Safe treatment and treatment of safety: call for a harm-reduction approach to drug-use disorders in South Africa

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The complex political, structural and socio-economic factors that influence drug use and corresponding responses have contributed to the increasing drug-related burden of disease in South Africa. As a result, the country's healthcare system is called on to manage the consequences of a public-health problem that has no 'good solutions'.

Internationally, regulation of drug use has largely relied on the criminal-justice system and the view that people who use drugs are 'the problem', deserving of punishment or 'rehabilitation'. Over the past 30 years, a number of well-resourced democratic governments have acknowledged the failure of such methods. This has resulted in a more medicalised approach to dealing with drug use, one that views habitual drug use as a chronic disease in need of treatment. Some recent South African policy documents have called for such an approach. In practice, however, enforcement and punishment remain the dominant response, with the country only paying lip service to the provision of harm-reduction programmes. In addition, little attention has been given to the socio-economic context that encompasses and contributes to drug use, this despite evidence that the existing policy and practice framework has created greater harms than public good (particularly with regard to public health), that it is ineffective in a context hamstrung by poor governance more generally, and that it does not improve public safety.

Walt and Gilson's Health Policy Triangle framework – which examines context, content, process and actors – was used to examine how existing governance approaches in South Africa have structured and continue to influence the current 'drug (policy) problem', and to provide recommendations for a harm-reduction approach. While acknowledging the implementation barriers, we demonstrate how this approach has the greatest potential to increase service access while maximising equity and quality along the continuum from prevention to the resolution of substance-use disorders.

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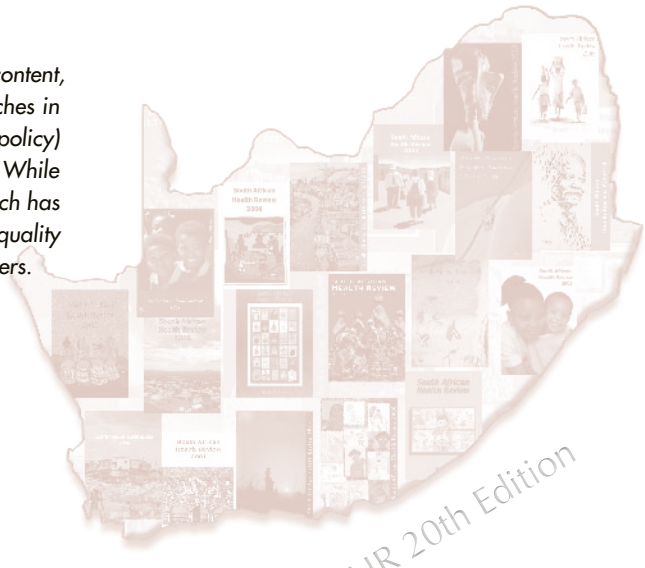

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Introduction

This chapter provides an analytical discussion on the effectiveness of South African drug policy and legislation in relation to health, social and safety outcomes. Drawing on Walt and Gilson's Health Policy Triangle framework,[1] a contextual overview is provided through examination of the following: policy-making, notably international approaches to drug use, political structures, departmental mandates, and the results of current policy on a vulnerable sector of society; the content of key drug-use policies, notably the National Drug Master Plan (NDMP); the actors involved, particularly the members of the Central Drug Authority (CDA); and the processes of policy development.

We argue that current approaches frame the use of drugs as a problem of the individual, without adequate consideration of the social and political context (the assumptions and definitions used in this chapter are presented in Box 1). This reinforces and intensifies social disruption and marginalisation and disallows effective responses. We further suggest that the dominant enforcement approach used to punish individuals who use drugs does not align with human-rights principles, and that it contributes to potential harms related to drugs and adds to the burden of disease.[2] We argue that a radical alternative to dealing with drug use is required in South Africa, and that this should run across all legislation, allowing for proper flow into programmatic responses. We believe that a comprehensive shift to a harm-reduction approach is an appropriate route to achieve health equity and improved safety while protecting individual and collective rights.[3]

Box 1: Definitions and assumptions

The terms and concepts used in this chapter are subject to intense debate and a variety of interpretations. The World Health Organization's (WHO) lexicon of definitions relating to drugs and alcohol does not provide a clear distinction between a medicine and a drug, but rather notes that the term 'drug' is used differently in medicine and in common parlance.[4] For the purposes of this chapter, we define drugs as substances taken for their psychoactive effects, often illegally.[5] In so doing, we acknowledge that the classification of some substances as legal and others as illegal is a function of economic interests, racial and cultural bias, social acceptability and medical use.[6]

Various terms exist to describe different drug-use patterns:

- *Drug dependence* refers to regular use of a drug to the extent that rapid cessation results in clinical withdrawal signs.[7]
- A *substance-use disorder* is defined in terms of the criteria set by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*.[7]
- *Drug addiction* is overwhelming involvement with drugs that is harmful to the individual, society or both.[8]

We do not assume that drug use inevitably has negative physical, psychological, or behavioural consequences. A very small percentage of people (6%) who ever use a drug become 'addicted' (20% among heroin users);[9] almost all substance-use disorders resolve; and over two-thirds of people will recover without any specific intervention.[10] Consequently, we work on the understanding that the consequences of drug use must be understood in relation to the frequency, amount, and manner of use, which are shaped by the context.

The International Harm Reduction Association defines harm reduction as "polices, programmes and practice that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption".[11] We suggest that harm reduction should also address the issues of current policy and the criminalisation of drug use, which contribute significantly to the harms related to the consumption of illicit drugs.

Methods

Data were obtained through a review of online sources, reference lists and the authors' knowledge of the literature. There is little published literature on how drug policy shapes health outcomes in South Africa. We therefore draw on reports and dissertations and make international comparisons where needed. Discussion between the authors, who are experienced in public health and infectious diseases, drug policy and addiction, anthropology, sociology and criminology, refined the analysis and informed the recommendations.

Findings

Understanding legislation and policy in South Africa requires that we not only examine the content of policies, but also the local context (and its political and historical underpinnings), the process of policy development, and the actors influential in this. This section examines these elements individually, while recognising that they should be understood in relation to each other. Thereafter, a discussion is presented on harm reduction as a means of alleviating some of the problems engendered by current policy approaches to drug use.

Context

International policy and approaches

Three international Conventions guide the approach to drugs: the Single Convention on Narcotic Drugs (1961),[12] the Convention on Psychotropic Substances (1971),[13] and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).[14] United Nations Member States are obliged to abide by the Conventions, and as such, the Conventions exert indirect control over the drug-control policies of most nations. As reflected in the language used, the Conventions were developed in a particular context and at a particular time. Nations are obliged to "prevent and combat" the "serious evil" of "drug addiction". This terminology has not been changed and it is therefore perhaps not surprising that the end of the 20th century was dominated by America's "war on drugs". Announced by President Nixon in 1971, this approach was based on moral discourses of drug use and trade as deviant and in need of eradication. It consequently focused on supply reduction and harsh punishment of people involved in drug trade and use, pitting the State against people who use drugs by extending the powers of the former and punishing the latter.

The supremacy of this moralistic approach started to face concerted challenges in the late 1990s as drug use came increasingly to be framed as a "chronic, relapsing disease of the brain".[15] This framing was proposed as a means to reduce stigma and improve clinical outcomes.[15] However, critics argue that the 'disease model' may increase stigma and has negatively impacted treatment outcomes through the focus on abstinence-based treatment,[16] arguably the only alternative to incarceration that sits comfortably within the framework of the Conventions.

The emerging HIV epidemic, and recognition that HIV is transmitted (inter alia) through injecting illicit drugs with contaminated needles due to restricted availability of sterile needles and syringes, led to wider acceptance of the harm-reduction approach. Harm reduction offers a non-judgemental response to drug use and a public-health alternative to the moral/criminal and disease models.[3] The

fundamental rights of people who use drugs is at the core of harm reduction, and this approach does account for social context.[3]

South African context

South Africa is a signatory to the three international Conventions on drug use. Approaches to drug use have also been greatly influenced by local political leadership. In apartheid South Africa, drug use was of concern to the State, particularly the effects it had on the governability of oppressed populations. In the transition to democracy, a more human rights-focused approach dominated all aspects of governance, including health and safety. This gave new impetus to public policy that responded to the needs of all citizens,[17] while aligning with global normative standards.[18] However, supported by the tone of the Conventions, local drug-use legislation and policy continues to view drug use as an 'evil', individualising the causes of and responses to it in ways that negatively impact the poor and marginalised and limit the realisation of their rights.[19]

The end of apartheid also led to the opening of borders and dismantling of specialised drugs units, which contributed to increased drug traffic through South Africa and the availability of heroin, cocaine and methamphetamine.[20] The relative cost of drugs has decreased – once inflation is accounted for, the price of heroin halved between 2004 and 2014.[21] As elsewhere, increasing socio-economic disparities and declining labour-market access have made the production and distribution of drugs economically attractive.[22] South Africa's inclusion in the global drug trade[23,24] has not been disrupted by law-enforcement strategies.[25] Legislative changes to the search and seizure powers of the police have changed operational practices, but have not had a notable impact on the availability of drugs on the street.

Epidemiology of drug use

There are limited data on the prevalence of drug use in South Africa. A nationally representative household survey estimated the lifetime prevalence of developing drug abuse at 4% and of developing drug dependence at 1%.[a,26] The South African Community Epidemiology Network on Drug Use provides self-reported surveillance data from drug-use disorder treatment centres across the country. These data are affected by selection bias, as financial and geographical barriers limit access.[27] However, the data provide insight into drug-use trends over time. Between January and June 2016, 10 540 patients were reported at 82 centres. Cannabis and alcohol were the most common primary substances of use, accounting for 33% and 26% of admissions, respectively. Other substances included heroin, also known on the streets as 'whoonga', 'nyaope' and 'pinch' (12%), methamphetamine also known as 'tik' (5%), methaqualone, also known as 'mandrax' or 'buttons' (5%), and cocaine, including 'crack' (4%).[28]

The health and social system

The Department of Social Development (DSD) oversees and implements prevention and treatment programmes for substance-use disorders, while the National Department of Health (NDoH) manages acute consequences, emergencies and psychiatric conditions as per their legislative mandate (discussed later).

The screening and treatment of substance-use disorders has not been a health priority, with few hours of instruction included in undergraduate medical training. Specialised postgraduate courses have only recently been introduced.[29] Few medical doctors screen for and have been trained in screening for substance use.[30] While the usefulness of maintenance therapies has been recognised, Stikland Hospital has the only State-funded medication-assisted withdrawal programme.[31] Despite international and national evidence pointing to the ineffectiveness of a strong law-enforcement approach, the Departments of Health and Social Development continue to receive fewer funds than South African law-enforcement bodies to manage the 'drug-use problem'.[32]

Drug-related harms

HIV prevalence is estimated to be 14% among people who inject drugs in three of South Africa's largest cities,[33] while hepatitis C prevalence is estimated at 65% in Pretoria.[b] The prevalence of tuberculosis among people who use drugs is unknown; however, substance use is an important risk factor.[34] Drug use is also directly and indirectly associated with violence[22] and crime.[35] Stimulant use is associated with high-risk sexual practices[36] and the intersection with the sex industry is described.[33,37]

These physical and behavioural consequences of drug use must be considered in the light of the effects of criminalisation and stigmatising approaches on people who use drugs, particularly by the media and state institutions.[38] Harms include:

- Exclusion from the formal economy: This applies particularly to males from poor communities who are arrested for drug possession. Criminal records limit entry to the formal economy and push people towards illicit activities and gangs.[39]
- Increased morbidity and mortality from communicable diseases: Viral hepatitis among people who inject drugs in Pretoria increased from 24% in 2012 to 65% in 2014.[b] This is linked to limited access to sterile injecting equipment and opioid substitution therapy.[2] In the case of tuberculosis, recent data at DP Marais Tuberculosis Hospital in Cape Town show that a quarter of those admitted had a recent history of methaqualone, heroin and/or methamphetamine use and over 90% of people leaving the hospital against medical advice used substances (including alcohol).[40]
- Inadequate service provision: Stigmatisation and fear of criminalisation have led to avoidance of health and social services.[41] This problem is amplified by harassment, and even arrest, of non-government actors attempting to close service gaps.[42]

Content

In South Africa, drugs are principally defined and legislated through three Acts, which draw on the international Conventions. The Medicine and Related Substance Act (101 of 1965)[43] defines the scheduling of drugs, thereby indicating legal and illegal use of substances. The Drugs and Drugs Trafficking Act (140 of 1992)[44] further defines illegal acts relating to substances, and covers penalties for drug use or possession and law-enforcement roles and processes. It is notably reactive, punitive, and prohibitionist.[45] The

a The terms 'abuse' and 'dependence' are the terminology used in the DSM-IV when the study was published. 'Dependence' was considered more severe than 'abuse' and was specified as 'with or without physiologic dependence'.

b Personal Communication: V Hechter, Sediba Hope Medical Centre Executive Officer, 10 February 2016.

result is lengthy sentencing (as much as 25 years for production); a focus on arrest rates to measure police performance; and the reinforcement of police actions that may be ineffective, divisive, or predatory.[46] The Prevention of and Treatment for Substance Abuse Act (70 of 2008)[45] outlines the broader social and legislative response to substance use with emphasis on the responsibilities of the DSD. Responsibilities include the development and oversight of the CDA, which in turn is required to oversee the implementation and evaluation of the NDMP.[47]

The third and current NDMP (2013–2017) describes itself as a "holistic approach" to drug regulation, treatment and prevention.[47] It introduces a local definition of harm reduction, namely "limiting or ameliorating the damage caused to individuals or communities who have already succumbed to the temptation of substance abuse", and claims that the international definition condones drug use.[47] It also indicates growing concern with human rights. Yet, scant attention is paid to how harms might be reduced in practice or what social problems should be resolved.

Public-health and public-safety interests should align with and reinforce one another because the problems they seek to address frequently have similar causes. However, in the NDMP, the overarching concern remains the eradication of drug use, with abstinence as the ultimate treatment goal. This implies that individual drug users are the problem, rather than the context they exist within, and it reinforces the continuation of a prohibitionist criminal-justice approach.[18]

Actors

The CDA comprises 18 national government departments, three other government bodies and 13 drug experts. It reports to the Inter-Ministerial Committee on Substance Abuse and is informed by Provincial Substance Abuse Forums that in turn are informed by and support Local Drug Action Committees. Despite this, the CDA has limited power, a negligible budget and little oversight capacity.[48] Civil-society engagement in the drug-policy process has largely been limited to abstinence-informed treatment providers, and religious and community organisations.[48] Discussions around (alternative) forward-thinking drug policy have been limited to a few outspoken public-health[49,50] and public-safety figureheads[51] who have suggested decriminalisation or legalisation. This position is often strongly countered by public commentary, with the media firmly supporting the punitive approach.[38] In 2016, voices of dissent found a platform in the South African Drug Policy Week[c] hosted by the TB/HIV Care Association, the first South African members of the International Drug Policy Consortium.

To date, there has been little public participation in drug-policy development. The current NDMP (2013–2017) claims broad community consultation but to the best of our knowledge, people who use drugs were not consulted in its development, reinforcing their marginalisation.[18]

Process

In terms of the legislation, the CDA should develop a NDMP based on expertise provided by the executive committee and wider and inclusive consultation. The NDMP then becomes the national policy document that informs the priorities, actions and focus of other government departments and related bodies as reflected in their individual drug-action plans.

However, the new NDMP is only due for completion in 2018. This timing does not align with the release of the NDoH's Drug Action Plan or the South African National AIDS Council's National Strategic Plan on HIV, STIs and TB (2017–2022). Furthermore, the CDA Executive Committee noted in relation to a recent policy position: "Regarding politics, it is important to emphasise that our position statement was authored by members of the Executive Committee of the Central Drug Authority (CDA). The broader CDA contains many civil servants representing different government departments and reporting to their ministers, each of whom may have different positions around cannabis and psychoactive substance use. For example, some departments are focused on adhering to the international agreements that South Africa has signed to outlaw drugs".[52]

The policy process thus seems to be influenced strongly by political or international relations agendas, with the CDA and the Departments of Health and Social Development often being excluded from key processes. For example, in March 2016 a Russia-Africa Anti-drug Dialogue was held in Durban with high-level police officers but was not attended by representatives from the CDA or the DSD.[53] National conservatism was further revealed in the highly publicised submission by the Africa Group Position (representing 14 African countries) at the 59th Commission on Narcotic Drugs, instead of the mandated Common African Position, developed by the African Union and endorsed by member states.[54] Moreover, the Minister of Police led South Africa's delegation to the 2016 United Nations General Assembly Special Session on the World Drug Problem, even though the DSD is legislated as government's lead agency. At the 60th meeting of the Commission on Narcotic Drugs in March 2017 there was no CDA representation, while the Department of International Relations and Cooperation and law enforcement were strongly represented.

Harm reduction as a viable and necessary alternative

Internationally, the criminalisation of drug use has resulted in the prejudicial arrest of populations deemed 'suspect', high arrest and low conviction rates, backlogged judicial facilities, and increases in police abuse and violence. These policing measures contribute to the marginalisation of people in need of State services, creating antagonistic configurations that ultimately limit the provision and uptake of health, social and other services.[2] These cyclical relationships, often spanning generations, define the State as 'the enemy' and delegitimise its authority while empowering criminal organisations.[55] The human rights violations experienced by people who use drugs negatively affect their health and access to services.[56] Criminalisation contradicts the constitutionally enshrined principles of equity and the right of freedom from discrimination and access to services.[57]

South Africa needs an approach to drugs that locates the individual within a social context, prioritises public health, and protects the rights of all. We believe this could be best achieved through adopting a harm-reduction framework that is fundamentally concerned with the rights of people who use drugs and the communities in which

c http://www.sadrugpolicyweek.com

they live. Harm reduction focuses on improving public-health and safety outcomes through providing people who use drugs with a range of services that are responsive, preventive and supportive, and ultimately aim at normative inclusion. For example, by limiting the onward transmission of HIV and viral hepatitis through the provision of sterile injecting equipment, these diseases are contained in the general population.[58] By providing opioid substitution therapy (OST) through the public-health system, people who use drugs and their families have access to unadulterated medication that improves their quality of life. The availability of OST through the public-health system has also been proven to lead to a radical decline in the interface between people who use heroin and the criminal justice system.[59] The WHO recognises that a legislative environment that supports public health is paramount to maximise health, and recommends the decriminalisation of drug use.[58]

Several countries have taken steps in this direction with positive effects. The Czech Republic's non-criminal approach to drug use averted the HIV epidemic among people who inject drugs, while the epidemic occurred in neighbouring countries that employed criminal-justice approaches.[2] Similarly in Portugal, civil penalties and health interventions replaced criminal sanctions, resulting in an eight-fold drop in HIV incidence with no significant increases in injecting or in the use of cannabis or amphetamines.[2,60] The success of harm-reduction approaches in Switzerland,[61] the Netherlands,[62] Spain[63] and Bolivia[64] is also well documented.

In a recent evaluation[d] of The Step Up Project, a harm-reduction initiative in which the authors have been involved, service users reported safer drug-use patterns and a belief in, and often a move towards, more conscious decision-making in respect of their drug use. One service user reported, "We realised that we have rights just because we are also human".[65]

From a policing perspective, adopting harm reduction allows police to focus on their core functions rather than wasting time and resources on arrests for drug possession or use. This in turn improves the relationship between police and neighbourhoods where 'the war on drugs' has alienated communities, predominantly those that are poorly resourced and heavily marginalised.

Police officers are harm-reduction champions in countries where harm reduction is well established (e.g. the Netherlands and Canada).[66] While South Africa has the potential to follow suit, this is hampered by the criminalisation of drug use, misconceptions about the effectiveness of harm reduction from a policing perspective, and law-enforcement targets that reward the punishment of individuals.[46] While policing organisations in South Africa are obliged to enact punitive legislation, many officers question the broader purpose of such legislation. Police are intimately familiar with the places and people they police and are often best positioned to discern the immediate results of the application of laws. Conversations with officers in Durban and Cape Town revealed that many recognise the futility of such actions as well as the cost and ineffectiveness of processes designed to meet numerical performance measurements rather than the more abstract 'public good'.[66] Such voices are often stifled by fears of being charged with insubordination, strengthened by a lingering understanding that effective responses require police to be 'tough on drugs'. Despite this, given the opportunity to speak, police officers can leverage their substantive knowledge of the daily lives of people who use drugs to become effective referral agencies. In these conversations, the authors began the process of identifying new pathways to reduce the harms caused by the policing of drugs, while increasing the effectiveness and efficiency of the policing of safety in communities.

d This evaluation was approved by the Research Ethics Committee of the University of the Western Cape, and included interviews with people who use drugs who accessed services provided by the Step Up Project.

Conclusion and recommendations

South African drug policy does not sufficiently heed growing evidence demonstrating the negative consequences of the war on drugs and prohibitionist policies. Rather than improving health, social or safety outcomes, such an approach serves to further marginalise already disadvantaged (and often traumatised) populations and undermines their right to dignity, privacy and service access. A new, inclusive approach is required that aims to address the social determinants contributing to drug use and to provide services that reduce drug-related harms. This requires a collective or social harm-reduction view of drug-use disorders, and a socio-medical framework aimed at reducing harms and improving quality of life.

The harm-reduction approach to drug use mitigates some contextually related problems and is a more equitable and effective policy framework, which is aligned with human rights principles and the social-justice agenda. It is slowly gaining traction in South Africa as a result of growing awareness of the negative public-health and safety impact of current policies and interventions. However, this currently small movement must gather momentum, especially in the policy arena.

A real commitment to harm reduction requires brave engagement by politicians, public servants and civil society to implement non-criminal approaches to drug use. It calls for reallocation of public spending from the war on drugs to harm-reduction approaches that would reduce the risks of infectious disease and address the health and social needs of people who use drugs. People who use drugs should be actively involved in dealing with the social problems that contribute to drug-use disorders and addiction as well as the architecture of intervention programmes.

The Department of Justice and Constitutional Development should task the South African Law Reform Commission to undertake a rigorous review of drug policy and provide recommendations for legislative change. This should be done in close consultation with the CDA Executive and with drug-policy experts located outside of the State. This process will be lengthy, and a concurrent effort to engage with the CDA and support a more progressive NDMP is essential. There have been indications that the CDA intends to include harm reduction in the NDMP, but as we have shown, their influence is often diluted by broader political agendas. The process should be accompanied by clearly stated mechanisms for instituting and operationalising harm-reduction programmes, particularly within public-health facilities and in community-based settings.

The National Department of Health should develop standard treatment guidelines for opioid substitution therapy as maintenance to manage people with heroin-use disorders, and requisite medications (i.e. methadone and buprenorphine/buprenorphine-naloxone) should be placed on the Essential Medicines List for use at primary-care level.

Integrated policy and practice with regard to health, safety and wellbeing should replace current punitive and prohibitionist approaches that stand in stark contrast to broader constitutional rights. At national level, we recommend that interdepartmental forums be arranged to align policy and ensure that interventions are in place across departments that lead to enhanced health and safety outcomes for people who use drugs.

Implementation of new policy will require significant shifts in thinking on the part of those who work in public-sector organisations such as the police, hospitals and social-welfare departments. Departments that directly engage with people who use drugs, such as health, police and social development, should sensitise and train staff to address misconceptions around drug use, the ineffectiveness and cost of current strategies, and the positive outcomes of non-criminalising approaches. Stigma and discrimination should be addressed and responded to. Medical, social science and police basic training should include harm-reduction and evidence-based understanding of drug use.

However, it is not sufficient to focus only on the State. Non-State groupings are equally significant in bringing about desired changes in policy, practice and outlook. Non-governmental organisations that are currently engaged in providing harm reduction and health services for people who use drugs should foster strong relationships with police. This would allow for proper and effective referral pathways and a continuum of interventions to address the needs of people who use drugs, in line with harm-reduction approaches.

Finally, civil-society groupings (including people who use drugs and their families) and individuals should form a strong and cohesive drug policy advocacy group. This group should find innovative techniques to push for greater access to public-health and welfare facilities and for programmes to address socio-economic inequity and poverty that usually underpin drug-use disorders. At the forefront of these advocacy groups and social movements should be people who use drugs, since they have the greatest expertise with regard to their circumstances. We recommend that all these processes take place in the immediate future before drug-use disorders become the next health epidemic. This is already on the horizon and South Africa's story of AIDS denialism should be instructive in terms of the need to prevent further harms afflicting to people who use drugs.

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