

**Zimbabwe situational
analysis of drug use in five
provinces to inform HIV and
TB programming for people
who use drugs.**

FINAL REPORT



**ZIMBABWE
CIVIL LIBERTIES
AND DRUG NETWORK**



MAINline

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FOREWORD NATIONAL AIDS COUNCIL OF ZIMBABWE

Since the discovery of the first case of HIV almost four decades ago in Zimbabwe, the country has made tremendous strides in the national response to HIV, TB and improving sexual and reproductive health and rights. Owing to a coordinated national response, which has seen an effective partnership between the public and private sector as well as civil society and communities at the grassroots level, the HIV and TB prevalence and incidence rates have significantly declined over the past 2 decades. This decline can be attributable to a plethora of combination prevention and treatment initiatives and programmes such as scaling up of voluntary testing and counselling, prevention of mother to child transmission and the antiretroviral treatment programme.

Notwithstanding this national achievement, the country's response to HIV and TB remained largely generalised, leaving behind key and affected populations, including young key populations. According to the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) IV, 2021-2025, those key and affected populations include, inter alia, sex workers in their diversity, men who have sex with men, LGBTI persons, people in prisons and other confined settings as well as people who use and inject drugs. Irrefutable evidence has revealed that the generalised response has resulted in disproportionately high HIV and TB prevalence rates amongst key and affected populations, including people who use and inject drugs, necessitating a more targeted and evidence-based approach.

The National AIDS Council of Zimbabwe and indeed the Government of Zimbabwe's approach to HIV & AIDS programming is anchored on the public health approach as encapsulated in the Constitution of Zimbabwe Amendment (No. 20) Act of 2013 and principally, though not exclusively, the Public Health Act [Chapter 15:17]. The Constitution, which was adopted in 2013, guarantees a catena of fundamental rights and freedoms including equality and non-discrimination and the right to access basic health-care and reproductive health by all. The country, through the Constitution, domesticated a number of regional and international human rights conventions' provisions which guarantee the right to health to all, including people who use and inject drugs, and prohibits discrimination on a benevolent list of explicit and implicit grounds. It is imperative to ensure that all laws and policies are aligned with the Constitution in order to respect, protect, fulfil and promote the rights of all persons, including key and affected populations, particularly access to health care and sexual and reproductive health.

Guided by the public health approach and the desire to ensure that the country attains the aspirational global goal of ending AIDS by 2030, the National AIDS Council, in partnership with the Ministry of Health and Child Care and the Zimbabwe Civil Liberties and Drug Network, with financial support from The Global Fund and UNAIDS, commissioned a situational analysis of drug use and injection in Harare, Bulawayo, Mashonaland Central, Mashonaland West and Manicaland provinces. The situational analysis was conducted to have an appreciation of the lived realities and access to health experiences of people who use and inject drugs. It is anticipated that the findings and recommendations of this process will provide valuable information to enable programming for people who use and inject drugs as well as legal reforms from a position of knowledge.

Dr. B. Madzima
CEO

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FOREWORD ZIMBABWE CIVIL LIBERTIES AND DRUG NETWORK

Zimbabwe is experiencing a challenge with drug use. This challenge is a cross-cutting issue affecting youthful populations in their diversity including key and vulnerable population groups. It is every nation's dream to have ample opportunities for youth to flourish, so they don't get desperate and resort to drugs. So, systems should be in place to improve the health of people who use and inject drugs. In trying to understand the challenges associated with drug use in Zimbabwe, there is a need for all stakeholders to put more effort and commitment in trying to mitigate challenges faced by people who use drugs.

Whilst Zimbabwe seeks a solution to drug use amongst its people, Zimbabwe's drug laws are not helping. The current drug laws, especially the Dangerous Drugs Act Chapter 15 and The Criminal Code Chapter 9:23 s56 have been developed mainly to counter drug trafficking and diversion of controlled drugs. It is high time Zimbabwe's drug laws are reformed to enable people who use and inject drugs to seek help and services without fear of criminalisation.

In considering the above, Zimbabwe Civil Liberties and Drug Network in partnership with the National AIDS Council and the Ministry of Health and Child Care in Zimbabwe, with funding from the Global Fund and UNAIDS, commissioned a Situational Analysis in five provinces of Zimbabwe, namely Harare, Bulawayo, Mashonaland West, Manicaland and Mashonaland Central, to find out on the types of drugs being consumed, the availability of and access to health services for people who use drugs, and stigma and discrimination towards this population.

We hope the findings and recommendations made by this research shall guide policy makers and all interested stakeholders in the formulation and promulgation of a health system that views people who use and inject drugs as human beings first and foremost. We also look forward to a humane drug policy which is evidence-based, observes human rights, and is anchored on scientific research, to help people who use and inject drugs and other key population groups in Zimbabwe to access HIV prevention and treatment services, especially harm reduction.

Thank you,

Wilson Box
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We are thankful for the important contributions to this study of the Zimbabwe Civil Liberties and Drug Network (ZCLDN), The National AIDS Council of Zimbabwe (NAC), the Community Advisory Board (CAB), the Ministry of Health and Child Care (MoHCC), the Zimbabwe National Key Populations Technical Support Committee (TSC), Mainline, EANNASO, UNAIDS and The Global Fund. Their supervision, support and advice during the various stages of the research helped the team to bring this study to a good end.

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Finally, we want to assert that all the information in this report, while based on information from the people mentioned here, is the sole responsibility of the undersigned consultants. We hope the report will contribute to addressing challenges faced by people who use drugs in the country and will help shape a future where HIV and TB are things of the past.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARVs	Antiretrovirals
CAB	Community Advisory Board
COVID-19	Coronavirus Disease 2019
FGD	Focus group discussion
GBV	Gender-based violence
GF	The Global Fund to fight AIDS, Tuberculosis and Malaria
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
KII	Key informant interview
KP Forum	National Key Populations Forum
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer and related communities
MoHCC	Ministry of Health and Child Care
M&E	Monitoring and evaluation
MRCZ	Medical Research Council of Zimbabwe
NAC	National AIDS Council
NFM4	New Funding Model, round 4
NSP	Needle and syringe programmes
OAMT	Opioid agonist maintenance therapy
PI	Principal investigator
RCZ	Research Council of Zimbabwe
RoA	Route of administration
STI	Sexually transmitted infection
TB	Tuberculosis
TSC	Zimbabwe National Key Populations Technical Support Committee
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation
ZCLDN	Zimbabwe Civil Liberties and Drug Network
ZNASP	Zimbabwe National HIV

SUMMARY

The [Zimbabwe National HIV and AIDS Strategic Plan \(ZNASP\) IV 2021-2025](#) identifies people who use drugs as a key population within the HIV response, but progress towards catering for their specific needs has been slow. The Strategic Plan acknowledges that there is a lack of data to determine the magnitude and burden of disease and vulnerabilities to HIV and TB among people who use drugs in the country. The [Zimbabwe National Drug Master Plan \(2020-2025\)](#), focuses on reducing the supply and demand of drugs and lists harm reduction interventions. Yet, Zimbabwe's national [laws](#) and [regulations](#) are strongly based on zero tolerance towards drugs, and **adopt a punitive approach towards drug use and drug possession.**

This study represents an attempt to **fill the knowledge gap around drug use and injection in Zimbabwe.** It intends to provide an exploratory account of lived experiences among people who use drugs in five provinces in Zimbabwe targeted by the study, emerging drug use patterns and the kind of support they would welcome. While this information is useful to start designing policies and programmes for people who use drugs, more information is needed for an in-depth understanding of drug use and the tools and messages needed to improve access to health services for people who use or inject drugs.

The **overall objective** of the research was to **conduct a situational analysis of drug use and injection to inform the national HIV and TB programming for people who use or inject drugs in Zimbabwe.** The research has provided insight into patterns of drug use, levels of knowledge and risk perception around HIV, HCV and TB, as well as barriers and facilitators for HIV and TB services and existing programmes through a survey, for which **293 people who use drugs were interviewed, focus group discussions with 103 other people who use drugs took place, as well as 16 key informant interviews with civil society and government representatives.** The research received **ethical approval** from the Medical Research Council of Zimbabwe (MRCZ) and the Research Council of Zimbabwe (RCZ). The study was of **exploratory** nature; it is not possible to know if the selected sample can be considered representative of the population of people using drugs (and its sub-groups) in the country. Besides, in a context of prohibitionist laws and where participants were not necessarily already engaged with some type of service provision, reaching people who use drugs to which more stigma is attached, and reaching those who inject their drugs, was more challenging, despite having people who use drugs in the research team.

The study found that the **most commonly used substances by research participants** were **cannabis** (including skunk), (legal and illegal) **alcohol, cough syrup (codeine), crystal meth** and - to a lesser extent - **pharmaceutical drugs.** The use of heroin and cocaine (both crack and powder) was relatively low. Crystal meth and pharmaceuticals are substances that were more often injected. **Over one third of the survey sample had ever injected** and more than a quarter had done so in the past month. **More than half of the women interviewed reported having ever injected.** The research revealed widespread **sharing of injection materials**, as well as **unsafe discarding** of those materials, entailing risks of reusing and sharing. There are also indications of **unsafe injecting practices**, such as injecting in the wrist, thigh, groin or neck, and reports of abscesses caused by injection.

The research revealed an **overlap between people who use drugs and other key populations**, such as sex workers and LGBTIQ+ communities. Similarly, indications were found that **drug use may be linked to sex work and (other forms of) transactional sex, unprotected sex and sex with multiple partners.** Also sexual violence was reported. Many respondents declared to have tried to quit drugs; most of them without professional help.

Data collected showed that **almost all survey participants correctly identified that HIV can be transmitted** through unprotected penetrative sex. However, all other modes of transmission were much less known. On TB transmission, over three quarters of respondents were able to identify coughing or sneezing as mode of transmission, but many myths were found on other ways of TB transmission. Ways of HCV transmission - or HCV itself - were virtually unknown among the research population. The study reported high rates of HIV testing (92.49%) and ART enrolment (96.36%). For those on ART, 84.91% reported they were adhering to their treatment. However, over 70% of the sample had never been tested for TB, despite belonging to a risk group in a high HIV-TB burden country.

People who use drugs as well as government and civil society representatives acknowledged that there was a **huge gap between people who use drugs and healthcare providers**. Both sides recognised the current health response is based on a general, **public health approach, that doesn't provide tailored services** and therefore fails to address the specific needs of people who use drugs. Lack of confidentiality by healthcare staff, judgemental attitudes and a general lack of care or capacity to address the needs of people who use drugs were also mentioned as standing in the way of accessing services by FGD participants. FGD participants also complained about **police harassment**, including raids and forced bribery.

No programmes or services were found specifically **addressing the needs of people who use drugs**; harm reduction services are non-existent in Zimbabwe, and services dedicated to drug treatment do not cater for the needs of the research participants. As for general health services, they generally adopt a public health approach and people who use drugs mostly access such services - if at all - without disclosing their drug use.

Suggestions from key informants on how to **strengthen national HIV and TB responses** for this population predominantly centred around **creating an enabling environment** for people who use drugs and for programmes targeting this population, decriminalising people who use drugs and leaving behind the 'policing approach.' The second priority informants mentioned was **capacity strengthening of staff working in the public healthcare system**, with a focus on attitude and confidentiality. Thirdly, informants stressed **the role of civil society organisations**, and in this regard some shared their concern on the current climate of restricting civil society space in the country. Lastly, informants stressed the need for an **intersectional approach**, addressing not only HIV and TB among people who use drugs, but including mental health, (gender-based) violence, drug use itself and integrating the services in the already existing HIV prevention package.

Based on the findings and on international WHO guidelines, the team has formulated a set of **recommendations**;

1. Creating an enabling environment

- Improving the legal and policy environment
- Reducing stigma and discrimination
- Fostering community empowerment

2. Adapting current services to better cater for the needs of people who use drugs

- Integrating HIV and TB services for people who use drugs
- Integrating sexual reproductive health and rights (SRHR) into HIV and TB services
- Integrating mental health services into those services
- Ensuring people who use drugs do not need to be abstinent from drugs before accessing health services
- Drug treatment services to be provided on a strictly voluntary basis and following the ethics of quality, evidence-based treatment
- Adapting the minimum package of HIV prevention to people who use drugs, addressing sexual behaviour in relation to drug use,
- Providing voluntary and confidential HIV and TB screening, testing and counselling targeted at people who use drugs:

- Providing HIV and TB treatment by staff trained in serving people who use drugs, at safe and friendly service delivery points, offering differentiated treatment services, ongoing treatment adherence support and low-threshold psychosocial counselling and interventions

3. Creating new and dedicated services to address drug use and related issues

- Establishing peer-led outreach work and community drop-in centres for people who use drugs
- Offering community-based and peer-led needle and syringe programming
- Developing specific harm reduction interventions for people who use stimulants
- Tailoring approaches for sub-populations who use drugs (women, youth, sex workers and LGBTIQ-members)
- Developing tailored information for people who use drugs
- Integrating economic empowerment programmes into harm reduction services

4. Research

- Investigate the needs and modalities for opioid agonist maintenance treatment (OAMT)
- Assess the needs and modalities for Naloxone distribution for opioid overdose management
- Perform a national size estimate of people who use drugs
- Broaden the current research to all provinces of the country
- Employ more in-depth investigation of drug using rituals
- Carry out needs assessments on service needs and preferences

1 BACKGROUND

1.1 Country context

According to [UNAIDS](https://www.unaids.org/en/regionscountries/countries/zimbabwe) (2021)¹ Zimbabwe has one of the highest HIV prevalence rates in sub-Saharan Africa, standing at 11.6% in the adult general population. The HIV incidence for adults was 2.37 per 1,000 in 2021². Within this generalised epidemic, signs of concentrated epidemics among men who have sex with men and sex workers are emerging³. Tuberculosis (TB) remains one of the biggest fatal diseases in Zimbabwe, especially among people living with HIV⁴. [The Stop TB dashboard](https://www.stoptb.org/static_pages/ZWE_Dashboard.html) for Zimbabwe shows that in 2020 an estimated 29,000 people developed TB in the country, 3,500 of whom were children⁵. People who use drugs⁶ have not been included in national statistics as a separate population and therefore specific data on HIV or TB in this population are not readily available. From [global data](https://www.cdc.gov/hepatitis/populations/idu.htm) however, it is known that the risk of acquiring HIV is 35 times higher for people who inject drugs as compared to the general population⁷. Besides, [people who inject drugs are at risk of acquiring viral hepatitis C \(HCV\)](https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update)⁸.

In several of its [reports](https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update), [UNAIDS](https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update) draws attention to inequalities in the HIV response in southern and eastern Africa and argues that people who inject drugs and other key populations are not benefiting equally from the progress the region is making towards global AIDS targets^{9,10}. Laws criminalising key populations undermine efforts to reach and engage them in national HIV responses, while stigma in health-care settings and a limited space for civil society organisations remain barriers to a robust service uptake. The [HIV Policy Lab](https://www.hivpolicylab.org/) similarly shows that, while Zimbabwe is doing well in having policies related to HIV treatment, when it comes to policies of political and social drivers of HIV, including criminalisation, gender and human rights issues, much more could be done¹¹.

The worrying consequences of this in various countries are well described in the “Protectors or Perpetrators”¹² report, containing evidence that criminalisation of marginalised populations opens the way for widespread human rights violations of members of such populations by law enforcement and other actors, undermining public health efforts. The report draws attention to “the problem of drug policies that disproportionately focus on apprehending people who use drugs (...) despite a wealth of evidence on the damage such punitive approaches have, not only on policing practices and rates of imprisonment, but on the prevalence of HIV, viral hepatitis and other infections, and on the overall health and lives of people who use drugs, their families and their communities.”¹³

¹ <https://www.unaids.org/en/regionscountries/countries/zimbabwe>

² Idem

³ Idem

⁴ Stop TB Partnership: https://www.stoptb.org/static_pages/ZWE_Dashboard.html

⁵ Idem

⁶ In this report the term “people who use drugs” is used to refer to all people who ingest, inhale, smoke, inject or otherwise use any legal or illegal drugs, including alcohol (excluding medication that is used as prescribed by a doctor). In some instances the term “people who inject drugs” is used to refer only to those people who consume drugs through injection.

⁷ In Danger: UNAIDS Global AIDS Update 2022 <https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update>

⁸ <https://www.cdc.gov/hepatitis/populations/idu.htm>

⁹ In Danger: UNAIDS Global AIDS Update 2022 <https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update>

¹⁰ UNAIDS (2021): Global AIDS Strategy 2021-2026 - End Inequalities. End AIDS. <https://www.unaids.org/en/Global-AIDS-Strategy-2021-2026>

¹¹ HIV Policy Lab - Zimbabwe <https://www.hivpolicylab.org/zw/>

¹² Frontline AIDS (2022): Protectors or Perpetrators? The Impact of Unlawful Policing on Human Rights and HIV <https://frontlineaids.org/resources/protectors-or-perpetrators/>

¹³ Idem

The [Zimbabwe National HIV and AIDS Strategic Plan \(ZNASP\) IV 2021-2025](#) identifies people who use drugs as a key population within the HIV response¹⁴, but progress towards catering for their specific needs has been slow. The Strategic Plan acknowledges that key populations are particularly vulnerable and disproportionately affected by HIV due to criminalisation, social marginalisation and certain risky behaviours, and that they face a range of pervasive human rights violations. The ZNASP IV also acknowledges that there is a lack of data to determine the magnitude and burden of disease and vulnerabilities to HIV and TB among people who use drugs in the country.

The government has adopted the [Zimbabwe National Drug Master Plan \(2020-2025\)](#), focusing on reducing the supply of drugs, reducing the demand of drugs (primary through prevention, drug treatment and rehabilitation) and harm reduction¹⁵. The Treatment and Rehabilitation Guidelines for Alcohol and Substance Use Disorders in Zimbabwe have also been launched, focusing on addressing mental health problems related to alcohol and substance use. Yet, implementation of both is lagging behind, potentially associated with constraints in accessing funds. Besides, increased police actions that are leading to the arrests of both dealers and users of drugs, reveal that drug use is still primarily seen as a security problem; Zimbabwe's national [laws](#) and [regulations](#) are strongly based on zero tolerance towards drugs¹⁶, and adopt a punitive approach towards drug use and drug possession¹⁷, resulting in police harassment, corruption and further marginalisation of drug-using communities.

Currently, Zimbabwe has no harm reduction interventions for people who use drugs, such as needle and syringe programmes (NSP), opioid agonist maintenance therapy (OAMT), or Naloxone distribution programmes that are central to management of overdose among people who use opioids. Moreover, current HIV and broader health programming lacks support for people who use drugs through differentiated care models and tailored services, further marginalising this community from accessing much needed interventions in a context of limited resources. Finally, COVID-19 restrictions in 2020 and 2021 seem to have correlated with an increase in mental health problems and drug use, especially among youth¹⁸.

Women who use drugs face additional vulnerabilities. An earlier community engagement¹⁹ indicated that Zimbabwean women who use drugs face domestic gender-based violence (GBV) and are victim to physical and sexual abuse. In the same study, women who use drugs also reported being sexually assaulted and intimidated by the police, and there are cases when women who use drugs are being denied their parental rights. Those findings fit into and confirm trends in the wider southern African region, as has been documented by ARASA; women tend to have less power in their relationships than men, making them more vulnerable to domestic and sexual violence; they also tend to have less economic security than men and are often poorer; besides, women who use drugs face more stigma and discrimination than men, being viewed as an anomaly; and they tend to be treated harsher than their male counterparts once they are arrested. All this leads to high levels of mental health problems and self-stigma, limited access to health services and consequently more negative health outcomes²⁰. In Zimbabwe, no gender-sensitive services for women who use drugs are currently available.

¹⁴ <https://www.nac.org.zw/policy-strategic-documents/>

¹⁵ <https://www.google.com/url?q=https://www.ltaz.co.zw/wp-content/uploads/2021/06/Zimbabwe-National-Drug-Master-Plan-7-5.pdf&sa=D&source=docs&ust=1668114398619655&usg=AOvVaw35abRUOCEHQhmuM5lfTxoX>

¹⁶ <https://www.google.com/url?q=https://www.law.co.zw/download/1918/&sa=D&source=docs&ust=1668114520610671&usg=AOvVaw3ANO44cvQNZNuMI4Inq8YF>

¹⁷ <https://www.law.co.zw/download/1698/>

¹⁸ <https://zimfact.org/factsheet-zimbabwes-drug-alcohol-abuse-problem-under-covid-19/>

¹⁹ ZCLDN 2022: Exploratory study on human rights and SRHR challenges for women who use drugs in Zimbabwe

²⁰ ARASA (2022): Hidden Gems; Addressing the needs of women who use drugs in southern and East Africa

As mentioned before, national data on people who use drugs is scant, not currently being captured through the national HIV/ TB surveillance systems. This is in sharp contrast with other key populations, such as sex workers and men who have sex with men, on whom data is being captured in the country²¹. Yet, a national size estimate among people who use drugs is still to be conducted and information on who are the people who use drugs, which drugs they use and how, which types of (drug using or sexual) risk behaviour they engage in, or what are their health or social needs is yet to be collected. Most of the information available is anecdotal and thus cannot serve as a basis for national policies or programming as part of a response strategy. Yet, this anecdotal evidence seems to point to a rise in drug use and injection in the country, raising concerns for society and policy makers.

This report presents an attempt to fill the knowledge gap around drug use and injection in Zimbabwe and inform a response strategy. It does not intend to provide a complete picture, but rather it is an exploratory account of lived experiences among people who use drugs in five provinces in Zimbabwe targeted by the study, emerging drug use patterns and the kind of support they would welcome. While this information is useful to start designing policies and programmes for people who use drugs, more information is needed for an in-depth understanding of drug use and for developing the tools and messages needed to improve access to health services for people who use drugs.

1.2 Research objectives

In 2021 the Zimbabwe Civil Liberties and Drug Network (ZCLDN), in collaboration with the Zimbabwe National Key Populations Technical Support Committee (TSC), within the auspices of the National AIDS Council (NAC) and the Ministry of Health and Child Care (MoHCC), and the Zimbabwe National Key Populations Forum (KP Forum), designed a proposal for a situational analysis of drug use and injection in Zimbabwe, which was funded by the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) and UNAIDS.

The **overall objective** of the proposed research was articulated as: to conduct a situational analysis of drug use and injection to inform the national HIV and TB programming for people who use or inject drugs in Zimbabwe.

The **sub-objectives** were formulated as follows:

1. To identify patterns of drug use and injection, including types of drugs used, types of drugs injected, polydrug use, extent of harms experienced by the users, numbers of women and minors who use or inject drugs;
2. To assess levels of knowledge, attitudes and perceptions of risk and vulnerability to HIV and TB among people who use or inject drugs;
3. To determine barriers and facilitators of uptake of HIV and TB services among people who use and inject drugs;
4. To document existing programmes targeting people who use or inject drugs and harm reduction services;
5. To identify gaps in the national HIV and TB responses for people who use or inject drugs;
6. To develop an implementation plan (road map), including suggestions for a package of services for people who use or inject drugs based on the service needs assessed, in order to mitigate against HIV and TB among this population. The plan will also address technical assistance needs.

The current report provides the results of the research, as well as conclusions and recommendations for the way forward.

²¹ UNAIDS (2022): Key findings from 2021 scorecards of the Global HIV Prevention Coalition - https://hivpreventioncoalition.unaids.org/wp-content/uploads/2022/04/JC3047_Key-findings-2021-HIV-UNAIDS_En-1.pdf

2 METHODOLOGY

2.1 Research design

The desk review for this study mainly drew from the [Mainline Love Alliance baseline on drug use in Zimbabwe](#), which was informed mostly by grey literature (news articles, reports from civil society organisations) and interviews with key informants, due to a lack of peer reviewed research on drug use in Zimbabwe. The review results helped the study design and drafting of study data collection instruments.

A steering committee was established, consisting of the Community Advisory Board (CAB) - members of civil society organisations working with key populations and networks of people living with HIV in Zimbabwe - with added representatives from the NAC, UNAIDS and the MoHCC. The steering committee reviewed the research proposal and instruments, as well as the preliminary version of the present report.

The study employed a mixed method approach, combining quantitative and qualitative data collection methods. The choice of methodology was informed by the need to explore the issue of drug use and injection in a holistic manner (Dawadi, Shrestha and Giri 2021). When combined, qualitative and quantitative methods provide a better understanding of a research issue than either research approach alone (Cresswell 2007). Qualitative methods included key informant interviews and focus group discussions (FGDs), while the main quantitative method was a survey. The **survey** component of the research collected basic socio-demographic information²² for the respondents and covered key topics such as drug use patterns, injecting practices, knowledge about HIV, HCV and TB, access to HIV and TB services and sexual behaviour and condom use (see annex 1 for survey questionnaire). The **focus group discussions** focussed on two themes complementing the survey data: a) drug use practices; and b) barriers and facilitators of uptake of HIV and TB services among people who use drugs (see annexes 2 and 3 for FGD topic lists). The **key informant interviews (KIIs)** focused on what stakeholders from civil society organisations and government institutions at provincial and municipal levels considered as barriers and facilitators to the uptake of HIV and TB services by people who use drugs, perceptions on quality of services, gaps and recommendations for future programme and policy planning (see annex 4 for KII topic list).

The survey was conducted through individual interviews, using structured questionnaires in English, Shona and Ndebele. The questionnaires were digitised and accessed through android devices (tablets). For the FGDs and key informant interviews, semi-structured topic lists were used and notes were taken on paper by two note-takers (except in a few cases when only one note-taker was available).

A series of forms and protocols was designed to guide field implementation: fieldwork & safety protocol, code of conduct, distress protocol, external communication sheet, coding memo and incident report form, among others. The research received ethical approval from the Medical Research Council of Zimbabwe (MRCZ, see annex 5) and the Research Council of Zimbabwe (RCZ)²³.

²² These include age, gender, sexual orientation, education, marital status, education, source of income, residence and experience with law enforcement.

²³ Not annexed because the research permits contain personal information from the researchers, such as passport numbers.

2.2 Fieldwork procedures

The team for data collection was composed of the principal investigator (PI), 2 co-investigators, 3 coordinators, 5 research supervisors and 10 research assistants. The research assistants and supervisors were recruited from the five provinces where the research took place, on the basis of interest, being from the community of people who use drugs, ethical behaviour, adaptability, and previous experience in conducting interviews. Nine of the fifteen assistants and supervisors identified as people who use drugs. The whole team participated in a two-and-a-half day training in Harare. The main goal of the training was to define and explain roles and responsibilities and to familiarise the field team with the tools and protocols. Besides, the training session emphasised the importance of protecting human subjects in research, adhering to the research protocol and protection of data.

As part of the training, the research supervisors and assistants conducted 15 pilot survey interviews, to familiarise themselves with the instruments, assess the usability of the questionnaire and test planned logistics. Following the pilot and based on feedback from the interview participants and the interviewers, minor adaptations to the questionnaire were made.

After the training, research assistants and supervisors returned to their provinces to start data collection. The start dates were phased to allow for supervision by the coordinators, the PI and one co-investigator. The team from Bulawayo was the first to start data collection, with the coordinator on-site for the first two days and the PI and a co-investigator arriving on the second day. In the same week the team in Mashonaland West started in the same way (with the PI and co-investigator arriving on day three). Similarly, in the second week the team in Manicaland started data collection, followed by the team in Mashonaland Central. The Harare team was the last to start, in the third week.

With support from the coordinators, and depending on circumstances and preferred ways of working, the research supervisors and assistants divided the tasks of mobilising, informing potential participants, obtaining consent, interviewing, leading FGDs, note taking during FGDs and reimbursement of participants among themselves. Each team completed data collection within five working days.

2.3 Mobilisation strategies and sampling

Across the five provinces, 293²⁴ people who use drugs were interviewed as part of the survey. Besides, two focus group discussions were conducted in each province, with approximately 10 participants per group, totalling 103 FGD participants (see table 1). Efforts were made to have gender-balanced samples and to include specific sub-populations who use drugs, such as youth, people living with HIV, sex workers, men who have sex with men and transgender people. Besides, sixteen key informants were interviewed across the five provinces. Seven of them represented civil society organisations, one was a church leader and eight of them worked for government institutions (three at province level, three at district level, one at municipal level and one at service provision level).

²⁴ While the original sample was set to 300, during data verification seven interviews turned out invalid. Those interviews have been discarded.

Table 1: Survey and FGD participants and their distribution per province

	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total
Survey	53	61	61	59	59	293
FGD1: Access to services	10	9	10	10	10	49
FGD2: Drug use practices	11	10	9	14	10	54
FGD Total	21	19	19	24	20	103
Total	74	80	80	83	79	396

The sample selection for the survey and the FGDs started from a mapping of sixteen areas²⁵ selected in five provinces of the country. The selection was made based on anecdotal evidence of drug use in these areas and/or the existence of self-support groups of people who use(d) drugs. Table 2 shows the sixteen selected areas, divided over the five provinces.

Table 2: Selected research areas in the five provinces

Province	Selected areas
Harare	1) Mbare
	2) Hopley
	3) Mabvuku
Bulawayo	4) Cowdry Park
	5) Makokoba
	6) Hillside
	7) Matscheumhlope
Mashonaland West	8) Cherima
	9) Central Business District
	10) Gadzema
	11) Chikonohono
Mashonaland Central	12) Mvurwi
	13) Mount Darwin
Manicaland	14) Dangamvura
	15) Sakubva
	16) Hobhouse

In each of the areas, the first research participants were mobilised by the data collection teams, with help from members of the self-support groups, other civil society organisations and NAC district officers. Following this, a snowballing method was employed to reach more research participants through the first ones. All individuals enrolled were people who use drugs above eighteen years of age. Participants enrolled either in the survey or in one of the FGD.

²⁵ These are a mix of neighbourhoods within major cities like Bulawayo, Mutare and Harare and towns such as Mount Darwin and Mvurwi.

Table 3 shows the different instruments used, and the average time taken to cover the different components of the research.

Table 3: Research components with average time and number of participants

Component	Average time taken to complete
Survey (Individual)	45 minutes to 1 hour
Focus group discussions	1 hour 30 minutes to 2 hours
Key informant interviews	30 to 45 minutes

2.4 Confidentiality and data protection

The researchers obtained informed consent from all participants of the study. Before participating, respondents received verbal and written information on the goals, risks, benefits and proceedings of the study in either English, Shona or Ndebele (or a mix thereof) and signed the informed consent form in the language of their choice (see annex 7). All participants from the community of people who use drugs (thus with the exception of key informants) received US\$5,- as a compensation for their time and related travel costs to partake in the study. Research assistants and supervisors were instructed to be discreet when mobilising participants for interviews and FGDs, so that the surrounding community would not identify them as people who use drugs. All research participants (including key informants) were assigned a code to guarantee their anonymity.

The data collected for this study was stored electronically on password-protected online servers and accessed by the PI and co-investigators only. The anonymised raw data will be stored in a secured server for three years upon completion of the study, and can be available to other researchers for replication and further research development upon reasonable request.

2.5 Limitations of the study

This study was of exploratory nature. Due to the lack of official data on drug use in Zimbabwe, it is not possible to know if the selected sample can be considered representative of the population of people using drugs (and its sub-groups) in the country. The teams had limited time, resources, and entry points for mobilisation of research participants, which influenced the reach in the different provinces²⁶. Besides, in a context of prohibitionist laws and where participants were not necessarily already engaged with some type of service provision, reaching people who use drugs to which more stigma is attached, and reaching those who inject their drugs, was more challenging, despite having people who use drugs in the research team. It generally took at least three days to reach people who inject drugs and gain enough trust to be able to interview them. Moreover, for next studies, a period of training longer than 2,5 days would be advisable to assure a more complete development of research skills for field workers, especially if the team does not have previous experience doing research among people who use drugs.

²⁶ For example, the team in Bulawayo reached relatively more people who use drugs from the lesbian, gay, bisexual, transgender, intersex, queer and related (LGBTIQ+) communities, because they operated from a drop-in centre targeting these communities. In other provinces without a dedicated service for these communities, much lower numbers of this subgroup were reached.

Along the study it became clear that certain additional methods, not foreseen in the initial research proposal, would be beneficial to the study. This was the case of the key informants interviews, which were made in addition to the original proposal. Key informant interviews helped to mirror the experiences reported by people who use drugs in health settings and to identify gaps in national HIV and TB programming. Due to the non-existence of dedicated resources for this, only a limited number of key informants were interviewed, not including representatives from the central government or from international agencies.

Finally, observation of drug preparation and drug use practices was also not foreseen in the research proposal and has not been done. However, to verify and triangulate information from the interviews, this would have been very valuable, more so since several research participants admitted they did not know which drug(s) they were using, how those drugs were prepared and if injection equipment was shared or used on them alone.

3 RESEARCH FINDINGS

3.1 Socio-demographic characteristics of survey participants

The survey counted 293 participants distributed across five provinces: Bulawayo, Harare, Manicaland, Mashonaland Central and Mashonaland West. Participants were on average 30.92 years old (median²⁷=30), with the youngest being 18 and the oldest 63 years old. The vast majority (96.59%) identified as African-Black in the survey. 69.92% were male, 25.94% female and 4.45% identified as transsexual or an “other” gender. The most common sexual orientation was heterosexual (85.32%) with homosexuality (8.54%) and bi-sexuality (5.12%) following.

Participants’ characteristics regarding gender and sexual orientation varied across the different provinces. Table 4 shows this variation, along with a more detailed account of participants’ characteristics per province for age and ethnicity. Bulawayo was the province with most representativity of gender diversity, with 13.21% of participants identifying as transsexual (males or females), or other. It had also the highest representativity of non-heterosexuals: 39.62% declared being homosexual, bi-sexual, or other. The accentuated diversity in Bulawayo can be explained by the fact that an organisation focussing on sexual rights in the province helped the mobilisation of survey participants and hosted the interview team in its drop-in centre. In contrast, neither in Harare nor in Mashonaland Central were gender-diverse people represented.

Table 4: Survey participants profile - age, ethnicity, gender

	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
N participants	53	61	61	59	59	293
Age						
Average age	30,42	29,95	29,34	32,90	32,02	30,92
Median	29	28	27	33	32	30
Youngest	18	18	19	19	18	18
Oldest	59	54	54	63	54	63
Ethnicity						
African-Black	96,23 %	100,00 %	93,33 %	96,67 %	94,92 %	96,59 %
Mixed race	3,77 %	0,00 %	6,67 %	0,00 %	5,08 %	3,07 %
Other	0,00 %	0,00 %	0,00 %	1,69 %	0,00 %	0,34 %
Gender						
Cis-male	58,49 %	56,67 %	86,67 %	68,33 %	76,27 %	69,62 %
Cis-female	24,53 %	45,00 %	8,33 %	30,00 %	22,03 %	25,94 %
Trans-male	5,66 %	0,00 %	1,67 %	0,00 %	1,69 %	1,71 %
Trans-female	7,55 %	0,00 %	0,00 %	0,00 %	0,00 %	1,37 %
Other	3,77 %	0,00 %	3,33 %	0,00 %	0,00 %	1,37 %
Sexual orientation						
Heterosexual	60,38 %	98,36 %	86,67 %	96,61 %	93,22 %	85,32 %
Gay	15,09 %	0,00 %	8,33 %	3,39 %	3,39 %	6,83 %
Lesbian	7,55 %	0,00 %	1,67 %	0,00 %	1,69 %	1,71 %
Bi-sexual	13,21 %	1,64 %	0,00 %	0,00 %	1,69 %	5,12 %
Other	3,77 %	0,00 %	3,33 %	0,00 %	0,00 %	1,02 %

²⁷ Median is the value exactly in the middle of the dataset. This report provides both median and average values to uncover potential extreme values in the dataset. When median and average differ, this is caused by the average being influenced by extreme values. For example in the case of the age of first injection (paragraph 3.4) the average age is higher than the median age, meaning there are more extreme values on the higher side of the age range.

About half (47.78%) of the total sample had completed secondary education, with the highest rate of completed secondary education being in Mashonaland Central (62.71%, see table 5).

In almost all provinces between 70 and 80% of participants did not have a stable relationship, being mostly single (and never married) or divorced. Only in Mashonaland West 45.75% of participants mentioned having a stable relationship, being either traditionally or legally married or cohabiting with a partner.

In all provinces, over 90% of the survey participants had stable housing: from the total sample, about half (47.78%) mostly stayed in their parent's house, 36.86% had their own (rented or owned) house and 10.92% stayed with a relative or a friend²⁸. Only in Bulawayo (5.66%) and Harare (3.28%) a few participants stayed in the streets or shelters. Other forms of housing, mentioned in Mashonaland Central only (5.08%), included living in an own house still under construction or as an intern in a college.

Table 5: Survey participants profile - educational, marital status, housing

Education	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
No education	0,00 %	1,64 %	0,00 %	3,39 %	0,00 %	1,02 %
Incomplete primary	7,55 %	1,64 %	3,28 %	3,39 %	3,39 %	3,75 %
Completed primary	22,64 %	42,62 %	16,39 %	11,86 %	23,73 %	23,55 %
Completed secondary	33,96 %	45,90 %	49,18 %	62,71 %	45,76 %	47,78 %
Completed high school	11,32 %	1,64 %	21,31 %	11,86 %	6,78 %	10,58 %
Completed tertiary (vocational/ technical)	13,21 %	3,28 %	4,92 %	3,39 %	3,39 %	5,46 %
Completed tertiary (university)	11,32 %	3,28 %	4,92 %	3,39 %	16,95 %	7,85 %
Marital Status						
Single; never married	66,04 %	39,34 %	44,26 %	38,98 %	30,51 %	43,34 %
Legally married	1,89 %	1,64 %	1,64 %	5,08 %	1,69 %	2,39 %
Traditionally married	9,43 %	8,20 %	19,67 %	16,95 %	25,42 %	16,04 %
Cohabiting	11,32 %	8,20 %	3,28 %	1,69 %	18,64 %	8,53 %
Divorced, separated	9,43 %	40,98 %	27,87 %	35,59 %	23,73 %	27,99 %
Widowed	1,89 %	0,00 %	1,64 %	1,69 %	0,00 %	1,02 %
Other	0,00 %	1,64 %	1,64 %	0,00 %	0,00 %	0,68 %
Mostly stayed at						
Parent's house	47,17 %	39,34 %	65,57 %	45,76 %	40,68 %	47,78 %
Own house	32,08 %	34,43 %	18,03 %	47,46 %	52,54 %	36,86 %
Spouse or steady partner's house	5,66 %	0,00 %	1,64 %	0,00 %	0,00 %	1,37 %
Relative's or friend's house	9,43 %	22,95 %	14,75 %	0,00 %	6,78 %	10,92 %
Shelter. welfare residence	1,89 %	0,00 %	0,00 %	1,69 %	0,00 %	0,68 %
Care of health institution (hospital, treatment centre, etc)	0,00 %	0,00 %	0,00 %	0,00 %	0,00 %	0,00 %
Streets or abandoned building (homeless)	3,77 %	3,28 %	0,00 %	0,00 %	0,00 %	1,37 %
Other	0,00 %	0,00 %	0,00 %	5,08 %	0,00 %	1,02 %

²⁸ Considered stable housing, since people may stay with friends or relatives for several years.

In all provinces except Harare, more than 40% of participants reported occasional jobs as their main source of income²⁹. The second most often mentioned source was small-scale owned business (24.91% of the total sample, see table 6). In Harare the most often mentioned source of income was sex work (36.07%); the higher rate in this province is linked to the mobilisation strategy, which included recruitment of respondents in an area where sex work takes place. Sex work was the third most often mentioned source of income in Mashonaland Central (18.64%) and the fourth in Mashonaland West (15.25%). Bulawayo (16.98%) and Mashonaland Central (13.56%) had the highest number of participants reporting not to be earning any money. 7.17% of all participants mentioned selling drugs as a source of income. Though this may look like a relatively small number, it shows that there is a group³⁰, who are selling drugs to finance their own habit.

Table 6: Survey participants profile - sources of income

Source of income	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
Not earning any money	16,98 %	4,92 %	8,20 %	13,56 %	0,00 %	8,53 %
Steady wage / salary from a legal job	30,19 %	6,56 %	6,56 %	6,78 %	20,34 %	10,58 %
Own business / self-employed	22,64 %	34,43 %	29,51 %	22,03 %	15,25 %	24,91 %
Occasional / odd jobs on the street	45,28 %	24,59 %	47,54 %	47,46 %	59,32 %	44,71 %
Money from family / partner / friends	13,21 %	13,11 %	13,11 %	10,17 %	16,95 %	13,31 %
Begging	1,89 %	3,28 %	0,00 %	0,00 %	0,00 %	1,02 %
Selling drugs	5,66 %	9,84 %	8,20 %	3,39 %	8,47 %	7,17 %
Theft / pickpocketing	1,89 %	3,28 %	0,00 %	0,00 %	0,00 %	1,02 %
Sex work	5,66 %	36,07 %	1,64 %	18,64 %	15,25 %	15,70 %
Transactional sex	5,66 %	3,28 %	1,64 %	5,08 %	5,08 %	4,10 %
Blesser(s) / sugar daddy / daddies	3,77 %	1,64 %	0,00 %	5,08 %	3,39 %	2,73 %
Prefer not to say	0,00 %	0,00 %	3,28 %	0,00 %	0,00 %	0,68 %
Other	0,00 %	0,00 %	1,64 %	1,69 %	1,69 %	1,02 %

²⁹ Multiple responses were possible.

³⁰ The 7% is very likely an underrepresentation; several prospective respondents didn't want to participate in the survey, because they were (also) selling drugs and were too scared they might face negative consequences from participating.

Half of the participants (50.51%) reported to have never had an encounter with law enforcement (see table 7). Police harassment was more often mentioned by participants in Harare (28.81%), Mashonaland Central and Mashonaland West (18.64% each). In all provinces 15-20% of participants had been taken into custody, without being convicted.

Table 7: Survey participants profile - law enforcement encounters

Law enforcement encounters	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
No	58,49 %	42,37 %	57,63 %	49,15 %	49,15 %	50,51 %
Yes, police have helped / supported me	7,55 %	8,47 %	5,08 %	10,17 %	6,78 %	7,51 %
Yes, I was stopped by the police, without further actions or consequences	3,77 %	3,39 %	13,56 %	10,17 %	0,00 %	7,17 %
Yes, I was harassed by the police	9,43 %	28,81 %	5,08 %	18,64 %	18,64 %	16,04 %
Yes, I was arrested by the police	11,32 %	15,25 %	8,47 %	5,08 %	10,17 %	9,90 %
Yes, I was taken into custody (not convicted)	15,09 %	15,25 %	20,34 %	15,25 %	20,34 %	17,06 %
Yes, I was in prison (convicted)	0,00 %	0,00 %	1,69 %	0,00 %	1,69 %	0,68 %

The relatively high level of education of survey sample participants, together with the low levels of homelessness and reported police harassment may lead to question to what extent the survey has reached marginalised groups of people who use drugs. Nonetheless, we believe that we managed to reach what could be considered vulnerable populations in terms of their marginalised position in society as people who use drugs. We have also reached a variety of subgroups of marginalised people who use drugs, including urban and rural poor (located in socio-economically disadvantaged neighbourhoods) and groups intersecting with other key population groups such as sex workers and the LGBTIQ+ community. In order to reach the respondents that inject drugs in the target areas we had to mobilise through partners and hosts within the locations as they were harder to reach and access.

No socio-demographic data were collected among the 103 participants of focus group discussions. Since they were mobilised from the same populations as participants of the survey, it is safe to assume they have similar socio-demographic characteristics as this first group. The data from focus group discussions confirmed that participants felt marginalised; they were aware of the negative stereotypes associated with drugs and people who use drugs in society, reported having problems accessing healthcare services and they feared police arrests and harassment.

3.2 Drug use during past year and past month

Survey participants were asked about their drug use in the past year and past month. A list of drugs was provided based on the literature review, an initial consultation with key informants and a pilot during the training of the research team. For those substances that participants affirmed to have used in the past month, further questions investigated the main route of administration and the frequency of use. Cannabis and skunk (a variety of cannabis) were listed as different substances in the survey, following advice from key informants from the community of people who use drugs during the research preparation phase. They affirmed that people consuming and selling these substances make a clear distinction between the two. According to those informants, skunk is grown indoors and in greenhouses, with use of chemicals, in contrast with a natural growth process in the case of cannabis. This would cause skunk to have a distinct and "chemical" smell as well as a harder texture, rendering it impossible to be grinded or screened by hand.

Table 8 shows drug use in the past year for the total sample and per province. Overall, the most used substances were cannabis, legal and illegal ('home brew') alcohol, skunk, and cough syrup (codeine). Nonetheless, over a third (36.52%) of the total sample reported using methamphetamine (crystal meth) and almost one in five participants (18.43%) declared to use pharmaceuticals without prescription. Strikingly, 3.41% reported having used something without knowing what it was. A much lower percentage of participants declared to have used powder or crack cocaine, heroin, glue, or nyaope³¹.

The types of pharmaceuticals were not specified in the survey, but participants of the FGDs mentioned to be using ARVs, haloperidol, ketamine, diazepam, diclofenac, pethidine and mangemba (the latter being water laced with psychiatric medications such as chlorpromazine, diazepam and benzodiazepines)³².

Table 8: Drug use past year

	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
N participants	53	61	61	59	59	293
Drugs used past year						
Cannabis (mbanje, ganja)	62,26 %	49,18 %	93,44 %	69,49 %	64,41 %	67,92 %
Legal alcohol	67,92 %	26,23 %	77,05 %	69,49 %	67,80 %	61,43 %
Cough syrup	37,74 %	44,26 %	63,93 %	54,24 %	38,98 %	48,12 %
Skunk	56,60 %	34,43 %	70,49 %	18,64 %	37,29 %	43,34 %
Crystal meth (mutoriro, guka)	22,64 %	32,79 %	49,18 %	38,98 %	38,98 %	36,52 %
Illegal alcohol (musombodia, kachasu, tumbwa)	49,06 %	6,56 %	34,43 %	37,29 %	32,20 %	31,40 %
Pharmaceuticals	7,55 %	26,23 %	11,48 %	20,34 %	25,42 %	18,43 %
Powder cocaine	11,32 %	3,28 %	4,92 %	1,69 %	10,17 %	6,14 %
Crack cocaine (rock)	7,55 %	0,00 %	8,20 %	8,47 %	1,69 %	5,12 %
Glue	5,66 %	1,64 %	3,28 %	11,86 %	0,00 %	4,44 %
Heroin	7,55 %	3,28 %	8,20 %	0,00 %	1,69 %	4,10 %
Sodium polyacrylate (from diapers)	0,00 %	1,64 %	1,64 %	0,00 %	3,39 %	1,37 %
Nyaope (Whoonga)	5,66 %	1,64 %	0,00 %	0,00 %	0,00 %	1,37 %
Others	3,77 %	24,59 %	8,20 %	5,08 %	1,69 %	7,51 %
Unknown substance	5,66 %	1,64 %	4,92 %	1,69 %	1,69 %	3,41 %

³¹ Nyaope is usually a mix of cannabis and a range of low quality substances. Whilst in the survey nyaope was reported only in Bulawayo and Harare, during the FGDs, its use was reported by participants in Manicaland. There, nyaope was reported as a mix of cannabis, rat poison and ARVs.

³² According to the [Global Press Journal](#).

The types of substances used in the past month mostly followed the pattern found for the past year use, with the most accentuated difference being in the use of cough syrup in the past month when compared to the past year. Figure 1 compares reported substance use in the past year and in the past month for the total sample. Table 9 shows a detailed account of past month's use of substances per province and for the total sample.

Figure 1: Drug use past year and past month (absolute numbers)

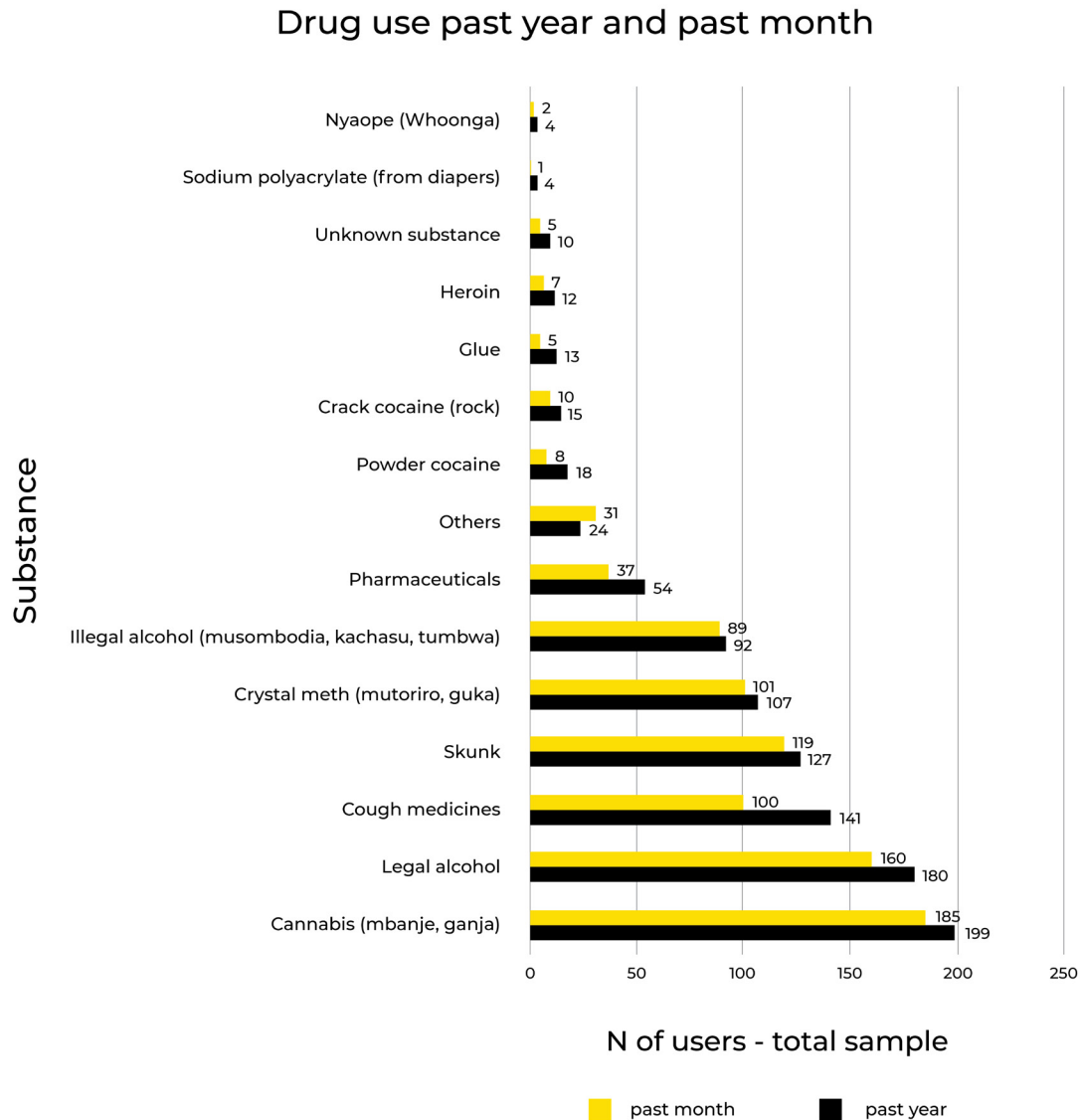


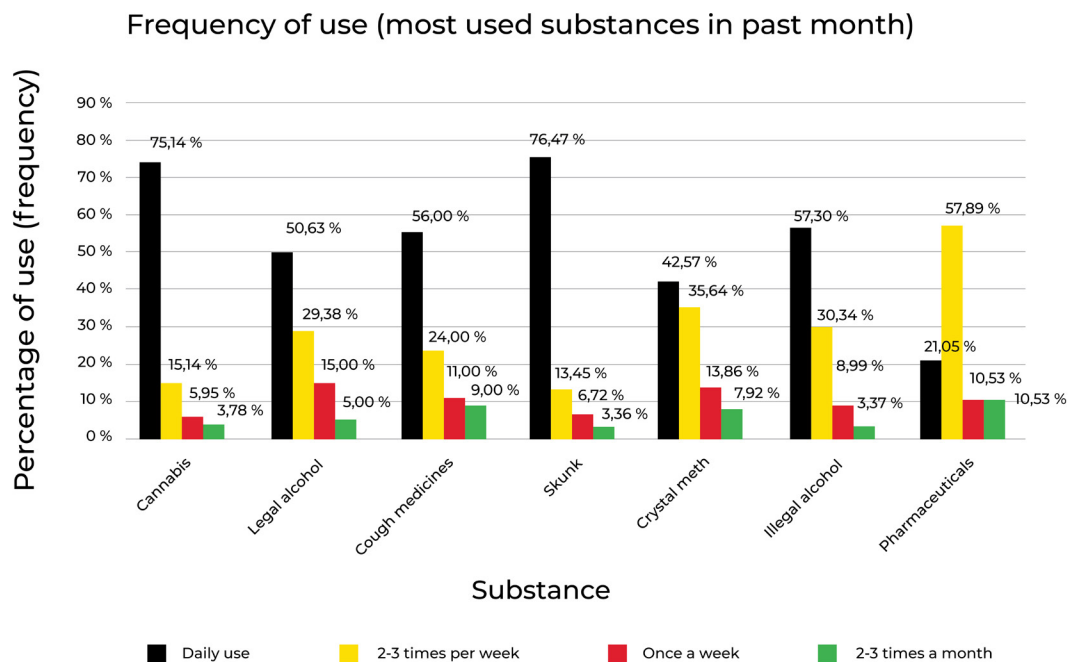
Table 9: Drug use past month

	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
N participants	53	61	61	59	59	293
Drugs used past year						
Cannabis (mbanje, ganja)	58,49 %	50,82 %	83,61 %	57,63 %	64,41 %	63,14 %
Legal alcohol	62,26 %	21,31 %	68,85 %	54,24 %	67,80 %	54,61 %
Cough syrup	28,30 %	40,98 %	42,62 %	23,73 %	33,90 %	34,13 %
Skunk	56,60 %	36,07 %	65,57 %	15,25 %	30,51 %	40,61 %
Crystal meth (mutoriro, guka)	22,64 %	36,07 %	44,26 %	28,81 %	38,98 %	34,47 %
Illegal alcohol (musombodia, kachasu, tumbwa)	45,28 %	9,84 %	29,51 %	35,59 %	33,90 %	30,38 %
Pharmaceuticals	7,55 %	14,75 %	4,92 %	10,17 %	25,42 %	12,63 %
Powder cocaine	5,66 %	0,00 %	0,00 %	1,69 %	6,78 %	2,73 %
Crack cocaine (rock)	5,66 %	0,00 %	3,28 %	8,47 %	0,00 %	3,41 %
Glue	3,77 %	1,64 %	0,00 %	3,39 %	0,00 %	1,71 %
Heroin	5,66 %	0,00 %	4,92 %	1,69 %	0,00 %	2,39 %
Sodium polyacrylate (from diapers)	0,00 %	0,00 %	0,00 %	0,00 %	1,69 %	0,34 %
Nyaope (Whoonga)	1,89 %	1,64 %	0,00 %	0,00 %	0,00 %	0,68 %
Others	7,55 %	19,67 %	6,56 %	15,25 %	3,39 %	10,58 %
Unknown substance	1,89 %	0,00 %	3,28 %	1,69 %	1,69 %	1,71 %

3.3 Frequency of use and routes of administration

Frequent use was high for the most used substances among the survey participants, as shown in figure 2. More than 70% of those using cannabis and/or skunk in the past month declared to do so daily. For cough syrup and (legal and illegal) alcohol, reported daily use was above 50%. A large proportion of those using crystal meth (42.57%) made daily use of the substance, and another 36.64% declared to use it at least two or three times a week. In the case of pharmaceuticals, 57.89% reported using them two or three times a week, and 21.05% used it daily. These general trends were similar across the provinces.

Figure 2: Frequency of use of most used substances in past month (as a % of those using the substances)



Regarding routes of administration (RoA) of substances, both cannabis and skunk were mostly smoked in a joint (respectively 65% and 81%) or smoked from foil (29% and 19%); a few others (5% and 3%) declared to swallow the substance. Crystal meth was mostly smoked from a (makeshift) pipe³³ (58%), smoked in a joint (15%), or swallowed (13%). Nevertheless, 12% reported injection as the main route of administration for crystal meth in the past month. Injection was the main route of administration for pharmaceuticals (for 51% of the sample); swallowing was the second most common RoA (42%).

³³ Most commonly made from a light bulb.

Figures 3a-3e show the preferred route of administration of substances used in the past month by more than 10 survey participants. The titles of the graphs show the name of each substance and the number of participants having used this substance in the past month. The body of each graph shows the various routes of administration and the number of participants reporting to use the substance in that particular way. Since some participants provided more than one preferred route of administration for some of the substances, this number can be higher than the total number of participants who reported using that particular substance.

Figure 3a: Preferred route of administration of cannabis in past month

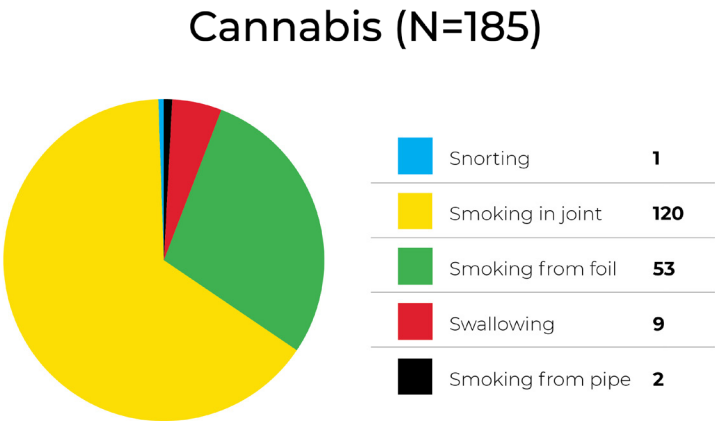
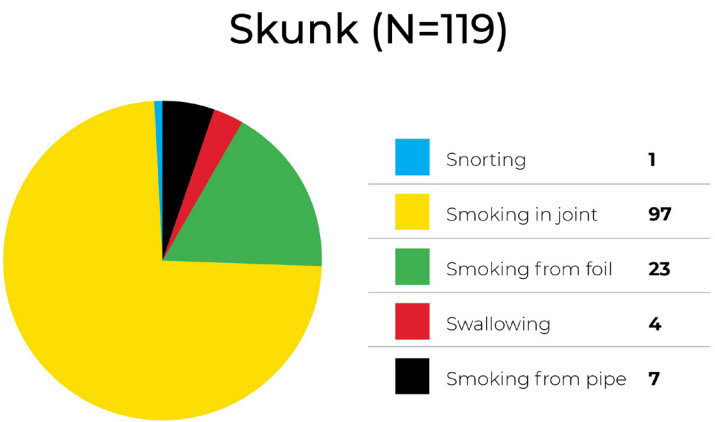


Figure 3b: Preferred route of administration of skunk in past month³⁴



³⁴ Several participants reported having two or more favourite routes of administration for skunk, which is why the answers add up to 132 instead of 119.

Figure 3c: Preferred route of administration of crystal meth in past month³⁵

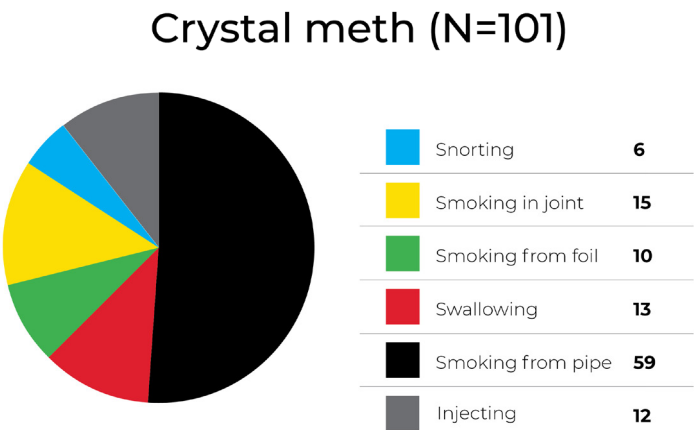


Figure 3d: Preferred route of administration of cough syrup in past month³⁶

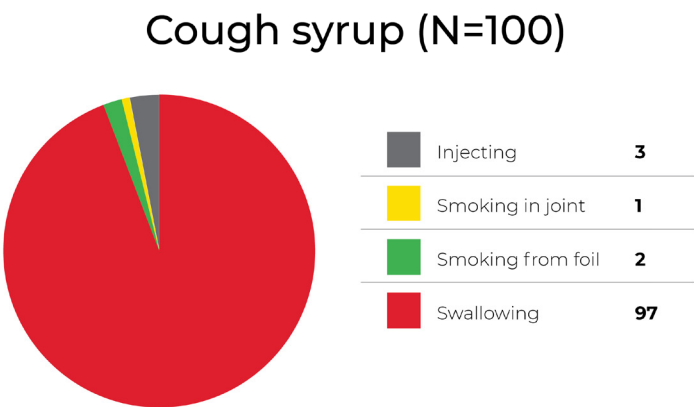
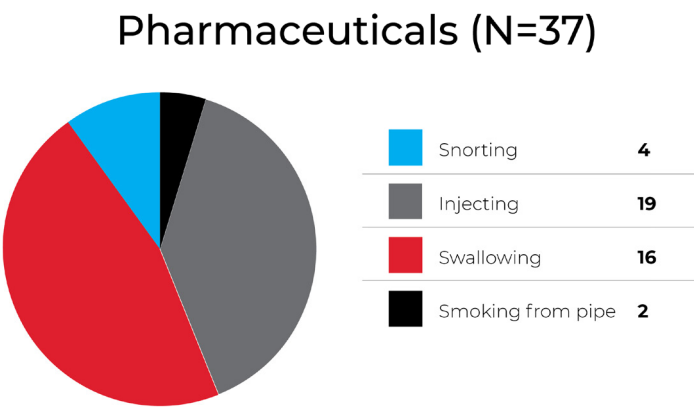


Figure 3e: Preferred route of administration of pharmaceuticals in past month³⁷



FGDs revealed that, rather than switching the route of administration of one's drug of choice, switching the route of administration often went hand in hand with switching drugs.

³⁵ Several participants reported having two or more favourite routes of administration for crystal meth, which is why the answers add up to 115 instead of 101.

³⁶ Three participants reported having two favourite routes of administration for cough syrup, which is why the answers add up to 103 instead of 100.

³⁷ Four participants reported having two favourite routes of administration for pharmaceuticals, which is why the answers add up to 41 instead of 37.

3.4 Age of onset and years of drug use

On average, survey participants were 19.22 years old when they first used drugs (median 18); for those ever injecting (N=100) their average age at the first injection was 23.95 (median 22). 83.28% of the survey participants stated they knew minors who use drugs, while 29.69% stated they know minors who inject drugs. The average ages for starting drug use and starting injecting were comparable across provinces, as described in table 10.

Table 10: Age of onset of drug use and injection

	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
Current age						N=293
Average age	29,26	29,95	29,34	32,90	31,77	30,64
Median	29	28	27	33	32	30
Youngest	17	18	19	19	18	17
Oldest	59	54	54	63	54	63
Age at first drug use						N=293
Average age	18,65	20,63	18,43	19,92	18,55	19,22
Median	18	19	17	18	17	18
Age at first injection						N=100
Average age	22,83	25,36	22,07	24,21	22,84	23,95
Median	21,5	25	19	21,5	21	22

FGDs revealed that most common motivations for starting drug use were the stressful context people found themselves in, ranging from the economic situation, discrimination (mostly among respondents from LGBTIQ+ communities), to stress in personal life and peer pressure or admiration for others who were already using drugs. Some of the respondents who identified as sex workers, stated drugs help them become more confident or less shy.

Reasons to continue using drugs were similar to those for starting drug use regarding coping with stress and shyness, but peer pressure and admiration were replaced by the liking of (or dependency on) the drug and (coping with) the lack of another activity. In Mashonaland West, FGD respondents added that COVID-19 restrictions, which led to income loss, made people resort to illegal brews and 'homemade' drugs. According to participants, in this period "the bases became a safe haven"³⁸. Bases are places where substances are consumed and distributed, usually coordinated by people who use drugs and drug suppliers.

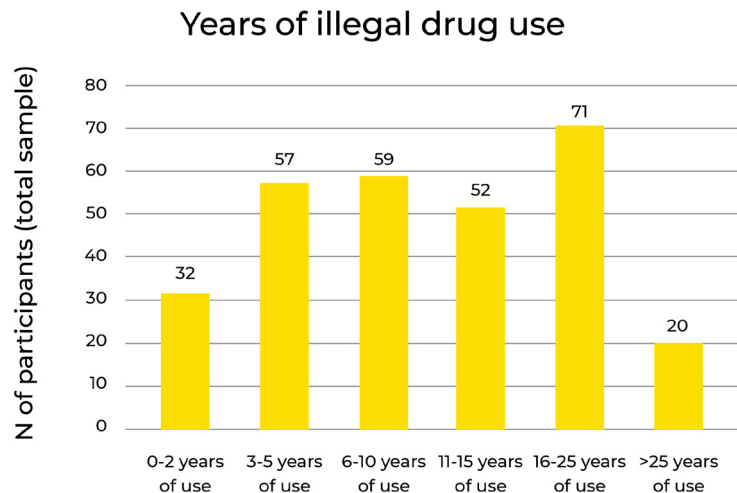
When asked which harms FGD respondents experience from their drug use, the most mentioned issues were the risk of sexually transmitted infections (STIs) through unprotected sex, and poor judgement, leading to accidents or unsafe situations. In three provinces³⁹ FGDs also touched upon harms caused by other people that can be attributed to drug use. In this regards, in Harare and Mashonaland West respondents complained mostly about police harassment, including raids and forced bribery, while in Harare respondents also said they suffered from discrimination by health staff and being admitted in mental institutions, which only worsened their problems. In Manicaland respondents reported being stigmatised by other members of society (being blamed for stealing, being denied job opportunities) was their greatest concern.

³⁸ Texts in double quotation marks are quotes from participants that had been noted down during interviews/FGDs.

³⁹ Harare, Manicaland and Mashonaland West

On average, at the time of the survey, participants had been using (illegal) drugs for 11 years (median 10); however, the length of drug use varied among the survey participants. Figure 4 shows the distribution of participants (in absolute numbers) regarding years of drug use. While 11% of respondents were using drugs for less than 3 years, 30.54% had been using drugs for more than 15 years.

Figure 4: Years of illegal drug use at the time of the survey⁴⁰

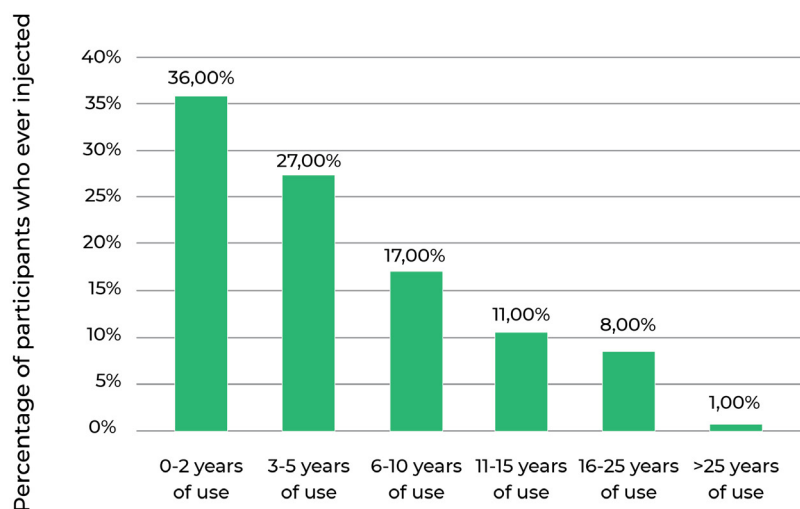


3.5 People who inject drugs

About a third of the total sample (34.13%; N=100) declared to have ever injected drugs. From those, 82% (N=82; 27.99% of the total sample) affirmed to have injected in the past 6 months. 63% (N=63) of those ever injecting their substances, started injecting 5 years or less after they had started using illegal drugs. As figure 5 shows, 36% started injecting within 2 years after their first illegal drug use. The average number of years between the start of drug use and the start of drug injection is 6 (median=4). Only one person declared to have started illegal drug use immediately by injecting.

Figure 5: Years of illegal drug use before injection

Years of illegal drug use before injection (N=100)



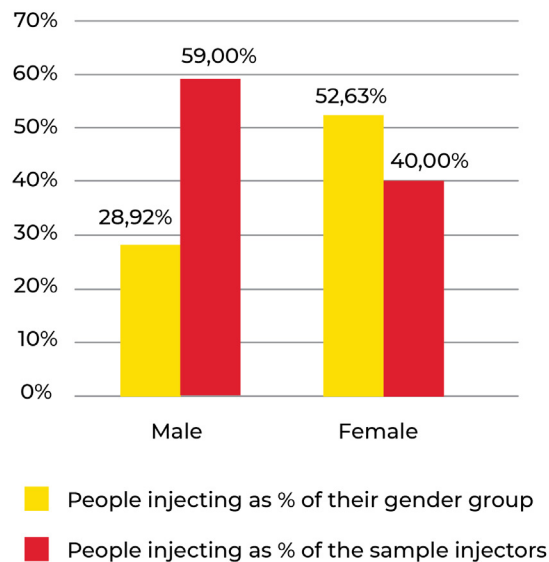
⁴⁰ Two participants reported not remembering when they started using drugs, and therefore it was not possible to calculate for how long they have been using.

Most participants who injected substances came from the provinces of Harare and Mashonaland Central. The higher representation of this population in those two provinces may be linked to the research mobilisation strategy; since these were the last two provinces to start fieldwork, the research team got more experienced in developing strategies to find those injecting, given that they are usually harder to reach than those not injecting⁴¹.

On average, those injecting did not seem to differ much⁴² from the sample composition of those not injecting in terms of age, ethnicity, or sexual orientation (see table 11). A difference, however, can be seen in terms of gender: although in absolute terms more men reported injecting in comparison to women, proportionally more women reported to have ever injected in comparison to men. Over half of the female sample (53.25%) declared to have injected, while for male sample about a third (28.23%) declared to have injected (see figure 6).

Figure 6: gender and drug injection

Gender and drug injection



⁴¹ Nonetheless, further research with larger samples would be needed to confirm this hypothesis.

⁴² The current research did not allow for statistical significance calculations.

Table 11: Age, ethnicity, gender and sexual orientation of people who inject drugs and those not injecting

	Injecting	Not injecting	Total sample
N participants	100	193	293
Province			
Bulawayo	6	47	53
Harare	34	27	61
Manicaland	14	47	61
Mashonaland Central	28	31	59
Mashonaland West	18	41	59
Age			
Average age	30,20	31,29	30,92
Median	29	31	30
Youngest	19	18	18
Oldest	63	59	63
Ethnicity			
African-Black	96,00%	96,89%	96,59%
Mixed Race	3,00%	3,11%	3,07%
Other	1,00%	0,00%	0,34%
Gender			
Cis-male	59,00%	75,13%	69,62%
Cis-female	40,00%	18,65%	25,94%
Trans-male	1,00%	2,07%	1,71%
Trans-female	0,00%	2,07%	1,37%
Other	0,00%	2,07%	1,37%
Sexual orientation			
Heterosexual	91,00%	82,38%	85,32%
Gay	4,00%	8,29%	6,83%
Lesbian	0,00%	2,59%	1,71%
Bi-sexual	5,00%	5,18%	5,12%
Other	0,00%	1,55%	1,02%

In terms of education, less participants who inject drugs seem to have completed secondary school as compared to those not injecting. The first group also seems to be more often single or divorced and less often staying in their parent's house, but more often having their own house or staying with relatives or friends in comparison to those not injecting (see table 12).

Table 12: Education, marital status, housing of people who inject drugs and those not injecting

	Injecting	Not injecting	Total sample
N participants	100	193	293
Education			
No education	3,00 %	0,00 %	1,02 %
Incomplete primary	2,00 %	4,66 %	3,75 %
Completed primary	32,00 %	19,17 %	23,55 %
Completed secondary	40,00 %	51,81 %	47,78 %
Completed high school	11,00 %	10,36 %	10,58 %
Completed tertiary (vocational/technical)	4,00 %	6,22 %	5,46 %
Completed tertiary (university)	8,00 %	7,77 %	7,85 %
Marital Status			
Single; never married	35,00 %	47,67 %	43,34 %
Legally married	3,00 %	2,07 %	2,39 %
Traditionally married	9,00 %	19,69 %	16,04 %
Cohabiting	12,00 %	6,74 %	8,53 %
Divorced, separated	40,00 %	21,76 %	27,99 %
Widowed	0,00 %	1,55 %	1,02 %
Other	1,00 %	0,52 %	0,68 %
Mostly stayed at			
Parent's house	36,00 %	53,89 %	47,78 %
Own house	47,00 %	31,61 %	36,86 %
Spouse or steady partner's house	0,00 %	2,07 %	1,37 %
Relative's or friend's house	14,00 %	9,33 %	10,92 %
Shelter, welfare residence	1,00 %	0,52 %	0,68 %
Care or health institution (hospital, treatment centre, etc)	0,00 %	0,00 %	0,00 %
Streets or abandoned building (homeless)	1,00 %	1,55 %	1,37 %
Other	1,00 %	1,04 %	1,02 %

Participants injecting substances more often earn money than those who don't inject; 11.40% of those not injecting reported not to be earning any money, compared to only 3.00% of those who inject. Respondents who are injecting also more often mention sex work as their main source of income in comparison to those not injecting; one third (33.00%) of those injecting receive most of their income from sex work against 6.74% of those who are not injecting drugs (see table 13).

Table 13: Sources of income of people who inject drugs and those not injecting

	Injecting	Not injecting	Total Sample
N participants	100	193	293
Source of income			
Not earning any money	3,00 %	11,40 %	8,53 %
Steady wage/salary from a legal job	11,00 %	10,36 %	10,58 %
Own business/self-employed	21,00 %	26,94 %	24,91 %
Occasional/odd jobs on the street	42,00 %	46,11 %	44,71 %
Money from family/partner/friends	12,00 %	13,99 %	13,31 %
Begging	1,00 %	1,04 %	1,02 %
Selling drugs	8,00 %	6,74 %	7,17 %
Theft/pickpocketing	0,00 %	1,55 %	1,02 %
Sex work	33,00 %	6,74 %	15,70 %
Transactional sex	4,00 %	4,15 %	4,10 %
Blesser(s)/sugar daddy/daddies	3,00 %	2,59 %	2,73 %
Prefer not to say	0,00 %	1,04 %	0,68 %
Other	1,00 %	1,04 %	1,02 %

People injecting substances are also more often harassed by the police - 24.00% against 11.92% - and also are more often arrested - 13.00% against 8.29% - in comparison with those not injecting (see table 14).

Table 14: Law enforcement encounters of people who inject drugs and those not injecting

	Injecting	Not injecting	Total Sample
N participants	100	193	293
Law enforcement encounters			
No	40,00 %	55,96 %	50,51 %
Yes, police have helped/supported me	6,00 %	8,29 %	7,51 %
Yes, I was stopped by the police, without further actions or consequences	9,00 %	6,22 %	7,17 %
Yes, I was harassed by the police	24,00 %	11,92 %	16,04 %
Yes, I was arrested by the police	13,00 %	8,29 %	9,90 %
Yes, I was taken into custody (not convicted)	19,00 %	16,06 %	17,06 %
Yes, I was in prison (convicted)	0,00 %	1,04 %	0,68 %

In terms of drug use in the past month, those injecting drugs seem to be using proportionally more pharmaceuticals, crystal meth, and heroin when compared to those not injecting (see table 15). While among people who do not inject drugs 2.59% declared to be using pharmaceuticals, among those injecting the percentage was more than ten times higher, rising to 32.00%. Regarding crystal meth, while over a quarter (27.98%) of those not injecting used this substance, among those injecting almost half (47.00%) of the sample reported using it. Worth mentioning is that, as already described in paragraph 3.3, pharmaceuticals and crystal meth are the top two substances being injected in our survey sample.

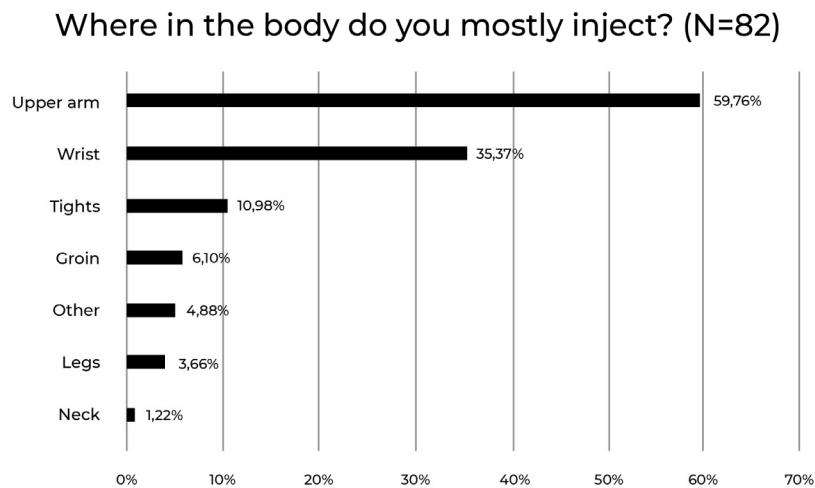
Table 15: Drug use in the past month - people who injecting drugs and those not injecting

	Bulawayo	Harare	Total sample
N participants	100	193	293
Drugs used past month			
Cannabis (mbanje, ganja)	57,00 %	66,32 %	67,92 %
Legal alcohol	42,00 %	61,14 %	61,43 %
Cough syrup	41,00 %	30,57 %	48,12 %
Skunk	41,00 %	40,41 %	43,34 %
Crystal meth (mutoriro, guka)	47,00 %	27,98 %	36,52 %
Illegal alcohol (musombodia, kachasu, tumbwa)	34,00 %	28,50 %	31,40 %
Pharmaceuticals	32,00 %	2,59 %	18,43 %
Powder cocaine	4,00 %	2,07 %	6,14 %
Crack cocaine (rock)	7,00 %	1,55 %	5,12 %
Glue	1,00 %	2,07 %	4,44 %
Heroin	6,00 %	0,52 %	4,10 %
Sodium polyacrylate (from diapers)	0,00 %	0,52 %	1,37 %
Nyaope (Whoonga)	2,00 %	0,00 %	1,37 %
Others	22,00 %	9,33 %	10,58 %
Unknown substance	4,00 %	0,52 %	3,41 %

For those injecting in the past 6 months (N=82), 93.90% reported injecting less than once a day. The 6.10% (N=5) who injected more than once a day, did so 1,6 times a day on average. 68.29% of those injecting in the past six months declared not having suffered from abscesses or wounds caused by injecting during this time. Nonetheless, 31.71% did suffer from them.

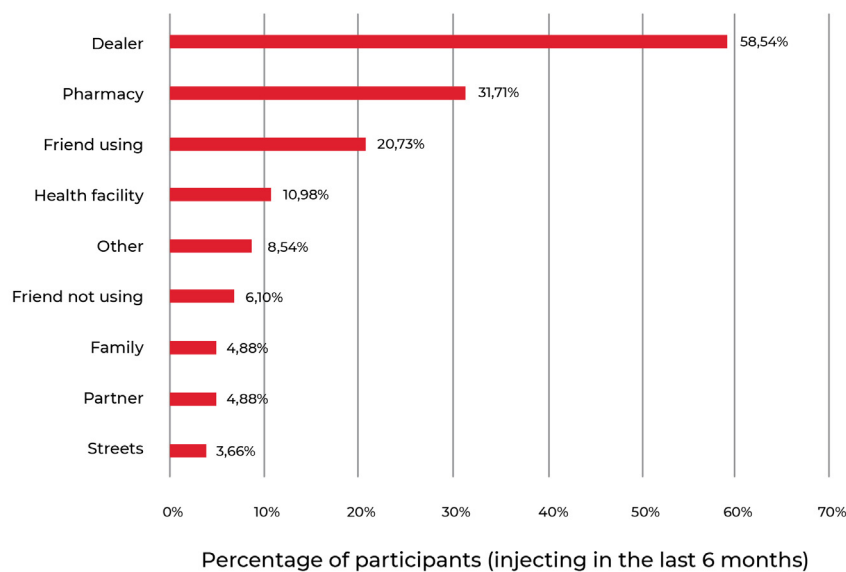
Figure 7 shows the places in the body where participants mostly inject (for those injecting in the past 6 months). Upper arm (59.76%) and wrist (35.37%) were the most popular areas of injection; thighs (10.98%), groin (6.1%) and legs (3.66%) followed. For participants mentioning "others" (4.88%), they referred to injecting in the buttocks. Thus, while the upper arm - a relatively safe spot - is the preferred spot of injection for more than half of the respondents in the survey sample, several (also) inject in body parts that are less safe (legs), or unsafe (wrist, thigh, groin and neck).

Figure 7: Places of injection in the body



Survey participants were also asked to select from a predefined list all the different sources from which they had acquired (needles and) syringes in the past month (multiple answers were possible, see figure 8). 58.54% of participants reported to have acquired at least some of their syringes from their drug dealers. Around a third (31.71%) (also) acquired syringes from pharmacies, while 20.73% got them from friends who use drugs. Health facilities (10.98%), non-drug using friends (6.10%), family and partners (4.88% each), or the streets (3.66%) were other mentioned sources.

Figure 8: All sources for acquiring syringes in the past month



When asked about the main source for acquiring syringes in the past month, proportions varied slightly (see figure 9). Half of the participants who injected drugs predominantly acquired their syringes from their drug dealers (50.00%). For 20.73%, pharmacies were the main source for acquiring syringes. Only 2.44% mentioned health facilities as their main source for acquiring syringes.

Figure 9: Main sources for acquiring syringes in the past month

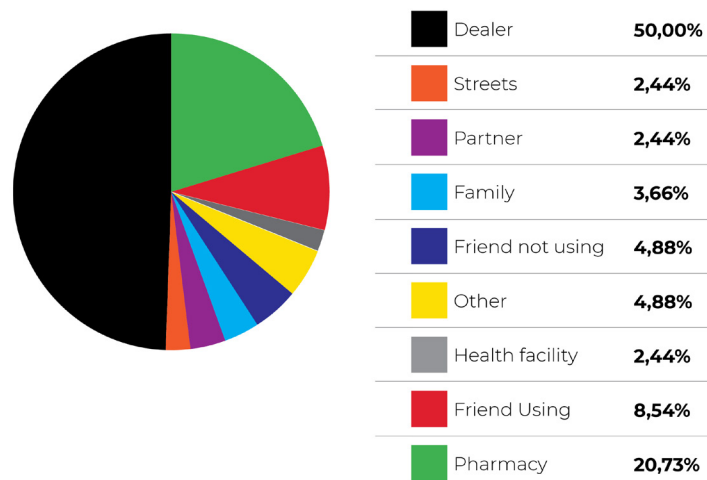
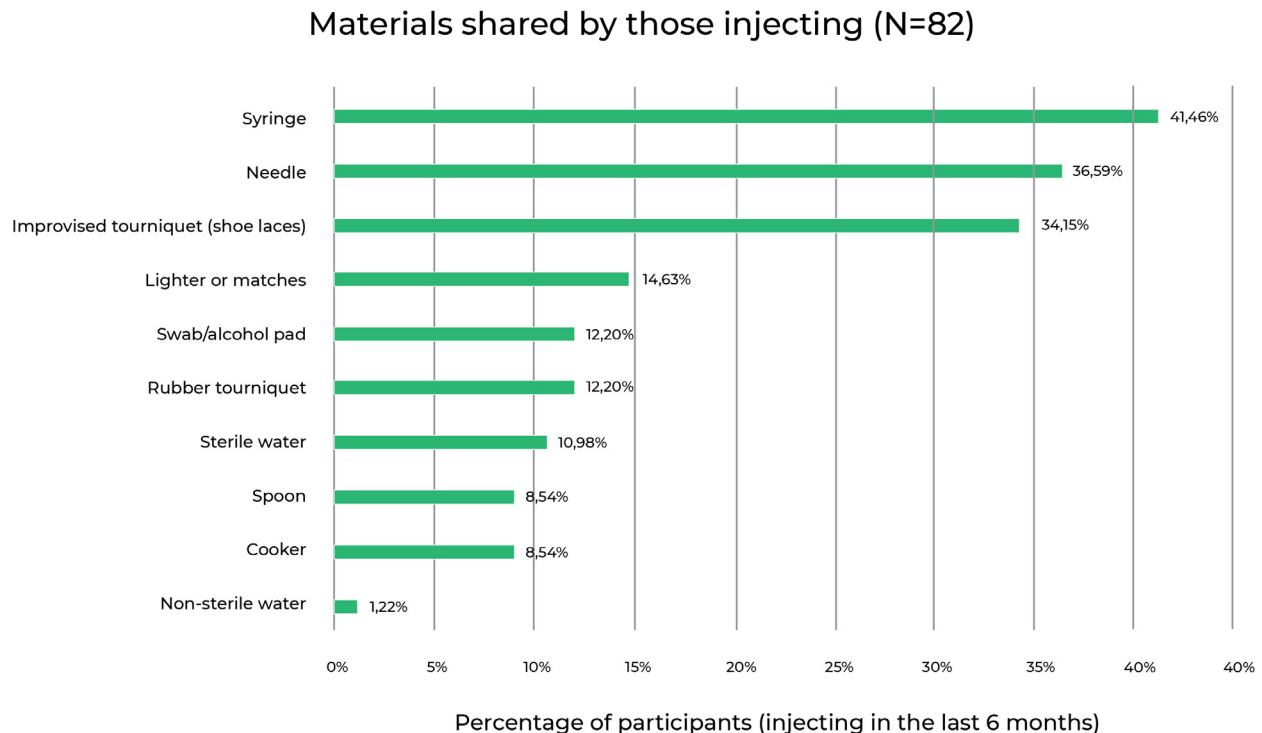


Figure 10 shows the proportions of those who reported sharing injection materials against the population who had injected in the past six months (N=82). Syringes (41.46%) and needles (36.59%) were the materials that were shared most often. FGD participants confirmed that sharing injection equipment is common, even though the risks to HIV transmission are known. Respondents said syringes and needles are often shared between two to four people. The decision whether or not to share equipment mostly depends on (family or friendship) bonds or on physical appearance ("if you don't look fit, you find your own syringe"). Some FGD participants stated that sharing injection equipment is more prevalent in so-called "ghetto" bases, where access to sterile equipment may be limited, while in "uptown" bases people are said to usually have their own gear. Respondents explained (ineffective) methods to reduce the risks of sharing, such as waiting eight minutes to use a syringe that has already been used by someone else, or burning a used needle with a lighter to sterilise it.

Many key informants mentioned bluetoothing, a practice whereby blood is taken from someone who has just injected, and then is being injected in another person, in the hope they will receive a small amount of the substance the other person just injected. A few FGD participants mentioned it when discussing other topics, with one of them stating the practice is not as widespread as it used to be. Based on the data collected in this research, no conclusions can be drawn on this phenomenon.

Figure 10: Sharing of injection materials

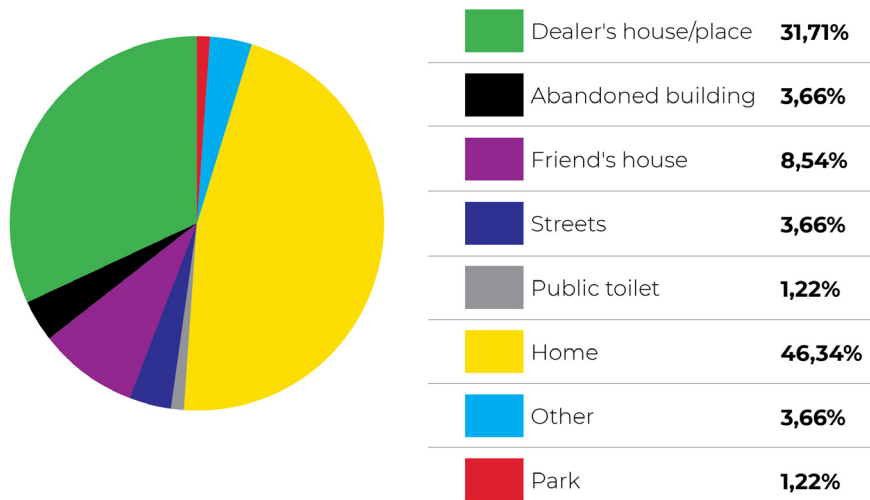


Participants were also asked about where they were the last time they injected their drugs. The vast majority declared to have injected indoors and in private spaces; most common places were their homes (46.34%; N=38) or the house of their drug dealers (31.71%; N=26), with fewer participants mentioning having injected in the house of their friends or relatives (8.54%; N=7). Figure 11 shows all the places of the most recent injection that were mentioned, proportional to the number of people who have injected in the past six months (N=82). Places mentioned in the category "others" were toilets in stadiums or bars.

In FGDs participants explained most drugs are taken (whether injected or administered in another way) in secluded places to hide from police, family members and the wider community. While hiding from the police was considered important to avoid arrest, raids and harassment, hiding from relatives or others was motivated by a variety of reasons, such as protecting others (especially own children should not be exposed to drugs, according to respondents), shame, fear of being judged and the opportunity to be at ease while and after consuming drugs. Some respondents stated they prefer using alone, for reasons of privacy ("we inject in our private parts"), costs ("when you have bronco these days you use it at home so that you don't share with a lot of people") or the effect of the drug ("crystal meth is best taken when there are no people around"). Respondents said they are aware using alone comes with a risk of not having help around in case of overdose or other problems.

For the majority of the FGDs participants hygiene was not a matter of concern when using drugs; they explained that the bases where they normally use are neither clean, nor ventilated, are often without the availability of clean water and may even be used as toilets at the same time.

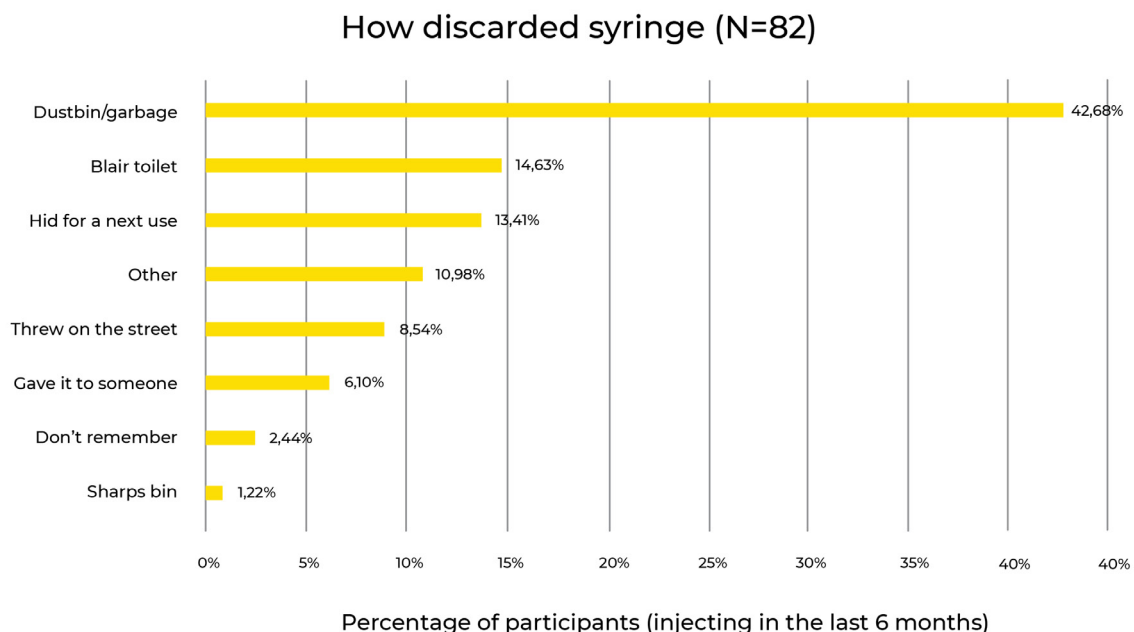
Figure 11: Places of latest injection



When it comes to discarding syringes, it is clear that there is a lack of options to safely discard used injection equipment (see figure 12). When asked what they did with their syringes the last time they had injected - choosing from a list - only one person mentioned having discarded syringes in sharps bins. Instead, most syringes (and needles) were discarded in dustbins (42.68%; N=35), in toilets (14.63%; N= 12) or in the streets (8.54%; N=7). As part of the 'other' option (10.98%), participants mentioned burying their used syringes or throwing them into the sewerage.

Several participants mentioned hiding their syringe for a next use (13.41%; N=11) or giving it to someone else (6.1%; N=5), indicating re-use and sharing of syringes. Also in the FGDs there were strong indications people keep their syringes for a next use, either on themselves, at home, or in communal spaces, like the "base", where they consume their drugs. In the latter case this entails a risk of someone else using the syringe, without the owner being aware of this - added to the risk of wounds, abscesses or vein damage by re-using one's own syringe and needle.

Figure 12: How/where participants discarded their syringe at latest injection



3.6 Other issues related to drug use

A high number of respondents (74.74%; N=219) reported having experienced (multiple) overdoses. 39.27% (N=86) stated having experienced an overdose 6 or more times and 50.51% (N=148) mentioned having seen other people overdosing 11 times or more (see table 16). Given the type of drugs mostly used by the population, this was unexpected. A closer look into the qualitative data showed that people who use drugs in the research sample understood overdose as taking a dosage which makes one lose control. Thus, although this data cannot be used to describe current risks and occurrences of an overdose in the medical sense, it does demonstrate that people may be taking high doses, and bingeing can be a point of concern.

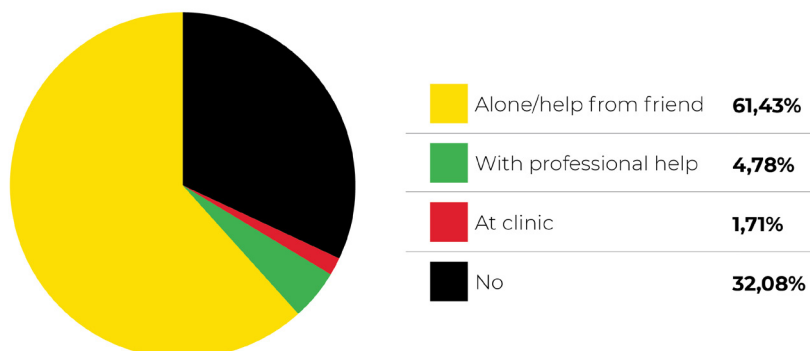
Table 16: Reported experiences with 'overdose' (bingeing)

Ever experienced an "overdose"		
Yes	219	74,74 %
No	74	25,26 %
How many times experienced an "overdose"		
1 time	44	20,09 %
2 times	38	17,35 %
3-5 times	49	22,37 %
6 or more times	86	39,27 %
Not sure	2	0,91 %
How many times saw others having an "overdose"		
1-2 times	36	12,29 %
3-5 times	41	13,99 %
6-10 times	47	16,04 %
11 or more times	148	50,51 %
Not sure	4	1,37 %
Never	17	5,80 %

Two thirds (67.92%) of the survey respondents reported having tried to quit drug use; 61.43% have done so without professional help, either alone or with the help from friends and relatives (see figure 13).

Figure 13: Attempts to quit drugs

Have you ever tried to quit drugs?



In FGDs respondents stated there is a clear distinction and therefore a separation between people who inject drugs and those not injecting. Since the drugs that are injected are generally more expensive, people who inject are generally (considered) richer. FGD participants also said there is a demarcation between those who use crystal meth and others who use cannabis; while the latter are considered more “stable” and more keen on socialising, people using crystal meth are said to stick to themselves, be easily agitated and more prone to hallucinations (kutsomwa).

3.7 Sexual behaviour and condom use

93.17% (N=273) of survey participants reported to have been sexually active in the past 6 months and 52.90% (N=155) declared to have had sex with more than one person during this time (see figure 14). For 45.79% (N=125) of those being sexually active in the past 6 months, sexual partners were not people who use drugs (figure 15).

Figure 14: Sexual activity in the past 6 months

Did you have sex in the past 6 months?

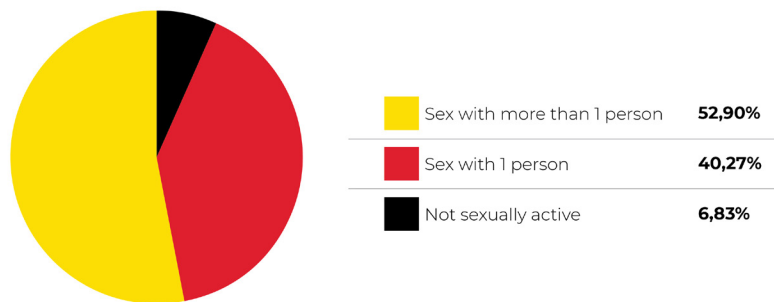
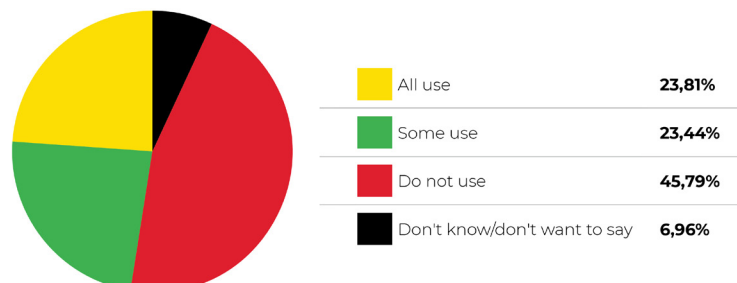


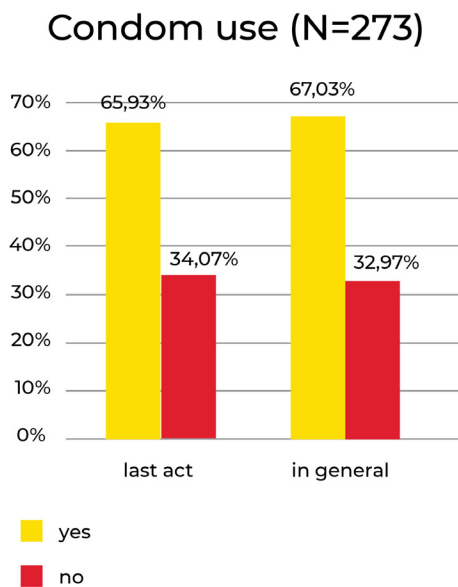
Figure 15: Drug use of sexual partners

Is/are the person(s) you had sex with in the past six months also using drugs? (N=273)



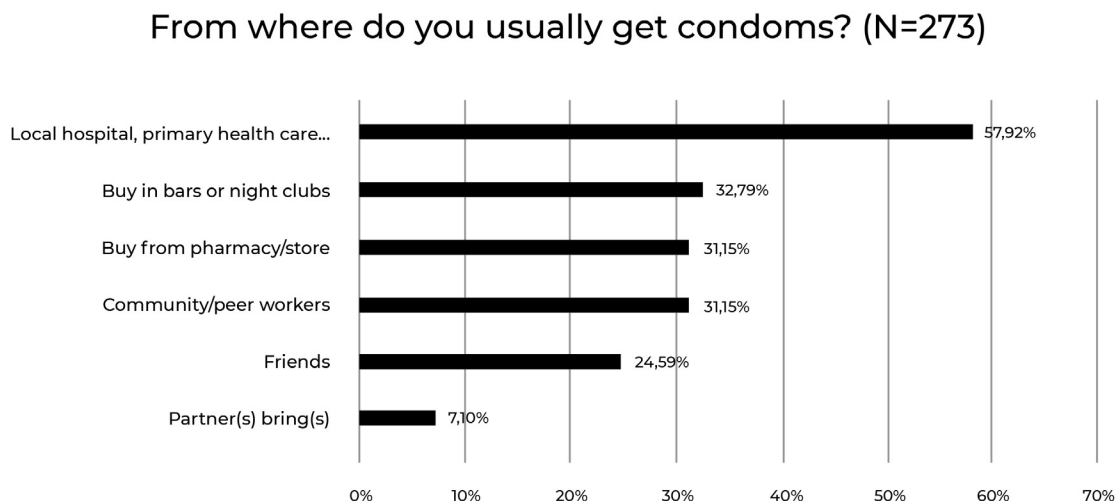
34.07% (N=93) of those having had sex in the past six months reported not to have used condoms in their latest sexual act and 32.97% (N=90) stated not to use condoms in general (see figure 16). Of those not using condoms, 28.89% (N=26) think that condoms are not needed because, in their perception, there is no risk. Almost half (47.78%, N=43) of those not using condoms said they don't use them because of trusting their partner or having a steady/frequent partner. Fewer (13.33%; N=12) mentioned not using them because their partners do not like it, or because they do not like it (11.11%; N=10), while others did not find it important to use condoms (12.22%; N=11). No one mentioned not being able to afford condoms, not knowing where to buy, or being ashamed of buying condoms as a reason why they do not use them.

Figure 16: Condom use



When using condoms, most participants said they get them for free at primary health care centres, public HIV clinics, or hospitals (57.92%) or from community or peer workers (31.15%). About a third (32.79%) mentioned (also) buying them in bars or nightclubs and also a third (31.15%) reported buying condoms from pharmacies or stores (see figure 17).

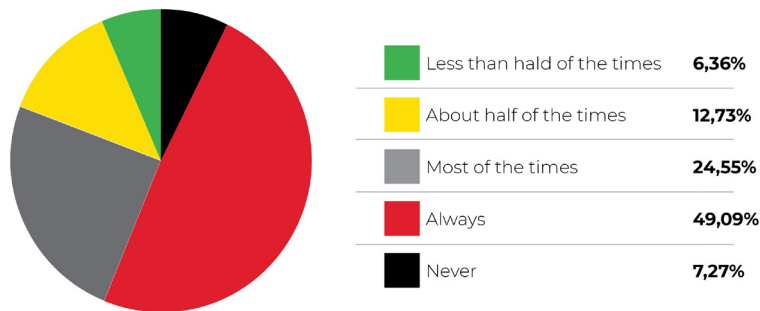
Figure 17: Sources for acquiring condoms



A fairly high number of participants (40.29% of those sexually active; N=110) declared to have engaged in transactional sex in the past six months, defined as either sex work or exchanging sex for money or for goods (including substances). From those, half (49.09%; N=5) reported they always use condoms in transactional sex.

Figure 18: Condom use in transactional sex

If you have engaged in transactional sex, did you use a condom? (N=110)



From FGDs and key informant interviews (KIIs) indications arose of various links between drug use and sex (work). Most FGD respondents agreed drugs tend to increase their sex drive. Respondents who sell sex mentioned they need drugs to be able to do their work; it gives them more confidence to approach clients, keeps them "calm and alert at the same time" and can even help them enjoying their work. There are also indications drug use may go hand in hand with an increase in unprotected sex and sex with multiple partners.

From the survey participants engaging in transactional sex in the past six months (N=110), 25.45% had suffered from some form of sexual violence, being forced into having either penetrative sex or oral sex (see figure 19). About a third (30.91%) of those engaging in transactional sex have had anal sex (see figure 20).

Figure 19: Sexual violence among respondents engaging in transactional sex

Sexual violence (N=110)

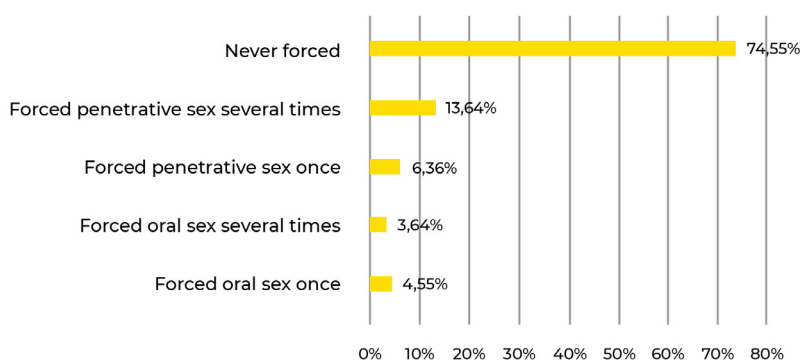
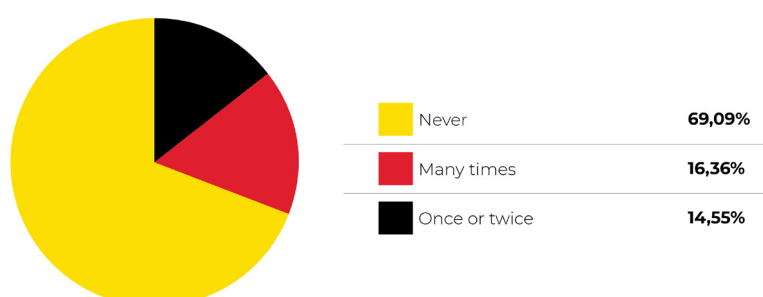


Figure 20: Anal sex among respondents engaging in transactional sex

Have you ever had anal sex? (N=110)



3.8 Knowledge of HIV, TB and HCV

When investigating the knowledge of respondents on the modes of HIV transmission, almost all survey participants (90.78%) correctly answered that HIV can be transmitted through unprotected penetrative sex. However, all the other modes of transmission are much less known; 60.07% confirmed HIV can be transmitted through sharing materials for injecting drugs, while less than half (44.71%) of all respondents recognised HIV can be transmitted from mother to child during pregnancy or birth. Even fewer respondents acknowledged unprotected anal sex (35.84%) or unprotected penetrative sex if the man withdraws before ejaculating (21.84%) are risk factors for HIV-transmission. On the other hand, some respondents think HIV can be transmitted by kissing (10.92%) or through penetrative sex with a condom (4.44%).

Table 17: Knowledge of the modes of HIV transmission

HIV Transmission - Correct Answers	N	%
Through unprotected penetrative sex	266	90,78 %
By sharing materials for injecting drugs	176	60,07 %
By re-using razor blades by traditional healers	155	52,90 %
By re-using non-sterilised medical equipment in hospitals or clinics	154	52,56 %
By sharing materials for tattooing	138	47,10 %
From mother to child during pregnancy or birth	131	44,71 %
Through unprotected anal sex	105	35,84 %
Through unprotected oral sex	91	31,06 %
From mother to child during breastfeeding	83	28,33 %
Through unprotected penetrative sex, if the man withdraws before ejaculating	64	21,84 %
By fighting with somebody until bleeding	38	12,97 %
HIV Transmission - Incorrect answers	N	%
Through kissing	32	10,92 %
Through penetrative sex with a condom	13	4,44 %
By sharing materials for smoking or snorting drugs	10	3,41 %
By mosquitos	7	2,39 %
From mother to child during bathing	3	1,02 %
By sharing materials for eating, drinking or cooking	3	1,02 %
By shaking hands, touching or hugging someone	2	0,68 %
None of the above	2	0,68 %
By sharing toilets	1	0,34 %
By spitting on somebody	1	0,34 %

On TB transmission (table 18), most respondents were able to identify coughing or sneezing (77.13%) as a mode of transmission, but singing or speaking were less recognised (31.74%). Besides, more than a third of the total respondents thought that TB is transmitted through kissing (37.54%) or by sharing tools for brushing teeth (32.42%). Slightly less than a third (26.62%) also thought TB can be transmitted by spitting on someone.

Table 18: Knowledge of the modes of TB transmission⁴³

HIV Transmission - Correct Answers	N	%
Through the air when coughing or sneezing	226	77,13 %
By smoking	187	63,82 %
Through the air when singing or speaking	93	31,74 %
HIV Transmission - Incorrect answers	N	%
Through kissing	110	37,54 %
By sharing tool for brushing teeth	95	32,42 %
By spitting on somebody	78	26,62 %
By sharing materials for using drugs	69	23,55 %
By sharing materials for eating, drinking or cooking	63	21,50 %
By reusing non-sterilised medical equipment in hospitals or clinics or by traditional healers	52	17,75 %
By sharing clothes or bed sheets	49	16,72 %
By shaking hands, touching or hugging someone	25	8,53 %
From mother to child during pregnancy or birth	24	8,19 %
By spending time in cold air	19	6,48 %
By sharing toilets	18	6,14 %
Through unprotected sex	18	6,14%
None of the above	10	3,41 %
By mosquitos	3	1,02 %

⁴³ https://www.cdc.gov/tb/publications/pamphlets/tb_disease_en_rev.pdf

It is worrying that 89.42% (N=262) of the survey respondents stated not knowing what viral hepatitis C (HCV) is. Moreover, from the mere 10.58% (N=31) reporting to know what HCV is, less than half correctly recognized the modes of transmission (see table 19)⁴⁴. FGDs confirmed the widespread lack of knowledge around HCV.

Table 19: Knowledge of the modes of HCV transmission (N=31)

HIV Transmission - Correct Answers	N	%
Through unprotected sex	14	45,16 %
By re-using razor blades by traditional healers	12	38,71 %
By sharing materials for injecting drugs	11	35,48 %
By reusing medical equipment in hospitals or clinics	11	35,48 %
From mother to child during pregnancy or birth	5	16,13 %
By sharing materials for tattooing	6	19,35 %
By sharing materials for smoking drugs	5	16,13 %
By sharing materials for snorting drugs	4	12,90 %
HIV Transmission - Incorrect answers	N	%
None of the above	6	19,35 %
By spitting on somebody	2	6,45 %
By sharing toilets	1	3,23 %
Through kissing	1	3,23 %
From mother to child during breastfeeding	1	3,23 %

3.9 Access to and use of HIV services

92.49% (N=271) of the survey sample had ever tested for HIV and this was consistent across the 5 provinces, with the lowest being 86.89% in Harare Province (see table 20). However, it could not be verified when the most recent test had been for participants. From those who got tested for HIV, 20.30% (N=55) reported that their results were positive⁴⁵ (figure 21) and 96.36% (N=53) of those had enrolled for ART. The two participants with a positive HIV test and not on ART mentioned as reasons not knowing where to go for treatment or being afraid they would not be well received at the treatment centre; both also did not consider it important to enrol in ART. Of those on ART, 84.91% (N=45) reported they were adhering to their treatment; the other 15.09% (N=8) were intermittently interrupting their treatment. Nobody reported not to be on ART (see figure 22)⁴⁶.

Table 20: HIV testing in the different provinces and total sample

HIV testing	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
Yes	96,23 %	86,89 %	88,52 %	94,92 %	98,28 %	92,49 %
No	3,77 %	11,48 %	11,48 %	5,08 %	3,45 %	7,51 %
N	53	61	61	59	59	293

⁴⁴ <https://www.who.int/news-room/fact-sheets/detail/hepatitis-c>

⁴⁵ It would have been interesting to disaggregate the positive HIV-test results for gender for route of administration (injecting versus non-injecting), but the number (N=55) is too low to allow drawing any conclusions from them that would have statistical value.

⁴⁶ It should be considered that respondents may prefer to say they are "on and off treatment", rather than saying they have completely dropped out.

Figure 21: HIV test results

Would you like to share the result of your last HIV test with us? (N=271)

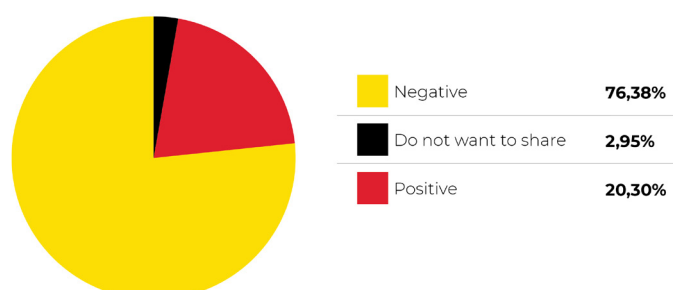
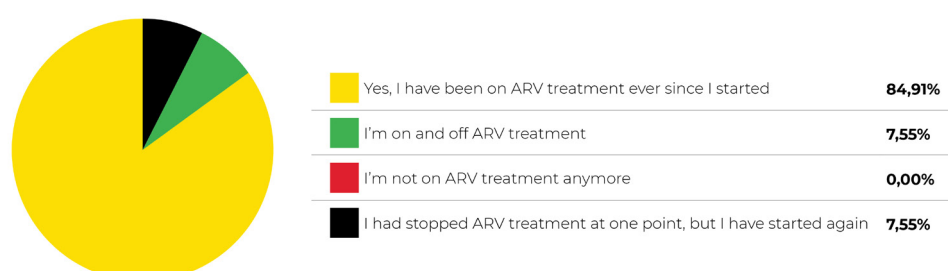


Figure 22: ART adherence among those testing positive for HIV

In case you have tested positive for HIV, have you enrolled in ART? (N=53)



3.10 Access to and use of TB services

70.31% (N=206) of the research sample had never tested for TB and this was consistent for all the provinces. Harare reported the highest rate of TB testing: 36.07% (see table 21). For those who never tested for TB, their most mentioned reason for not testing was not considering it important / not seeing a reason to test (86.21%), while 57.47% stated there was no particular reason for not testing for TB (see table 22). Also participants of the FGDs displayed a general unwillingness to test for TB, and explained that this was due to the stigma associated with TB and with TB treatment. Of those survey participants who did have a TB test (N=87), 16.09% (N=14) reported a positive TB test result (see figure 23). All who reported positive test results said they enrolled in TB treatment and none had defaulted at the time of the study; 12 (85.71%) respondents stated they had been cured, while two (14.29%) were still on treatment (see figure 24).

Table 21: TB testing per province and total sample

TB Testing	Bulawayo	Harare	Manicaland	Mashonaland Central	Mashonaland West	Total Sample
Yes	24,53 %	36,07 %	26,23 %	26,23 %	25,42 %	29,69 %
No	75,47 %	63,93 %	73,77 %	73,77 %	74,58 %	70,31 %
N	53	61	61	59	59	293

Table 22: Reasons for not testing for TB

Reasons for not testing for TB	N	%
I don't consider it important (no need to test)	75	86,21 %
I don't know/no reason	50	57,47 %
Other	37	42,53 %
I don't know where to go for testing	23	26,44 %
Testing is not accessible or available near me or at times that are convenient to me	18	20,69 %
I don't want to get tested	15	17,24 %
I had never heard of TB or I don't know what this is	14	16,09 %
Fear of the results	11	12,64 %
I don't feel welcomed or I feel stigmatised at testing sites	7	8,05 %
I don't want to be seen at a testing site/fear for stigma by community or family	6	6,90 %

Figure 23: TB test results

TB test results (N=87)

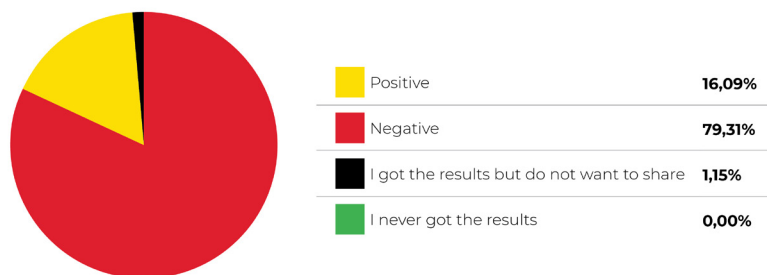


Figure 24: TB adherence among those testing positive for TB

TB treatment adherence (N=14)



3.11 Access to and use of other health services

Participants were presented with a range of other health services (see table 23) and asked if they had accessed any of those in the past six months. 48.12% reported having accessed Covid-19 testing or treatment, 28.67% went for testing or treatment for sexually transmitted infections in the past six months and 17.06% had used family planning or contraceptive services. Moreover, almost all of those injecting who reported having suffered from abscesses (32 participants), had accessed wound dressing (29 participants). On the other hand, participants mentioned stress as a reason to use drugs, but only 8.19% of the survey sample reported having visited psychosocial services. Use of psychiatric treatment is also very low (1.37%); as mentioned earlier, most people who ever tried to quit drugs, did so outside of drug treatment spaces.

Table 23: Health services accessed in the past six months

Health Services Accessed	N	%
Covid-19 testing or treatment	141	48,12 %
Testing or treatment for sexually transmitted infections	84	28,67 %
Other	68	23,21 %
Family planning or contraceptive services	50	17,06 %
Drug treatment (hospital/clinic)	35	11,95 %
Wound dressing (including abscesses)	29	9,90 %
Psychosocial counseling (mental health)	24	8,19 %
Malaria testing or treatment	21	7,17 %
Drug treatment (faith/based/traditional healer/herbs)	8	2,73 %
Psychiatric treatment (medicated)	4	1,37 %
Hepatitis B testing or treatment	2	0,68 %
Hepatitis B vaccination	2	0,68 %
Post (gender-based) violence treatment	2	0,68 %

FGD participants lamented the lack of services targeting people who use drugs, more so since specific community-based services are available for members of the LGBTIQ+ communities and for sex workers. Key informants also elaborated on the lack of services targeting people who use drugs. The only places mentioned were a few private rehabilitation clinics, a faith-based counselling service and the public mental health hospitals in the country. Besides the fact that all of them focus on abstinence from drugs, most respondents agreed that mental health hospitals are currently not equipped to provide evidence-based drug treatment.

3.12 Barriers and facilitators of uptake of HIV, TB and other health services

Despite the fairly high numbers of survey respondents accessing HIV testing and treatment services, participants of the FGDs were rather critical when it came to accessing such services. Some of the respondents highlighted that people who use drugs are not accessing and using services due to the fear of stigma and discrimination from staff. In addition, people who use drugs enter services as general citizens, not disclosing their drug use, hence there are no targeted services and medication that address their specific needs. When asked about their experiences in using health services, they mentioned judgemental attitudes, a lack of confidentiality, and care by health staff due to lack of capacity to address the needs of people who use drugs. The respondents also mentioned that at present health staff and other service providers are not trained to handle people who use drugs as clients. In addition, some of the participants in the FGD alluded to their poor health seeking behaviours which affects their access to services.

Key informants from government and civil society institutions were also asked their opinion on access to health services for people who use drugs. Most of them stated that HIV and other health services are available and that people who use drugs should or could have access to those services. However, all key informants agreed that people who use drugs are not “seen” accessing the services, partially because they do not access services, and also because those who do use them, do not disclose their drug use. In line with what was heard in the FGDs, several key informants noted that the health system is implementing a “public health approach” or a “one-size-fits-all approach”, without differentiation for specific key populations. “Hence specific needs are not being addressed.”

Key informants from civil society were most critical about healthcare facilities, talking about user fees, a lack of confidentiality⁴⁷, stereotypes, prejudices, stigma, judgemental attitudes, shaming and discrimination. Some said people who use drugs are “looked down upon” and “ridiculed” when coming for ART, especially the women. Others said staff is “not ready” to serve people who use or inject drugs. Two of the government representatives also mentioned “stereotypes and attitudes”, “stigma associated with injecting”, “discrimination”, “shame” and “fear of not being accepted” as barriers for people who use drugs to access healthcare services; another one said “we don’t know how to handle them”.

This resonates with the notion of some key informants that people who use drugs are said to be “unfriendly” and don’t want to use services, possibly linked to the “brutal nature” of drugs that would “impair the psychosocial functioning” of the people taking them. Linked to this, there was some level of agreement that people who use drugs may have a low risk perception and are not aware of health risks or health services. However, almost half of the informants also stated that “the criminalised environment in Zimbabwe”, and the risk of being arrested are serious barriers to access healthcare services, or to disclose drug use when such services are being accessed.

People who use drugs partaking in the FGD specifically discussed mental health services and how they have experienced those over the years. According to FGD participants, mental health services are generally not available and where they are available they are provided by private facilities and the cost is out of reach for most of them. In the few cases where mental health services are provided in public institutions they are considered to be poorly administered and lacking confidentiality. As noted earlier, people who use drugs highlighted that staff from public health care settings are not able to provide a safe and comfortable space for most people using drugs. Such attitudes are further pushing them away from the mental health services in public health facilities. Also of importance was the fact that for most FGD participants the fear of detention in a psychiatric hospital for drug related illness negatively affected their decision to seek help.

FGD participants stated that COVID-19 lockdowns also restricted access to health services, through limited transport options and increased transport costs. In some areas though, civil society organisations decentralised their services, which made it easier to access them.

⁴⁷ Due to the way facilities are designed; “all patients are in big, central waiting rooms, from where they are called to line up for specific services, such as ART. Besides, the doors of the cabinets indicate which service is provided inside, disclosing the status of the patient” as one informant put it.

3.13 Strengthening the national HIV and TB responses for people who use drugs

Key informants were asked if people who use drugs should be prioritised in the national HIV and TB responses. Practically all of them agreed they should be, because of the public health threat and the evidence at global level that drug use contributes to HIV transmission. However, when asked if HIV should be a priority when dealing with people who use drugs, the opinions were more diverse. Several informants⁴⁸ stated that HIV is one of many priorities when dealing with people who use drugs and that it needs to be linked to other issues such as mental health, gender-based violence, rehabilitation, the root causes of drug use and broader public health. Among civil society representatives there was a consensus that drug use is a societal issue; rather than singling out HIV and TB programming, they stated that a multisectoral approach is needed to deal with drug use. Six out of the sixteen key informants alluded to the fact that HIV & TB programmes for people who use drugs should be mainstreamed into other programmes. Respondents said the approach should be multi-sectoral and people-centred and suggested integrating them in existing HIV programming for other key populations; “we have to take an intersectional approach, making sure the HIV prevention toolkit is complete by adding harm reduction services. The minimum service package for HIV prevention for key populations needs to be tailored to the needs of people who use drugs and based on evidence.”

Criminalisation of drug use or drug possession came out strongly as an issue that needs to be addressed to strengthen HIV & TB programming for people who use drugs. While four key informants literally mentioned this, five others formulated it in similar ways, stating there is a need to “create an enabling environment” and suggesting policies to be based on evidence, “leaving the policing approach behind.” Two respondents mentioned the need to start implementing the Drug Master Plan, while two others referred to the (review of the) Zimbabwe National HIV and AIDS Strategic Plan, stating it “needs to include drug users”.

Another pressing issue, mentioned by eleven of the sixteen key informants, was around capacity strengthening. According to respondents this should focus on the attitude of health workers towards people who use drugs, formulated as “demystifying drug use”, “being sensitive and confidential”, “becoming drug-user friendly” and “changing the mindset of healthcare providers”. Other suggestions in this area were 1) improving access to prevention technology; 2) training student nurses; 3) strengthen the capacities of civil society; 4) training police; 5) training on drug use, HIV and harm reduction in workplaces; and 6) strengthening referral and reporting systems within the healthcare system.

Half of the key informants explicitly stressed the need for civil society (NGOs, CBOs) to have a role in the national HIV & TB responses. In this regard, three civil society representatives shared their worries on the current legal environment, mentioning the “NGO bill”⁴⁹, that would seriously restrict the freedom of civil society. There was a broad consensus that the government cannot and should not work alone in this area. Also the importance of working with communities of people who use drugs was mentioned. Four informants suggested churches should play a role and four mentioned schools. Three informants pointed to the social responsibilities of the private sector, especially mining and farming companies, where - according to them - a lot of drug consumption takes place, suggesting 1) private-public partnerships; 2) supportive workplace policies; 3) workplace programmes (education, information, training); 4) clinics at the workplace to facilitate access for workers; and 5) bringing interventions to communities.

⁴⁸ This question was added to the topic list halfway through the research, based on answers from some of the informants. Therefore only six key informants answered the question.

⁴⁹ Referring to the Private Voluntary Organizations (PVO) Amendment Bill, H.B. 10, 2021

Strikingly, only one out of the sixteen key informants was able to explain what harm reduction is. Most others were guessing or managed to give a definition they had heard somewhere, without being able to elaborate on what that definition meant. Once interviewers explained the concept, most respondents said harm reduction services are, “important”, or “definitely needed”, though many made reservations, like “won't it look like we're promoting something we don't want?”. Those reactions may have been triggered by the mentioning of needle and syringe programming as part of the package of harm reduction interventions. One informant stated that “giving sterile syringes is like sanitising drug use. You don't want to appear like you're promoting drug use.” Another one saw a more practical challenge; “syringes are considered a medical commodity, so it may not be easy to make them available outside health facilities”. This was contradicted by a third informant, who said “everybody can already purchase syringes from a pharmacy anyway. So that's not controversial”, while a fourth respondent concluded “we want to see the effectiveness of interventions.”

Three key informants advocated for more research, such as a population size estimate, a needs assessment and hotspot mapping, while two respondents stressed the need for evaluation and sharing results once services start being implemented.

4 CONCLUSIONS & RECOMMENDATIONS

4.1 Conclusions

This was a first and exploratory study into drug use and HIV- & TB-related risks and service needs, aiming to provide input for national HIV and TB programming for people who use drugs in Zimbabwe.

The **first sub-objective** of the study was to **identify patterns of drug use and injection**, including types of drugs used, types of drugs injected, polydrug use, extent of harms experienced by the users, and numbers of women and minors who use drugs. The study found that the most commonly used substances by research participants were cannabis (including skunk), (legal and illegal) alcohol, cough syrup (codeine), crystal meth and - to a lesser extent - pharmaceutical drugs. The use of heroin and cocaine (both crack and powder) was relatively low. Crystal meth and pharmaceuticals are substances that were more often injected. Over one third of the survey sample had ever injected and more than a quarter had done so in the past month. More than half of the women interviewed reported to have ever injected. The research revealed widespread sharing of injection materials, as well as unsafe discarding of those materials, entailing risks of reusing and sharing. There are also indications of unsafe injecting practices, such as injecting in the wrist, thigh, groin or neck, and reports of abscesses caused by injection.

The research revealed an overlap between people who use drugs and other key populations, such as sex workers and LGBTIQ+ communities. Similarly, indications were found that drug use may be linked to sex work and (other forms of) transactional sex, unprotected sex and sex with multiple partners. Also sexual violence was reported.

Many respondents reported having tried to quit drugs, but most of them without professional help.

As a **second sub-objective**, this research assessed the **levels of knowledge, attitudes and perceptions of risk and vulnerability to HIV and TB** among people who use drugs. Almost all survey participants correctly identified that HIV can be transmitted through unprotected penetrative sex. However, all other modes of transmission were much less known. On TB transmission, over three quarters of respondents were able to identify coughing or sneezing as mode of transmission, but many myths were found on other ways of TB transmission. Ways of HCV transmission - or HCV itself - were virtually unknown among the research population.

92.49% of the sample had ever tested for HIV, though for most participants it was not clear when their latest test had been. From those who tested positive, 96.36% had enrolled for ART and of those on ART, 84.91% reported they were adhering to their treatment. This indicates that the 95-95-95 targets for 2025 may be within reach, even though the research could not provide insight in viral suppression of HIV. 70.31% of the sample had never been tested for TB, despite belonging to a risk group in a high HIV-TB burden country. Nonetheless, all those testing for TB and having a positive result reported to have enrolled into treatment, showing that increased effort for testing may also bring positive spin-off effects regarding the curing of TB.

The **third sub-objective** of the study was to determine **barriers and facilitators of uptake of HIV and TB services** among people who use drugs. In that regard, practically all research participants acknowledged that there is a huge gap between people who use drugs and healthcare providers. It was generally agreed that the current health response is based on a general, public health approach that doesn't provide tailored services and therefore fails to address the specific needs of people who use drugs. Lack of confidentiality by healthcare staff, judgemental attitudes, discrimination and a high level of ignorance on how to deal with people who use drugs were also mentioned as standing in the way of accessing services, as well as the existence of user fees.

Moreover, many key informants stated that the criminalised environment in Zimbabwe, and the risk of being arrested are serious barriers to access healthcare services, or to disclose drug use when such services are being accessed. FGD participants indeed complained about police harassment, including raids and forced bribery, and almost a quarter of the people who inject drugs in the survey sample reported being harassed by police. From international literature it is evident that criminalisation of drug use and possession facilitates widespread abuse by law enforcement agents and other government representatives.

As the **fourth sub-objective**, the research aimed at **documenting existing programmes** targeting people who use drugs and harm reduction services. No programmes or services were found specifically addressing the needs of people who use drugs; harm reduction services are non-existent in Zimbabwe, and services dedicated to drug treatment do not cater for the needs of the research participants. As for general health services, they generally adopt a public health approach and people who use drugs mostly access such services - if at all - without disclosing their drug use.

The **fifth sub-objective** was **identifying gaps in the national HIV and TB responses** for people who use drugs. Suggestions from key informants on how to strengthen national HIV and TB responses for this population predominantly centred around creating an enabling environment for people who use drugs and for programmes targeting this population, decriminalising people who use drugs and leaving behind the 'policing approach.' The second priority informants mentioned was capacity strengthening for staff working in the public healthcare system, with a focus on attitude and confidentiality. Thirdly, informants stressed the role of civil society organisations, and in this regard some shared their concern on the current climate of restricting civil society space in the country. Lastly, informants stressed the need for an intersectional approach, addressing not only HIV and TB among people who use drugs, but including mental health, (gender-based) violence, drug use itself and integrating the services in the already existing HIV prevention package.

Finally, the research results were intended to help develop an **implementation plan (road map)**, including suggestions for a package of services for people who use or inject drugs, in order to mitigate against HIV and TB among this population. This objective will be further developed in the section below.

4.2 Recommendations

Based on the findings presented above and on international WHO guidelines⁵⁰ (see annex 9), while keeping in mind the 2025 targets and commitments on HIV services, integration and social enablers as described in the Global AIDS strategy 2021-2026⁵¹ (see annex 10), the team has formulated a set of recommendations that is presented here. The recommendations are organised around four themes, each one bringing more detailed guidance to enable stakeholders to analyse and address them appropriately both in the short and long term. The four main recommendation themes are related to: 1) Creating an enabling environment for people who use drugs; 2) Adapting current services to better cater for the needs of the population who uses drugs; 3) Creating new and dedicated services to address drug use and related issues; and 4) Further developing research, to inform policy and programme planning.

The first set of recommendations covers issues related to **creating an enabling environment**. The research has shown this is utterly important for HIV and TB programming targeting people who use drugs to succeed. Besides, international literature is showing that a criminalising environment is harmful for reaching public health objectives and international agencies are reporting Zimbabwe can still improve in this area. Most of the recommendations in this set don't require large investments, while they will hugely improve the potential for successful HIV and TB programming. Therefore we categorise them as **high priority**. The WHO has labelled the following interventions "essential for impact" and also The Global Fund attaches great importance to them in its new 2023-2028 Strategy⁵²:

- Improving the legal and policy environment:
 - Revise the Dangerous Drugs Act [Chapter 15:02] and the Criminal Law (Codification And Reform) Act (Chapter 9:23, Section 156), with a focus on decriminalising⁵³ the use and the possession for personal use of currently illegal substances;
 - Review the Zimbabwe National HIV and AIDS Strategic Plan (ZNASP) IV 2021-2025 and refine its indicators on key populations, formulating specific indicators for people who use drugs;
 - Operationalise and cost the Zimbabwe National Drug Master Plan (2020-2025), making sure it is in line with the ZNASP IV, and starting its implementation - with a priority for the harm reduction part;
 - Design protocols and SOPs for HIV and TB prevention, diagnostics, treatment and care services for people who use drugs, including harm reduction services.
- Reducing stigma and discrimination:
 - Ongoing capacity strengthening for staff working in healthcare settings (medical and paramedical staff, and support staff who may deal with patients, such as receptionists and guards) on health needs of people who use drugs and respectful and ethical communication with patients who may be using substances, including attention to guaranteeing their privacy;
 - Training and sensitisation for law enforcement agents addressing (gender-based) violence targeted at people who use drugs and how to move away from a punitive approach towards one that facilitates health-seeking behaviour - even in the current legal context.
 - Mass campaigns that ask attention for the plight of people who use drugs, rather than warning for the (real and presumed) dangers of drugs;

⁵⁰ Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2022.

⁵¹ Global AIDS Strategy 2021-2026 - End inequalities. End AIDS. UNAIDS, 2021

⁵² The Global Fund Strategy (2023-2028) - Fighting Pandemics and Building a Healthier and More Equitable World, 2021

⁵³ Decriminalisation refers to the repeal of laws and policies that define drug use and/or the possession of drugs for personal use as a criminal offence. The act remains illegal, but sanctions are administrative, or abolished entirely.

- Fostering community empowerment:
 - Actively and meaningfully engage people who use drugs in processes and decisions that concern them, such as policy development, capacity strengthening of stakeholders, the design of services, as well as implementation and monitoring of services;
 - Support and facilitate the creation of networks and organisations of people who use drugs, through capacity strengthening and structural resources;
 - Stimulate, facilitate and support peer-led initiatives in harm reduction programming, health service & human rights monitoring and emergency response systems.

The second set of recommendations addresses **adapting current services to better cater for the needs of people who use drugs**. While a few of these recommendations require some level of investment, great strides can be made by reorganising activities and establishing linkages between various programmes and actors. Therefore we also categorise the following recommendations as **high priority**:

- Integrating HIV and TB services for people who use drugs, to strengthen diagnostics and treatment, especially taking into account the low TB testing rate in the high-burden setting.
- Integrating sexual reproductive health and rights (SRHR) into those services, to address (unprotected) sex under the influence of substances, as well as the high percentage of people engaging in transactional sex, and keeping in mind the overlap between drug use and sex work.
- Integrating mental health services into those services, to address potential trauma and other mental health issues of people who use drugs.
- Ensuring people who use drugs do not need to be abstinent from drugs before accessing health services.
- Though the WHO explicitly does not recommend interventions that promote abstinence, rehabilitation or cessation of drug use (because they create barriers to service access), for those who want to quit using drugs, drug treatment services should be provided on a strictly voluntary basis and following the ethics of quality, evidence-based treatment.
- For the prevention of HIV and TB, viral hepatitis B & C and STIs:
 - Adapt the current minimum package of HIV prevention services to the needs of people who use drugs by providing community-based and peer-led dissemination of informative materials in a simple language explaining the main forms of transmission of HIV, TB, HCV and STIs, also addressing stigma and myths around those and their relation with drug use;
 - In existing HIV-prevention programmes, address sexual behaviour in relation to drug use, including sexual and gender-based violence and abusive relationships, through targeted and tailored non-judgemental information, counselling and empowerment strategies for people who use drugs in their diversity.
- For the diagnosis of HIV, TB, viral hepatitis B & C⁵⁴ and STIs, provide voluntary and confidential screening, testing and counselling for people who use drugs:
 - In an integrated way (one-stop-shop) and person-centred, rather than disease-centred;
 - At places that are safe for people who use drugs (through outreach and in drop-in centres - see next set of recommendations);
 - As much as possible delivered by trained peer workers and other community workers.

⁵⁴ HCV testing may not yet exist in the public health system, but is nevertheless addressed here to stress the importance of integrating HCV testing with other testing services, while providing insight into the needs for HCV treatment.

- For the treatment of HIV, TB and STIs:
 - Ensure staff is trained in serving people who use drugs in a friendly and confidential way;
 - Ensure safe and friendly service delivery points - consider decentralising treatment into community centres as much as possible;
 - Provide differentiated treatment services such as out-of-facility ART distribution or community ART groups (CAGs), based on and tailored to the needs of people who use drugs (needs assessment to be done; see final set of recommendations);
 - Promote ongoing treatment adherence support by peer workers and other community workers through individual counselling, facilitated ART support groups, buddy systems, case management and linkage to other (social) services;
 - Provide low-threshold psychosocial counselling and interventions by trained lay counsellors as part of HIV and TB treatment, addressing links between HIV & TB, mental health and substance use and taking into account potential trauma.

The third set of recommendations touches upon **creating new and dedicated services to address drug use and related issues**. For this set of recommendations additional resources and new structures are necessary, that may or may not be available at this moment. They are however utterly important to contribute to the success of strengthened HIV and TB programming for people who use drugs, which is why we consider them a **priority**, to be implemented as soon as possible.

- Establish peer-led outreach work and community drop-in centres for people who use drugs, offering safe spaces and non-judgemental services. Outreach work should start with the mapping of hotspots, before deciding on where drop-in centres are most needed and useful.
- Establish community-based and peer-led needle and syringe programming, providing safe injection kits (needles, syringes, sterile water, alcohol pads, cookers, tourniquets) through outreach work and in specific drop-in centres for people who use drugs, combined with information and training on safer injection and (opioid) overdose prevention & management and addressing myths and misconceptions around those topics.
- Develop specific harm reduction interventions for people who use stimulants, such as crystal meth: Based on and tailored to the needs of people who use stimulants (needs assessment to be done; see final set of recommendations), this could include safer smoking kits (foil, pipes, mouthpieces, lip balm), information on safer stimulant use and behavioural interventions like self-regulation, coaching and various forms of mental health support ⁵⁵.
- Tailor approaches for sub-populations who use drugs:
 - Ensure harm reduction services are female-friendly; consider offering women-only opening hours at drop-in centres with female (peer) staff only, providing a safe space to discuss and address (gender-based) violence, empowerment strategies to negotiate safer sex and safer drug use and child care, and to provide hygiene packs tailored to their needs; also consider organising regular (peer) outreach targeting women who use drugs (since many may not be able or willing to visit drop-in centres);
 - Ensure harm reduction services are youth-friendly; consider offering youth-only opening hours at drop-in centres, providing entertainment, sports, (vocational) training and a safe environment to discuss drug use and issues like peer pressure and mental wellbeing; organise outreach work targeting young people who use drugs; provide a framework unequivocally allowing youth under 18 years of age to access services without parental consent;

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For more guidance on harm reduction for people who use stimulants, see UNODC (2019); HIV Prevention, Treatment, Care and Support for People Who Use Stimulant Drugs. Technical Guide https://www.unodc.org/documents/hiv-aids/publications/People_who_use_drugs/19-04568_HIV_Prevention_Guide_ebook.pdf

- Ensure harm reduction services address overlaps in criminalised or marginalised identities, such as sex workers who use drugs and members of LGBTIQ+ communities who use drugs; establish close working relations with organisations already serving other key populations, to ensure an integrated approach for members of those key populations who use drugs, addressing multi-layered stigma and overlapping risk behaviours.
- Develop tailored information for all sub-populations of people who use drugs, such as women, youth, sex workers and members of LGBTIQ+ communities. This can be in the form of brochures, websites, training curricula, counselling and health talks in drop-in centres and outreach.
- Consider integrating economic empowerment programmes into harm reduction services, to support people who use drugs (re-)gaining their place in society.

Finally, the fourth set of recommendations focuses on further supporting and developing **research**. While some of the suggested research will require significant effort and resources, other research can be implemented with available resources. The information from the various researches will be the basis of informed and effective policy and programming, therefore we consider the following recommendations **high priority**:

- Investigate the needs and modalities for opioid agonist maintenance treatment (OAMT): A limited number of studies is available on OAMT with buprenorphine⁵⁶ or buprenorphine-naloxone⁵⁷ to treat codeine or pethidine⁵⁸ dependence. More research is needed to assess whether such treatment would be desirable for people who use opioids (codeine, heroin and pethidine) in Zimbabwe and what such treatment could look like.
- Similarly, assess the needs and modalities for Naloxone distribution for opioid overdose management.
- Perform a national size estimate of people who use drugs with attention to the different sub-groups in the population, in order to have a picture of the magnitude of substance use and to be able to better design, cost and plan for interventions.
- Broaden the current research to all provinces of the country to allow for a cross-country comparison, as well as for a more in-depth understanding of the differences within each province (e.g. more or less urbanised areas).
- Employ more in-depth investigation of drug using rituals to provide an in-depth understanding of the preparation and consumption of the substances used by various (geographic) sub-groups and the risks associated with it (for example bluetoothing or the preparation of home-made substances).
- Carry out needs assessments on:
 - Service needs and preferences of specific sub-groups of people who use drugs (women, youth, sex workers, LGBTIQ+ members);
 - Needs and preferences for differentiated ART services;
 - Needs and preferences for harm reduction interventions addressing stimulant use.

⁵⁶ Nielsen S, e.a.: Treating codeine dependence with buprenorphine; Dose requirements and induction outcomes from a retrospective case series in New South Wales, Australia, Drug Alcohol Rev. 2016 Jan; 35(1):70-75 - <https://pubmed.ncbi.nlm.nih.gov/26223631/>

⁵⁷ Van Hout, M.C. e.a.: Buprenorphine-Naloxone in the Treatment of Codeine Dependence; a Scoping Review of Clinical Case Presentations, Int J Ment Health Addiction 15, 224–237 (2017) - <https://doi.org/10.1007/s11469-016-9655-5>

⁵⁸ Ahmadi, J.: Pethidine Abuse, A Novel Finding, Journal Addict Depend 2(2): 1- 3 (2016) - <https://www.ommegaonline.org/article-details/Pethidine-Abuse-a-novel-finding/806>

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ANNEX 1: SURVEY QUESTIONNAIRE

Form No. ☐ ☐ ☐ ☐ ☐ ☐

A. Socio-demographic Information		
No.	Questions	Responses
A 1	Age	___ years old [Interviewer: Code “don’t know” as 99; code “no response” as 98.]
A2	Ethnicity	<input type="checkbox"/> African - Black <input type="checkbox"/> European - White <input type="checkbox"/> Asiatic <input type="checkbox"/> Mixed race <input type="checkbox"/> Other; specify
A3	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans-male <input type="checkbox"/> Trans-female <input type="checkbox"/> Other; specify
A4	Sexual orientation	<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual (gay, MSM) <input type="checkbox"/> Homosexual (lesbian, WSW) <input type="checkbox"/> Bi-sexual <input type="checkbox"/> Other; specify
A 5	Education	
	What is the highest level of education you have completed?	<input type="checkbox"/> No education <input type="checkbox"/> Incomplete Primary <input type="checkbox"/> Completed Primary (Grade 7) <input type="checkbox"/> Completed Secondary School (O Level) <input type="checkbox"/> Completed High School (A Level) <input type="checkbox"/> Completed Tertiary (Vocational College /Polytechnic /Teachers College) <input type="checkbox"/> Completed Tertiary (University) <input type="checkbox"/> Do not remember <input type="checkbox"/> Other (specify)
A 6	Marital Status	
	What is your marital status?	<input type="checkbox"/> Single; never married <input type="checkbox"/> Legally married <input type="checkbox"/> Traditionally married <input type="checkbox"/> Cohabiting <input type="checkbox"/> Divorced, separated <input type="checkbox"/> Widowed <input type="checkbox"/> Other; specify

A7	Source of Income	
	<p>What is your primary source of income?</p> <p>Multiple responses possible</p>	<input type="checkbox"/> Not earning any money <input type="checkbox"/> Steady wage/salary from a legal job <input type="checkbox"/> Own business/self-employed <input type="checkbox"/> Occasional/odd jobs on the street <input type="checkbox"/> Money from family/partner/friends <input type="checkbox"/> Begging <input type="checkbox"/> Selling drugs <input type="checkbox"/> Theft/pickpocket <input type="checkbox"/> Sex work <input type="checkbox"/> Transactional sex <input type="checkbox"/> Blesser(s) / sugar daddy or sugar mummy <input type="checkbox"/> Other, specify: <input type="checkbox"/> Prefer not to say
A8	Residence	
	<p>Where have you stayed mostly during the past 6 months? (primary residence)</p> <p>Mark one response only</p>	<input type="checkbox"/> Parent's house <input type="checkbox"/> Your own house (rented or owned) <input type="checkbox"/> Your spouse or steady partner's house <input type="checkbox"/> Relative's or friend's house <input type="checkbox"/> Shelter, welfare residence <input type="checkbox"/> Care or health institution (hospital, treatment centre, etc) <input type="checkbox"/> Streets or abandoned building (homeless) <input type="checkbox"/> Other; specify:
A9	Law enforcement	
	<p>In the past 6 months, have you had encounters with the law enforcement system?</p> <p>Multiple responses possible for different occasions/encounters</p>	<input type="checkbox"/> No <input type="checkbox"/> Yes, police have helped / supported me <input type="checkbox"/> Yes, I was stopped by the police, without further actions or consequences <input type="checkbox"/> Yes, I was harassed by the police <input type="checkbox"/> Yes, I was arrested by the police <input type="checkbox"/> Yes, I was taken into custody (not convicted) <input type="checkbox"/> Yes, I was in prison (convicted)

B. Drug use trends and patterns		
No.	Questions	Responses
B1	<p>Have you used the following substances in the past year?</p> <p>Multiple responses possible.</p>	<input type="checkbox"/> Cannabis (mbanje, ganja) <input type="checkbox"/> Skunk <input type="checkbox"/> Heroin <input type="checkbox"/> Nyaope (whoonga) <input type="checkbox"/> crack cocaine (rock) <input type="checkbox"/> powder cocaine <input type="checkbox"/> crystal meth (mutoriro; guka) <input type="checkbox"/> illegal alcohol (musombodia, kachasu, industrial ethanol, tumbwa) <input type="checkbox"/> legal alcohol <input type="checkbox"/> Cough syrup (Broncleer, Histalix, Brongo, PP) <input type="checkbox"/> other pharmaceuticals (diazepam/Valium or other sedatives, aceclofenac/Betadol or other painkillers etc.) <input type="checkbox"/> glue <input type="checkbox"/> sodium polyacrylate (from diapers) <input type="checkbox"/> Powder from TVs <input type="checkbox"/> a substance I am not sure what it was/is <input type="checkbox"/> other, specify
B2	<p>Which of these substances have you used in the past month?</p> <p>Multiple responses possible.</p>	<input type="checkbox"/> cannabis (mbanje; ganja) <input type="checkbox"/> Skunk <input type="checkbox"/> heroin <input type="checkbox"/> Nyaope (whoonga) <input type="checkbox"/> crack cocaine (rock) <input type="checkbox"/> powder cocaine <input type="checkbox"/> crystal meth (mutoriro; guka) <input type="checkbox"/> illegal alcohol (musombodia, kachasu, industrial ethanol, tumbwa) <input type="checkbox"/> legal alcohol <input type="checkbox"/> cough syrup (Broncleer, Histalix, Brongo, PP) <input type="checkbox"/> other pharmaceuticals (diazepam/Valium or other sedatives, aceclofenac/Betadol or other painkillers, etc.) <input type="checkbox"/> glue <input type="checkbox"/> Sodium polyacrylate (from diapers) <input type="checkbox"/> Powder from TVs <input type="checkbox"/> a substance I am not sure what it was/is <input type="checkbox"/> other; specify

B3	How do you use these substances? fill in only for those used in the past month	
B3a	Cannabis (mbanje; ganja) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing (drinking or eating) <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3b	Skunk Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing (drinking or eating) <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3c	Heroin Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month

B3d	Nyaope (whoonga) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing (drinking or eating) <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3e	Crack cocaine (rock) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3f	Powder cocaine Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month

B3g	Crystal meth (mutoriro; guka) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3h	Alcohol (legal and illegal) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3i	Cough syrup (Broncleer, Histalix, Brongo, PP) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3j	Pharmaceuticals (diazepam/ Valium or other sedatives, aceclofenac/Betadol or other painkillers, etc.) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month

B3k	Glue Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3l	Sodium polyacrylate (from diapers) Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month
B3m	Powder from TVs Multiple answers possible	<input type="checkbox"/> Not used in the past month (skip) (Preferred) mode of administration in the past month: <input type="checkbox"/> smoking - in joint <input type="checkbox"/> smoking in (glass/makeshift) pipe or tube <input type="checkbox"/> smoking - from foil <input type="checkbox"/> snorting <input type="checkbox"/> swallowing <input type="checkbox"/> injecting Frequency of use in the past month: <input type="checkbox"/> daily use <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> once a week <input type="checkbox"/> 2-3 times a month

B3n B3o B3p B3q B3r	Other; specify	<input type="checkbox"/> Not used in the past month (skip)
	Multiple answers possible	(Preferred) mode of administration in the past month:
		<input type="checkbox"/> smoking - in joint
		<input type="checkbox"/> smoking in (glass/makeshift) pipe or tube
		<input type="checkbox"/> smoking - from foil
		<input type="checkbox"/> snorting
		<input type="checkbox"/> swallowing
		<input type="checkbox"/> injecting
		Frequency of use in the past month:
		<input type="checkbox"/> daily use
		<input type="checkbox"/> 2-3 times per week
		<input type="checkbox"/> once a week
		<input type="checkbox"/> 2-3 times a month
B4	How old were you when you started using illegal drugs?	___ years old [Interviewer: Code “don’t know” as 99; code “no response” as 98.]

C. Injecting practices		
No.	Questions	Responses
C1	Have you ever injected drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No (>>Skip to D)
C2	How old were you when you first injected drugs?	___ years old [Interviewer: Code “don’t know” as 99; code “no response” as 98.]
C3	Have you injected drugs in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No (>>Skip to D)
C4	In the past 6 months, on average how many times a day did you inject drugs?	<input type="checkbox"/> less than once per day <input type="checkbox"/> _____ injections per day [Interviewer: Code “don’t know” as 99; code “no response” as 98.]
C5	On which part(s) of the body do you mostly inject? Multiple answers possible	<input type="checkbox"/> Upper arm <input type="checkbox"/> Wrist <input type="checkbox"/> Groin <input type="checkbox"/> Thighs <input type="checkbox"/> Neck <input type="checkbox"/> Legs <input type="checkbox"/> Other; specify
C6	Have you suffered from abscesses / wounds caused by injecting in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No Don’t know (interviewer explains what abscess is and tries to get yes or no)

C7	<p>In the past one month what have been different sources to acquire needles and syringes?</p> <p>Multiple answers possible</p>	<input type="checkbox"/> From a pharmacy <input type="checkbox"/> From a health facility <input type="checkbox"/> From a partner <input type="checkbox"/> From family members <input type="checkbox"/> From a friend who uses drugs <input type="checkbox"/> From a friend who does not use drugs <input type="checkbox"/> From a drug dealer <input type="checkbox"/> From finding it on the street <input type="checkbox"/> Other; specify
C8	<p>In the past one month what has been the main source to acquire needles and syringes?</p> <p>(Mark one response)</p>	<input type="checkbox"/> From a pharmacy <input type="checkbox"/> From a health facility <input type="checkbox"/> From a partner <input type="checkbox"/> From family members <input type="checkbox"/> From a friend who uses drugs <input type="checkbox"/> From a friend who does not use drugs <input type="checkbox"/> From a drug dealer <input type="checkbox"/> From finding it on the street <input type="checkbox"/> Other; specify
C9	<p>The last time you injected, were the syringe and the needle you used new or had they already been used before?</p>	<input type="checkbox"/> New (sterile) <input type="checkbox"/> Already used by yourself before <input type="checkbox"/> Already used by someone else before
C10	<p>Besides a syringe and a needle, which other materials do you usually use for injecting and for preparing your injection?</p>	<input type="checkbox"/> spoon / cooker / other container for preparation <input type="checkbox"/> (cotton) filter <input type="checkbox"/> swab/alcohol pad <input type="checkbox"/> other material to clean injection spot (cloth, t-shirt) <input type="checkbox"/> lighter or matches <input type="checkbox"/> rubber tourniquet <input type="checkbox"/> improvised tourniquet (shoe laces,) <input type="checkbox"/> sterile water <input type="checkbox"/> non-sterile water <input type="checkbox"/> Other; specify

C11	<p>When injecting, do you usually share any of these materials with other people?</p> <p>(Multiple responses possible)</p>	<table border="1"> <thead> <tr> <th></th><th>never</th><th>sometimes</th><th>always</th><th>Do not use this</th></tr> </thead> <tbody> <tr> <td>syringe</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>needle</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>spoon</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>cooker</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>swab/alcohol pad</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>lighter or matches</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>rubber tourniquet</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>improvised tourniquet (shoelaces)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>sterile water</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>non-sterile water</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Other; specify _____</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>Other; specify _____</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		never	sometimes	always	Do not use this	syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	needle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cooker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	swab/alcohol pad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lighter or matches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rubber tourniquet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	improvised tourniquet (shoelaces)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sterile water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	non-sterile water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other; specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other; specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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C12	<p>Where (in which place) did you inject last time?</p>	<p> <input type="checkbox"/> Home <input type="checkbox"/> Public toilet <input type="checkbox"/> On the streets / open space in the neighbourhood <input type="checkbox"/> Friend / relative's house <input type="checkbox"/> In an abandoned building / squat <input type="checkbox"/> In the house of the dealer / place where I bought the drugs <input type="checkbox"/> In a park / woods <input type="checkbox"/> Other; specify </p>																																																																	

C13	What did you do with the used needle and syringe?	<input type="checkbox"/> Threw it in dustbin / garbage <input type="checkbox"/> Threw on the street <input type="checkbox"/> Gave it to someone <input type="checkbox"/> Put it in sharps bin <input type="checkbox"/> Hid it for a next use <input type="checkbox"/> Don't remember <input type="checkbox"/> Other; specify
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D. Other drug using practices and experiences		
No.	Questions	Responses
D 1	Have you ever experienced an overdose?	<input type="checkbox"/> Yes <input type="checkbox"/> No (>>Skip to D3)
D2	How many times have you experienced an overdose?	<input type="checkbox"/> Never <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3-5 times <input type="checkbox"/> 6 or more times <input type="checkbox"/> I am not sure/don't know how to identify an overdose
D3	In your life, how many times have you seen someone else overdose?	<input type="checkbox"/> Never <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3-5 times <input type="checkbox"/> 6-10 times <input type="checkbox"/> 11 or more times <input type="checkbox"/> I am not sure/don't know how to identify an overdose
D4	Have you ever tried to stop using drugs?	<input type="checkbox"/> No, I never tried to quit <input type="checkbox"/> Yes, I've tried to quit by myself / with help from relatives/friends <input type="checkbox"/> Yes, I've tried to quit with professional help (counselling, medication) <input type="checkbox"/> Yes, I've been admitted to a clinic to quit
D5	Can you estimate how many women you know who use drugs?	<input type="checkbox"/> None (>>go to D7) <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> more than 50 <input type="checkbox"/> don't know
D6	Can you estimate how many of these women who use drugs are injecting their drugs?	<input type="checkbox"/> None <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> more than 50 <input type="checkbox"/> don't know

D7	Can you estimate how many minors (under 18) you know who use drugs?	<input type="checkbox"/> None (>>go to E) <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> more than 50 <input type="checkbox"/> don't know
D8	Can you estimate how many of these minors (under 18) who use drugs are injecting their drugs?	<input type="checkbox"/> None <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> more than 50 <input type="checkbox"/> don't know
D9	How many people are usually present when you use/inject drugs?	<input type="checkbox"/> None <input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-50 <input type="checkbox"/> more than 50 <input type="checkbox"/> don't know

E. Knowledge about HIV, hepatitis C (HCV) and tuberculosis (TB)

No.	Questions	Responses
E1	Through which of the following ways can HIV be transmitted? (Multiple answers possible)	<input type="checkbox"/> Through kissing <input type="checkbox"/> Through unprotected penetrative sex <input type="checkbox"/> Through unprotected penetrative sex, if the man withdraws before ejaculating <input type="checkbox"/> Through penetrative sex with a condom <input type="checkbox"/> Through unprotected oral sex <input type="checkbox"/> Through unprotected anal sex <input type="checkbox"/> From mother to child during pregnancy or birth <input type="checkbox"/> From mother to child during breastfeeding <input type="checkbox"/> From mother to child during bathing <input type="checkbox"/> By mosquitos <input type="checkbox"/> By sharing materials for eating, drinking or cooking <input type="checkbox"/> By sharing materials for tattooing <input type="checkbox"/> By sharing toilets <input type="checkbox"/> By sharing materials for injecting drugs <input type="checkbox"/> By sharing materials for smoking/snorting drugs <input type="checkbox"/> By spitting on somebody <input type="checkbox"/> By fighting with somebody until bleeding <input type="checkbox"/> By shaking hands, touching or hugging someone <input type="checkbox"/> By re-using non-sterilised medical equipment in hospitals / clinics <input type="checkbox"/> By re-using razor blades by traditional healers <input type="checkbox"/> None of the above

E2	<p>Through which of the following ways can tuberculosis (TB) be transmitted?</p> <p>(Multiple answers possible)</p>	<input type="checkbox"/> Through kissing <input type="checkbox"/> Through unprotected sex <input type="checkbox"/> Through the air when coughing or sneezing <input type="checkbox"/> Through the air when singing or speaking <input type="checkbox"/> From mother to child during pregnancy or birth <input type="checkbox"/> By smoking <input type="checkbox"/> By spending time in cold air <input type="checkbox"/> By mosquitos <input type="checkbox"/> By sharing materials for eating, drinking or cooking <input type="checkbox"/> By sharing tools for brushing teeth <input type="checkbox"/> By sharing toilets <input type="checkbox"/> By sharing materials for using drugs <input type="checkbox"/> By sharing clothes or bed sheets <input type="checkbox"/> By spitting on somebody <input type="checkbox"/> By shaking hands, touching or hugging someone <input type="checkbox"/> By re-using non-sterilised medical equipment in hospitals / clinics or by traditional healers <input type="checkbox"/> None of the above
E3	<p>Do you know what viral hepatitis C (HCV) is?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (>>Skip to section F)
E4	<p>Through which of the following ways can HCV be transmitted?</p> <p>(Multiple answers possible)</p>	<input type="checkbox"/> Through kissing <input type="checkbox"/> Through unprotected sex <input type="checkbox"/> From mother to child during pregnancy or birth <input type="checkbox"/> From mother to child during breastfeeding <input type="checkbox"/> By mosquitos <input type="checkbox"/> By sharing materials for eating / drinking / cooking <input type="checkbox"/> By sharing materials for tattooing <input type="checkbox"/> By sharing toilets <input type="checkbox"/> By sharing materials for injecting drugs <input type="checkbox"/> By sharing materials for snorting or smoking drugs <input type="checkbox"/> By spitting on somebody <input type="checkbox"/> By shaking hands, touching or hugging someone <input type="checkbox"/> By re-using non-sterilised medical equipment in hospitals or clinics <input type="checkbox"/> By re-using razor blades by traditional healers <input type="checkbox"/> None of the above

F. Access to HIV and TB care and services		
No.	Questions	Responses
F1	Have you ever been tested for HIV?	<input type="checkbox"/> Yes (>>go to F3) <input type="checkbox"/> No
F2	What are the reasons you never had an HIV test? Multiple answers possible. Interviewer: ask the question without reading the answers. Let the interviewee answer, tick the box(es) that correspond best to what they say and check with them if they agree those are the correct answers. (>>go to F8)	<input type="checkbox"/> I had never heard of HIV / I don't know what this is <input type="checkbox"/> I don't consider it important (no need to test) <input type="checkbox"/> I don't know where to go for testing <input type="checkbox"/> Testing is not accessible or available near me or at times that are convenient to me <input type="checkbox"/> I don't feel welcomed or I feel stigmatised at testing sites <input type="checkbox"/> I don't want to be seen at a testing site (fear for stigma by community or family) <input type="checkbox"/> Fear of the results <input type="checkbox"/> I don't know / no reason <input type="checkbox"/> Other; specify
F3	If yes, when was the last time you tested for HIV?	_____ months back [Interviewer: Code "don't know" as 99; code "no response" as 98.]
F4	If yes, would you like to share the result of your latest test with us?	<input type="checkbox"/> Yes, results were positive <input type="checkbox"/> Yes, results were negative >> go to F8 <input type="checkbox"/> No, I never got the results >> go to F8 <input type="checkbox"/> No, I got the results but do not want to share >> go to F8
F5	If you were found to be positive HIV, have you enrolled in antiretroviral (ARV) treatment?	<input type="checkbox"/> Yes (>>go to F7) <input type="checkbox"/> No
F6	What are the reasons you never enrolled in ARV treatment? Multiple answers possible Interviewer: ask the question without reading the answers. Let the interviewee answer, tick the box(es) that correspond best to what they say and check with them if they agree those are the correct answers.	<input type="checkbox"/> I don't know where to go for treatment <input type="checkbox"/> Treatment is not available or accessible (place / time) <input type="checkbox"/> I was denied treatment by the staff in the treatment centre <input type="checkbox"/> I don't want people to know about my status (fear of stigma) <input type="checkbox"/> I don't consider it important <input type="checkbox"/> I am afraid I will not be well received in the treatment centre <input type="checkbox"/> I'm not ready for a lifelong treatment <input type="checkbox"/> I'm scared of side effects <input type="checkbox"/> I don't believe in the treatment <input type="checkbox"/> I went for another type of treatment or cure instead <input type="checkbox"/> Other; specify
F7	If you started treatment, are you still continuing?	<input type="checkbox"/> Yes, I have been on ARV treatment ever since I started <input type="checkbox"/> No, I'm not on ARV treatment anymore <input type="checkbox"/> I had stopped ARV treatment at one point, but I have started again <input type="checkbox"/> I'm on and off ARV treatment

F8	Have you ever been tested for tuberculosis (TB)?	<input type="checkbox"/> Yes (>>go to F10) <input type="checkbox"/> No
F9	What are the reasons you never got tested for TB? Multiple answers possible Interviewer: ask the question without reading the answers. Let the interviewee answer, tick the box(es) that correspond best to what they say and check with them if they agree those are the correct answers. (>>go to F15)	<input type="checkbox"/> I had never heard of TB or I don't know what this is <input type="checkbox"/> I don't consider it important (no need to test) <input type="checkbox"/> I don't know where to go for testing <input type="checkbox"/> I don't want to get tested <input type="checkbox"/> Testing is not accessible or available near me or at times that are convenient to me <input type="checkbox"/> I don't feel welcomed or I feel stigmatised at testing sites <input type="checkbox"/> I don't want to be seen at a testing site fear for stigma by community or family) <input type="checkbox"/> Fear of the results <input type="checkbox"/> I don't know/no reason <input type="checkbox"/> Other; specify
F10	If yes, when was the last time you tested for TB?	_____ months back [Interviewer: Code "don't know" as 99; code "no response" as 98.]
F11	If yes, would you like to share the result of your latest test with us?	<input type="checkbox"/> Yes, results were positive <input type="checkbox"/> Yes, results were negative >> to F15 <input type="checkbox"/> No, I never got the results >> to F15 <input type="checkbox"/> No, I got the results but do not want to share >> to F15
F12	If you were found to be positive for TB, have you enrolled in treatment?	<input type="checkbox"/> Yes (>>go to F14) <input type="checkbox"/> No
F13	What are the reasons you never enrolled in TB medical treatment? Multiple answers possible Interviewer: ask the question without reading the answers. Let the interviewee answer, tick the box(es) that correspond best to what they say and check with them if they agree those are the correct answers. Go to F15	<input type="checkbox"/> I don't know where to go for treatment <input type="checkbox"/> Treatment is not available or accessible (place / time) <input type="checkbox"/> I was denied treatment by the staff in the treatment centre <input type="checkbox"/> I don't want people to know about my status (fear of stigma) <input type="checkbox"/> I don't consider it important <input type="checkbox"/> I am afraid I will not be well received in the treatment centre <input type="checkbox"/> I'm not ready for the treatment <input type="checkbox"/> I'm scared of side effects of the treatment <input type="checkbox"/> I don't believe in the treatment <input type="checkbox"/> I went for another type of treatment or cure instead <input type="checkbox"/> Other; specify
F14	If you started medical TB treatment, did you complete it?	<input type="checkbox"/> Yes, I have completed the treatment and got cured of TB <input type="checkbox"/> Yes, I have completed the treatment and I'm waiting for the final results to see if I'm cured <input type="checkbox"/> No, I stopped the treatment before completing it <input type="checkbox"/> No, I'm still taking the treatment

F15	What other health services have you accessed in the past 6 months?	<input type="checkbox"/> Malaria testing or treatment <input type="checkbox"/> Hepatitis B testing or treatment <input type="checkbox"/> Hepatitis B vaccination <input type="checkbox"/> Testing or treatment for sexually transmitted infections <input type="checkbox"/> Family planning or contraceptive services <input type="checkbox"/> Post (gender-based) violence treatment <input type="checkbox"/> Wound dressing (including abscesses) <input type="checkbox"/> Psychosocial counselling (mental health) <input type="checkbox"/> Psychiatric treatment (medicated) <input type="checkbox"/> Drug treatment (hospital / clinic) <input type="checkbox"/> Drug treatment (faith-based / traditional healer / herbs) <input type="checkbox"/> Opioid agonist treatment (methadone / buprenorphine) <input type="checkbox"/> Covid-19 testing or treatment <input type="checkbox"/> Other; specify
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G. Sexual Behaviour and Condom Use		
No.	Questions	Responses
G1	Did you have sex in the past 6 months?	<input type="checkbox"/> No (the interview ends here) <input type="checkbox"/> Yes, with one person <input type="checkbox"/> Yes, with more than one person
G2	Is / are the person(s) you had sex with in the past six months also using drugs?	<input type="checkbox"/> Yes, the person(s) I had sex with in the past six months (all) use(s) drugs <input type="checkbox"/> No, the person(s) I had sex with in the past six months don't / doesn't use drugs <input type="checkbox"/> Some of the people I had sex with in the past six months use drugs and some don't <input type="checkbox"/> I don't know / I prefer not to say
G3	Did you use a condom in your latest sexual act?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G4	Do you generally use condoms?	<input type="checkbox"/> Yes (>>Go to G6) <input type="checkbox"/> No
G5	What are the main motivations for you not to use a condom? Multiple answers possible Interviewer: ask the question without reading the answers. Let the interviewee answer, tick the box(es) that correspond best to what they say and check with them if they agree those are the correct answers. Go to G7	<input type="checkbox"/> I do not believe in condoms / they don't work <input type="checkbox"/> I don't consider it important <input type="checkbox"/> I don't like condoms <input type="checkbox"/> My partner(s) don't like it / don't believe in condoms <input type="checkbox"/> There is no protection needed / no risk <input type="checkbox"/> I/ we don't want people to know that I am/ we are sexually active <input type="checkbox"/> I am/ we are ashamed to get/buy them <input type="checkbox"/> I/ we cannot afford them <input type="checkbox"/> I/we don't know where to get condoms <input type="checkbox"/> I don't know how to use a condom <input type="checkbox"/> Other; specify

G6	<p>From where do you usually get condoms?</p> <p>Multiple answers possible</p>	<input type="checkbox"/> I buy them from a pharmacy or general store <input type="checkbox"/> I buy them in bars or nightclubs <input type="checkbox"/> My partner/s bring/s them <input type="checkbox"/> I get them from a local hospital, primary health care centre or HIV clinic <input type="checkbox"/> I get them from community workers or peer educators <input type="checkbox"/> I get them from friends <input type="checkbox"/> I don't use condoms <input type="checkbox"/> Other; specify
G7	<p>Have you engaged in transactional sex, sex work, exchanging sex for money or for goods in the past 6 months?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No (interview ends)
G8	<p>If yes, did you use a condom?</p>	<input type="checkbox"/> Yes, always (-> go to G10) <input type="checkbox"/> Yes, most of the times <input type="checkbox"/> About half of the times <input type="checkbox"/> Less than half of the times <input type="checkbox"/> No, never
G9	<p>If you did not use a condom during transactional sex, sex work, exchanging sex for money or sex for goods, what are your main motivations for this?</p> <p>Multiple answers possible</p> <p>Interviewer: ask the question without reading the answers. Let the interviewee answer, tick the box(es) that correspond best to what they say and check with them if they agree those are the correct answers.</p>	<input type="checkbox"/> I do not believe in condoms / they don't work <input type="checkbox"/> I don't consider it important <input type="checkbox"/> My partner(s) don't like condoms <input type="checkbox"/> There is no protection needed / no risk <input type="checkbox"/> I don't want people to know that I am sexually active <input type="checkbox"/> I am ashamed to get or buy them <input type="checkbox"/> I cannot afford them <input type="checkbox"/> I get paid more/better gifts if I have sex without condoms <input type="checkbox"/> I don't know where to get condoms <input type="checkbox"/> I don't know how to use a condoms <input type="checkbox"/> Other; specify
G10	<p>In the past year were you ever beaten or otherwise physically forced to have sexual intercourse with someone even though you did not want to?</p> <p>Multiple answers possible</p>	<input type="checkbox"/> Yes, I was forced to have oral sex once <input type="checkbox"/> Yes, I was forced to have oral sex several times <input type="checkbox"/> Yes, I was forced to have penetrative sex once <input type="checkbox"/> Yes, I was forced to have penetrative sex several times <input type="checkbox"/> No, I was never forced to have sex
G11	<p>Have you ever had anal sex?</p>	<input type="checkbox"/> Yes, once or twice <input type="checkbox"/> Yes, many times <input type="checkbox"/> No, never

Thank you very much for the interview.

ANNEX 2: TOPIC LISTS FOCUS

GROUP DISCUSSION 1

ON DRUG USE PRACTICES

Topics for FGD 1 with people who use or inject drugs

On patterns of drug use and injection

1. The environment where people use drugs

Drug using spaces

- Describe the places where people usually use drugs (incl. cleanness, ventilation, crowd, availability of water & soap / disinfectant)
- What motives do people have to choose a specific place to use your drugs? Does hiding from police or others play a role in this?
- Are there places where one would not use? Which places and why?

Social interactions during drug consumption

- How do people usually interact with each other at the moment of using drugs? Are they all using at the same time? Can you describe the general ambiance of such a moment?
- Do people socialise (keep an eye on each other) in those moments? Or do they mostly stick to themselves?
- Is there a separation between injectors and non-injectors within the drug using community? How do people perceive each other? Examples?

Optional (if time allows)

- Is it common to pass things on to each other (sharing risks)?
- Is there a hierarchy between men and women, or based on age, or other criteria? How does this play out in drug using practices?

2. Preferences in terms of drugs and consumption modes

Motivations for drug use

- What are reasons for people to start using drugs? Describe a situation how a person starts using.
- What are reasons for people to continue using drugs?

Types of drugs used & injected

- Describe in detail the whole process of preparing and injecting drugs (if different drugs are injected, ask for each drug - look out for risks)
- Describe in detail the whole process of preparing and smoking / inhaling / snorting/ ingesting drugs (ask for each drug and each mode of consumption - look out for risks)
- What makes people choose a certain body part for injection?

Optional (if time allows)

- Which are main reasons for people to switch from sniffing / smoking / inhaling to injection? (price, quality, availability, matching resources and needs, (non-)availability of syringes, sources of supply and systems of selling, possible influence of infectious diseases)
- What would it take for people to switch from injection to a less risky consumption route?

Extent of polydrug use (based on combinations coming out of questionnaires)

- How do people combine different drugs?
- What are the reasons for combining drugs?

3. Risks and harms

Extent of harms experienced by the users

- Which harms do people experience from their drug use (*for probing, think of overdose, psychosis, lung problems, HIV, HCV, abscesses, but also job loss, lost contact with family / friends*)?
- Which harms do other people inflict on people who use drugs because of their drug use (police, health care workers, family, friends, peers – think of discrimination, violence, exclusion)?

Sharing practises

- How often do people re-use their drug using gear? (syringe, needle, water, swab, tourniquet, pipe, tube, straw, cigarette, joint, mouthpiece, razor blade)?
- Where do people keep their equipment in between using it?
- With how many people and in which ways is drug using or injection equipment shared? (lending and borrowing a syringe previously used by another user; sharing the same container; using a hidden or thrown away previously used syringe; frontloading; share one after another “half/half” with the same syringe; using one and the same syringe to divide drugs bought jointly; sharing the preparation and washing water; sharing or using the same razor blade for cutting doses)
- What makes people decide to share or not share drug using equipment?

Sexual practices

- What are the various relationships between drug use and sex (need one for the other, increased pleasure, enhancement, other)?

ANNEX 3: TOPIC LIST FOCUS GROUP DISCUSSION 2 ON BARRIERS AND FACILITATORS OF UPTAKE OF HIV AND TB SERVICES

Topics for FDG 2 with people who use or inject drugs On barriers and facilitators of uptake of HIV and TB services

1. Use of (facility-based) health services

- Are people who use or inject drugs using any health services? Which ones?
- What are common experiences there?
- Are HIV, TB and other health services easy to access for people who use or inject drugs? (include travel distance, transport costs, registration costs, waiting time, place/setting of the treatment centre, opening hours, is there a mobile service, specific opening hours for youth, women, key populations, any restrictions like bringing your partner or parent, knowledge and attitude of staff, peer navigation / support, attitude of other patients, confidentiality, being informed about the process and the treatment options)
- Has COVID19 changed the way services are provided and accessed? (positively / negatively)
- Do people who use or inject drugs have any health needs that are not being addressed, including psycho-social / mental / emotional needs? How come?

2. Community-based services

- Are there any places in the community where people who use or inject drugs can go for HIV or TB information, testing, treatment or support or other health services? Which ones / where?
- What are the advantages and disadvantages of their services as compared to facility based (health centre / hospital) services?

3. Existing programmes for people who use/inject drugs

- Who knows of a programme or a service that has tailored services for people who use or inject drugs or that specifically targets people who use or inject drugs?
- Who knows of any formal / official or informal / unofficial / underground harm reduction services in the country?

Optional (if time allows)

4. Support services / personal situation

- What are the top three priorities in the life of a person who uses or injects drugs? Where would HIV and TB be on that list?
- What would need to be in place / improved for HIV and TB to receive more of attention from a person who uses or injects drugs?
- What could national / local governments do to make this happen?
- What could people who use or inject drugs themselves do to make this happen?
- What could the wider community do to make this happen?

5. Drug-resistant TB

- Does anybody know people who use drugs who've been on (and off) TB-treatment for more than a year?
- Does anybody know of people who use drugs, who have been diagnosed with multidrug-resistant (MDR) or extensively drug-resistant (XDR) TB?

ANNEX 4: TOPIC LIST KEY INFORMANT INTERVIEWS

Topic list for key informant interviews

For (non-drug using) stakeholders

Text in Italic is background information for interviewers

Barriers and facilitators of uptake of HIV and TB services

- Do you think people (both men and women) who use and inject drugs are able to access existing HIV and TB services? *They are available, but are they accessible?*
- If not, what are the reasons for this? *For probing: reasons linked to the person, the service location, staff or form of organisation, the (legal) environment*
- Would you consider it a priority to focus on people who use or inject drugs in HIV & TB programming? Why (not)?
- What would need to change (at programme and policy level) to ensure inclusion of people who use and inject drugs into HIV and TB services? *For probing into the policy level:*
 - *Supportive legislation & policy (incl. decriminalisation of drug use and possession)*
 - *Eliminating stigma and discrimination*
 - *Engagement of people who use or inject drugs in policy and programming*
- Who would need to do what or be responsible for what?
- (Is addressing HIV a priority in working with / dealing with people who use drugs?)

Existing programmes for people who use or inject drugs, including harm reduction services, and gaps in the national HIV and TB responses for people who use or inject drugs

- Do you think specific services or programmes for people who use or inject drugs are needed in Zimbabwe? Why (not)?
- Do you know of a programme or a service that has tailored services for people who use or inject drugs or that specifically targets people who use or inject drugs? If yes, what do they do differently than other programmes / services?
- Do you know what harm reduction is? Can you explain it?
- Do you think harm reduction services are needed in Zimbabwe? And would they be possible/ accepted?
- If so, which ones should be prioritised? *For probing:*
 - *Needle & syringe programming*
 - *Opioid agonist treatment (methadone, buprenorphine)*
 - *HIV testing and counselling*
 - *HIV treatment and care (incl. prevention from mother to child transmission (PMTCT) services)*
 - *Prevention and management of viral hepatitis B & C (incl. HBV vaccination & HCV treatment)*
 - *Prevention, diagnostics and treatment of TB*
 - *Sexual and reproductive health interventions (incl. STI management, abortion, cervical cancer screening, condoms and other contraception methods, pregnancy care and maternal & new-born care)*
 - *Naloxone provision for opioid overdose management*

- *Mental health services (counselling, peer support groups)*
- *Services addressing gender-based violence and other forms of violence against people (esp. women) who use drugs*
- *Pre- and post-exposure prophylaxis (Prep & PEP)*
- *Drop-in centres (women-only or with specific opening hours & services for women)*
- *Safe houses / shelters (women-only or with separated places for women)*
- *Drug consumption / safe injection rooms*
- *Testing of drugs for safer use*
- *Legal advice & support services*
- *Educational & employment opportunities*
- Do you know of any existing formal / official or informal / unofficial / underground harm reduction services in the country?

Existing TA needs and gaps in the national HIV and TB responses (at various levels)

- Based on your previous answers, what do you think government / public health care institutions, private sector and civil society can (should) do to strengthen the HIV & TB responses for people who use or inject drugs?
- Where would support from outside be needed? *For probing:*
 - *Adapting laws and policies*
 - *Integrating existing health services and/or decentralisation of those into community*
 - *Research*
 - *Programme design & implementation (differentiated services, linkages from community to facility)*
 - *Training health staff / community workers / peers / law enforcement staff*
 - *Monitoring & evaluation*
- Where would you suggest this support should come from?

ANNEX 5: ETHICAL APPROVAL LETTER MEDICAL RESEARCH COUNCIL OF ZIMBABWE

Telephone: 0242791193/08644073772
E-mail: mrcz@mrcz.org.zw
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
20 Cambridge Road
Avondale
Harare
Zimbabwe

MRCZ/A/2885

19 April, 2022

Johanna E. G. Voets
2311 Bluffhill Area C
Harare

RE: - Zimbabwe Situational Analysis of Drug Use and Injection in Five Provinces to Inform HIV and TB Programming for People Who Use or Inject Drugs

Thank you for submitting your application for review.

Please be advised that the MRCZ has **reviewed** your application to conduct research and it met the ethical requirements. Final approval will be granted by the Research Council of Zimbabwe upon meeting requirements for registration of foreign researchers. Study activities can commence upon issuance of a foreign researcher registration certificate by RCZ.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



ANNEX 6: CONSENT FORM FOR SURVEY PARTICIPANTS

INFORMED CONSENT FORM

STUDY TITLE: Zimbabwe situational analysis of drug use and injection in five provinces to inform HIV and TB programming for people who use or inject drugs

Principal Investigator: Johanna E.G. VOETS ("Ancella")

Co-Investigator: Obrian F. Nyamucherera

Phone Number: 077 344 7006

What you should know about this research study:

- We give you this consent form so that you may read about the purpose, risks, and benefits of this research.
- The main goal of research studies is to gain knowledge that may help the government, communities and the community of people who use and inject drugs.
- We cannot promise that this research will benefit you.
- You have the right to refuse to take part, or agree to take part now and change your mind later.
- Please review this consent form carefully. Ask any questions before you make a decision.
- Your participation is voluntary.

PURPOSE

You are being asked to participate in a research on people who use or inject drugs. The objective of the research is to conduct a situational analysis of drug use and injection to inform the national HIV and TB programming for people who use or inject drugs in Zimbabwe.

Sub-objectives:

- To identify patterns of drug use and injection, including types of drugs used, types of drugs injected, polydrug use, extent of harms experienced by the users, numbers of women and minors who use or inject drugs;
- To assess levels of knowledge, attitudes and perceptions of risk and vulnerability to HIV and TB among people who use or inject drugs;
- To determine barriers and facilitators of uptake of HIV and TB services among people who use and inject drugs;
- To document existing programmes targeting people who use or inject drugs and harm reduction services;
- To identify gaps in the national HIV and TB responses for people who use or inject drugs;
- To develop an implementation plan (road map) to mitigate against HIV and TB among people who use or inject drugs, including technical assistance needs.

You were selected as a possible participant in this study because you have stated that you currently use illicit drugs, you either live or use drugs in one of the selected districts, and you are over 18 years of age. We would like you to share your views on drug use in Zimbabwe and other associated questions above.

PROCEDURES AND DURATION

If you decide to participate, you will have an individual interview where you will be asked questions on which you choose from various answers. There will be questions about your life and about your experience of drug use. The interview will be coded to protect your identity. This means your name will not be on the interview.

RISKS AND DISCOMFORTS

The potential risks and discomforts for this study are;

- Disclosure during interviews of confidential information on drug use, sexuality, sexual practice and HIV status (loss of privacy and/or breach of confidentiality);
- Harassment from law enforcement bodies, because of being linked to the research programme;
- Emotional discomfort caused by some of the questions about experiences in the past;
- Data collection using electronic devices and potential data leaking;
- Length of the interview;
- The publication of findings of this study that can be traced to the particular research participants, their identity and their communities in the form of the thesis and publications.

In order to minimise the risks, I will take responsibility for;

- Ensuring ethical clearance of the study by the responsible authorities (Medical Research Council of Zimbabwe);
- Obtaining informed consent (verbal and written) from you and all participating in the study;
- Keeping the profile of the research programme as low as possible outside of the drug using community (to society and authorities it will be presented as research focussing on health habits);
- Ensuring the whole research team will adhere to a strict code of conduct, which includes keeping all information coming out of the research confidential;
- Ensuring that nobody in the research team is linked to law enforcement bodies (and avoiding contact with and involvement of law enforcement bodies);
- Offering a safe space to conduct the interview; you will be in a closed room with the interviewer, where nobody but the interviewer can hear you, and the place of the interview is chosen in such a way that it does not attract attention or raise suspicion among the wider society or from authorities;
- Coding the interviews so that no one can trace and link the identity of interviewees;
- Keeping consent forms in a safe place where only the principal investigator, co-investigators and supervisors can access them;
- Collecting and processing data with stringent confidentiality to protect the identities of all respondents;
- Password protection of electronic data storing sites and limiting access to the raw data;
- Distribution and publication of research findings in fully anonymous ways;
- Providing voluntary (accompanied) referral to appropriate health services, including psychosocial counselling, through ZCLDN provincial focal persons, in case of any serious (emotional) harm caused, relived or revealed by this research.

In case you encounter any challenges during or after your participation in this research that are linked to this research and you require support, please contact the Zimbabwe Civil Liberties and Drug Network:

- **Wilson Box** **077 705 6475**
- **Hilton Nyamukapa** **077 292 1667**

BENEFITS AND/OR COMPENSATION

Your participation in this research is entirely voluntary. It is your choice whether to participate or not, and you may decide to only answer some of the questions or all of them. Any communication with me and my colleagues will be confidential. This means that we won't identify who told us something to anyone else in the community, to the authorities, or in our research write-up.

We cannot and do not guarantee or promise that you will experience any benefits from this study. You will receive USD 5.00 for your participation, as a compensation for your time and to reimburse your transport and refreshments costs.

CONFIDENTIALITY

If you indicate your willingness to participate in this study by signing this document, we plan to disclose the overall findings of the study to the Ministry of Health and Child Care, the National AIDS Council, UNAIDS, the Global Fund to fight AIDS, Tuberculosis and Malaria, the Zimbabwe Civil Liberties and Drug Network and other actors implementing the TB and HIV and AIDS response in Zimbabwe. As stated before, the interview will be anonymous so that any information you provide cannot be traced back to you. Any information that is obtained in connection with this study that can be identified with you will remain confidential and will be disclosed only with your permission. Following national and international research guidelines, we will store all the information in an anonymous way on servers that will be secured with passwords. All information will be stored for three years and can be shared with other researchers upon request. Those data will always be anonymised and will not allow anybody to link any of the information to you or other research participants.

ADDITIONAL COSTS

The researcher will bear all costs related to this study and the participants will not be expected to bear any costs at any point during this study.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you decide not to participate in this study, your decision will not affect your future relations with the Ministry of Health and Child Care or any of its implementing partners in the HIV and TB response in Zimbabwe. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without penalty and without losing the right to compensation.

PROJECT TITLE: Zimbabwe situational analysis of drug use and injection in five provinces to inform HIV and TB programming for people who use or inject drugs

Protocol Version Number/date: _____

OFFER TO ANSWER QUESTIONS

Before we proceed with this research, please ask any question on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over. If you have understood everything, you can give me the go-ahead and ask you questions verbally or you can sign this document.

AUTHORIZATION

You are making a decision whether or not to participate in this study. If you decide to participate, I would like you to give me your clear verbal authorisation and to sign this form to allow me to start the interview, as an indication that you have understood the reasons for this study and that all your questions have been answered. This authorisation indicates that you have decided to participate.

Name of Research Participant

Signature

Date

Name of Staff obtaining Consent

Signature

Date

Name of Witness (*if required*)

Signature

Date

YOU WILL BE OFFERED A COPY OF THIS CONSENT FORM TO KEEP.

If you have any questions concerning this study or consent form beyond those answered by the investigator, including questions about the research, your rights as a research participant, or research-related injuries; or if you feel that you have been treated unfairly and would like to talk to someone other than a member of the research team, please feel free to contact the **Medical Research Council of Zimbabwe (MRCZ)** on telephone **(04) 791 792** or **(04) 791 193** or cell phone **0784 956 128**. The MRCZ Offices are located at the National Institute of Health Research premises at Corner Josiah Tongogara and Mazowe Avenue in Harare.

ANNEX 7: GLOBAL AIDS TARGETS (TOP-LINE)

HIV services			Integration	Social enablers		
95–95–95 testing and treatment targets achieved within all sub-populations and age groups.	95% of women of reproductive age have their HIV and sexual and reproductive health service needs met; 95% of pregnant and breastfeeding women living with HIV have suppressed viral loads; and 95% of HIV-exposed children are tested by 2025.	95% of people at risk of HIV infection use appropriate, prioritized, person-centred and effective combination prevention options.	Adoption of people-centred and context-specific integrated approaches that support the achievement of 2025 HIV targets and result in at least 90% of people living with HIV and individuals at heightened risk of HIV infection linked to services for other communicable diseases, non-communicable diseases, sexual and gender-based violence, mental health and other services they need for their overall health and wellbeing.	10–10–10 targets for removing social and legal impediments towards an enabling environment limiting access or utilization of HIV services		
				Less than 10% of countries have punitive legal and policy environments that deny or limit access to services.	Less than 10% of people living with HIV and key populations experience stigma and discrimination.	Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.
				Achieve SDG targets critical to the HIV response (i.e. 1, 2, 3, 4, 5, 8, 10, 11, 16, 17) by 2030		

ANNEX 8: WHO RECOMMENDED PACKAGE OF INTERVENTIONS FOR PEOPLE WHO INJECT DRUGS

Essential for impact: enabling interventions

Removing punitive laws, policies and practices
 Reducing stigma and discrimination
 Community empowerment
 Addressing violence

Essential for impact: health interventions

Prevention of HIV, viral hepatitis and STIs

Harm reduction (NSPs, OAMT and naloxone for overdose management)
 Condoms and lubricant
 Pre-exposure prophylaxis for HIV²⁴
 Post-exposure prophylaxis for HIV and STIs
 Prevention of vertical transmission of HIV, syphilis and HBV
 Hepatitis B vaccination
 Addressing chemsex

Diagnosis

HIV testing
 STI testing
 Hepatitis B and C testing

Treatment

HIV treatment
 Screening, diagnosis, treatment and prevention of HIV associated TB
 STI treatment
 HBV and HCV treatment

Essential for broader health: health interventions

Conception and pregnancy care
 Contraception
 Mental health
 Prevention, assessment and treatment of cervical cancer
 Safe abortion
 Screening and treatment for hazardous and harmful alcohol and other substance use
 TB prevention, screening, diagnosis and treatment

MAIN*line*

**Frederik Hendrikstraat 111 115,
1052 HN Amsterdam**



December 2022