

## Reflections on harm reduction policy and practice in South Africa



Andrew Scheibe, *MBChB, MPH, Dip HIV Man*  
Cape Town, South Africa

I have been working in the field of harm reduction for about ten years. I am happy to report that some encouraging changes have taken place in South Africa. Unfortunately, many of the negative consequences of our current drug policies, and their implementation, continue.

In 2011, colleagues and I synthesised information around injecting drug use and HIV in South Africa. Our work was used to inform the National Strategic Plan on HIV, STIs and TB (2012 – 2016). Fortunately, the Strategic Plan did include people who use drugs as a key population in need of tailored interventions, even though few people at that time considered interventions for people who use drugs a priority. The lack of data confirming links between HIV and drug use, specifically injecting drug use and HIV, and workable population size estimates, were cited as reasons to not provide appropriate HIV services for people who use drugs.

Two years later I led a team of community researchers to conduct a multi-site prevalence and risk survey among people who inject drugs (PWID) in five cities across the country. Despite our tiny budget and methodological limitations, we successfully recruited 450 PWID. Participants represented major racial groups, and included 20% women – debunking the myth that injecting drug use in South Africa was restricted to white men. I clearly remember several stories I heard during this project about the lives of people who took part in the study. Stories included episodes of rummaging in dustbins in search of needles, renting needles, or being chased out of pharmacies when trying to buy needles. One participant explained how he would share his gear with his girlfriend and friends and how he had tried to stop injecting several times. I remember how he tried to verbalise how difficult it was to find money to pay for opioid substitution therapy (OST). (His situation did not change and he committed suicide a few months after the study was completed.) We found that women were at higher risk for HIV than men. Over half of the women had been involved in the sex industry, and a third of them reported symptoms of a sexually transmitted infection the previous year. Women also reported higher levels of needle and syringe sharing than men. I think the main finding of our study was to show the need for evidence-based HIV prevention and treatment services for PWID in South Africa.

Encouragingly, the findings of our study enabled the implementation of a needle and syringe demonstration project (*The Step Up Project*) that started in 2015. TB/HIV Care Association and OUT LGBT Wellbeing is implementing the project in three cities, with support from the United States Centers for Disease Control and Prevention, the United States President's Emergency Plan for AIDS Relief, Mainline and the Ministry of Foreign Affairs of the Netherlands. In its first year, the project has reached over 2 100 PWID with harm reduction interventions, distributed over 380 000 needles and tested 768 PWID for HIV. The number of PWID reached continues

to increase. Accessing females who inject drugs remains a challenge, and access to OST is still limited to those who can pay for it.

Despite the great successes of *The Step Up Project* it still operates in a kind of political 'grey zone'. The lack of national guidelines around needle and syringe programmes, and National Orders from the South African Police Services, mean that outreach teams frequently encounter and have to answer to angry (wealthier, more powerful) citizens and police when providing health services to PWID, most of whom live on the street.

This year, the Deputy Minister of Social Development and the Chief Executive Officer of the South African National AIDS Council have publically confirmed the need for needle and syringe programmes and increased access to OST in South Africa. 2016 is the first time that funding from the Global Fund will be directed to HIV programmes for PWID. Political statements of support and international donor funding are essential, but we still need supportive policy (including guidelines for the use of OST in primary care settings and the decriminalization of drug use) and domestic funding for these programmes to be sustainable. Most importantly, supportive policies need to be implemented using the principles of harm reduction. Until our government makes these changes and supports, and does not punish, people who use drugs, we will continue to exclude and marginalise them. Attempts to arrest our way out of our current situation is fool hardy. We need to implement, evidence-based, rights affirming policy and programmes for PWID to mitigate the negative health, social and economic consequences of our current approaches.