AWACC CONFERENCE | DURBAN, KWAZULU-NATAL

Breaking the Cycle: Strategic Substance Abuse Interventions



An integrated, bio-psycho-social health approach to substance use disorders, HIV, TB and Hepatitis C across PHC facilities and community networks

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STOP!
DRUG ABUSE & ADDICTION

FIVE THEMES

Five themes, one integrated response

1	**District-level care for PLWH with comorbidities** How SUD erodes ART and TB retention	Slides 4-6
2	**KZN Health Sector Drug Master Plan** Agent-Host-Environment model, goals	Slides 7-11
3	**UNODC-WHO standards and SBIRT scale-up** Screening, brief intervention and referral inside HIV and TB care	Slides 12-14
4	**Institutional capacity and quality assurance** Workforce training, DHIS indicators, SACENDU and quality measures	Slides 15-17
5	**Human rights and multi-sectoral governance** Non-stigmatising care, harm reduction, LDACs and community structures	Slides 18-21

THE CASE FOR ACTION

Framing the syndemic

7x

Rise in illicit drug use

1.5% to 10% of South African adults, 2002-2017 (over 4 million people)

16.5%

Lifetime prevalence

Adults with a mental or substance use disorder (SASH survey)

2.3%

Receive adequate care

Adults with past-year SUD who get minimally adequate treatment (SAMRC)

52%

In eThekwini, 52.7% of the study population avoided healthcare due to stigma and/or discrimination because of drug use

Comorbidity of substance use, HIV, Tuberculosis (TB), and Hepatitis C (HCV) in South Africa stems from the 2023 National Bio-Behavioural Survey (BBS)

SUD, HIV, TB and Hepatitis C feed one another. Treating one disease without the others loses patients.

Substances speed viral replication and weaken immunity

Co-receptor upregulation

- Opioids and methamphetamine upregulate CCR5 and CXCR4, helping HIV enter cells and replicate.
- Substance use speeds progression from HIV to AIDS and worsens TB lung cavitation.

Immune suppression

- Impaired CD4+ T-cell reconstitution, cytotoxic T-cells and natural killer cell activity.
- Heavy episodic drinking accelerates CD4 decline and opportunistic infections.

Liver and organ strain

- Alcohol, tik and anti-TB or ARV regimens together raise the risk of drug-induced liver injury.
- Nyaope adulterants add kidney damage and endocarditis.

Neurocognitive impairment

- Alcohol and methamphetamine compound HIV-associated neurocognitive disorder.
- Poor memory and executive function make daily pill-taking harder.

Two pathways disrupt care, and Drug use amplifies both

Pathway 1: chemical disruption

- Hepatotoxicity complicates TB regimens (alcohol, methamphetamine)
- Drug interactions can lower ARV bioavailability
- Immunosuppression accelerates opportunistic infections

Pathway 2: behavioural disruption

- Missed visits and chaotic routines undermine strict ART adherence
- High-risk sex and injecting raise HCV and STI transmission
- Fear of scolding or police contact keeps clients from clinics

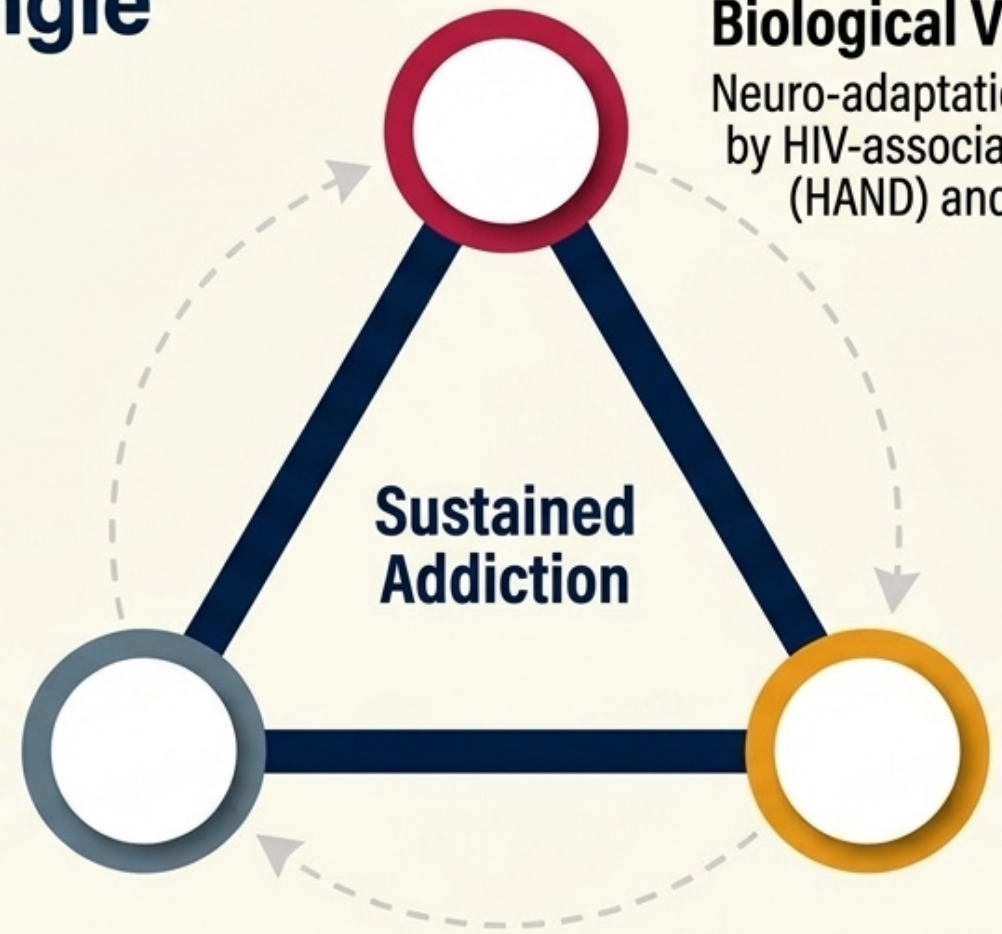
Nyaope in KZN townships

- Injecting has replaced smoking in many townships
- "Bluetoothing": blood drawn and re-injected into peers
- Among people who inject drugs: up to 55% HCV, 21% HIV and 5% HBV
- Efavirenz, nevirapine and lopinavir are crushed into street mixes, driving default and resistance risk

Decoding Addiction: The Bio-Psycho-Social Activation Triangle

Biological Vulnerabilities

Neuro-adaptation to substances, compounded by HIV-associated neurocognitive disorders (HAND) and systemic inflammation.



Social Determinants

KZN's resource constraints, high unemployment, and localized stigma creating environments that trigger relapse.

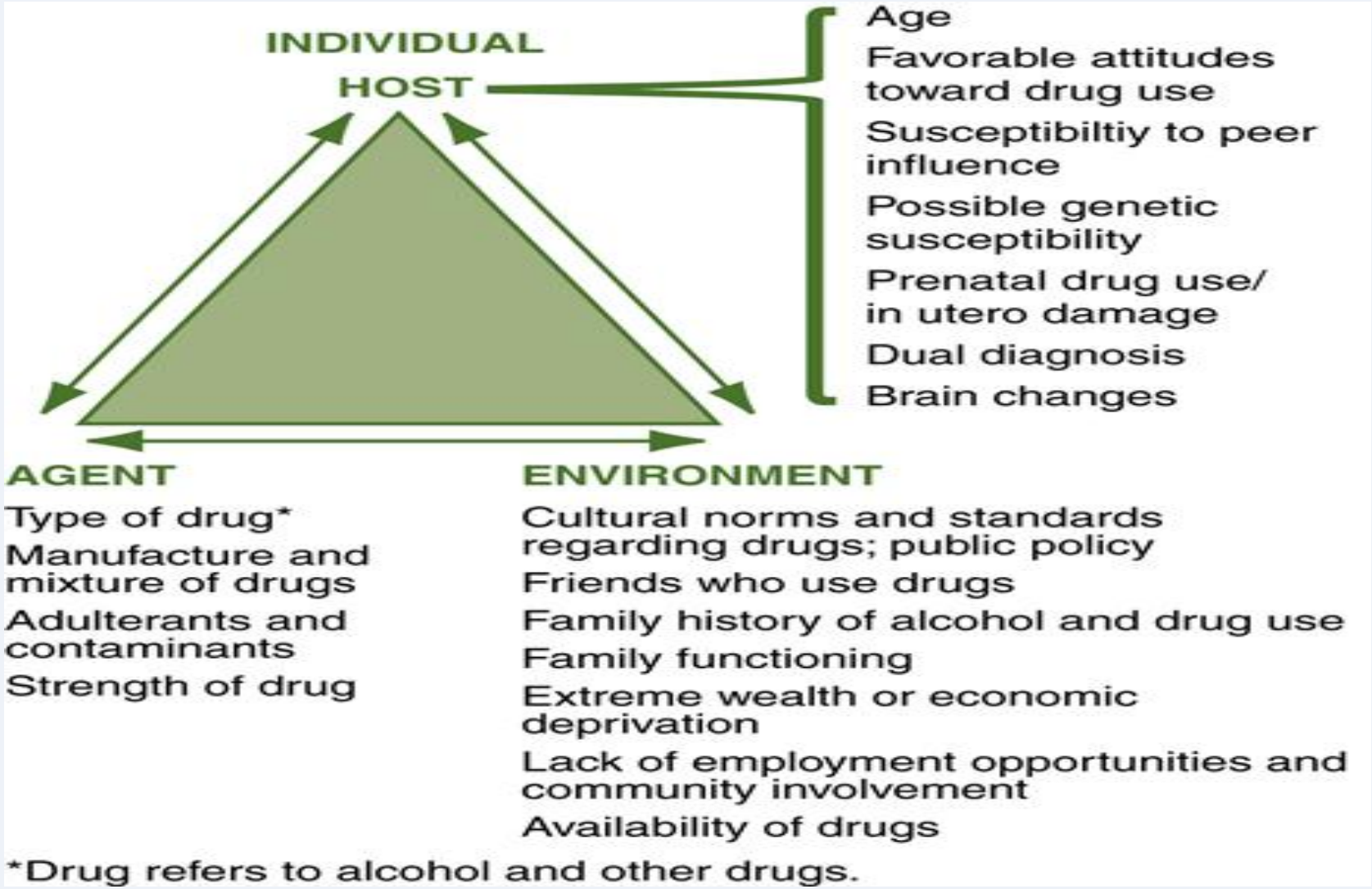
Psychological Factors

Untreated trauma, depression, and the mental burden of living with Advanced HIV Disease (AHD) driving self-medication.

Clinical Insight: Medical detox clears the biological node. Without immediate psycho-social interventions, the remaining two nodes force a relapse.

Gemini Notebook

The Drug Master Plan applies a public health model



How do we apply this model?

Agent: substances

- Regulate controlled substances while keeping medical access
- Expand OST and MAT, such as methadone, on the EML
- Prevent ARV diversion into street mixes

Host: people

- Universal SBIRT at clinic entry
- Prioritise youth, pregnant women, PWID and PLWH
- Early detection with mental health support

Environment: settings

- Move from criminalisation to supportive public health
- Provide condoms and prophylaxis(PEP & PrEP)and naloxone in communities
- Health education in shebeens and liquor out lets

Governance: systems

- Align Health, Social Development and SAPS
- Fix past NDMP gaps in coordination
- Link PHC clinics to municipal and community structures

Public health model from the National HSDMP, applied across KZN's 11 health districts

THEME 2 | KZN HEALTH SECTOR DRUG MASTER PLAN

Four goals – 2025- 2030

Goal 1: Demand reduction

Screening patients for substance use disorders; health education and healthy lifestyle programs to prevent substance abuse.

Goal 2: Treatment access

Managing medical emergencies, medical complication

Provide detoxification as indicated by available protocols

Goal 3: Acute and inpatient care

Manage co-morbidities including other mental disorders and infectious diseases as prescribed by the National Health Act 63 of 2003 and the Mental Health Care Act 17 of 2002.

Goal 4: Institutional Capacity

To improve institutional capacity for prevention, early detection, treatment, rehabilitation and after care services for substance use disorder

PROVINCIAL OBJECTIVES

- To identify risks in communities and the harm associated with substance use/abuse, including the spread of communicable diseases, e.g. HIV; Hepatitis B and C; injuries and premature death.
- To ensure that programmes targeting youth are developed and co-ordinated within the various health components and interdepartmental programmes are supported.
- To improve availability and accessibility to information on treatment, counselling, rehabilitation and after- care services for individual substance users.
- To ensure that persons suffering from mental illness and substance abuse morbidity (dual diagnosis) receive appropriate and accredited treatment.
- To promote healthy lifestyles through the advocacy of tobacco Control; WHO 10 POINT PLAN ON ALCOHOL ABUSE and to prevent diseases of lifestyle.
- To ensure the coordination of efforts to prevent the harm caused by drugs/ substances of abuse through prevention of addiction and dependency and treatment of the substances abusers, including detoxification services at all district hospitals.

PROVINCIAL OBJECTIVES

- To promote the integration of substance abuse issues into the mainstream of Primary Health Care – Introduction of Screening/ assessment and Brief Interventions
- To promote partnerships and the participation of all stakeholders at National, Provincial and local level in the fight against substances abuse.
- To acknowledge the link between HIV&AIDS and substance abuse and to devise inter sectoral programmes to deal with the problem.
- To Effectively management substance abuse in the workplace through the development of a framework of interventions at different levels, viz, prevention, care and treatment.
- To ensure that FBO's including traditional healers are capacitated to identify persons with substance abuse problems and refer them appropriately.
- To assist in the prevention of relapse amongst substance abusers through use of CCGs and psycho-social clubs at a ward level

UNODC-WHO standards replace punishment with health care

Outdated approach

- Punitive, morality-based framing
- Abstinence-only mandates for access to care
- SUDs treated outside the primary health system

Result: stigma, criminalisation and catastrophic loss to follow-up

Evidence-based future

- Human-rights and health-centred framing
- Harm reduction with integrated clinical support
- Chronic, relapsing conditions managed in PHC
- Voluntary, confidential care; no forced treatment

Result: sustained engagement, viral suppression and trust

SBIRT turns every HIV and TB visit into an opening for care

S — Screening

Universal, at vitals

- WHO ASSIST, AUDIT or CRAFFT at ART and TB check-ins
- Delivered by nurses, CHWs or counsellors
- Routine and non-judgmental for every client

BI — Brief intervention

5-15 minute conversation

- Motivational interviewing for mild to moderate risk
- Links substance use to ART adherence and viral load
- Sets realistic goals without scolding

RT — Referral to treatment

Warm hand-offs

- Immediate referral for severe dependence
- District hospital detox, social work, psychiatric care
- Co-located with HIV and TB services

54% to 70% of PHC headcount screened by 2030. Now: uThukela 66.3%, Harry Gwala 62.2%

Evidence shows how to embed SBIRT in HIV and TB care

Kalichman 2007: venues and binge drinking

- Drinking quantity per episode predicts HIV risk more than frequency
- Over 85% of new-partner meetings overlap with informal alcohol venues
- Pair PHC AUDIT screening with venue-based peer opinion leaders

Parry 2007: triple diagnosis

- Mental illness, SUD and HIV together compromise ART adherence
- Parallel silos fail; co-located care keeps clients engaged
- STIRR and PATH integrate screening, testing, immunisation and referral

SAMHSA 2006: medication safety

- Efavirenz, nevirapine and lopinavir/r can lower methadone levels
- Use detox as a gateway to HIV, HCV and TB screening
- Never stop psychiatric medicines during detox

Integrated Training Model -RTC/ HIV promoting better health outcomes

Strengthen human resources to manage substance use disorder	Develop a training programme on substance use disorder
Improve knowledge and skill for personnel on substance use disorder.	Improve knowledge and skill for personnel on substance use disorder s including Staff at trauma units, medical obstetric units (MOs), social workers ; registered counsellors and social auxiliary workers; traditional healers Training on SBIRT; clinical Screening tools and motivational interviewing; CBT and MATRIX approach to Therapy. Training in detoxification protocols & withdrawal management.

Allied health: 180 PER ANNUM

- Social workers, OTs, counsellors, psychologists
- SBIRT, brief mental health screening, CBT and MI

Medical: 240 nurses + 240doctors

- Clinical detox Protocols/guidelines acute intoxication &withdrawal protocols; mental health
- Training PHC nurses on the brief mental health and substance abuse screening tool

A multidisciplinary team keeps care close to home

Core: medical stabilisation

HIV clinicians, PHC nurses and pharmacists keep ART and TB continuity, manage detox and check drug interactions.

Secondary: psychosocial scaffolding

Social workers, psychologists and counsellors provide CBT, trauma therapy and motivational interviewing.

Outer: community anchor

CHWs, peer educators and ACT teams trace defaulters and sustain harm reduction in communities.

Task-shifting works

- Nurse-led ART and chronic care maintained viral suppression in trials (Scanlon & Vreeman, 2013)
- CHW home delivery of ART and TB medicines cuts travel costs and loss to follow-up
- SMS reminders improve adherence in sub-Saharan Africa

Quality over headcounts: the SACENDU loop and SQM

1 Clinic level

PHC teams log substance trends and SBIRT outcomes in DHIS

2 SACENDU synthesis

District data are aggregated to flag emerging epidemiological shifts

3 Policy adjustment

KZN DoH adjusts HSDMP priorities to real-time threats

4 Resource allocation

Training, harm reduction supplies and funding go where burden is highest

The shift

Move from admission tallies to outcome-driven measurement: effectiveness, efficiency, access, person-centredness and quality.

The tools

SAMRC Service Quality Measures evaluate service delivery. The SAATSA tool captures patient-reported outcomes: social connectedness, quality of life and risk reduction.

Stigma and punitive practice keep people out of care

2.3%

of adults with past-year SUD receive minimally adequate treatment (SAMRC)

- Structural: poverty, transport costs, few beds
- Institutional: crowded clinics, stockouts
- Social: moral stigma and rejection by staff

Universal access

Availability, accessibility and affordability of care for everyone.

Ethical care

No forced, degrading or punitive interventions.

Confidentiality

People seek help without fear of law-enforcement reporting.

Humane language

Person-first terms such as people who use or inject drugs; no "amaphara".

WHAT DO WE NEED???Low-threshold harm reduction that protects health and dignity

Harm reduction programmes

- Distibution of condoms; access to PrEP; PEP; ART
- Prevent HIV and HCV; drop-in sites lead to voluntary ART and TB testing
- Partnerships with civil society organisations and other Government departments to advocate for PWUD services.

Treatment of addictions

- Apply the KZN guidelines for management of intoxication and withdrawal whilst engaging in behavior change programmes cravings and stabilises routines
- Supports daily ART adherence and viral suppression
- Stable clients collect refills at PHC clinics

Overdose reversal and drop-in

- Naloxone in clinic and community teams to prevent overdose.
- Food, hygiene, wound care and HIV, TB and HCV testing
- Peer navigators join clients in consultations

Monitor dosing: efavirenz, nevirapine and lopinavir/r can lower methadone levels and precipitate withdrawal.

LDACs and outreach teams carry care beyond the clinic

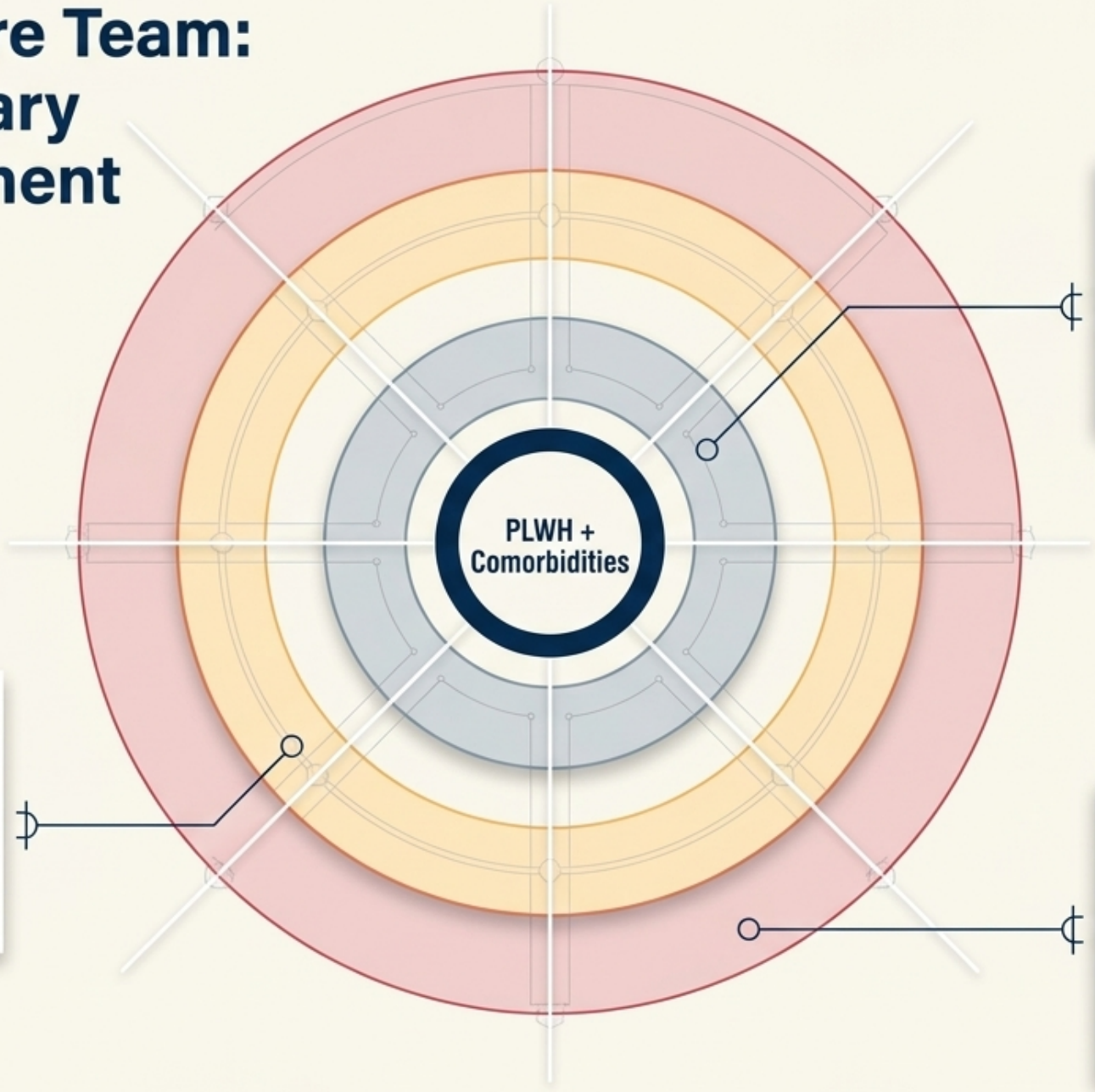
Local Drug Action Committees

- Statutory mandate under Act 70 of 2008 in KZN municipalities
- Bring together Municipalities; Health, Social Development, SAPS, Education and civil society
- Sensitise SAPS commanders so clients carrying OST or sterile supplies are not harassed
- Work with liquor boards and shebeen owners on safer venues
- Provincial Anti-Substance Abuse Forum is active; local committees need strengthening

Assertive community outreach

- Mobile teams of nurses, social workers and CHWs reach informal settlements and hotspots
- Psychiatric nurse home visits support ART and psychotropic adherence
- Defaulter tracing returns clients to care
- Help with ID documents and SASSA social relief grants
- Links to skills, housing and family reunification

The Radial Care Team: Multidisciplinary SUD Management



Core Ring

HIV Clinicians, Primary Care Nurses, Pharmacists.

Role: ART/TB management, acute detox, pharmacokinetic monitoring.

Secondary Ring
(Psychosocial Scaffolding)

Social Workers, Psychologists, Mental Health Counsellors.

Role: Trauma therapy, behavioral modification, family integration.

Core Ring
(Medical Stabilisation)

HIV Clinicians, Primary Care Nurses, Pharmacists.

Role: ART/TB management, acute detox, pharmacokinetic monitoring.

Outer Ring
(Community Anchorage)

Peer Educators, Community Health Workers (CHWs), Outreach Teams.

Role: Tracing defaulters, harm reduction supply, sustained community support.

Gemini Notebook

Peers, families and traditional leaders extend the system

Paid peer navigators

- Peers with lived experience guide clients through the system
- They accompany clients into consultations to protect dignity

Family caregivers

- Include caregivers in consultations for clear communication
- Family cohesion links to higher ART and TB adherence confidence

Traditional and faith partners

- Inyangas, sangomas and faith leaders are often first contacts
- Train them in adherence and mental health support for trusted referrals

Venues and communities

- Peer-led education in shebeens, informal settlements and hotspots
- Support groups for recovering clients and families

TAKE-HOME MESSAGES

Four messages to carry back to facilities and districts

1 Substance use is a clinical comorbidity

Treat it like diabetes or hypertension: it drives ART and TB default and speeds viral replication.

2 Dignity drives viral suppression

Replacing scolding with non-judgmental SBIRT builds trust, retention and HIV testing.

3 Harm reduction and standards save lives

Prevention; early detection; treatment and referral to care, delivered to UNODC-WHO standards, prevent HIV and HCV transmission.

4 Integration needs people and partners

Peers, families, traditional leaders and LDACs sustain care beyond the clinic.

RECOMMENDATIONS

Who acts, and how, at every level of the system

Frontline clinical teams

- Mandate SBIRT at vitals in all HIV and TB consultations
- Set up detox pathways and detoxification access with district hospitals
- Monitor ARV and methadone interactions
- Replace scolding with trauma-informed care

District managers and LDACs

- Convene LDACs monthly (Health, DSD, SAPS) under Act 70
- Track standardised SUD indicators in DHIS
- Fund annual training: 180 allied and 200 medical staff
- Contract peer-led CBOs for paid navigators

Community and peer leaders

- Lead peer education in shebeens and hotspots
- Partner with traditional healers and faith leaders
- Involve families in consultations
- Report police harassment or clinic refusal

CALL TO ACTION

Operational mandates to break the cycle

- Mandate universal SBIRT screening across all HIV and TB primary care consultations.
- Establish multidisciplinary assertive community treatment teams in high-burden districts.
- Expand low-threshold harm reduction (condom distribution; PrEP/PEP;detox) and protect key population rights.
- Implement SAMRC quality measures for routine, patient-centred outcome monitoring.

Thank you | Questions and discussion

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Policy frameworks, surveillance and research sources

POLICY AND SURVEILLANCE

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