COSUP COMMUNITY ORIENTED SUBSTANCE USE PROGRAMME IN SOUTH AFRICA

A MODEL FOR DOMESTIC HARM REDUCTION FUNDING

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. Through research and advocacy, we promote the rights of people who use drugs and their communities 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.

Shaun Shelly carried out research and analysis for this report in consultation with Catherine Cook and Gaj Gurung.

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"I think the most important thing about COSUP was that we did it, and nobody could take that away. That changed the whole discourse in the country. People couldn't discuss the approach anymore as a theoretical issue. It was there to be looked at, with its mistakes and whatever… But now that we have done it, it's a matter of how we take it further."

Prof. Jannie Hugo

Head of the Department of Family Medicine,
University of Pretoria

EXECUTIVE SUMMARY

The Community Oriented Substance Use Programme (COSUP) in Tshwane represents an innovative model of domestic harm reduction funding. Established through collaboration between the City of Tshwane and the University of Pretoria's Department of Family Medicine, COSUP adopts a Community-Oriented Primary Care (COPC) approach to address drug use, particularly heroin and injecting drug use. This approach combines harm reduction, human rights, and community integration into a continuum of care, providing comprehensive services such as opioid agonist therapy, needle and syringe programmes, psychosocial support, and vocational training.

COSUP was initiated in response to increasing drug use in Tshwane and the limitations of traditional abstinence-based and punitive responses. The programme combines primary care and public health principles to meet specific community health needs. Interventions include motivational interviewing, brief interventions, opioid agonist therapy, HIV and HCV prevention, and peer-led initiatives. These services are integrated into existing public sector services to ensure comprehensive care for people who use drugs.

Established in 2015, the programme grew rapidly to 17 sites by 2019, enrolling nearly 3,000 clients, and maintaining high retention rates for opioid agonist therapy. Research, monitoring, and evaluation have been central to COSUP and to supporting the programme's effectiveness, improvement, and sustainability. COSUP's success has been recognised nationally and internationally, positioning it as a model for other cities.

During the COVID-19 pandemic, COSUP adapted to ensure continuity of care for vulnerable populations, including people with experience of homelessness. The programme's flexibility and collaboration with health departments enabled the provision of essential services despite the lockdown. From 2020 to 2023, COSUP focused on consolidating services, aligning with national policies, and securing additional funding. Future goals include expanding services across Tshwane, integrating mental health services, and promoting harm reduction-informed education and vocational programmes.

COSUP has faced challenges such as stigma, funding uncertainties, and the need for greater integration within health structures. However, the programme's successes in reducing drug-related harms and HIV transmission, increasing community acceptance, and providing sustainable support for people who use drugs highlight its effectiveness and potential for broader application. COSUP's innovative approach and proven outcomes offer valuable insights for policymakers, advocates, and communities seeking to develop effective and compassionate responses to drug use.

The following recommendations draw from the experience of COSUP in South Africa. They are explored more fully in the recommendations section of this report.

General Recommendations

- Promote cooperative governance and social contracting
- Build communities, not programmes

Recommendations for Municipalities

- Consider implementing a COSUP in your city or town
- Prioritise community-based harm reduction services
- Ensure sustainable funding along the continuum of care
- Invest in community development and employ people who use drugs in service delivery roles
- Address stigma and integrate harm reduction services into broader health and social systetms

Recommendations for Implementors

- Build on existing relationships – don't knock on closed doors
- Communication, collaboration, and coordination – not competition
- Work with what you have, not what you wish for
- Employ people who use drugs
- Position COSUP as a service for the community

1 INTRODUCTION

South Africa has a long history of drug prohibition and has emphasised criminal justice approaches to drugs to reduce the supply and demand of drugs. Despite the attempts to reduce drug supply, the South African drug market for cocaine, heroin, and methamphetamine is estimated to be USD 3.5 billion and is seemingly increasing[1]. There are an estimated 84,000 people who inject drugs in South Africa, and in the City of Tshwane, prevalence rates of hepatitis C virus (HCV) and HIV are reported to be 84% and 38%, respectively.[2]

There is a clear need for a continuum of drug-related services from early prevention to those that respond to severe dependence. Considering the increase in injecting drug use and the incidence of HIV and HCV among people who inject drugs, harm reduction interventions are critical. However, harm reduction services remain limited, underfunded, and reliant on international funding (see Harm Reduction International's report on the funding landscape in South Africa). Government-funded interventions for drugs are limited to abstinence-based programmes and inpatient rehabilitation, and medications for opioid dependence are not listed on the essential drugs list for long-term treatment. Significantly more money is spent on catching, convicting, and incarcerating people who use drugs than on harm reduction and treatment.[3]

One notable exception is the City of Tshwane, which funds the world's first Community-Oriented Substance Use Programme (COSUP). The Tshwane COSUP is a collaboration between the City of Tshwane and the University of Pretoria's Department of Family Medicine. Taking a systems approach, COSUP builds on the foundational principles of Community-Oriented Primary Care (COPC), emphasising human rights, using harm reduction strategies, and offering support services to people who use drugs along a comprehensive continuum of care. Services include opioid agonist therapy (OAT)[a], needle and syringe programmes (NSP), psychosocial support, skills training, and job placements. The objective is to meet people "where they are at," providing care and respect irrespective of their choices or circumstances and changing the emphasis from criminalisation to care and support. In South Africa, COSUP is the only government-funded response to drugs that includes harm reduction, OAT, and NSP.

COSUP provides around 50% of all harm reduction services in South Africa and relies mainly on funding from the City of Tshwane[4]. COSUP has survived opposition from prohibitionists, several changes in political leadership, a city placed under financial administration, and significant budget cuts.

The Tshwane COSUP is increasingly recognised as an effective model for encouraging cities to invest in similar programmes that are effective both in terms of outcomes and costs.

In an independent review of COSUP, The South African Cities Network: [5]

- Recognised COSUP's unique and effective governance model, inclusivity, and multi-sectoral approach
- Selected COSUP as the best example of innovative and effective ways of addressing social issues in South Africa.

a. This report uses the term opioid agonist therapy or OAT, except for quotations. Other terms used are opioid substitution treatment (OST), medically assisted treatment (MAT) and methadone maintenance treatment (MMT)

The review[6] concludes that:

"COSUP has demonstrated the efficacy of a substance-use approach based on compassion, human rights, science, and community-oriented primary care. Quantifiable performance indicators have been met, such as client participation in OST or NSP, medical services provided, training sessions facilitated, and people have been reached who were over-serviced through policing because health services are inaccessible. Furthermore, COSUP has directly informed the current draft of the National Department of Health's opioid substitution health therapy implementation plan."

In 2024, the Global Commission on Drug Policy invited the Tshwane Group Head of Health to present the COSUP model as an example of best practice at the Mayor of Amsterdam's Drug Policy and Cities conference. The Tshwane example supports the Commission's position paper on Drug Policy and City Government[7], which states:

"*While they are not mandated with drug control policies, cities have been able to provide the most innovative and protective drug policies, policies that have inspired the adoption by the national institutions of policies such as harm reduction, effective prevention, and peaceful law enforcement."*

This report explains how the COSUP model was developed, describes the path to implementation, and summarises the lessons learned over nine years of COSUP implementation.

COSUP can provide inspiration for policymakers, advocates, activists, and communities to break away from failed policies and explore alternative responses to drug use and broader health and well-being for communities, especially those affected by stigma, exclusion, and discrimination.

2 COSUP IN THEORY

" … without theory, there is nothing to revise. Without theory, experience has no meaning. Without theory, one has no questions to ask. Hence, without theory, there is no learning."

– William Edwards Demming, September 2015

In 2015, the City of Tshwane tasked the Department of Family Medicine at the University of Pretoria to design and implement a response to drug use and the growing levels of drug dependence in the City. The response team was created, which included senior managers, academics, health professionals, and a community representative. The community representative provided an important link with people who use drugs in Pretoria through the newly-formed Drug Users of Gauteng group and the community advisory groups which had been established as part of the first harm reduction programme, *Step Up*[b]. The role of the community representative was to provide expert input on harm reduction and to identify and educate the team on the best responses to drug use in the context of Tshwane.

The community-oriented primary care implemented by the Department of Family Medicine in Tshwane (see Annex 1) provided the foundational approach used to develop COSUP (see Annex 2).

2.1. Treatment as usual

Drug use responses in South Africa have been focused on the individual, with the emphasis on punishment or treatment. Drug treatment has been provided through inpatient facilities with people often requiring multiple admissions into abstinence-focused rehabilitation, at extensive costs to the individual or the state. For people living in poverty, there are long waiting lists. There are also reports of rehabilitation centres employing ineffective drug treatment methods[8].

For most people living in poor communities, the most common point of contact with authorities is with the police. In 2016, in Gauteng, there were 62,837 arrests for drug-related crimes, most of which were people who use drugs[9].

Community-level interventions were limited to educational and anti-drug campaigns framed as "drug prevention." These campaigns lacked evidence of effectiveness[c] but created public perception of government action on drug use.

Research conducted by the University of Pretoria and the community-oriented primary care team indicated that heroin and injecting drug use were on the rise[10]. Harm reduction services were new to the country (2014), and only the PEPFAR-funded *HarmLess* programme operated in Tshwane.

For COSUP to be effective, a completely different approach was required.

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b. The South African Network of People Who Use Drugs was not yet a registered entity.

c. See https://www.drugpolicyfacts.org/chapter/prevention for several studies that show no benefit

2.2. The foundation of COSUP

A broad continuum of care that could respond to heroin use and injecting drug use, as well as changing drug markets, was required. Harm reduction services were prioritised and made available in the community.

The five principles of Community-Oriented Primary Care (COPC), when applied to drug use, translated as follows:

- Services were delivered to individuals, communities, and families in a geographically defined area. A local health and institutional analysis assessed the availability and suitability of current services. COSUP integrated with these services, avoiding duplication and filling gaps.
- COSUP delivered comprehensive care along a continuum of health promotion, targeted prevention, treatment, psychosocial and medical interventions, support to minimise discomfort and risks, community integration, cross-sector and organisational collaboration and harm reduction.
- The COSUP model ensured equity by providing accessible, appropriate, affordable, and relevant drug use interventions.
- The principle of “practice with science” meant all interventions were informed by the best scientific evidence and delivered by interdisciplinary and multi-professional teams. Academic research with the intention of peer review and publication monitored the programme’s effectiveness.
- Services used person-centred approaches and care, collaboration between service provider and service user, and continuity of care.

2.3. What is COSUP?

COSUP is a community-based, evidence-informed response to drugs that uses and supplements existing resources such as government services and community-based organisations to deliver essential drug prevention, treatment, harm reduction, health, well-being, and support services to people at risk of using drugs or who already use and inject drugs and the communities they live in. The services make up a continuum of care for all stages along the spectrum of drug use and dependence. COSUP prioritises risk reduction and health over abstinence and addresses the social determinants of drug use by reducing stigma and exclusion through education and results in people who use drugs becoming accepted and productive members of the community. People who use drugs are included in all stages of design, implementation, and research, and community advisory groups are consulted to ensure contextually relevant services. COSUP works through collaboration, coordination, and capacitation and is not in competition with existing services or organisations. COSUP integrates formal peer-reviewed research to monitor and share data on the effectiveness of the services.

The theoretical design phase of COSUP (see Figure 1) involved extensive negotiations between the University of Pretoria and the City of Tshwane.

The next section of this report will describe what led to the initial agreement, how the COSUP model was implemented, and the difficulties, opportunities, changes, and outcomes.

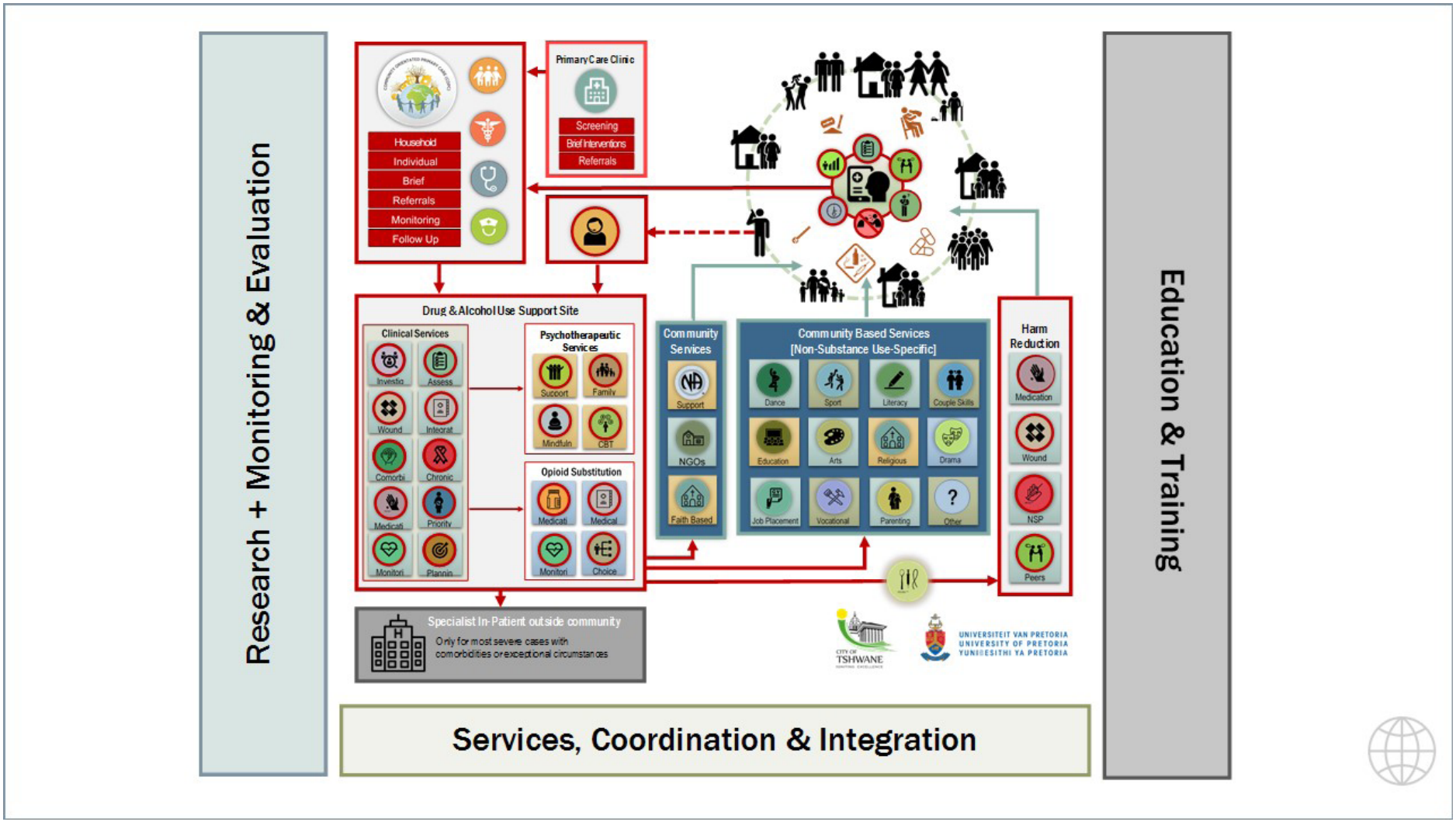

Figure 1: The COSUP model represented visually in COSUP planning documents

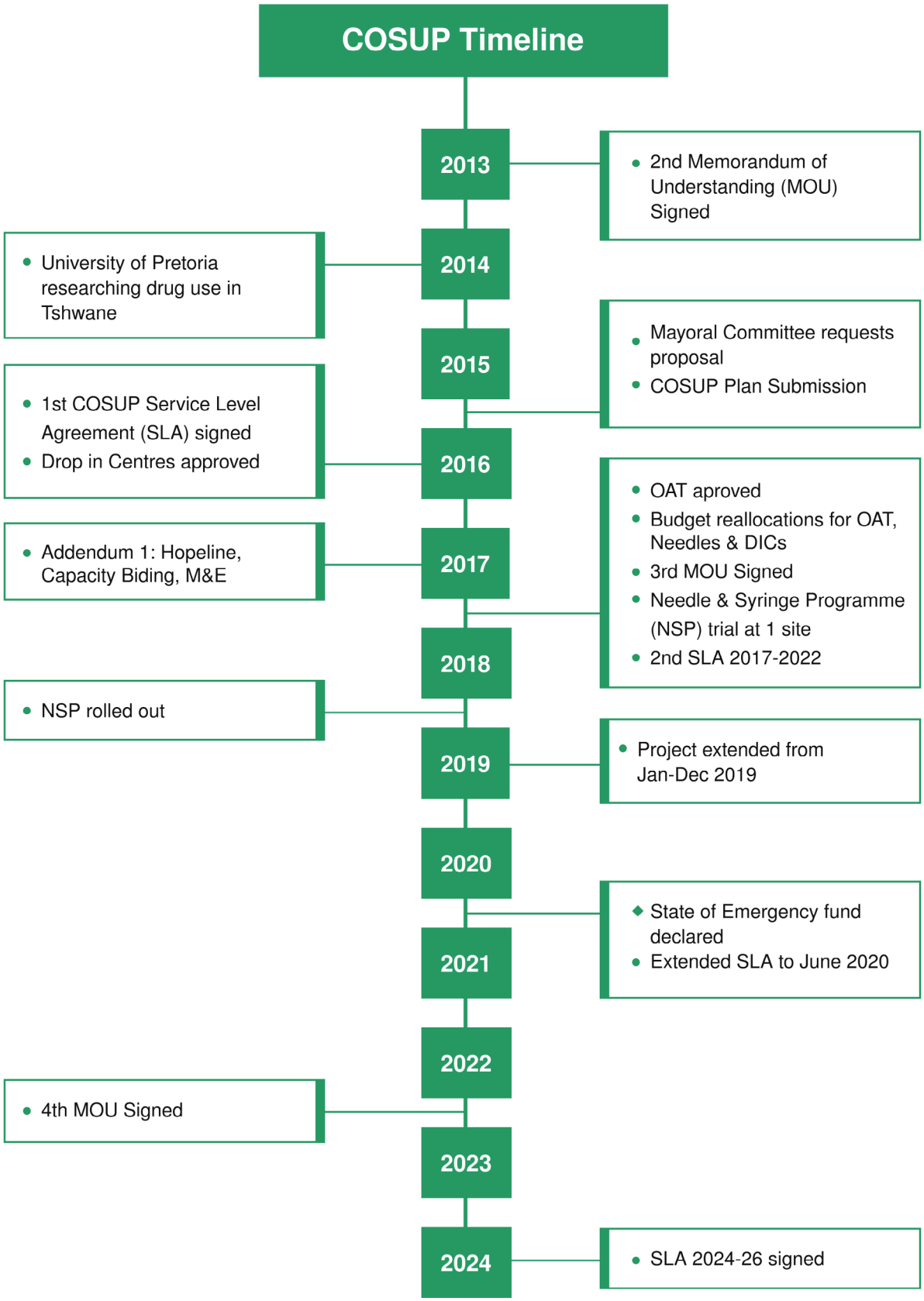

Figure 2: COSUP Timeline

3 COSUP IN PRACTICE

3.1. The City of Tshwane[d]

The City of Tshwane is a 6,345 sq km metropolitan municipality in the Gauteng Province[11]. The population of 3.27 million people[12] is young, with more than 60% aged under 45 and 24.5% under 14 years old[13]. Of the potential working population, 49% are unemployed (with 24% of these not seeking work) and 51% are employed. The level of inequity is one of the highest in the world.

Tshwane is South Africa's research and development capital and home to 26 international organisations. Around 90% of South Africa's research and development is carried out by organisations based in Tshwane.

Municipal governance in South Africa is highly structured and regulated with processes following a prescribed linear sequence and little scope for deviation. The flow of authority and information is hierarchical. The mayor of the City of Tshwane holds executive authority over all decisions and strategies,[14] with support from the mayoral committee. A city manager works closely with the mayor and instructs the various heads of departments to implement the city strategy. Oversight and monitoring of the executive is the responsibility of the council and oversight committees. Despite the rigidity of the municipal structures, the constant shifts in political power have resulted in a precarious city management structure.

Between 2016 and 2020, the City of Tshwane had seven mayors and eleven city managers. Loose financial management, poor governance, unauthorised expenditure, service delivery concerns, and diminished institutional capacity resulted in the Auditor General of South Africa placing the City under administration in March of 2020, which the Constitutional Court overturned in October 2020.

3.2. Contracting with the City of Tshwane

In 2010, the City of Tshwane and the University of Pretoria signed a Memorandum of Understanding (MOU) – a formal agreement to work together on various projects. The City sought to leverage research and expertise to inform public policy and enhance service delivery. Collaborative projects are managed through a Joint Working Group and formalised via Service Level Agreements (SLAs) appended to the MOU, reducing bureaucratic hurdles for project implementation.

In 2011, a service level agreement (SLA) was signed to implement the Tshwane COPC and by 2015, ward-based outreach teams had assessed 84,685 households. Although the COPC contract ended, the relationship between the Department of Family Medicine and the City had matured, creating a solid foundation of mutual trust that assisted in establishing COSUP.

In 2014, under African National Congress (ANC) leadership, the City of Tshwane identified drug use as one of its priority areas. The City asked the University of Pretoria to study and report on drug use problems in Tshwane. The Department of Family Medicine and the COPC Research Unit were familiar with the emerging issues due to their work in the community, where drug use and homelessness could not be ignored.

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d. All figures in this section are from 2016 unless otherwise stated

In 2015, after the research findings were presented to the City, the Mayoral Task Team asked the Department of Family Medicine, which had run the COPC programme, to develop a proposal on how the City should respond to the increasing levels of heroin use, general drug use, and injecting drug use. The Department of Family Medicine submitted a proposal in November 2015; the proposal relied heavily on the COPC infrastructure but was not a community-oriented drug programme. The original proposal did not budget for peers, or the supply and disposal of needles and syringes. There was no budget for methadone, but it was presumed that the Gauteng Department of Health would pay for 6mg per day for six months of Buprenorphine for people who needed substitution therapy. The focus was on people who use opioids and alcohol, and there was no plan for people who use stimulants or those with health issues such as HIV and HCV.

After internal consultation with communities and other stakeholders, the City decided not to put the project out to tender but to sign an SLA with the University of Pretoria. Under the Municipal Systems Act, 32 of 2000, an agreement was prepared, which underwent several oversight processes and final scrutiny by the legal department.

On 17th May 2016, the first agreement was signed. In 2016-2017, COSUP received USD 944,921 from the City's Drug and Substance Abuse budget of USD 2,372,918, which was part of the overall funding for addressing drug-related issues. The aim was "to minimise the health, social and economic impacts of substance use through the prevention, identification and resolution of substance use disorders in the City of Tshwane using a community-oriented primary care approach."

Immediately, the programme hit an obstacle: The 2016 election results were announced on the day that the first payment for the contract was made, and a coalition government replaced the ANC in Tshwane.

While the technocrats remained, their political managers changed. When the coalition announced that the Member of the Mayoral Committee for Health and Social Development was a former minister of religion in the military from the most conservative party, it seemed inevitable that COSUP would die before it was born.

It took 18 months of discussion for the City of Tshwane to commit to the 36-month contract and allocate the USD 3.5 million needed to run COSUP. The budget fell under the Department of Health's substance abuse budget.

3.3. The Service Level Agreement (SLA)

In terms of the SLA, the University is responsible for:

- Creating a team of experts to guide the programme.
- Developing and managing the programme.
- Consulting with the community and involving people who use drugs in the process.
- Providing a range of care services, including harm reduction and medical treatments.
- Operating the programme at various sites.
- Training and supporting staff across all locations.
- Collecting and managing data.
- Conducting research and publishing findings.

The University must submit monthly reports to the City management. As per ACT 32 of 2000, an annual progress report comparing achievements with key performance indicators must be submitted. In the final year of the three-year contract, a detailed report must be produced on compliance, progress, and areas for improvement. By the end of year three, 20 regional support offices were expected to be operational.

The City of Tshwane is committed to supporting the partnership, ensuring decision-makers availability when needed, meeting payment schedules, and appointing and funding community-based organisations and other service providers as part of the Drug and Substance Abuse programme.

One of the challenging tasks was to ensure the inclusion of people who use drugs both as employees and in consultations. This was ensured by including the Chair of the South African Network of People who Use Drugs (SANPUD) in the central management team. Peer educators from the community of people who use drugs are central to the programme and services. Peer-led outreach services include screening, brief interventions, referrals, distributing and collecting needles and syringes, behavioural interventions, and engaging with the community of people who use drugs. The University is responsible for identifying, employing, capacitating, managing, and coordinating peer activities. The University also maintains relationships with networks of people who use drugs and encourages and supports networks to participate in research and policy processes in the City and Province. The University collaborates and consults with SANPUD when needed.

Community advisory groups provide regular feedback on services. The groups decide their structure, which various stakeholders may lead. COSUP also engages with people with experience of homelessness and sex workers. Collaboration with stakeholders is broad and includes health, social, law enforcement, mental health, educational, and other service providers from the government, NGO, and private sectors.

3.4. Governance

A governance committee comprises directors from the City's Department of Health and Social Development, the Director of Support Services, the Dean of the Faculty of Health Sciences, and the Head of Family Medicine from the University of Pretoria, or their appointed representatives. Committee meetings are scheduled quarterly, and the role of the Governance Committee is to ensure legal and financial accountability, strategic direction, and oversight.

A management team comprising the project leads and a city Deputy Director meet every two weeks. The team is responsible for daily operations, resource allocation, and assigning operational roles and tasks, and are held accountable for all operational aspects of COSUP.

3.5. Funding model

Social contracting is common in South Africa[e]. Typically, funding from local and national governments to NGOs is based on the procurement and contracting model. Organisations apply for funding as part of a call for services or are invited to apply to meet a particular need. Funding for drug services falls almost exclusively under the national and local Departments of Social Development.

The funding model used to fund COSUP combines procurement contracting and grant funding. Like procurement and contracting models, the City of Tshwane makes scheduled payments based on the SLA and contract timeline. However, there is also the flexibility and up-front payments that are typical of grants. The level of trust and historical dealings with the Department of Family Medicine meant that the funding was flexible, and line items were adjusted as priorities shifted. Unlike other municipalities, interventions for drug use in Tshwane are funded by the Department of Health.

e. For more details on social contracting examples in relation to harm reduction, see Domestic public financing and social contracting for harm reduction - Harm Reduction International (hri.global)

4 COSUP IMPLEMENTATION PHASES

"In theory, there is no difference between theory and practice. But in practice, there is."
– Benjamin Brewster

4.1. 2016-2020 Pilot phase

Shortly after the initial proposal was submitted to the city, the documentation tools, Standard Operating Procedures (SOPs) and guidelines for the COSUP were developed. Although COSUP shared principles with the original submission, there were significant differences in design, implementation, and, most importantly, budget.

"Initially, we thought we would work with people for six months, and then they would be OK, but as we learned and read more, we understood harm reduction differently. Initially, we did not even budget for methadone and needle and syringe programmes. Later, when we changed the budgets, Sakkie du Plooy and his administrators supported us."

– Prof. Jannie Hugo, Head of the Department of Family Medicine, University of Pretoria

5.1.1. Negotiating budgets

Period	Original Budget
July 2016 – June 2017	USD 944,921
July 2017 – June 2018	USD 1,581,228
July 2018 – June 2019	USD 2,242,788
July 2019 – December 2019	USD 887,132
January 2020 – June 2020	USD 1,126,396

Table 1: Agreed budgets for COSUP over time showing financial adjustments made to keep the programme running effectively

In the original project plan, the Provincial Department of Health was to provide OAT with an estimated cost of USD 292 per person per year. However, because there are no national guidelines for maintenance prescribing, and no OAT medication is on the essential medicines list for maintenance therapy, this was not possible. The Mayoral Committee for Health and Social Development and the Head of Health worked with the project team to advocate reallocating the budget to fund OAT and this reallocation was approved in July 2017. In many cases, clients and their families paid for medication where possible, but retention was far lower than when the programme sponsored the cost of OAT. Apart from OAT, all COSUP services are provided free of charge to the public.

Establishing COSUP was a learning process for the COSUP team, the University, and City management. Several amendments to the SLA were made to accommodate the emerging gaps, issues, and evolution of COSUP.

June 2017	• In June 2017, an addendum was signed with an additional USD 315,000 budget. The additional responsibilities were: • To establish the HopeLine call centre for people in crisis or wanting advice, or referrals related to drug use. • To build the capacity of local and regional drug action committees. • To support and monitor the non-profit organisations (NPOs) funded by the City of Tshwane under the Drug and Substance Abuse budgets.
July 2017	The Governance Committee approved reallocating the budget for harm reduction services and drop-in centres.
January 2019	The project was extended to 31st December 2019, and then to March 2020.

Table 2: Amendments to the COSUP SLA during the pilot phase

5.1.2. Rapid expansion

Number of	(In 5000 households)	Estimated for 900,000 households
People using drugs	4,621	64,000
People reporting that they need help	1,737	24,000
People reporting injecting drug use	171	2,400

Table 3: Data gathered by community health workers from drug use triages in 5,000 households.

The implementation and expansion of COSUP were intended to follow a stagewise approach to ensure that the teams at each site understood harm reduction and the proposed interventions. However, based on the information received from the initial household drug use screening (see Table 4), the City wanted a rapid expansion, and within 12 months, 17 sites in six regions were operational. COSUP employed 17 clinical associates, two nurses, 14 social workers, 7 community health workers (CHWs) and 15 peers, two doctors, two experts, and the project management team. A total of 2,957 people who use drugs had been enrolled

and had attended 19,533 counselling, social work, or support sessions.

More than 600 people were initiated on OAT, around half of whom were self-funded, and the other half city-funded. Retention rates for six months or more were 87% for people sponsored by the City and 62% for self-funded people, highlighting the need for cheaper and funded OAT services.

In the first year of operation, COSUP maximised the existing structures, engaged with 65 NGOs, signed five cooperative agreements with NGOs, and established 11 Community Advisory Groups holding 129 meetings. More than 200 COSUP clients were in or had completed skills development programmes through collaborations.

From the first day, services were in demand and COSUP was off with a sprint (see Annex 5 for 2019 figures).

Figure 3: Stills from a social media and internal advocacy video for the City of Tshwane

"Life just keeps getting better since I met the COSUP programme. Now I am even back at night school and help others who need this help. I have attended a life skills course at POPUP and I am ready for the next phase of my life, thanks to COSUP!"

– COSUP Client

4.2. 2020 COVID-19

One of the intentions of community-oriented programming is to be present in communities and react quickly and decisively to emerging health issues. What the nation did not anticipate was a pandemic.

On 27th March 2020, in response to the COVID-19 pandemic, the South African government declared a state of disaster and implemented a national lockdown to control the spread of the virus. The lockdown made it harder to provide regular healthcare services, but COSUP worked with the City and health departments to continue helping people, especially people with experience of homelessness.

Managing healthcare for this population in the City of Tshwane during the lockdown was challenging, as many were vulnerable, mobile, without shelter, and in need of their regular medication, COVID testing, and support. The University of Pretoria's Department of Family Medicine, in collaboration with the City of Tshwane and the Tshwane District of the Gauteng Department of Health, ensured the continuity of

healthcare services for people with experience of homelessness.

Healthcare services, including primary healthcare, drug use management, mental health referrals, chronic medication supply, and OAT were available for people with experience of homelessness. The Occupational Therapy Department of the University of Pretoria set up activity-based interventions and trained pastors and social workers on digital platforms to implement the programme.

Disease screening, chronic medication supply, and COVID-19 prevention measures, such as mask provision, hand washing talks, and social distancing guidelines, were implemented in the shelters. The number of COVID-19 cases in the shelters remained low compared to people who weren't in shelters. More than 2,000 new people received services, including initiating 1,076 on methadone, resulting in daily observed doses for more than 500 people on methadone in 26 shelters. In addition, all COSUP sites remained open during lockdown.

The pandemic presented opportunities for innovation, such as new partnerships, increased collaboration, and bold interventions. Lessons learned from the response include the importance of trust, accountability, and effective cooperation in managing healthcare crises. COSUP was able to implement additional services and adapt rapidly to the pandemic.

COSUP's response to the COVID-19 pandemic confirms the model's inherent adaptability, collaboration, and innovation in addressing healthcare challenges during times of crisis. The lessons learned from this experience can inform future collaborative initiatives, particularly in the context of people with experience of homelessness and drug use management. The City of Tshwane was described as the most positive example of the scale-up of harm reduction services in South Africa during the global COVID-19 pandemic (21st March, INHSU).

The City of Tshwane (also known as Pretoria) is the most positive example of the scale-up of harm reduction services in South Africa during the lockdown.[15]

4.3. 2020-2023 Phase two: Consolidation & Refinement

Period	Original Budget
July 2020 – June 2021	USD 2,650,175
July 2021 – June 2022	USD 2,707,522
July 2022 – June 2023	USD 2,808,605

Table 4: The budgets agreed in the SLA for 2020-2023.

The pilot phase led to a better understanding of the needs, responses, and resources required for COSUP to be effective. It was beyond question that a community-based harm reduction programme could be delivered at a large scale and retain people in its services. The focus of phase two was to consolidate services, align COSUP with the National Draft Master Plan and other policy documents, and capacitate and train people working with people who use drugs.

COSUP worked with the City to establish the Local Drug Action Committee, a structure mandated by the National Drug Master Plan to coordinate stakeholder engagements and establish consultations to inform policy.

With the crisis around funding and resources, finding additional funding for OAT and supplying sterile injecting equipment was essential. Close working relationships in the harm reduction sector and the multiple roles key stakeholders play across organisations made it possible to collaborate with the TB HIV Care harm reduction programme in Tshwane, funded by CDC/PEPFAR. This enabled COSUP to expand the OAT programme through an additional USD 400,000 for methadone. Due to a federal ban on US funding for needle and syringe procurement, support from the Global Fund enabled a supply of 60,000 needles and syringes per month to COSUP.

During phase two, COSUP was increasingly accepted and recognised as an effective response to drug use in Tshwane (see Annex 6 for 2020-2023 figures).

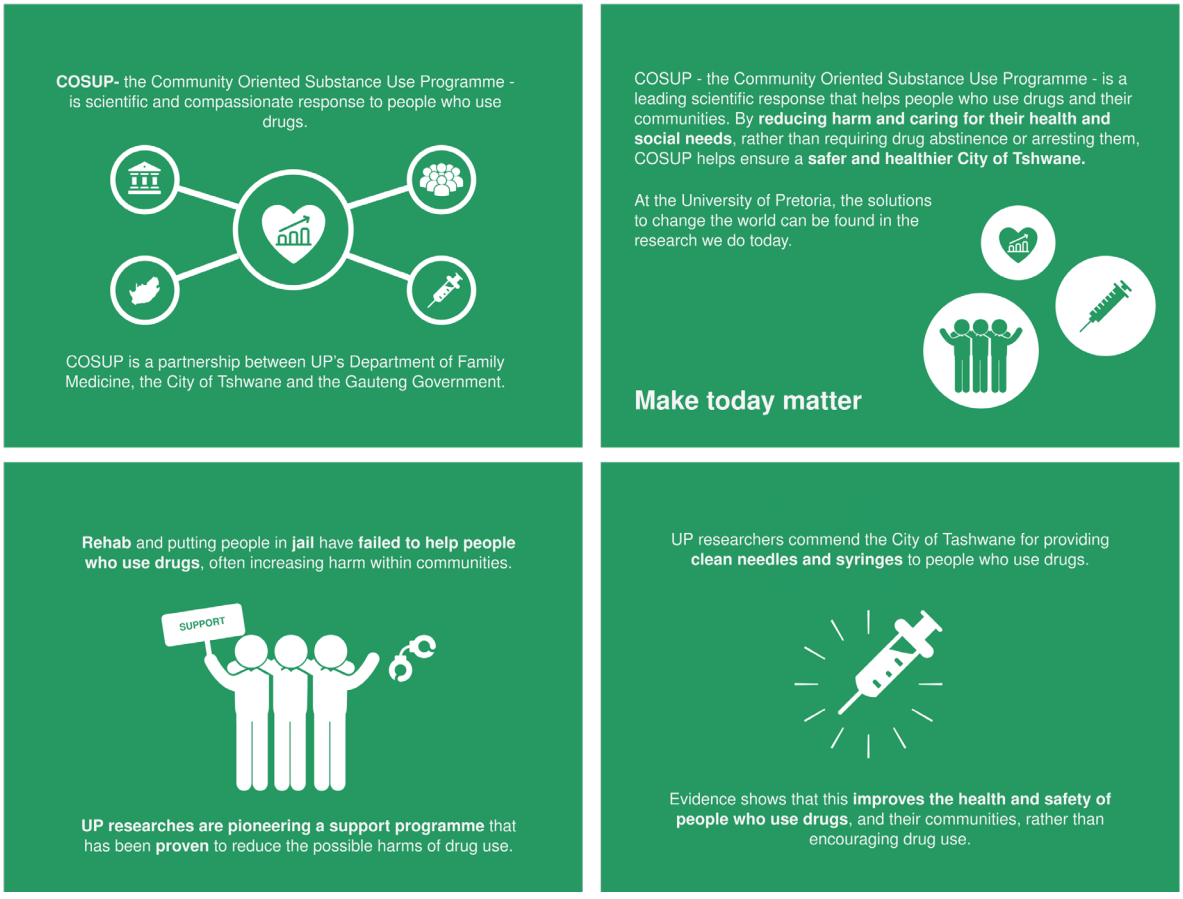

Figure 4: Stills from a social media and internal advocacy video for the City of Tshwane

5 IMPACT OF COSUP AND LESSONS LEARNED

5.1. Impact

COSUP clearly shows that harm reduction works, and local government can fund harm reduction services.

Health

Research by the University of Bristol in 2022 showed that needle and syringe programmes prevented around 50% of new HIV infections[16]. In a parallel study, modelling showed that nationally, people retained in OAT had a 60% reduction in HIV transmission. COSUP retention is above the world standard of between 57% at twelve months and 38.4% at three years%[17].

A recent study[18] on the perceptions of NSP in Tshwane concluded that they benefitted the whole community and not just people who use drugs. Although the sample was small, this is a significant difference compared to other national perceptions of NSP. The study participants reported that NSP also encourage people to engage with services, participate in group sessions and activities, improve health, and reduce the needles in the community.

Since the inception of COSUP, access to drug interventions and treatments has significantly improved through the implementation of harm reduction strategies and comprehensive support services. COSUP's multidisciplinary approach, which includes OAT, NSP, and COPC, has been crucial in retaining clients and reducing health risks. This has contributed to over 80% of stakeholders observing an improvement in clients' health, as the programme addresses risks associated with drug use and provides vital social and medical services, enhancing overall well-being[19].

Quality of life

Internal research among COSUP service users has consistently shown improvements in quality of life.

Over 80% of stakeholders believe COSUP has improved the community integration of people who use drugs. There is an increased sense of agency and belief in the possibility of change in the community. This has led to a reduction in stigma and helps resolve societal trauma for all.

A 2023 study concluded that stakeholders believed that COSUP was beneficial for service users, their families, service providers, and the community[20]. The programme received positive feedback from clients, with testimonials highlighting its positive impact on their lives, such as increased access to education and improved overall well-being. This community acceptance and support have contributed to the programme's influence on national policies[21].

> ***"This programme has restored our health, and we also now have normal relationships with other people in the community. We are now treated as complete human beings in our communities".***
>
> *– COSUP Client*

> ***"For me, they [COSUP] have done an extra mile for my life because I have seen bigger changes in my life ever since I came to COSUP. … I found a job through COSUP, so it has made a huge impact on my life."***
>
> *– COSUP Client*

Policy

The City of Tshwane has achieved significant recognition by implementing COSUP:

- COSUP was named a best practice case for governance in the 2020/21 South Africa State of Cities Report[22].
- A stakeholder survey on COSUP highlights the collaboration between the University of Pretoria and the City of Tshwane to provide access to health care for people who use drugs as a global leader in partnering to improve urban city life.
- The City of Tshwane is the first (and only) city in South Africa to:
    - Provide and fund services for people who use drugs, including those who are unwilling or unable to stop using drugs. The approach slows the initiation and progress of drug use towards dependence and more harmful ways of using drugs like injecting. It keeps people in contact with services and reduces barriers to treatment.

    - Promote services that are proven to reduce the drug-related risks and harm people who use drugs and the communities they live in may face, ensuring people remain healthy and can contribute to their community.
    - Support and fund the WHO comprehensive package of interventions for people who inject drugs, including OAT and the provision and collection of sterile injecting equipment, reducing infections like HIV and hepatitis C and the health burden on the individual and broader community.
- The City of Tshwane was described as the most positive example of the scale-up of harm reduction services in South Africa during the COVID-19 national lockdown.
- 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.

The result is that COSUP is starting to influence national policy through participation in stakeholder discussions, alongside generation of data and evidence.

Financial Implications

Logically, COSUP provides a cost-effective solution because it maximises the use of existing resources. It is well documented that harm reduction is a cost-effective response to drug use and it is well known that the cost of preventing HIV and HCV through harm reduction costs the state less than treatment (for cost-effectiveness evidence, see Harm Reduction International's Making the Investment Case for Harm Reduction briefing).

When compared with the Global Fund programme in South Africa, COSUP costs around half the amount for a similar number of people on OAT. Since the Global Fund is an HIV programme that focuses on preventing HIV transmission among people who inject drugs and COSUP is a programme designed to address all types of drug use, a direct comparison cannot be made.

Breaking down the cost of treatment, training, capacitation, outreach, and management costs is almost impossible because the resources required to deliver COSUP are integrated into the overall cost of the programme.

A cost-benefit analysis is necessary to explore this more fully. COSUP is working with external researchers to explore the economic benefits and create a model to calculate the implications of expanding COSUP.

What is clear is that COSUP requires less money to achieve wide engagement and deliver evidence-based interventions when compared to inpatient rehabilitation, repeated detoxification, and allowing the transmission of HIV and other diseases among people who inject drugs.

5.2. Realities and lessons from Tshwane

The realities of implementation often challenge the theoretical approach to any programme; Tshwane was no exception. Integrating programmes into existing structures was challenging for several reasons, and despite the intention of integration, sites often became stand-alone vertical services. Funding for COSUP and NGOs, stigma, the cost of medication, conflicting agendas, restricted resources, and uncertainty for the future of COSUP were some of the realities that required careful considerations, adaptions, and responses.

5.2.1. Stigma

In 2017, a new head of health was appointed who recognised the value of COSUP and was responsible for the Drug and Substance Abuse Unit and budget whilst facing significant opposition to implementing COSUP.

Perhaps paradoxically, the need to advocate for COSUP was most significant after the SLA was signed. Opposition to COSUP within the health structures was due to the harm reduction approach and the budget.

"The first thing I needed to deal with was resistance and lack of support within the department. It was seen more as a problem for that unit or section. For example, people from the primary health care section of our department, as well as those from your pharmacy section, had no interest at all.

– Senior Official, City of Tshwane

"They didn't want to hear anything about it, which made it difficult because there's a need for integration. You cannot run this programme in isolation from the rest of the programmes. My role was first to fight that resistance within the department itself and bring the teams together. I think we managed to get the team together around COSUP, and they are able to integrate, work together, and even share resources in some cases."

– Senior Official, City of Tshwane

Stigma, the moral objection to harm reduction, and a dogmatic dedication to prohibition have prevented COSUP from being a fully integrated programme within the National Department of Health structures. There is a real risk of COSUP becoming a vertical programme, and opportunities to integrate and rationalise resources being lost.

However, there is an opportunity to expand COSUP services to include essential health services, making COSUP sites both health and drug service resources in the community.

An example of the level of stigma is when the COSUP clients planted and looked after a vegetable garden on the ground of a state-run clinic; staff would pick the vegetables and either use or sell them. When COSUP management complained about the staff stealing the vegetables, the hospital staff started dumping refuse in the vegetable garden. Consequently, there is no longer a vegetable garden in that area. Food security was compromised, and the clients lost potential earnings and opportunities for learning and skills development.

However, there has been a remarkable drop in stigma among the communities where COSUP is operational. These communities have begun to witness and accept the benefits of harm reduction.

"Over the years, I have witnessed changes in attitude, behaviour and the response to harm reduction in communities where COSUP operates. At a recent meeting, people were demanding more comprehensive coverage for needle and syringe programmes and methadone. A decade ago, they wanted the death penalty."

– Member of the South African National AIDS Council Technical Working Group on People Who Use Drugs

5.2.2. Funding for NGOs

The NPO Act No. 71 of 1997, Chapter 2, asserts that the State's responsibility to nonprofit organisations is as follows: "within the limits prescribed by law, every organ of state must determine and coordinate the implementation of its policies and measures in a manner designed to promote, support and enhance the capacity of non-profit organisations to perform their functions".

Before COSUP, the City and Province funded several ad hoc community-based NGOs in the drug field. There would be an annual call for submissions to tender for services. In 2015, when the city commissioned the University Enterprises Unit to research the drug situation, they realised that the dispersed and one-dimensional response to drugs that focused only on abstinence was not going to resolve growing heroin dependence or reduce related harms. These findings were a catalyst for the design and implementation of COSUP.

In 2015/16, the City's Drug and Substance Abuse budget was USD 2.4 million. COSUP was allocated a significant proportion of the total budget (USD 0.94 million), and some NGOs lost funding. As COSUP has become more entrenched, budgets have been drastically cut, and since 2022, there have been no more city-funded rehabilitation NGOs.

COSUP continues collaborating with a wide range of community organisations and institutions by providing services from their premises and through continued capacity building.

Perhaps understandably, some NGOs are frustrated with the lack of funding and have complained to the Provincial and National Governments. The success of COSUP has highlighted the need for a new response to drug use, and part of the long-term vision is to work with NGOs and identify organisations that can effectively run a COSUP site. In the future, NGOs will likely run most COSUP sites; the COSUP central team will coordinate, monitor, and evaluate the services; and the city will be responsible for the funding.

5.2.3. Inter-organisational collaboration

Despite the lack of funding for NGOs, COSUP engages with and coordinates the efforts of a broad range of stakeholders. Local rehabilitation centres funded by the National Department of Social Development are included in the referral network. They occupy a space at the far end of the continuum of care reserved for people with serious drug dependence or co-occurring mental health issues.

Several NGOs, funded by the Department of Trade and Industry, the Department of Social Development, or other provincial and national government departments provide prevention-related services as well as skills and vocational training.

Moving forward, COSUP plans to increase the integration between NGOs and COSUP, with COSUP providing resources, guidance, and capacitation to organisations that will be funded by the City to provide services, including harm reduction services.

Government structures that collaborate with COSUP include the Community and Social Development Service Department, Metro Police, the Multi-Sectoral AIDS Management Unit, South African Police Services, the Department of Social Development, the Gauteng Department of Health Mental Health Services, the Gauteng Department of Health/Tshwane District Health, and the National Department of Health. In addition, COSUP works with and includes postgraduate students from four institutions of higher learning.

5.2.4. COSUP funding

COSUP has continuously operated under the risk of losing funding and the reality of reduced funds and delayed payments. Due to legal and policy restrictions on registering competitors, the cost of methadone in South Africa is exceptionally high, and COSUP has worked with other experts and activists to ensure that a broader range of products is available in South Africa. More work needs to be done with the National Department of Health to supply commodities, such as needles and syringes, and with the regulatory authorities to have methadone added to the essential medicines list for maintenance.

COSUP has also partnered with other organisations to fill funding gaps. The Global Fund supplied 60,000 needles and syringes a month, and CDC/PEPFAR, with their service provider, TB HIV Care, provided funding to expand the methadone programme. Plans for future integration with primary health sites would help rationalise some of the costs.

One way to continue mobilising funding is to quantify the savings made because of COSUP. The cost per person is significantly less than inpatient rehabilitation, and the savings in medical costs are due to the prevention of HIV and HCV infections, as well as the numerous cases of sepsis and infective endocarditis that sterile needles prevent. A formal economic evaluation is required to further articulate the value of funding COSUP.

5.2.5. Advocacy

Advocating for COSUP is an ongoing activity both externally and within the City structures. Animations and messaging cards have been distributed on the University and City intranets, websites, and social media platforms. While some press has misrepresented COSUP and repeated the stigmatising and misinformed opposition to harm reduction, positive press reports have had a significant effect on changing the perceptions of the programme and people who use drugs. Internally, peers have sometimes been stigmatised, unfairly judged, or held accountable to a standard not applied to other multidisciplinary team members.

Internal advocacy efforts centred around training, integration with people who use drugs, and using authoritative and trusted senior experts to support COSUP.

"…. why we bring in the academics is because we want to drive this programme from an evidence point of view. It's not about how we feel."

– Senior Official, City of Tshwane

The most effective advocacy tool has been positive results:

"That helped a lot, in effect, to quell down the naysayers politically and all those who doubted that this programme was worth what the city was investing in."

– Senior Official, City of Tshwane

5.2.6. Mental health services are a priority

There is a need to provide more mental health services. Mental health services are often limited and there are no easily accessible resources available in communities. People who use drugs will frequently present with acute severe symptoms like psychosis and suicidality or have underlying disorders such as ADHD, anxiety, depression, or PTSD. These may be exacerbated or medicated by their drugs and having qualified mental health professionals available regularly would help address these issues, which can be challenging for staff and other clients. Where it is not possible to have mental health professionals permanently embedded in the programme, staff members need to be trained in how to de-escalate and remain calm in order to keep staff and clients safe.

6 THE FUTURE OF COSUP

6.1. 2024 and beyond

The Tshwane experiences validated several parts of the programme, now seen as essential components of the COSUP approach. These have been included in the latest SLA that will run from 2024 – 2026 and include:

- **Multidisciplinary teams** that include peers, clinical associates, nurses, social workers, and regular access to family physicians and mental health clinicians result in more efficient and effective services.
- **Drop-in centres:** when community-based drop-in centres are available in Tshwane, there is more engagement and utilisation of services. Drop-in centres are particularly attractive to unemployed people and provide some stability and social integration.
- **A comprehensive continuum of care** is essential and should include evidence-based prevention for school children and targeted prevention for vulnerable children and unemployed youth. There is also a need to educate schools and parents about how best to handle drug use among young people.
- **Education of a broad range of stakeholders and people in contact with people who use drugs:** effective programmes and widespread education result in reduced stigma. Communities that once wanted harsher policing are now asking for expanded COSUP services.
- **Support groups and skills training:** one of the conclusions of the evaluation of COSUP is that it indirectly increases employment by improving the functionality of people previously dependent on drugs.

In early 2024, the City of Tshwane entered into a new SLA worth USD 6.8 million with the University of Pretoria to continue the COSUP programme until 2026. This further validates the success of COSUP as a model for city-wide interventions for drug use.

The focus in the next period is to expand services throughout all the regions of Tshwane to ensure equitable service delivery, focus on prevention by implementing a harm reduction-informed school programme, the expansion of services to unemployed youth with sports and skills development programmes, and increased access to mental health services while continuing to promote comprehensive and integrated care for vulnerable populations.

Two of the goals of the City of Tshwane Integrated Development Plan 2022-2026 are to create a caring city that supports the vulnerable and provides social relief and a healthy and vibrant city. However, these goals will not be achievable without a comprehensive response to the dependent use of drugs.

Since 2016, COSUP has shown that harm reduction, people-centred, and community-based responses are more effective than the traditional abstinence-based and punitive responses that have failed worldwide. COSUP has clearly shown that municipalities can fund effective and comprehensive harm reduction services through collaboration and social contracting.

It is now time for other cities to follow the example Tshwane has set and ensure that people who use drugs get the services they need and that risks to the health and well-being of all communities are protected without relying on international donors.

7 RECOMMENDATIONS

General Recommendations

1. Promote cooperative governance and social contracting

By framing drug use as part of a system, COSUP emphasises the need for a combined and multi-sectoral response involving all levels and branches of government and networks of stakeholders such as universities, community-based organisations, and service providers. Social contracting by national and local governments de-centralises power and necessitates broader consultation and government investment in civil society. Cooperative governance and social contracting approaches to governance are evident in the Tshwane COSUP and demonstrate the benefits of collaboration, shared responsibility, relationship-building, the strength of networks of organisations and government, and their role in inclusive and effective governance processes.

2. Build communities, not programmes

To sustain programmes, you need sustainable communities. Invest in the community. Donor funding will come to an end, often sooner than realised. Investment in a programme limits the benefit to the programme's scope, focus, and duration and does little for the local economy or long-term sustainability. Invest in the community by employing and building the capacity of community members. Time-limit the role of external consultants and organisations and limit their role to capacity building, training, and mentorship. Ensure that the needed skills are transferred to local organisations and staff are recruited from the immediate community. The money invested in the community benefits the whole community and improves everyone's lives.

Recommendations for Municipalities

When establishing services to reduce the impact of dependent drug use in a city, local governments should:

1. Consider implementing a COSUP in your city or town

By establishing and supporting a knowledgeable entity to coordinate, capacitate, and evaluate all service providers, the efforts of multiple organisations and resources can operate synergistically and be far more effective than ad hoc funding of independent organisations and service providers.

2. Ensure sustainable funding along the continuum of care

Recognising the complex systems that underlie drug use, local governments should combine budgets to create a cross-sectoral response to drug use and the underlying issues. Budgets should be rationalised, and priority must be given to funding organisations that can implement effective services. Funding should be distributed in a coordinated manner to ensure that each part of the continuum of care is funded. More inpatient rehabilitation centres and anti-drug campaigns are not the answer.

3. Invest in community development and employ people who use drugs in service delivery roles

Invest in communities and embedded services that include people who use drugs. Build communities and not only programmes or organisations. By employing people from the community, new micro-economies emerge, making communities economically active and viable.

4. Address stigma and integrate harm reduction services into broader health and social systems

Recognise that drug dependence at a community level is a symptom of underlying problems and forms part of a complex system that impacts everyone. By integrating services and maximising the utility of existing and future resources, marginalised and stigmatised people are integrated into the community and stigma is reduced.

Recommendations for Implementors

1. Build on existing relationships – don't knock on closed doors

This is a general rule for all advocates and activists. Maximise any relationships within the targeted structures to create trust, communication, and regular contact. If no relationships exist, develop them by finding common ground. Trying to convince people to change their thinking about emotionally charged issues like drug use or harm reductio, is exhausting and often counterproductive. Work with people who are curious and invested in solving the problem. Let the people who are listening help open the doors.

2. Communication, collaboration, and coordination – not competition

The COSUP's primary role is to coordinate services rather than provide services. To positively impact the lives of people who use drugs, reduce stigma and help change the system, a COSUP should not be seen as competition but an opportunity for organisations to learn and find a place in an effective continuum of care. Model preferred language and non-stigmatisation through your behaviours and language rather than through correction, instruction, or mandating language use.

3. Work with what you have, not what you wish for

Work with the infrastructure, organisations, people, funding, and available resources already in place. Start as soon as possible and accept that there will be gaps and things will not be perfect. Once you implement a COSUP, continuous monitoring allows for testing and adjustments. Collaborate with and include prohibition-based rehabs and community services. As they see the benefits of the COSUP interventions, things will change.

4. Employ people who use drugs

People who use drugs are the people most likely to reach and recruit people who use drugs into the COSUP. They increase local knowledge, build trust with people who use drugs, and are a living testimony to the benefits of harm reduction. It is also a way of understanding and destigmatising one of the most marginalised, misrepresented, and vulnerable groups in our communities. Peer navigators, peer-led outreach, and ambassadors help COSUP operate more effectively and keep COSUP management informed about community needs, perceptions, and the quality of COSUP services. The principle of “nothing about us, without us” must be respected, and people who use drugs must not be limited to traditional roles, but also be included in programme design, service delivery, and monitoring and evaluation.

5. Position COSUP as a service for the community

COSUP is more than a vertical programme for people who use drugs. A well-run COSUP benefits more than people who use drugs. By improving the lives of the most stigmatised members of the community and showing that people who use drugs are valuable and contributing members of the community, COSUP gives hope to the community and makes it safer and more integrated. When embedded in a CBO, clinics or social service sites, COSUP adds to those organisations. When COSUP is a stand-alone site, they can offer support groups, HIV and TB screening and testing, and essential health services. Funding is less likely to be withdrawn when the community sees COSUP as valuable, as it is in many of the Tshwane communities.

8 ACKNOWLEDGEMENTS

This report acknowledges the prominent role played by different individuals throughout the conception, implementation, and evolution of COSUP and are listed here separately.

Team members to conceptualise the COSUP included:

- **Professor Jannie Hugo,** Department Head, Department of Family Medicine at the University of Pretoria
- **Dr Lorinda Kroukamp**, Family Medicine/COPC Research Unit, University of Pretoria (UP) Pretoria, South Africa Project Manager, Community Oriented Substance Use Project (COSUP)
- **Professor Tessa Marcus Emeritus** Professor in the Department of Family Medicine (Health Sciences Faculty – University of Pretoria)
- **Shaun Shelly**, Senior Researcher, Department of Family Medicine (Health Sciences Faculty – University of Pretoria)
- **Andrew Scheibe**, Senior Researcher, Department of Family Medicine (Health Sciences Faculty – University of Pretoria)

Over time, other members of the Department of the Family Medicine joined the team in various roles:

- **Mr Koena Nkoko** MBA, MPH, OHN, RN, IPPHL, Tshwane Group Head of Health who presented the COSUP model as an example of best practice at the Mayor of Amsterdam's Drug Policy and Cities conference in 2024.
- **Mr Nkoko**, a head of Health appointed in 2017, who recognised the value of the COSUP and emerged as champions of COSUP.
- **Mr Sakkie Du Plooy**, a Member of the Mayoral Committee for health and development, a champion of COSUP.

9 ANNEXES

Annex 1: Community-oriented primary care

Community-Oriented Primary Care (COPC) combines primary care and public health principles in a geographically targeted community to meet residents' specific health needs and address the social and environmental determinants of health.

Implementing COPC involves a structured, step-by-step process that starts with a thorough community assessment to identify health needs and available resources. This is followed by the Local Health Institutional Analysis (LISA) process, which evaluates local health systems and their capacity to address these needs. Based on the assessment and analysis, priorities for health interventions are established, leading to the planning and implementation of targeted health programmes. The final step involves evaluating these interventions to measure their impact on community health. This cycle of assessment, planning, intervention, and evaluation is central to the COPC approach, ensuring that health programmes are responsive to community needs and effective in improving health outcomes.

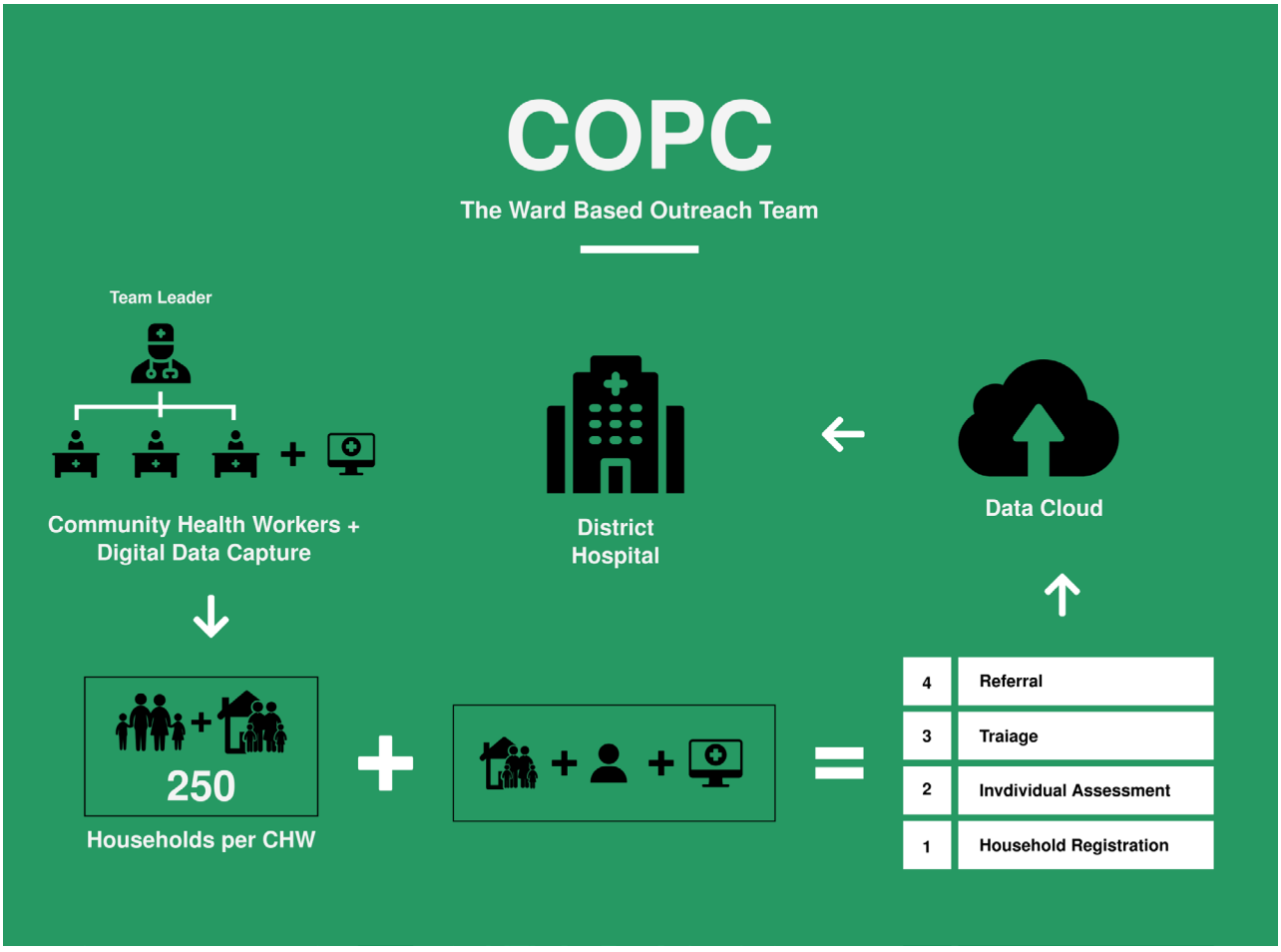

Figure 5: A representation of the COPC Ward-Based outreach teams in Tshwane.

The experiences of implementing COPC in South Africa and specifically in Tshwane, supported by the research and advocacy efforts of the COPC Research Unit at the University of Pretoria, highlight the model's adaptability and impact. By focusing on individual and community health, COPC contributes to creating more robust and healthy communities and demonstrates a path forward for health systems worldwide, seeking to enhance well-being and reduce health disparities.

In 2010, the Gauteng Department of Health, the University of Pretoria Department of Family Medicine, and other partners collaborated to implement a COPC approach in Tshwane[23]. Community health posts were created in partnership with community organisations. Teams of community health workers (CHWs) operate from these community-based health posts, and each CHW is responsible for between 150 and 200 households. Household registrations are done using digital devices and a specialised software package. Regular visits to the household help develop a deep understanding of each household's health and related issues.

By 2011, seven health posts were mapped with 105 community health workers and nearly 28,000 households. By 2016, more than 64,000 household assessments had been carried out.

Annex 2: COSUP design process

2.1. Establishing Services

Several existing resources were available to COSUP:

- Community health workers doing household health assessments using handheld data devices.
- Government primary care clinics in the community.
- Non-government community health clinics run by local medical doctors/NGOs.
- Non-profit organisations funded by the City's Drug and Substance Abuse budget.
- The OUT Wellbeing Step Up harm reduction programme and access to peers.

COSUP planned to establish sites within the existing public sector district services and integrate them within primary care services to ensure inclusion and reduce barriers to treatment. COSUP staff trained in harm reduction would support and collaborate with clinic staff, providing comprehensive care, improving skills, and understanding the options available and the correct referral and monitoring processes among clinic staff and ward-based outreach teams. Peer outreach workers and educators led mobile and outreach services to reach people who use and inject drugs in the spaces they congregate in the wider community. For the first time in South Africa, people who use drugs became part of the multidisciplinary teams at each site.

COSUP then established a set of essential interventions and capacitated the staff on implementation. Using CHWs, peer outreach, clinic staff, and COSUP sites, people were screened for risk using the World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST 3.0).

2.2. Interventions

Interventions were selected based on criteria including evidence strength, impact on health and well-being, implementation ease, training expertise, and cost-benefit analysis. A list of interventions is included below. The core interventions are rooted in the principles of harm reduction and supportive services that are non-punitive.

All interventions were decided using a standard set of criteria:

- Strength of evidence and effectiveness.
- The potential impact on risk, health, and well-being.
- Pragmatism and ease of implementation.
- Expertise in providing training and capacitation.
- Cost vs benefit.

Motivational interviewing principles guide conversations between service providers and service users. It is a directive, client-centred counselling style that helps clients explore and resolve ambivalence whilst fostering behaviour change.

Brief interventions, which are pieces of information, advice, or education delivered in non-specialist settings, are effective and can be provided by all COSUP and COPC staff and community organisations interacting with people who use substances.

Preventing HIV, HCV, and other potential consequences of injecting drugs was the highest priority. Providing **harm reduction commodities, like sterile injecting equipment,** is crucial for engaging hard-to-reach people who use drugs. For heroin-dependent individuals, **opioid agonist (methadone) and partial agonist (buprenorphine) prescribing** effectively reduces drug use and associated risks, petty acquisition crime, and improves their quality of life.

Outreach services run by people who use drugs, with support from clinical associates and nurses, offer **harm reduction packages, sterile injecting equipment, hygiene packs, and infield wound care.**

COSUP sites and drop-in centres provide **substance-specific services, essential health services, HIV and STI testing, and referrals t**o specialist medical and use services. Fixed sites also offer opioid agonist prescribing, voluntary psychosocial services, **and other support services.**

Social services address individuals' unique needs, facilitating community integration, resolving past trauma and mental health issues, fostering positive family relationships, and providing support and motivation for service users. **Practical support services** encompass assistance in securing identity documents, referrals to other community services, navigated medical treatment referrals, and adherence to treatment for chronic conditions, particularly HIV and TB. **Human rights abuses** should be recorded, and support, advocacy, and referral to specialised services should be provided.

The Contemplation Group is a programme developed as a harm reduction-focused open facilitated group combining motivational interviewing, mindfulness, brief problem-solving, mutual support, life-skills development, and personal goal setting. Other services provided in the community, including **skills development, vocational training, emergency accommodation, hospice care, and sports and recreational activities,** are provided according to community needs and resources.

2.3. Capacitation

Recognising the initial lack of knowledge on harm reduction, the programme prioritised educating and capacitating service providers, starting with the Department of Family Medicine and COPC unit staff. Training focused on motivational interviewing, brief interventions, and harm reduction principles. Champions were identified to further train service providers, with ongoing education integrated into the COSUP framework.

2.4. Research and monitoring

The City needed proof that COSUP was working, that the chosen interventions were effective in the context, that lives were improving, risk was reducing, and that COSUP was a worthwhile investment. The most robust way of proving this is through research that follows formal protocols and is written and published in peer-reviewed journals. From the start, research was emphasised as an essential and integral part of COSUP. An omnibus protocol approved by the University of Pretoria ethics committee was in place for the COPC research and COSUP was added as a research project under the main study.

Research and publications take a significant amount of time from inception to publication. We knew that the City of Tshwane would need to justify its investment in COSUP early in the process, so monitoring and evaluation systems using various data collection tools were included at the site level.

2.5. Documentation

Detailed documents were created to guide both the theory and practice of COSUP, including visual charts to show how the programme was expected to work and achieve its goals. These included:

- A log frame of all the interventions.
- A continuum of care describing potential interventions along the spectrum of drug use and dependence.
- Intervention tables for each intervention, including a brief description, the rationale for inclusion, the expected outcomes, key findings and benefits, the essential tools, barriers to implementation, quality of evidence, and the literature.
- An intervention log frame listing each intervention class, the objectives and sub-objectives, activities, outputs, outcomes, the means of assessment, and indicators for reporting.
- Algorithms describing the screening and intervention processes.
- A visual overview of the COSUP with explanation.
- Educational material, including presentations, videos, a curriculum and supporting material.
- A complete set of SOPs for site establishment, clinical protocols, prescribing methadone, and data capture.

2.6. Screening

Screening people for drug use, risk, and the presence and severity of a drug dependence is extremely important for a programme like COSUP. COSUP is a city-wide programme that uses public funds to provide a wide range of services, some of which are expensive and potentially lifesaving. An effective screening tool must demonstrate reliability, validity, predictive value, and the right mix of sensitivity and specificity. The correct tool ensures equity of service access based on risk score and justifies the referral pathways. Repeating the screening at regular intervals should maintain reliability.

The World Health Organization's Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST 3.0) is a user-friendly, non-judgemental, culturally neutral 8-item questionnaire that determines a risk score for each substance a person uses. After evaluating several screening tools, the WHO ASSIST 3.0 met all the criteria.

ASSIST covers alcohol, tobacco, cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives or sleeping pills, hallucinogens, and opioids. It is designed for repeated administration to monitor changes in risk levels over time to see if the programme benefits people. The ASSIST is also a brief intervention and facilitates motivational interviewing-informed conversations about drug use and risk management. Any COSUP service provider can quickly complete ASSIST in 5-10 minutes using a paper-based template in any setting. Once screened, appropriate referrals can be made, and a person's score is calculated.

Annex 3: Figure of COSUP screening and triage for referral pathways

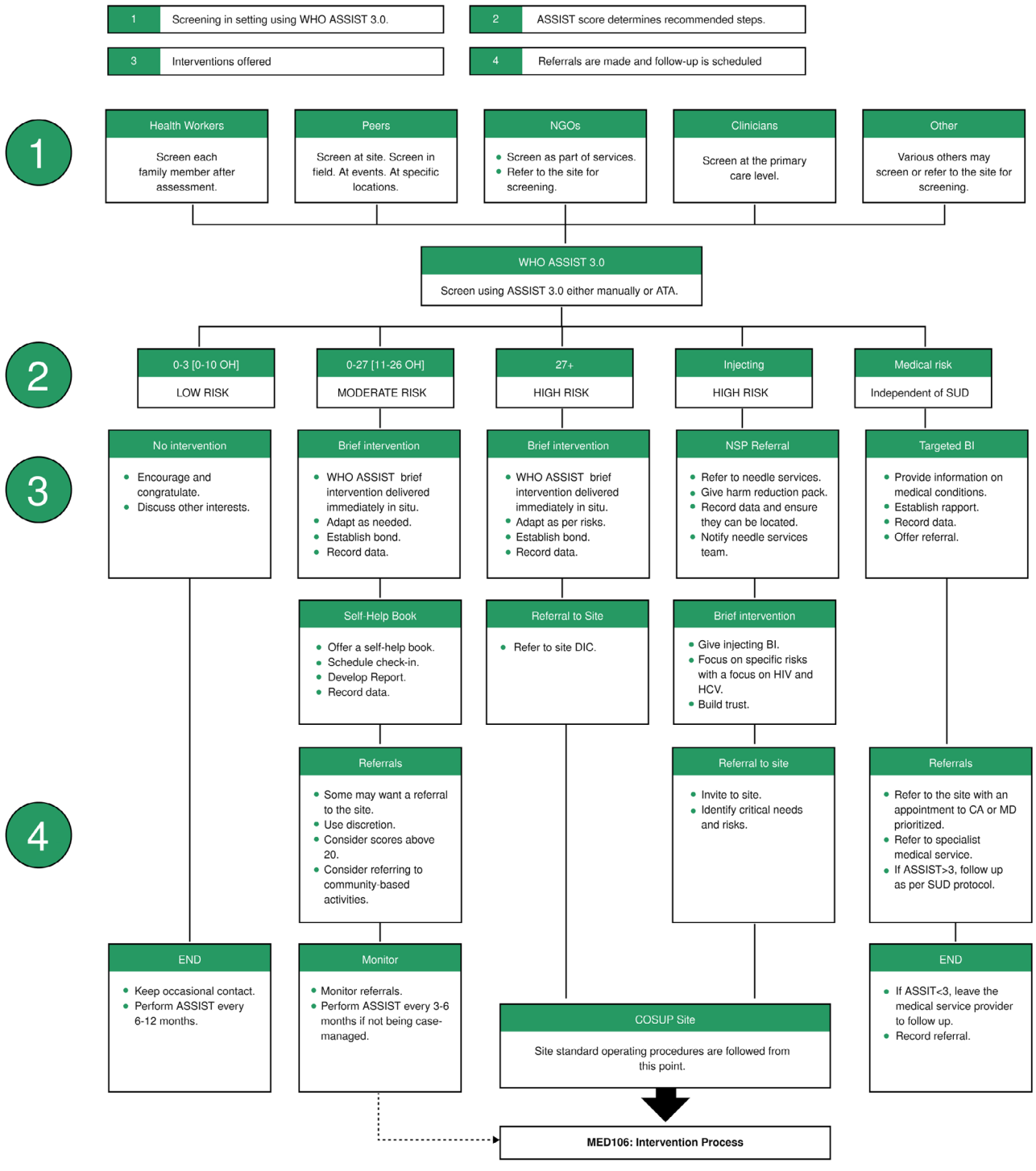

Figure 6: COSUP screening and triage for referral pathways

Annex 4: Example table of interventions for a COSUP

Intervention	Description	Resources	Objective	Implementers	Capacitation
Inpatient treatment	Specialist intensive treatment for up to 90 days in a specialised facility and 24-hour care.	High.Requires physical resources, human resources, skills, and financial resources.	• To assist people with chronic dependence and co-occurring mental health issues. • Provide respite from the environment and supervised medical withdrawal.	Existing rehabs and mental health facilities.	Educate staff on their role and position in the continuum of care.
Outpatient treatment	Intensive regular clinical contact with mental health, prescribing, and specialist clinicians. Use a combination of interventions in a structured programme.	Clinical, mental health, and peer support.	• To provide intensive treatment and medication to resolve drug and alcohol dependence.	Medical sites – primary care clinics, COSUP sites, clinics.	Requires skills development and development of standard operating procedures and protocols.
Community-based	Less intensive community-based support and therapeutic treatment.	Counsellors, peer support, NGOs.	• To support people who use drugs no matter what their end objective and to reduce the risks.	Peers, Department of Social Development.	Train in contemplation group, screening, brief interventions, and refer for treatment (SBIRT), motivational interviewing, and brief interventions.
Needle and syringe programmes	For people who inject drugs: exchanging used injecting equipment with sterile injecting equipment.	Easy. Need needles. Waste management.	• Reduce HIV, HCV transmission, infective endocarditis, sepsis. • Establish regular contact with people who inject drugs, who would otherwise not visit services.	General practitioners, pharmacies, peer teams, fixed sites, NGOs.	Peer-trainers. Easily taught. Mindset can be challenging.
Medication prescribing	Prescribe methadone, Buprenorphine for opioid dependence. Alcohol dependence: Acamprosate.	High resource need. General practitioners, pharmacies, medical aides.	• Move people from unregulated to regulated medications. • Creates stability, reduces crime, improves QoL, and reduces heroin use.	General practitioners with support from pharmacies.	Train clinicians and pharmacists.
Overdose prevention	Availability of Naloxone in all service settings and for peers.	Naloxone and overdose prevention kits.	• In cases of overdose, overdose can be reversed.	Everyone.	Basic overdose training is needed.
Mental health services	Screening, assessment, and treatment of co-occurring mental health conditions.	Psychiatrists and psychologists.	• To address underlying mental health issues and ensure appropriate medications.	Medical and COSUP sites.	Capacitate sites for dealing with psychosis, suicidality, etc.
CRAFT	A family and community intervention that preserves family relationships and encourages people who use drugs to seek help	The core group of facilitators. Low resource requirements.	• To provide effective support for families struggling to deal with a member using drugs. The aim is to retain family unity and safety and encourage drug users to seek help.	Department of Social Development, social workers, NGOs	Requires training and monthly follow-ups via Zoom.
Contemplation group	A support group for people wanting to make changes in their lives.	Core group of facilitators. Low resource requirements.	• To create the social connections and support for people changing their lives in difficult circumstances – is used for drug dependence, GBV, mental health.	DSD social workers, NGOs, peers.	Requires 4 days of training and monthly follow-ups via Zoom.
Social services	Statutory and general social services.	Department of Social Development, COSUP, NGOs.	• To ensure the relevant social service needs are met.	Department of Social Development.	Existing resources.
Aftercare support	To support people who have resolved their drug issues but need continued support.	Peer groups, vocational interventions, social services, counselling, and medical services.	• To provide continued support and ensure that the SUD does not return, to help maintain positive changes, and to assist with reintegration with families and the community.	Department of Social Development, NGOs.	Will use COSUP resources.
Skills development	Vocational and skills training for employment.	Skills and trade centre – high resources but funding opportunities.	• Ensure people have the skills to enter the formal economy or start their own enterprises.	Business resources.	Help develop strategies and secure funds.
Economic enterprises	Projects and programmes that encourage micro-enterprises real-time skills and economic development.	Funding and knowledgeable support mentors.	• Develop economic stability, generate income, and provide services to the community.	SANPUD, COSUP, NGOs.	Programmes like Double or Quits.
Motivational interviewing	An evidence-based way of having change conversations in ambivalent people. It is both collaborative and directive.	Training is required.	• A solid foundation is essential for all conversations with people who want to change. It ensures no harm is done, and it helps people find internal motivation, strengthening their resolve and motivation for change.	Anyone who comes into contact with people who use drugs.	Basic training, plus follow-up. There are online resources.
e-ASSIST	An essential screening tool that measures current risk and changes over time for drugs and alcohol.	Easy to implement.	• Screen for risk. • Monitor progress and change. • Contribute to the knowledge base.	All clinicians and intake or assessment staff.	Training is available and online.

Table 5: Example table of interventions for a COSUP

Annex 5: COSUP 2019 in numbers

Infrastructure	Number of sites and facilities established by COSUP for people who use drugs.	• 17 sites • 12 drop-in centres • 64 transitional housing spaces • 3 hospice spaces
General Services	Number of service users, counselling sessions, and calls to the helpline. Retention of clients.	• 5,182 service users • 53,198 appointments and counselling sessions • 11,945 people supported through the HelpLine • 64% retention rate
Harm Reduction	People initiated on OAT, people retained for 6 months or more. Needles provided and return rates.	• 1,414 people on OAT • 70% retained for 6 months or more • 6,157 needles distributed per month and 85% collected
Personal Development	Clients attending skills and vocational courses. Employment rates and independent living with an income.	• >800 clients attended vocational courses • 397 self-sustaining • 31 service users are now employed as peers
Training and Education	Training stakeholders and clinicians on harm reduction and COSUP.	• >1,000 medical students, clinicians, and service providers trained
Community Engagement	Advisory groups, collaborations, combined activities and alternative activities such as sport.	• 503 Community Advisory Group meetings • 121 NPOs engaged • 14 cooperative agreements • 24 soccer teams formed as part of SAPS Sports is Your Gang.
Research	Research projects approved by the Ethics Committee and articles published in peer reviewed journals.	• 33 research projects initiated
Staff and internal capacitation	Resources and staff available to provide services to COSUP.	• 16 clinical associates • 1 nurse • 17 social workers • 10 community health workers • 20 peers • 5 doctors • 10 data capturers • 121 professional support or part-time staff

Table 6: The City of Tshwane key performance indicators at the end of 2019

Annex 6: COSUP 2020-2023 in numbers

Infrastructure	Number of sites and facilities established by COSUP for people who use drugs.	• 16 sites after consolidation (down from 20) – this was required to maximise resources
General Services	Number of service users, counselling sessions, and calls to the helpline.	• 213,108 appointments and counselling sessions completed by COSUP staff • >1,707 support group meetings held • >15,000 people sought assistance from COSUP
Harm Reduction	People initiated on OAT, people retained for 6 months or more. Needles provided and return rates.	• 2,457 clients initiated on OAT • 2,000 people received needles • >60,000 needles distributed per month • 95% return rate
Personal Development	Clients attending skills and vocational courses. Employment rates and independent living with an income.	• 350 COSUP clients are now formally employed • 600 COSUP clients are earning an income
Community Engagement	Advisory groups, collaborations, combined activities, and alternative activities such as sport.	• 1554 community outreach campaigns were organised to advocate for COSUP • > 45 000 people attended these meetings in the community
Research	Research projects approved by the Ethics Committee and articles published in peer reviewed journals.	• 37 papers published
Training and Education	Training stakeholders and clinicians on harm reduction and COSUP	• > 1,200 healthcare workers • 806 Multisectoral AIDS Response Management Unit peer educators, • 153 health workers from 44 primary health clinics • 131 healthcare professionals • 381 employees at 101 NGOs

Table 7: The results from phase two of COSUP based on key performance indicators

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COSUP IN SOUTH AFRICA

A MODEL FOR DOMESTIC HARM REDUCTION FUNDING

HARM REDUCTION INTERNATIONAL