

The Nature and Extent of Heroin Use In Cape Town: Part 1 - A Pilot Study

Andreas Plüddemann & Charles Parry
Alcohol & Drug Abuse Research Group
Medical Research Council

Alan J. Flisher
Department of Psychiatry and Mental
Health and Adolescent Health Research
Institute
University of Cape Town

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Contents

	Page
1. Background	3
2. Aims of the study	6
3. Methods	6
4. Results	7
5. Discussion & conclusion	16
References	17

1. BACKGROUND

1.1 What is heroin?

Heroin is classified as an opiate. Opiates act on opioid receptors on the central nervous system and include drugs like morphine, codeine, methadone and Wellconal (dipipanone, a derivative of methadone). Heroin, known chemically as diacetylmorphine, is produced from morphine, which is extracted from the Asian poppy (*Papaver somniferum*). Heroin is four to eight times as potent as morphine. It has the appearance of a white or brownish powder. It was put under international control at the UN Single Convention in 1961 (International Council on Alcohol and Addictions, 2000).

1.2 Global trends

The 2002 United Nations Office of Drugs and Crime's (UNODC) report on Global Illicit Drug Trends estimates that globally about 13 million people abuse opiates. About 70% of opiate abuse relates to heroin. Of 63 countries reporting trend data (1999-2000) 71% reported an increasing trend in heroin abuse. In Asia, Europe and Oceania, which together have 73% of the world's total population, between two thirds and three quarters of substance abuse treatment demand is related to opiate abuse.

1.3 Health consequences of heroin use

Heroin use holds a number of implications for the health and well-being of the individual user. The depressant action of the drug on the central nervous system (CNS) places the user at risk for an overdose and pulmonary complications, such as pneumonia and tuberculosis. In addition, a long-term health outcome of heroin use is psychological and physical dependence (Darke et al., 1996; Mientjies et al., 1996; Fernandez, 1998).

Research commissioned by the WHO estimated that globally for the year 2000 a median estimate of 69 152 deaths could be attributed to opioid overdose (Degenhardt et al., in press). Data from the Australian Bureau of Statistics indicates that in 2000, a total of 737 deaths attributed to opioid overdose occurred among persons aged 15 to 44 years (National Drug and Alcohol Research Centre, 2000). A review of all forensic cases from July 1995-February 1997 in Sydney, Australia, found that 4% of all cases were related to drug overdose and 80% of these were related to heroin (Garrick, Sheedy, Abernethy, Hodda, & Harper, 2000). A retrospective analysis of the deaths of over 2700 heroin injecting drug users (1985-1998) in Italy showed that 37% were due to overdose and a further 33% were due to AIDS (Quaglio et al., 2001). Non-fatal overdose may also have consequences including paralysis, seizures, nerve palsy, peripheral neuropathy and cardiac arrhythmia, many of which result in a lifelong compromise of health and well-being (Strang, 2002).

The use of heroin also holds important implications for public health. Injection drug use (IDU), through the direct and indirect sharing of injection equipment, is a well-known risk factor for the transmission of blood-borne viral infections, such as HIV, hepatitis B, hepatitis C, and hepatitis G. The United States Centers for Disease Control reported that in 1999, 5932 AIDS-related deaths occurred in the United States that were attributed to IDU. Non-injection users (NIUs) are also at increased risk for contracting HIV and hepatitis due to the high risk sexual behaviours associated with patterns of drug dependence and the possibility of NIUs becoming IDUs as heroin dependence develops and users seek a more efficient means of administering the drug (Diamantis et al., 1997; Neiaigus et al., 1998; Koester et al., 1996).

1.4 Research on heroin use in South Africa

Although prevalence rates for heroin consumption are generally low in Africa, UN reports point to a steady increase in heroin use in a number of African countries, especially countries located along the primary drug trafficking routes, such as Ghana, Nigeria, and South Africa. According to the UNODC's report for 2004, South Africa is estimated to have one of the highest prevalence rates of heroin use in Africa (United Nations Office for Drugs & Crime, 2004).

Treatment demand for heroin-related problems

The South African Community Epidemiology Network on Drug Use (SACENDU), a project monitoring drug abuse trends in the cities of Cape Town, Durban, Port Elizabeth, and Gauteng and Mpumalanga province has shown an increasing demand in recent years for treatment of heroin abuse in the urban areas of Cape Town and Gauteng, but not in the other sites (Plüddemann et al., 2003a). In Cape Town only 2% of all patients (N = 2301) in substance abuse treatment during the first half of 1998 has heroin as a primary substance of abuse. However, in the second half of 2003, 7% of all patients (N = 1659) were in treatment for heroin abuse. The trend in Gauteng has followed the same pattern, with 8% of 2617 patients treated for heroin during the 1st half of 2003, although decreasing to 6% in the 2nd half of that year. In both these sites a further 2% of all patients reported heroin as a secondary substance of abuse in the 2nd half of 2003. Most patients are white and relatively young. Since January 1997, the mean age at which patients present for heroin abuse treatment has decreased from 29 to 24 years in Gauteng and 27 to 24 years in Cape Town. From 1997 to 2003, between 22% and 34% of persons seeking treatment for heroin abuse in Cape Town and between 24% and 43% in Gauteng, were female. This contrasts with drugs like cannabis and Mandrax, where over 90% of patients are male. An increase in injection heroin use has also been noted, with the proportion of patients reporting injection drug use increasing from 29% in the second half of 1999 to 51% in the second half of 2001 in Cape Town, however decreasing again to 44% in the second half of 2003. In Gauteng the proportion of heroin patients reporting injection has increased steadily from 36% in the second half of 2001 to 49% in the second half of 2003. Heroin was also the third most common primary drug of abuse amongst patients who are younger than 20 years in Cape Town and in the second half of 2003. Anecdotal information from professionals working in substance abuse treatment and prevention also suggests a possible increase in heroin use in certain township areas, such as Hammanskraal in Pretoria and Langa in Cape Town (Plüddemann et al., 2004a; Plüddemann et al., 2004b).

Quantitative community/school surveys

Household, school and community surveys on drug abuse have been conducted from time to time in South Africa, however all reported very low levels of heroin use.

A household survey of youth aged 10-21 years conducted during 2000 and 2001 by WHO and UNDCP (WHO & UNDCP, 2003) in greater Pretoria and in Bela-Bela (a rural town) found that 1% of the 193 respondents reported lifetime use of heroin, while none of the rural respondents had used it.

A national household survey of persons 15 years and older in 2002 by Shisana et al. (2003) found that 0.01% of the respondents reported having used heroin in the past 30 days. This would translate to a national past 30 days prevalence of 4500 users, probably an underestimate given the nature of household surveys.

A national survey conducted amongst 10-21 year olds in black communities in 1994 by the Human Sciences Research Council found that 0.9% of the 1378 respondents reported life-time, past 12-month and neighbours use of heroin respectively (Rocha-Silva, 1996).

A survey conducted in the uThukela health district in KwaZulu-Natal during 2002 amongst youth aged 13-23 (both in-school and out-of-school) found that 4% of in-school males reported life-time use of heroin and 1% of the in-school females, while 3% of the out-of-school males reported life-time use of heroin and <1% of these females. Furthermore, 3% of the in-school males reported current use of heroin (1% of females) and 1% of out-of-school males reported current use (<1% of females). A total of 1692 in-school youth and 562 out-of-school youth participated in the survey (Adejumo, 2003).

A non representative survey conducted in five high schools in the Helderberg region of the Cape Metropole during 2000 by a substance abuse prevention NGO (Bridges) found that 1.9% of the 3474 respondents had tried heroin at least once (Fisher, 2000). Another survey by Bridges conducted in 2002 in both primary and high schools in the Helderberg region found that only one primary school pupil (N = 991) and one high school pupil (N = 387) reported having tried heroin at least once (Fisher, 2003).

High-school surveys conducted among large, representative samples in Cape Town in 1997 (Flisher et al., in press), Durban in 1998 (Bhana et al., 1998) and Port Elizabeth in 1999 (Terblanche, 1999) did not report any use of heroin.

Even a survey of 3082 adult arrestees, conducted in Cape Town, Durban and Johannesburg at total of ten police stations over an 18-month period from 1999 to 2000, found that very few participants reported heroin use. Interviews were conducted in August/September 1999, February/March 2000 and August/September 2000 to establish changes over time. Results showed that across the three sites and for each of the three phases of the survey between 0.2% and 2.5% of the arrestees reported having used heroin at least once. Johannesburg and Cape Town had slightly higher levels than Durban (Plüddemann et al., 2002). A national survey of 1143 arrestees conducted by the HSRC during 2000 did not report any use of heroin.

Quantitative surveys with non-representative samples

Surveys conducted amongst young people in 'special settings' also did not find particularly high levels of heroin use, or the sample sizes were very small. For example, a survey conducted by a volunteer organisation known as Ravesafe at three raves in Johannesburg between December 2000 and February 2001 found that 8% of the 80 participants had tried heroin, but only one used it daily (Gillespie, 2001). A second survey conducted at two raves in Johannesburg in 2001 found that 4.8% of the 126 respondents had used heroin at least once, however only one person reported weekly use of the drug (Gillespie, 2002). A second survey by the same organisation at a rave in Boksburg in 2002 found that 7% of the 54 respondents had used heroin at least once, although only one person reported daily use (Gillespie, 2003). Both surveys conducted by Ravesafe relied on volunteer participation, although the latter survey did offer an incentive for participation in the form of a draw for two music concert tickets.

A number of small surveys conducted at rave parties in Gauteng found some use of heroin. A study of 56 'ravers' in Johannesburg in 1999 found that 12% reported having used heroin at least once (Willmers, 1999).

Qualitative studies

A study commissioned by the UNODC of drug markets in Johannesburg, using mainly key informant interviews reported that use of heroin is used by some sex workers in Hillbrow and surrounding areas (Leggett, 2000). However, research conducted by the same author amongst over 50 sex workers in Durban did not report any use of heroin (Leggett, 2001).

A qualitative investigation into the use of heroin in Cape Town by Gossman (2003) indicated that heroin use appeared to be increasing and that heroin was available in many suburbs in Cape Town.

Police data

Currently purity testing of heroin samples seized by police is not routinely conducted, however statistics on heroin seizures and arrests made by police are available. On a national average an increase in heroin seizures has been reported by the South African Narcotics Bureau (SANAB) over the past few years. SANAB reports that in 1996 only 800g of heroin were seized nationally. This increased steadily to 13.5kg by 2000, with a slight decline from this figure being recorded in 2001 (9.5kg) and 2002 (9.5kg). The number of arrests made nationally for either the possession of or dealing in heroin has also increased steadily from 12 in 1996 to 284 in 2002. Seizures of heroin reported by the Forensic Science Laboratories in Cape Town and Pretoria also increased drastically in the 2nd half of 2002, with over 73kg reported by the Pretoria lab in the 2nd half of 2002, compared to no more than about 6kg in previous periods (Plüddemann et al., 2004a). According to the UNODC's Country Profile on Drugs and Crime (UNODC, 2002) heroin is sourced from markets in Southeast and Southwest Asia, couriered principally via Johannesburg International Airport. Other sources include seaport entry via Mombasa and Dar es Salaam. The drugs are then transported down East Africa's main arterial road networks toward South Africa. Most of the heroin available in South Africa is known as "Thai White".

2. AIMS OF THE PILOT STUDY

The proposed study had the following aims, with a view to a more extensive community survey of heroin users subsequent to this study:

- Aim 1: To obtain qualitative data from key informants and heroin users (in treatment/recovery) on the nature, extent and consequences of heroin use in Cape Town.
- Aim 2: To develop an instrument to be used in a planned community survey of heroin users.
- Aim 3: To identify ways of accessing heroin users.

3. METHODS

1. Questions to key informants – A semi-structured interview was conducted with 15 key informants, focussing on obtaining input on who uses heroin, how and where do they use it, different types of users, how many, and questions relating to crime and HIV/AIDS.

The key informants represented the following sectors:

- Specialist substance abuse treatment centre personnel.
- Social workers and outreach workers outside treatment centres.
- Prevention specialists at selected NGOs focussing on substance abuse.
- Police: Organised Crime Unit.
- Private practitioners: social workers, psychiatrists, psychologists.

2. Three focus groups were conducted with adults (i.e. 18 years or older) to obtain qualitative data on the nature and extent of heroin use in Cape Town, to obtain input on the questions which should be included in a questionnaire for the community survey, and to obtain ideas and opinions on how to access heroin users for the purpose of a community survey:

- Two focus groups were conducted with people who had received inpatient treatment recently. These people were recruited from a post primary treatment ‘halfway house’ and a private primary treatment facility.
- One focus group was conducted with people who were attending or have attended outpatient treatment.

The focus group discussions were recorded and transcribed. The principal investigator was the primary interviewer in all focus groups with one additional member of the research team assisting with the recording of the discussions.

Informed consent & ethical approval

All focus group participants signed an informed consent form and were assured that their names would not be associated with the study and all personal particulars would be kept strictly confidential. Ethical approval for the study was obtained from the University of Cape Town’s Research Ethics Committee.

Protection of participants

A trained substance abuse counsellor was present for all the focus group interviews to ensure that the recovery process of those who are undergoing treatment was not impeded. Subjects were not asked to narrate their own experiences directly but were asked about their views on issues related to heroin in their community.

4. RESULTS

A total of 17 questions were asked of the key informants (KIs). Responses to the questions will be described in this section on a question by question basis. Responses from the focus groups on these topics will also be provided under the applicable questions. In addition, where possible, reference will be made to the findings from the SACENDU project data for Cape Town (July – December 2003).

Question 1a: What are the demographics of heroin users in Cape Town?

Age range: Most of the KIs thought that most heroin users are in their early twenties, with the majority falling between late teens and early thirties, and a few in their forties. The focus groups generally agreed, although more comments were made on younger users:

- “You get quite a few 15-16 year olds – mainly girls that use heroin– but that’s like random. It is not like specific group – just like one random person but out of most of my friends I am probably the youngest to use.”
- “I think it varies. In the last three years I sponsored three girls who started using heroin at the age of 13. One year, one girl I was sponsoring was 12, so I think it just varies.”
- “There’s a lot of the young you can see on the streets and I live in Observatory – but it’s also [the same in] Woodstock, Mowbray – but there’s a lot of older guys and women – both sexes. On the street you notice quite a lot of young boys definitely.”

The latest data available (July - December 2003) from the South African Community Epidemiology Network on Drug Use (SACENDU) indicated that the mean age of heroin patients in Cape Town treatment centres was 24 years, with a range of 14-44 years.

Gender & ethnicity: Interestingly a slight majority of the KIs thought that female heroin users slightly outweighed males by about 3:2, while a few thought there is a 50/50 split. Most users were thought to be White, although some KIs were of the opinion that heroin use is increasing among Blacks and Coloureds.¹

The focus groups agreed that most users were white, middle class youth, both male and female. A few participants felt that heroin use was increasing among Blacks and Coloureds:

- “OK my experience has been predominantly like middle class white people. I am sure there are black heroin users but it seems to be quite a white thing.”
- “More men than women but there are definitely women using it specifically white women. I reckon some coloured – ja the coloured population are also affected – possibly even more than the white population in my experience. Black, foreign nationals, not so much the local black population. But I do believe it is taking place in places like Nyanga but not the numbers like the coloured and white population.”

¹ The terms “White, Black, and Coloured” refer to demographic markers and do not signify inherent characteristics. These markers were chosen for their historical significance. The demographic characteristics of substance users are important in identifying vulnerable sections of the population and in planning effective prevention and intervention programmes.

- “My general experience as well is that it is more well to do white people – has not caught on really with as many as cocaine or crack – more well to do white people.”

One focus group participant mentioned that dealers seem to be targeting young black people in certain areas:

- “Something I would like to mention – it might not be fact but it is something that I found quite interesting – I was told at one stage that dealers are trying to get into the black market – they are selling [for] even less – the black and very young – “baby” market – they are trying to sell them less than R50 – like R10 or R15 shots at the station so that they can get them hooked without selling them big quantities or anything like that but they are aiming at selling to “babies” little bits at a time. Something I heard that is starting to happen because they, obviously the Nigerians, come here and they see that the black people aren’t using, the whites are the target and they have cottoned onto it.”

The latest data available from SACENDU (July – December 2003) indicated that 66% of patients in treatment for heroin use were male. Furthermore, 66% were white and 31% were coloured, representing a significant increase in coloured patients over previous periods.

Employment status: Except for those who are students, it appears that most heroin users are unemployed or ‘between jobs’, especially by the time they enter a treatment programme. A number of KIs indicated that users are often employed as waitrons or in the professional sector. The focus group participants had the following comments:

- “I never managed to hold down a steady job when I was an addict. It would always like infiltrate. I would start steal money or not arrive for work or just be completely strung out. Ja it just got to the stage that I was unemployable.”
- “I managed to carry 3 jobs in order to keep my addiction going.”
- “Everybody at my work sort of knew something was up but they did not know what it was. And I was not going to tell them and when I came clean then I told them look I have gone and taken time off this is why. I was lucky enough that I had understanding employers. I could I take at work where I could operate and nobody would see I was stoned or high or whatever because it just centres you.”

SACENDU data for the second half of 2003 indicated that 59% of heroin patients entering a treatment programme in Cape Town were unemployed, 27% were working full or part-time and 14% were students.

Home language: Most KIs thought that an equal number of heroin users were English versus Afrikaans speaking, while some thought most were English speaking. A number of KIs thought that heroin use has become more prominent among Afrikaans speakers fairly recently. Some Xhosa speaking heroin users have also been encountered by outpatient counsellors.

The focus group participants agreed with this.

SES & Education: Most users were perceived to be middle or upper class, although an increase among lower income groups was mentioned. Most users seem to have high school education, with a number entering tertiary education, but many not completing it.

SACENDU data for July - December 2003 indicated that 76% of heroin patients entering treatment had secondary education, and 12% had tertiary education.

Geographic locations: The KIs indicated that heroin users came from both the northern and southern suburbs of Cape Town, with some also mentioning towns outside the metropole, like Paarl. The focus group participants agreed with this.

Question 1b: Has there been a change in the above, if so what is it?

As mentioned above, KIs thought that heroin use has moved into lower income areas, including the Cape Flats, that more Afrikaans speakers appear to be using now, and that the number of female users has increased. KIs also mentioned that it is now used in schools, sometimes as a secondary drug, and that injecting is increasing.

Comments made in the focus groups concurred with this:

- “Definitely. Every day you start seeing people you never thought would ever, you know. It’s seeping into all sorts of classes you know. Before it was quite a dirty list—the old drug users that was using it – but now it is seeping into the business world, everywhere.”
- “I started 2 years ago and then I couldn’t get it in the Northern suburbs, but the last year and a half I could get it there. It is on the increase.”

Question 1c: Is there a distinct profile of different types of users? If yes, describe.

Most of the KIs agreed that heroin is not a drug used in large groups. Users often become anti-social and isolated, have low energy levels, low self-esteem, and lack a conscience or values. A few KIs mentioned that they often come from a dysfunctional home environment. Eating disorders were also perceived to be fairly common among female users. Heroin users appear to have an above average intellect and were also perceived as “difficult to treat” by a number of the treatment providers interviewed.

Question 2: Is the number of heroin users increasing in Cape Town? Elaborate. Estimated number of users?

Most of the KIs thought heroin use is increasing in Cape Town, while a few thought it may be stabilising. Availability was mentioned as the main reason for the increase in heroin use, with law enforcement seeing it as a major problem, noting that enquiries from the public about heroin had increased, that informers had more information about heroin and that many young people knew about heroin. Some mentioned permissive parenting, the pace of modern living and people’s naivety about the drug as contributing factors. The fact that heroin appears to have become less stigmatised, even glamorised was also mentioned. Some also thought that the fact that a heroin habit can be maintained relatively cheaply may also be contributing to an increase in use.

Only a few of the KIs were willing to estimate the number of heroin users in Cape Town, with estimates ranging between 1000-5000 users. A few thought that the treatment centres were only encountering a small fraction of the actual number of users. One KI reported having come across a ‘den’ in Sea Point where heroin was being used daily.

Law enforcement mentioned the suburbs of Table View, Edgemoed, Sea Point, Muizenberg, Woodstock, Observatory, Mowbray, Parow and the city of Bellville as particular “problem areas”.

Most of the focus group participants agreed that heroin use seems to be on the increase (see comments under question 1b).

Question 3: Drug use history – do most users start with heroin or other drugs? If so, which drugs?

Most users appear to start with drugs like cannabis and alcohol, often progressing to Ecstasy, cocaine and then heroin. Some KIs felt it was becoming more common for people to use heroin as their first drug. There was also the opinion that Ecstasy has ‘paved the way’ for the use of other drugs (like heroin).

Focus group participants also generally thought that heroin is not the first drug used, although there are exceptions. Some users reported starting to use heroin to ‘come down’ from crack:

- “They say most people start on something else. The reason I did, is to come down because you reach such a high on crack, but eventually whatever you are using is not bringing you down and heroin brings you down.”
- “It has often happened that they eventually only use heroin because they have become so addicted to that – as we all know you can’t just stop heroin and financially you start letting go of the crack because you can’t afford that so it becomes primary where it used to be a secondary drug – that’s the trend.”

Question 4: Average age of first initiation to heroin use and the setting?

Most start using heroin in their late teens and they are usually introduced to the drug by friends (i.e. through their social networks).

Question 5: What proportion of heroin users attend treatment and after what period of use? How many times do they attend treatment?

The opinions on what proportion of users attend treatment varied between 10% and 50%, while some responded that a low proportion go to treatment and others responded that most go to treatment. Most estimated the period of use before first seeking treatment as 6-18 months, although some knew of addicts who had used for a few years before attending treatment.

The relapse rate was perceived to be very high with most heroin users apparently needing three to five treatment episodes. Some users are, however, successful after the first treatment episode, especially if they attend treatment out of personal motivation and if the post-treatment follow up system is good. The three to four week period in most treatment programmes was perceived by most as being too short to treat opiate addiction. The KIs also mentioned that many patients are not “ready” for treatment at the first presentation to treatment, often only seeking “medical” and not psychological help, hence resulting in relapse.

Question 6: Are there enough treatment options? Elaborate

The KIs unanimously felt that there were not enough treatment options in Cape Town. They indicated that there is a need for more affordable, state subsidised, inpatient centres. They also felt that medical aids could review their policies relating to substance abuse treatment. Most

of the KIs thought that heroin addiction would be difficult to treat on an outpatient basis, but that outpatient treatment could be successful if a detox clinic was available and if there was a strong support system attached to the outpatient centre. Some of the KIs felt that a special treatment centre for heroin addicts may be needed. Some outpatient counsellors expressed their frustration at not being able to offer effective treatment to heroin patients. Even law enforcement felt that treatment affordability was an issue and that government assistance is needed.

Focus group participants also felt that affordability of treatment was a major issue:

- “No. Because of the price the majority of people out there could not afford it. The majority users don’t work as such, majority users steal etc – even if they want to come clean they cannot.”
- “We are very fortunate because a lot of people I know would like to come clean but cannot.”

Question 7. Knowledge of frequency of overdose occurrences (fatal and non-fatal)?

Non-fatal overdoses were reported to be very common, often occurring after treatment, when the user is not used to their “usual dose”. The maximum number of fatal overdoses one of the KIs was able to recall was 10 in the past 2 years. Most of the KIs had not had frequent direct contact with fatal overdoses. Suicides and road accidents (driving under the influence) were mentioned as “unknown” mortality factors.

Question 8: Do users make use of general emergency services?

Most heroin users seem to make use of emergency services at some point, however hospital staff often seem to lack the knowledge of how to deal with overdoses. Some of the KIs also expressed that sometimes hospital staff are reluctant to treat addicts as they view addiction as a self-imposed problem and not an illness. Hospitals also do not have a follow-up system for drug addicts.

Question 9: Do most users inject? Do they share needles? Users’ knowledge of safe injection practices? Where are needles sourced?

Although most of the KIs thought that most heroin users smoke the drug, they did feel that injecting is increasing and that needles have become less stigmatised. Responses from the KIs indicated that heroin users are aware of the dangers of needle sharing, but most felt they would share when desperate for their next “fix”. Needles seem to be mostly obtained from pharmacies. Law enforcement also mentioned the theft of a range of medical supplies from clinics as a problem.

Responses from the focus group varied. Some of the participants had never injected, but many felt that most users would progress to injecting:

- “There’s still a big stigma around needles. I personally held that stigma for quite a while as I am sure other people do like that if I was injected then it was like I was in big trouble but when I started injecting then it was like well I have not been awake and its not that serious anyway. But I do think there is a progression – but then there’s professional people in business who will have a toot or smoke after a dinner party like”

- “When I started shooting up first other people were shooting me up in the beginning and I kind of like told myself it was not that bad because I was not doing it, someone else was.”

One issue discussed in the focus group was whether people should have access to clean needles, through needle exchange programmes or not. Most of the participants seemed to be in favour of enabling access to clean needles:

- “You know how many times I have stashed my needles in the dustbin up the road and like three o’ clock in the morning you want needles you go to like three hospitals they will all turn you away they don’t actually care what you tell them and you end up taking your own needles out of the dustbin after being there for a week and sticking them in the So that you can like use them which is crazy. So like preventing you from getting a needle at 4 o’clock in the morning causes more damage than giving them.”
- “No I think it is a problem in this country that there isn’t easy access to needles. I mean I know there is a big difference because I spent a long time in London and they’ve got a needle exchange system going. There’s a lot of chemists involved wherever you are going. They will give you a disposable thing where you can dispose of your old needles you take that back and they give you another pack and they give you everything. They will give you sterile things, tourniquets, and new needles, and I mean my experience is that it stops people from sharing needles.”

Question 10: Opinion of HIV prevalence among heroin users versus the general population?

Most of the KIs did not seem to view HIV as a major problem among heroin users to date, although some thought that their sexually irresponsible behaviour may place them at higher risk of contracting the virus. They also thought injecting users were probably at higher risk of contracting HIV. Very few had encountered HIV positive heroin users thus far. Those users who become involved in sex work were also perceived to be at higher risk.

The focus group participants had varying opinions on the issue of HIV risk and infection, although some thought an addict may be more likely to have multiple sexual partners.

- “I don’t know I don’t think so. I think the person is more at risk from having casual unprotected sex. When I was a heroin addict I could not get it up – I was impotent while I was using it. So I was not having sex which means I was only using the needle. But I think the fact of that is that most women heroin users that use heroin for 5-10 years plus turn to prostitution.”
- “Basically I think it looks like this – everybody has sex, most people have unprotected sex, addicts are more susceptible to casual sex and then the needles just add to the problem.”

One participant also alluded to heroin use in the (male) sex work industry.

- “I would say yes. I was exposed to it for the first time while I was working in Cape Town sex industry that’s where I was exposed to it for a while. The boys would sit in the back and wait and while I was sitting in the room at the back somebody would

have some. It started with just my friend and myself – I'd arrive for my weekend shifts and he'd say guess what I've got cause I knew you were coming as an excuse for his own use. Didn't get hooked that time because he was buying it himself – eventually the whole group of friends were taking it you know – just the two of us – and then another person gets brought into the bathroom, and then its four people doing their hair and its five people doing their hair at the same time and we then move from the bathroom to the back room where we end up taking it and smoking lots of cigarettes and getting so high and wasted. So I would definitely say in the industry, you take it to do what you have to do.”

Another issue that emerged was that eventually addicts are no longer concerned with their health, focussing only on the next “high”.

- “I used to use shared needles occasionally. I was fortunate, I know I was fortunate because it can easily happen. I mean it's got to be increasing. I mean it is sort of blood transfusion, when I was sticking needles in my veins with other people I could get what they've got and it is not just that one dude - so I think it compounds the risks and when I'm on drugs I don't give a shit about myself. I just don't care as long as you are getting high you know that is what you are worrying about. You don't worry if you are taking your vitamins or you know what I mean – this does not come into the equation.”

Question 11: Methadone use – Is this common? Sources?

It appears that many heroin addicts attempt to ‘come off’ heroin using methadone, which they obtain from general practitioners (Physeptone *linctus*). This methadone is of a very low concentration and hence often not successful. Often general practitioners also prescribe too much methadone at once, creating dosage administration problems.

Focus groups participants differed about the usefulness of methadone, with some seeing it merely as a substitute for heroin.

- “Methadone is the worst thing ... I did a lot of programmes over the years and it was the hardest thing ever to come off – it is just substituting heroin for heroin. It does not have quite the kick but it is the same feeling – that warm thing you know.”
- “The first time I was using it I was on methadone for 2 weeks and using 60mls a day and the last 2 times that I have detoxed it has been 30mls a day so it has been a day or two of complete hell and then it is over so I am not of the opinion that it might keep you sicker for longer. Just a day or two.”
- “Oh it was easy. Give me 150mls of Methadone a day and I could have carried on for the rest of my life. I know in England that was a big thing – people weren't registered as addicts – if you were registered the doctor would give you 150mls for the rest of your life. It is not a solution, I mean in my eyes it is not a solution. I could quite happily have done it but then I would still be in the shit if I did not use that.”

The issue of the low dose of methadone in Physeptone *linctus* was also mentioned by one of the participants:

- “I think unfortunately what I found was that most of what was prescribed was Physeptone *linctus* with a very small amount of methadone in it and it did not really

work very well. Large quantities of it was needed and I could not get a prescription big enough to help me through the sickness. Had they been prescribing a better quality methadone like I find in the clinics it probably would have certainly helped me.”

Question 12: Do users experience other (a) health and/or (b) psychological problems

Most of the KIs agreed that heroin users often have a poor general health, poor hygiene and weight loss, poor nutrition, skin problems, sleep disorders, and poor dental health. On the psychological side they are often depressed, suffer from mood disorders, sometimes personality disorders, and sometimes have a history of abuse. Eating disorders also seem to be fairly common among female users.

This question was not discussed with focus group participants.

Question 13: Are users involved in any criminal activity?

Most users eventually become involved in petty theft, especially from their family members. Some become involved in organised crime and drug dealing. Most crime is related to obtaining money to buy heroin. The focus group participants commented as follows:

- “Well it would be doing whatever it would take to get money. For me it was when the work dried up it was then selling my family’s possessions and then begging. Going around saying I ran out of petrol or whatever and then stealing from other people.”
- “I agree with him it is a necessity. It is certainly madness, I’m sure all of us in this room are fairly nice decent individuals being brought up by reasonably well, but necessity prompts it.”
- “I know with me I wanted to be the biggest drug dealer in Cape Town by the age of 21. For me it was like adoration that spurred on the whole thing.”

Question 14: Are users arrested or imprisoned for drug related or other offences? How common is this?

Most of the key informants thought heroin users don’t have much contact with the criminal justice system, while a few thought it was quite common for them to get arrested. Law enforcement confirmed that prison sentences are fairly uncommon, with most users who are arrested receiving a fine.

Opinions of the focus group participants varied, based mostly on their personal experience.

- “My experience is I got arrested on numerous occasions but was fortunate enough not to get convicted and do time. I was permanently in trouble with the law.”
- “Not really. Heroin made me sleep a lot. Other drugs maybe, but heroin – I was not doing anything against the law or a person. I would just sit and listen to house music.”
- “I don’t think the police do anything about it. It is very difficult to get caught with possession.”
- “Generally I think heroin addicts they don’t hang around – they hang around waiting until they got it and then they are out of there. It is not as easy to be caught with it

because you use it before they even got to that stage and they are not social – it is not like coke where you are still part of society because you isolate yourself.”

Question 15: Is sex work common among users?

Most of the KIs (including law enforcement) responded that it was fairly common for female users to provide sexual favours for money or drugs (often to the dealer). Some male and female users become involved in sex work.

Although this issue was not discussed in detail in the focus group discussions, one of the focus group participants mentioned becoming involved in sex work (see question 10) and a few commented in general:

- “Either to the dealers or anybody. Especially the white girls with the dealers sex is a big issue. The dealers are becoming sexually involved with those girls. They are not pimping them, they are just using them for themselves.”

Question 16: Knowledge of price, purity, type and availability? Have any changes occurred recently?

Although heroin is readily available, users still need to have a contact/dealer, as the heroin trade still seems to operate in a ‘closed network’. Some KIs reported being aware of areas where “visible dealing” was taking place. A few of the KIs reported that heroin currently available was of a poor quality. Both “Thai White” and “Brown Sugar” heroin appear to be available. Law enforcement commented that the price had decreased from R40 per quarter in 2003 to R30 per quarter in 2004 and that heroin was readily available, mostly Thai White.

The focus group participants concurred that heroin was easily available in both the southern and northern suburbs of Cape Town.

- “Oh it is the easiest thing in the world. You don’t have to leave home, it is so easy.”
- “.....when I decided I wanted to use heroin I did not have any contacts, I did not know who used heroin, I just walked down the road and talked to a couple of guys and within half an hour I was sorted – quite literally – just a matter of asking a couple of Nigerians, there’s this, the other and you find your man.”
- “It is not just Sea Point area it is also Table View and there you find it easy, even Durbanville – it is readily available in all areas.”
- “You walk down in the main road in Mowbray and you get offered at least, like 10 times from one side to the other.”

One participant had this to say on the issue of price:

- “It stayed constant for 2½ years. It was R50, now R40 for a quarter [gram]. A friend of mine told me – we were using the same dealer – it seems to like now the people who have been using it they don’t want to drop the price, they only do it for new people. They don’t tend to - obviously if you have been paying R50 they are not going to drop that - but if it does change any newcomers they come in at the new price. Sometimes you win and sometimes you loose.”

According to law enforcement dealing is mostly controlled by foreign nationals (Nigerians and Tanzanians), although locals are used as “runners”.

Question 17: Do heroin users use other drugs concurrently? If so, which drugs?

Although heroin usually becomes the “priority drug” for most users, some also use cocaine, Ecstasy, cannabis, alcohol or benzodiazepines. Some users also seem to try to ‘medicate’ their withdrawal symptoms by using other drugs.

Other general comments

Most of the KIs agreed that treating heroin addiction on an outpatient basis is very difficult and they felt that methadone should only be used in an inpatient setting. Some commented on the lack of support groups, like NA, in the lower income areas. Some questioned the effectiveness of current drug education campaigns and felt the state was doing nothing to address a growing problem. They were also concerned about the renowned high mortality rate among heroin users and about the poor detoxification service provide by most hospitals.

5. SUMMARY

The discussions with both the key informants and the focus group participants left little doubt that heroin use is increasing in the Cape Metropolitan area. The comments from focus group participants on availability of the drug supported this strongly, as well as comments on ‘user areas’ within the metro with few suburbs appearing to be “excluded” from heroin use. Furthermore the demographic profile of heroin users also appears to be changing, with use now also increasingly occurring among the Coloured population and also starting in the Black population. It would also appear that more young people are starting to experiment with the drug than has previously been the case.

The lack of affordable treatment options for users emerged as a key theme throughout the discussions and interviews and this issue requires urgent attention. Some participants in the study also felt that access to and availability of detoxification services also needs to be improved, particularly in the state hospital setting.

Although there were mixed views from participants on harm reduction strategies and whether they would be effective or not, it did become clear that these strategies need to be considered and debated in the light of the increase in heroin use. Currently no harm reduction strategies, such as needle exchange programmes, are operational in Cape Town and while injecting heroin use may currently still be relatively low, this situation may well change.

HIV/AIDS does not appear to be a serious issue among heroin users in Cape Town yet, although there is a potential for this to change very quickly, as has been the case in other countries. Thus every effort should be made to attempt to curb needle sharing and risky sexual behaviour. However, it became clear that there are a number of other negative health and social consequences associated with heroin use, including weight loss and poor general health (with continued use), depression in many users, risk of overdose, strained family relationships and social isolation, petty crime, and sometimes sex work that need to be addressed.

This qualitative study did assist in developing the survey instrument for the subsequent community survey, specifically clarifying a number of issues and highlighting other issues for inclusion in the survey. It also provided an indication of the extent of use in Cape Town and provided guidelines for the identification of suburbs which could be used as starting points for snowball recruitment for the community survey.

Finally, it is anticipated that the community survey of 250 heroin users in Cape Town during July – August 2004 will yield further detail on issues related to heroin use in Cape Town; will give an indication of the extent of the problem; and will quantify some of the themes emerging from the qualitative research discussed in this report.

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