Common Concerns

Resolving Public Drug Use & Overdose

TBHIVCARE

The Epidemiological Reality of the Mother City

75,701

Estimated population of people who inject drugs (PWID) in South Africa.

The Western Cape has seen a massive shift from smoking methamphetamine ("tik") to injecting heroin ("unga"), fundamentally altering the disease risk profile.

83%

Hepatitis C prevalence among PWID (vs. 0.47% in the general population).

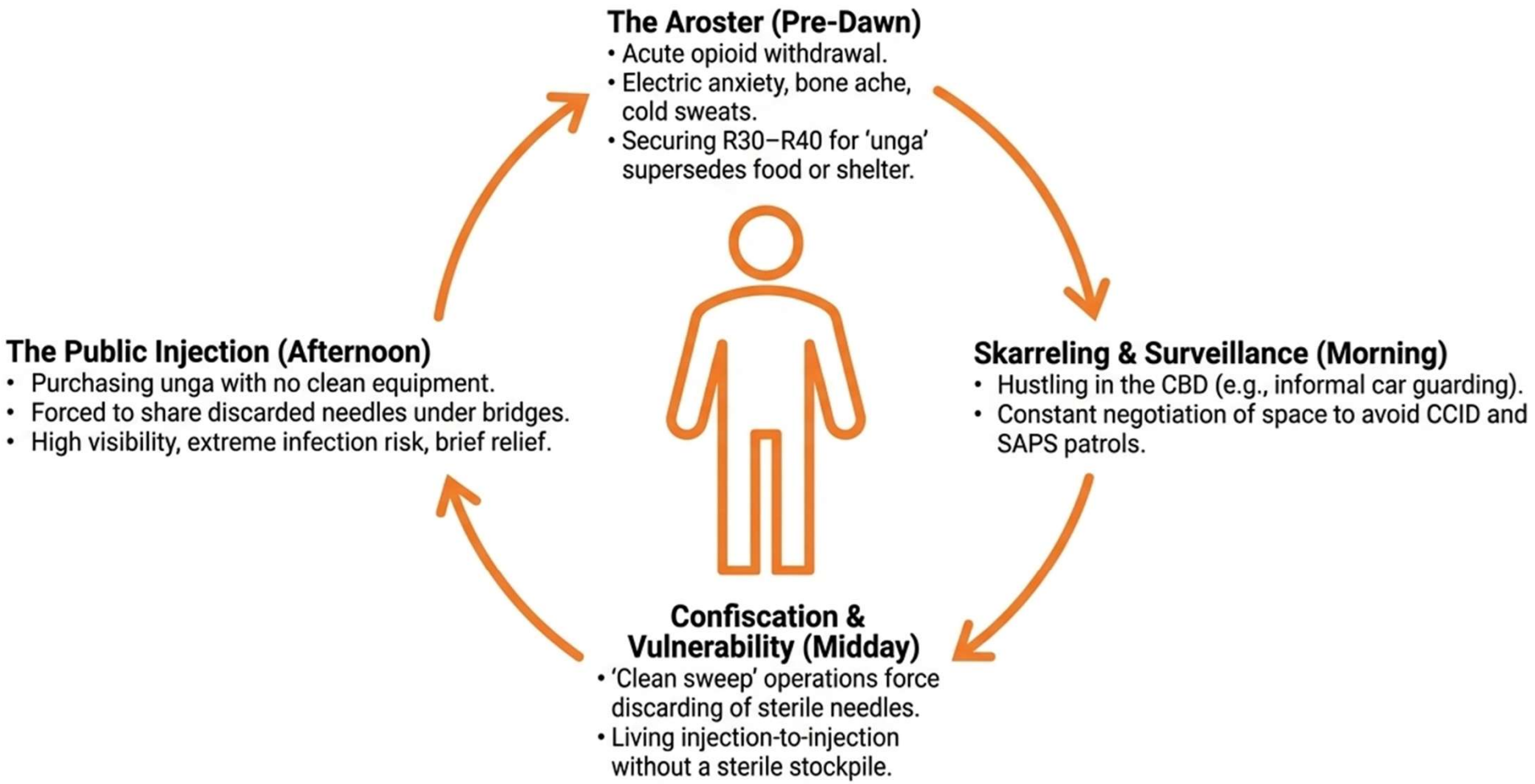
~176x Risk Multiplier

55%

National HIV prevalence among PWID (vs. 13.9% general population).

~5x Risk Multiplier

The Physiology of Dependence and Public Nuisance



The Conflict of City Mandates

The Public Health Mandate

Actor: Western Cape Government Health (WCGH) / NGOs
Action: Spends money to distribute sterile injecting equipment via Needle and Syringe Programs (NSP).

Goal: Prevent catastrophic downstream health costs of HIV and endocarditis.

The Safety & Security Mandate

Actor: City of Cape Town / Law Enforcement

Action: Spends money utilizing the 'Nuisances' by-law to confiscate medical equipment as illegal 'paraphernalia.'

Goal: 'Clean up' the streets and disperse loitering.

The Net Result: A fiscal and social loss. The Department of Health's disease prevention tools are thrown into municipal bins by Law Enforcement, forcing users into unsafe, highly visible public injections

The ‘Safe Space’ Fallacy and the Geographical Gap

Zone 1: Drop-In Centers (DICs)

The Rule: Prohibit drug consumption on-site.

The Reality: Users access clean needles, but must leave to manage withdrawal.

Zone 2: City ‘Safe Spaces’ (Shelters)

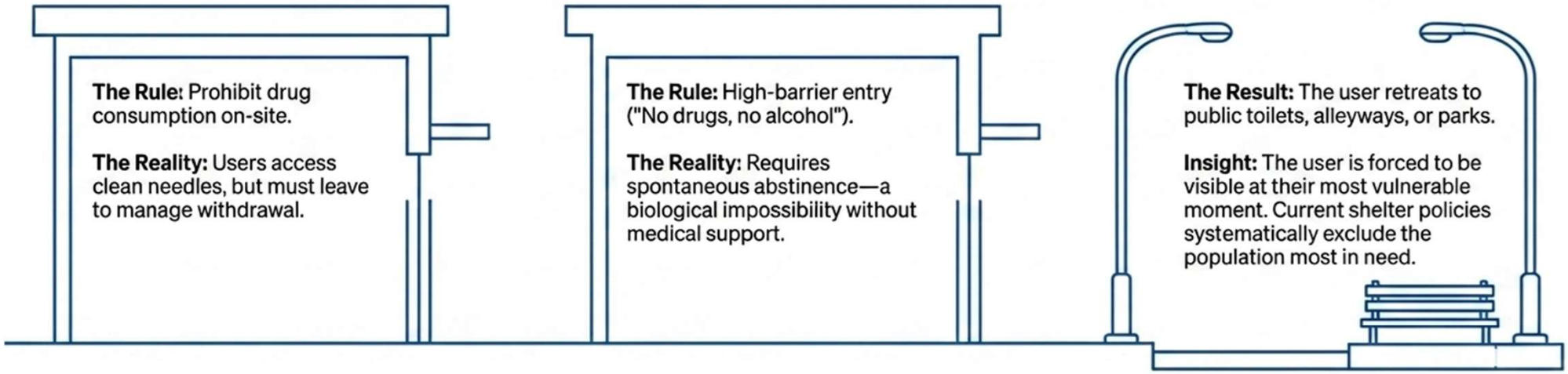
The Rule: High-barrier entry ("No drugs, no alcohol").

The Reality: Requires spontaneous abstinence—a biological impossibility without medical support.

Zone 3: The Street (The Forced Outcome)

The Result: The user retreats to public toilets, alleyways, or parks.

Insight: The user is forced to be visible at their most vulnerable moment. Current shelter policies systematically exclude the population most in need.



The Missing Infrastructure: Overdose Prevention Sites (OPS)

An OPS is not a “safe space to get high.” It is a specialized, low-threshold clinical facility designed to manage a chronic health condition.

Medical Supervision

Trained staff present to monitor consumption and administer immediate emergency response (Naloxone/Oxygen).

Sterile Equipment

Access to clean drug use equipment and safe, immediate biohazardous disposal.

Wound Care

Basic onsite triage for injection-related infections (abscesses, cellulitis).

Referrals to Care

A direct, low-barrier bridge to Opioid Agonist Therapy (OAT), detox, and social work.

Global Evidence: Three Decades of Indisputable Data

Zero

Fatal overdoses ever recorded inside a supervised consumption site globally. Complete prevention of mortality at the point of use.

67%

Reduction in overdose deaths recorded in the immediate 500-meter radius surrounding established sites.

Up to 28%

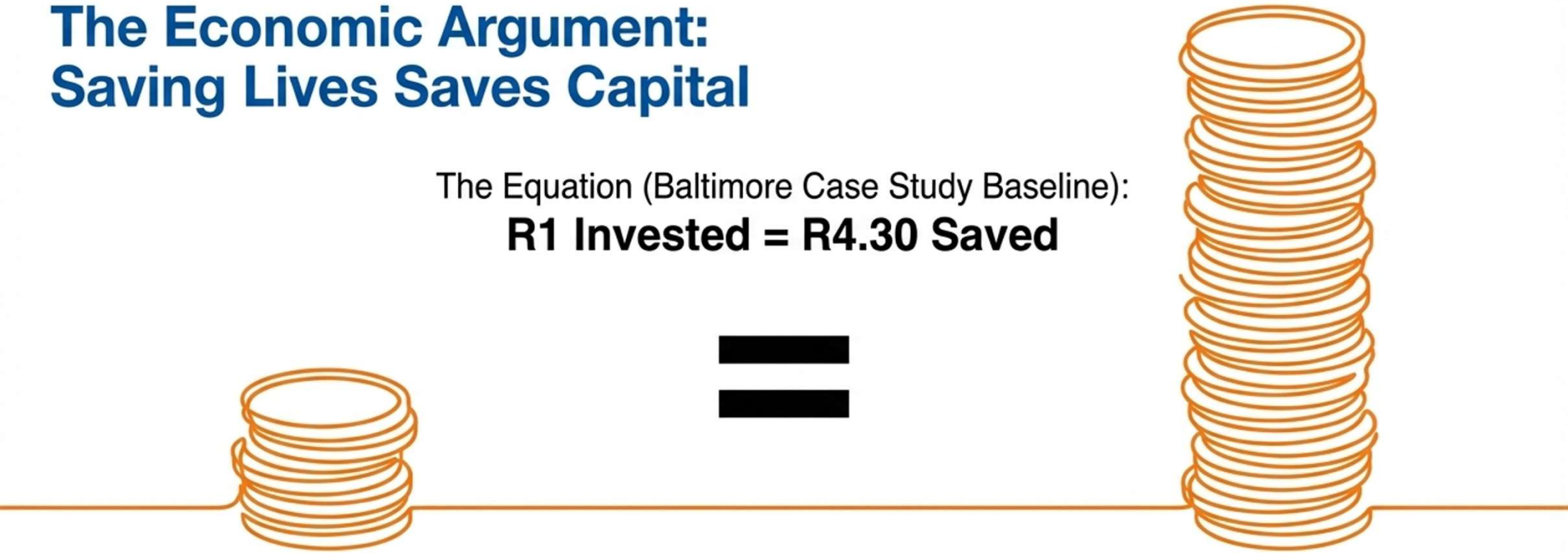
Prevention of new Hepatitis C infections over a 10-year period, achieved by systematically breaking the chain of syringe sharing.

**Extensive peer-reviewed studies confirm these sites cause ZERO increase in neighborhood crime or public disruption.*

The Economic Argument: Saving Lives Saves Capital

The Equation (Baltimore Case Study Baseline):

R1 Invested = R4.30 Saved



The Cost of Criminalization (What we pay now):

- Arresting and processing users for petty possession.
- Treating endocarditis (heart valve infections) in ICUs.
- Managing lifetime HIV/HCV antiretroviral regimens.
- Dispatching emergency ambulances for street overdoses.

The Financial Return of OPS:

- **R34 Million** Annual operational cost.
- **R147 Million** Annual savings generated.
- **54% Drop** in emergency room visits by site users.
- **50% Fewer** nights spent in the hospital.

Selecting the Optimal Operational Blueprint for South Africa

	Fixed/Specialized	Mobile Unit	Hospital-Based	Integrated Service (The Chosen Model)
Best Use Case	High capacity, high capital cost. Comprehensive care.	Van/bus moving to hotspots. Low cost, flexible.	Inside acute care for admitted patients. Stops AMA discharges.	**Best Use Case:** Housed within existing health services (e.g., TB HIV Care Drop-in Centers).
Infrastrue Cost	High capacity - effective.	Low cost, flexibt. Low cost, flexible.	Stops AMA discharges.	**Cost:** Highly cost-effective; minimizes capital expenditure.
Core Advantage	High capacity, – high tnper cost for initial SA pilot.	Limited medical/ancillary capacity.	Too niche for broad street intervention.	**Core Advantage:** Leverages pre-existing community trust and zoning footprint.
SA Viability	Too resource-intensive for initial SA pilot.	Limited medical/ancillary capacity.	Too niche for broad street intervention.	**SA Viability:** Optimal. Accelerates deployment timeline significantly.

The Impending Threats: The Early Warning System

The Catalyst

The potential arrival of highly potent synthetic opioids and novel psychoactive substances (NPS) in the local illicit market risks a mass mortality crisis. Current street drug testing is non-existent.

Systemic Defense: Continuous feedback loop ensures rapid, evidence-based policy deployment before an overdose cluster becomes a city-wide crisis.

The SA-EWS Anchor: Data is fed directly to the SA Medical Research Council (SA MRC) and SACENDU.

Data Collection: OPS provides real-time testing of consumed/discarded substances at the point of use.

Navigating the Legal Architecture

The Barrier: The Drugs and Drug Trafficking Act 140

Current national legislation retains a punitive focus, creating an environment where healthcare providers face prosecution risks for operating an OPS (“crack house statutes”).

The Precedent: The Canadian Exemption

In 2003, Vancouver’s Insite bypassed federal drug laws by securing a targeted Health Canada exemption, proving that public health mandates can legally supersede drug enforcement laws for life-saving interventions.

The SA Solution: NDOH Indemnity

Protracted legislative reform is too slow. The National Department of Health (NDOH) must grant a targeted public health exemption. This provides immediate legal indemnity to service providers (THC, SA MRC), transforming a legal blockade into a managed administrative process.

A Pragmatic Roadmap for Central Cape Town

Pillar 1: City & Law Enforcement

- **Cease Medical Confiscation:** Enact an immediate moratorium on the confiscation of sterile injecting equipment.
- **Lower Shelter Barriers:** Pilot a 'Housing First' Safe Space that does not mandate immediate abstinence.

Pillar 2: Provincial Health (WCGH)

- **Scale Core Services:** Decentralize and dramatically expand funding for maintenance Opioid Agonist Therapy (OAT) to Community Health Centers.
- **Eliminate Caps:** Remove restrictive artificial targets on needle distribution to meet WHO standards.

Pillar 3: Ratepayers & Civil Society

- **Advocate for DCRs:** Recognize that an Overdose Prevention Site is the only proven method to permanently remove injection from public parks and beaches.
- **Support the Pilot:** Back the formation of a multi-sectoral task force to launch an Integrated Service Model pilot before the Fentanyl threat materializes.