

Harm reduction – a neglected policy option in South Africa

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Introduction

The term “harm reduction” has a very specific meaning in relation to drugs of abuse (whether licit or illicit). Harm reduction is defined as “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption”.¹ The Harm Reduction

Coalition has expanded on the definition, by listing a set of principles.² These state that harm reduction:

- “Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people’s vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.”

The Harm Reduction Coalition’s principles pose significant challenges for pharmacy, in all sectors, and in particular to the often paternalistic and judgmental attitudes of pharmacists in relation to the use of a range of psychoactive medicines. They challenge the knee-jerk reaction of pharmacists that see abstinence as the only option, and who shy away from involvement in programmes that they perceive as permissive. This paper points to the key evidence for the role of

pharmacists in harm reduction, and asks whether this is a neglected policy option in the South African setting.

The role of pharmacists in harm reduction

The role of pharmacists in harm reduction was systematically reviewed by Watson and Hughes in 2012.³ This review was based on published literature from the period 1995 to 2011, underscoring the relatively recent application of harm reduction in pharmacy settings, and focused particularly on the involvement of community pharmacists. Many trace the involvement of community pharmacies in particular to the 1993 recommendations of the United Kingdom’s Advisory Council on the Misuse of Drugs, which resulted in the creation of the Glasgow Drug Problem Service.⁴

Watson and Hughes were only able to review publications in English, so may well have missed important examples of pharmacist involvement in harm reduction. They also noted that the available literature was “primarily based on surveys and, as such, does not necessarily reflect what is actually happening in practice or include an evaluation of health outcomes”. The predominant forms of harm reduction provided by pharmacists were syringe and needle exchange programmes, opioid substitution therapy (including the supervised administration of oral methadone), and sexual health services (ranging from testing for chlamydia, HIV and hepatitis C to safe-sex advice). Watson and Hughes summarised the key points from their systematic review as follows:

- “The benefits of introducing harm reduction programs into community pharmacies include reducing the spread of blood-borne infections, as well as increasing entry of intravenous drug users into detoxification programs.
- Harm reduction programs in community pharmacies do not result in a significant increase in criminal activity in the store, nor do they result in reduced clientele due to fear or discomfort.
- Pharmacists are supportive of their role in harm reduction and identify a lack of time, training and interdisciplinary communication as major barriers to implementation.
- Centralized support of pharmacy involvement in harm reduction programs through financial and administrative support is a potential means for overcoming barriers”.

The available evidence is therefore of limited applicability to hospital pharmacy, even though some of the core elements may be easily applied in hospital settings. Needle and syringe exchanges, for example, can be provided in out-patient clinic areas. It might also be possible to provide safe injection spaces (sometimes referred to as “shooting galleries”) within health facilities. The key is to ensure that such services meet the demands of being “non-judgmental, non-coercive”, are rooted in a human rights approach, and acknowledge the autonomy of drug users and their role in the process.

South African standard treatment guidelines and policies

The current (2015) issue of the National Department of Health's Standard Treatment Guidelines (STGs) for Adult Hospital Care list the management of opiate (heroin) withdrawal under Psychiatric Disorders.⁵ The STG recommends that patients with moderate to severe withdrawal symptoms should be hospitalised, and offered opiate substitution, but as a short-term aid to withdrawal. The suggested withdrawal schedule is as follows:

Day 1: Only if clinical signs of withdrawal are present

- Methadone, oral, 5–10 mg
 - If symptoms are still present after 2–4 hour, give another 5–10 mg
 - The initial dose to suppress withdrawal symptoms may be repeated after 12 hours
 - The total 24 hour dose should rarely be more than 30 mg. Consult a person experienced in opioid withdrawal when prescribing > 30mg/day

Day 2:

- Methadone, oral
 - Repeat total dose of day 1 as a single or 2 divided doses
 - Monitor for on-going sign and symptoms of withdrawal
 - If the signs and symptoms of withdrawal are still present on day 2, top-up doses of 5 mg may be given at 2–4 hourly intervals with a total daily dose of 30 mg

Day 3 onwards:

- Methadone, oral
 - Decrease by 5 mg/day to a total of 10 mg. Thereafter, reduce by 2mg/day
 - The withdrawal regimen may be shortened if the patient's withdrawal symptoms allow it
 - Repeat total dose of day 2 if top-ups were needed and begin reductions on day 4

If methadone is unavailable:

- Tramadol, oral, 200 mg 12 hourly for 14 days may attenuate withdrawal symptoms.

Other STG entries cover withdrawal from stimulants (such as cocaine and amphetamines), methaqualone, cannabis and benzodiazepines. There is no mention, therefore, of long-term substitution in an ambulatory setting. Nor is there mention of the supply of needles or syringes for those who continue to inject drugs, let alone of the provision of low dead space versions that can reduce the risks of disease transmission.⁶ Although listed in the STG, oral methadone does not appear on the NDOH procurement catalogue and was not listed in the most recent solid dose tender (HP09-2016SD).

The total quantities of methadone reported to the International Narcotic Control Board as having been imported into South Africa is modest: 3902g in 2011, 7352g in 2012, 9757g in 2013, 16947g in 2014 and 11155g in 2015.³ Almost all opioid use in South Africa in the period 1980–2009 was in the form of morphine.⁷

The potential gains from integrating HIV and drug services for injectable drug users (IDU) have been identified in South Africa, but do not appear to have been implemented at scale.⁸ A renewed focus on vulnerable populations is, however, becoming evident in South Africa.

³ pers comm. Medicines Control Council secretariat

The Central Drug Authority's National Drug Master Plan 2013–2017 does call for the use of "proven opioid treatments, including detoxification, and inpatient and outpatient pharmacotherapy" and encourages "treatment programmes for drugs at health facilities".⁹ Although it notes the evidence for methadone-based substitution therapy, it makes no concrete recommendations on how this is to be delivered. The existing legislation (the Prevention and Treatment of Drug Dependency Act (Act 20 of 1992) and the Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008)) does not specifically enable a harm reduction approach. South Africa is also a signatory to dated and restrictive international agreements, particularly the 1961 Single Convention on Narcotic Drugs.¹⁰

Latest South African development

On Friday 31 March 2017, a full bench of the Cape High Court ruled in three linked cases relating to the possession and use of cannabis. The court found that sections of the Drugs and Drugs Trafficking Act and the Medicines and Related Substances Act (and the Schedules published in terms of those Acts) were inconsistent with the Constitution and were therefore invalid. However, the court suspended the finding of invalidity for 24 months, in order to allow Parliament the opportunity to remedy the situation. The court judgment also specified that the invalidity applied "only to the extent that they prohibit the use of cannabis by an adult in private dwellings where the possession, purchase or cultivation of cannabis is for personal consumption by an adult".

A way forward

Globally, societal attitudes to what have been termed drugs of abuse are changing. Liberalised access to cannabis for either medicinal or recreational use is increasingly common. A wide-ranging policy debate about decriminalisation of other currently illicit drugs is also gathering momentum. Pharmacy, as a profession, needs to engage with this debate and address the policy lacunae that have been identified above. Continuing to ignore the potential benefits of more widespread application of harm reduction principles in a country with high HIV and viral hepatitis prevalence, and a growing problem of injectable drug use, is simply unconscionable.

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