HARM REDUCTION PROGRAMMES FOR MINORS WHO USE DRUGS

SUMMARY

- Substance use among adolescents and young adults is a **growing public health concern** in Southern Africa, with increasing rates of drug use among minors, including injection drug use.
- Minors who use drugs, particularly those who inject drugs, face **increased risks of HIV, hepatitis C and other health harms**. Despite evidence supporting harm reduction approaches, access to services such as needle and syringe programmes (NSPs) remains limited for minors in South Africa.
- Current **legal and policy frameworks create barriers** to accessing harm reduction services. Criminalisation of drug use and possession, unclear guidance for service providers, stigma and limited youth-focused programmes contribute to exclusion from health services.
- A **child rights-based harm reduction approach** is aligned with South Africa's constitutional obligations, the Children's Act 38 of 2005, the National Adolescent and Youth Health Policy and international child rights standards.
- Key recommendations include **reforming legislation and policy** to enable access to NSPs, developing youth-centred harm reduction services, integrating harm reduction with HIV, sexual and reproductive health, mental health and social support services, strengthening provider capacity, reducing stigma, and improving data collection on minors who use drugs.
- **Expanding harm reduction services for minors** would support prevention of avoidable health harms, improve access to care and strengthen protection of children's rights.

Introduction

Substance use among adolescents and young adults in Southern Africa is a growing public health concern. In the Southern African region, approximately 37% of adolescents and young adults use substances, with alcohol (41%), tobacco (46%), and cannabis (26%) being the most common.[1] In South Africa specifically, school-going young people primarily use alcohol (22–66%) and tobacco (46%), though cannabis and other substances have also been observed.[2] The growing prevalence of drug use among minors in South Africa poses significant public health challenges. Despite global evidence supporting harm reduction approaches, minors in South Africa face limited access to services that reduce drug-related harm.

Despite robust evidence supporting harm reduction approaches, interventions for minors remain largely abstinence-based, focusing on prevention rather than harm reduction. This has made harm reduction for minors a contentious policy issue.[3] While global evidence and international best practices affirm that Needle and Syringe Programmes (NSPs) effectively reduce bloodborne infections,[4] most harm reduction services in South Africa are designed for adults, often excluding minors who could benefit.[5] This exclusion is especially concerning because other health services, including sexual and reproductive healthcare, are accessible to minors without parental consent.

According to the Children's Act 38 of 2005, the age of majority in South Africa is 18 years[6]. This brief focuses on individuals under this age, advocating a child rights-based harm reduction approach that addresses the specific vulnerabilities, legal ambiguities, and access barriers faced by children who inject drugs. These children fall squarely within the constitutional child protection mandate.

Although national data on injecting drug use among minors are limited, the absence of data does not imply absence of need. Population health research in South Africa shows that the mean age of substance use experimentation among high school learners is around 12 years, with many beginning substance use at younger ages, including before age 10, highlighting the urgency of early intervention.[7]

ACKNOWLEDGEMENTS

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In recognition of the urgent need for early intervention, this brief recommends establishing 12 years as the minimum age for accessing harm reduction services. This recommendation aligns with Section 129(2) of the Children's Act, which permits minors aged 12 and above to independently consent to medical treatment, provided they demonstrate sufficient maturity. Establishing this threshold enables timely, evidence-informed intervention, reduces the risk of disease transmission, and strengthens harm reduction efforts, while ensuring that service delivery is legally sound and rights-aligned.[8] Adopting this approach enables the coherent integration of harm reduction services with South Africa's constitutional obligations and internationally recognized best practices, ensuring that all young people access the care they require while safeguarding their rights to health, dignity, and protection.

Background

South Africa is experiencing increasing rates of drug use among minors, including injection drug use, which heightens their vulnerability to infectious diseases and social exclusion. The current legal framework criminalises drug use and possession for all age groups, leaving minors particularly susceptible to harm, without access to preventive health services. The absence of needle and syringe programmes (NSPs) for minors contradicts international best practices and fails to prioritise the best interests of children.

The rise in drug use amongst young people worldwide poses a significant public health challenge, with serious implications for their health, safety, and overall well-being.[9] In 2020, approximately 27% of people who inject drugs were under the age of 25.[10] According to the World Health Organisation, 23 % of new hepatitis infections are attributed to unsafe injecting drug use, with the risk of contracting HIV 35 times higher for those who inject drugs than those who do not.[11] In South Africa, injecting drug use among adolescents is becoming a growing concern. While comprehensive, disaggregated national data on injecting drug use among all under-25-year-olds in South Africa remains limited, there are some indicative trends and partial figures from surveillance systems and service provider reports. Service providers reported that while minors are often hidden due to stigma and legal barriers, the 19–24-year-old group appears to have a higher prevalence of injecting drug use.

NSPs are internationally recognised as harm reduction tools that prevent the transmission of blood-borne viruses by providing sterile injecting equipment, information of safer drug use, mechanisms for collection and destruction of used equipment and linkage to other health and social services. However, adolescents and young people are frequently governed by distinct ethical and legal standards compared to older individuals who use drugs, influencing their access to harm reduction services. These frameworks are often grounded in paternalistic perspectives that prioritise protecting young people from drug use over respecting their autonomy.[12] Consequently, policies tend to be unduly restrictive and do not fully reflect the realities of young people's lives and drug-related behaviours. Moreover, the legal status of various harm reduction interventions varies considerably across regions and countries, resulting in inconsistencies in the availability and accessibility of these services for younger populations.[13] As such, **legal and policy barriers often exclude minors from accessing these services**, increasing their risk of contracting HIV and hepatitis C through needle-sharing. Minors and young people who inject drugs are **50 times more likely to acquire HIV and hepatitis C** compared to their adult counterparts.[14] Minors who lack access to NSPs face heightened risks of preventable illnesses, and the developing adolescent brain also increases their susceptibility to substance use disorders due to neurobiological changes during this period.[15] Furthermore, South Africa's current health infrastructure provides limited integrated care options for minors with these diagnoses.

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Despite these alarming trends, service providers face significant obstacles in delivering harm reduction services to minors. Testimonies from frontline organisations during a stakeholder consultation, indicated being actively discouraged or outright prohibited from providing harm reduction packs to minors. Many providers report being instructed to refer minors to rehabilitation centres—an intervention model that is often inaccessible, inappropriate, and underfunded. Service providers also cite extensive bureaucratic barriers and law enforcement interference, with reports of police confiscating clean needles. Furthermore, minors themselves express fear of stigma, community backlash, and parental discovery. Many are hesitant to access harm reduction services due to concerns over confidentiality and prejudice.

Addressing these gaps requires evidence-based, youth-focused harm reduction interventions.

Current Policy and Legislation

The **National Adolescent and Youth Health Policy (AYHP)**[16] provides a guiding framework for advancing adolescent health through **non-discriminatory, youth-friendly services**. Aligning NSPs with the AYHP's emphasis on preventive, age-appropriate healthcare would reduce health risks, improve treatment outcomes, and uphold minors' right to health.[17]

Moreover, South Africa's ratification of the **UN Convention on the Rights of the Child** obliges the government to prioritise the best interests of children.

The **Committee on the Rights of the Child** outlines recommendations to strengthen adolescent harm reduction services:

- **Non-criminalisation** of adolescent key populations by ending arrest and prosecution for drug use and abolishing involuntary custodial rehabilitation.
- **Voluntary, confidential, and adolescent-friendly** health services that include harm reduction.
- **Respecting minors' rights** to participate meaningfully in health-related policy and service decisions.
- **Waiving parental consent** for life-saving harm reduction services. South Africa, as demonstrated by the Children's Act 38 of 2005. Section 129 of the Act permits a child to consent to their own medical treatment if they are over 12 years old and possess sufficient maturity and decisional capacity to grasp the treatment's implications, including its risks and benefits. However, the Act does not define what constitutes 'sufficient maturity' nor does it specify how health professionals should assess a child's decisional capacity.
- **Tailoring harm reduction** to the specific age, gender, and risk factors of recipients.
- **Integrating harm reduction into HIV prevention programmes** with school-friendly service hours.
- **Expanding social protection services**, including cash-plus-care models, to reduce vulnerability.
- **Incorporating harm reduction and health education** into school curricula using non-judgmental, interactive methods.

These are further emphasised in the UN's international guidelines on human rights and drug policy which establishes clear obligations for countries regarding children's rights in the context of drug use and involvement in the illicit drug trade.[18]

PROTECTION AND PARTICIPATION

Children have the fundamental right to be protected from the harmful effects of drugs and exploitation, particularly in the drug trade. States are obligated to ensure that children's best interests are central in drug laws and policies. This includes taking measures to safeguard children from illicit drug use and trafficking, through evidence-based and human rights-compliant actions.

PREVENTION AND EDUCATION

Children are entitled to accurate information about drugs and drug-related harm. Prevention efforts should be based on sound evidence, particularly within schools. States must avoid punitive measures such as exclusion from education, drug testing, or intrusive searches, ensuring children's access to education remains uninterrupted.

HEALTH INTERVENTIONS

Children who use drugs have a fundamental right to access health services that are tailored to their specific needs. States must develop accessible, child-sensitive drug treatment and harm reduction services that are both comprehensive and supportive. These services should prioritise the best interests of the child, ensuring decisions about care and treatment are made in accordance with the child's evolving capacities. Crucially, children should have access to drug-related health information and counselling without requiring parental consent, especially when such services are in the child's best interest. States must also remove legal age restrictions for drug-related health services to ensure young people can access care when needed. Efforts should focus on diverting children away from the criminal justice system, promoting rehabilitation and harm reduction over criminalisation, and ensuring all responses align with international juvenile justice standards.

PROTECTION FROM PARENTAL DRUG DEPENDENCE

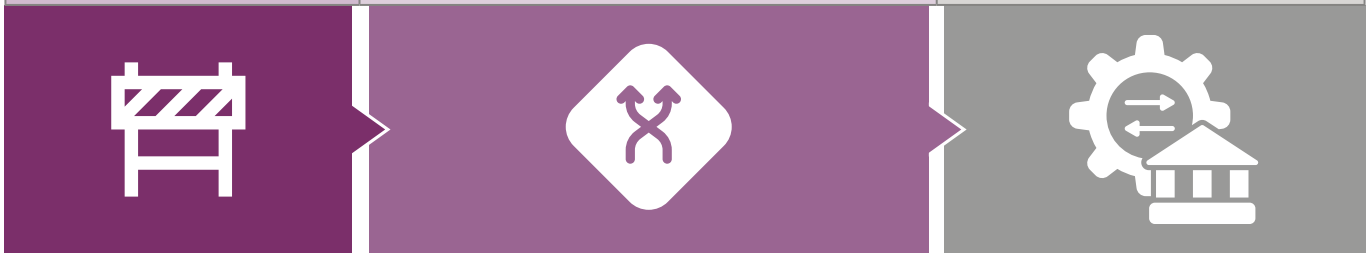
In cases where parents struggle with drug dependence, children's well-being must remain the primary concern. States must ensure that parental drug use is not the sole reason for child removal, focusing on supporting families to maintain or regain parental care through assistance to drug-dependent parents.

PREVENTION OF EXPLOITATION IN THE DRUG TRADE

Children have the right to be shielded from exploitation, including within the illicit drug trade. States should address root causes such as poverty and social marginalisation, ensuring that children's involvement in activities like rural drug crop cultivation is not mischaracterised as exploitation without specific evidence. Children should not be criminalised for involvement in the drug trade, especially when it stems from exploitation.

CHALLENGES, LEGAL CONTEXT AND REFORM RATIONALE

CHALLENGE	LEGAL OR POLICY INTERSECTION	REFORM NECESSARY
Legal Barriers Criminalisation of drug use among minors restricts access to harm reduction services.	• Children's Act 38 of 2005, s129: minors ≥12 may consent to medical treatment if they have sufficient maturity. • Drugs and Drug Trafficking Act 140 of 1992: criminalises possession/use of drugs, including for minors. • Constitution Sections 27 & 28: right to health care and child protection, highlighting the need to reconcile criminal law with health rights. • *Landmark Judgment*: Centre for Child Law v Minister of Justice and Constitutional Development [2012] ZACC 23 — affirmed that children's constitutional rights to health, dignity, and best interests take precedence.	**Human Rights**: Affirms constitutional right to health. **Social Equity**: Protects marginalised minors from legal deterrents to accessing care.
Stigma Social stigma deters minors from seeking help and perpetuates discrimination.	• Constitution Sections 9 & 10: equality and human dignity. • Societal and institutional norms perpetuating discrimination against minors who use drugs.	**Human Rights**: Protects dignity and equality. **Social Equity:** Reduces marginalisation and promotes inclusion in services.
Service Gaps Youth-focused harm reduction programmes, including NSPs, are scarce or non-existent.	• Most NSPs and harm reduction interventions are adult-focused; lack of youth-specific policy guidance. • Absence of age-appropriate programmes limits minors' access.	**Public Health**: Improves prevention and early intervention. **Social Equity:** Ensures vulnerable minors can access appropriate services.
Health Risks Minors who inject drugs are at significant risk of contracting HIV, Hepatitis C, and other blood-borne infections.	• Constitution Section 27: right to health care. • WHO and UNAIDS youth harm reduction guidelines emphasize disease prevention and early intervention.	**Public Health**: Reduces transmission of infectious diseases. **Human Rights**: Protects minors' right to health.
Mental Health Poor mental health support and lack of gender-sensitive services, including pregnancy, sexual health, and trauma	• Children's Act 38 of 2005: child protection provisions. • National Mental Health Policy Framework: youth and trauma-informed care. • Constitution Section 27: reproductive health rights.	**Human Rights**: Protects vulnerable minors, particularly girls. **Public Health**: Supports mental and reproductive health outcomes. **Social Equity**: Addresses marginalisation of young girls and those with trauma.
Social & Peer Dynamics Young people who use drugs are unlikely to link with older users accessing adult services.	• Constitutional rights to equitable access, dignity, and health. • Policy guidance recommends peer-informed and age-appropriate service models.	**Public Health**: Supports effective harm reduction among age-appropriate peer networks. **Social Equity**: Increases engagement and uptake for minors.



Implications

LEGAL AND POLICY ALIGNMENT

Reforming drug legislation to ensure minors' access to Needle and Syringe Programmes (NSPs) is not merely a technical adjustment—it is a necessary step to uphold constitutional and international obligations, protect children's health and rights, and align South Africa's drug policy with globally recognized best practices, including the United Nations Convention on the Rights of the Child (CRC)[19] By placing the best interests of minors at the forefront, policymakers can transform punitive approaches into a framework that prioritises care over criminalisation.

COURT DEVELOPMENTS

An example of reforms was seen with the High Court's judgement Centre for Child Law v Director of Public Prosecutions[20], on children found using or in possession of cannabis. The purpose of the hearing was to ensure that the outcome of the review judgment applied to all other children in similar circumstances, and to address the alleged constitutional defect. The High Court considered two issues: (a) the applicability to a child of the "crime" of contravening section 4(b) of the Drugs Act; and (b) whether the section is constitutional. The applicant argued that section 4(b) is unconstitutional, and that a child-oriented approach should be followed to respond to drug use amongst children. All the respondents supported the view that section 4(b) of the Drugs Act is unconstitutional as far as it applies to a child. Importantly, the Court stated:

> *"An appropriate response that recognises the child's best interests should be located in social systems as opposed to the criminal justice system."*

The Court reaffirmed the State's international legal obligations to provide harm-reducing, prevention and dependence treatment services as alternatives to punitive approaches. This sets a precedent for expanding harm reduction services — including NSPs — to minors in South Africa, in line with child rights obligations under the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child.

They also supported the argument that the Prevention of and Treatment for Substance Abuse Act and the Children's Act are more appropriate mechanisms to deal with cannabis related offences and although this applies to cannabis, it needs to be applicable to other substances.

ENHANCED PUBLIC HEALTH OUTCOMES

The integration of NSPs for minors stands to substantially reduce the transmission of HIV, hepatitis C, and other blood-borne infections. This pre-emptive public health strategy averts the long-term, costly burden of advanced medical interventions.

Furthermore, by addressing the unique vulnerabilities of young people, this reform will promote sustained improvements in community health.

EQUITY AND SOCIAL INCLUSION

A harm reduction model tailored to minors directly confronts and mitigates systemic inequities. By extending services to marginalized groups—including street-involved youth and girls at heightened risk of exploitation—the policy not only upholds individual rights but also promotes social justice. Targeted outreach strategies could further strengthen this approach, such as identifying schools with high dropout rates and mapping local shelters or safe houses where vulnerable adolescents may seek support. These sites may serve as critical entry points for harm reduction services and support programmes. However, the voices of young people who use drugs are rarely included in policymaking or service design, highlighting the need for participatory approaches that incorporate their lived experiences. Such measures would contribute to a more inclusive public health system that responds to the diverse needs of young people.

Policy Recommendations

POLICIES ON MINORS WHO USE DRUGS

Minors who use and inject drugs in South Africa are addressed across multiple legislative and policy frameworks, yet most remain punitive, abstinence-focused, or exclusionary, resulting in marginalization and limited access to harm reduction services.

Key frameworks include:

- **Drugs and Drug Trafficking Act** (No. 140 of 1992) criminalizes possession and use of drugs and drug paraphernalia.
- **Children's Act** 38 of 2005 protects children's rights but does not explicitly integrate harm reduction for substance-using minors.
- **Medicines and Related Substances Act** 101 of 1965 limits legal distribution of sterile injecting equipment outside formal healthcare settings.
- **Criminal Procedure Act** 51 of 1977: policing discretion can criminalize minors accessing harm reduction.
- **National Drug Master Plan** (NDMP 2019–2024) emphasizes harm reduction for adults; youth interventions remain largely abstinence-centred.
- **SAPS NSP Directives** support harm reduction for adults; guidance for minors is unclear.
- **DSD Harm Reduction Policy & Guidelines** endorse harm reduction in principle; operational guidance for minors is vague.
- **HIV prevention and treatment guidelines**: age-restricted services often exclude minors who use drugs.

These policies collectively provide a partial framework for addressing substance use, but gaps in inclusion, legal protection, and access to services leave minors vulnerable to criminalization, health risks, and social marginalization.

LEGISLATIVE AND POLICY FRAMEWORKS RECOMMENDED FOR REVISION

LEGISLATION/POLICY	CURRENT LIMITATION	RECOMMENDED REVISION
Drugs and Drug Trafficking Act (No. 140 of 1992)	Criminalizes possession and use of drugs and paraphernalia, including for minors	Decriminalize possession of drug paraphernalia for minors to allow lawful access to NSPs and other harm reduction services
Children's Act 38 of 2005	Does not explicitly integrate harm reduction into child welfare and protection services	Explicitly recognize harm reduction as part of the continuum of care for minors, including NSP access and OST where appropriate
Medicines and Related Substances Act 101 of 1965	Limits legal distribution of sterile injecting equipment for minors outside formal medical institutions	Amend to allow distribution of sterile injecting equipment in community and youth-focused settings
Criminal Procedure Act 51 of 1977	Policing discretion enables criminalization of minors accessing harm reduction	Remove discretionary powers that criminalize possession of injecting equipment; provide protection for minors accessing harm reduction
National Drug Master Plan (NDMP 2019–2024)	Focuses on adult harm reduction; youth interventions remain abstinence-centered	Include explicit strategies for adolescents, integrating NSPs, OST, and psychosocial support for minors
SAPS NSP Directives	Primarily adult-focused; policing guidance does not cover minors	Extend guidance to explicitly protect minors accessing harm reduction services
DSD Harm Reduction Policy & Guidelines	Application to minors is vague; youth framed through protective lens	Include clear operational guidance for harm reduction services for minors, emphasizing rights-based, non-punitive approaches
HIV prevention and treatment guidelines	Age-restricted access often excludes minors who use drugs	Expand adolescent access to HIV testing, treatment, and prevention integrated with harm reduction services

ESTABLISH PROTECTIVE GUIDELINES

Develop ethical and legal guidelines to shield healthcare and harm reduction practitioners from prosecution, ensuring that NSPs are delivered safely, confidentially, and equitably. This can be done following the steps below:

- **Stakeholder Engagement:** Convene a multidisciplinary team—including healthcare professionals, legal experts, harm reduction practitioners, and community representatives—to collaboratively identify legal and ethical vulnerabilities in current NSP delivery.
- **Review and Analysis**: Examine existing national and local legal frameworks alongside international best practices to identify gaps that expose practitioners to prosecution, ensuring a comprehensive understanding of potential legal risks.
- **Drafting Guidelines**: Develop detailed ethical and legal guidelines that outline safe, confidential, and equitable practices for NSP delivery. These guidelines should include protocols for maintaining patient confidentiality, ensuring informed consent, and safeguarding practitioner liability.
- **Legal Validation**: Work closely with legal advisors to vet the guidelines, ensuring that they provide robust protection against prosecution while complying with existing laws.
- **Training and Dissemination**: Implement training programmes for healthcare and harm reduction staff to familiarise them with the guidelines, ensuring consistent application and understanding of protective measures.
- **Continuous Evaluation**: Establish mechanisms for regular review and updates of the guidelines, allowing for adjustments in response to legal changes, emerging best practices, and feedback from practitioners in the field.

DEVELOPMENT OF YOUTH-CENTRED NSPS

- **Co-Creation with Young People:** Minors must be actively engaged in the design and implementation of drug policies, strategies, and programs, especially needle and syringe programs (NSPs) and harm reduction services. This includes co-designing harm reduction packs to ensure they align with PWUD best practices, containing safer smoking equipment, naloxone with overdose training, condoms and lubricant for sexual health, and age-appropriate, graphically driven IEC materials on safer use, overdose response, and access to help. Participatory design ensures services are non-judgmental, accessible, and culturally sensitive, while paid youth roles on advisory boards operationalize the principle of "Nothing about us, without us", creating programs that truly reflect young peoples' lived experiences and developmental needs.

- **Flexible, Accessible Service Models**: Needle and syringe programs (NSPs) should have operating hours and outreach strategies that accommodate school schedules and the realities of youth life, ensuring services remain discreet, accessible, and effective. Proven PWUD programming models can be applied, including mobile outreach units, peer-driven distribution, and integration with existing youth services such as after-school clubs in high-risk areas or shelters, to meet young people where they are and reduce barriers to harm reduction access.

INTEGRATION WITH COMPREHENSIVE HARM REDUCTION SERVICES

Holistic Health Approach: Needle and syringe programs (NSPs) should be embedded within a broader spectrum of services, including mental health care, addiction counselling, and sexual and reproductive health, to provide a continuum of care addressing both immediate risks and long-term well-being. This must include naloxone distribution and overdose response training, as minors are often first responders when peers overdose and are currently unequipped to provide life-saving assistance in their spaces and communities. Integrating these services ensures that young people who use drugs have access to comprehensive, practical, and youth-centred support.

CAPACITY BUILDING FOR FRONTLINE PROVIDERS

Specialised Training: Invest in extensive training programs for health and social workers, focusing on child-friendly harm reduction practices. This will enhance provider sensitivity to the unique challenges faced by young people who inject drugs, reducing bias and improving service delivery.

ROBUST COMMUNITY ENGAGEMENT AND PUBLIC EDUCATION

Targeted Awareness Campaigns: Implement community education initiatives to dispel myths around harm reduction and foster understanding of youth-focused NSPs. Engaging parents, educators, law enforcement, and traditional leaders in evidence-based discussions will be pivotal for reshaping public perception, reducing stigma, and generating broader support for harm reduction programs. Such engagement ensures that communities are informed, supportive, and able to create safer environments for young people who use drugs.

MONITORING, EVALUATION AND DATA COLLECTION

- **Establish a National Framework:** Create a comprehensive, age-disaggregated monitoring and evaluation framework to track the health and social outcomes of minors accessing NSPs. The framework should use anonymous unique identifiers to follow outcomes over time without breaching the confidentiality of the minors, ensuring that data collection supports program improvement while safeguarding privacy and trust.
- **National Harm Reduction Registry**: Develop a centralised registry to document service utilisation and outcomes, thereby strengthening the evidence base for continuous policy improvement and resource allocation.

Conclusion

South Africa's current approach to drug policy fails to adequately protect minors from preventable health harms associated with injecting drug use. The absence of legal and policy frameworks that allow minors to access NSPs not only exacerbates their vulnerability to HIV, Hepatitis C, and other health risks, but also runs counter to constitutional and international human rights obligations.

Current laws criminalising drug use such as the Drugs and Drug Trafficking Act, contribute to systemic barriers that prevent minors from accessing life-saving harm reduction services and ethical and legal challenges that discourage service providers from offering NSPs to minors. This punitive model prioritises enforcement over public health, perpetuating cycles of stigma, exclusion, and preventable harm. Additionally, restrictive parental consent requirements further delay or deny access to essential services, placing minors in even greater jeopardy.

By integrating NSPs for minors within a broader harm reduction framework, policymakers have the opportunity to shift towards a health-based, rights-affirming approach that aligns with best practices recommended by the United Nations Convention on the Rights of the Child. Comprehensive reform should focus on decriminalisation, the removal of age-related barriers to service provision, and the establishment of accessible, youth-centred harm reduction interventions that address the specific needs and vulnerabilities of minors and adolescents who inject drugs.

Additionally, research on the unique needs of minors who inject drugs must also be prioritised. Adolescents are a dynamic and hidden population, making data collection challenging, yet essential for developing tailored interventions. Harm reduction services for minors who use drugs must move beyond treating substance use disorders to include innovative outreach, comprehensive care, and pragmatic responses to ethical and legal complexities. Without urgent reform, South Africa will continue to face escalating health costs and burdens on the health systems, widening inequalities, and avoidable human suffering. It is imperative that harm reduction policies be expanded to prioritise minors, ensuring that their rights, health, and dignity are upheld.

Endnotes

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Watch a video about the experiences of young women who use drugs: