

**DRUGS ARE THE SOLUTION NOT THE PROBLEM:
EXPLORING DRUG USE RATIONALES AND THE NEED
FOR HARM REDUCTION PRACTICES SOUTH AFRICA**

Monique Marks,¹ Sibinelo Gumede² and Shaun Shelly³

ABSTRACT

In the past ten years, the use of low-grade heroin (known as whoonga or nyaope) by people from marginalised communities in Durban, South Africa has become increasingly prevalent. Focus groups held with young homeless people who use whoonga have shown definitive rationality in their choice to use drugs, as well as high levels of a sensibility in terms of what is required to make daily living less risky. The more time we spent on the streets speaking to whoonga users, the more we became aware of the absolute need for opioid substitution therapy (OST) to be publicly available as a maintenance medication and therapy, which is currently used in South Africa in any significant way. The Urban Futures Centre at the Durban University of Technology, together with the TB/HIV Care Association, is embarking on the first non-profit OST Demonstration Project in the country as a means of advocating for the wider roll out of OST in public facilities. This agonist-based OST Demonstration Project is low threshold and is not necessarily aimed at abstinence, but rather toward the improvement of the quality of life for and the reduction of harm to users, particularly as it pertains to health and safety. This article speaks to the pathways, as described by people who use drugs themselves, into heroin use and present the initial findings regarding changes in quality of life from service users who are a part of the OST Demonstration Project. In so doing we make the case for the centrality of connections and rights-based interventions as the most effective approach to working alongside people who use drugs so as to reduce harms and to promote self-defined resolution of what they define as problematic drug use.

Keywords: *low-grade heroin – whoonga, nyaope; homeless people drug use; marginalised communities; Durban.*

INTRODUCTION

Tonight I dine and wine with kings and queens

By Menelisi Ngidi

*I was born with a death certificate
granted no permission of living had no reason, of breathing
Because I was judged and sentenced before I could plead my innocence
I've felt pain and been punished for sins I have not yet done, so
I could blame on becoming a son of a gun
Under the spotlight of heaven, I have danced with the devil
But tonight, tonight, I wine and dine with kings and queens
Shattered by pain and misery till I became a slave off poetry
I've written rhymes till my head starved of word poverty
Fantasy of living a normal life has been my dream
But failed miserably, of making it reality*

1. Prof. Urban Futures Centre, Durban University of Technology. Email: moniquem@dut.ac.za.
2. Mr. Researcher. Urban Futures Centre, Durban University of Technology. Email: SiboneloG@dut.ac.za.
3. Mr. Lecturer & Researcher. Department of Family Health, Pretoria University.
Email: shaun.shelly@yahoo.com.

*Understanding my responsibilities, I question my integrity, loyalty, humanity
I start to see that my blood is poetry
Royalty runs in my veins and those who have questioned it were left with their heads hung in shame
But tonight, tonight I wine and dine with kings and queens
Filling pages with black ink
I fill it until the pen runs out
I can't stop writing I would rather cut my wrist and fill it with red blood
Fill it until the heart stops to pump eyes go blind and turns numb
Cut! I am out
But tonight I have wine and dined with kings and queens.*

This powerful poem was composed by Menelisi Ngidi, a 28-year old man who has been using heroin for six years and is now part of South Africa's first low threshold Opioid Substitution Therapy (OST) Programme. The poem was written prior to his entry into the OST programme, but remains a symbolic marker of his larger life story. What he describes so powerfully in this poem is the absolute rejection he has experienced as a person who uses drugs – a sense of failure and hopelessness. It tells of his consequent retreat into the private world of writing poetry, of expression and of connecting if only with himself.

Menelisi's extraordinary writing skills mask perhaps the fact that he lives in the most dire of social circumstances, which for the most part are on the streets of Durban, South Africa. He thus shares his experiences of stigmatisation and marginalisation with thousands of other dependent drug users in South Africa, through reciting his poems in a variety of public forums (mostly informal) in Durban. Both poetry and drugs are used to numb him to and from his reality of 'being born with a death certificate'. Menelisi's choice to use psychoactive drugs is not extraordinary, nor remarkable. Nor is it unexpected given the social circumstances he was born into which include inter-generational trauma and the burden of a future with little hope of having a 'normal' life, if only understood as such by mainstream society. Menelisi, through his poem, speaks out for those who both historically and contemporarily use drugs, some problematically and others not.

The use of substances that create psychoactive or sedating effects has been a feature of human history (Nadelmann, 1990). Alcohol, tobacco, opium, cannabis, coffee, coca and a variety of other psychoactive substances have each been consumed in different societies and in various forms for many hundreds or, in some cases, many thousands of years (Nadelmann, 1990). Prior to the twentieth century, most substances now deemed illegal were widely available in largely entirely un-regulated markets. Today many of these substances have come to be called 'drugs' and some are deemed to be illicit, while others are not. How exactly one drug (or substance) is legally classified compared to another depends on a range of social and political factors and has little to do with pharmacology or toxicology of the substance or drug (Bancroft, 2009). The prohibition of drugs, in this apparently arbitrary manner, has often impacted disproportionately on minority and first people groupings (Taylor & Buchannan, 2016).

The global prohibition and criminalisation of certain drugs and the people who use them was formalised by the United Nations in the 1971 Convention on Psychotropic Substances. For nearly 50 years the production, sale and even possession of cannabis, cocaine and most opiates, hallucinogens, barbiturates, amphetamines and tranquilizers – outside strictly regulated medical and scientific channels – has been punishable by criminal sanctions in most countries globally (Count the Cost, 2016). The role of criminal justice agencies in most countries now takes primacy

in dealing with drug supply and demand through investigating and prosecuting drug law violations. Nadelmann argues that the prohibition of certain substances is the result of what he describes as:

“... a confluence of the perceptions, interests and moral notions among dominant sectors of the more powerful states along with the exceptional influence of American protagonists in shaping the regime according to their preferred norms” (Nadelmann, 1990:503).

The war on drugs has been globalised since at least the 1980s. This is not just a war on drugs, but a war on people who use a particular group of drugs that have been deemed illegal.

The reasons for the use of substances that have a psychoactive effect are various. They range from medicinal, to recreational and to cultural. It has also been documented that, in both humans and animals, drug use has been used to mitigate the effects of environmental stressor (Siegal, 2005). Problematic drug use, which is defined by the high salience attributed to a drug in the daily life of an individual despite negative consequences, is often the result of a desire or a need to escape from past trauma (Ullman, Relyea, Peter-Hagene & Vasquez, 2013), social exclusion (Buchanan & Young, 2000), lack of alternative activities and a sense of psychosocial dislocation (Graham, Young, Valach & Wood, 2007). It is thus not surprising that problematic drug use is more obvious in disadvantaged communities where trauma is greater and access to life chances and choices is low. In addition, these areas are more heavily policed and people who use drugs are more visible, increasing chances of arrest, further marginalisation and exclusion (Brunson & Miller, 2006). Problematic drug use is also frequently associated with underlying mental health or psychiatric issues, translating into problems of comorbidity (Graham, Birchwood, Oxford, McGovern, Maslin, Muesser, Tobin & Georgian, 2003). Supporting the idea that marginalisation and co-occurring disorders contribute to problematic drug use is research that indicates that the resolution of problematic drug use is less likely in the presence of lower levels of education, unemployment, mental health issues, early onset of disease and arrest (Moos, Nichol & Moos, 2002).

While poly-drug use is now broadly accepted as being most likely amongst people with a pre-existing drug use disorder, heroin use disorders are one of the most chronic, life-threatening and harmful substance use disorders (Nutt, King & Phillips, 2010; UNODC, 2014). People who use heroin tend to have an earlier onset of problematic drug use and compared with other drug use choices and are part of a consistently high use group (Yih-Ing Hser, Evans, Huang, Brecht & Li 2008). It is thus not surprising that the World Health Organisation (WHO) (2004) views heroin use disorders as a complex health condition that often requires long term treatment and care, rather than the more prevalent criminalisation response.

While the data on the prevalence of heroin use in South Africa is currently not very reliable, the number of people accessing treatment for heroin use disorders is increasing (Lize, 2010) yet concomitant to this there has also been an increase in the trafficking of heroin into South Africa. What is anecdotally clear is that in Durban, heroin is widely available in a highly unregulated market. As a port city, Durban is the main gateway in Southern Africa for drug trafficking, with the availability and use of heroin (mostly low grade) has been reported in the press as growing steadily in the Central Business District (CBD) and neighbouring suburbs and townships (Steinberg, 2005; Rall, 2017: np).

The primary mode of use of heroin in Durban is by smoking, rather than injection. In Durban the street name for heroin that is smoked is *whoonga*. In other parts of the country it is referred to as *Nyaope*. The drug is not pure heroin but is rather a concoction of bulking agents (including other drugs), opioids (such as codeine) and heroin (Aye, Huma, Mokwena & Fernandes,

2015). The resulting mixture is typically a brown powder that is sprinkled onto cannabis that is then rolled into a “joint” and smoked (Mokwena & Huma, 2014). The majority of the city-based *whoonga* users are from economically disadvantaged backgrounds and to survive and maintain their drug use habits they find work in the informal sector or in committing petty crimes. As a result, the *whoonga* users quickly became demonised by the wider community and have been scapegoated for numerous broader issues of urban decay and insecurity.¹

Recognising that little has been done by state agencies to reduce the harms associated with problematic drug use and an unregulated illicit drug market in a prohibitionist policy context, a group of non-state actors joined-up to understand the pathways into heroin use in Durban and to find evidence-based approaches to improving the lives of people who identify their drug use behaviour as problematic. A network was formed in late 2014, coordinated by the Urban Futures Centre at the Durban University of Technology. It named itself the KwaZulu-Natal Harm Reduction Network.

HARM REDUCTION AND PROBLEMATIC DRUG USE

Internationally, the regulation of drug use has primarily been left to the criminal justice system, driven and supported by an underlying belief that people who use drugs deserve punishment and rehabilitation. Yet this approach to drug use, particularly problematic drug use, has proven to be not only unsuccessful in its aim to eradicate drug supply and demand, but also harmful to people who use drugs and their communities (Count the Costs, 2016). This failure has been well documented and one response to this has been to medicalise the treatment of drug use by viewing drug use as a chronic disease of the brain that requires treatment (Leshner, 1997). While the medical approach described as less stigmatising, it still “others” people who are dependent drug users (Buchanan and Reiner, 2009) and critically, it fails to pay relevant attention to the social and economic context in which problematic and dependent drug use is likely to occur (Wayne, Carter & Forlini, 2015). In different ways then both the law enforcement and medicalised approach lead to policy and practice that intensify social disruption and marginalisation. These approaches also hinder the provision of effective services to people who use drugs (Scheibe, Shelly, Versfeld, Howell & Marks 2017).

An alternative to these two approaches moves away from the singular goal of abstinence and rather takes a pragmatic view of the use of drugs that is fundamentally concerned with the rights of people who use drugs, their socio-economic contexts and the provision of services that are responsive, preventive and supportive. This approach is known, broadly, as harm reduction. While contested definitionally, for the purposes of this analysis harm reduction seeks to meet people where they are at rather than judging their circumstances and choices. In so doing, harm reduction practitioners offer people who use drugs an inclusive public health and safety response aimed at normalising their lives and reducing harm through a range of interventions and forms of support. Harm reduction advocates and practitioners promote the human rights of people who use drugs, including their right to access appropriate health care and to be treated with dignity (Marlatt, 1996; Rhodes, 2009). According to Harm Reduction International, harm reduction is geared toward reducing the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community’ through a strong commitment to public health and human rights. Harm reduction interventions or programmes are evidence based, easy to implement, effective, safe and cost-effective.

Despite proven results of the effectiveness of harm reduction Ritter & Cameron 2006endorsements from United Nations Office on Drugs and Crime (UNODC), the WHO and

other high-level organisations across the world it remains contested and implementation is far from universal (Harm Reduction International, 2016). In South Africa, despite some policy rhetoric that embraces harm reduction, the dominant policies and practices remain within the law enforcement model, with only those that can afford it able to access services in formed by the medical model. This negates not only the rights of people who use drugs, but also impacts negatively on their communities.

This article describes the pathways into drug use and the lived experience of people who use *whoonga* and are living in Durban. We further describe the early implementation stage of South Africa's first low-threshold opioid substitution therapy programme and the associated impact on the quality of life of those accessing the programme. There is a lack of similar research in the South African literature and an understanding of the drivers of problematic and dependent *whoonga* use are critical in 'packaging' legitimate and effective responses.

The research was conducted by a team of researchers from the Urban Futures Centre at the Durban University of Technology. Ethical approval was given by the Durban University of Technology and the KwaZulu-Natal Department of Health in early 2016. All the interviewed participants signed an informed consent and were 18 years and above at the time of the study. The participants included both smokers and injectors and all used *whoonga*. Ethnographic observations which are recorded in a continuous basis were also used in this article. The observations are a documentation of the change of quality of life of the participants in the OST project. Furthermore, five focus group discussions (FGD) and fourteen individual in-depth interviews were conducted. The focus groups were held in 2016 and the interviews in 2017. These were conducted in both English and Zulu, depending on the language skills and preferences of the participants. Pseudonyms are used for all respondents who participated in the study.

PATHWAYS INTO DRUG USE

The aim of the research was to understand, from the perspective of people who use *whoonga*, what the drivers into problematic drug use were for them and to develop an understanding of the context the individual drug users found themselves in. In understanding sense making around the use of *whoonga* from the perspective of users themselves, we shift from imposing a moralistic understanding to one that takes account of social context and is cognisant of the drug use community as having agency to make choices based on their social reality.

One of the key drivers to emerge from the research was a strong desire to fit in with a social network that was already using drugs. *Whoonga* is readily available, inexpensive and has a potentially powerful psychoactive effect. As one 18-year-old male focus group member, Mandla, said: "*I started smoking whoonga with friends when I was coming from school and we would play cards. I agreed to buy whoonga with these friends just to experiment and to see how it would make us feel after smoking*".

For Mandla, this was clearly a choice that was based on a desire to experiment and to be part of a social network. Another respondent spoke of trying a new drug which was more powerful than marijuana; Petro, was without work and in a new city. For him a stronger substance than marijuana in this context of disconnect seemed to make sense: "...when I got here to Durban, I got other friends as I was trying to get a better life with the prospect of getting a job here in Durban... They then told me that what they were smoking was better than what I was smoking" [weed].

Like Petro, many initial users were unaware of what substance was being used. A minority of the users thought they were smoking cannabis, when in fact they were smoking *whoonga*. They only realised this when they started to feel the physical withdrawals when they stopped their daily

use of the drug after a period long enough to develop a physical dependence. Smoking *whoonga* then became a way to manage the pain and discomfort of the withdrawals.

Others continued to smoke *whoonga* because it provided a sense of physical and psychological wellbeing. Focus group members like Themba did not view themselves as ‘victims’, with no knowledge, choice or care about their drug use. While initially Themba was not aware of the substance he was using, he acknowledged that once he did find out, it was his choice to continue using:

“He then passed me the dummy and after one puff I felt different and my energy came back and it refreshed me. At a later stage he told me that it’s whoonga that we were smoking. I was shocked and I said to him: ‘My friend how can you give whoonga to me?’ He apologized but I told him it’s okay because it’s nice. I liked it after that and it was me who would ask him to bring more”.

Most of the interviewees and focus group members started using drugs at a very young age, some reporting to be as young as 12 years old. The early initiation of drugs (prior to age 16) is worth investigating further due to the prognosis being significantly worse for people who start using drugs at an early age (Anju & Gautam, 2017). The answer to this use seems to lie in the harsh social realities of their childhoods, either as having experienced severe rejection or a complete lack of connection with any social structure resembling a family. Early trauma, socio-economic disadvantage and early feelings of disconnect were drivers for almost all the focus group members and interviewees. 20-year-old Ayanda described the precedents of his living on the street and using heroin, his stepmother did not want him in the house. For Ayanda leaving ‘home’ to live on the street was less painful than staying in a family environment in which he felt unwanted. It is no coincidence then that they chose *whoonga* as heroin and indeed other opioids, are effective physical and emotional analgesics. The strong correlation between the socio-economic status and problematic drug use amongst our respondents was a clear theme in the focus groups and interviews. It fits with other studies that talk to this correlation both locally (Mokwena & Huma, 2014; Kalichman, Simbayi, Kagee, Toefi, Joost, Cain & Cherry, 2006) and internationally (Buchanan & Young, 2000).

All the women participants in the focus groups were living life on the streets and were sex workers. Whether drugs came before sex work or the other way round is not the issue. What is an issue is the lack of life opportunities and supportive interventions that could allow these young women to have a wider range of choices. It was clear that in their experience, sex work was the only income generating industry available to them as they transitioned out of primary ‘family’ life. The lack of choice resulted in a sense of helplessness and a lack of a clear vision for the future. Drugs in this context were a solution in that they could numb the feelings associated with their harsh realities. Mbali, a 23-year-old woman who participated in one of the focus groups put it like this:

“Well, there are pushing factors that pushed me to start smoking. On my part I faced the burden of looking after my home [as a sole breadwinner] as my parents had died and I had to look after my two little cousins...I was still too young mentally to be taking care of a home”.

For Mbali, sex work was the answer to her need to take over the economic requirements of her family and drugs became her mechanism for coping with the demands she felt from an early age as a young orphan with adult responsibilities. Mbali was not alone in her experiences of significant trauma within as a driver toward both homelessness and problematic drug use. Nkhosi, a 26-year-old male, shared the following life experience: “...in the year 2000, a tragedy happened

at home. I lost my father and that is when all my challenges started. My father was the only one who was taking care of us and when he died he left us without anyone to take care of us.”

At this point, while at a very young age, Nkhosi left home for the streets where life seemed less complicated. It was on the streets that he first starting using drugs as a means for escaping the tragedy of his father’s death and the reality of heard living.

During the focus group, another participant shared a similar experience. As Mvu recalls: *“My story is almost the same as Nkhosi’s because I started when both my parents died. I was still young and I was doing Matric. I landed up with nowhere to stay and so here I am on the streets trying to forget the past and get by.”*

Trauma, loss, financial exclusion is all part of the narratives of our respondents in the focus groups. Early onset of drug use and its course towards problematic drug use and, was a common feature of the focus groups and the interviews. A small number of participants such as Duncan came from ‘middle class’ families, but there too there was a feeling of being harshly judged and not quite fitting in. In addition, childhood problems linked to serious learning and concentration problems that were untreated or diagnosed, led to a spiralling downwards in terms of self-esteem and a disjuncture between actual ‘achievement’ and self-expectation.

Others who came from more middle-class homes and had access to educational opportunities, sometimes had to find their way in a context of a family where substance use was already problematic. As Marobe put it:

“I finished school in 2005 and I got a university exemption. I got a bursary and went to study at Mangosuthu Technical University. I was doing electrical engineering and I have an S2 in Electrical Engineering. I was born into a family of addicts as everyone in my family is an addict of some sort. So, I started to take drugs and alcohol at an early age because it seemed like a normal thing to do.”

While Marobe might have grown up in a setting where drug use and ‘addiction’ was normalised, he ultimately realised that this was not serving him well. Despite having at technical diploma, he found himself living a very precarious life on the street, using substances as a way of coping with his perceived self-failure. Similarly, as a trained hairdresser who worked at an established hair salon in a large shopping mall, Thandi tried to make sense of her path to problematic drug use. While she continued to have ties to her family in the township, she did not feel connected to her family members, other than her sister who also used drugs. She opted to leave her home, moved in with her boyfriend, also a dependent *whoonga* user, in a sub-economic one room apartment with six other adults and a teenager.

Feelings of self-doubt, disconnect and hopelessness were compounded by the interaction between participants and the criminal justice system, particularly the police. There is a correlation between problematic drug use in a prohibitionist environment and involvement in criminal behaviour (Dembo, Linda, Werner, James & Hendricks, 1992). Yet while several participants had never been involved in criminal activities – opting for various forms of hustling to get by – they had all had very negative experiences with the police whom they believed had prejudged them as society’s junk and constantly harassed them and found cause to arrest them.

Arrests and periods of prison usually for minor possession of drugs, led to increasing marginalisation and feelings of stigmatisation. Both structural marginalisation and stigma reinforced social exclusion and low self-esteem. Traumas that were experienced in childhood were compounded by trauma experienced at the hands of the police. Nkosi tells the story of being arrested despite the police having no cause for the arrest and his vulnerability as a street person:

“When they [the police] arrested me, they said the person who committed that crime was wearing a red T-shirt. So, because I was wearing a red T-shirt on that day and I am a ‘pharah’ [a colloquial term for a whoonga user as a ‘parasite’], then they said it was me... I opened a case against the police who arrested me and against the lady who accused me. But when I went to the police station for a follow up on the case, I discovered the file is no longer there and they cannot find that docket. The reason for that is because I am someone who lives on the street, something that is useless, which you can do anything you want to do to it. Something that you can just violate its rights and get away with it.”

The *whoonga* users – like other street level drug users – are after all easy targets for the police. They are the “low hanging fruit” that generate high arrest rates which feed into a very poorly conceptualised performance management system in the public police in South Africa (Bruce, 2011). Nkosi’s recalling tells a lot about how drug users are treated by the police but also the manner in which they are dismissed and mistreated reinforces a sensibility that the community of people who use drugs is not deserving of rights and of due process. For most of the respondents, their interaction with the police has been extremely negative, as has been their experience in prison. Criminalisation has, in their eyes, deepened their drug dependency, reinforced their self-stigmatisation and cautioned them about the possibility of receiving any form of assistance.

VOICES OF REASON: THE CALL FOR OST FROM PEOPLE WHO USE DRUGS

Attempts to develop a comprehensive programme by city officials have failed dismally (See Marks & Howell, 2016). Dependent drug users who are seeking help in normalising their lives have turned towards ‘rehabilitation’ centres for assistance, both public and private. Drug prohibition laws, stigmatisation and heavy-handed policing have all led to low levels of help or health seeking behaviour, distrust of the health system and little faith in the interventions that are available among the low-income community of people who use drugs in Durban. However, despite significant barriers to accessing services, every participant in the focus groups and in individual interviews had at one time or another, been enrolled in some form of rehabilitation centre. Some had been to multiple and all claimed that none of these experiences assisted in any real way in normalising their lives. Instead participants spoke of fairly punitive regimes within these centres and the fear and pain of withdrawal without medical assistance.

Most of those who had been to Durban’s only public rehabilitation facility, Newlands East, spoke of how they spent most of their time at this facility plotting ways of ‘escaping’. Indeed, more than half of the respondents did abscond before the end of the treatment period. Duncan shares his negative experience about being in a state rehabilitation facility:

“I have been there [state rehab] for like three weeks, ja. I was supposed to be there for six months. But that rehab is crazy my brother. They do not give you anything, no subuxone or methadone and no sleeping tablets. They take you to another room, it’s like a hospital. They say it’s a detox ja, they say you detox when you in that room. They see you for like two days. I did not stand a chance. I kept going to the reception and I was telling them, I want to get out of here. They don’t really care. If you want to go out, you just sign a paper. It is a joke really.”

Even those who were fortunate enough to have family support to go to private short-term residential centres spoke of a very quick ‘relapse’ into problematic drug use and their desire to be on the streets once more where they felt less judged and where the anxiety of disappointing others was not a feature of daily life. Shudu, a female sex-worker who comes from a middle-class family

also shared her encounter with private and public rehab facilities: *“I have tried more than five times, in and out of treatment and rehabs, like I said earlier...I went to rehab and stayed there for three months. I came back and relapsed.”*

Most of the participants had given up hope of ever living a positive, integrated and productive life. They were well aware that the facilities and programmes that were available did not have the outcomes that were desired. Aside from not offering required medical assistance, the facilities were abstinence based, leaving participants feeling shamed and incompetent because the goal of a ‘drug free’ life did not resonate with their inability or unwillingness to abstain completely. What they were seeking was assistance in reaching their individual goals that they had set for themselves, whether or not they were using drugs, in a non-judgemental environment, with the necessary support to reduce or curtail their drug use when ready in order to improve their quality of life and their life chances.

Participants in the focus groups were not familiar with the words ‘harm reduction’ but they had a very good understanding of the potentially positive role that opioid substitution therapy (OST) could play in providing a scaffolding for moving forward with their lives and in reducing problematic drug use. The word Methadone came up time and again, as the OST medication that participants were most familiar with because of its availability on the black market on the streets of Durban. Msa, a male who is part of the OST project has been wanting to use methadone rather than attempt to engage a rehab facility prior to even knowing about the programme. In an in-depth interview, he shares a conversation he had with his grandmother where he convinced her to rather buy him methadone rather than being taken to a rehab facility after observing a high relapse rate from his friends who came from rehabs: *“She told me that she wants to take me to rehab but I told her no do not take me to rehab they will require money and you do not have that kind of money, but if you can buy me methadone maybe I will try myself and get a job.”*

While some of the participants had experimented with Methadone on their own, this had generated anxiety as they were aware that there are real risks in using Methadone without proper supervision and guidance. They were also aware that the Methadone that was being bought without prescription might not be ‘pure’ and several participants had the medication but were too afraid to use it.

This evidence from the interviews and focus groups was reinforced when one of the authors joined the police on their drug operations in Durban. Many young heroin users were arrested and they spoke at length about needing Methadone to assist them. One woman that was apprehended while buying *whoonga* had an empty Methadone bottle in her possession. She could not afford to buy another bottle (approximately US\$ 70 for 500ml/1000mg) and so a quick fix and inexpensive solution to her severe withdrawals was to buy *whoonga* while trying to source enough money to fulfil her desire to use Methadone in a more systematic manner. Methadone is not available in the South African public health sector as a maintenance medication and is only available in the private sector for anything other than 14-day detoxification regimens. This leaves people dependent on heroin with few options when they try and moderate or stop their heroin use and avoid the discomfort of withdrawal.

OST was not the only pathway out of problematic drug use identified by focus group members or by interviewees. They spoke too of the need to have meaning and purpose in their lives through engaging in work or studies. They talked of their desire to reconnect with family members and old friends too. Yet their fear of withdrawal on their own or in an environment where this was forced upon them was overwhelmingly frightening and in many ways blocked the possibilities of other normalisation activities.

THE DURBAN DEMONSTRATION PROJECT: IMPROVING QUALITY OF LIFE THROUGH A LOW THRESHOLD OST PROJECT

In April 2017 the Urban Futures Centre (UFC), in partnership with the TB/HIV Care Association, a non-governmental organisation started the first low threshold OST programme demonstration project in the country. Fifty low-income heroin users, of which a minimum of 80% will be people who smoke *whoonga* (20% of the places will be for people who inject heroin) are in the process of being recruited into this project. They will be able to access Methadone under medical supervision by a team of a part-time general practitioner, a nurse, a social worker and a counsellor, who has been trained in opioid substitution therapy. Voluntary psycho-social programmes are available at the site and many of the beneficiaries are accessing these. The groups focus on making conscious choices under difficult circumstances and developing social skills that the community have identified as being helpful. There is a mindfulness component that informs the approach. During these group sessions individual beneficiaries are able to talk openly about their drug use, behaviours, their experience of OST and their own personal goals. Goals are diverse, for some the goal is abstinence while for others it is to reduce the use of only certain drugs or to change the means of use.

The Demonstration Project takes on a very clear harm reduction approach. The team at the clinic meets beneficiaries where they are at, being conscious that there are a variety of reasons for drug use and that the goal of abstinence is not the best indicator of 'success. Instead, success is measured by an improvement in quality of life and a reduction in harmful drug use practices, such as sharing of needles. Quality of life improvement measures include a decreased negative interaction with the criminal justice system; enhanced personal health and hygiene; adherence to chronic medication; reconnection with significant others such as previous friends and family; and re-entry into secondary socialisation institutions such as schools and the work place. The project also serves as a learning site for health professionals in the public and private sector with regard to best practice OST. A further aim is to demonstrate (at both the micro and macro level) the cost effectiveness of OST as compared with simply leaving heroin users to self-resolve their issues, arresting and charges people who use drugs, or placing them in 'rehabilitation' programmes. This OST Demonstration Project operates in accordance with a detailed and robust protocol which has been approved by the Durban University of Technology and the Department of Health ethics committees. The protocol is written to take local conditions into account while aligning with the extensive international knowledge base on best practices for the implementation of OST programmes at the public health level.

The project aims to model low-threshold access to health services and methadone. Low threshold programmes differ from other programmes in that they do not see abstinence as the only acceptable outcome, apart from an initial screening to confirm opioid use, there is no biological screening for drugs unless clinically relevant, concurrent poly-drug use is tolerated unless there is a significant clinical risk, dosing is flexible, there is no expectation of participation in psychosocial programmes and take-home dosing initiated as soon as practical. Typically, the requirements for entry are low and the time from access to initiation is as short as possible. In this particular project, due to the limited size of the cohort and the research component, requirements for entry include being able to take the medication at the site daily for the first three months, having some form of stable accommodation and having a support person that is contactable. To ensure continuity of ability to access the programme beneficiaries need to be free of pending court cases and of serious psychiatric illnesses. The WHO Assist tool is used to assess substance use habits and high scores on benzoid and alcohol use are also exclusionary given how they can potentially negatively interact with Methadone. The project is situated at the drop-in-centre for people who use drugs which is

run by TB/HIV Care Association, close to the Durban CBD. A range of other harm reduction services are provided at this site such as a needle syringe programme, HIV and Hepatitis testing, counselling and referrals for medication and health risks requiring further care.

The project has experienced some challenges and has had to manage a range of adverse events. These isolated events include incidences of theft, aggressive behaviour and occasional skipped doses by those beneficiaries who have not been able to get to the drop-in centre on time, particularly on weekends. There have also been incidences of arrest of beneficiaries charged with possession of cannabis. This has led to a need to develop standard operating procedures to address these issues which have been in consultation with the people who are accessing services. Flexible dosing is a further feature of low threshold programmes and due to the half-life of methadone and the principle of 'start low, go slow, aim high', the realisation of optimal dose can take up to 14 days or more.

Qualitative and quantitative data is collected on an ongoing basis to assess changes in quality of life of the beneficiaries. After short periods of time on the OST programme a range of quality of life improvements have been noted and recorded through interviews and observations. Clients, while knowing the possible dangers of methadone as a medication and the reality of long term methadone maintenance, are very clear about the improvement to their lives since joining the programme. Many clients have reunited with family members. About half of the beneficiaries have stopped all illicit drug use, while others have reduced their use dramatically, for example from smoking *whoonga* five times a day to smoking once a day or twice a week.

There is a marked change in the personal health and hygiene of the 34 services users currently recruited. Generally, service users are adhering to other chronic medication. There have been notable improvements in quality of life, although it is too soon to assess whether these will be sustained. Four service users have found employment and one has gone back to school after dropping out three years ago. One of the beneficiaries spoke to the nursing sister about how he is now able to look at himself in the mirror for the first time in many years. His sense of dignity is being restored. Perhaps most importantly, beneficiaries have found a space where they are not judged. This has allowed them to form strong connections with the staff and with other service users on the programme who provide ongoing mutual support. In individual interviews, beneficiaries have expressed that they are now beginning to normalise their lives and have hope, for the first time, that their substance use disorder will be resolved.

They speak highly of the OST programme and can articulate clearly why it has been more effective than previous attempts to resolve their problematic drugs use using residential abstinence-based rehabilitation programmes. They have described how they felt judged and under pressure to give up their drug use when they were either unwilling or unable. Hashim, a 44-year-old respondent stated:

"Ever since I started in the programme, I have reduced my substance use drastically and I now know the risks of using drugs and overdosing. I now spend one fifth of the amount on illicit drugs than I used to before I entered the programme."

For Hashim, this is significant. It allows him to provide for his elderly mother who lives with him. Being on the programme has provided him with a mechanism to be able to budget and benefits for him at a personal level are very significant.

Twenty-four-year-old, Thabo, who has been using *whoonga* for six years stated that since he joined the programme he has not smoked *whoonga*. He acknowledges that this was very tough initially but that being on the programme and receiving medical assistance helped him adjust and gave him hope that it was possible to stop using heroin. Helen, a 29-year-old woman who has been

smoking heroin for most of her adult life has started to care for her six-year-old child in a more responsible way and is less dependent on her mother to play the primary parenting role. She is one of the beneficiaries who has found work as a waitress at a nearby coffee shop. Interestingly, her partner is also on the programme and they are each other's support persons.

Menelisi, whose poem is the introduction to this article, has begun reciting his poems in public platforms and is seriously considering registering for a tertiary education course. He has reunited with his father for the first time in six years and both of his parents are regular visitors to the drop-in centre. He has also started a serious relationship with a young female student and is to become a first-time father in six months. While Menelisi took about two months to stabilise on the medication, he is now no longer using drugs and is a great support to other beneficiaries on the programme. His poem which is sited at the beginning of this article talks to his historic feelings of disconnect, stigma and marginalisation as a person who uses drugs.

The Durban OST Demonstration Project is in its early phases but there is no doubt that it has transformed the lives of those who are on the programme dramatically. The socio-economic challenges remain real and need to be understood within a country context where unemployment is close to 40% in some areas. There are a variety of processes underway aimed at assisting beneficiaries in finding work through appealing to business networks to give drug users who are normalising their lives a chance in the formal workplace. The social worker who works with the OST beneficiaries plays a critical role in assisting with getting necessary identification documents, providing testimonials and linking to required health and welfare services near the clinic.

CONCLUSION

As is the case internationally, there are multiple social drivers that underpin individual decisions to use drugs, sometimes problematically. Without understanding these drivers, it is incredibly difficult to develop programmes that will reduce harm and improve the quality of life of individuals who use drugs in a problematic way. For many of the beneficiaries of our demonstration project, drugs are a solution to a range of social problems which need to be understood. Once this understanding is present, individuals are no longer treated as pathological or as deviant, but as social actors with choices to make that will reduce harms to themselves and to their families and communities.

The Durban OST Demonstration Project, after a fairly short period of time, has shown the huge benefits of access to OST for individuals with drug dependency issues, particularly those from low-income backgrounds. Yet despite the call for various United Nations organisations promoting a harm reduction approach to addressing drug use, including the provision of OST and needle syringe programmes, these are not available in the public sector in South Africa and the dominant legislative framework and social narrative remains prohibitionist and abstinence based. This stands in stark contrast to a human rights approach to public health and public safety for all, as enshrined in the South African constitution. OST and NSPs are health-care services that people who use drugs need to prevent HIV infection and to stay alive and are crucial entry points to other health services.

The authors are well aware that Methadone is not the only option for OST. Buprenorphine remains a viable option for those that choose it. The choice to use Methadone in this demonstration project resulted from a confluence of the fact that it is the most well tested and well researched of the OST medications and that Equity Pharmaceuticals came to the table to provide this medication with 'no strings attached' and that considering the possibility of concurrent heroin use and cycling in and out of the programme, a full agonist presented the least issues with re-initiation. While not blinded to the possible harms dangers associated with methadone (particularly if taken in an

unsupervised manner), there is no doubt that those on the programme have benefited enormously from its availability and proper use. The Durban OST Project is the starting point for providing much required local evidence of the efficacy of low threshold OST provision, ideally in a community based and primary health care setting, in South Africa and in other developing countries.

ENDNOTES

1. This was described in several local press articles, for example, Dawood, 2014: np

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