Towards Housing First and harm reduction: addressing opioid dependence and homelessness in Tshwane during the COVID-19 pandemic

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People need a home, social connections and access to evidence-based interventions to achieve health. A national policy on homelessness should be developed, funded and implemented.

Pandemics can increase mortality and drug-related harms among people experiencing homelessness. The Housing First approach prioritises housing and service access. Harm reduction, a principle of Housing First, minimises the consequences of drug use. This chapter presents lessons learnt from the application of Housing First and harm reduction principles with homeless people in Tshwane, South Africa, between April 2020 and March 2021.

Quantitative service delivery data were retrospectively reviewed and analysed using descriptive statistics. Accounts by authors who participated in the COVID-19 response were collectively discussed in relation to the Housing First and harm reduction actors and process. Issues were synthesised in relation to two six-month periods.

A task team was established to co-ordinate Tshwane's response. In the first six months, 1 440 temporary bed-spaces were created at 25 shelters, and 2 066 people at shelters received food, social support and on-site healthcare services. Across shelters, 1 076 residents were started on methadone to manage opioid withdrawal. By the second six-month period, many gains were lost. Changes in political leadership stalled plans to reintegrate people housed in temporary shelters, and reduced funding led to shelter closures. By April 2021, more shelters operated than in pre-COVID-19 times, harm reduction capacitation for shelter staff continued, and local government committed to establish a street homelessness unit.

Through a combination of funding and collaboration, progress was made towards Housing First and harm reduction for homeless people in Tshwane. A national policy on homelessness should be developed, funded and implemented. This should be informed by additional research, developed in partnership with affected populations, and built on a common understanding of Housing First and harm reduction.

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Introduction

Structural failures and intersecting social, political and economic factors contribute to homelessness[1] and substance use,[2] which can negatively affect health. People experiencing homelessness have up to 13-fold higher mortality rates than their stably housed counterparts.[2] They are exposed to violence and harassment[3] and experience a high mental health burden.[2] Many use substances for their supporting, distracting, sedating, anaesthetic or stimulating properties.[4]

The criminalisation of and conservative views around drug use exclude people who use drugs (PWUD) and increase their risk for homelessness[5] and drug-related harms.[4] Stable housing improves health,[1] reduces drug-related harms and increases retention in drug services.[6]

This chapter presents lessons learnt from the application of principles underlying Housing First (Box 1) and harm reduction (Box 2) with people experiencing homelessness in Tshwane, South Africa, between April 2020 and March 2021. Box 3 provides definitions of commonly used terms in the chapter.

Box 1: Housing First[1]

Housing as a basic human right is the foundation of the Housing First approach. This approach emerged in New York City in 1992, motivated by the need to provide cost-effective approaches to address rising levels of homelessness. It aims to rapidly house people experiencing chronic homelessness who have a substance-use disorder or a mental health condition. Clients select their home from various housing options. Housing is neither 'earned', nor conditional on health-service utilisation, compliance or abstinence. Services are offered by mobile multi-disciplinary teams, supported by case managers. A harm reduction approach is applied to substance use (see Box 2). This model has improved housing stability and health outcomes for residents in high-income countries with developed health and social services.

Box 2: Harm reduction[7–9]

The harm reduction movement began in the Netherlands in the 1970s and gained traction in England in the 1980s. It emerged as resistance to the criminalisation and forced treatment of PWUD. From the outset, it included interventions to mitigate HIV transmission among people who inject drugs (PWID) and the provision of opioids to manage opioid dependence. This approach is rooted in social justice and human rights. Harm reduction principles embrace humanism, pragmatism, individualism, autonomy, incrementalism and accountability, without exclusion from services. Harm reduction empowers people to make decisions on ways to reduce immediate risks and supports them to achieve their goals. The World Health Organization includes needles and syringe services (NSS) and opioid substitution therapy (OST) in its package of harm reduction interventions.

NSS provide sterile injecting equipment and collect used materials to reduce transmission of blood-borne infections and attract people to services.

OST is a long-term intervention that involves prescription of an opioid agonist medication (most commonly methadone and buprenorphine) by a clinician at an adequate dose, with access to voluntary psychosocial services, and is the recommended treatment for opioid dependence. OST also reduces the use of unregulated drugs, crime, injecting, HIV and hepatitis C virus transmission, and mortality.

Detoxification involves supported opioid withdrawal management, often with agonist medications. Most people return to opioid use within six months of detoxification, which is associated with increased morbidity and mortality. It is not recommended as effective treatment.

Box 3: Definitions

Claimed buildings: buildings that usually lack electricity and sanitation where people experiencing homelessness live

Homeless: people living on the street, in open spaces or derelict buildings and those moving between shelters

Shelter: buildings/spaces usually managed by a government entity or a civil society organisation (CSO) that comply with norms and standards and have documented intake, exit and management processes

Temporary shelter: set up as part of an emergency response, not necessarily intended to become permanent

Transitional housing: medium-term accommodation with a plan to transition the person into long-term housing

Long-term housing: provides people with secure tenure

Homelessness in South Africa

Accurate data are lacking, but South Africa's homeless population is estimated at 100 000 – 200 000 people.[10] Strategies to address homelessness have been characterised by a 'one-size-fits-all' approach operating within a national policy vacuum.[11] Short-term interventions have dominated, with an emphasis on overnight shelters. Generally, there has been little integration between housing, health and other social services.[11]

Drug use in South Africa

National estimates of PWUD are limited. Cannabis and heroin[a] (an opioid) are the most widely used non-regulated drugs, with 4% and 0.3% respectively of people aged ≥15 years estimated to have used these drugs in the previous three months (2012).[12] No shelters allow on-site drug consumption and very few provide harm reduction services. Consequently, many PWUD opt to live on the street.[13] Two-thirds of PWID who participated in a 2018 study on blood-borne infections across three cities (n=943) were homeless.[14]

Harm reduction in South Africa

The majority of opioid treatment services supported by government are abstinence-based.[15] However, local studies have demonstrated the ineffectiveness of these services for retaining clients[16] and maintaining abstinence.[17] Nonetheless, harm reduction remains controversial.[15] NSS operate in nine health districts[18] and OST services are available in four metros.[18] Only 1% of PWID have access to OST.[18] The Essential Medicines List (EML) restricts methadone to opioid detoxification at hospital level (with tramadol as an alternative).[19] OST maintenance is unavailable in the public sector (apart from in Tshwane).

Homelessness in Tshwane

The most recent estimate suggests that there were 6 244 homeless people in Tshwane (2011).[20] The City of Tshwane Metropolitan Municipality's (CTMM) Integrated Development Plan (2017–2021) refers to the adoption of a homelessness Policy and Strategy (2019), but without any dedicated budget.

Historically, the CTMM employed ad hoc responses to manage homelessness crises. The Tshwane Homelessness Forum[b] (THF) has been engaging with the CTMM to enhance policy and programmes around homelessness since 2004. The first city-owned and managed shelter (No. 2 Struben Street) was established in 2005 to cater for 150 people. In 2013, the first CTMM homelessness policy was approved without a committed budget. It aimed to establish shelters across Tshwane with an emphasis on policing to deal with homelessness.[20] The policy was not implemented, and the city-managed shelter deteriorated as it did not operate appropriately. No alternative city-funded shelters were established. A failed eviction in 2014 led to constructive engagements between the CTMM, THF, the University of Pretoria (UP) and the University of South Africa (UNISA). These resulted in the multi-disciplinary 'Pathways Out of Homelessness Research Project' that developed a bottom-up policy on homelessness for the CTMM.[20] The revised policy was adopted in 2019, without a reserved budget or implementation plan.

Prior to the outbreak of COVID-19 in South Africa, No. 2 Struben Street remained the only city-owned shelter (with ± 900 residents) and CSOs managed eight housing facilities (for ± 123 residents), with partial support from the provincial government.[28]

a Also known as nyaope, whoonga, unga, sugars.
b A collective of CSOs, universities, and people with lived experience of homelessness that seeks to co-ordinate services and enable collective advocacy.

Substance use and harm reduction in Tshwane

Cannabis and heroin (nyaope) are the most prevalent drugs used in the city, but accurate estimates are lacking.[18] In 2017, there were an estimated 4 514 PWID in Tshwane, with an HIV prevalence of 58.4% and a hepatitis C virus (HCV) prevalence of 94.1%.[21] Two-thirds of PWID in Tshwane (n=324) participating in the aforementioned blood-borne infection survey (2018) were homeless.[14]

The city's first NSS was launched by a CSO in 2015. This continues, funded by an international donor.[18] In 2016, CTMM became the first (and remains the only) municipality to fund OST and NSS through the Community Oriented Substance Use Programme (COSUP) implemented by UP's Department of Family Medicine (DFM).[22] By 2019, COSUP had established 17 service sites and initiated 1 513 adults onto OST, distributing 17 000 needles to PWID per month. The high cost of methadone and limited funding have restricted expansion.[22]

Initial responses to COVID-19

The COVID-19 pandemic and related response brought to the fore the health and social issues affecting people experiencing homelessness in Tshwane. The CTMM initially set up a mass shelter (at a stadium without requisite infrastructure, sanitation or management) without consultation with the THF and health counterparts outside government structures.[23] Within three days of the first lockdown being announced in March 2020, over 2 000 people were placed at the stadium. Concerns emerged regarding the unsuitable environment and inadequate planning to support opioid withdrawal. Consequently, the Homelessness and COVID-19 Response Task Team (including the CTMM, THF, UP, UNISA and CSOs) was established to co-ordinate interventions.[23]
The research involved retrospective review and analysis of data collected for intervention monitoring and reflections of the experiences of authors who participated in the COVID-19 response in Tshwane. Quantitative data were collected at baseline (on demographics, reported symptoms, chronic conditions, drug use, and medication) as part of initial health screening and service delivery. UP's Health Faculty Research Ethics Committee approved the research (Ethics Reference No.: 310/2020). Clients provided informed consent.

Due to the emergency nature of the response and mobility of people, different systems were used for data collection and record-keeping. Data from some services rendered by other partners were not available for analysis. Stakeholders not involved in the development of this chapter may have views on the process, challenges and implications that are not included here.

Key findings

This section begins by describing the beneficiaries who received baseline health screening and management at 25 shelters during the first six months. This is followed by a discussion on progress and challenges in implementation (during two six-month periods) and a reflection on outcomes and limitations.

Beneficiaries

Baseline data were recorded from 2 066 people (see Table 1). Most beneficiaries were men (93.3%) with a median age of 33. Almost two-thirds (57.6%) reported current opioid use, among whom 532 (44.7%) reported current injecting, and two reported current OST use. HIV infection was reported among 5.9%, with 58.2% reporting antiretroviral therapy use. Overall, 1 079 (52.2%) people were symptom-screened for COVID-19/TB; 110 (10.2%) were symptomatic for COVID-19 and 24 (2.2%) were diagnosed as having TB.

Table 1: Baseline characteristics of beneficiaries served at 25 shelters and claimed buildings (April – September 2020) (n=2 066)

Variable	N	%
Gender		
Male	1 927	93.3%
Female	106	5.1%
Missing data	33	1.6%
Population group		
Black African	1 132	54.8%
White	69	3.3%
Indian	5	0.2%

Variable	N	%
Coloured	21	1.0%
Other/ Not specified	839	40.6%
Age		
<15	0	0.0%
15 – 24	119	5.8%
>=25	1 730	83.7%
>=60	42	2.0%
Unknown	109	5.3%
Substance use		
Current illicit drug use	1 299	62.9%
Current opioid use	1 189	57.6%
Medical condition (self-reported)		
HIV-positive	122	5.9%
HIV-positive on antiretroviral therapy (n=122)	71	58.2%
Current TB client	20	1.0%
Current TB client on treatment (n=20)	6	30%
Other diagnosed mental health condition and receiving treatment	23	1.1%

Towards a co-ordinated response (April – September 2020)

During the first three months of the response, encouraging progress was made towards a systematic housing intervention and the integration of health and harm reduction services at shelters. However, from June 2020 onwards, several gains were lost. Table 2 summarises milestones in relation to the epidemiological context and stakeholder responsibilities.

Developing a systematic housing intervention

Government and civil society partners collaborated to respond to the COVID-19 pandemic in Tshwane. The Homelessness and COVID-19 Response Task Team oversaw the planning, shelter identification, management, standard operating procedure (SOP) development, training, documentation, service delivery and delegation of responsibilities. In September 2020, the Unit for Street Homelessness at UP created the Pathways Operational Centre, comprising representatives from the CTMM and CSOs, to support homeless policy implementation.

Early recognition by the CTMM of the need for broader stakeholder engagement enabled review and adoption of processes included in the CTMM's 2019 Street Homelessness Policy, particularly the establishment of smaller shelters for individualised care. Within the first six months, 1 440 new temporary bed-spaces were created at 25 shelters. The Level 5 lockdown Regulations that mandated government to provide shelter without entry criteria were aligned with the fundamental concept of Housing First.[1]

On the road to integrated healthcare and harm reduction services

The CTMM Group Head of Social Development and CTMM Drug and Substance Abuse Unit tasked the DFM with providing health and harm reduction services at shelters. Family physicians and registrars led health teams (comprising clinical associates, pharmacists, social workers, data capturers and volunteers). DFM and COSUP staff were deployed from their community health centres, hospitals and COSUP sites to shelters. The health teams enabled on-site health service delivery.

The baseline assessment identified and (re)started people living with HIV, TB and chronic diseases on treatment. Pre-COVID-19 restriction of HIV and TB service delivery to fixed health facilities and other challenges identified through previous qualitative research were likely barriers to care for some residents.[24] Offering voluntary health services at shelters was a step towards Housing First's principle of taking services to residents.[1]

During this period, 1 076 people were initiated onto methadone, 82 of whom reported previous engagement with COSUP services. The lockdown reduced access to illegal opioids, forcing people into involuntary withdrawal, and concomitant anxiety and instability. Collaboration between partners and leverage of existing COSUP expertise enabled rapid implementation of withdrawal management. Harm reduction services were provided at the majority of shelters for the first time.

As lockdown restrictions eased, the DFM and COSUP were able to organise a workshop in May 2020 for social workers at 20 shelters around harm reduction and mental health. Organisers believed that social workers' exposure to harm reduction at shelters in the previous month contributed to active participation in the workshop.

However, some shelter staff were resistant to harm reduction. DFM medical teams reported that staff at some shelters reduced residents' methadone doses. Some shelter managers stated that harm reduction conflicted with their beliefs and/or experience in the use of abstinence- and faith-based approaches. The reasons for managers' resistance to harm reduction were not researched. However, in local contexts, such resistance has been linked to misunderstanding of harm reduction principles and evidence of effectiveness.[15] As a result, many PWUD placed in shelters where staff contested harm reduction sought alternative sleeping arrangements.

Housing First does not make housing contingent on abstinence and ensures that harm reduction services are available, tolerating continued use while reducing harms. Comprehensive application of the harm reduction philosophy was impossible because none of the shelters enabled safer drug use, nor were NSS allowed onsite. The Tshwane Metro Police Department (TMPD) was involved in drug searches at shelters.

Mounting challenges

In June 2020, the country moved to lockdown Level 3 and the requirement that government provide housing was removed. As a result, there was less political will and less financing for housing.

During May and June 2020, stakeholders developed a 10-Point Plan and Reintegration Strategy[c], with a view to operationalising the Tshwane Homeless Policy into a short-term action plan. In local government, key drivers of the homeless project were suspended, acting staff were appointed, and financial irregularities were investigated. The THF, CSOs and involved academics did not implement the 10-Point Plan during the period in which the city transitioned to a new administration.

In the light of the limited budget and the high cost of methadone, additional people were not placed on methadone from June despite ongoing, unmet demand. Attempts to use tramadol as an affordable alternative were unsuccessful due to insufficient symptom alleviation, side-effects and clients' preference.

At the same time, COSUP staff were required to return to their COSUP sites. COSUP therefore gradually shut down methadone services at shelters.

During July 2020, medical teams returned to their posts at hospitals to manage COVID-19 clients and provide other services, reducing healthcare service delivery at shelters.

By the end of September 2020, 14 of the temporary shelters had closed. Encouragingly, 11 later became permanent. Furthermore, two long-term housing sites were opened for people older than 55, one being for those needing frail care. The latter incorporates several Housing First principles. Residents have tenure and access to case management, and psychosocial and health services. While changes in residents' wellbeing have not yet been measured, safe and stable housing has been shown to reduce anxiety, trauma and service interruptions associated with short-term housing.[1]

Table 2: Alert levels, epidemiology, response milestones and stakeholder roles (April – September 2020) in Tshwane

Month	April	May	June	July	Aug	Sep
Alert level[d]	Level 5	Level 4	Level 3	Level 3	Level 3	Level 2
COVID-19 epidemic trajectory	Very few cases	Slow increase in cases	Rapid increase in cases	Peak of 1st wave	Reduction in new cases	Few new cases

c Plan elements: equitable housing; reintegration after temporary shelters; service provision at shelters; creation of the Tshwane Partnership on Homelessness; financing, and strategic information.

d https://www.gov.za/covid-19/about/about-alert-system#

Month	April	May	June	July	Aug	Sep
Milestones	Task team established Mass shelter challenges managed Scale-up of methadone access Decentralisa-tion to smaller shelters Health services at shelters	Closure of selected temporary shelters Social Worker harm reduction workshop	Net reduction in temporary beds Methadone service in several shelters stopped Change in provincial leadership of DSD 10-Point Plan drafted	Further temporary shelter closures Medical and COSUP staff return to pre-COVID-19 posts	First PWUD with confirmed coronavirus infection moved to the COVID-19 hospital, with continued methadone access	11 temporary shelters became permanent shelters Two long-term housing sites established Pathways Operational Centre established
Stakeholders and their main roles and responsibilities						
Provincial government	• The DSD funded CSOs for nutrition and shelter services; accessed tents. • The Department of Health (DoH) provided access to tramadol and methadone; supported establishment of COVID-19 hospital; and increased access to ambulance services.					
Local government	• Co-ordinated the response to homelessness, and funded CSOs that provided services at shelters (food, hygiene packs, tents, blankets). • Provided shelters with site managers, social workers and technical support. • Opened and ran nine shelters (800 – 1 200 people).					
CSO housing service providers	• Rapid scale-up of shelters. • The THF opened and managed 16 small shelters (500 – 800 people). • Provision of shelter, food and psychosocial support.					
Health service providers	• The CTMM, Tshwane DoH and DFM supported efforts to stop COVID-19 spread, screened for infectious diseases, and initiated and sustained health management. • Developed, trained and supported the implementation of COVID-19 SOPs for shelters. • Developed educational videos[e] (on harm reduction, overdose, and opioid withdrawal). • Conducted COVID-19 screening, testing, prevention and referral. • Initiated chronic medication and home delivery services. • Linked shelters with healthcare facilities. • Provided opioid withdrawal management. • Built capacity to implement withdrawal management in 20 shelters. • Facilitated weekly co-ordination with service providers at shelters. • Conducted data collection, collation and reporting.					
Academic institutions	• Co-ordination of policy implementation, supported service delivery.					
Law enforcement	• The TMPD provided security, drug searches, crowd management and security for health teams. • The South African Police Service enforced Regulations, facilitated crime prevention, and transported homeless people to shelters and mental health services.					
Private sector	• Isuzu South Africa loaned 15 bakkies to DFM for transporting staff and clients, and for medicine delivery.					

COSUP = Community Oriented Substance Use Programme
CSO = civil society organisation
CTMM = City of Tshwane Metropolitan Municipality
DFM = Department of Family Medicine
DoH = Department of Health
DSD = Department of Social Development
PWUD = people who use drugs
THF = Tshwane Homeless Forum
TMPD = Tshwane Metro Police Department

e https://bit.ly/3ebPhjc

Embracing a new normality (October 2020 – March 2021)

Table 3 summarises milestones and changes in stakeholder roles during the second six-month period. This period commenced under Level 1 lockdown restrictions, enabling greater movement of people. By this time, most service providers had institutionalised COVID-19 SOPs. However, many services regressed towards pre-COVID-19 models of delivery.

Housing

The city was no longer under provincial government administration, and no substantial progress was made in housing homeless people while new CTMM leadership emerged. The provincial DSD committed to provide financial assistance for temporary shelters until March 2021. The Tshwane Homeless Task Team launched a new initiative to provide technical support to existing shelters to improve service delivery.

During this period, efforts were made towards better regulation of the city-run shelter and addressing overcrowding by reducing the number of beds at the site. By March 2021, there were around 650 fewer bed-spaces across the city compared to the previous six-month period.

Healthcare service

Health services reverted to being facility-based. DFM registrars were withdrawn from shelters, resulting in fewer on-site services. While not measured, reduced access to healthcare services at shelters is likely to have contributed to the losses in follow-up of clients with chronic conditions and in the benefits of early intervention.

Harm reduction

By late 2020, prioritisation of harm reduction services within shelters decreased. COSUP staff returned to COSUP sites.

A substantial number of people dependent on drugs, especially heroin, returned to live on the street or moved into claimed buildings. PWUD reported that experiences of stigma, fears of exclusion and limited methadone availability contributed to people leaving shelters and returning to heroin use. Shelter-related restrictions on movement, social networks and mixed accommodation were other reasons for some people choosing to leave shelters.

During the first six-month period, many PWUD played active roles in supporting the methadone and food provision services. Empowerment of PWUD through community-led responses is an important part of harm reduction and integrated healthcare services.[7,9] The termination of the methadone service at shelters meant that many people lost their sense of responsibility and meaning. While not measured in the Tshwane context, a sense of meaning and responsibility has been shown to reduce harmful substance use in other contexts.[25] Many welfare gains among PWUD who participated in harm reduction services in Tshwane are likely to have been lost.

In February 2021, CTMM halted delivery of health and harm reduction services at claimed buildings. Drug-related harms were likely to have increased as geographical distance from harm reduction services contributes to risky drug-using practices (e.g. needle- and syringe-sharing).[9]

Table 3: Response milestones and stakeholder actions (October 2020 – March 2021) in Tshwane

Month	October	November	December	January	February	March
Alert level	Level 1	Level 1	Level 1	Level 3	Level 3	Level 1
COVID-19 epidemic trajectory	Stable, few cases		Rapidly increasing cases	Peak of 2nd wave	Reduction in new cases	Levelling off of cases
Milestones	CTMM no longer under provincial administration Voluntary movement of people	Capacitation of shelter service providers	Methadone service continued at four shelters New CTMM leadership orientated	All harm reduction services return to COSUP sites	Additional temporary shelters closed CTMM halts services at claimed buildings	Introductory training for shelter management on harm reduction

Stakeholders and their core actions	
Provincial government	• The Gauteng DSD funded shelters for street homeless people.
Local government	• Closed several temporary shelters.
Housing service providers	• Reduced the number of shelters. • Provided capacity-building for managers at persisting sites.
Health service providers	• DFM services re-focused on health facilities and hospitals. • OST services were limited to COSUP sites.
Law enforcement	• The TMPD was present as shelters closed, and conducted searches for weapons, drugs and stolen items at shelters. • The South African Police Service enforced State of Disaster Regulations.
Academic institutions	• Conducted research • Co-ordinated policy implementation • Delivered capacity-building for service providers

COSUP = Community Oriented Substance Use Programme (civil society organisation)
CTMM = City of Tshwane Metropolitan Municipality
DFM = Department of Family Medicine
DSD = Department of Social Development
OST = Opioid Substitution Therapy

Outcomes

Many of the achievements towards Housing First and integrated harm reduction at shelters in the early part of the COVID-19 response were lost. However, notable outcomes were achieved.

During the launch of the Homelessness and COVID-19 research report (April 2021)[20], the CTMM announced the establishment of a dedicated unit on street homelessness within the Department of Community and Social Development Services (with a dedicated budget pending). This would partner with UP's Unit of Street Homelessness (formalised in April 2021) to ensure ongoing research–action–reflection cycles on behalf of the CTMM in collaboration with universities and CSOs.

By June 2021, there were 21 shelters, transitional housing or special needs housing facilities for homeless persons in Tshwane (three managed by the city and 18 managed by CSOs) with 1 069 bed-spaces.[26]

Overall, 138 clients were absorbed into the OST programme at COSUP sites. A series of training workshops was held (reaching 50 shelter managers and 41 shelter staff) that included elements of Housing First and harm reduction. Engagement between COSUP, the CTMM and the national DoH continues towards provision of affordable methadone.

The DFM's health interventions at the shelters led to several research projects, including five qualitative and four quantitative studies[f] and a quality improvement project on TB and HIV screening. These data are being analysed.

Conclusions

While the full implementation of Housing First and harm reduction may not currently be feasible in South Africa, the potential to move in this direction was demonstrated in Tshwane. The collaboration demonstrated by the task team led to several gains.

To break the cycle of chronic homelessness, it is necessary to move beyond restrictive, short-term and fixed approaches to housing. Recent events have opened opportunities for engagement around and testing of other principles of Housing First.

A legislative mandate during lockdown led to political action and funding for housing support. Encouragingly, CSOs increased the number of shelters and long-term housing facilities (but not nearly enough to meet demand). Clear, supportive policy and a dedicated budget are required for municipalities to move towards addressing homelessness. These processes should continue, despite changes in political leadership or fresh emergencies. Social and housing agencies (including local and provincial government) are key stakeholders in this process.

The benefits of OST in shelter settings were demonstrated. Stakeholders are keen to learn more about harm reduction and for effective responses, the principles of harm reduction should be institutionalised.

f Topics include client functioning, withdrawal management, burden of disease, access to healthcare and healthcare expectations.

The model for integrated healthcare and harm reduction services at shelters was tested, and shows promise, but requires resources. The high cost of methadone and unmet demand for harm reduction among the homeless population in Tshwane remain unresolved.

The involvement of PWUD in COVID-19 service delivery suggests that this approach is possible and is likely to benefit individuals and support service integration.

Recommendations

The following recommendations draw on the Tshwane experience. Additional local evidence is needed to further inform policy towards Housing First and integrated harm reduction:

- Academic institutions should partner with CSOs and local government to develop and test models that apply the principles of Housing First and harm reduction. These findings should inform homelessness policy.
- National government, with support from the President's Office and in collaboration with the National Homeless Network Collaboration, should establish a national inter-departmental and multi-sectoral homelessness task team comprising civil society representatives and experts. This team should develop a national policy on street homelessness, including mandated national and municipal budgets, to provide direction and a framework for implementation.
- The Department of Human Settlements and social housing providers should engage with all spheres of government to establish their respective roles in building a 'housing pipeline', which must form part of the national policy on street homelessness.
- Provincial and local government shelter policies must include norms and standards that integrate harm reduction services, including collaboration with NSS providers and OST services.
- Collaborative institutional mechanisms should be established at local government level – including local and provincial government officials, homeless fora and CSOs, and involved academics – to steer implementation of adopted policies and strategies, ensuring continuity despite political or administrative changes in government. An example of this is UP's newly created Pathways Operational Centre.
- Policy and service providers should adopt a value-neutral understanding of drug use that positions clients at the centre of services (providing options, enabling informed decision-making); lower thresholds to services (minimal intake procedures, no requirement for abstinence); and take services to where people are (in the street, in claimed buildings). Peer-led services, including outreach and microplanning supported by community-based drop-in centres, are cost-effective implementation approaches.[25]
- National, provincial and local government departments must meaningfully include PWUD and people experiencing homelessness in developing policies and services that affect them. PWUD must be members of local drug action committees. Municipalities should develop relationships with local and national networks of people who use drugs (e.g. South African Network of People Who Use Drugs).
- The National Department of Health should prioritise affordable opioid agonist medication. The National Essential Medicines List Committee should include methadone and buprenorphine on the EML for use at primary-care level for maintenance. Provincial and local counterparts should ensure that these medications are on their formularies, with mechanisms for CSOs implementing public health programmes to access medication.
- Municipalities should establish a central command centre for homelessness and substance use, including key stakeholders. These centres should support improvements in health information systems and data, and secure resources to ensure implementation of homelessness policy.

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