives. Not only can it assist with the symptoms of opioid withdrawal, but it is also an effective means of preventing blood-borne disease transmission. Not providing opioid agonist therapy in prisons is violation of states' human rights obligations.

- **Prison staff must engage positively to enable prison with NSPs to be effective.**

Prison authorities must work to understand the benefits of NSPs as an essential health service, and must adapt their practices to maximise the benefits of these programmes. In particular, possession of injecting equipment must not be used as a reason to target prisoners for invasive searches or punishment.

- **Services (both in the community and in prison) must be humane, accessible and non-stigmatising.**

The common factor when women described improvements to services, or the positive aspects of harm reduction services in and outside prison was humanity, compassion and personal connections. Women commonly referred to their experiences of harm reduction services outside prisons that are holistic and do not medicalise or pathologise their experiences.

Endnotes

[i] Walmsley, R., 2018. *World Female Imprisonment List*. London: World Prison Brief

[ii] van der Meulen, E., de Shalit, A. & Ka Hon Chu, S., 2017. 'A legacy of harm: Punitive drug policies and women's carceral experiences in Canada.' *Women and Criminal Justice*, 28 (2).

[iii] Human Rights Council. Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez (1 February 2013), para. 54. UN Doc A/HRC/22/53; Human Rights Committee. Concluding observations on the seventh periodic report of the Russian Federation (28 April 2015), para. 16. UN Doc. CCPR/C/RUS/CO/7

[iv] *The other is Armenia*. Source: Stone, K. & Shirley-Beavan, S., 2018. *The Global State of Harm Reduction 2018*. London: Harm Reduction International.

[v] UN Common Position
<https://www.unsceb.org/CEBPublicFiles/CEB-2018-2-SoD.pdf> United Nations, 2019.