HARM REDUCTION FINANCING LANDSCAPE ANALYSIS IN SOUTH AFRICA

HARM REDUCTION INTERNATIONAL

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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Table 1: Summary indicators

People who inject drugs	**84,500**
Services for people without private healthcare	
Needle and syringe services	23,863 people reached
Opioid substitution therapy (OST)	Six districts with 1,279 people on OST
Total harm reduction funding for direct service delivery is approximated per annum.	USD$ 6,332,206
Of which domestic funding is	USD$ 2,451,657

Post-Apartheid South Africa has a history of AIDS denialism[1] and a prohibitionist approach to drugs.[2,3] Even with increasing drug dependence, heroin use, injecting drug use, and the spread of HIV and HCV among people who inject drugs, it is not surprising that harm reduction isn't a national priority. Conflicting and ambiguous policies, misinformation, lack of political will, and moral conservatism delayed implementing or prioritising harm reduction services.[4] Despite the challenges, a small group of harm reduction pioneers, working out of TB HIV Care, OUT LGBT Well-being, The Durban University of Technology (DUT) Urban Futures Centre, and later the University of Pretoria Department of Family Medicine, have been advocating for harm reduction services and the decriminalisation of drug use. With newly secured funding, this core group began to establish South Africa's first harm reduction services.[5]

The high price of methadone, opposition to and closure of needle and syringe services, ongoing objections, lack of political will, and limited domestic resources continue to hinder the implementation of harm reduction services. Despite the challenges, the success of early harm reduction programmes, the establishment of the South African Network of People Who Use Drugs (SANPUD), ongoing advocacy, education, local research and data, and increases in funding have accelerated progress over the past few years. Significantly, harm reduction is now a central component of the National Strategic Plan and the National Drug Master Plan.

South Africa has an estimated 84,500 people who inject drugs,[6] most of whom are opioid-dependent. One in five people who inject drugs lives with HIV,[7] and the HIV prevalence among people who inject drugs is as high as 21%[8] - far higher than in any other key population group. Hepatitis C rates are 55% nationally, but almost 90% in Tshwane,[9] and TB is also common.

The main foreign funders of harm reduction in South Africa are the Global Fund and CDC/PEPFAR. The Global Fund is now in the third round of three-year funding cycles. In the 2022-2025 country allocation (NMF3), the Global Fund doubled its investment in harm reduction services for people who use drugs to USD$ 14,801,042. Even with increases in funding, needle and syringe service coverage is still only 30% of the WHO target of 200 per person per year.[10] Only 1% of people who inject opioids receive OST. If South Africa is going to reach the 2025 Global AIDS Strategy prevention targets for people who use drugs, needle and syringe services coverage needs to increase by four times the current size, and OST coverage by ten times.

Local, sustainable financing of harm reduction services is critical to retain or advance any gains toward HIV epidemic control among people who use drugs. Yet, apart from one notable exception, no national or local government funding for harm reduction exists. The exception is the City of Tshwane, which funds South Africa's largest OST and needle and syringe programme: the Community Oriented Substance Use Programme (COSUP). Built on the principles and lessons of community oriented primary care (COPC), COSUP is unique in its approach to drugs and is the only low-threshold city-wide OST and needle service programme in the country. COSUP currently accounts for almost half of all South Africa's harm reduction services and provides these at about half the cost of the Global Fund programme. Surprisingly, COSUP's success has gone largely unrecognised and unnoticed by government and policymakers. The COSUP approach offers a significant opportunity to advocate for further domestic funding for harm reduction at the municipal level.

Within the South African National AIDS Council (SANAC), the Civil Society Forum consists of 18 sectors representing South African society.[11] People who use drugs are not represented in the Civil Society Forum. The absence of a formal sector limits the voice of people who use drugs. There are ongoing efforts to establish the sector, but it is unlikely to happen at this stage, and people who use drugs have to participate through the NGO sector.[12]

The 2019-2022 NMF2 Global Fund allocation funded human rights and advocacy work through SANPUD, the only people who use drugs representative network at the national level in South Africa. Despite good performance and continued efforts and successes in increasing OST accessibility, there were no funds for SANPUD under NMF3. In addition, Global Fund peers had their salaries slashed by 30%. The consensus among peer employees and networks of people who use drugs is that the mantra of "nothing about us without us" is meaningless within the civil society and country coordinating structures. It remains to be seen if SANPUD will receive funding for community-led monitoring. Despite setbacks, SANPUD continues to play a critical advocacy role and continues the advocacy and human rights roles previously funded by the Global Fund.

Although it is unlikely that the national government will implement large-scale OST programmes or needle and syringe services, there are several opportunities for increased domestic funding for harm reduction. The most obvious option is to encourage municipalities to adopt a solution similar to COSUP. For cities to consider a harm-reduction-informed community-oriented substance use programme, there needs to be widespread support and collaboration with benefits for the whole community.

Generally, networks and advocates feel somewhat optimistic about the policy situation and their involvement in and ability to shape policies. There is significantly less optimism regarding funding allocation, budget transparency, service development, and programme implementation. After ongoing engagement with the community of people who use drugs and their networks, priorities and recommendations have emerged. Some of these recommendations directly prioritise securing domestic funding for harm reduction, while others aim to ensure an enabling environment for active participation in securing or attracting funds. A national advocacy roadmap has been developed after broad consultation with communities of people who use drugs. The priorities are decriminalisation, comprehensive harm reduction services, less stigma, and fewer human rights abuses.

An intensified and coordinated effort is needed to ensure domestic funding sustains and

expands harm reduction services in South Africa. Ultimately, harm reduction is about protecting the rights of all people and ensuring that policies and responses to social issues, mental health, and stigmatised behaviours do not create undue harm. Policies should create a context and response that will assist people by providing the support and services that can reduce inequity, increase opportunity, and help people live with a sense of belonging and meaning. In South Africa, if we ensured that all policies and responses for people who use drugs aligned with the constitution, we would have gone a long way towards achieving that goal.

Recommendations

Access to harm reduction services is critical for South Africa to meet HIV targets and commitments. Expanding services to the required levels needs sustainable and significant domestic funding. The following recommendations will help secure and motivate domestic harm reduction funding to ensure increased access to harm reduction services and contribute towards safeguarding and protecting the rights and well-being of people who use drugs. The recommendations are informed by conversations with service providers, service users, funders, researchers, the priorities and guidance of the advocacy roadmap developed through consultation with people who use drugs, and the objectives of community-led networks and SANPUD.

1. The decriminalisation of drug use and possession should be prioritised.

- The arrest, prosecution, and incarceration of people who use drugs cost the state millions of rand per year. Financial resources can be reallocated by decriminalising drug use and possession to fund community-based services, including harm reduction.
- The Department of Social Development, The Department of Justice and Correctional Services, the Department of Health, and the Central Drug Authority must be encouraged to critically examine the adverse financial and health effects of criminalising the use and possession of drugs and compare this with the health, economic, and societal benefits of decriminalising drug use and possession, and reallocating funding to harm reduction responses.
- SANAC, SANPUD, and member networks of people who use drugs, civil society, actors in the HIV sector, international donors, academics, like-minded stakeholders, and community leaders must highlight the harms and costs of criminal justice responses to the use and possession of drugs.

2. The establishment of a formal people who use drugs sector within the South African HIV coordination structures (AIDS Councils)

- A formal people who use drugs sector will increase the legitimacy, inclusion, and influence of people who use drugs in policymaking processes and the prioritisation of harm reduction and human rights funding requirements at all levels of government.
- SANPUD, UNAIDS, UNODC, The Global Fund, advocacy groups, Provincial Councils on AIDS, and supportive government and civil society structures must combine and coordinate efforts to advocate for and put pressure on the Civil Society Forum, SANAC and the Country Coordinating Mechanism (CCM) to establish a formal people who use drugs sector.

3. Expand the understanding of harm reduction and include a broader range of service providers.

- The current understanding of harm reduction as needle and syringe services and OST must be expanded to include non-biomedical and non-opioid-only harm reduction services and strategies to ensure the inclusion of people who use but don't (yet) inject drugs and the growing number of stimulant-dependent people.
- By capacitating and expanding the range of services offered by existing and well-funded "addiction" treatment services, such as the South African Council on Alcoholism and Addiction (SANCA), there will be a broader base of funded harm reduction-informed services, a better understanding of the need for traditional harm reduction services, and an existing and funded platform for expanding service delivery.
- SANPUD and like-minded stakeholders and harm reduction service providers must engage with and strengthen relationships with organisations like SANCA and provide training, education, and support to capacitate staff and management in delivering harm reduction-informed services.

4. Highlight the successes, utility, and potential of COSUP to encourage increased municipal and local government funding for harm reduction services.

- The COSUP model enables municipalities to maximise their investment in health, 'substance abuse'*, social development, and related services. The approach will assist municipalities in ensuring the well-being of communities and will provide increased domestic funding for harm reduction services.
- The COSUP management, researchers, SANPUD, and the City of Tshwane must increase the programme's visibility and ensure that the data is made visible and accessible to a wide range of stakeholders, especially other municipalities. International donors, academics, and stakeholders should highlight the programme to the government.

5. For people who use drugs, network funding, inclusion, consultation, and equitable peer compensation must be prioritised.

- The meaningful inclusion of community-led organisations in policymaking, service development, and delivery results in better services, policies, and return on investment. The employment of peers is critical for service development and delivery, and forms the basis of the harm reduction approach, as expressed in the phrase "nothing about us, without us."
- SANPUD and the Global Fund Country Team, advocacy organisations, and INPUD must hold the CCM, Civil Society Forum, SANAC, policymakers, and funders accountable to the principles of the National Drug Master Plan, commitments made in the National Strategic Plan, and the budgets and commitments made in the South African Funding Request for 2022-2025 submitted to the Global Fund.

* The term 'substance abuse' is used in South Africa's legislation and many policy documents. It is not a term supported by harm reduction activists, INPUD, or SANPUD, but is used here to avoid confusion and align with policy and legislation.

- The Global Fund, Principal Recipients, service providers, international donors, and other organisations that provide services to people who use drugs must ensure equitable salaries for peer and community workers within harm reduction services.

6. Ensure funding to continue the work of harm reduction advocates, researchers, and activists.

- Significant progress has been made towards reducing the price of methadone; establishing National Guidelines for OST and needle and syringe services; developing a National OST Implementation Plan; Clinical Guidelines; getting methadone and buprenorphine onto the essential medicines list; establishing a people who use drugs sector; ensuring representation in provincial and national policy structures; and ensuring the rights of people who use drugs in national policies, including the decriminalisation of drug use and possession.
- It is critical that these initiatives and related activities continue. The funding for the core team that drives these activities is at risk due to the end of a funding cycle and closure of the Open Society Foundations (OSF) Global Drug Policy Program and the diversion of advocacy and human rights funding earmarked for SANPUD in the Global Fund Country Application towards principal recipients and SANAC.
- SANPUD, service providers, and funders must ensure that there is unrestricted funding that allows the current advocacy efforts to continue with the same level of flexibility that has produced significant changes to policy, services, awareness, and inclusivity over the past six years.

SECTION 1: HARM REDUCTION IN SOUTH AFRICA

1.1 Background

In 1994, South Africa became a new nation after the first democratic elections saw the African National Congress come to power with a landslide victory with 62% of the vote. The new constitution restored and guaranteed the rights previously denied for the majority of South Africans. However, AIDS denialism[1] and blind acceptance of US-inflicted drug policy[2,3] continued to harm many people. Rapid urbanisation, increasing levels of inequity and open markets contributed to the rapid increase in drug use among marginalised communities. As injecting drug use started to spread, politicians doubled up on the failed war on drugs approach.

In 1999, the new Central Drug Authority launched South Africa's first National Drug Master Plan (NDMP). Despite the progressive constitution, the lack of critical thought is evident in the rhetoric and prohibitionist approach described in the plan. Harm reduction is mentioned briefly, but only as a means to abstinence. The second NDMP includes the term harm reduction, but no guidelines as to what is to be implemented. In 2011, before the development of the third NDMP, misinformation and lobbying by groups with a moral agenda resulted in harm reduction being described as "limited to the holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance abuse".[13]

Despite the rejection of and resistance to harm reduction and the continued emphasis on criminal justice responses towards people who use drugs, a small yet diverse group of harm reduction pioneers found and supported each other and started a movement. An initial study led by Dr Andrew Scheibe across five cities established that people injected drugs, mainly heroin, in marginalised communities, and 20% of those recruited into the study were women.[14] Shortly after the study's publication in 2015, the first multi-city harm reduction programme started in South Africa. The Step Up Project was funded by the United States Centres for Disease Control and Prevention (CDC), the United States President's Emergency Plan for AIDS Relief (PEPFAR), and the Ministry of Foreign Affairs of the Netherlands through Mainline.[15]

Before the first foreign-donor-funded OST programme, harm reduction pioneers from TB HIV Care and the Durban University of Technology established the first low-threshold OST project at a CDC-funded drop-in centre in Durban.[16] The local methadone supplier donated medication for 54 people. After 12 months, retention in the project was unexpectedly high at 74%. The project served as an excellent proof of concept for expanding services.

In the first year, the Step Up Project established drop-in centres and outreach services in Tshwane, eThekwini (Durban), Nelson Mandela Bay, and Cape Town. The project reached 2,100 people who use drugs, distributed more than 380,000 needles, and tested 768 people who inject drugs for HIV.[17] Since 2015, due to ongoing advocacy, engagements, research, data dissemination, and collaborations, the policy landscape has shifted significantly despite the fact that the number of people who inject drugs has continued to rise. However, there is still a significant gap between available and optimal services. There is a continued need for advocacy to ensure these gaps are filled and domestic funding is secured to sustain and expand services.

1.2 Services, population, and coverage

Table 2: Harm reduction package of services for people who use drugs (Global Fund)[18]

Global Fund and CDC Harm reduction services		
• risk assessment • harm reduction packs, • needles for secondary distribution (for injecting drug users), • TB screening,	• HIV testing, the offer of condoms and lubricants, • harm reduction counselling, • peer education (HIV-negative people who use drugs) and peer navigation (HIV-positive people who use drugs),	• sensitisation on gender and power issues, and GBV screening and awareness
Based on the risk assessment, additional services may be added.		
Biomedical	**Behavioural**	**Structural**
• OST • Hep B & C testing and treatment, • STI screening & treatment, • ART initiation or linkage, • TB treatment, • PEP • overdose management • mental health services • cervical cancer awareness, • screening and referrals for women who use drugs	• Emotional and psychosocial support • adherence support, • rehabilitation centres.	• Reporting human rights • violations, dignity packs • skills building and economic strengthening, • social grant support, • legal services, • post-violence care

1.2.1 Population size

The size estimate for people who use and inject drugs differs widely in South Africa. The reality is that there is very little reliable data. In a recent study of the drug market, it was estimated that in South Africa 400,000 people use heroin, 350,000 use cocaine, and 290,000 use methamphetamines. There are 84,500 people who inject drugs in South Africa, and the figure is reportedly rising rapidly.[19]

1.2.2 Coverage

The current coverage of harm reduction services is extremely low. Only a minority of people who inject drugs have access to needle and syringe services, and those that did access services in 2021 received only 65 needles per year. Less than 1% of people who inject opioids were on opioid substitution therapy.[20] Even though funding from the Global Fund for 2022-2025 (NFM 3) doubled, the coverage will remain low and be limited to 8 districts where the Global Fund finances services, plus Tshwane, funded by CDC/PEPFAR and the City of Tshwane. The Global Fund aims for 90% reach (11,436)[21] in eight priority districts. In 2021, saturation was

only 23%.[22] The WHO target for sterile needles is 300 per person who injects drugs annually and recommended OST coverage is 40%. Compared with the coverage at the beginning of NFM3 (2022), South Africa needs to quadruple needle and syringe service coverage and increase access to OST fifty-fold to meet the 2025 Global AIDS Strategy prevention targets for people who use drugs.[23]

1.2.3 The inequity of access

Methadone is not available for maintenance therapy in the public sector. However, a general practitioner in private practice can prescribe a thirty-day supply of methadone to any patient, and the patient can collect the methadone from their pharmacy as a take-home medication. The cost of methadone, at a dose of 80mg a day, until recently, was about USD$ 2,000 per year, excluding the monthly doctor's appointment required to get the prescription. Most South Africans cannot afford to access methadone privately. Similarly, access to needles is far more challenging for marginalised groups. Sponsored spaces in treatment facilities are the exception, government facilities are outside the community, and the waiting lists are long. People in marginalised communities are also more likely to be arrested and incarcerated for drug use and possession.

Table 3 Harm reduction coverage targets 2022/23

Key	WHO target met	Available	Services planned	No services

Province	Location	Reach	OST	Needle Services Contacts	HIV T&T	TB	Hepatitis	Condoms & IEC	Naloxone
Global Fund									
Eastern Cape	Nelson Mandela Bay	696		2,758					
Gauteng	Ekurhuleni	369		5,083					
	Sedibeng	1,501	35	2,201					
	Johannesburg	6,979	218	14,553					
Kwa-Zulu Natal	eThekwini	1,280	82	8,465					
	uMgungundlovu	495		3,500					
Western Cape	Cape Town	1,399	156	15,591					
CDC/PEPFAR									
Gauteng	Tshwane	3,112	46	4,819					
	Ehlanzeni	680		772					

COSUP									
Gauteng	Tshwane	7,355	738	19,225					
Belhaven Harm Reduction Centre									
Kwa-Zulu Natal	eThekwini	200							
Prisons									
Early discussions about pilot projects									
National totals									
National numbers		24,066	1,279	76,967					

SECTION 2: OPERATIONAL LANDSCAPE

2.1 Legal and policy environment

2.1.1 Civil society organisation (CSO) registration

South Africa has a very supportive and relatively simple process for registering non-profit organisations and not-for-profit companies. Registration with the Department of Social Development is free and can be done online. Annual reporting requirements are not particularly challenging and can also be submitted online. The reported timeframe for registration is two months. There are no restrictions on registering a network of people who use drugs, harm reduction service providers, or any other conditions that present a challenge to establishing a CSO to provide harm reduction services. There are also no arbitrary restrictions in registering with the Receiver of Revenue or opening a bank account. For example, SANPUD has not had any issues registering as a CSO, participating in government discussions, opening bank accounts, or entering into rental or other agreements. However, registering as a recognised drug treatment service provider for people who use drugs can be complicated and time-consuming. It needs to be clarified whether community-based harm reduction services must register.

2.1.2 Social contracting

Social contracting between the government and CSOs is well established, and mechanisms are in place to transfer funds from the treasury to CSOs. The National Department of Health and the National Department of Social Development have contributed significant amounts to large NGOs and lesser amounts to community-based organisations. The National Department of Health transfers around 1% of its annual budget to non-profit organisations. Provincial Departments of Health also have a history of contracting with civil society. For example, TB HIV Care received USD$ 6.2million from the National Department of Health and USD$ 2.2 million from the Western Cape Government in 2022. The majority of the funding for CSOs is related to HIV prevention and treatment.

Payments to civil society are determined via tenders and invitations to submit a business plan that includes targets. This process includes an RT35 agreement between the CSO and the National Treasury. These are essentially grant payments as opposed to direct service delivery agreements, even though tranches are dependent on results. One concern is that often payments are delayed and this presents a significant risk to the continuity of services. Percentage contributions of provincial budgets to civil society vary widely between the provinces.

2.1.3 Harm reduction

Harm reduction in South Africa is underpinned by frequently conflictual laws and policies in which constitutional rights are invariably buttressed against a legacy of moral conservatism. The result is a fragmented policy environment that is often in conflict with itself. This tension can be seen in the primary substance-related policy document, the National Drug Master Plan (NDMP) 2019-2024. On the one hand, the plan commits to a harm-reduction-based framework of regulation while, on the other, still expresses a desire to eradicate drug use from South African society completely. The NDMP 2019-2024 is the fourth incarnation of the

plan. It mandates for (and yet is also produced by) the Department of Social Development and positions the department as a critical facilitator of substance-related policy in the country, often via the Central Drug Authority. A lack of a clear mandate, decisive leadership, and little authority or independence has hamstrung the Central Drug Authority. Other government departments have also formulated substance-related policies, such as the Department of Health, which are more aligned with harm-reduction principles, as seen in the Health Sector Drug Master Plan and procedures related to the accessibility of opioids for the management of pain. Beyond this, in the vacuum left by the Central Drug Authority, the default stance taken by the government is control through enforcement and policing.

Legislatively, the three primary laws governing drug use in the country are the Drugs and Drugs Trafficking Act 140 of 1992, the Medicines and Related Substances Act 101 of 1965, and the Prevention of and Treatment for Substance Abuse Act 70 of 2008. The first is primarily focused on the policing of substances, the second on the classification of substances, and the third on the treatment of substance use. The last of these is the most enabling and specifically supports harm-reduction-based strategies and projects in the country. However, the Minimum Norms and Standards that accompany Act 70 of 2008 are geared towards abstinence-based approaches but do state:

> *"Out-patient services **must be evidence-based and holistic in nature and must be presented as a comprehensive package of services** which must include any one or a combination of the following: (a) Education for the service user and the service user's family about the dangers of substance abuse and other related health problems; (b) life and social skills training; (c) **harm reduction activities;** and (d) access to self-help and mutual help support groups."*

The contradictions between these laws create a contested treatment and rehabilitation landscape. The Prevention of and Treatment for Substance Abuse Act creates the legislative space for OST and NSS-type outreach services. Yet, when these services were established, law enforcement agencies used the Drugs and Drugs Trafficking Act as the basis for arresting anyone attempting to use these services.

The Constitutional Court has ruled in Soobramoney v Minister of Health (KwaZulu-Natal) 1998 (1) SA 765 (CC) and Minister of Health v Treatment Action Campaign (No 2) 2002 (5) SA 721 (CC) that the state has a duty to prioritise primary public health needs and that HIV/AIDS is "the greatest threat to public health in our country." This ruling provides a clear legal argument for prioritising harm reduction services.

Table 4: National legislation influencing harm reduction

Act	Jurisdiction	Impact
The Prevention of and Treatment for Substance Abuse Act 70 of 2008	Prevention and treatment campaigns and regimes, the provision of services and engagement with community structures.	Little substantive impact, with the Act not being widely utilised or even known.

The Medicines and Related Substances Act 101 of 1965	The classification, scheduling and distribution of all medicines and controlled substances.	The Act was, at one stage, essential and had a broad impact. It has, however, been diluted and side-lined by the establishment of the South African Health Products Regulatory Authority.
The Drugs and Drugs Trafficking Act 140 of 1992	The control and enforcement of the country's production, distribution, and use of controlled substances.	The default and principle Act by which substances and their use are regulated via law enforcement agencies in the country. Once all-encompassing, much of the Act has now been repealed.
National Health Act 61 of 2003	The mandate and scope of work relating to health provision and services in the country.	The Act influences and sets the context of health services provision in the country, but harm reduction approaches and efforts may fall beyond its scope in practice.

A further complication is a requirement that service providers register with the National Department of Social Development as a drug treatment service, even if the service forms part of a broader medical service and is registered with the National Department of Health. The registration process is time-consuming, and the required norms and standards and the types of registration available do not include harm reduction services. As a result, most harm reduction services are not registered with the Department of Social Services. The COSUP has received significant pushback and is often considered to operate outside the regulations when it suits political leaders.

No laws prevent the provision of harm reduction services by community-led organisations (CLOs), community-based organisations (CBOs), and CSOs. Still, from the few examples in the country, it is clear that the establishment and provisioning of such services will face moral outrage from some members of society and face punitive efforts by local law enforcement agencies. Again, the meaningful participation of CSOs is typically dependent on the sector and under which national government department their activities fall – those who operate in the health and community development sectors may find a greater willingness to engage and establish interventions. At the same time, those focusing on law enforcement reform are unlikely to make much headway in the country. Such differences are also vertically stratified, with levels of cooperation often dependent on which local government agencies, which municipal areas, and which sectors within each of these are engaged – experience suggests that some local government organisations in particular regions or localities may be far more open to engagement by CLOs, CBOs, and CSOs than in others, some of which may be actively antagonistic to any civil society interventions or activities. CSOs and grassroots mobilisation efforts do, however, have a long tradition in South Africa and can become essential role-players in shaping the policy and legislative landscape, as well as important forums for highlighting abuses and injustices that occur in their respective sectors. Despite the lingering

moral conservativism regarding substance use and harm reduction efforts in the country, the possibility of change and reform remains tantalisingly close.

Table 5: Descriptions and inclusion of harm reduction in key policy documents

The National Strategic Plan for HIV, TB and STIs 2017-2022	
Objective 4.4	Implement and scale up a package of harm reduction interventions to address the harmful use of alcohol and drugs in all districts, including OST and NSS
Objective 3	Describes targeted interventions, including harm reduction counselling, needle and syringe services, OST and HCV screening and treatment
Description of harm reduction	It uses the UNAIDS terminology and calls for a better definition of harm reduction services and a scale-up of service provision.
The National Drug Master Plan 2019 - 2024	
Change in definition of harm reduction	A harm reduction philosophy emphasises the development of policies and programmes that focus directly on reducing the social, economic, and health-related harm resulting from alcohol or drugs. Harm reduction interventions are evidence-based public health principles to support people who use drugs.
Integral to the plan	The three strategies and pillars of the plan are demand, supply and harm reduction.
Alignment between sectors	“It is necessary to form relationships between the criminal justice and public health sectors and to change laws and norms to support evidence-based harm reduction.”

2.1.4 Integration in national policy

Even though the National Strategic Plan and the National Drug Master Plan highlight harm reduction as an essential part of both plans, there is no current commitment to fund harm reduction from any National Government Department. The National Department of Health is developing guidelines for OST and an implementation plan, but that is some time away from being part of the official policy.

Within state facilities, methadone may only be prescribed for a limited time as part of a supervised and medically assisted withdrawal process. Needle and syringe services are not described in the Department of Health policies. The National Department of Health has consulted extensively with the core group of harm reduction pioneers in South Africa. As a result, the National Guidelines for Needle and Syringe Services and Opioid Substitution Therapy have been developed. Still, they have not yet been released due to financial constraints of implementing harm reduction services through the state health system and the need for capacitation and resource allocation amid competing health priorities.

There are ongoing efforts to ensure that methadone and buprenorphine are included for maintenance on the Essential Medicines List. Together with ensuring that cheaper variants of methadone are available, it is critical to ensure the wide availability of state-funded OST.

Table 6: National policies influencing harm reduction services

Policy	Jurisdiction	Impact
The National Drug Master Plan 2019-2024	The primary policy document shapes the perspective, activities and programmes related to the use of substances in the country.	The NDMP has little substantive impact on the activities of government and others and usually remains confined to policy instead of practice.
The National Strategic Plan	The NSP outlines the strategic framework for a multi-sectoral partnership to accelerate further progress in reducing the morbidity (illness) and mortality (death) associated with HIV, TB and STIs in South Africa. It is Embedded in the National Development Plan and is endorsed by Cabinet	Has a significant impact on the acceptability and justification of services. Can shift National policy. It plays a critical role in setting the policy direction and practice and implementing services described in the plan.
Health Sector Drug Master Plan	Confined to the health sector and the provision of healthcare services	More forward-looking and supportive of harm reduction efforts but of limited impact in practice with negligible implications beyond the health sector.
National Key Population Health Implementation Plan	National Department of Health and aligns with the NSP but focuses on KP	It remains to be seen, but it can feed into the NSP

2.1.5 National vs provincial vs metropolitan policies

Even though national policies can be interpreted to be generally supportive of harm reduction approaches, they often need more clarity. The possible ambiguity has, at times, been used to disrupt services, and by-laws have been reinterpreted to suit the agenda of municipalities. For example, in eThekwini, the needle services were closed for over 18 months. The closure occurred despite extensive previous consultations with all stakeholders. Still, the new Deputy Mayor denied this and a set of by-laws was misrepresented to create an apparent legal argument for the closure. Some people who provided details believed that the closure was a perfect opportunity for civil disobedience. By defying the ban, there would have been an opportunity for the court to rule on the programme's legality. Unfortunately, there were no donor funds to fight a court battle, so the programme remained closed until the Deputy Mayor was replaced by someone who supported the programme.

Municipalities have significant discretionary power that can be exploited to progress or oppress. City Governments offer significant reform opportunities even when national laws are punitive.[24]

2.1.6 The Constitution of South Africa

Overall the policy landscape is not as restrictive as in many other countries. There is still significant space for improvement, and policies and laws need aligning. However, where the policy does fall short, the South African Constitution provides a robust foundation for ensuring the rights of all South Africans and can be used to drive legislative change. The recent cannabis ruling by Judge Zondo that effectively decriminalised the use, possession, and cultivation of cannabis for individual use[25] is an example of how robust the constitution can be. Yet, at the same time, the cannabis example highlights how even with broad legislative changes, the interpretation, implementation, and adherence to new laws take significant time and precedents before it brings widespread and tangible difference for people in the community.

Ultimately, South Africa can resolve many human rights issues, including drug-related issues, by aligning all policies and legislation with the constitution.

Table 7: Policymakers: Progress, challenges, and outlook

Policymaker	Progress	Challenges	Outlook
Department of Social Development & Central Drug Authority	More comprehensive consultation, including discussions with people who use drugs for the development of the NDMP 2019-2024.	There are still elements within DSD who oppose progressive policies. The local drug committees need further capacitation.	Generally positive. Recent engagements with UNODC, SANPUD, CDC and Global Fund have been very positive.
Department of Health & SAHPRA	New cheaper methadone available after years of advocacy. Significant progress has been made to include methadone for maintenance on the essential medicines list. The opioid agonist treatment implementation plan is currently in development.	The price of methadone remains high, as does the cost of implementation. The bureaucratic challenges are significant, and the time it takes for the changes to happen is excessive. The price of implementation and the resource requirements. The rollout will be slow and limited. The need for further demonstration projects	Generally good, with cheaper methadone and several initiatives underway to make methadone more accessible. However, the processes are slow, and there are protracted processes.
SANAC	The National Strategic Plan is supportive of harm reduction.	Possible dilution of the new strategic plan when reviewed by parliament	The new National Strategic Plan is under development and is very progressive. It includes clear support for harm reduction with appropriate indicators.

Civil Society Forum (CSF) and Country Coordinating Mechanism	The lack of a formal people who use drugs sector is being addressed, and a funding application has been submitted. At the provincial level, there has been progress and people who use drugs sectors are established in the provinces.	Opposition to the existing leadership within the CSF.	Uncertain.
Local Government	The continued service level agreement with the City of Tshwane is a unique advocacy opportunity. Some progress has been made with previously hostile municipalities – e.g. eThekwini.	Local governments often disregard national policy. A moral or populist agenda often drive local governments because of the proximity of political leaders to be closer to the community than national-level politicians. Local by-laws can be manipulated, rapidly amended or repurposed.	Local government is the most viable possibility for sustained funding for harm reduction. Other municipalities may adopt a similar model by maximising the lessons from Tshwane.

SECTION 3: FINANCIAL LANDSCAPE

Considering the legacy of AIDS denialism[1] and morality- and drug war-informed responses,[2,3] it is not surprising that historically the government has not funded harm reduction programmes. Although attitudes and policies are shifting, the National Government does not fund any harm reduction services or commodities in South Africa. The only domestic funding is from the City of Tshwane Municipality. The major harm reduction service delivery funders have been CDC/PEPFAR and the Global Fund. OSF, Mainline, INPUD, and the Dutch Foreign Ministry, through Bridging the Gaps and Love Alliance, have provided support for advocacy, policy, human rights, and various support services and emergency short-term commodity funding. In the case of the Belhaven Centre, some private and corporate donors contributed toward methadone. Established during COVID, the Belhaven Harm Reduction Centre was a great success, received media coverage, and was recognised internationally. Due to a lack of funding, the Centre closed the OST program in October 2022.

Although the Global Fund process is supposed to be transparent, it isn't easy to source clear, consolidated, and granular budgets. This report collected information from multiple sources and in various formats. Presentations and notes from Global Fund OPEC meetings and mid-term audits were used to cross-reference data and to check the alignment between the country application, budgets, disbursements, and expenditures.

3.1 Harm reduction direct service funding

Table 8: Domestic vs foreign funding for services

Domestic			
The City of Tshwane	Four districts, 17 sites	US$ 2,451,657	Per year until the end of 2023
Foreign			
The Global Fund	Eight sites across the country	US$ 4,933,680	Per year March 22 – March 25 [Total $ 14,801,042]
CDC PEPFAR	1district in Gauteng	US$ 1,172,260	Per year
Total annual funding for harm reduction services = US$ 5 926 248			

3.1.1 The City of Tshwane

In 2015, the City of Tshwane allocated almost their entire budget (USD$ 2,762,430) for drug interventions towards establishing the COSUP. The COSUP is a partnership between the City of Tshwane and the University of Pretoria, and the University has been appointed a service provider in terms of Act 32 of 2000, Local Government: Municipal Systems Act. The partnership includes a service level agreement between the City and the University. Despite several changes in political leadership in the City and ongoing opposition from some city officials, the project has managed to retain funding. In 2020, a further 3-year contract was

signed. The programme is the largest OST and needle and syringe programme in South Africa. There are 17 sites distributed over four districts.

COSUP also supports implementing the CDC/PEPFAR programme in Tshwane through a cooperative agreement and collaboration with TB HIV Care.

COSUP was evaluated as part of the South African Cities Network and recognised for the unique and effective model of governance, inclusivity and multi-sectoral approach.

> *City officials also realised that drug use is a complex social issue with multiple causes and impacts and that achieving its strategic objectives demanded a high level of resources, specialised skills and knowledge. This insight motivated officials and politicians to co-create a network of partners to deliver a targeted community-orientated drug use programme. COSUP's success has helped people overcome their initial aversion to a harm-reduction approach, and the demand for COSUP services is currently greater than the programme's capacity. The Tshwane story highlights how the municipality's ability to initiate, establish and participate in cross-sectoral partnerships and programme implementation has enhanced its capacity to deliver services. COVID-19 brought to the fore the value of a network governance model as the existing multi-disciplinary engagement between the City and its partners allowed teams to work together and continue providing services, thereby meeting citizens'.*[26]

What is notable and offers a significant opportunity is that COSUP numbers make up almost half of all the harm reduction numbers of people who receive services in South Africa and supply additional medical services to people who use drugs and homeless people in Tshwane for half of the annual Global Fund Budget (USD$ 2,451,657 vs USD$ 4,933,680). It must be noted that COSUP does not provide the full range of comprehensive services at all their sites. However, the reach of the programme is significant and the integration of additional HIV services would not be particularly challenging. Despite this apparent success and return on investment, COSUP has received very little formal recognition, and other Cities have ignored the approach despite the multiple and cross-cutting benefits.

3.1.2 The Global Fund

The total value of the current cycle of Global Fund Allocation for direct people who use drugs services is USD$ 14,694,487, which is less than 3% of the country allocation of USD$ 546,766,626. There is a single principal recipient (PR) who appointed three sub-recipients (SR). 34% of the funds are spent on medications, commodities for harm reduction packs, and medical equipment. 14% of the total allocation for people who use drugs is for methadone only.

Among the SRs, the vast majority (USD$ 5,979,379) of their USD$ 6,9 million allocation goes to human resources, and of that, USD$ 216,477 is for management support. The total allocation to medical procurement and the SRs is USD$ 12,010,480. The balance of USD$ 2,790,561 is presumably for principal recipient management costs and activities directly performed or contracted by the PR.

Table 9: Global fund expenditure

PR procurement – medical supplies	
People who use drugs commodities	$ 2,880,713
Methadone	$ 2,007,298
Buprenorphine	$ 65,303
Other meds	$ 120,286
Equipment	$ 29,885
Total	**$ 5,103,487**

SR expenses - Implementation	
Human Resources	$ 5,971,148
Indirect Overheads	$ 408,657
Travel and related	$ 272,520
External Services	$ 132,555
Client support + health	$ 122,111
Total	**$ 6,906,993**

3.1.3 CDC/PEPFAR

CDC/PEPFAR funded the first multi-city harm reduction project in 2015. Currently, they fund services in Tshwane, where TB HIV Care implements the programme in close cooperation with COSUP and with support from the Global Fund. 31% of the funds are spent on commodities, a significant portion of which is for methadone.

Table 10: CDC/PEPFAR expenditure

Costs		
Commodities	$ 367,874	It must be noted that the CDC/PEPFAR program in Tshwane works closely with COSUP and the Global Fund. Because of Federal regulations, the Global Fund supplies the needles and syringes, and CDC provides some methadone for the COSUP program.
Operational	$ 679,224	
Infrastructure & Indirect	$ 117,120	
Total	**$ 1,047,099.48**	

3.2 Funding gaps & sustainability

According to the South African country submission to the Global Fund in September of 2021, there's a 96% funding gap for HIV interventions for people who use drugs. In a preliminary sustainability assessment, the people who inject drugs sector had made little or no progress towards sustainability in 10 of the 16 sustainability goals listed in the Draft National Sustainability Framework for HIV/AIDS and TB 2021-2024; partial progress in five; and substantial progress in one area, namely the procurement and supply chain. Without the Global Fund and CDC/PEPFAR funding, only the City of Tshwane would continue to have harm reduction services.

3.3 Funding for an enabling environment

Harm reduction rose out of the necessities of the AIDS pandemic and often had to contend with multiple frustrations and legal and social barriers. Many of these barriers remain, but there is increasing recognition of the need to advocate for and encourage an enabling social, policy, and funding environment. Some may not regard these activities as harm reduction

initiatives, but in reality, they meet the definition of harm reduction. It is essential to note the harm reduction funding for promoting and protecting human rights, advocacy, harm reduction capacitation and training. It can support advocates working to ensure an environment and context where harm reduction services can be easily accessed and implemented and that people who use drugs do not suffer undue policy and law enforcement-related harms.

Table 11: Funding for an enabling environment

Domestic			
No domestic advocacy and human rights grants			
Foreign			
Global Fund human rights and advocacy grants	Previously these grants went to community-based organisations. One grant has now gone to the people who use drugs PR, and another to a national Human Rights PR, and SANAC will be the SR.	US$ 7,399,730	2022 - 2025
The Dutch Ministry of Foreign Affairs via the Love Alliance	Support and advocacy grant for SANPUD as a Love Alliance partner	US$ 1,392,606	2021 - 2025
The Dutch Ministry of Foreign Affairs via the Love Alliance	Advocacy grants for people who use drugs led and harm reduction CSOs	US$ 500,000	2021 - 2025
Open Society Foundations	An unrestricted grant for advocacy and policy work	US$ 300,000	2021 - 2023

3.3.1 Advocacy and support funding

Several international donors fund advocacy and capacitation activities that aim to influence policy, educate service providers, and support people so they can participate in various policy-making spaces. Mainline filled in service delivery gaps and capacitated staff unfamiliar with harm reduction. Without unrestricted funding from OSF, it is unlikely that the significant progress made would have been possible. Most donors require adherence to a strict set of activities and track and audit hours against the level of effort. This approach leaves little space or opportunity to work outside the boundary of project activities or operate outside the expected role. The rigidity of grants limits how organisations can respond to opportunities.

Many initiatives and activities now funded by the Global Fund were initiated using OSF funding. Examples include advocacy for reduced methadone prices, reporting human rights violations, and many research outputs. Perhaps the most significant achievement of the unrestricted OSF funding is the establishment of SANPUD. SANPUD is the only peer-led and representative organisation for people who use drugs and their networks in South Africa.

3.3.2 Global Fund human rights funding

Although not directly related to harm reduction, funding human rights programmes are essential; A rights-focused approach would increase motivation to expand harm reduction services.

> *The Breaking Down Barriers initiative encourages countries to adopt a theory of change that describes how the scaling up of quality programs to remove human rights-related barriers can improve access to HIV and TB services, especially for key and vulnerable populations, and protect individuals from infection and reduce the burden of disease.*[27]

As part of the Breaking Down Barriers programme, AIDS Foundation South Africa (AFSA) was awarded USD$ 9.1 million in April 2019. As reported in the mid-term assessment, TB HIV Care's drug policy team and SANPUD, working with partners and consultants, continued advocacy efforts to ensure an improved policy framework for agonist treatment by ensuring inclusion in the National Drug Master Plan, The National Department of Health Drug Master Plan, and the National Strategic Plan. There have also been significant and concerted efforts to introduce cheaper methadone to the market and have methadone and buprenorphine registered as essential drugs.

SECTION 4: COMMUNITY & PEER INVOLVEMENT

4.1 Peer employment and community support

The South African Funding Request Form, 2022-2025, refers to the importance of community-led networks and peer outreach workers. For example:

> *"To do the CLM, seven national networks will be contracted by SANAC: one PLHIV network, one TB network, one sex worker network, one LGBTI network, one women's network, one people who use drugs network, and one youth network."* [28]

The 2022-2025 PWUD Programme Description drafted by the Networking HIV and AIDS Community of Southern Africa (NACOSA) states: *"a peer-led combination prevention programme is the most effective method of improving health outcomes for PWID."*

Many initiatives now funded by the Global Fund were initiated by SANPUD or the TB HIV Care Drug Policy Program that gave birth to SANPUD. These initiatives include human rights monitoring and reporting, methadone inclusion on the essential medicines list, registering cheaper generics, the first methadone maintenance programme in South Africa, and several smaller initiatives.[29,30,31] The human rights report and other initiatives were used to secure funding for South African people who use drugs in the first round of Global Fund funding.

Many people from civil society and the funding organisations made it clear that peers are the backbone of the Global Fund and CDC people who use drugs programmes and are an essential part of COSUP or any future harm reduction services.

4.1.1 Disregard of peers

> *"Outreach will be led by 80 peer educators/navigators (ratio of 1 peer educator to 150 people who use drugs), 16 of whom are young people who use drugs, and 24 of whom are specially trained linkage officers who will link people who use drugs to services."* [32]

For the 2022-2025 Global Fund Grant cycle, peer salaries were cut by 27%, from USD$ 517 to USD$ 379. In interviews with the peer workers, many expressed that they felt unappreciated and were demotivated. These changes were made without any consultation with any of the community of peers. There were very few other salary cuts, and where they were, it was due to a reduced workload. Some positions received an increase. If inflation is considered, the peers that started working in the programme in 2019 have had a 50% reduction in salary, and their workload has increased.

4.1.2 Exclusion of community-led networks

> *"Implementers and community networks (e.g. SANPUD) should work together to expand these services."* [33]

Under the Global Fund Grant 2019-2022, SANPUD, the only community-led people who use drugs organisation in the country, was awarded two grants, people who use drugs advocacy

as an SR and people who use drugs human rights as a sub-sub-receipient (SSR), with TB HIV Care as the SR. AFSA was the PR for both of the grants.

The value of these grants was ZAR 2,957 million per year for human rights and ZAR 980,000 for advocacy. The funds were used to support the human rights and advocacy work of SANPUD across the various districts where the Global Fund SRs provided people who use drugs services, supported the emerging network members in the districts, and provided the salaries of the relevant coordinating staff within the SANPUD head office.

It must be noted that SANPUD and partners initiated many of the advocacy and human rights activities for people who use drugs before the Global Fund started to support these activities. In the latest round of funding (2022-2025) funding allocated to SANPUD for human rights and advocacy was discontinued despite the Global Fund describing the work as critical. SANPUD continues with the crucial activities but faced severe financial and resource consequences when the CCM decided to prioritise SANAC as a sub-recipient and exclude SANPUD. In the words of a peer worker:

> *"Harm reduction? More like harm production."*

4.1.3 The Civil Society Forum

The South African National AIDS Council (SANAC) coordinates the country's response to HIV, develops the National Strategic Plan at National Level, and coordinates the provincial and district councils on AIDS. There are three sectors: the government, private, and civil society. There are 18 civil society sectors. People who use drugs are not recognised as a separate sector. Despite efforts to establish a sector, it is unlikely to be established soon. The Civil Society Forum has suggested that the people who use drugs sector operate under the NGO sector until the reality of a formal sector is possible.

4.2 Participation and collaboration

Table 12: Sentiment among PWUD organisations about inclusion and consultation

Domain	Sentiment	Challenges	Recommendations
Policy making	Fairly positive	Limited resources Uncertain ownership between DoH and DSD. CDA is not resourced and not afforded due powers	Establish an independent CDA outside of all social Development and Health Structures including SANAC
Funding	Excluded	Lack of transparency, lack of detail, no coherent or consolidated readily available information. At all levels (National, PR, SR), decisions are made with little consultation or understanding.	People who use drugs must be included in planning budgets and priorities. Funding for community-led organisations is essential and will provide cheaper services.

		It is impossible to fund nascent organisations due to funder restrictions.* Civil society forum remains elitist and exclusionary	Ensure people who use drugs sector formalised and adequate representation within SANAC
Program Design	Superficial	People who use drugs and their allies are often only consulted as a tick-box exercise, and lessons learned from community initiated-programs are often appropriated without consultation or understanding.	Please stick to the principles of nothing about us without us. Fund networks Consult with the people who initiated the service delivery
Service Delivery	Little - none	Despite the apparent importance of peers, they are often relegated to positions of servitude. Peers are seldom consulted on services;	Involve networks of peers. Value and respect the work and knowledge of peers.

* Most funders require two years minimum annual audited statements, registered offices with infrastructure, matching funding or similar arrangements, they restrict the use of mobile banking and insist on reporting mechanisms that are nearly impossible for truly grassroot organisations to comply with.

4.2.1 Policy development

In recent years, the level of participation in developing national policy has improved significantly. The first significant change was the inclusion of people who use drugs in the development of the NDMP. With support and funding from UNODC, a series of consultations took place where members of the Central Drug Authority executive met with cohorts of people who use drugs.[34] The subsequent report was used to inform the new plan, and many felt it was a turning point for the rights of people who use drugs in South Africa. Ahead of the review of the NDMP, the Central Drug Authority is starting to consult with community leaders, experts, and others to guide the direction of the new plan and get assistance in aligning policies and legislation. This will provide a significant opportunity to include specific harm reduction targets that can be used to motivate various government departments to prioritise funding for harm reduction services.

The development of the current National Strategic Plan, including extensive consultations, ensured that representatives from the key population networks were actively involved in the technical working groups. Civil society response has been favourable, and SANPUD has participated extensively. However, the considerable concern is that the plan may not pass parliamentary review. The concern is that some concepts and recommendations, such as decriminalising drug use and possession and sex work, may be cut from the final document.

An official partnership between the National Department of Social Development and SANPUD has facilitated discussions at various levels and continues to be a valuable and productive collaboration that keeps the department and communities informed of developments and mutual needs and activities.

4.2.2 Funding

> *"I don't know. How can someone implement a program when they don't know the budget and are just told there are no funds to do critical work..."* [35]

The funding landscape is particularly challenging. Even within allied organisations, accessing detailed budgets is frustratingly complex. There has always been very little collaboration between the people who develop the budgets and the community or implementors. For example, the cuts in peer salaries were not discussed with the sub-recipients, and once the budgets were presented, the cuts were not discussed with programme managers and the peers were informed when given their contracts. It has taken significant advocacy efforts and caused massive distress, return to using unregulated drugs, and a suicide attempt among peers. Had there been earlier consultation, the solution proposed by the peers and ultimately accepted by the principal recipient would have been implemented, and many of the issues prevented.

4.2.3 Programme design & implementation

> *"They claim that the IDUIT guidance reportedly informs the approach to people who use drugs. However, many of the local people who use drugs familiar with the document, feel that the spirit and intention of IDUIT are largely ignored."*[36]

Initially, programmes held regular community consultations and feedback sessions that profoundly affected people accessing services[37]. More recently, a lack of funding has reduced these consultations, and the general feeling is that any suggestions have no way of bringing short-term change.

Initial consultations that helped develop interventions and establish principles have not continued. Generally, communities do not feel actively involved in programme design.

SECTION 5: OPPORTUNITIES

Current coverage of harm reduction is far from optimal. The country has not yet fully felt the impact of the lack of effective services and support for people who use drugs. With the continued criminalisation of drug use and possession, the revolving door of recidivism and the increasing levels of incidence of HIV and the incidence of HCV approaching 100% among injecting drug users in some regions, the burden on an overextended health system could be catastrophic. There is a desperate need for harm reduction services that reduce the transmission of HIV and HCV, reduce medical harms related to non-sterile injecting and sharing of needles, and other preventable health issues. Women, people experiencing homelessness, and other marginalised and stigmatised people who use drugs are particularly at risk and require community-based harm reduction services and support to stay alive and have any hope for a future.

The reality is that South Africa has a limited pool of financial and other resources available and many problems and priorities competing for these resources. The general attitude towards drugs and people that use them is still largely informed by drug war rhetoric, moral judgement, and misinformation. While harm reduction programmes show good returns on investment, the return is not immediately obvious to many people. Methadone programmes delivered in hospital settings by the state are prohibitively expensive. Although progress has been made, it is unlikely that the National Department of Health will establish widely available methadone programmes in the public sector shortly.

To ensure the expansion of harm reduction services, harm reduction advocates and advocates of rights-based drug policies will need to ensure that harm reduction is mainstreamed, expanded, and delivered through accessible community-based programmes sustainably and affordably. Further, to solicit domestic funding, programmes must meet more than the needs of a highly stigmatised and marginalised group to create an environment where stakeholders can justify funding.

Pragmatically, the most viable potential sustainable funding source lies with municipalities rather than the national government. The Global Commission on Drug Policy issued a position paper in 2017 that describes why City Governments are more likely to be able to fund progressive drug programmes, and the COSUP experience has shown that it is possible in South Africa.

The COSUP programme is an excellent example of how government, academia, non-profit organisations, and people who use drugs can collaborate to establish a network of community-based health services to address drug use and other community priorities. COSUP is cheaper than the Global Fund programmes and can be further streamlined to maximise community benefits.

The increased employment and capacitation of peers and community organisations can further increase the viability of harm reduction programmes. Peer-run needle and syringe services, clean-up teams, health-system navigation, psychoeducation, peer-run groups, and many other services run by peers have been shown in the literature to be more cost-effective and have better reach and impact.

By consulting the community and peers, funding can be optimised and critical context-dependent interventions prioritised. In the ever-changing drug milieu, it is essential to

understand the changing patterns, means, and types of drug use. Most people see harm reduction as a narrow set of biomedical interventions aimed at people dependent on heroin. In South Africa, there is a rapid expansion of methamphetamine use. In this context, harm reduction could be seen as superseded and funding diminished. Harm reduction principles can be applied in almost all drug settings. Without broadening the scope of interventions to a broader set of drugs and methods of use, harm reduction will be seen as an add-on or different service that does not meet communities' many and changing needs.

Similarly, traditionally abstinence-based organisations should be educated, capacitated, and integrated into a continuum of care. Organisations such as the South African Council on Alcoholism and Addiction (SANCA) have national coverage of services, are well funded, and are well connected within the government and the NGO sector. By capacitating SANCA staff to embrace a more harm-reductionist approach, there will be increased awareness and a shift in thinking among drug service providers. Organisations like SANCA could become the leading harm reduction service providers. Even if they do not embrace the full range of services, they would be a referral path for people to access counselling and therapeutic services without adding to the service delivery costs of harm reduction services.

The change that will make the most significant difference is de facto or eventual de jour decriminalisation. Not only will decriminalisation reduce the burden of drug use and prohibitionist responses on communities, the recruiting conduit of gangs would be compromised and disrupted, the over-crowding of prisons would end, the exorbitant cost of policing drugs would plummet, and the funds could be diverted. It would reduce the power of gangs, violence, and the revolving door of recidivism and disease transmission would essentially end. The most significant benefit would be the massive amount saved in policing drugs in communities, which could be diverted to fund harm reduction and other community-based services.

While decriminalisation at a national level is some way off, there are already partnerships between diverse organisations collaborating within defined city areas, and the intention is to provide a range of harm reduction services, including supervised consumption spaces and alternatives to arrest, such as housing first and LEAD-type programmes.

While these opportunities are explored, evaluated, and developed, advocacy efforts must be intensified, policies modified, laws aligned, and government and service providers at all levels must be held accountable to their commitments, policies such as the NSP and the NDMP, country HIV commitments, and the high expectations and non-negotiable demands of the constitution.

SECTION 6: APPENDICES

6.1 Stakeholders

The number of potential funders is limited. Broad cooperation, collaboration and unexpected partnerships are needed to ensure that harm reduction services are available in South Africa beyond the next round of Global Fund allocations.

Table 13: Harm reduction funding stakeholders

Funding Stakeholders – Service delivery and support		
Organisation	**Type**	**Role**
Global Fund principle recipient	International Donor	Majority of funding for 50% of services. May be one further round until 2028, then likely to stop.
CDC/PEPFAR	International Donor	Was original funder of multi-city project – doubtful if future funding will be significant
City of Tshwane	Domestic Donor	Only domestic funder – must be nurtured and used as an example
Potential Funding Organisations – Service delivery and support		
Organisation	**Current Role**	**Possible Role**
National Department of Health	No funding, but government obligated to provide some funds	Working with NDoH to cost national OST implementation and NSS services. Could fund methadone and commodities with CSO service delivery.
National Department of Social Development	Currently limits funding to abstinence-based programs and rehabs	Opportunity to secure some funding for harm reduction, but more of an advocacy partner as their funding is not substantial Could receive additional funding if budget for prohibition through Department of Justice is cut.
Local government (apart from Tshwane)	Tend to fund generic and ineffective programmes that are heavily abstinence focused.	Strongest possibility for domestic funding. Need to show how to coordinate CSOs and current initiatives to include harm reduction and achieve results.
Civil Society Donors	Currently there are a few who fund fund advocacy,	There could be potential for civil society donors to fill gaps in local service delivery

Harm Reduction Service Organisations		
Global fund subrecipients	Currently three SRs	Objective is to empower community-based organisations to provide services – will create leaner and more cost-effective service delivery model suitable for local funding.
COSUP	Tshwane only	Model could be expanded nationally
Potential Harm Reduction Service Organisations		
Community Organisations	No current role	Need to capacitate networks to become service providers. Will facilitate local funding by local government & private sector
SANCA	Well-funded for abstinence-based services	By capacitating SANCA as a harm reduction-informed service, there will be an automatic increase in funding and increased likelihood of securing further funding.

6.2 Glossary

Table 14: Glossary of Terms Used

Community-led responses	Organisations that have a majority of staff who have lived experience of drug dependence and members of the community of people who use drugs play an active role in designing, managing and implementing programmes and services for their community.
Harm Reduction	A set of practical strategies and ideas aimed at reducing negative consequences associated with drug use for individuals and communities. Harm reduction is also a movement for social justice based on a belief in, and respect for, the rights of people who use drugs. Harm reduction does not condone the use of illegal drugs rather it acknowledges that the problem exists and that there is a responsibility to develop and implement public health and law-enforcement measures designed to reduce the harm that such behaviours can cause.
Hepatitis	Inflammation of the liver caused by viruses, alcohol, drugs and other toxins or, less commonly, by a breakdown in a person's immune system.
Hepatitis C	A viral infection caused by the HCV which belongs to the flavivirus family of ribonucleic acid (RNA) viruses. Discovered in 1988 HCV is spread through blood-to-blood contact. The slow progression of the disease means that people are often unaware of being infected until symptoms present many years later.
IDUIT	The IDUIT outlines the key concepts of Implementing Comprehensive HIV and HCV Programs with People who Inject Drugs: Practical Guidance for Collaborative Interventions (the IDUIT) related to prevention, treatment and empowerment with regard to HIV and HCV, and point to how activists and professionals from among the communty of people who use drugs might promote better policy and practice.

Law Enforcement	Law enforcement police by-laws and laws of the City Council to uphold social order. They are distinct from Metro and have powers of arrest, issuing of warnings, fines, to confiscate goods or shut down illegal operations. There are 11 speciality units including a displaced person's unit and rapid response team.
Low Threshold services	Low threshold services have few selection criteria and aim to make services as easy to access as possible.
Methadone	A regulated opioid agonist prescribed by a doctor and used for opioid substitution therapy
Needle-syringe Services (NSS)	Needle and syringe services distribute sterile, free injecting equipment (needles and syringes) to people who inject drugs at identified sites where people who use drugs congregate. They also distribute containers to store used syringes and collect used needles and syringes and dispose of them appropriately.
Nyaope	A local name for heroin
Opioid Substitution Therapy (OST)	Opioid Substitution Therapy (OST) is a medical intervention for opiate dependency consisting of the administration of long-acting opioid agonists, replacing an unregulated opioid drug such as heroin with a longer-acting opioid, usually methadone or buprenorphine, that is taken under medical supervision.

6.3 Key Reference Documents

Below are the key reference documents available from:

https://www.dropbox.com/sh/lorvq105lcce80m/AABHjKyK-RBQty-abEaQ448Ka?dl=0

- 2022-07-21 - 2022-2025 People Who Use Drugs Programme Description
- AFSA (2021) Baseline Study on The Experiences of Key and Vulnerable Populations in Their Interactions with Law Enforcement Agents
- amfAR (2021) KPIF & Key Populations Data for PEPFAR COP21 Planning
- amfAR (2021) KPIF & Key Populations Data for PEPFAR COP21 Planning
- APMG (2018) South Africa Key Populations Packages Assessment
- APMG (2018) South Africa Key Populations Packages Assessment
- Community-based harm reduction services Gauteng & Mpumalanga.pdf
- Community-based harm reduction services Gauteng & Mpumalanga.pdf
- Coordination Framework and Action Plan for GF Human Rights & other programmes
- Country Funding Request Narrative Global Fund April 2022
- Global Fund (2021) South Africa Mid-term Assessment Global Fund Breaking Down Barriers Initiative
- Global Fund (2021) South Africa Portfolio Analysis
- Global Fund Grants in South Africa

- Global Fund updates Meeting_3 March 2022
- IDUIT
- INHSU (2021) Harm Reduction Responses in the Age of COVID-19 – Documenting the experiences of people who use drugs in South Africa
- INHSU (2021) Harm Reduction Responses in the Age of COVID-19 – Documenting the experiences of people who use drugs in South Africa
- INHSU (2021) Harm Reduction Responses in the Age of COVID-19 – Documenting the experiences of people who use drugs in South Africa
- INHSU (2021) Harm Reduction Responses in the Age of COVID-19 – Documenting the experiences of people who use drugs in South Africa
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- Introducing and Developing Harm Reduction Strategies in South Africa
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