HARM REDUCTION INTERNATIONAL

INVEST IN JUSTICE

CASE STUDY

SOUTH AFRICA

From Punishment to Public Health: The Community-Oriented Substance Use Programme (COSUP)

Summary

Historically, South Africa's response to substance use and related harms has been shaped by criminal justice enforcement and short-term abstinence-led interventions, with limited access to sustained, evidence-based care.

The Community-Oriented Substance Use Programme (COSUP), established in 2016 through a partnership between the City of Tshwane and the University of Pretoria, demonstrates how a publicly funded health intervention can be advocated for, financed, and sustained within a municipal system. COSUP was advanced through a pragmatic case built on local data, professional accountability, and fiscal logic. It now stands as the country's clearest example of divesting from punitive responses and investing in health-based solutions.

COSUP supports over 6,000 clients across 17 service delivery sites (fixed and mobile). The average cost per client is approximately 22 times lower than the cost of incarceration, and the Tshwane health budget contribution increased from ZAR 17.4 million (USD 945,000) in 2016 to ZAR 29 million (USD 1.6 million) in 2023/24.[1,2] COSUP's value is not only financial: it reduces preventable harms and strengthens pathways into health care and social support.[3]

Key statistics:

6,000

Over 6,000 people are supported annually by COSUP.[3]

17

COSUP has 17 fixed and mobile service delivery site.[3]

$1.6 M

The dedicated municipal health budget allocation is approximately USD $1.6 million.[1]

148%

The prison population is at 148% capacity: 156,600 people in space for just 105,474.[4]

22X

Supporting one person through COSUP costs ~22× less per year than imprisonment.[2,4]

$10,430

The cost of imprisoning one person for a year is ~ZAR 169,700 (USD 10,340).[3]

The punitive approach

Prior to COSUP, opioid use and related harms (including heroin and the street drug nyaope [a]) were primarily addressed through policing, detention, and abstinence-oriented treatment. People who use drugs were repeatedly arrested for non-violent offences and cycled through detention without access to sustained, evidence-based harm reduction.

Public sector treatment options, including NICRO's diversion programmes [b], were largely limited to short-term detoxification or abstinence-based residential care, both associated with high relapse rates.[6] Services were often inaccessible due to stigma, homelessness, criminal records, and administrative barriers, including the lack of identity documents (ID) required to access healthcare.[c,7] Needle and syringe programmes were limited and donor-funded, and methadone was not available through routine public sector procurement. [3]

Challenging the punitive approach

The shift in Tshwane was driven by clinicians and public health leaders who reframed substance use as a health issue that require ongoing, evidence-based care.[6] They argued that health professionals and public administrators have an ethical and professional duty to act on evidence, not ideology. This framing was crucial: it translated a harm reduction approach into the language of service delivery, accountability, and cost-effectiveness that resonated with municipal decision-makers.[3]

The punitive approach and limited access to harm reduction placed immense strain on the public health system. A multi-province cohort analysis of people who inject drugs engaged with harm reduction services in South Africa recorded 283 new HIV infections over 2,306 person-years of follow-up; HIV incidence in the broader Gauteng province was 16.7 per 100 person-years, underscoring ongoing transmission risk without consistent HIV care, harm reduction and OAT coverage. [d,8]

Parallel policy advocacy and technical engagement with municipal leadership strengthened the case by demonstrating that the city was already paying heavily for punitive approaches through prisons, policing, and unmanaged health consequences, and that a health-based alternative could deliver better outcomes at lower cost.[3]

Instigating change

In 2016, following sustained engagement between the City of Tshwane and the University of Pretoria, COSUP was formalised through a service-level agreement (SLA).[3] Crucially, the programme was established as a municipal health intervention, not a pilot. The City committed domestic funding, while the University provided clinical, operational, and research capacity, enabling rapid scale-up with public accountability.

Municipal funding began at approximately ZAR 17.4 million (USD 945,000) in 2016 and rose to around ZAR 41.5 million (USD 2.53 million) by 2019, reflecting rapid expansion.[3] Funding later stabilised, with approximately ZAR 29 million (USD 1.6 million) allocated in 2023/24 as a dedicated budget line.[1] In early 2024, the City of Tshwane entered into a new SLA valued at ZAR 111.6 million (USD 6.8 million) to continue COSUP through to 2026, with a focus on geographic equity and integrated prevention and service delivery.[3]

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a. Nyaope is a cheap street drug common in South Africa, typically composed of heroin mixed with cannabis and other substances.

b. NICRO diversion programmes are court-mandated interventions for low-level offences (typically abstinence-based counselling/life-skills/restorative justice) and do not include OAT or clinical treatment for opioid dependence.

c. Without a South African identity document, individuals are frequently denied access to public healthcare services. COSUP assists clients in navigating identity registration processes.

d. "Person-years" refers to total time participants are observed in a study (e.g., 100 people followed for 1 year = 100 person-years).

Investing in Community, Health and Justice

Municipal funding was invested in tangible service capacity, including a diversity of fixed and mobile clinics, clinical staff, peer outreach workers, data systems, and logistics.[3] COSUP delivers opioid agonist therapy (OAT), sterile injecting equipment, HIV and tuberculosis screening, wound care, psychosocial support, and assistance with identity documentation, supported by a strong peer workforce to maximise outreach.[6] This investment demonstrated that harm reduction can be financed and delivered through public systems in South Africa.[3]

Tshwane evidence also shows why low-threshold harm reduction is essential for women. Qualitative research with women who inject nyaope describes stigma and exclusion from care, elevated safety risks (including violence), and HIV vulnerability linked to social marginalisation, reinforcing the need for accessible services that combine OAT, NSP, and social support rather than relying on arrest or abstinence-only pathways. [9]

A defining feature of COSUP is its peer workforce and community inclusion. Peer educators strengthen continuity of care through outreach, screening, referral navigation, NSP distribution/returns, and ongoing engagement, while governance mechanisms reflect lived experience through SANPUD representation and community advisory feedback. [3]

Retention and affordability are decisive, and they strengthen the Divest/Invest case. COSUP reports solid OAT retention overall (around 60%), and retention beyond six months was substantially higher when OAT was city-funded (87%) compared with self-funded (62%) during 2016–2020, showing that public financing is a key driver of treatment continuity and outcomes.[e,10]

When OAT is unaffordable or interrupted, people cycle back into instability, emergency care, and repeated criminal justice contact, the most expensive pathway.[3] By contrast, stable, publicly funded, low-threshold delivery improves engagement and functioning, and reduces avoidable downstream costs.[3] COSUP has proven resilient in the face of a funding crisis for harm reduction in the country and region, providing reliability and security while services reliant on donor-funding collapsed.[11]

Shifting resources from punitive enforcement and short-term abstinence-only responses toward publicly funded harm reduction and OAT delivers better outcomes at lower long-term cost and treats opioid dependence as a health issue rather than a revolving door through courts and detention.[3]

e. USD conversions are approximate and based on a mid-market exchange rate of US$1 ≈ ZAR 16.41 (18 January 2026).

Sources

1 City of Tshwane. (2023/24). Health Budget / COSUP allocation (ZAR 29 million).

2 National Treasury. (2023/24). Vote 22: Correctional Services — Adjusted Appropriation (ZAR 26.570966 billion).

3 Harm Reduction International. (2025). Community-Oriented Substance Use Programme (COSUP): Case Study and Midterm Review.

4 Department of Correctional Services (DCS). (2023/24). Annual Report 2023/24 (inmate population, approved accommodation, overcrowding, remand detainees).

5 Department of Correctional Services (DCS). (2023/24). Annual Report 2023/24 (inmate population, approved accommodation, overcrowding, remand detainees).

6 NICRO. (2023). Diversion and Alternative Sentencing Programmes. National Institute for Crime Prevention and the Reintegration of Offenders.

7 Scheibe, A., et al. (2020). Community-oriented primary care for people who use drugs in Tshwane (COSUP model).

8 Artenie, A., et al. (2024). HIV incidence among people who inject drugs engaged with harm reduction services in South Africa (multi-province cohort).

9 Lefoka, M.H., & Netangaheni, T.R. (2021). Utterances by women who inject nyaope in Tshwane.

10 Goeieman, D.S., et al. (2023). Retention of service users on opioid substitution therapy in the City of Tshwane, South Africa. African Journal of Primary Health Care & Family Medicine, 15(1).

11 Harm Reduction International. (2025). Breaking Point: Impact of US Funding Cuts for Harm Reduction Programmes in South Africa.

This is one in a series of case studies which captures the experiences of governments and donors around the world divesting from punitive approaches to drugs, and investing in programmes which prioritise community, health and justice. These case studies are not meant to be comprehensive but provide examples of effective divestment and investment, and related advocacy strategies.