Injecting drug use in South(ern) Africa

Realities and the need for action

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Disclosures

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Overview

• Concepts & terms
• Drug use in South Africa
• Why do people inject drugs?
• What risks do people who inject drugs face?
• What solutions are there?
• The regional situation
• Conclusions & recommendations

Source: TB HIV Care 2018
What is a drug?
Why do people use drugs?
The war on drugs has been a war on people
South Africa is part of (injectable) drug trafficking

Adapted from World Drug Report 2015
* Several routes involving other regions not shown
Heroin related admissions, SACENDU sites (1998 – 2016)

Heroin use is increasing

Source: Shelly, analysis of SACENDU data 2018
Why do people inject drugs?
What risks are associated with injecting?
DRUG USE

DIRECT RISK
- Needle & syringe reuse
- Ineffective cleaning
- Sharing

INDIRECT RISK
- High risk sexual practices
- Low levels of knowledge
- Limited access to appropriate services
- Violence
- Stigma, discrimination & exclusion
- Drug use in unsafe environments

HCV & HIV Infection
Sibo’s experience of the criminal justice system...
Charlize explains what happened to her when the eThekwini municipality halted the needle and syringe service in Durban?

My name is [redacted] and I have really been suffering tremendously since we do not receive needles anymore. T.B.H. I have Hepatitis C and I'm HIV+ and I have to end up sharing needles with my partner because we can't afford to purchase needles from the pharmacy. Therefore I put my partner at risk every time we use. The statistics are so high for HIV in S.A. and now they will rise because of this situation.

Source: TB HIV Care 2018, client testimonial, June 2018
The death of Boots

_The fatal consequences of stigma, discrimination & violence_
Barriers to health services

• Prior experiences of stigmatisation
  “They’re not helping you, they’re oppressing you” (Male, Pretoria, 32)

  “When [the doctor] heard I was using drugs he went off!... It was the worst experience I have ever had with a doctor. ” (Male, Cape Town, 30)

• Concerns about waiting periods, withdrawal & treatment access

• Affected by prior negative experiences & low sense of self-worth
  “Death didn’t seem that unappealing.” (Male, Cape Town, 45)

Source: Versfeld et al. 2018
What solutions are there?
WHO, UNODC, UNAIDS comprehensive package of interventions:

1. Needle and syringe programmes (NSPs)
2. Opioid substitution therapy (OST) and other evidence-based drug dependence treatment
3. HIV testing and counselling (HTC)
4. Antiretroviral therapy (ART)
5. Prevention and treatment of sexually transmitted infections (STIs)
6. Condom programmes for people who inject drugs and their sexual partners
7. Targeted information, education and communication (IEC) for people who inject drugs and their sexual partners
8. Prevention, vaccination, diagnosis and treatment for viral hepatitis
9. Prevention, diagnosis and treatment of tuberculosis (TB)
   • Opioid overdose prevention and management
The Southern African situation
PWID size, HIV & HCV prevalence estimates and services

In sub-Saharan Africa:
- 1.4 million PWID
- 18% HIV prevalence
- 16% HCV prevalence

Madagascar
- 15,500 PWID
- HIV+ 5%
- HCV+ 6%

Mozambique
- 29,000 PWID
- HIV+ 46%
- HCV+ 67%

Lesotho
- 2,600 PWID
- HIV+ 5%
- HCV+ 6%

Mauritius
- 11,667 PWID
- HIV+ 46%
- HCV+ 97%
- NSP+ & OST+

Sources: Larney et al. 2017; HRI 2018 (unpublished)
South African HIV/HCV data & services

**Johannesburg (4 500 PWID)**
- *Hep initiative* (n=324)
  - HIV+: 38%
  - HCV PCR+: 73%
  - HIV-HCV+: 29%

**TipVal (n= 544)*
- HIV+: 56%
- HCV+: 93%
- HIV-HCV+: 48%

**Cape Town (1 500 PWID)**
- *Hep initiative* (n=299)
  - HIV+: 7%
  - HCV PCR+: 34%
  - HIV-HCV PCR+: 1%

**TipVal (n= 348)*
- HIV+: 8%
- HCV+: 63%
- HIV-HCV+: 6%

**Durban (1 000 PWID)**
- *Hep initiative* (n=318)
  - HIV+: 17%
  - HCV PCR+: 29%
  - HIV-HCV PCR+: 7%

**Port Elizabeth (500 PWID)**
- HIV+: 15% (26/177)

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Sources: SANAC 2018, THC, OUT et al. 2018; Lane et al. 2018; (1)TB HIV Care (Step Up); (2) Anova Health Institute (JAB Smart), OUT Wellbeing (Harmless)
Naz is hopeful
Conclusions & recommendations

• PWID exist, and social & structural factors are major contributors to the high HIV & HCV prevalence and consequences of infection

• (Co)-Infection burden varies, likely reflecting contextual factors

• Needle and syringe programmes, opioid substitution therapy and a harm reduction approach is critical to reduce HIV, HCV and other harms

• Voluntary psychosocial services are needed to build a sense of self-worth, dignity and the desire to access and remain in treatment

• Clinicians & the health and social system need to provide accessible, sensitized, evidence-based and integrated community-based services

• HIV clinicians should call for the decriminalisation of people who use drugs, with a move towards legal regulation
Thank you

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References:
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