People Who Inject Drugs & Other People Who Use Drugs

An Introductory Manual for Health Care Workers in South Africa
PEOPLE WHO INJECT DRUGS AND OTHER PEOPLE WHO USE DRUGS

An introductory manual for health care workers in South Africa

First Edition 2012

Benjamin Brown, Zoe Duby and Linda-Gail Bekker
DEDICATION

This manual is dedicated to all Africans who have been unjustly discriminated against and who have been denied the support and services they need.
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Abstinence
Abstinence in the context of drug-taking behaviour refers to abstaining or not using drugs.

Addiction
A condition in which a physical or mental dependence exists for a particular substance, without which adverse effects occur. The use and abuse of a chemical marked by increased tolerance, craving, preoccupation, withdrawal when the substance is not available, and failed efforts to stop or reduce intake despite recurring problems in major life areas.

Aftercare
Follow-up care that offers ongoing support to maintain sobriety or abstinence, continues personal growth, and assists with reintegration into the community/family.

Amphetamine
A synthetic, addictive, and mood-altering drug, used illegally and legally as a prescription drug, which acts as a central nervous system stimulant. Amphetamines are usually ingested orally but can also be snorted, smoked, injected or inserted anally.

Anxiety
Anxiety can be described as worrying about the future over which you have no control. It affects how you feel and behave and has very real physical symptoms.

Assessment/Evaluation
The systematic identification of a patient’s/client’s condition and needs within a framework based on professionally accepted best-practice guidelines.
Backloading
Sometimes referred to as piggybacking. Backloading refers to a single syringe which is used to draw up equal amounts of the liquid drug (e.g. heroin), which can then be carefully squirted into the back of each person’s syringe after the plunger has been removed.

Bipolar disorder
A mood disorder characterised by alternating episodes of depression and mania or hypomania.

Cannabis
Known as marijuana or dagga. This substance acts as a central nervous system depressant and hallucinogen. Cannabis is usually inhaled by smoking but can also be ingested orally.

Chipping
This term refers to heroin users who stick to very strict rules, such as only using on weekends, using once a week, and so forth. They are considered to be not (yet) addicted to heroin.

Chrystral Meth
See Methamphetamine.

Cocaine/Crack cocaine
Substances derived from the coca plant that act as a central nervous system stimulant. Cocaine and crack cocaine can be snorted, smoked and injected.

Comorbidity
See Dual diagnosis.

Cooker
A term used to describe any variety of containers used to heat or dissolve drugs in solid form into liquids to prepare them for injection.

Depression
Depression can be described as a low or depressed mood with loss of interest or pleasure in life and activities that lasts for a period of two weeks or more and is disruptive to everyday functioning. It is characterised by sadness, inactivity, difficulty concentrating and thinking, significant increase or decrease in appetite, difficulty sleeping and suicidal thoughts.

Detoxification
Detoxification, or detox, is a process in which the body is allowed to free itself of a drug. During this period, the symptoms of withdrawal are also treated. Detoxification is the primary step in any drug treatment programme and is used as the initial phase in treating addictions to alcohol, heroin, inhalants, sedatives and hypnotics. The goal of detoxification is to clear the toxins out of the body so that the body can adjust and heal itself after being dependent on a substance.
Discrimination
Discrimination refers to the unfair treatment of people because of certain traits or characteristics.

Downer
Downer refers to a type of depressant or tranquilising drug.

Drug addiction
Drug addiction is often described as a physical disease affecting the brain, characterised by compulsive behaviour that is hard to control. The individual has difficulty resisting the urge to take drugs despite the negative consequences.

Drug dependence/Substance dependence
Drug dependence occurs when an individual has a physical dependence on a drug and becomes dependent on it for normal physiological functioning of the body. (See Appendix II for a detailed definition of Dependence.)

Dual diagnosis
A dual diagnosis is given when an individual has signs and symptoms of two co-occurring conditions (e.g. TB and HIV), each requiring treatment and management.

Ecstasy
This substance belongs to the class of drugs known as amphetamines. (See Amphetamine.)

Frontloading
Frontloading refers to when the liquid drug (e.g. heroin) is carefully squirted into the front of each person’s syringe, which still has the plunger in it but from which the detachable needle has been removed.

Hallucination
A common side effect of some drugs that causes individuals to perceive objects that are not present in reality.

Harm reduction
A philosophy for drug treatment that emphasises reducing the risks that PWID face when using drugs.

Heroin
This substance belongs to the class of drugs known as opiates. It acts as a central nervous system depressant and analgesic. It is usually injected but can also be smoked. Also known as H, horse, or smack.

Hotspot
Refers to a community space that is commonly understood to be affiliated with drug use or the buying or selling of drugs.
Injection drug user (IDU)
See PWID.

Junkie
A stigmatising term used to refer to PWID.

Khat/Cat
This substance belongs to the class of drugs known as methcathinone. It acts as a central nervous system stimulant. It is usually snorted but can also be taken orally, injected and smoked.

Mandrax
This substance belongs to the class of drugs known as methaqualone. It acts as a central nervous system depressant. It is usually ingested orally but can also be smoked.

Methamphetamine
This includes speed, crystal meth or tik, which act as a central nervous system stimulant. It can be snorted, ingested orally, injected or smoked.

Methadone maintenance therapy (MMT)
The most widely known and well-researched treatment for opioid dependence. Goals of therapy are to prevent abstinence syndrome (withdrawal), reduce narcotic cravings and block the euphoric effects of illicit opioid use.

Morphine
This substance belongs to the class of drugs known as opiates. It acts as a central nervous system depressant and analgesic. It is a powerful narcotic analgesic and its primary clinical use is in the management of moderately severe to severe pain. After heroin, morphine has the greatest potential for dependence of all narcotic analgesics.

Needle (syringe)
A medical tool used to deliver liquids into the blood stream that is commonly used among PWID to deliver injection drugs.

Needle and syringe exchange (NSE)
Needle and syringe exchange programmes provide sterile syringes and needles in exchange for used syringes and needles to reduce transmission of HIV and other blood-borne infections associated with reuse of contaminated syringes and needles by PWID. The programmes can help to prevent blood-borne pathogen transmission by increasing access to sterile injecting equipment and enabling safe disposal of used syringes and needles. Often, programmes also provide other public health services, such as HIV testing, risk-reduction education and referrals for substance-abuse treatment. Also referred to as needle syringe programmes (NSP).
Opioid dependence

Opioid dependence is a medical diagnosis of a chronic brain disease characterised by an individual’s inability to stop using opioids (e.g. morphine, heroin, codeine, oxycodone, hydrocodone) even when it is in his or her best interest to do so. This physical, psychological and behavioural need for an opioid drug is unrelated to medical necessity for pain relief.

‘Opioid dependence develops after a period of regular use of opioids. The time required for dependence to occur in a person varies according to the quantity, frequency, and route of administration, as well as factors such as individual vulnerability and the context in which drug use occurs. Opioid dependence is not just a heavy use of opioids, but a complex health condition that has social, psychological, and biological determinants and consequences. It is not a weakness of character or will’ (World Health Organisation definition).

Opioid substitution therapy (OST)

An evidence-based intervention for opiate-dependent persons that replaces illicit drug use with medically prescribed, orally administered opiates such as buprenorphine and methadone. OST reduces HIV risk behaviours and harms associated with injecting (such as abscesses, septicaemia, and endocarditis), overdose and participation in criminal activity, thereby improving the quality of life and health of PWID. It is endorsed by UNAIDS, UNODC and WHO as part of a comprehensive package of nine core interventions for PWID programmes that collectively maximise impact for HIV prevention and treatment.

Paraphernalia

Paraphernalia refers to any assorted collection of tools that are used to facilitate drug use or drug-taking behaviour.

Popping

A process called popping or skin popping refers to injecting heroin right under the skin.

Post-traumatic stress disorder (PTSD)

A disorder that develops after exposure to a highly stressful event (e.g. threats to one’s life, rape, war, natural disasters, being robbed). Symptoms include flashbacks of the incident, difficulty sleeping, recurrent nightmares about the incident and avoiding reminders of the incident.

Psychosis

A mental disorder characterised by delusional thinking, disorientation, detachment from reality and hallucinations.
PWID (People who inject drugs)
This refers to people who inject drugs or a person who injects drugs.

PWUD (People who use drugs)
This refers to people who use drugs or a person who uses drugs.

Relapse
Relapse refers to a period of substance use following a period of no substance use. The term relapse usually refers to drinking or using drugs again after a period of abstinence, or trying to quit drinking or using and not being able to do so. Sometimes it is used interchangeably with the terms slipping or falling off the wagon. Many alcohol- and drug-abuse clinicians differentiate between a slip and a relapse by defining a slip as a one-time, isolated mistake followed by a renewed commitment to and effort at treatment and abstinence. A slip may be seen by the recovering person as a wake-up call regarding how much more effort will be required to achieve lasting, continuous abstinence.

Slip
See Relapse.

Sobriety
Sobriety refers to the moderation of or abstinence from consumption of alcoholic liquor or use of drugs.

Sexually transmitted infection (STI)
Infection transmitted and acquired through sexual contact.

Stigma
Shame or disgrace attached to something regarded as socially unacceptable.

Withdrawal
Withdrawal refers to the group of symptoms that occurs upon the abrupt discontinuation of or decrease in intake of drugs and/or alcohol. (Also referred to as abstinence syndrome.)
PEOPLE WHO INJECT DRUGS (PWID)
SENSITIVITY TRAINING
PRE-COURSE
ASSESSMENT AND QUESTIONNAIRE

Before using this manual or participating in a related training programme, please complete the following multiple-choice questions.

A post-course assessment is available at the end of this manual on page 82.
PREVIOUS EXPERIENCE WITH PWID

1. How many clients have you had in the past 3 months who have injected drugs?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any clients who inject drugs

2. In your career, how many clients have you managed who have injected drugs?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any clients who inject drugs

3. If you have had clients who injected drugs previously, how many did you refer to mental health services?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any clients who inject drugs

4. If you have had clients who injected drugs previously, how many did you provide with risk-reduction counselling?
   a. fewer than 5
   b. between 5 and 10
   c. more than 10
   d. I have not had any clients who inject drugs

5. Have you ever received sensitisation training for People who Inject Drugs (PWID) before?
   a. Yes, I have received sensitisation training on PWID before
   b. No, I have not received sensitisation training on PWID before
   c. I am unsure if I have received sensitisation training on PWID before

PWID KNOWLEDGE

1. PWID are at higher risk for HIV than the general community because
   a. they may share needles to inject drugs
   b. they may be exposed to violence or sexual assault
   c. they do not get effective health care because of stigma or discrimination
   d. all of the above
2. **PWID may be stigmatised because**
   a. They may have injection marks on their arms
   b. They may be dirty or smell bad
   c. They may engage in an illegal activity
   d. All of the above

3. **PWID stigma can be addressed in a health care setting by**
   a. Having a separate queue for PWID away from the other clients
   b. Encouraging the police to visit the clinic regularly
   c. Addressing the use of inappropriate language used towards PWID
   d. Refusing to provide PWID the same services as other clients

4. **PWID find it hard to access health services because**
   a. They face ill-treatment and discrimination from health care staff
   b. They don’t have money for transport
   c. They worry that they will get arrested if they go to the clinic
   d. All of the above

5. **People take drugs because**
   a. They experience peer pressure
   b. They want to experiment
   c. They need a coping mechanism
   d. All of the above

6. **Which of the following is a strategy that PWID can use to reduce their risk when injecting drugs?**
   a. Injecting with heroin instead of with cocaine
   b. Getting tested for HIV and STIs
   c. Only injecting with other drug users in a communal area
   d. Only sharing needles with people that they trust

7. **PWID share needles because**
   a. They want to save money
   b. They are scared to buy needles
   c. It is a way of showing that you are friends with someone
   d. All of the above
8. Risk-reduction counselling is a behavioural technique meant to reduce HIV risk
   a. By convincing PWID to stop taking drugs
   b. By eliminating all risk that PWID may experience
   c. By decreasing the risk experienced by PWID according to their actions and circumstances
   d. None of the above

9. A PWID can reduce risk of getting HIV by
   a. Not injecting drugs
   b. Not sharing needles
   c. Getting tested for STIs regularly
   d. All of the above

10. Which of the following is a factor that affects the mental health of a PWID?
    a. High levels of stigma and discrimination
    b. The high expense of needles
    c. The shortage of drugs
    d. All of the above

11. To provide better services to PWID, health care services should do which of the following
    a. Provide confidential and sensitised risk-reduction counselling
    b. Include input from PWID in the design of the service
    c. Provide combination HIV prevention strategies for their use
    d. All of the above

12. Combination HIV prevention for PWID is
    a. Useful because it addresses the multiple risks PWID face
    b. Inclusive of NSE and OST programmes
    c. Inclusive of psychological support for PWID
    d. All of the above

13. Which of the following is NOT a sign of external stigma?
    a. A nurse gossips to a receptionist about the drug-taking behaviour of their client who injects drugs
    b. A counsellor believes that drug use is immoral and tries to counsel the drug user to stop drug use immediately
    c. A nurse refuses to draw blood from a client suspected of injecting drugs because he or she does not want to contract an illness.
    d. A health care worker refuses to provide medication to a PWID until he or she stops using drugs because of the belief that the medication will be ineffective
FOR THE FOLLOWING STATEMENTS, INDICATE WHETHER YOU
AGREE OR DISAGREE BY CIRCLING A NUMBER BELOW:

14. People who inject drugs do not visit my clinic.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

15. People who inject drugs are immoral.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

16. PWID deserve to get HIV because of the behaviour that they engage in.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

17. If a PWID came into my clinic, I would provide him or her services.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

18. If a PWID wanted treatment for an STI, I would not provide it because he
    or she will just get infected again.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

19. If a PWID came into my clinic, I would advise him or her to quit using drugs
    rather than provide harm-reduction strategies.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

20. I am comfortable providing health care services to PWID.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

21. I believe that I can effectively counsel a PWID to reduce his or her risk for
    getting HIV.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

22. I am aware of PWID-friendly services that a client could be referred to for
    more in-depth care.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

23. I am aware of PWID organisations that work in my community.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

24. PWID should not have a right to access clean injection equipment such as
    needles and syringes.
   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree
25. PWID have specific kinds of health care needs that have to be considered to enable best health outcomes.
   Strongly Disagree  1 2 3 4 5 6 7 8 9 10  Strongly Agree

26. PWID should be offered services unique to their needs because they are more vulnerable than other people and may need special treatment.
   Strongly Disagree  1 2 3 4 5 6 7 8 9 10  Strongly Agree
INTRODUCTION AND OVERVIEW

Why was this manual developed?

This manual was developed as a resource for health care workers who work with clients who inject or use drugs. Some health care workers may have limited experience with people who use drugs (PWUD), and many more may be unfamiliar with the practice of injection drug use or people who inject drugs (PWID). Drug use is common in South Africa, and there are indications that the practice of injection drug use is increasing. Many HIV- and health-related risks are associated with injection drug use; these risks can have a negative impact on both individuals and broader communities. The National Strategic Plan on HIV, STIs and TB 2012–2016 specifically states that health care services need to be responsive to the health needs of drug users. Therefore, health care workers in South Africa should be sensitised and informed about the specific risks and health needs of PWID to improve health care services and contribute to the treatment and prevention of HIV and other health issues.

How was this manual developed?

Information in this manual was developed collaboratively with expert contributors from across South Africa. All content was then compiled by a team of experienced editors from the Desmond Tutu HIV Foundation and appraised by a series of peer reviewers. The manual was presented at multiple stakeholder engagement meetings with South African key stakeholders, academics and service providers to provide further opportunities for input, review, and buy-in.

Who is the target audience of this manual?

This manual is designed for health care workers in South Africa who have varying degrees of experience with PWID. It is designed specifically for individuals who already have a basic understanding of and experience in health service provision.
What are the aims and objectives of this manual?

This manual aims to supply health care workers with the necessary skills and knowledge that are needed to provide support for PWID within South African health care settings. This manual also aims to provide health care workers with an opportunity to understand and address both social and personal stigma towards PWID.

After reviewing this training manual, health care workers should be able to do the following:

i Describe injection drug use, the associated risks, and why people inject drugs;
ii Describe PWID in South Africa, their risk behaviour, and their overall needs;
iii Describe the effects of stigma and discrimination and their impact on the overall well-being of PWID;
iv Describe how health care workers can contribute to and affect PWIDs’ access to effective health care;
v Understand how and why PWID are at great risk for HIV infection and describe methods for reducing risk;
vi Understand the role that mental health plays in the lives and risk profiles of PWID;
vii Describe effective and supportive prevention programming for PWID; and
viii List various methods throughout their health care facility that can improve services for PWID.

How is this manual structured?

This manual is divided into eight modules that address important topics related to PWID. Each module includes a brief introduction, a set of learning outcomes, and a series of questions and answers. At the end of each module are a brief summary and a list of recommendations. Many modules include exercises and reflection tasks to provide an opportunity for assessment of knowledge, attitudes and beliefs. Furthermore, practical case studies are presented in story form throughout each module. The case studies are based on real experiences and provide an opportunity for participants to practise newly learned skills and knowledge. Pre- and post-course assessments are included to measure levels of experience, knowledge and attitudes before and after completing the course. More in-depth information and resources are included in the appendices.
Is this manual part of a training programme?

This manual was designed as part of a full sensitisation training programme, but it can also be used as a stand-alone resource. The full training programme should be led by an experienced facilitator and make use of the supplemental Facilitator’s Guide (please contact the editor for a free electronic copy). Content was developed for both individual reflection and small-group work. Health care workers who are able to take part in a full programme should review the information presented in the manual beforehand, as the training programme will focus more on interactive and reflective activities. If a full training programme is not available the manual can be used for individual study, although it is recommended that small study groups be established to discuss the content with others.

What are the next steps?

The development of tools for South African health care workers is an ongoing process. This manual builds on the work of the Desmond Tutu HIV Foundation’s training programme Men Who Have Sex With Men: An Introductory Guide for Health Care Workers in Africa, first published in 2009. We encourage users of this manual and other stakeholders to provide input and suggestions for improving this training tool. Comments can be sent to ben.brown@hiv-research.org.za.

A note on terminology

This manual primarily focuses on people who inject drugs (PWID). However, much of the information presented can also be applied to the broader population of people who use drugs (PWUD). To simplify the text, PWID will primarily be used instead of continual referral to both PWID and PWUD. When PWID is used, it can be assumed to also apply to PWUD – unless injection drug use is specifically mentioned.

Previously, the term injecting drug user (IDU) was used instead of PWID. Please also note that the term intravenous drug user is incorrect because subcutaneous and intramuscular routes may be involved. The term PWID refers to any person who has injected drugs in the past 12 months. The term PWID is preferable to drug addict or drug abuser, which are derogatory terms that are not conducive to fostering the trust and respect required when engaging with people who use drugs. Hence, the term PWID is preferable because it places the emphasis on people first.
Drug use is common in South Africa and the practice of injection drug use is increasing; however, for many health care workers it still remains an unfamiliar topic. This leaves South African health care workers underprepared to manage the unique health care needs of people who use drugs (PWUD) and even less prepared to respond to the needs of people who inject drugs (PWID). As this manual will document, PWUD are at high risk for HIV and other sexually transmitted infections (STIs); PWID are at even higher risk due to the specific behaviours associated with injection drug use. They also experience significant stigma and discrimination, as well as multiple barriers to accessing effective health care and treatment. While the specific behaviours associated with injection drug use and the needs of PWID are complex, they are also manageable. Therefore, a general understanding of drug use, PWID and their behaviours and needs is essential for health care workers. This module will provide an introduction to drug use, how drug use works, and the ways in which injection drug use increases PWIDs’ vulnerability to HIV and STIs. This module will also discuss the basic health needs of PWID, their common risk behaviours and the human rights abuses and stigma they may experience.
Learning outcomes

At the end of this module health care workers should be able to do the following:

i Define drug use and explain why some drug users inject drugs
ii Characterise injection drug use in South Africa
iii Describe the overall vulnerabilities of PWID
iv Understand why PWID are at high risk for HIV and other STIs
v Describe the types of treatment options available to PWID in South Africa

What is a drug?

A drug is a substance that has some type of physical or mental effect on a person when they take it. There are many types of drugs in South Africa. Some have been developed to treat people for medical conditions. These drugs are legal and regulated by the government. They include HIV medications and drugs available at the pharmacy, such as tablets for headache relief. Some drugs however, can also be used for stimulation or as a narcotic and are illegal. These include drugs such as cannabis and methamphetamine.

How do drugs work?

Drugs affect the human body by altering the chemicals in the brain. The effect of drugs can differ greatly, depending on how the drug enters the body and other factors. Many drugs are first processed through the body before affecting the brain. For example, alcohol is consumed and first processed by the liver before the user experiences its effects.

Drugs can also enter the body by being snorted (taken nasally) or inhaled. Cocaine, for example, can be snorted and passes through the membranes in the nose. Nicotine, the drug found in cigarettes, is smoked and passes through the lungs. Other drugs can be absorbed through contact with the skin or mucus membranes.

What are the different types of drugs?

Drugs can commonly be divided into three categories: uppers, downers, and hallucinogens.

Uppers

Drugs described as uppers (e.g. cocaine, ecstasy, methamphetamine [tik] and crack cocaine) are stimulants designed to make the user feel energised, excited and capable of doing anything. The increased activity experienced after using uppers usually lasts from 20 minutes to 12 hours. Users often
have decreased appetite, which results in severe weight loss and deterioration of general health. Users can develop a tolerance to the drug over time, requiring larger amounts to reach a high.

Users who become addicted will need the drug regularly to gain the strength and energy to do usual chores. Tik addicts, for example, can sleep for days until they use again, to regain their energy. Methamphetamine use is also associated with an increased sexual appetite and this, coupled with violent and aggressive behaviour associated with chronic and high-dosage usage, can be very dangerous. Long-term use can also lead to heart failure, brain damage and stroke. Mental disorders, such as delusions, hallucinations and depression, may even lead to violent behaviour and/or suicide.

**Downers**

Drugs referred to as downers (e.g. alcohol, dagga, mandrax and heroin) have a calming effect. They reduce anxiety, make the user feel relaxed, and provide a feeling of detachment from emotions, especially from pain and sorrow. However, long-term use results in feelings of lethargy, lack of ambition, and failure to meet responsibilities. Some of the physical symptoms of using downers include slowed breathing, slowed heart rate, and lowered body temperature. Too much of a downer drug can result in bodily systems slowing or shutting down and possibly cause death. Uppers and downers are often both misused by addicts. For example, tik may be used to awaken the senses and to reach the ultimate high, while dagga may be used to bring the user down, either because the high the user experiences is too intense or because the user might need to come down for a specific reason.

**Hallucinogens**

Hallucinogens are drugs that cause interference in the user’s brain that leads to visual and auditory distortions in their perception. In other words, users see and hear things that do not exist. For example, a person who is having a hallucination may see another person who is not actually present. Hallucinogens can also cause feelings of euphoria but also feelings of anxiety and confusion. If large quantities are taken, physical side effects such as ruptured brain vessels, seizures and respiratory failure can occur.
What is injection drug use?

Injection drug use involves the direct injection of a drug into the body. Drugs are not only injected into the blood stream (although this is most common), but also into the muscle (intramuscular injection) or under the skin (subcutaneous injection). Many of the same drugs that can be smoked, snorted or otherwise consumed can also be directly injected by the user. The most commonly injected drugs in Africa are heroin and cocaine. While methamphetamines (also known as tik) are usually smoked, they are increasingly also injected in combination with heroin (1).

Why do people inject drugs?

Injecting drugs provides the quickest route to the brain, so the user generally experiences a stronger sensation than through other methods. Injecting a drug directly into the blood stream will usually result in intense feelings of euphoria within 7–8 seconds – much quicker compared to intramuscular injection, which may take 5–8 minutes.

People also choose to inject drugs to avoid the physical side effects that result from other methods of drug use. For example, stomach cramps and nausea are generally avoided because the drug does not pass through the digestive system. Injecting a drug also avoids damage to the inner lining of the nose, throat and lungs that can occur when drugs are inhaled or smoked.

Most people who use drugs do not start by injecting them. This behaviour usually happens as a person’s dependence on the drug increases. Over time, the repeated use of a drug will cause its initial effects to decrease. Eventually, the user will need to increase the dose to get the same high. Using more of the drug means that the user will need to buy larger amounts of it. For some users, this is not an option because of the cost; therefore, they may turn to injecting their drugs to increase the effects. Some drug users may live in communities where their drug supply is limited or hard to access. This may cause the cost of the drug to be higher, meaning that the user can only afford a smaller amount. In these instances, users may choose to inject to more effectively use what they are able to buy.
For others, injecting drugs may not be a choice. Partners of injection drug users may be pressured into injecting to sustain their relationships. Sex workers may also be forced into injecting drugs as a way for their managers, or pimps, to control them and thus secure their business. Still other drug users may inject drugs after having experimented with injection, which may have led them to become dependent on the drug. (Drug dependence will be discussed further in Module 6: Mental Health Amongst PWID.)

Does injection drug use occur in South Africa?

Injection drug use occurs all over the world, including South Africa. The World Health Organisation (WHO) estimates that approximately 16 million people around the world inject drugs, and 3 million of them are living with HIV (18). In Africa, there is evidence to suggest that the overall number of PWID is increasing, and it is estimated that 0.2% of African adults inject drugs. Drug trafficking and weak border controls are believed to be increasing the spread of drug use in Africa. Many drugs enter South Africa from Asia and South America; most heroin enters from Mozambique (2).

FROM THE NATIONAL STRATEGIC PLAN ON HIV, STIS AND TB 2012–2016

- There are an estimated 10,000–50,000 injecting drug users in South Africa.
- In the 2008 household survey, there was an 11% HIV prevalence among recreational drug users.
- Research from the Medical Research Council (Parry, 2008) shows that 86% of South Africans who inject drugs share injection equipment, not only syringes but also other drug paraphernalia.
- The same MRC study (Parry, 2008) shows that 65% of South Africans who inject drugs practice unsafe sex.
- The NSP 2012-2016 recognises that there is a large and growing problem with crack cocaine, especially among the youth and sex workers.
- In light of this data, the NSP recognises the need to consider scaling up substance abuse reduction programmes and needle exchange programmes.

In South Africa, drug use came later than it did to more-developed countries – but it came rapidly. Before 1994, South Africa’s drug users mainly had access only to cannabis (dagga); mandrax (methqualone) and prescription tablets. After the end of apartheid, however, national borders reopened and international trade increased. This created an avenue for new drugs to enter the country. As a nation, South Africa was underprepared for the influx of drugs such as heroin and methamphetamine (tik) (19).
While heroin and methamphetamine are still less prevalent than other drugs such as alcohol or cannabis, there are signs that their use is increasing. For example, the proportion of admissions to treatment programmes related to heroin use increased from 2% in the first half of 1998 to 14% in 2006. Similar increasing trends in heroin-related admissions have also been reported in Gauteng Province (3).

**EXERCISE 1**

**Mind-map**

When you hear the words ‘drug user’ or ‘people who inject drugs’, what is the first thing that comes to your mind? Using a blank piece of paper, take 5 minutes and write down a brief description of what you consider to be a typical PWID. Make sure to consider the following:

- Do they have a job?
- Are they a man or a woman?
- How much money do they earn?
- How did they become an injecting drug user?
- Are they South African or foreign?
- Are they educated?
- Are they in a relationship?
- Where do they live?
- How old are they?

**What types of people inject and use drugs?**

Often, PWID are hidden and do not readily practise their drug-using habits in public. Research has shown that PWID exist in all major cities in South Africa. They have been identified in all racial groups and in many age groups, as well as in different social and economic groups. In South Africa, PWID have varying education levels, ranging from no formal education to tertiary level education. While the PWID community is diverse, South African studies have shown that injection drug use is highest amongst secondary students, sex workers and prisoners (4).
Overall, it is thought that there are between 10 000 and 50 000 PWID in South Africa (4). Although this may seem like a small part of the general population, experience in other African countries has shown that any size population of PWID can grow rapidly (4). That potential for rapid growth is attributed to the highly addictive nature of injection drug use.

EXERCISE 2

Case study

Read the following case study and answer the questions that follow.

*Simphiwe is a 37-year-old man who lives in Kimberley. Simphiwe has a university degree and is a qualified accountant. He has a good job working as an accountant in one of the mines just outside Kimberley. Since Simphiwe started the job at the mine, he has joined his colleagues every Friday night after work to go drinking at one of the local bars. Often after several drinks he has ended up at a nightclub in the centre of town with one of the barmaids, who also worked as an exotic dancer at the club. Simphiwe was first introduced to cocaine at the nightclub. He liked the feeling that cocaine gave him and, because it was expensive to buy, taking cocaine gave him prestige amongst the ladies at the club. After taking cocaine regularly for about 6 months, Simphiwe was offered some heroin. He had heard that heroin was the next step up from cocaine, so he thought he’d try some. Simphiwe really liked the ecstatic feeling that heroin gave him, and he started injecting heroin regularly when he went to the nightclub. He sometimes wakes up after a night out in an apartment he doesn’t recognise, not remembering anything from the night before. Simphiwe has managed to limit his heroin use to weekends, and has kept his job at the mine.*

1. How did your description from Exercise 1 compare to Simphiwe? Was it similar or different?

2. Consider the reasons why Simphiwe started to use drugs and specifically why he started injecting. What do you think are the most significant influences on his drug use? How could these influences have been avoided?

3. Can you identify any activities that Simphiwe engages in that could affect his overall health or put him at risk of exposure to HIV? If so, what are they?
While the South African PWID community may be small, its effect on HIV prevention and treatment can be significant. The PWID community does not exist in isolation; PWID regularly interact with other people and sexual partners who do not inject drugs. Therefore, any risks for HIV and STIs that PWID face can quickly bridge into other populations and communities.

What are the health issues or risks associated with injection drug use?

HIV, STIs and other infections

People who inject drugs are especially vulnerable to blood-borne and bacterial infections because they may use unsterilised injection equipment or share needles when they inject drugs. In these situations, PWID may become infected if they use a needle, syringe or other equipment that is contaminated with bacteria, viruses and/or other foreign material. These infections can lead to a variety of illnesses and can cause death of drug users, their sex partners, and their children through mother-to-child transmission.

Tuberculosis (TB)

Injecting drug use is associated with increased rates of TB infection. Increased TB disease rates among drug users are likely due to other risk factors for TB disease, such as incarceration, homelessness and poverty. Tuberculosis is a leading cause of death among PWID living with HIV. Both all-cause and TB-associated death rates are several times higher among drug users living with HIV than among other people living with HIV (4).

Social risks and vulnerabilities

Also, PWID may experience a variety of social factors that can have an impact on their health, such as unemployment, poor living conditions and poor education (5–7). In some instances, these factors are a direct consequence of using drugs; in others, they may have been the reason a person began using drugs.

In addition, PWID may also experience social isolation and marginalisation because of their drug use and related behaviours (8). Such vulnerabilities result from the significant stigma surrounding injection drug use. Overall, most societies tend to accept the use of certain substances such as alcohol; however, perceptions exist that certain substances are better than others or that some drugs are “soft drugs”. Injected drugs are often seen as the “hardest” and least acceptable substances. This perception and the stigma it creates often cause PWID, in particular, to experience discrimination from family
members, health care workers and law enforcement agencies. Discrimination and stigma surrounding injection drug use have been reported as barriers to accessing HIV testing services and other medical services in South Africa, which adds to the overall vulnerability of the PWID community (9–12). Fear often prevents PWID from seeking help, not only because of the punitive legal aspects, but also because of a lack of easy access to evidence-based treatment interventions and medication. Module 3 will further discuss the impact of stigma and discrimination on the lives and health of PWID.

The interconnectedness and collective effect of the above risks significantly challenge the health of PWID. Additional modules will further highlight these vulnerabilities and explore their effects on the lives and well-being of PWID.

**EXERCISE 3**

Exploring norms

1. Make a list of all the substances that you know are used in your community.

2. Rank the substances in order of which ones are most socially acceptable (with the most acceptable at the top and the least acceptable at the bottom).

3. Considering this list, why do you think some substances are more acceptable or less acceptable than others?

4. How is injection drug use viewed in your community?

What types of care and treatment options are available for PWID?

International guidelines support the use of policies, programmes and approaches that work to reduce the health, social, and economic risks associated with the use of drugs. This is also known as harm reduction (13). Harm-reduction strategies support PWID in finding ways to engage in their behaviour more safely.

The following interventions are internationally recognised by the United Nations Office on Drugs and Crime (UNODC) as comprehensive interventions for PWID (13). These interventions are based on scientific evidence proving their ability to prevent HIV with PWID.
1. **Needle and syringe exchange (NSE) programmes.** Needle and syringe exchange programmes are services that provide clean equipment to PWID and/or assist them in properly discarding their used equipment. The programmes also create opportunities for outreach workers, health care workers or peer educators to meet with PWID and provide them with information on rehabilitation services, broader health care and other treatment options. The NSEs can take many forms, depending on the context within which they are implemented. Some NSE programmes may take place in formal health care settings, such as a pharmacy, or they can be community-based, taking place in a mobile unit (4).

2. **Opioid substitution therapy (OST) and other drug dependence treatment.** Opioid substitution therapy provides medication, specifically methadone or buprenorphine, to users who are addicted to opiates. These medications counteract the physiological effects of withdrawal and can be used in combination with outpatient support services to facilitate rehabilitation for PWID. The therapy was developed to be a long-term maintenance programme for PWID. By holding back the effects of drug withdrawal, OST provides PWID with the option of slowly reversing their dependence.

3. **HIV counseling and testing (HCT).** This intervention provides the client both HIV testing and some type of basic counselling, such as risk-reduction counselling or standard pre- and post-test counselling.

4. **Antiretroviral therapy (ART).** Antiretroviral therapy can be provided at many standard clinics; it will need to be continued for the remainder of a client’s life.

5. **Prevention and treatment of STIs.** Local clinics should follow standard STI treatment protocols. The prevention and treatment of STIs has been shown to greatly reduce an individual’s likelihood of becoming infected by or spreading HIV.

6. **Condom programmes for PWID and their sexual partners.**

7. **Targeted information, education, and communication for PWID and their sexual partners.** Information should be directed specifically at PWID and include details on HIV and STI prevention, as well as harm-reduction strategies and other methods of safe injection.

8. **Vaccination, diagnosis, and treatment of viral hepatitis.** Hepatitis is a common infection among PWID because the virus can often be directly transmitted via blood from shared needles. All PWID should be offered vaccinations (if test results are negative) and treatment (if test results are positive).
9. **Prevention, diagnosis, and treatment of TB.** Often, PWID are exposed to other factors that expose them to TB, such as living in prisons. All PWID should be screened for TB and treated as per standard protocols.

**EXERCISE 4**

**Case study**

Read the following case study about George, a young PWID from Gauteng. After you have finished, answer the questions below.

George is a 23-year-old man who lives in Boksburg, on the outskirts of Johannesburg. A few years ago, George became involved with a group of ‘bad kids’ at school and started smoking dagga and buttons (mandrax) to be cool and fit in. George started skipping classes to take drugs, and his grades suffered. Due to financial difficulties, George’s parents were too busy and stressed to worry about him and he eventually dropped out of school. George started selling dagga to make ends meet. His parents were evicted from their house for not paying rent, so George went to live with some friends in a disused factory building. Some other guys who lived in the building told George and his friends about heroin. His friends said they never wanted to try heroin because they’d heard how dangerous it was. But George was curious to try heroin because he had heard that it makes you forget about all your worries and stress. George became addicted to injecting heroin and started shoplifting to pay for the drugs. George’s friends moved out of the building and stopped seeing him. George became very skinny. He stopped eating properly because all he cared about was his next hit of heroin.

1. What reasons do you think led to George becoming a PWID?
2. What types of vulnerabilities do you think George experiences?
3. How is George at risk for HIV? Is he more or less at risk than his friends who do not inject drugs?
4. If George wanted to seek treatment, what do you think his options could be?

**What services for PWID are available in South Africa?**

Rehabilitation and aftercare programmes do exist for PWID in South Africa, but their coverage is not widespread and their availability is minimal. In addition, South African national guidelines for the treatment of heroin and
opiate dependence are not currently available, and the accreditation of practitioners and treatment facilities are not effectively enforced or monitored. Thus, there is a gap in the provision of evidence-informed and standardised care for PWID in South Africa. Many barriers also exist for PWID who do choose to seek this treatment. These barriers can include the cost of treatment, legislation preventing access to treatment, restrictive inclusion criteria at rehabilitation centres, limited governmental support of effective treatment options, lack of confidentiality within treatment centres, and stigma and discrimination aimed at people who use drugs (14–17).

The Prevention of and Treatment for Substance Abuse Act (70/2008) in South Africa outlines the state’s responsibility to use harm reduction to combat substance abuse. However, NSE is not available in South Africa despite continued evidence to show that the programmes are effective in decreasing the spread of HIV among the PWID community. While some OST does exist in South Africa, its availability is limited and the full range of needed medications is not available. At present, methadone can be prescribed by any registered prescriber in South Africa, based on their primary qualification. The new drug act seeks to make it only available to practitioners who are trained and registered to treat substance-dependent patients or PWID.

**WHY HARM REDUCTION?**

The goal of harm reduction is to help reduce the risk that PWID may face when using drugs, not necessarily to promote abstinence from drug use. Even though PWID may continue to use drugs after engaging in harm reduction interventions, it will be safer for them to do so and they will face less risk of becoming infected with or transmitting HIV. In fact, harm reduction interventions can be some of the most effective methods for reducing the spread of HIV within communities. This is important to consider, since PWID also interact and engage with individuals who do not inject or use drugs. Health care workers who implement harm reduction interventions are therefore not only supporting PWID in improving their health, but also providing services that can support their broader community as well.

Harm reduction interventions can also support the development of trusting relationships between PWID and health care workers, since these interventions are non-stigmatising. These relationships can be useful for health care workers to foster, since PWID will be more likely to return for follow-up care and services and more likely to uptake referral services from health care workers they trust.
Some health care workers may feel uncomfortable with aspects of harm reduction interventions. For example, some may interpret a needle and syringe exchange programme as actively promoting drug use, since these programmes provide the equipment needed for PWID to use drugs. This may be challenging for some health workers who feel that they should be actively encouraging PWID to discontinue drug use completely.

It is important to understand that health care workers who implement harm reduction interventions do not promote drug use. In fact, a core approach for harm reduction is to take a neutral stance on drug use. This means that the health care worker does not promote or condemn the use of drugs. In this way, health care workers are able to actively address the health risks that PWID face, particularly HIV acquisition, and support PWID in receiving care without stigmatising or isolating them.

**SUMMARY**

- Injection drug use refers to the act of directly injecting a drug into the bloodstream. This results in a faster and more significant high for the user while at the same time reducing the amount of drug that is needed.
- People who inject drugs make up a small percentage of the general South African population, but injection drug use is highly addictive and growing rapidly in South Africa.
- Injection drug use is an incredibly high-risk behaviour because it directly and frequently exposes users to HIV through the use and sharing of injection equipment and through risky sexual behaviour.
- Because of their drug use, PWID are affected by other medical conditions in addition to HIV and STIs. They often also experience social isolation in addition to unemployment, violence and stigma.
- Limited treatment options for PWID currently exist in South Africa despite the continually proven effectiveness of certain therapies and treatment strategies such as NSE and OST to prevent new HIV infections among PWID.
Introduction

Often, PWID do not discuss their drug use and may remain hidden within their communities. Therefore, it is not surprising that many health care workers may be unaware of some of the basic behaviours and risks related to injection drug use. A deeper understanding of the basic workings of injection drug use will facilitate more effective medical care for PWID. A critical understanding of drug dependence and drug-seeking behaviour is also necessary. Thus, this module will provide a more in-depth perspective into the logistics of injection drug use and common drugs used in South Africa.

Learning outcomes

By the end of this module, health care workers should be able to do the following:

i  Describe how drugs work and why people use drugs
ii Identify the signs and symptoms of drug use
ii Explain how individuals develop drug dependence
iv List the drugs commonly used for injection and their effects
v  Describe risks involved with injection drug use
Why do people start to use drugs?

Even though drugs are physically harmful, many people use them because they can provide intense feelings that are very appealing and desirable. These feelings include well-being, elation, happiness, ecstasy, excitement and joy. Many people use drugs in search of these feelings, and they continue misusing drugs because these emotions are lacking in their lives. Other users also report using drugs merely out of boredom and because they are common in their communities.

Most drugs are freely available and can easily be bought on the streets or through drug-using friends and contacts. Teenagers may use drugs as a way of rebelling, and some use drugs because they are curious about how drugs will make them feel. Because drug use is so common, peer pressure becomes increasingly difficult to resist, more so for individuals with low self-esteem.

Different drugs cause different feelings and effects. Some of the most commonly used drugs – including alcohol and tobacco (which are legal), dagga (cannabis), mandrax (methaqualone) and tik (methamphetamine) – are chosen for different reasons. Dagga is the most prevalent illicit drug used in South Africa, followed by mandrax. These drugs are most commonly smoked using a pipe made out of the top part of a broken bottle or a lightbulb globe (see image 1).

People may also continue to use drugs because they develop drug dependence and experience both physical and psychological need for the drug.

Image 1: Broken bottle neck and lightbulb used to smoke drugs
EXERCISE 1

Why engage in risky behaviour?

Everyone has made a decision at some point in their lives that has resulted in dangerous or harmful behaviour. More than likely, there was a good reason for engaging in that behaviour. Like the rest of us, PWID have psychological, economic or social reasons for making the decision to start using drugs.

To better understand why PWID may have started or continue to use drugs, think of a time that you engaged in a behaviour that may have been harmful to you. Use the list below for ideas, or think of your own. Think about why you took a chance.

- Smoking cigarettes
- Having unprotected sex
- Driving while drunk
- Driving over the speed limit
- Crossing the road when the light is red for pedestrians
- Having a baby or child ride in the front seat of the car
- Eating a lot of fried food
- Walking alone at night in the street
- Not brushing your teeth
- Exercising less than three times per week
- Being very drunk

1. What were some of the reasons you took a chance with a risky behaviour?
2. Did it have to do with pressure from another person?
3. Was it because you felt like there were no other options?
4. What factors played a role?
5. What are some of the reasons you think PWID engage in risky behaviour such as injection drug use? How do they relate to your own reasons?

What is drug dependence?

Not everyone who uses a drug will develop drug dependence, which occurs when a person physically and mentally requires the drug to function normally. When the drug is stopped abruptly the individual experiences
withdrawal symptoms (e.g. vomiting, diarrhoea, sweating) which indicate that physical dependence has developed. Drug dependence can also be identified when an individual experiences disturbances in their psychological functioning, such as difficulty in concentrating, anxiety, depression, irritability, insomnia, headaches and muscle cramps. Drug dependence will be further discussed in Module 6: Mental Health Amongst PWID. Also, Appendix 2 provides more details on dependence.

**What is drug tolerance and how does it affect PWIDs’ behaviour?**

After using drugs for a period of time, a person’s body will begin to adjust to the drug and its effects. This means that, over time, users will no longer experience the same effects from the drugs as they did when they began using them. To continue to experience the maximum effect, more of the drug needs to be used. Because all drugs cost money, increasing the dosage can become a barrier for some drug users. To meet the financial demands of their drug use, drug users may engage in criminal activity or sex work. Drug tolerance and the need to increase the dose is also how dependence begins.

**What is an overdose?**

People who inject drugs are also vulnerable to overdose, which occurs when they take too much drug in a single episode of injecting or using. Overdosing can have significant consequences, including death. For PWID, accessing care to manage an overdose can be challenging because of fear of being arrested or otherwise becoming involved in the criminal justice system after disclosing their drug use to a health care worker. There is also very little information available for PWID on what to do if an overdose occurs, and often the health care system is not capacitated to manage such a situation.

**What is withdrawal?**

Withdrawal occurs when a PWID suddenly stops using the drug on which he or she has become dependent. This usually results in a number of physical and mental withdrawal symptoms, including abdominal cramps, muscle spasms, vomiting, chills, high fever, restlessness, irritability or depression (1).

**What is a relapse?**

A relapse occurs when a PWID begins using drugs again after having successfully stopped using drugs for a certain period of time. Relapse is common for PWID and is a normal part of recovery. Drug use, particularly injection drug use, is highly addictive and it can often take a number of attempts before a PWID can stop using drugs.
What are common signs of drug use?

Drug use can result in common physical, behavioural and psychological symptoms. A few of these are listed below; however, be aware that these symptoms could also be associated with a variety of other conditions.

Physical symptoms

- Unusually red eyes or dilated pupils
- Changes in appetite
- Changes in sleep patterns
- Sudden weight loss or weight gain
- Deterioration of physical appearance
- Skin manifestations such as abscesses or ulcers

Behavioural symptoms

- Drop in attendance and lack of interest in work or school
- Unexplained need for money that leads to borrowing and stealing
- Engaging in secretive or suspicious behaviours
- Sudden change in friends, favourite hangouts and hobbies
- Frequently getting into trouble (fights, accidents, illegal activities)

Psychological symptoms

- Unexplained change in personality, attitude and behaviour
- Mood swings, irritability, angry outbursts or unexplained excitement
- Periods of unusual hyperactivity, agitation or giddiness
- Lack of motivation and ambition
- Appears lethargic or spaced out
- Appears fearful, anxious or paranoid with no reason

How do PWID inject drugs?

For a drug to be injected, it must first be in liquid form. Many drugs, however, including cocaine and heroin, may come in a crystal, solid or powder form. A PWID will typically dissolve the drug in water in some sort of container. This container, sometimes referred to as a cooker, could be a spoon, the bottom of a soda can or another object. Some drugs may require heat to be dissolved.

Once the drug has been turned into a liquid, it is then collected using a syringe and needle. Typically, a piece of cotton will be used to filter the drug as it is collected in the syringe. Once the drug has been collected in the syringe it is ready for injection. The veiny area on the inside of the elbow is a common place for PWID to inject drugs, although many other less noticeable
spots may also be used (e.g. the inner thigh or between the toes). A tourniquet, belt or other strap is used to restrict blood flow and encourage the blood veins to stick out so they are easier to prick with the needle.

As with any regular intravenous injections, after a few uses the same vein grows hard and may collapse, which means that the user is often in search of new veins. For long-term injectors the dependence becomes so intense that they would inject almost anywhere in the body, as long as a hit is assured.

Together, the cooker, needle, syringe, heat source and tourniquet form the gear or paraphernalia that is normally needed to inject drugs (see image 2). Someone who frequently injects drugs may have evidence of needle punctures, which may be referred to as track marks.

EXERCISE 2

Case study

Read the following case study and answer the questions that follow.

Only 6 months ago, Michaela was a loving single mom to her 2-year-old daughter. Her once caring and loving boyfriend started becoming involved in drugs, and soon he started to change and neglect her and the baby. Due to his drug dependence, he lost his source of income. Michaela could no longer afford day care and soon lost her job because she was absent too often looking after the baby. Michaela, struggling alone with a 2-year-old, gradually slipped into depression as everything seemed to fall apart. She started smoking cigarettes ‘to relieve her stress’. Although it helped initially, the pressure built up and her depression became worse. One day she took a few drinks ‘only to forget about everything for a while’. However, it soon became common practice for her to try to forget about her problems by drinking too much alcohol. Michaela is now ashamed to seek help because she does not want her family to know of her weakness or be accused of being a bad mother.

1. What types of drugs are being used in this case study?
2. Why is this person engaging in drug use?
3. What options would this person have for care for her drug problem?
4. Brainstorm how you would support this person if she were your client.
What is needle and drug sharing?

Needle sharing occurs when two or more people use the same injecting equipment to inject a dose of liquefied drugs, such as heroin, other opiates, cocaine or amphetamine. The association between needle sharing and HIV infection will be further discussed in Module 5.

There are two methods for sharing injection drugs. Frontloading refers to a method of drug sharing where drug from one syringe is injected into the front end of another syringe. This allows for an equal division of the drug between two or more users. Backloading refers to injecting drug from one needle into the back, open end of another syringe. This may be more difficult because it requires that the plunger be reinserted carefully without wasting any drug. Both methods can easily lead to contamination of the injection equipment by HIV and other infections.

Why do some PWID share needles?

Reasons for sharing needles and syringes vary. In some areas, it has been found that there are strong cultural aspects to sharing needles and syringes; these items are shared in the same way that a bottle of vodka or a glass of wine or a tobacco or cannabis cigarette may be shared. In other contexts, poverty is cited by drug users as a key reason for sharing needles and syringes: having expended great energy and time procuring the necessary money to purchase drugs, they feel that the cost of a new needle and syringe is too expensive.
However, the most-cited reasons for sharing needles and syringes are the fear of purchasing and carrying needles and syringes, as well as the inability of PWID to purchase sterile injecting equipment from pharmacies that also stigmatise PWID. While injectable drugs may be hidden in many places on the body, needles and syringes are easily found during police searches.

Within the networks of drug consumers, use of drugs is rarely an individual act. The sharing of drugs is an important and frequent communal activity, associated with economic and social incentives. One situation, strongly associated with HIV infection, is the use of so-called shooting galleries – communal spaces that are well known among PWID as venues where injection drug use can occur. Shooting galleries may also provide or rent injection equipment. Another context is the use of professional injectors, where those selling the drugs also do the injecting, using the same syringe and needle for many clients.

What types of drugs can be injected?

In South Africa, the most commonly injected drugs are heroin and cocaine.

Heroin and other opiates

Heroin is a highly addictive drug that was originally created from morphine and used medically as a pain killer. Heroin is used recreationally and is a popular drug; its effects can be felt almost immediately because it is the most fat-soluble of the natural opiates. Being fat-soluble, it enters the blood stream faster and moves to the brain faster, whether it is injected or smoked. Injected heroin causes a brief, intense rush of pleasure minutes after injecting, followed by a 4- to 6-hour period of feelings of euphoria and well-being. Breathing slows, heart rate drops, and all pain disappears. Some users inject heroin right under the skin, a process called skin popping or just popping, to delay the onset of the high. In the heroin subculture, chipping is a term that refers to heroin users who adhere to very strict rules, such as only using on weekends or once a week. Such users are considered to be not (yet) addicted to heroin.

Cocaine

Cocaine is a stimulant that is derived from the coca plant. When used, cocaine stimulates the nervous system and results in feelings of euphoria, increased energy and heightened sexual arousal. Cocaine comes in many forms and can be inhaled, snorted and injected. Similar to heroin and any other drug, injecting cocaine allows a more intense and faster high than smoking it. Long-term use of cocaine can result in stroke, seizures, chest pain and heart attack.
Methamphetamine

Methamphetamine (meth, crystal meth, or tik) is a type of stimulant that when used may result in feelings of euphoria, increased libido and higher self-esteem. Drugs such as tik are both highly addictive and easily abused.

What are the side effects to injection drug use?

Because the drugs are not metabolised when injected, the effects are more intense and addictive – and so are the risks for overdosing. There are also many social, physical and mental consequences of using injection drugs. For example, injection drug use is much more addictive than other forms of drug use, creating physical dependence and often leading to more severe withdraw symptoms than when non-injection users stop taking the drug. In addition to the high risk for overdosing, injection drug use can also result in damage to the arteries and scarring of the peripheral veins. Bacterial infections can also occur at injection sites. A common effect is skin irritation or itching that is relieved by scratching. Some injectable drugs such as heroin also activate the part of the brain that governs vomiting and users often throw up right after injecting. They sometimes use the force of their nausea to judge the strength of the dose.

SUMMARY

- People choose to use drugs for a wide variety of reasons. Some people are looking for the pleasant feelings or effects that drugs provide, while others are seeking a means of escape or avoidance.
- Cocaine and heroin use are both common in South Africa.
- Despite the many reasons for initiating drug use, most drug users will inevitably experience a type of drug dependence, a strong compulsion that will compel them to continue despite extensive negative consequences.
- Drugs can be classified as uppers, downers and hallucinogens.
- Needle and drug sharing is a common practice among some PWID and carries an extremely high risk for HIV infection.
STIGMA AND DRUG USE

Introduction

Drug use is a powerful target of stigma and discrimination that can have a significant impact on the lives of PWID. Often, PWID are perceived to be bad or immoral people and are often labelled as junkies. While stigma affects all aspects of the lives of PWID, it specifically affects their access to health care and reduces the impact of targeted HIV prevention programming. Understanding this negative impact is an important component to providing health-related services to PWID. Therefore, this module will explore stigma and discrimination and their effects on the lives of PWID in more depth. It will provide an overview of the types of stigma, where stigma comes from, and how stigma affects PWID. Opportunities will be given to reflect on personal stigmas and explore how health care workers can perpetuate stigma in a health care setting. Suggestions will also be provided on how to reduce stigma within the workplace.

Learning outcomes

At the end of this module, health care workers should be able to do the following:

i  Define stigma and discrimination
ii  Explain the different types of stigma and where they come from
iii List the ways in which stigma can negatively impact the health of PWID
iv  Describe ways in which health care workers can influence the stigma experienced by PWID
v  Describe ways in which stigma may be reduced in the workplace
What is stigma?

Stigma refers to the strong negative feelings or significant disapproval connected to a person, group, or characteristic. For example, at the beginning of the HIV epidemic a significant stigma developed towards people who were HIV-positive. Consider Nozuko, a 23-year-old university student who recently found out she was HIV-positive. When Nozuko disclosed her status to her friends, they begin to act differently around her and no longer spent time with her after lectures. When she confronted her friends about their behaviour, they told her that they did not want to be seen or spend time with someone who was HIV-positive. In this scenario, Nozuko was being stigmatised because of the negative feelings her friends had towards her being HIV-positive.

Often, such feelings may cause people to act differently towards what they are stigmatising. For example, Nozuko’s friends may no longer want to share drinking glasses with her or live in the same flat. This change in behaviour can often lead to discrimination, which is the unfair treatment of an individual or group because of a certain characteristic. If Nozuko’s friends force her to move out of their flat because she is HIV-positive, she would be experiencing discrimination.

There are two types of stigma that can affect an individual or group and lead to discrimination. External stigma is stigma that is experienced outwardly because of the way in which a person is being treated by others. Nozuko was experiencing external stigma because her friends were stigmatising her and she was affected by their negative feelings and actions.

Often, external stigma may result in another type of stigma, known as internal stigma. Internal stigma can occur when a person who is experiencing stigma begins to believe and accept the stigma they have experienced. After being treated so negatively by her friends, Nozuko may over time begin to think that she is in fact dirty or unclean and may begin to hate herself for being HIV-positive. This is internal stigma, because Nozuko is now experiencing negative feelings towards herself because of the negative associations tied to her HIV status.
How does stigma develop?

Stigma develops because of many factors but is often influenced by the values and beliefs of an individual or group. A person can become stigmatised when they are considered to be different from other people and when that difference is considered to be negative or undesirable. Often, a person’s values and beliefs determine what they believe is negative or undesirable; therefore, a person’s values and beliefs can lead them to stigmatise others. Later in this manual we will discuss the ways in which certain beliefs, attitudes, and values towards PWID lead to stigma.

What are the signs of stigma?

In certain situations, stigma may be very clear; in other circumstances, it may be more difficult to define. In some instances, individuals may even be unaware that they are stigmatising someone or that they are being stigmatised by others. Therefore, it is important to understand the signs of both external and internal stigma so that proper actions can be taken to address it.

EXERCISE 1

Stigma self-reflection

Think back to a time when you were in any way treated differently by other people. For example, it may have been a time when you moved into a new area and attended a new school, and the learners there teased you for being new. It may have been when you lived in an area where you were from a different group from other people around you. It could have been when you were taken care of by a distant family relative who was not your mother or father and who treated you with less love and affection than they did their own children.

Try to remember such an experience and what happened. How were you treated differently? Then answer the following questions:

1. In what way were you treated differently by others around you?
2. How did this make you feel?
3. How do you think this experience affected you in the long term?
4. What did you learn from this experience?
Most of the signs of external stigma are centred on the way people interact with one another. These include the following:

**Avoidance.** Avoidance occurs when individuals do not want to be around or spend less time with stigmatised people. This might include a person who begins to avoid their close friend because he or she is stigmatised.

**Rejection.** Rejection occurs when individuals are no longer willing to associate with or welcome stigmatised people into their lives. This might include a family member rejecting a stigmatised relative and no longer allowing him or her to live with them.

**Moral judgment.** Moral judgment happens with individuals begin to see a stigmatised person as immoral or when they use their values to justify stigmatising someone. This might occur when an individual gets stigmatised because they do something that conflicts with the religious beliefs of others.

**Stigma by association.** Stigma by association occurs when people who associate with someone who is stigmatised also get stigmatised themselves. This may happen to someone who remains a close friend to someone who is stigmatised.

**Gossip.** Gossip happens when individuals begin to speak negatively about other people. Gossip could occur within a social circle when one of the members becomes stigmatised.

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EXERCISE 2

**Identifying values, attitudes, and beliefs**

Learning to address both the stigma that may occur in your health facility and the stigma that may occur because of your personal actions is a process that begins with identifying what may cause stigma to develop. For many people, strongly held values and beliefs may lead to the development of stigma. Therefore, the first step to understanding and identifying stigma is to better identify your own values and beliefs. Take a moment to reflect on the following questions:

1. **How would you describe your most important values?**
2. **What are the five most important beliefs that you have? List them below.**
3. **For each of these values and beliefs, can you identify when you developed them and why?**
**Unwillingness to employ.** Someone may be exhibiting external stigma when they are unwilling to hire an individual who would otherwise be qualified, only because of certain characteristics that may be stigmatised.

**Abuse.** When a person physically, emotionally or verbally abuses someone, they may be doing so because of feelings of stigma they have for that person.

**Victimisation.** Victimisation occurs when someone is blamed for problems that are unrelated to them and singled out for cruel or unjust treatment. People who are stigmatised may often be victimised.

Unlike external stigma, the signs of internal stigma may be much harder to identify because many of them occur within the individual and are focused on the way they feel about themselves. Some signs of internal stigma include the following:

**Self-exclusion from services (including health services) or opportunities.** Self-exclusion may occur when stigmatised individuals deny themselves opportunities because they are afraid of being further stigmatised, or do not consider themselves worthy of those opportunities.

**Perceptions of self.** A person who is experiencing internal stigma may have low self-esteem or other self-confidence issues.

**Social withdrawal.** Often a person who is experiencing internal stigma may disengage from their social networks.

**Overcompensation.** Overcompensation may occur when a person who is feeling internal stigma feels the need to overly contribute to a situation to make up for his or her perceived stigmatisation. This could happen when a stigmatised individual is overly grateful when someone is kind to him or her.

**Mental health issues.** Internal stigma may cause a person to become depressed or develop mental health issues. For example, a stigmatised person may develop generalised anxiety disorder because he or she feels continually stressed and anxious from perceived stigma.

**Substance abuse.** Substance abuse may be the result of internal stigma because a stigmatised person may turn to it to cope with his or her stigma.

**Suicide or attempted suicide.** Some individuals may not be able to cope with their internal stigma and may turn to suicide to escape the pain of their stigma. In some circumstances, PWID may resort to trying to kill themselves to escape the pain of stigma.
EXERCISE 3

Identifying stigma through self-reflection

The signs of internal and external stigma can sometimes be difficult to identify. Consider the following questions about stigma in your work place:

- Have you ever witnessed any of these signs of stigma within your own health care facility?
- If other staff members were involved, what is their position in your health care facility?
- What role did you play in each of the examples?
- Did you only witness the stigma or did you play a more direct role?
- Can you think of any examples in which you were directly involved in the stigmatisation of a patient? If so, what happened?

Why are PWID stigmatised?

The reasons PWID are stigmatised can be complex and may be due to many interrelated reasons, most of which relate to the following three common themes:

Deviancy and illegality

The first reason that PWID experience stigma is because the primary characteristic that describes PWID – the fact that they use drugs – is seen as deviant and is illegal in South Africa. Injection drug use carries even greater stigma than other kinds of drug-taking behaviour. Actions, behaviours or characteristics tend to be more heavily stigmatised when they are perceived to be immoral or heavily connected to strongly held values (5). In addition, because injection drug use is illegal in South Africa, PWID may immediately be perceived as wrongdoers, criminals and deviants. It may be extremely difficult to move away from this perception if it is the first impression individuals make when engaging with a PWID. Perceiving PWID to be deviant and criminal further distances people from the harsh realities that many PWID experience.

Associations with other stigmatised characteristics

Another reason PWID are heavily stigmatised is because of the association PWID have with other stigmatised behaviours or characteristics. For example, PWID may be homeless, they may suffer from mental or physical illness, and
they may have been arrested previously (1). All are examples of characteristics that tend to be stigmatised by society, and PWID experience stigma because they are often connected to these typically stigmatised characteristics. For example, PWID may have poor hygiene because they may not have access to facilities such as bathrooms, showers or running water, which may make individuals less likely to engage with PWID and judge them for being unclean. Also, PWID may be associated with people who commit crimes such as robbery or assault, which further adds to an image of violence and danger.

The independent choice of drug use

Lastly, PWID are stigmatised because they are perceived to have actively chosen to be drug users. This perception significantly contributes to the overall level of stigma experienced by PWID, because actions that are interpreted by others to be a personal choice rather than an unchanging circumstance tend to receive higher levels of stigma.

*Simphiwe and Hector are both HIV-positive young men from Port Elizabeth who regularly attended their local clinic to collect their antiretroviral drugs (ARVs). During a consultation with his nurse, Simphiwe explained that he acquired HIV through a blood transfusion when he was younger. The nurse responded by sympathising and apologising for his misfortune. When Hector explained to his nurse that he acquired HIV because he had unprotected sex with a girl he met one evening, she told him that people like him are to be blamed for HIV and that he should be ashamed of himself.*

In the above scenario, Hector is experiencing greater stigma than Simphiwe even though they have the same diagnosis. This is explained because Hector’s HIV status was perceived by the nurse to have resulted from his poor personal choice whereas Simphiwe was unable to influence the situation that led him to be HIV-positive.

People who inject drugs experience the same reaction that Hector received; they are stigmatised and seen as deserving of the consequences of their drug use because it was their personal choice that led them to use drugs. In these situations, where personal choices seem to lead to justified consequences, individuals who stigmatisate may not be aware of the full circumstances leading to the choice or behaviour.

Double or overlapping stigma

Overall, PWID experience layers of stigma that create an additive burden on their lives and well-being. This burden is often greater than any of the individual stigmas alone. Addressing these multiple layers of stigma can be challenging, given their interconnectedness.
**EXERCISE 4**

**Cause and effect**

Fold a blank piece of paper into three parts. Label one part ‘Examples’, another part ‘Effects’, and the last part ‘Causes’. Think of every time you or someone else in your health care environment has stigmatised a drug user and write this under ‘Examples’. For each of these examples, think of the potential effect it had on the PWID and write this under ‘Effect’. Conclude by identifying the potential cause or reasons for each of these examples of stigma and write this under ‘Causes’.

Once you have finished, compare your list to the table below.

<table>
<thead>
<tr>
<th>Examples</th>
<th>Causes</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name calling</td>
<td>Withdrawal</td>
<td>Lack of knowledge or understanding</td>
</tr>
<tr>
<td>Labelling</td>
<td>Depression</td>
<td>Lack of information</td>
</tr>
<tr>
<td>Gossiping</td>
<td>Loneliness</td>
<td>Ignorance</td>
</tr>
<tr>
<td>Making assumptions about PWID</td>
<td>Isolation</td>
<td>Religious beliefs</td>
</tr>
<tr>
<td>Judging and criticising</td>
<td>Sadness</td>
<td>Cultural beliefs</td>
</tr>
<tr>
<td>Rejecting</td>
<td>Anger</td>
<td>Society’s norms and expectations</td>
</tr>
<tr>
<td>Excluding</td>
<td>Feelings of hopelessness</td>
<td>Perceived difference</td>
</tr>
<tr>
<td>Denying services to individual PWID</td>
<td>Low self-worth</td>
<td>Fear</td>
</tr>
<tr>
<td>Discriminating against PWID</td>
<td>Substance abuse</td>
<td>Competition over resources (e.g. health care or jobs)</td>
</tr>
<tr>
<td>Prejudice</td>
<td>Self-destructive behaviour (e.g. not looking after health)</td>
<td></td>
</tr>
<tr>
<td>Physically attacking the individual</td>
<td>Lack of access to services such as health care</td>
<td></td>
</tr>
<tr>
<td>Chasing PWID away</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How are PWID affected by stigma?**

Stigma can affect PWID in many of the same ways as everyone else. It can result in extraordinary mental distress that can erode self-esteem and ultimately affect psychological and, potentially, physical health (2). Most significantly, stigma can have a great impact on a PWID’s ability to access health services and create a barrier to accessing the justice system.
Access to care

While there is still research needed among the PWID community in South Africa, there are studies to show that PWID are not accessing health care through public health facilities because of fear of stigma and discrimination (6). As detailed above, health care workers may see PWID as immoral and as sinners who are to blame for their own HIV infection and are therefore less deserving of health care. Such feelings of judgment and inferiority may cause individuals to disengage from social and health care services, which can have a significant impact on both HIV-positive and HIV-negative PWID. For those PWID who are HIV-positive, these negative attitudes, misperceptions and lack of care create a barrier towards accessing their ARVs and treatment needed for concurrent conditions. For those PWID who are HIV-negative, an unwelcoming environment created by these attitudes can discourage HIV testing and treatment for an STI or other conditions. People who are stigmatised will delay approaching and accessing health care services, resulting in a prolonged risk for transmission, poor treatment adherence, and increased risk of disability and drug resistance (3). For all PWID, this environment can create problems accessing preventive material such as clean injecting equipment, condoms and information and education about safe injecting and safe sex.

Access to justice

Also, PWID are likely to be discriminated against by the police, not just because of the illegality of injecting drug use but also because of their status as second class citizens. They may experience violence and sexual assault, as well as infringements on their right to justice. In a similar context to the health care setting, negative attitudes from police make addressing these violations nearly impossible, thereby leaving PWID vulnerable to experiencing them again. Health care workers may be unable to address police stigma, but understanding the effects and influences it has on PWID can assist in treating clients who use or inject drugs (7).

How can health care workers influence stigma towards PWID?

Health care workers are meant to provide support, care and treatment to all people who are in need. However, discrimination against PWID is widespread and it often leads to some health care workers refusing to provide proper medical care or access to social services. Relationships with health care workers are often negatively affected if they suspect or know that a client or patient is an injecting drug user (4). It is this poor relationship with health care workers that may drive away many PWID who are in need of health care.
support. Some health care workers may perceive this as a rare interaction with few ramifications; however, without adequate testing and treatment for HIV and other STIs, PWID may have an impact on broader community health.

EXERCISE 5

Case study

Read the case study below about Sarah, a nurse in a local clinic in Mbekweni, and answer the following questions:

Sarah works as a nurse at the government clinic in Mbekweni. One afternoon a new client came to see Sarah, complaining about bad stomach pains. The new client was a young woman in her early 20s. Her clothes were old and torn and she smelled unwashed. When the young woman sat down in Sarah's consulting room, Sarah moved her chair away from her and held her nose to avoid the smell. When the client rolled up the sleeve of her jersey so Sarah could take her blood pressure, Sarah noticed some marks on the inside of her arm that looked like needle wounds. When the young woman slowly started explaining her symptoms, Sarah became impatient and shouted at the young woman, telling her it was her own fault she was sick if she was doing these bad things like taking drugs. Sarah told the young woman there was nothing she could do to help her if she continued taking drugs as she was just killing herself. The young woman started crying and left the clinic without receiving any medication for her stomach problems.

1. What types and forms of stigma were being experienced by Sarah's client?
2. What are the effects that stigma and discrimination had on Sarah's client?
3. Do you think Sarah's actions were intentional? Why or why not?
4. What do you think influenced Sarah's thoughts and actions towards her client?
5. Brainstorm one to three ways you think that this situation could have been prevented.
How can stigma towards PWID be addressed?

There are many ways to address personal stigma as well as stigma that occurs in the health care environment and in the broader community.

Personal stigma

Get to know drug users who frequent your clinic to break down stereotypes.
Stigma can often grow from misconceptions and stereotypes. Health care workers can work to break down personal stigma by making an effort to learn more about PWID who are visiting their health care facility. This will also create new opportunities for learning and can challenge biases and misconceptions. It can provide health care workers with the background information and perspective needed to look beyond their stereotypes and see a client who is in need.

Treat PWID just like any other client.
Sometimes health care workers may be unaware that they are stigmatising a client. To address this situation, health care workers should constantly ask themselves if their responses or level of service delivery for a PWID would be similar for an average client. This provides an opportunity for health care workers to evaluate their work and establish a better level of awareness for their own actions and internal biases.

Institutional stigma

Remind other staff members to treat PWID with respect.
If other colleagues are discriminating or stigmatising PWID within a health care facility, it can be useful to remind them that they most likely entered into the health care profession to support and help people. People who inject drugs are in great need of support and help and should be addressed, interacted with and supported just as any other client in the health care facility. Health care providers should treat all clients in the same way. If this is not the case, it should be brought to their attention and they should be reminded that all clients deserve respect. Consider the following quote from a health care provider:

*I know it’s easy to just see the ‘drug user’ when you look at him, and think that he doesn’t deserve help. I know he made that choice [to use drugs] the first time, but I’ve seen what this stuff [tik] does to people. It takes away their choice, it takes away their life. That man, standing there, he deserves help, in fact he needs it, because he doesn’t have a choice.*

Discourage the use of language that is stigmatising towards PWID.
It is not uncommon for individuals to disregard PWID by referring to them as druggies or junkies. It is important to create a welcoming environment in a
health care facility that is safe for all those who are seeking care. Specifically, by using stigmatising language, health care workers are showing disrespect for and dehumanising the client.

**Create PWID case studies to share with staff.**
Often, health care clinics or centres will schedule regular meetings with the entire staff. These meetings can be an opportunity to share with other health care workers a case study of a PWID client. This will create an opportunity to have an open dialogue and discuss stigma and PWIDs’ right to health care.

**Display welcoming material for PWID.**
Among the many HIV educational posters, clinic staff can also place affirmative posters for PWID. They should include messages that show that the clinic space is welcoming to all people and that confidentiality is assured with any health service.

**Establish a formal stigma advisory board.**
Some clinics have successfully established small working groups within the clinic to develop a stigma policy and guidelines for the entire staff. These are used to set behavioural standards and can help keep staff accountable for their actions towards PWID.

**Community stigma**

**Train peer outreach teams to include PWID.**
If health care facilities provide any type of peer outreach or education, then efforts should be made to connect with PWID in the community to facilitate their engagement with health services. An effective means of doing this would be to include recovered drug users within the peer educator team. Having a peer who can interact and engage with PWID will facilitate learning, trust, and potential uptake of health services by the PWID community.

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**EXERCISE 6**

**Stigma in your workplace**

Use the table you developed in Exercise 4 and brainstorm a way you can address each of the examples of stigma that you listed as occurring in your workplace. Take into consideration the cause of each example and how your solution would uniquely address that cause. Would these solutions be able to realistically be implemented in your workplace? If not, what barriers would you anticipate experiencing? How could you overcome the barriers?
SUMMARY AND RECOMMENDATIONS

- Stigma is defined as an attribute or quality that shames an individual or group of people in the eyes of another individual or group.
- Stigma is a common experience for PWID and has multiple effects on them.
- PWID who are HIV-positive may experience double stigma because of their drug-taking behaviour and their HIV-positive status.
- External stigma refers to how PWID are treated negatively by others. Examples include gossip, being ignored, avoidant behaviour, judgement, abuse and violence.
- Internal stigma refers to how PWID feel and act because of external stigma. Examples include low self-esteem, depression, not seeking medical assistance, withdrawal from contact with people and suicide.
- Health care workers have a significant impact on the way in which PWID experience stigma in a health care setting.
- Stigma can have a negative impact on PWID and create barriers for them to access effective health care.
- Health care workers should address stigma within their facilities by treating PWID just as they do other clients and by encouraging their colleagues to do the same.
- Health care workers should address personal stigma through self-reflection, education and self-awareness exercises.
- Health care workers should discourage the use of stigmatising language in their facilities.
- Health care workers should support the development of peer educator teams to work with clients who inject drugs.
- Appropriate support and counselling can minimise the effects of stigma and assist PWID in their well-being.
Introduction

South African law has a significant impact on the lives of PWID. The law can complicate the interactions that PWID have with health care workers and can make service delivery to this population more challenging. To more effectively deliver services to PWID, health care workers need to have a strong understanding of how South African law affects their own service provision. This module will review South African law and discuss its impact on both PWID and health care workers. Through exploring these laws, health care workers will gain a better understanding of their legal obligations and be provided with suggestions on how to more effectively support PWID.

Learning outcomes

By the end of this module health care workers should be able to do the following:

i Discuss the laws that affect injection drug use
ii Understand the ways in which criminal laws impact PWIDs’ access to health care
iii Describe the ways in which criminal laws affect health care service providers
Is drug use illegal in South Africa?

Many types of drugs in South Africa are legal and regulated by the government. These may include prescription medications, alcohol and nicotine. Drugs such as heroin and methamphetamine, however, are illegal in South Africa. Punitive laws do exist regarding the possession, selling and use of these and similar drugs. In 1999, the South Africa government drafted the National Drug Master Plan to address substance abuse, and in 2000 created the Central Drug Authority (CDA) to lead the nation’s drug control efforts. According to the Medicines and Related Substances Control Act (101/1965), it is illegal for a person to be in possession of an excessive quantity (in excess of normal dose for a maximum of 30 days) of a legal prescription medicine. However, there is no legal restriction governing the sale of needles in South Africa. The sale of needles at pharmacies is unofficially supported in most instances as a harm-reduction type measure.

Is providing health care to PWID illegal?

Even though injection drug use is illegal in South Africa, it is not illegal to provide health care services to PWID. In fact, the South African Constitution protects a PWID’s right to health care. Section 27 of the Constitution clearly states that everyone has the right to access health care services and that no one may be refused emergency medical treatment. Other parts of the Constitution more broadly address a PWID’s right to access care. For example, Section 10 states that everyone has ‘inherent dignity and the right to have their dignity respected and protected’. PWID and their right to access care are further protected by the National Health Act of 2003, which more broadly promotes the right of everyone to access medical treatment.

Are health care workers required to provide medical care to PWID?

All South Africans are equal before the law and the South African Constitution binds all branches of government, including public health care settings, to ‘respect, protect, promote, and fulfil’ the obligations set out in the Bill of Rights. This means it is every health care worker’s duty to provide to PWID the same care and treatment that they provide to other clients. Health care workers may have personal beliefs that make providing care to PWID challenging for them. It is important, though, that health care workers see all PWID as human beings who deserve fair treatment and not as powerless victims or irresponsible criminals.
Are health care providers required to report to the police if a client discloses that they inject drugs?

Health care providers are not required to report to the police if a client discloses that he or she injects drugs. South African law does, however, require anyone to report to the police if they personally come in contact with heroin, which is an illegal substance. In a health care setting, this would only apply if a client brought heroin with them into the clinic. Such a situation is highly unlikely and has little impact on a health care worker’s ability to provide services to PWID.

How does the law affect the health service received by people who inject drugs?

The fact that injection drug use is illegal in South Africa significantly affects PWID and their ability to access health care. Many PWID may not disclose to a health care worker that they inject drugs because they may be afraid that they will be arrested. If a client does not disclose to a health care worker that they inject drugs, the health care workers will be unable to provide the full scope of services they may need. In addition, health care workers would not be able to take this behaviour into consideration when prescribing medications that could potentially interact with the drugs the client is already using.

Reports have shown that PWID experience very poor care when they do disclose their injecting drug use to health care workers (1). People who inject drugs have reported situations where health care workers refused them treatment, provided them with inadequate treatment, and/or made very abusive remarks to them when discovering or even suspecting that a client was a PWID.

South African law upholds a PWID’s right to access equal health care. In many ways, however, the illegality of injection drugs means that many PWID will not seek health care or may not receive supportive treatment when they do.
Is it legal to provide OST and NSE to PWID?

South African legislation regarding the control of substances does not specify the implementation and use of NSE and OST, which are proven, effective measures of reducing HIV transmission among the PWID community and effective means of treating substance abuse. These programmes are not illegal to implement, and support from government for these measures is cautious but increasing. The National Strategic Plan on HIV, STIs and TB 2012–2016 highlights ‘the need to consider scaling up substance abuse reduction programmes and needle exchange programmes’. In South Africa, PWID are at a significant disadvantage without these recognised forms of care and treatment.
The South African government supports the harm-reduction approach, which is currently being used by the Department of Social Development in developing a new strategy.

**SUMMARY AND RECOMMENDATIONS**

- Injecting drugs is illegal in South Africa but providing health care services to PWID is not.
- South African law requires that all health care workers deliver equal treatment and unbiased care to PWID.
- Health care workers are not required to report PWID to the police.
- Because injecting drugs is illegal, PWID may be unwilling to disclose information to health care workers, thus limiting the services that can be provided to them.
- Health care workers should make sure that their facilities and colleagues are aware of how South African law does not prevent them from providing effective services to PWID.
Introduction

Substantial risk is associated with HIV exposure and transmission and injection drug use. In fact, injection drug use carries a significantly greater risk for HIV exposure and transmission than vaginal or anal intercourse. Health care workers must educate their clients who inject drugs about these risks. They should also support PWID in reducing their risk when injecting drugs. This module will detail the related risks associated with HIV and other common infections for injection drug users. It will also provide health care workers with various strategies to support PWID and assist in lowering their risk.

Learning outcomes

At the end of this module, health care workers should be able to do the following:

i. Explain how HIV transmission occurs among PWID
ii. Describe the most common health problems associated with injection drug use
iii. Understand harm reduction and other ways PWID can reduce their exposure to HIV
iv. Articulate various HIV intervention strategies for PWID
**Why are PWID more vulnerable to HIV and STIs?**

People who inject drugs may face a higher risk of contracting HIV through sexual transmission for a variety of reasons. South African research studies have shown that, depending on the drug used, drug users may have increased numbers of sexual partners (1). They may experience difficulty in using condoms, and they have reported engaging in sexual activity in exchange for drugs. In such situations, PWUD could easily and repeatedly expose themselves to HIV and STIs.

Studies have shown that there is a substantial overlap between other high-risk populations and PWID (5). For example, many PWID also engage in sex work. The vulnerability of PWID who exchange sex for drugs or money, and of sex workers who use drugs, is heightened for several reasons. It has often been observed that sex workers use stimulants to cope with the stress of their profession. In fact, among drug users, sex work is often seen as an alternative to criminal behaviour to obtain cash or drugs. Evidence from all regions indicates that the fastest-growing HIV epidemics occur in settings where sex work and injecting drug use co-occur (6).

Secondly, PWID who are sex workers may also be migrant and mobile and thus difficult to reach with outreach and health services. They may face cultural and linguistic obstacles in accessing services and information. Laws and regulations relating to illegal migrants, trafficking, sex work, and injecting drug use also make it much more difficult for these groups to access services. For many, violence, stigma and discrimination is a daily reality – one that increases vulnerability by increasing conditions that promote drug use as a coping mechanism, by preventing negotiation of condom use, or by reducing access to services out of fear of harassment by law enforcement authorities or ill treatment by service providers.

**What other vulnerabilities do PWID experience?**

People who inject drugs are further vulnerable due to injection, which creates high risk for HIV and other STIs in multiple ways. First, PWID may use injection equipment that has already been used, which means they could be directly exposed to blood from other people. Direct blood-to-blood transmission is the most effective means of getting infected with HIV. In fact, the risk for HIV transmission through injection can be up to six times greater than that of vaginal or anal sex. In addition, HIV can spread rapidly through the PWID community because of the closed social networks that many PWID interact within (2). Furthermore, the effect of some drugs, such as cocaine, does not last very long. Therefore, users will be more likely to inject frequently, which further increases their potential exposure to both unclean injecting equipment and HIV.
Injection drug use can cause high-risk sexual behaviour because it can decrease social and sexual inhibitions, known as disinhibition. Injection drug use, depending on the drug, can also increase an individual's sexual desire and drive. Furthermore, a PWID’s decision making can be reduced when using drugs, thereby creating difficulty in having safe sex. In addition, reports from Cape Town indicate that some male PWID will rape women after providing them with injection drugs (7).

What other infections and diseases are PWID prone to?

People who inject drugs are particularly vulnerable to the following infections or diseases:

**Hepatitis B and Hepatitis C viruses**

People who inject drugs may be exposed to the Hepatitis B or Hepatitis C viruses through the infected bodily fluids of another PWID when sharing needles or through unprotected sex. Hepatitis B and C viruses both lead to the inflammation of the liver and can lead to liver cancer.

**Abscesses and ulcers**

People who inject drugs may be affected by abscesses or ulcers around the areas of their bodies where they inject, usually the arms or legs. Abscesses are pus-filled cavities that are created as a reaction to a bacterial infection or foreign element. Abscesses may be difficult to heal and can have a foul odour. Ulcers are generally not deep and can heal with good wound care and antibiotics.

**Septicaemia**

Septicaemia is a potentially fatal blood infection resulting from bacteria that has been injected via the tools or paraphernalia of PWID. Symptoms of septicaemia include high fever, shivers, headache and possibly convulsions.

**Endocarditis**

Endocarditis is an inflammation of the heart due to infection from foreign matter that PWID may introduce into their blood through injection. Endocarditis symptoms include irregular heartbeats and chest pain.

**Cellulitis**

Cellulitis is a common bacterial skin infection that can affect PWID. Cellulitis presents as a localised inflammation of the skin.
**Phlebitis**

Phlebitis results in the development of track marks along the veins where a PWID has injected. Track marks are actually damaged or infected veins that can lead to the formation of blood clots.

**How can PWID reduce their risk for infection when injecting drugs?**

Health care workers should make all PWID aware of the following strategies that will not eliminate but can help to reduce the risks associated with injection drug use.

**Getting tested for HIV, STIs and other infections**

People who inject drugs can reduce their risk for HIV and STIs by testing regularly to know their status and identify any potentially curable STIs. They can reduce their risk for HIV and STIs by getting current STIs treated. This is because STIs cause swelling and increased blood flow to infected areas and cause sores (or ulcers) that break the skin’s surface. The increased blood flow and broken skin make it easier for HIV and other infections to enter the body (3). Early and frequent testing of STIs is useful for PWID because early treatment of STIs may reduce the risk for future HIV infection.

**Using condoms and condom-compatible lubrication**

Using male or female condoms may be one of the most effective means for preventing sexually transmitted HIV. Male and female condoms can be used for penile-vaginal sex, penile-anal sex, and penile-oral sex. For penile-anal sex, a condom must be used in addition to lubrication.

For more information the appropriate use of male and female condoms and lubrications, please see Appendix 4.

**Using new equipment**

People who inject drugs should be encouraged to never share their injection equipment and always use new equipment when injecting. This includes the syringe, needles, cookers and swabs. This will help to reduce the chances of HIV or bacterial infection.

**Using clean equipment**

Unfortunately, there are times when PWID will not choose to or will be unable to use new equipment for injecting. In these situations, PWID should be encouraged to attempt to clean their equipment before use. Whether
using new or used equipment, PWID should always use sterile water and clean spoons. This will reduce the risk for infection from bacteria or other pathogens. They should also wash their hands before use and clean the site of injection with warm water or alcohol swabs.

**Post-exposure prophylaxis**

Post-exposure prophylaxis (PEP) is an HIV prevention tool that could help reduce risk for HIV infection among PWID. Post-exposure prophylaxis refers to a treatment that can be given to a person who was exposed to HIV within the last 72 hours. PEP requires an individual to take a daily regimen of ARVs for 28 days. The ARVs are also prescribed as treatment for people with HIV and can cause side effects such as diarrhoea, headaches, nausea/vomiting and fatigue. Some of the side effects can be quite severe, and it is estimated that one in five people gives up the treatment before completion (4). The aim of this regimen is to allow a person’s immune system a chance to provide protection against HIV and to prevent HIV from becoming established in a person’s body.

For PWID who may have been exposed to HIV through unprotected sex or sharing of needles, PEP can be an effective means of preventing HIV infection. The regimen must be strictly adhered to and should be distributed according to the guidelines of the health care facility that is administering it.

It is important for health care workers prescribing PEP to counsel their clients on the importance of drug adherence and managing minor side effects of the medication but also to refer the clients to specialist care for serious side effects. Common side effects are temporary and can be relieved with standard medications against pain, fever and nausea. Completion of the 28-day course is necessary for maximum efficacy of PEP.

For more information regarding biomedical HIV prevention and the use of ARVs to prevent HIV, please review Appendix 5.

**How can health care workers support PWID to lower their risk?**

Health care workers have a special opportunity to engage with PWID and offer them tools, strategies and services that can significantly reduce their risk for HIV and STIs.

**Provide sensitive HIV, STI and TB testing and treatment**

All health care workers should provide non-judgemental and sensitive testing for HIV, STIs, TB and other infections such as hepatitis. Many PWID may have experienced poor service or have been discriminated against when trying to access testing services. Providing these services offers PWID
an opportunity to know their HIV status, potentially start ART, and potentially receive vaccinations or treatment for certain STIs.

**Provide referrals for other services**

Health care workers may have limited time or resources to fully provide the range of services needed by PWID; however, their needs may still be met through referrals to care by other organisations. Support for mental health issues is a strong example of services that may require referral to more extensive care. Module 6 will cover mental health in more detail.

**Provide education**

Each engagement with PWID in a health care setting offers an opportunity to educate them and make them aware of HIV risks and the prevention tools available to them. Health care workers should take this opportunity to provide facts and support to PWID.

Furthermore, health care workers should educate PWID by dispelling common misconceptions or myths associated with HIV. For example, it is a common misconception that HIV-positive individuals do not face any risk if they are re-exposed to HIV after they have become infected. This is known as HIV reinfection and, unfortunately, it can significantly reduce future treatment options as well as increase a client's viral load. Many HIV-positive PWID are at significant risk for HIV reinfection because they may be unaware of the consequences associated with continually exposing themselves to HIV.

Health care providers should also actively work to educate PWID against the dangers of infecting other people in their community. If a PWID is HIV-positive, he or she risks infecting his or her sexual partners and anyone with whom injection equipment has been shared.

**Provide risk-reduction counselling**

Health care workers should never counsel PWID from a moral standpoint. Instead, they should provide counselling that assists and supports PWID in reducing their risk for infection and disease. There are many reasons why it is challenging for PWID to change their drug-taking behaviour. One of these reasons is because injection drug use is both mentally and physically addictive. Module 6 will further discuss the mental health issues related to injection drug use. Because of this dependence, it can nearly impossible for a PWID to stop using drugs completely or be successful the first time they try to quit. This is why immediate abstinence-only counselling approaches for injection drug use may not be effective. Abstinence-only approaches refer to those strategies that require no drug use at all.
EXERCISE 1

Changing behaviours

Changing a bad habit or behaviour can be challenging. This is because there are often social, mental, or emotional factors that support these behaviours. Can you think of behaviour that you have tried to change in yourself? For example:

- Smoking cigarettes
- Biting your finger nails
- Having unprotected sex
- Driving while drunk
- Driving over the speed limit
- Eating a lot of fried food
- Walking alone at night in the street
- Not brushing your teeth
- Exercising less than three times per week
- Being very drunk

1. Were you successful in changing your behaviour the first time you tried? Why or why not?
2. What factors influenced that behaviour that made it easier or more difficult to change? Did it have to do with pressure from another person? Was it because you enjoyed it or felt like a better person when you did it?
3. What are some of the reasons you think it may be challenging for PWID to stop using drugs? How do they relate to your own reasons?

How should counselling be conducted with PWID?

Please review Appendix 6 for a full overview of risk-reduction counselling. Risk reduction-counselling with PWID should include the following steps.

Step 1: Identify risks

The necessary first step towards reducing risk for a PWID is to identify what those risks are. Many PWID will face the same risks, which could include sharing needles and injection equipment, having unprotected sex or being exposed to violence or assault.
Step 2: Provide education about the risks

Once PWID have identified the risks that threaten their health, it may be necessary for a health care worker to better inform them about those risks. For example, while many PWID know that sharing needles can be dangerous, some may require more information about why sharing can lead to HIV or bacterial infections.

Step 3: Setting short-term goals to address the risks

The ultimate goal to reduce the risk for PWID may be to have them stop injecting drugs entirely. While this is an important goal, it can be incredibly difficult to achieve. Instead, focus should be put on more achievable short-term goals that will eventually lead to a larger ultimate goal. The following are examples of short-term goals that could lead towards a larger goal of reducing drug use:

1. Always clean equipment before use
2. Never share equipment
3. Always use new equipment for injection
4. Only inject while alone (to minimise sexual encounters)
The following levels of risk can be a useful tool when supporting PWID in reducing their risk:

1. You will not get infections from sharing needles if you stop or never start injecting drugs.

2. If you cannot stop using drugs, use them in any way except injecting. If you do not inject drugs, you cannot catch infections through needle sharing.

3. If you cannot stop injecting drugs, do not share needles, cookers, spoons or filters with other drug users, or use new injecting equipment every time. If you use new injection equipment every time you cannot catch viral infections such as HIV through needle sharing.

4. If you need to reuse any equipment, use your own injecting equipment every time. If you reuse your own injection equipment every time you cannot catch viral infections such as HIV unless someone else has used your equipment without your knowledge.

5. If you need to reuse any equipment and you believe you need to use someone else’s equipment, then clean needles by an approved method. There is some risk for HIV transmission after needle cleaning, but cleaning in an approved manner will reduce the likelihood of transmission.
EXERCISE 3

Matching risks with reduction strategies

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Never uses clean equipment</td>
<td>• Goes for HIV and STI testing/</td>
</tr>
<tr>
<td>• Always uses clean equipment</td>
<td>treatment regularly</td>
</tr>
<tr>
<td>• Has unprotected sex after injecting</td>
<td>• Cleans equipment after every use</td>
</tr>
<tr>
<td>• Never shares equipment</td>
<td>• Joins a PWID support group for</td>
</tr>
<tr>
<td>• Always shares equipment</td>
<td>users who are trying to quit</td>
</tr>
<tr>
<td></td>
<td>• Stops sharing equipment</td>
</tr>
<tr>
<td></td>
<td>• Uses new equipment for each</td>
</tr>
<tr>
<td></td>
<td>injection</td>
</tr>
</tbody>
</table>

1. Match the characteristics in Column A with possible short-term goals in Column B.
2. Why did you select strategies for each characteristic?
3. Could certain characteristics benefit from more than one strategy?

SUMMARY AND RECOMMENDATIONS

- People who inject drugs are most significantly at risk for HIV infection through sharing needles that may have been used by other PWID.
- People who inject drugs are also at risk for HIV through sexual exposure and experience a variety of other disease risks.
- People who inject drugs can reduce their risk for HIV and other STIs by using new and clean equipment every time they inject and by using condoms with sexual partners.
- Health care workers should employ harm-reduction strategies to more holistically address injection drug use with clients who inject drugs.
- Health care workers should provide PWID with appropriate education in terms of safe injection and HIV prevention.
- Health care workers should provide referrals for PWID who need more in-depth support for mental health or drug rehabilitation.
- Health care workers should counsel PWID to reduce their behaviour in such a way that is realistic for their lifestyles.
Mental health issues can significantly affect PWID, including their risk for HIV infection and their overall health. While it is not expected that all health care workers will be equipped to manage mental health issues, it is useful to have an awareness of the impact mental health can have on PWID. It is also helpful to be aware of established referral pathways, as these can be used to support PWID. This module will further explore the issue of drug dependence as a mental illness, how to identify common symptoms of mental illness, and suggested methods for the support of PWID suffering from mental illness.

Learning outcomes

By the end of this module health care workers should be able to do the following:

i. Explain the relationship between drug use and mental illness
ii. Understand drug dependence as a mental illness
iii. Know the importance of mental health in the overall treatment of PWID
iv. Understand common mental health issues amongst PWID
v. List suggested methods for supporting the mental health of PWID
Is drug dependence a mental illness?

Drug dependence is a complex and often chronic brain disease; it is classified as a relapsing mental illness. It occurs when the use of a drug dominates a person's life and becomes a compulsive behaviour that is hard to control. When a PWID is experiencing drug dependence, he or she has extreme difficulty in resisting the urge to use drugs despite the negative consequences and harmful effects. Drug dependence is considered a mental illness because it changes the chemistry of the brain, which leads to changes in an individual's behaviour.

When drug dependence occurs, a PWID becomes dominated by a strong and powerful motivation to use. The drug-seeking, compulsive behaviour weakens the individual’s ability to control impulses. This is due to changes in the brain structure and function, which then leads to taking the drug despite the negative consequences. These changes occur in some of the same brain areas that are affected by other mental disorders, such as depression, anxiety or schizophrenia.

Common signs of drug dependence

- Drug-seeking behaviours (obtaining the drug from multiple doctors, illegally obtaining the drug)
- Cravings for the drug
- Preoccupation with obtaining the drug
- Misusing the drug for intoxication or pleasure
- Dependence and withdrawal upon stopping the drug
- Interference with normal life functions (decreased work productivity; decreased motivation; social, family and relationship problems)
- Continued use despite negative consequences

Drug dependence is challenging to overcome and it should not be expected for PWID to be successful at their first attempt to quit. In fact, overcoming drug dependence may take months or years and often requires continuous attempts involving multiple methods such as therapy, support groups, and self-exploration (1).

Do all PWID suffer from mental illnesses?

While there is a high prevalence of mental illness among PWID, it does not mean that all PWID are mentally ill. Mental illness does, however, have a complex interaction with drug use. In some cases, mental illness may already be present before an individual becomes a drug user. In this situation, mental illness may be one of the factors that lead individuals to drug use as a method of coping. In other cases, mental illness may occur as a direct result of drug
use. This may be due to a variety of reasons. For some, drug use creates situational and social stressors, such as homelessness or unemployment, which can lead to mental illness. For others, mental illness may be a physiological result of drug use, since some drugs manipulate neurotransmitters in the brain.

The complex interaction of mental illness and drug use can often make diagnosis difficult. For example, a client may be experiencing symptoms of bipolar disorder, but determining if this is a result of mental illness or reactions to drug use may be complicated. Regardless of the cause, mental illness can have a profound impact on the lives of PWID.

**How does mental illness affect PWID?**

Mental illness can affect everyone including people who do not use drugs. For PWID, however, mental illness can add to the complications they may already be experiencing as a result of their drug-taking behaviour. For health care workers, even those less involved with mental health treatment, these complications are necessary to understand as they can influence and affect non-mental health-related treatments and care. Firstly, a PWID who is experiencing mental illness may be more difficult to treat for HIV and other issues. For example, a PWID who is experiencing depression or anxiety may be less likely to come to a clinic to receive ARVs or other medication and adhere to the regimens. Furthermore, PWID who exhibit signs of a behavioural disorder may act out in a clinic setting and become challenging to treat.

Mental illness may also be a significant barrier to overcoming drug use and, in some cases, may encourage PWID to continue using drugs. Similarly, a PWID who is experiencing depression or bipolar disorder may be less likely to protect his or her health and may choose to engage in riskier behaviours. For PWID, mental illness such as depression, anxiety or personality disorders may affect the effectiveness of substance abuse treatment. In addition, injection drug use may lead to drug dependence – a mental illness – that can further complicate the lives of PWID, their risk for HIV and the potential opportunities for treatment.
EXERCISE 1

Case study

Janice is a 31-year-old woman who lives in Port Elizabeth. She works part-time as a barmaid in a popular nightclub in the centre of town. Three months ago, Janice was dumped by her long-term boyfriend, who left Janice for her best friend, Ayanda. Since the breakup Janice has felt really low. She often cries, and she finds it difficult to get out of bed in the mornings as she has nothing to look forward to. Janice has felt really lonely since she lost her boyfriend and her best friend. She has started hanging around with some of her co-workers from the club, John and Thulani. Her new friends suggested that Janice try taking heroin to forget about her broken heart. Janice was willing to try anything to escape her misery, so one evening Janice went back to Thulani’s flat after work. Thulani prepared the heroin, shot himself up, and then injected Janice with the same needle. Janice really liked how the heroin made her feel. The pain of her loneliness and heartache went away while she was high, and she felt so good. Janice started going back to Thulani’s place regularly, sometimes with John too. The three of them would shoot up together, using the same needle, as Thulani said it was difficult to get needles so they must not waste them. One night, neither Thulani nor John came to work, and Janice was worried because she really needed a hit. She found she could not concentrate and was getting very anxious and upset. Before her shift ended, Janice walked out of the club as she was desperate to find some heroin. Janice walked to the house where she knew Thulani bought his drugs. The man there said he would give Janice a hit if she has sex with him. Janice did not hesitate and ended up having unprotected sex with the man, who shot her up afterwards. The next morning Janice remembered what happened and went to the clinic to get the morning after pill (emergency contraceptive pill).

1. What are some of the psychological, health and social issues that Janice faced because of her drug-taking behaviour?

2. As a health care provider, how would you suggest providing support to Janice?

3. What effect do you think depression had on Janice’s drug-taking behaviour?
What are other common mental illnesses amongst PWID?

People who inject drugs, just like the general population, may experience a broad range of mental illnesses. Below are a few key disorders that PWID may be more likely to experience. Understanding these disorders can be helpful when caring for a PWID client, as it may influence treatment.

**Depression**

Depression is a psychological disorder that involves decreased mood, low self-esteem and a loss of interest in things that were previously stimulating to the individual for an extended period of time. Signs and symptoms can include the following:

- Depressed mood most of the day and nearly every day
- Loss of interest or pleasure in all or almost all activities most of the day
- Feelings of worthlessness and hopelessness
- Inability to think or concentrate
- Recurrent thoughts of death or suicide

Many factors may cause someone to become depressed, such as genetics or stressful life events. For PWID, depression may act as a catalyst that initiates their drug use or, alternatively, depression can be a result of recurring drug use. Depression can prevent PWID from adhering to medical treatments or even inhibit them from seeking initial health care.

**Anxiety**

Anxiety is a normal psychological response experienced by everyone. Anxiety can become a mental illness when it is prolonged or never-ending or when the anxiety becomes out of control and affects an individual's daily functioning. Signs and symptoms of anxiety may include excessive worry, fear, feelings of uneasiness, tightness in the chest, difficulty breathing, heart palpitations, dizziness, light headedness, nausea, diarrhoea and excessive sweating. Anxiety may be caused by genetic factors, a physical condition or stress. Anxiety can also be caused by injection drug use, particularly the use of stimulants such as cocaine.

**Social anxiety disorder**

A special type of anxiety disorder that may affect PWID is social anxiety disorder. When someone suffers from social anxiety, they experience intense fear, panic or stress while engaging in everyday social situations. It can create feelings of humiliation, embarrassment and judgement. Social anxiety may
include symptoms such as sweating, blushing, trembling, nausea and stammering. It may even lead to panic attacks. Social anxiety is particularly acute among PWID as they may experience high levels of social discrimination and stigma. A PWID who is experiencing social anxiety may be less likely to seek health care services because of fear of being judged or scrutinised by health care staff.

**Post-traumatic stress disorder**

Another severe anxiety disorder that may affect PWID is post-traumatic stress disorder (PTSD), which occurs after an individual has been exposed to a severely traumatic event. After the event, an individual who suffers from PTSD may experience panic attacks and extreme fear or they may re-envision the event continually. The disorder can have a significant impact on normal everyday functioning, and PWID may experience traumatic events regularly. For example, they may be sexually assaulted after using drugs, they may experience or witness extensive violence, they may witness other drug users dying, or they may experience an overdose themselves. After these events, PWID may experience high levels of stress, anxiety and fear, all of which could encourage them to continue their drug use in order to cope.

**Bipolar disorder**

Bipolar disorder is a psychiatric condition where moods can fluctuate between high levels of energy or happiness and low moods or depression. Bipolar disorder can especially affect PWID because of the level of risk they can engage in while experiencing elevated or high moods as well as the dangerous behaviours that can result from their low or depressed moods. People who inject drugs and who experience bipolar disorder may be more prone to continue drug use, despite treatment, and may be more difficult to retain into care or treatment. In addition, PWID with bipolar disorder may further engage in high-risk sexual behaviours and increased levels of drug use. Clients who suffer from bipolar disorder may also experience paranoia towards health care workers or other service providers. This can complicate health care provision because clients may not disclose information needed to determine their treatment.
EXERCISE 2

Case study

Read through the case study and answer the following questions.

Luke is a 35-year-old man who was recently divorced. His ex-wife won custody of their two children and refused to allow him visitation rights. Three months ago he was retrenched from his job and is currently unemployed. A few months ago his mother was diagnosed with cancer and told that she does not have long to live. Luke and his mother have a very good relationship and she is his support structure. Luke’s father is an alcoholic and was never present in his life. Ever since the divorce Luke has not had a good night’s sleep. He wakes up in the early hours of the morning and cannot go back to sleep. He stays indoors increasingly and does not want to visit family or friends. He used to love playing soccer but now refuses his friends’ invitations to play a game. He also said that he sees no reason to continue living and was wondering that maybe it would be better if he ended his life. On weekends Luke smokes dagga and drinks heavily. About a year ago a friend introduced him to heroin. Luke found the feeling extremely euphoric and it made him forget all his problems. He now injects heroin more frequently, almost daily. He and his friends share needles because the pharmacy down the road refuses to sell them needles. The pharmacist thinks that by selling them needles he will be encouraging their drug-taking behaviour. His friend has also introduced him to many women, and often Luke wakes up next to a woman that he does not know. Luke’s mother tried to talk to him about his deteriorating behaviour and suggested that he seek help. Luke got angry with her, told her that there is nothing wrong with his life, and it’s only a phase that he is going through.

1. Can you identify the mental illness/illnesses that Luke is suffering from?
2. Can you list the signs and symptoms of his mental illness/illnesses?
3. What are the contributory factors or causes of Luke’s condition?
4. What is a possible treatment plan for Luke’s condition?
How can health care workers support PWID with mental illness?

- Conduct a non-judgmental but thorough psychological assessment on all clients who use drugs, including those who inject drugs, to establish a feasible treatment plan.

- Treat PWID for their drug use and its affiliated side effects, but first educate PWID about the relationship between their drug use and any psychological illness they may have. They should be continually monitored throughout their treatment so they can cope with the effects of their mental illness.

- Health care workers should be familiar with referral pathways that are available in their community. They will then have the capacity to connect PWID with mental illness to effective mental health services.

- Remaining aware of the presence and impact of mental illness on the lives and health of PWID is a critical step that any health care worker can take to support clients who use drugs, including those who inject drugs.

- All health care workers should take into consideration the impact that mental illness may have on any treatment they are providing to PWID. For example, PWID with mental illness may be neglectful in taking long-term medication or may find it difficult to return to a clinic for follow-up visits. These factors should be considered when developing a care and retention plan for clients who use drugs.

- Attempts should be made to link clients who use drugs with self-help groups and supportive psychotherapy or other related services that may be available. These services can help PWID with their coping strategies and hopefully reduce their need to use drugs.
EXERCISE 3

Case study

Read through the case study and answer the following questions.

Rita and Jamil have been in a relationship for six months now. They started using heroin together a few weeks ago, when the dealer they usually buy mandrax from suggested that they should try it. Rita was scared at first, because she doesn’t like injections, but Jamil convinced her that it would be ok and that he would look after her. Rita had seen a programme on television about drugs which said that you shouldn’t share needles with anyone, so she said to Jamil that she would only try heroin if they could each use a new needle. The two of them decide to go to the pharmacy to buy some needles, but when the pharmacist starts questioning them on what they need the needles for Rita gets nervous and runs out; Jamil follows her and so they don’t manage to buy any needles. They tell their problem to the dealer and he says that he can only give them one free needle with the heroin, because they are difficult to get. That evening they are at home and have taken some mandrax, when Jamil suggests that they try the heroin. Rita has smoked quite a bit of mandrax already and feels very relaxed, so she doesn’t feel so worried about the needles. Jamil decides to inject himself first to see if he can do it properly. After he has successfully injected himself he re-loads the needle and injects it into Rita’s arm.

1. Why do you think Rita and Jamil shared a needle?
2. What would have made it easier for Rita and Jamil to use clean needles?
3. What risks do Rita and Jamil expose themselves to in this case study?
SUMMARY AND RECOMMENDATIONS

- Mental illness may be the cause of injection drug use or may result from it.
- Drug dependence is a challenging mental illness that can influence a PWID’s behaviour and may take extended periods of time to overcome.
- Mental illness can especially affect a PWID’s overall health by encouraging continued drug use or influencing high-risk behaviour.
- Mental illness needs to be considered when providing care and support for all clients who use drugs.
- If direct mental health services are not available, health care workers should facilitate referrals for all clients who use drugs.
- Health care workers should be aware of the basic signs and symptoms of common mental health issues among PWID to facilitate care and referrals as needed.
- Health care workers should understand and be aware of the available mental health services to which PWID can be referred to provide more effective care for PWID.
Introduction

Every health care worker has an ethical and legal obligation to provide effective, equal and non-discriminatory health care to all of their clients. This manual has shown, however, that because of stigma, discrimination and misinformation this level of care and access is often not provided to a significant majority of PWID. Additionally, many basic health care facilities are not equipped to provide a full range of drug treatment services.

Every health care worker has a unique opportunity to change this reality by providing better services to all PWID. This module will provide an overview of the services that should be offered to PWID as well as describe opportunities to improve and expand current levels of service provision.

Learning outcomes:

By the end of this module health care workers should be able to do the following:

i Identify the services that should be offered to all clients who inject drugs
ii Describe ways in which clients who inject drugs may be difficult to manage as well as effective methods of managing them
iii Describe useful methods for retaining PWID within the health care system
iv Identify communication strategies that should be implemented when working with a client who is a PWID
v Understand the role of self-awareness when providing services to PWID
Why should health care workers provide sensitive health services to PWID?

People who inject drugs are part of every community in South Africa and their numbers are increasing across the country. They are at high risk for HIV infection, and they also experience human rights abuses as well as stigma and discrimination that can affect their access to sensitive health care services. Health care workers have a number of obligations to address these situations.

Legal and ethical obligations

The South African Constitution protects all people and provides for health care access for all. Therefore, health care workers are obligated by law to provide fair and equal health care to PWID. (Please review Module 4: Drug Use, Health Care and the Law for further information.) In addition, all health care workers are bound by a common code of medical ethics that holds them accountable to provide medical care and treatment. Therefore, health care providers are ethically obligated to provide the same type of health care to PWID as they do to other clients. To do otherwise would violate this moral obligation.

Impact on the broader community

People who inject drugs are not an isolated part of South Africa; in fact, they regularly interact with many communities where they live and work. If health care workers deny PWID the opportunities to have infections such as HIV or STIs treated, they are simply encouraging their spread through the many communities of which PWID are a part. Therefore, health care workers also have an obligation to the broader communities of South Africa to provide an effective and fair service for PWID.

Comorbidity

People who inject drugs may experience multiple conditions or illnesses at the same time. For example, a PWID may also be HIV-positive or be suffering from depression; this is known as comorbidity. Drug-taking behaviour can often complicate the treatment of other diseases or illnesses. Often, if drug-taking behaviour is not addressed, the other conditions will be more complicated, if not impossible, to treat. Therefore, providing sensitive services to PWID is important in the treatment of other illnesses. If drug-taking behaviour is not addressed as part of the health care services they receive, it is unlikely that other treatments or services will be effective.
How can a patient be identified as a PWID?

Identifying a client as a PWID is a necessary first step to being able to provide important health care services. If health care workers do not identify clients who inject drugs, then they may be unable to provide the necessary services that they require. This could facilitate an increased risk for HIV and STIs for the client. The best approach is for clients to identify themselves as PWID. Unfortunately, this may be challenging for health care workers, because PWID may be unwilling to disclose their drug-taking behaviour due to fear of being arrested because of their behaviour, or concerns about experiencing stigma or discrimination within the health care facility. For health care workers, a number of strategies can be used to assess drug-taking behaviour.

Identifying withdrawal symptoms or other conditions related to drug use

Even though a client may not directly disclose to a health care worker that he or she uses drugs, the individual may come to the clinic with a number of conditions or symptoms related to drug use. For example, a client may come to the clinic because of a persisting infection that is not healing. If these infections are located around typical injection sites, such as the arms or inner elbows, they may indicate injection drug use. In addition, a PWID client may be identified if he or she exhibits typical signs of withdrawal, as discussed in Module 2.

Not all clients who visit a health care facility with withdrawal-like symptoms or certain types of infections are PWID. However, when these signs are present, it can provide health care workers an opportunity to further investigate the potential of drug-taking behaviour.

Standardised assessments or questionnaires

The best way to identify clients who are PWID is to have a direct, confidential, and non-judgemental way of documenting their behaviours. Health care workers should establish trusting relationships with clients before directly asking them about their potential drug-taking behaviour. Health care workers should do this in a private space and assure the clients that answers they provide will be kept in strict confidence. Even in these situations, some clients may still not be forthcoming about their behaviour. If this occurs, health care workers should remind their clients that if they are not honest about their behaviour, the services they receive may not completely meet their needs.
What role should health care workers play in service provision to PWID?

Health care workers perform one of the most important roles in service provision for PWID. This role can be broken into the following three parts.

Establishing a welcoming environment

Health care workers can significantly influence the health care environment within which they work. They can address personal and group stigma and they can welcome all clients for care. Creating this welcoming environment is a critical first step in providing services to PWID.

Establishing a trusting and supportive relationship with clients who inject drugs

Clients who inject drugs may be hesitant to disclose their behaviour to health care providers. Therefore, establishing a trusting relationship is necessary in order to engage PWID about their risk behaviour and health needs.

Providing services and acting as a referral pathway into care for clients who inject drugs

Health care workers may be a PWID’s first access point into the health care system. Therefore, they can perform a very crucial role of assessing the PWID’s needs as well as providing him or her with the basic health services that are required. Not all health care workers will be equipped to manage the specific needs of all PWID; therefore, having a keen understanding of the possible referral pathways is necessary.

What type of services should be provided to PWID?

People who inject drugs can benefit from many of the same services that are provided to general clients in health care facilities, and they should not be excluded from these services. They can also benefit from the following services and harm reduction interventions, as described in Module 1.

HIV, STI, hepatitis, and TB testing, treatment and vaccination

As previous modules have detailed, HIV, STIs and TB are very prevalent within the PWID community. Given the high risk that they face, all clients who inject drugs should be tested for HIV, STIs, TB and hepatitis B and C. Where possible, they should be offered immediate treatment. Should a client who uses drugs test positive for HIV, he or she should be provided sensitive risk-reduction counselling, as discussed in Module 5, and provided ART, if appropriate and
eligible as determined by your facility’s standard procedures. If clients are eligible, they should be offered vaccinations for hepatitis B and C.

**Risk-reduction counseling and condom distribution**

A lot of attention may be paid to reducing the risk associated with drug taking, but PWUD and PWID are also at risk for the sexual transmission of HIV and other STIs. Therefore, all clients who use drugs should be provided condoms, condom-compatible lubricants, and appropriate risk-reduction counselling, as discussed in Module 5. Counselling should be centred on the prevention of HIV and STIs but should also address preventing the spread of HIV or other STIs to their sexual partners.

**Education**

All PWID should be educated about the risks of drug use – particularly injection drug use – and should be provided with informational resources that can assist in the reduction of their risk, as discussed in Module 5.

**Wound care**

As discussed in Module 2, a possible risk associated with injection use is infection that can lead to conditions such as ulcers and abscesses. With this in mind, health care workers should conduct a visual inspection of clients who use or inject drugs to assess the presence of such infections. If infections are found, these clients should be provided immediate wound care as per standard protocol. Wound care could include the cleaning and bandaging the wound and possibly distributing antibiotics. Health care workers should also educate clients about these infections, as well as how they can continue to clean and care for the wound outside the health care facility.

**Overdose management**

Where available, health care workers should provide medication to PWID that can be used to counteract the effects of an overdose. This can include the provision of naloxone.

**Mental health and substance abuse referral**

All people who inject drugs should be offered mental health screenings to determine whether they suffer from common mental illnesses such as depression or anxiety. As discussed in Module 6, these conditions may interfere with attempts to treat people who use drugs. Not all health care facilities may be equipped to provide these services comprehensively; therefore, clear referral pathways should exist so that PWID can be referred for more in-depth care.
Provision of OST and/or NSE

As discussed in Module 1, OST and NSE are proven, effective strategies for the treatment of people who inject drugs. Not all health facilities offer these services; therefore, referral pathways should be established whereby clients can be linked to further support.

Psychosocial support

Many types of psychosocial support are appropriate for PWID. Some examples that can be drawn from existing services are the buddy system, support groups, community care centres, drop-in centres, halfway houses, outpatient facilities and anonymous telephone call-in services.

WHAT DO COMPREHENSIVE SERVICES FOR PWID INCLUDE?

- Needle and syringe exchange programmes (NSE)
- Opioid substitution therapy (OST) and other drug dependence treatments (detox and rehab)
- HIV voluntary and confidential counselling and testing (HCT)
- Antiretroviral therapy (ART)
- Prevention and treatment of STIs
- Condom programmes for PWID and their partners
- Targeted education and communication (IEC) for PWID and their partners
- Vaccination, diagnosis and treatment of viral hepatitis B and C
- Prevention, diagnosis and treatment of TB
- Referral for mental health support
- Referral for group counselling or support
- Overdose management

NB. Within the services your facility already provides, many of these are appropriate for and needed by PWID.
EXERCISE 1

Assessing your facility’s service provision

1. Which of the services listed above does your health facility offer to clients?
2. Would these services be easily accessible to PWID who were visiting your facility? Why or why not?
3. How would you describe the experience of a PWID who did access one of these services at your health care facility?

What are common difficulties in treating PWID and how can these be managed?

Health care workers need to establish clear communication and trust with clients who inject drugs to facilitate support and treatment. For these clients, communication and trust may be difficult due to the stigma and discrimination they face as well, as the effects that using drugs have on their behaviour. Following are common behaviours that may be exhibited by PWID, as well as suggested methods for coping with them.

Defensive or aggressive behaviour

One of the biggest problems encountered when dealing with PWID is their reluctance to come forward and admit their use of drugs and injections. This may be as a result of not trusting the system or fear of being arrested or imprisoned because of their drug use. To protect themselves, they may apply defence mechanisms to justify their behaviour. Aggression may be used as a defence mechanism and may be directed towards themselves or others. The aggressive approach may often result in physical or verbal violence to cover up a basic lack of self-confidence. Typically, an aggressive client will maintain eye contact for prolonged periods so that a health care worker will experience it as invasive. They may also use gestures that are unambiguous and may seem threatening, such as waving their fists towards health care workers or showing insulting hand gestures.

ACTION: Help a PWID to find alternative ways of expressing a feeling of anger by encouraging him or her to speak softly while presenting a calm appearance, speak in a neutral way with space between parties, avoid intense eye contact, avoid interrupting, and listen to show respect for the other person’s opinion. When working with people who inject drugs, it is important to present a calm appearance and speak softly to help reduce any anxiety they may feel from
fear of discrimination or from an anxiety disorder they may have. Because PWID have a history of experiencing stigma and discrimination in health care settings, it is important to speak in a non-judgemental manner, to show respect to them, and to listen to them. This may also require a more proactive approach because some PWID may not readily volunteer information on their drug-taking behaviour to health care workers. People who inject drugs may be behaviourally challenging or unwilling to fully disclose their drug-taking behaviours, so it is also important to demonstrate control over the situation without assuming an overly authoritarian stance and to avoid early interpretations that may pre-empt any information they may provide.

**COMMON DEFENCE MECHANISMS OF PWID**

**Denial:** Occurs when a client actively denies involvement in drug-taking behaviour.

**Selective recall:** The client chooses to remember only those occurrences and aspects of a situation that support and excuse the behaviour or are not too painful to look at. This is a conscious suppression of the facts and feelings as opposed to unconscious denial and repression.

**Euphoric recall:** The client chooses to remember the behaviour in a more favourable light than others would have witnessed it.

**Repression:** The client completely suppresses unpleasant events from his or her consciousness and therefore may be unable to provide certain information or recall previous actions or behaviours.

**Minimising:** The client downplays the extent of his or her injection drug use and minimises the consequences.

**Projection:** The client blames others for his or her current situation or behaviour rather than taking responsibility for it or acknowledging the impact his or her own behaviour had on the current situation.

**Rationalisation:** The client tries to make his or her drug use and behaviour seem justifiable and right, offering reasonable excuses and reasons for the behaviour.

**Intellectualisation:** Occurs when the client disconnects his or her emotional response to a certain situation and instead only responds intellectually to the situation.

**Regression:** Often as a last resort, the client acts in an immature manner with behaviour similar to a child, such as temper tantrums, crying, sulking and so forth.
EXERCISE 2

Case study

Read through the case study and answer the following questions.

Mavuso is a regular heroin user who has been injecting for the past four years. He believes that he has his heroin use under control because he doesn’t take heroin every day and manages to keep his job as an electrician. One morning when he is getting ready to go to work, he has a very painful sensation when he tries to urinate, and some pain in his abdomen. He tries to forget about it but all day at work he suffers from the same burning sensation whenever he tries to urinate. Mavuso decides he should go to the clinic on his way home from work. He describes his symptoms to the nurse, and she asks him a few questions about his health. She asks him to roll up the sleeve of his jersey so that she can take his blood pressure. Mavuso does not want her to see the track marks (injecting punctures) on his arm so tells her that he doesn’t have a problem with his blood pressure, he just needs treatment for his urinary infection. The nurse explains that she just needs to carry out some routine procedures before she can provide him with any medication, and so she needs to take his blood pressure. Mavuso starts shouting at the nurse, he grabs her arm and starts calling her names. This frightens the nurse and so she tells Mavuso to get out of her room. Mavuso gets up and walks out of the clinic, shouting swear words at the nurse as he leaves.

1. Why do you think Mavuso wanted to hide his track marks from the nurse?

2. Why do you think Mavuso reacted the way he did?

3. How would you have reacted in this situation?
Retention into care

People who inject drugs may be particularly challenging clients to retain into care or keep adherent to their prescribed medical treatments. This may result in missed appointments and losing contact with a client for long periods. Health care workers should anticipate this difficulty by obtaining multiple types of contact details so they can efficiently follow up with clients.

**ACTION:** First, during visits with people who inject drugs, health care workers should collect more than the standard contact details required by their clinic so that they have a variety of options through which to contact the client. People who inject drugs are a mobile population and may not be able to sustain a cell phone for long periods. Therefore, it is advisable to collect contact details from individuals who regularly interact with the client who is a PWID but who do not do drugs. Collecting multiple addresses of places that the client frequents as well as multiple cell phone numbers can also be useful. Also, health care workers can restrict the amount of medication given to PWID so that they will be required to return on a more frequent and regular basis to collect more. This method allows health care workers to have steady interactions with the clients and monitor their adherence, risk behaviour and drug use.

Adherence to medications

Although HIV is one of the most significant health threats to PWID, maintaining ART for HIV may be especially difficult for PWID.

**ACTION:** Health care workers can help support PWID in remaining adherent to their ART or other drug regimens through basic counselling that can be administered during an HIV test or health screening. In addition to adherence counselling, there are some practical tools that health care workers can use to support PWID in improving their adherence to ART.

**SUPPORT:** When giving adherence counselling, health care providers should make sure that the PWID has emotional and practical support in his or her life and is able to fit the ART regimen into a daily routine.

**EDUCATION:** Education is critical so that all clients who inject drugs understand that non-adherence (to ART, antibiotics, and so forth) leads to resistance and treatment failure, and recognise that all doses must be taken. Especially for clients who inject drugs, it is useful to provide an overview of the side effects of ARVs and antibiotics and their interactions with OST and drugs they may be taking.
TREATMENT: It may be difficult to follow up over the long term with PWID; therefore, providing them long-term supplies of ARVs is not advised. Instead, providing small amounts at frequent intervals can encourage continued engagement. This also offers a way in which adherence problems can be detected before they lead to drug resistance. Another method is to engage PWID in directly observed ART to ensure adherence.

EXERCISE 3

Identifying individual and facility-level barriers

Using the list of services that you developed in Exercise 1, identify, for each service, at least one potential barrier that could prevent a PWID from effectively engaging with that service. What is the cause of each barrier? Is it a health care worker, facility based, or both?

How can comorbidity be managed effectively?

Addressing comorbidity is an important component to effectively treating and providing services for PWID. Comorbidity may pose a challenge for health care workers by making it difficult to establish a treatment plan for their client. For example, if a client is depressed and addicted to opiates, should he or she be treated first for the depression or the drug use? Which caused the other to occur, and how do they interact?

Create a treatment plan

When working with PWID, it is critical to gain a comprehensive perspective of their treatment needs. It will be important to understand their various health issues and create a long-term plan to address each of them. Certain conditions will need to be addressed immediately, while others may need to be addressed or revisited in the future.

Always address the drug-taking behaviour

Regardless of the co-occurring disorders, drug-taking behaviour will always continue to complicate treatment and should be addressed as soon in the treatment plan as possible. Take, for example, a client who comes to the facility with extensive ulcers on his or her arm, a side effect of injection drug use. The ulcers are an immediate health concern, but the drug use is the underlying cause. If the ulcers are treated without addressing the drug use, they will simply reoccur and require treatment again. Therefore, in addition
to taking care of immediate health needs, health care workers should also begin addressing the drug-taking behaviour.

**Address care in short-term and long-term goals**

When working with PWID, it is helpful to establish a long-term health care goal that takes into consideration each of their specific ailments over time. That goal should be broken up into more manageable time frames and objectives, for instance, dealing with drug-taking behaviour while simultaneously addressing immediate health needs, and then slowly building layers of treatment to address other issues such as depression or mental health.

**How can standard health services for PWID be improved?**

Even though they are just one part of a much larger system, health care workers do have the potential to considerably influence the services that PWID may receive. All improvements should follow a human rights-based approach. This means that each improvement will respect the human rights of PWID and accord them basic dignity – including basic sexual and reproductive health rights, informed decision making, and choices and confidentiality.

Below are various strategies that health care workers, as individuals, can use in any health care setting to improve services for PWID.

- **Be informed about PWID behaviour**
  
  Understanding the common behaviours, practices and risks of PWID will allow health care workers to interact more genuinely with them and build a stronger client-provider relationship. It is also important to understand the factors that influence PWID and to avoid making false assumptions about their risks or behaviours (1).

- **Do not include judgement or personal values in service provision**
  
  It is not the job of health care workers to judge their clients, because doing so will not provide a client with any helpful service. For example, if a man is in a relationship with a woman but is having sex with others on the side, a health care worker should not encourage him to stop having sex with others because he is cheating on his girlfriend. Instead, the health care worker could encourage the man to decrease his risk for HIV infection by always using condoms with his sexual partners, creating open communication with his girlfriend, and getting regular HIV testing. Likewise, with a PWID, a health care worker should not immediately encourage him or her to stop using drugs because he or she believes it is immoral. This does not provide a PWID with useful health care support.
Rather, health care workers should support PWID by identifying risky behaviour and working together to reduce the risk.

✔ **Respect confidentiality**

Health care workers should ensure that PWID’s right to privacy and anonymity are protected at all times. Not only is this an ethical and legal obligation on the part of all health care workers; PWID could experience greater consequences should their privacy be broken.

✔ **Address stigma in the health care facility**

This may be the most important strategy to implement to improve services for PWID. Module 3 contributed a number of suggestions for how to reduce stigma in health care facilities.

✔ **Provide client-centred advice and recommendations**

Every client has different needs and responds differently to certain strategies for improving his or her health. For example, when trying to quit smoking some people may find it more helpful to stop smoking altogether; others may find it useful to slowly decrease the number of cigarettes they smoke over time. Each of these strategies may work for the individual who is using them, but may not be as effective for others. This same principle applies to PWID. There are many different strategies to lower the risks that PWID experience and improve their overall health. However, these strategies need to centred on the needs, behaviours and lifestyle of each individual client. Therefore, health care workers should seek to empower PWID to identify their own options and find ways to support them in these actions.

✔ **Build referral partnerships and linkages to care**

Not all health care facilities are able to provide comprehensive substance abuse or counselling programmes for PWID. Therefore it is important to have access to a strong network of referral partners who can provide these services in a non-judgemental manner for PWID. It may also be useful for health care workers or facilities to seek out partnerships with local organisations for PWID. These organisations can provide advice and training and can support the establishment of referral partners.

Finally, health care workers should sustain good contact with other health care providers that may be providing services to the client. For example, maintaining contact with rehabilitation centres who may be providing support to the IDU PWID can be useful in that they may have more up to date contact details and could connect the PWID back into care if needed.
SUMMARY AND RECOMMENDATIONS

- While PWID could benefit from specialised services such as rehabilitation or OST (which may not be offered in most health care facilities), there are still many services that can be provided effectively within most clinical settings.

- Health care workers should attempt to educate and support PWID in more effective methods of communication.

- PWID may have difficulty in adhering to drug regimens and, therefore, health care workers should engage in adherence counselling with PWID.

- PWID may be difficult to retain in health care settings. Retention methods, such as collecting contact details for individuals related to the client, should be implemented.

- Health care workers should be self-aware and understand how personal biases and stress can affect the services they offer to PWID.

- A health care worker should provide a PWID with
  - HIV and STI screenings;
  - treatment for infections and wound care;
  - referral for mental health support;
  - referral for group counselling or support; and
  - linkage to NSE and OST programmes, as available.

- A health care worker should provide client-centred advice that supports the current needs and lifestyle of the client.

- A health care worker should understand drug use and drug-taking behaviour to more thoroughly understand the needs of clients who inject drugs.

- Health care workers can improve service delivery individually but can also support improved services at the facility level.
The purpose of this flow chart is to provide a basic guideline of things to consider when seeing a PWID Client.

Ensure that you stick to your facility guidelines at all times.
Introduction

Taking an active role in supporting change in your health care facility can be challenging, but it is a necessary step to providing more effective care for PWID in your community. This module will assist you in the development of an individualised action plan that you can implement within your health care facility to provide better care for PWID.

Learning outcomes

By the end of this module health care workers will be able to do the following:

i  Identify both individual and facility-based barriers and challenges in your clinic
ii  Identify specific areas of change to address
iii  Set a SMART goal for change
iv  Explore the facilitators and barriers towards enacting change in your facility
EXERCISE 1

Identifying areas for change in your health facility

People who inject drugs experience many barriers and challenges when accessing health care services. These can range from stigma and discrimination to breeches in confidentiality. (Think back to the barriers you came up with in Exercise 3, Module 7.)

Using these examples, list the challenges that you believe most affect PWID at your clinic, specifically. If you are not able to identify barriers for PWID (perhaps you do not know of any who attend your clinic), then select barriers that make it difficult for other types of clients.

Once you have completed your list, divide the barriers into two groups. First, please list those barriers or challenges that are linked to individual health care workers (either you or colleagues). Next, list those that are associated with facility-level difficulties (operational time, service limitations etc.).

Fill in the table on the next page with your answers.

Understanding the cause of the barrier or challenge

For this exercise, select one of the challenges or barriers (from Exercise 1) that you would like to support changing at your health care facility.

Before you develop specific actions to achieve your goal, it will be helpful to first understand the main causes behind the barriers you would like to change. Identifying the underlying cause of a barrier will better support you in determining a course of action to take to correct it.

For example, suppose that PWID did not attend your clinic and this was the problem you were attempting to change. This problem could have many different causes. Are PWID not coming because they do not know about the services you offer at the clinic, or because they have come before but had poor experiences? Each of these causes led to the same problem (PWID not attending your clinic) but they would require drastically different courses of action to change.
## EXERCISE 1 (TABLE)

<table>
<thead>
<tr>
<th>Type of Cause</th>
<th>Cause(s)</th>
<th>Challenge</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Staff stigmatisate PWID</td>
<td>Example: PWID do not come to this clinic</td>
<td>Hold sensitisation training with staff</td>
</tr>
<tr>
<td>Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Setting a goal for change

Now that you have identified a barrier or challenge and its causes, begin to consider how you would like to see it change. In other words, set a goal that you would like to achieve by changing this barrier or challenge. When setting goals for change, make sure they fit the SMART criteria:

Specific: Your goal should be clear and direct. For example: Over the next four months, I would like to conduct two training in my clinic to address stigma among the staff.

Measurable: You should be able to effectively monitor your progress towards your goal. It should not be ambiguous.

Achievable: You should be able to actually reach your goal within a set amount of time.

Realistic: Your goal should be feasible and not impossible to reach.

Timeframe: Your goal should be able to be achieved in a reasonable amount of time.

SMART GOALS

The following goals illustrate the components of the SMART criteria:

Goal: I will reduce stigma in my work place.

This goal is not specific because it does not indicate how stigma will be reduced. The goal is also not measurable; that is, how will stigma be monitored? The goal does not indicate a set amount of time, so it is not attainable. The goal may or may not be realistic, depending on the health care worker’s position and organisation of their clinic. It is difficult to determine whether this goal is timely because the actions associated with it are not specified, measurable or attainable.

Goal: I will attempt to reduce stigmatising behavior in my workplace over the next 2 months conducting a 2-hour training with the 10 counsellors in my clinic to better sensitise them to the experiences at our clinic of PWID.
This goal is specific because it states how the goal will be achieved and with whom. The goal is measurable because it indicates not only the number of people to be trained but also the length of the training. This goal is attainable because the time frame, amount of work and individuals involved are clearly stated and it could easily be implemented. It is very realistic to conduct one training session for 10 individuals, and it is realistic to assume that education will assist in lowering stigma among health care workers. This goal is timely because it provides a sufficient amount of time needed to carry out the activities that have been declared.

**EXERCISE 4**

**Understanding SMART goals**

For each of the following goals, determine which of the SMART criteria are met and which ones are not. Rewrite each goal to better fit the SMART criteria.

1. I will make all of my colleagues work better with PWID.

2. I will address stigma in my workplace.

3. I will set up a stigma committee in my clinic that consists of nurses, doctors and counselling within two months of my training.

4. I will ask each of my clients who inject drugs in the next three months about their experiences in my clinic and how they think I can improve them.

5. I will get 100 new PWID to attend my clinic by next month.

**Achieving your goal**

Use the following questions to assist you in developing a specific plan to address your goal for change.

1. **How long will you need to achieve your goal?** Consider if this is a goal that you can work on daily, or if you will need a certain amount of time before it can be implemented. Will you need to repeat an action regularly to achieve this goal or will you be able to achieve it once off?
2. **What resources will you need?** Will achieving this goal require other people, or are you able to achieve it by yourself? Will this goal require additional funding or other tools that your facility would need to contribute? Will you or your colleagues need to contribute additional time during work hours to achieve this goal?

3. **Who will need to be involved to make this goal a success?** Will this be a goal that you can implement by yourself or will you need to involve other staff? If other staff are involved, from what level will they be employed?

4. **How will you determine whether or not you have reached your goal?** Will your goal be achieved at one final point, or can it be achieved in smaller increments and timeframes?

5. **What challenges do you see that may be a barrier toward achieving your goal?** A barrier could develop during the planning or implementing of your action plan. Are there facility or individual barriers that could prevent you from reaching your goal?

6. **What do you need to make your goal a success?** What are the most important parts of your goal and action plan? How can you guarantee that those parts are available to you for your plan?

**Establishing a next step**

Change can sometimes be difficult, and achieving big goals can understandably feel overwhelming. The most effective way to make progress towards a large goal is to break that goal down into smaller action steps. Each action step should be easily achievable and move you one step closer to achieving your overall goal. If a person succeeds with enough of their action steps, they eventually make progress towards achieving their overall goal.

Take, for example, someone who is trying to lose a lot of weight. What steps are needed to achieve this? Perhaps their first step could be to join a gym or learn more about good nutrition habits. What ever the next step may be, it is easier to focus on and achieve it than their major goal of weight loss.

Take into consideration your goal. What is the very first step you can take when you return to your health care facility?

**Conclusion**

People who inject drugs in South Africa are urgently in need of better care and support. This manual has detailed the significant challenges and barriers that they face on a regular basis. It has explained the effects of stigma and discrimination, and it has explored how human rights abuses increase the vulnerability of PWID to
HIV and STIs. Most importantly, it has illuminated the impact that health care facilities and individual health care workers can have on the ability of PWID to access much-needed health care. Knowledge can often be one of the most important facilitators of change. Therefore, consider the following questions:

- What information was the most useful to you?
- What knowledge do you feel is critical to pass on to your fellow health care workers?

Despite the difficulties that PWID face in accessing health care services, there is still great potential for change. This opportunity for change begins with health care workers and with public health facilities. Ultimately, the ways that PWID experience and access health care services in South Africa are entirely dependent on people like you and the decisions you make in moving forward.

**Key Populations**

People who Inject Drugs and other people who use drugs are not the only group of people who experience many of the issues discussed in this manual. Other groups who have specific needs, experience high levels of stigma and discrimination, and have difficulty accessing health care include Men who have sex with men (MSM), Sex workers, Migrant populations, Prisoners, and Transgender people. Individuals from across these populations are subject to the same vulnerabilities and are often treated unfairly in the health care setting. This manual has focused on sex workers, but much of what is covered here also applies to these other population groups.

A minimum service package for all key population groups should include:

- Access to non-discriminatory and quality health care services
- Peer-based outreach activities
- Provision of appropriate information, education and communication material
- Provision of male and female condoms and condom-compatible lubrication
- Voluntary and confidential HIV counselling and testing
- STI and TB screening
- Referral for sensitive provision of: HIV, STI, TB treatment, care and support, substance abuse and mental health services; post-exposure prophylaxis (PEP) and reproductive health services, including family planning, termination of pregnancy and cervical cancer screening programmes
PEOPLE WHO INJECT DRUGS (PWID)

SENSITIVITY TRAINING POST-COURSE ASSESSMENT AND QUESTIONNAIRE

Thank you for completing this manual on PWID Sensitivity Training. Please take a moment to complete the post-course assessment. This can be used to compare your change in knowledge since the beginning of the course.
PWID KNOWLEDGE

1. PWID are at higher risk for HIV than the general community because:
   a. They may share needles to inject drugs
   b. They may be exposed to violence or sexual assault
   c. They not get effective health care because of stigma or discrimination
   d. All of the above

2. PWID may be stigmatised because:
   a. They may have injection marks on their arms
   b. They may be dirty or smell bad
   c. They may engage in an illegal activity
   d. All of the above

3. PWID stigma can be addressed in a health care setting by:
   a. Having a separate queue for PWID away from the other clients
   b. Encouraging the police to visit the clinic regularly
   c. Addressing the use of inappropriate language used towards PWID
   d. Refusing to provide PWID the same services as other clients

4. PWID find it hard to access health services because:
   a. They face ill-treatment and discrimination from health care staff
   b. They don't have money for transport
   c. They worry that they will get arrested if they go to the clinic
   d. All of the above

5. People take drugs because:
   a. They experience peer pressure
   b. They want to experiment
   c. They need a coping mechanism
   c. All of the above

6. Which of the following is a strategy that PWID can use to reduce their risk when injecting drugs?
   a. Injecting with heroin instead of with cocaine
   b. Getting tested for HIV and STIs
   c. Only injecting with other drug users in a communal area
   d. Only sharing needles with people that they trust

7. PWID share needles because:
   a. They want to save money
   b. They are scared to buy needles
   c. It is a way of showing that you are friends with someone
   d. All of the above
8. Risk-reduction counselling is a behavioural technique meant to reduce HIV risk:
   a. By convincing PWID to stop taking drugs
   b. By eliminating all risk that PWID may experience
   c. By decreasing the risk experienced by PWID according to their actions and circumstances
   d. None of the above

9. A PWID can reduce risk for getting HIV by:
   a. Not injecting drugs
   b. Not sharing needles
   c. Getting tested for STIs regularly
   d. All of the above

10. Which of the following is a factor that affects the mental health of a PWID?
    a. High levels of stigma and discrimination
    b. The high expense of needles
    c. The shortage of drugs
    d. All of the above

11. Health care could do which of the following to better provide services to PWID?
    a. Provide confidential and sensitised risk-reduction counselling
    b. Include input from PWID in the design of the service
    c. Provide combination HIV prevention strategies for their use
    d. All of the above

12. Combination HIV prevention for PWID is:
    a. Useful because it addresses the multiple risks PWID face
    b. Inclusive of NSE and OST programmes
    c. Inclusive of psychological support for PWID
    d. All of the above

13. Each of the following is a sign of external stigma towards a PWID except:
    a. A nurse gossips to a receptionist about the drug-taking behaviour of their client who injects drugs
    b. A counsellor believes that drug use is immoral and tries to counsel the drug user to stop drug use immediately
    c. A nurse refuses to draw blood from a client suspected of injecting drugs because he or she does not want to contract an illness.
    d. A health care worker refuses to provide medication to a PWID until he or she stops using drugs because of the belief that the medication will be ineffective.
FOR THE FOLLOWING STATEMENTS, INDICATE WHETHER YOU AGREE OR DISAGREE BY CIRCLING A NUMBER BELOW:

14. People who inject drugs do not visit my clinic.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

15. People who inject drugs are immoral.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

16. PWID deserve to get HIV because of the behaviour that they engage in.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

17. If a PWID came into my clinic, I would provide him or her services.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

18. If a PWID wanted treatment for an STI, I would not provide it because he or she will just get infected again.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

19. If a PWID came into my clinic, I would advise him or her to quit using drugs rather than provide harm-reduction strategies.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

20. I am comfortable providing health care services to PWID.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

21. I believe that I can effectively counsel a PWID to reduce his or her risk for getting HIV.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

22. I am aware of PWID-friendly services that a client could be referred to for more in-depth care.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

23. I am aware of PWID organisations that work in my community.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree

24. PWID should not have a right to access clean injection equipment such as needles and syringes.
   Strongly Disagree   1   2   3   4   5   6   7   8   9   10   Strongly Agree
25. PWID have specific kinds of health care needs that have to be considered to enable best health outcomes.

   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

26. PWID should be offered services unique to their needs because they are more vulnerable than other people and may need special treatment.

   Strongly Disagree  1  2  3  4  5  6  7  8  9  10  Strongly Agree

If you would like to receive more information on the Pre and Post course assessments, please email ben.brown@hiv-research.org.za)
APPENDIX I

LEGISLATION IN SOUTH AFRICA PERTAINING TO DRUGS (1)

The control of drugs in South Africa is organised and managed through a number of pieces of legislation, two of which are of special note.

1. The Medicines and Related Substances Control Act (101/1965): This supports the processes set out in the major United Nations Conventions on drug control and provides the definitional and conceptual basis for drug control policy in South Africa.

2. The South African Drugs and Drug Trafficking Act (140/1992): This makes it an offence to supply substances to anyone while knowing or suspecting they will be used for the manufacture of illegal drugs. The Act further prohibits any person from converting property that he or she knows or suspects to be gained from the proceeds of drug trafficking, and it makes dealing in dangerous and undesirable drugs an offence punishable by up to 25 years’ imprisonment. The maximum sentence for the possession of drugs is 15 years. There are no prescribed minimum sentences.

3. Other relevant legislation includes:
   i. The Mental Health Act (18/1973)
   ii. The Criminal Procedures Act (51/1977)
   iii. The Prevention and Treatment Act (20/1992)
   iv. The Financial Intelligence Centre Act (38/2001)
Substance Dependence

According to the DSM-IV-TR (1), the essential feature of substance dependence is a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal and compulsive drugging behaviour.

The term “substance dependence” has come to be favoured over the terms “addiction” and “habituation” in scientific writing (2). An individual is said to have developed dependence when there is a strong, compelling desire to continue taking it. This desire may derive from a wish either to experience its effects and/or to avoid or escape the adverse experiences produced by its absence. Dependence on a substance may in origin be largely psychological or physiological. Substance dependence is defined as the physiological dependence on the drug or drugs, the requirement of greater and greater amounts of the drug (tolerance), and responding physically in a negative manner when the substance is no longer taken (withdrawal) (3).
Another view of substance dependence concentrates on drug-seeking behaviours as a measure of an individual’s dependence on a drug or drugs, such as repeated use of the drug, a desperate need to ingest more of the substance, and the likelihood of resuming the drug after a period of abstinence. This reaction is different from a physiological reaction and is sometimes referred to as psychological addiction (4). The DSM-IV-TR definition of substance dependence, as shown in Table 1.3.1.1, combines the physiological aspects of tolerance and withdrawal with the behavioural and psychological aspects (1).

**DSM-IV-TR Criteria for Substance Dependence**

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance as defined by either of the following:
   - (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect
   - (b) Markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   - (a) The characteristic withdrawal syndrome for the substance (refer to Criteria a and b of the criteria sets for Withdrawal from the specific substances)
   - (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g. chain-smoking), or recover from its effects
6. Important social, occupational or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)
Specify if:

- **With physiological dependence:** Evidence of tolerance or withdrawal (i.e. either Item 1 or 2 is present)
- **Without physiological dependence:** No evidence of tolerance or withdrawal (i.e. neither Item 1 nor 2 is present)

Course specifiers:

- **Sustained full remission:** This specifier is used if none of the criteria for Dependence or Abuse have been met at any time during the period of 12 months or longer.
- **Early partial remission:** This specifier is used if, for at least one month but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).
- **Sustained partial remission:** This specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.

The following specifiers apply if the individual is on agonist therapy or in a controlled environment:

- **On agonist therapy:** This specifier is used if the individual is on a prescribed medication such as methadone. This category applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.
- **In a controlled environment:** This specifier is used if the individual is in an environment where controlled substances are restricted, and no criteria for Dependence or Abuse has been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities or locked hospital units.
The Constitution of the Republic of South Africa lays the foundation for ensuring that all people are treated equally and that each person is afforded basic rights. Nurses must at all times protect and maintain the rights of people they provide care to.

These rights are contained in the Bill of Rights in the Constitution of the Republic of South Africa and must be adhered to all times… Do not discriminate on the grounds of race, colour, creed, gender, religion, culture, politics, social status, personal attributes or the nature of the health problem… Nurses must not permit considerations of religion, nationality, race or social standing to influence the quality of the care they render.
Male and Female Condoms

A condom is a protective sheath used during anal, vaginal or oral sexual intercourse. It creates a physical barrier between the genitals and sexual fluids of two partners engaging in intercourse. It can be used for contraception and/or HIV and STI prevention. There are two main types of condoms – male condoms and female condoms.

Male condoms are usually made out of latex (rubber). Female condoms are usually made out of polyurethane (a thin, strong plastic). Male condoms made out of polyurethane also exist (but are not widely available) and are useful for avoiding latex allergies.

Currently, the female condom is approved for vaginal use only – that is why it is called the female condom. However, female condoms can also be used for anal sex, and research shows that some MSM use the female condom for HIV/STI protection (1).
Table 2 compares the male condom with the female condom.

Table 2: Similarities and differences between male and female condoms

<table>
<thead>
<tr>
<th>Male Condom</th>
<th>Female Condom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latex (rubber)</td>
<td>Polyurethane (plastic)</td>
</tr>
<tr>
<td>Water-based lubricants only (e.g. KY Jelly®)</td>
<td>Any lubricant, preferably water-based (although oil-based lubricant, such as Vaseline®, body cream or oil are also possible)</td>
</tr>
<tr>
<td>Can break if not used correctly</td>
<td>Does not break easily</td>
</tr>
<tr>
<td>Some men find it too tight/restrictive</td>
<td>Not tight on penis</td>
</tr>
<tr>
<td>Must be put on/taken off the erect penis immediately before/after penetration</td>
<td>Can be inserted before penetration and left in for longer</td>
</tr>
<tr>
<td>Does not conduct heat</td>
<td>Warms up to body temperature</td>
</tr>
<tr>
<td>Must be worn on the penis (insertive partner)</td>
<td>Can be inserted into anus (receptive partner) or used over the penis (insertive partner)</td>
</tr>
</tbody>
</table>

How well do condoms work?

When used correctly and for all sex acts, condoms are 80–95% effective at preventing HIV and STIs. These estimates are based on research among heterosexual couples engaging in regular sexual intercourse using condoms consistently (2-4). Often, however, individuals do not use condoms correctly or consistently (5), resulting in potential exposure to HIV/STIs.

Male and female condoms are manufactured according to strict quality standards and are tested for strength, leakage, lubrication, proper packaging and labelling.

Instructions for correct male condom use

1. Store condoms in a place away from heat and humidity. Check the expiration date on the package. Check that the package is not damaged and has no holes by feeling the air in it.
2. Do not rip or puncture the condom when opening the package. Open it with the fingers, NOT with teeth, scissors, a knife, or anything sharp.
3. Check that the condom is not dry.
4. Make sure the tip of the condom is the right way around—the lubricated side should be on the outside, and the condom should roll down easily.
5. Pinch the tip (teat) of the condom with one hand. This removes the air and makes space to hold the semen.
6. Place the condom on the erect penis and unroll it to the base of the penis with the other hand, while still pinching the tip of the condom. If uncircumcised, pull back the foreskin before putting on the condom. After it has been put on, push the foreskin forward again (toward the tip) to let the foreskin move without breaking the condom.

7. Smooth out any air bubbles.

8. Add a water-based lubricant (e.g. KY Jelly®) to the outside of the condom if necessary. Do NOT use oil-based lubricants.

9. If the condom breaks or slips during intercourse, STOP, remove the broken/used condom, and put on a new one.

10. After ejaculation, hold the condom at the base of the penis and pull it off before the penis softens.

11. Remove the condom, taking care not to spill any semen.

12. Wipe any ejaculate off the penis.

13. Make a knot in the condom and dispose of it appropriately out of the reach of children.

14. Use a new condom for each new act of intercourse.

Instructions for correct female condom use

Method 1: Use by receptive partner

1. Check the expiration date.
2. Find the arrow on the packaging and tear downwards.
3. Insert the female condom into the vagina or anus.
4. Either keep or remove the inner ring, depending on preference. The inner ring can be used to insert the female condom, and then be removed thereafter.
5. Leave the outer ring on the outside of the body.
6. Add lubricant to the inside of the female condom or on the penis if needed.
7. Guide the penis inside the outer ring into the female condom. If the penis enters to the side of the female condom or pushes one of the sides of the outer ring inside the vagina or anus, STOP, adjust the outer ring, and start again.
8. To take out the female condom, twist the outer ring and gently remove.
9. Tie a knot and dispose of it in the trash.

Method 2: Use by insertive partner

1. Remove the inner ring. The ring can be placed on the outside of the condom, as this can provide additional stimulation to the receptive partner.
2. Place the condom over the erect penis like a sock.
3. Add lubricant to the condom and/or to the partner’s anus/vagina.
4. Holding both rings in place at the base of the penis, insert the penis into the anus or vagina.
Challenges of using the female condom include difficulty inserting and keeping it in place, irritation, unpleasant texture, and noise of the condom (6-7).

Advantages of female condoms are that they allow for more sensation by the insertive partner their material and texture means that the receiving partner/cannot feel the condom. Female condoms are a more satisfactory option for men who do not enjoy using male condoms.

**Lubricants**

Lubricants (or “lubes”) are substances that reduce friction between the penis, vagina, or anus during sex. Lubrication helps prevent condom breakage, and decreases the risk of slippage during anal sex (8). Lubrication is very important during anal sex in order to prevent anal/rectal trauma.

**Water-based and oil-based lubricants**

There are two main types of lubricant: water-based and oil-based.

Water-based lubricants can be used with male latex condoms, as they do not damage the latex. Examples include KY Jelly® and Assegai®. Most male and female condoms already have water-based lubricant on them; however, adding lubricant is especially important for anal sex, as the lining of the anus does not produce its own natural lubrication and is sensitive to tearing.

Oil-based lubricants must NOT be used with the male condom, as they damage the latex and may increase the risk of condom breakage. Examples of oil-based lubricants include hand lotion, body lotion, baby oil, vegetable oil, cooking oil, massage oil and petroleum jelly (e.g. Vaseline®).

In many communities throughout Africa, water-based lubrication is not freely available and may be too expensive for most individuals to buy. In these cases, many individuals use other substances that provide lubrication during sex. It is critical when counselling clients about alternatives types of lubrication that only water-based products are used. It is important to also educate a client that alternatives to lubrication that are oil-based, such as butter or fat, are just as dangerous to use with a condom as oil-based lubricants.

**Giving advice on lubricant use to clients**

- Ask the client whether he/she usually uses lubricant during sex.
- If he/she does not use lubricant, ask whether the client ever experiences pain or discomfort during sex.
- Explain what a lubricant is and inform him/her of the importance of ensuring smooth intercourse in order to minimise pain and the risk of tearing/bleeding.
- Explain that a lubricant can be used during intercourse regardless of whether a condom is used.
- Explain that condom use is the safest way to prevent HIV infection during sex, and that you recommend using a lubricant to ensure smooth intercourse (this is particularly important for anal sex, as the anus does not produce natural lubrication).
- If possible, demonstrate correct lubricant use and give out water-based lubricants during the counselling session.
- Explain to clients that water-based lubricants (e.g. KY Jelly®) can be bought at most pharmacies.

As a counsellor, it is important to be able to explain to clients what lubricants are and the differences between water-based and oil-based lubricants, and to recommend water-based lubricants.
Preexposure prophylaxis

Another potential HIV risk reduction tool for sex workers is preexposure prophylaxis (PrEP), which refers to a prevention tool that involves HIV-negative patients taking a daily ARV in order to prevent HIV. PrEP is a very new biomedical HIV prevention tool that has only shown efficacy in one trial including only men who have sex with men (MSM), but could provide up to 44% additional protection against HIV. Since PrEP is currently only proven to be of limited efficaciousness in reducing HIV among MSM, it should only be offered to a sex worker who is MSM (1).

Vaginal and rectal microbicides

Microbicides are gels or creams that are designed to be inserted into the rectum or vagina before sexual intercourse. In 2009, a clinical trial showed that vaginal microbicides added an additional 33% protection from HIV (1). Unfortunately, a publicly-available microbicide is not on the market, but could be a potential HIV prevention in the future. Likewise, rectal microbicides are still being research to determine their ability to prevent HIV in men and women. Both of these tools could someday be potential tools that sex workers could use to protect themselves from HIV.
Following is an outline for one particular method of risk-reduction counselling.

**Step 1: Assess the behaviours of clients**

To assist clients in developing risk-reduction goals, it is first important to gain a better understanding of their sexual practices, including both safe and risky behaviours. Particular focus can be placed on behaviour from the previous 3 months, as this may have an impact on their need for further HIV testing. This basic assessment can be achieved by asking them key questions regarding the number and type of sexual partners they have, the types of sexual acts they have engaged in, and their use of alcohol or other substances.

**Step 2: Assist clients in identifying a risk behaviour to address**

Clients should select a behaviour that they are motivated to change. Generally, this will be one that is causing them some type of physical or emotional distress or other negative side effect. It is important that clients be significantly involved in choosing which behaviour to address. When they are actively involved in the identification process, they will be more motivated to follow through on the risk-reduction goals or strategies than if the counsellor selects the behaviour.

**Step 3: Discuss the cost and benefits of this behaviour**

Once a behaviour has been selected, it can be helpful to assist clients in exploring and understanding the reasons why they engage in this behaviour. This will involve discussing their motivators or benefits for doing so. It is critical also to explore and discuss the consequences of this behaviour, in
other words the costs the participant will pay for engaging in it. For example, when discussing the cost and benefits of engaging in unprotected anal sex, a participant may list such benefits as ‘it feels good,’ ‘it is more intimate,’ or ‘it is cheaper than buying condoms.’ Some costs might be the danger of becoming infected with an STI or HIV, or the fear and emotional stress associated with not knowing their HIV status. The counsellor should use the cost and benefits listed by their clients to assist them in understanding why they engage in the risk behaviour and why they should consider altering that behaviour.

Step 4: Set goals

Once clients have a deeper understanding of why they engage in the risk behaviour and the motivators that influence them, they should create a personalised goal to change this behaviour in some way to become safer. This goal should be specific, achievable and measurable. Goals that are less detailed can be difficult to achieve or follow through with. Most importantly, a behaviour-change goal should be realistic for clients and based on their specific circumstances. Setting a behaviour-change goal that is impossible for them to achieve right away may lead them to becoming demotivated or disappointed in themselves. For example, it may be unrealistic for a client who very regularly has a large number of sexual partners to set a behaviour-change goal of becoming monogamous. Instead, a smaller but achievable goal might be for such clients to reduce their sexual partners to a smaller number of people, which may also be something that they can sustain over time.

Step 5: Discuss barriers

It can also be helpful to discuss with clients any potential barriers that may prevent them from achieving their goal and to help them develop strategies to overcome them. Barriers could include pressure from friends or a dependence to a drug. Predicting potential barriers that could make behaviour difficult for the client is particularly helpful if you have infrequent contact with clients or will only see them once.

Step 6: Reinforcement

Ultimately, changing behaviour can be a difficult process; therefore, it can be helpful to make clients feel proud and motivated when they conclude their session and to remind them that a new goal brings a new opportunity to improve their behaviour. Furthermore, it needs to be stressed and emphasised that not all MSM engage in risky behaviour. Clients may easily be engaging in a number of safe behaviours that they enjoy, and reinforcing these behaviours is a great way to encourage their self-esteem and support behaviours that are protecting their health.
APPENDIX VII

ORGANISATIONS THAT SUPPORT PEOPLE WHO USE DRUGS IN SOUTH AFRICA

Western Cape Government Treatment Clinics

**De Novo Treatment Centre**
Old Paarl Road Kraaifontein
**T:** 021 988 1138
Dr De Smidt
E-mail: scdesmidt@pgwc.gov.za

**Kensington Treatment Centre**
Kensington Road, Maitland
Ms F. Davids
Cell: 083 275 9574
Fax: 021 510 1057

**SANCA Western Cape**
Regional Office: 18 Karoo Street, Bellville
Tel: (021) 945 4080/1
Email: sanca@sancawc.co.za
Atlantis:
1 Dolly Center, 3 Adeness Crescent
Westfleur, Atlantis
Tel: (021) 572 7461
Tygerberg:
3 2nd Avenue, Boston, Bellville
Tel: (021) 945 2099

Paarl:
JF Phillips Building, 1st Floor
34 Lady Grey Street, Paarl
Tel: (021) 872 9671

Athlone
Child Welfare Offices, 157 Lower Klipfontein Road, Athlone
Tel: (021) 638 5116

Mitchells Plain
11 Daphne Crescent, Eastridge, Mitchells Plain
Tel: (021) 397 2196

Khayelitsha
Catholic Welfare Centre, E505 Scott Street, Khayelitsha
Tel: (021) 364 5510 / 6131

Durbanville In-Patient Centre
32 Protea Road, Durbanville
Tel: (021) 9754927/87

**Western Cape Treatment**
Old Faure Road, Eerste Rivier
Ms F. Davids
T: 021 843 3200

**Western Cape Subsidised Treatment Clinics**

**Hesketh King Treatment Centre**
Corner Old Paarl Road and Klipheuwel Road
T: 021 884 4600

**Ramot Treatment Centre**
54 Toner Street, Parow
T: 021 939 2033
E-mail: pltheron@ramot.co.za or admin@ramot.co.za
Toevlug Treatment Centre
40 Noble Street, Riverview, Worcester
Rev. Van Rooy
T: 023 342 1162
E-mail: rehab@toevlug.org

Cape Town Drug Counselling Centre
Observatory, Cape Town
T: 021 447 8026
E-mail: ctdcc@iafrica.com

Western Cape Municipal Outpatient Treatment Centres

Tafelsig Matrix Site
Tafelsig CHC
Kilimanjaro Street, Tafelsig, Mitchells Plain
T: 021 557 1065 / 556 7103

Delft South Matrix Site
Delft South CHC
Corner Boyce Street and Delft Main Road, Delft South
Tel: 021 955 9200

Tableview Matrix Site
South Road, Table View
T: 021 557 1065 / 556 7103

Khayelitsha Matrix Site
C Block, Stocks & Stocks, Khayelitsha
Ntlakhohlaza Street, Khayelitsha, 7784
T: 021 360 1256
Cell: 073 884 5069

Gauteng

Elim Addiction Clinic
133 Plane Road, Spartan
Kemptonpark, Johannesburg
Email: info@elimclin.co.za
T: 011/9752951
SANCA Phoenix
Sophia Town
T: 011 673 0400
E-mail: sanca@sanca-jhb.org.za

SANCA Soweto
T: 011 984 4290

Wits Reproductive Health and HIV Institute (WRHI)
Address: Corner of Esselen and Klein Streets, Hillbrow, Johannesburg

*Services provided: HIV counselling and testing, TB screening and treatment, psychosocial support groups, mobile clinic outreach services, ART initiation*

**Free State**

SANCA: Aurora Alcohol & Drug Centre
Navelview, Bloemfontein
T: 051 447 4111
E-mail: aurorasentrum@xsinet.co.za

**Northern Cape**

SANCA Kimberley
T: 053 831 1699
E-mail: sancakimberley@telkomsa.net

**North West**

SANCA Klerksdorp
T: 018 462 4568

**Limpopo**

SANCA Pietersburg
T: 015 295 3700 / 015 291 5985

**Mpumalanga**

SANCA Nelspruit
T: 013 755 2710

SANCA Swartfontein
White River
T: 013 751 2235
KwaZulu-Natal

SANCA Morningside
Durban
T: 031 303.2202

Eastern Cape

SANCA East London
T: 043 743 4350

SANCA Port Elizabeth
T: 041 487 2827

Emergency help numbers

Lifeline
National Counselling Line: 0861 322 322
National AIDS Helpline: 0800 012 322
Stop Gender Violence Helpline: 0800 150 150

Narcotics Anonymous
National 24-hour helpline: 083 900 69 62
REFERENCES BY MODULE

Module 1: Background on drug use and people who inject drugs


Module 2: Common drug-taking behaviour

1. SANCA Western Cape. ‘Providing Substance Abuse Solutions: Substance Abuse and Dependency Guide’ www.sancaw.com

Module 3: Stigma and drug use


Module 4: Drug use, health care and the law


Module 5: Reducing the risk for HIV and other common infections amongst PWID


**Module 6: Mental Health amongst PWID**


**Module 7: Providing services for PWID**


**Appendix I**

Appendix II


Appendix IV


Appendix V


Additional resources and readings:


People Who Inject Drugs and Other Drug Users: An Introductory Manual for Health Care Workers in South Africa


This training manual provides an introduction to the knowledge and skills necessary for health care workers to effectively provide non-judgmental health services to People Who Inject Drugs (PWID) and other People who Use Drugs.

Drug use is common in South Africa, and there are indications that the practice of injection drug use is increasing. Many health-related risks, including HIV, are associated with injection drug use. Despite these risks, stigma and other barriers can often prevent PWID from accessing effective health care in South Africa.

In order to meet objectives established in South Africa's National Strategic Plan for HIV, STIs, and TB (2012-2016), health care workers must provide more appropriate and sensitive health care to all South Africans, including PWID.

This manual was developed in partnership with key stakeholders and contributors from across South Africa in order to provide health care workers with the most up-to-date information and informed perspectives regarding PWID and their health needs.

This manual is comprised of 8 modules:
1: Background on Drug Use and People Who Inject Drugs (PWID)
2: Common Drug-Taking Behaviour
3: Stigma and Drug Use
4: Drug Use, Health Care, and the Law
5: Reducing the Risk for HIV and Other Common Infections Amongst PWID
6: Mental Health Amongst PWID
7: Providing Services for PWID
8: Creating a Plan of Action for Your Health Facility

Additional contents include:
- Pre and Post Course Assessments
- Resource and Referral Information
- Exercises and Case Studies
- Glossary

Partners
The Desmond Tutu HIV Foundation (DTHF) is a registered non-profit organisation focused on the pursuit of excellence in research, treatment, training, and prevention of HIV and related infections. The DTHF operates community sites in greater Cape Town, South Africa, providing treatment, testing, and outreach services to at-risk communities.

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