

Community Oriented Substance Use Programme in the City of Tshwane: A Cross-sectional Survey of Stakeholder Perceptions

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Abstract

The City of Tshwane and University of Pretoria's Community Oriented Substance Use Programme (COSUP) is an applied research intervention to address drug use-related harms in the city by using a harm reduction community-oriented primary care approach. This is a study of stakeholder perceptions of South Africa's first publicly funded community-based harm reduction programme. In late 2021, purposively sampled respondents were surveyed using a cross-sectional survey. Electronically captured data were collected on respondent demographic characteristics, familiarity with COSUP and perceptions of COSUP's effect on service users' well-being, access to drug use services, family relationships, community integration, and on effective approaches to managing drug use. Frequencies and proportions were analysed as a total and by the degree of familiarity with COSUP, using descriptive statistics. Overall, 338 (93.1%) of the 363 stakeholders who consented to participate in the study had some familiarity with COSUP. Socio-demographically, 68.1% were female and over half (52.4%) were aged between 25–39 years. Most (70–80%) thought COSUP improved client well-being, family relationships and community re-integration. Most (80–84%) perceived

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COSUP to have increased service provider willingness to support people who use drugs, improved stakeholder networking and raised awareness of drug-related services. Most (76%) considered harm reduction to be the best approach to manage harmful drug use in the city. Stakeholders exposed to the work of COSUP perceive the intervention to be beneficial for individuals, families and service-providing organisations. Most favour a harm reduction approach to drug use and believe COSUP should be sustained and expanded.

Keywords: harm reduction; drug use; South Africa; stakeholder perceptions; drug use disorder treatment

Background

Globally, the vast amount of psychoactive substances consumed contributes to significant physical, mental and social harms (UNODC 2022a, 16). The potential for harm is influenced by the nature of the substances used, the frequency, dosage and method of use, the characteristics of the person and context in which use takes place (Zindberg 1984). Although a comprehensive assessment and comparison of harms related to different psychoactive substances have not been conducted in Southern Africa, international experience points to opioids, and heroin in particular, as being among the most harmful.

A multi-criteria analysis of psychoactive substances (Nutt, King, and Phillips 2010, 1561) found heroin to be second to alcohol as contributing to the largest amount of overall physical and social harm to individuals and society in the United Kingdom. The health burden of opioids, of which heroin is the most widely used (UNODC 2022a, 16), is monitored in many countries. According to the 2019 Global Burden of Disease Study, opioid use disorders accounted for 12.9 million “healthy years of life lost” due to premature death and disability and 69% of drug-related deaths (UNODC 2022a, 16).

Heroin is also the most widely injected opioid (UNODC 2022b, 71). Opioid injecting is associated with a high risk of overdose and the transmission of blood-borne viruses, particularly HIV and hepatitis C (WHO 2022, 49). In 2022, one in two people who injected drugs was living with hepatitis C, and one in eight was living with HIV (UNODC 2022a, 32).

Opioids and Heroin

In 2020, an estimated 61 million people used opioids worldwide (UNODC 2022a, 16). Opioids include opiates (e.g., morphine and codeine), semi-synthetic opiate derivatives (e.g., heroin, hydrocodone and oxycodone) and synthetic analogues (e.g., tramadol, fentanyl and methadone) (WHO 2019). Opioids act on opioid receptors in the brain, which depresses breathing, blocks pain and produces a sensation of pleasure (UNODC 2022b, 71). Ingestion of an opioid may result in intoxication (WHO 2019). Repeated exposure to opioids can result in the development of dependence and neurological and behavioural changes (WHO 2019). Cessation or reduction of the amount of opioids

consumed by a person with opioid dependence results in opioid withdrawal syndrome (WHO 2019). Symptoms include dysphoric or depressed mood, craving, anxiety, nausea, vomiting, abdominal cramping, muscle pain, sweating, sleep disturbance, diarrhoea, and pupillary dilation (WHO 2019).

Heroin is produced from the opium poppy (UNODC 2022a, 16). In 2021, between 495 and 755 tons of heroin were produced globally, mostly in Afghanistan and Myanmar (UNODC 2022b, 75). Europe is a major market for heroin produced in Asia (UNODC 2015, 44). Over the past 20 years, the increase in volume of heroin being transported there via east and southern Africa (Eligh 2020, 11–15) has been accompanied by the establishment of local markets for heroin across the Indian Ocean islands, Kenya, Tanzania, Mozambique and South Africa (Eligh 2020, 18).

Managing Opioid Dependence and Reducing Related Harms

The World Health Organisation (WHO) recommends a set of enabling and health-specific interventions to maximise the impact of HIV and viral hepatitis interventions for people who inject drugs (WHO 2022, 49–51). Enabling interventions include removing punitive laws, policies and practices; reducing stigma and discrimination; empowering communities; and addressing violence (WHO 2022, 16–24). Specific health interventions include needle and syringe programmes, opioid agonist maintenance therapy (also known as opioid substitution therapy or OST) and naloxone (medication approved by WHO to rapidly reverse opioid overdose) for overdose management (WHO 2022, 51).

Harm Reduction

The WHO defines the health interventions for people who inject drugs listed above as harm reduction, and also notes that harm reduction includes policies and strategies that prevent and reduce individual and public-related health harms that are not contingent on abstinence (WHO 2022, 49). Harm reduction arose in response to the criminalisation and forced treatment of people who used drugs in Europe and the United Kingdom in the 1980s (Seddon 2020, 1). Hawk et al. (2017) proposed a set of harm reduction principles for healthcare settings, which include humanism, pragmatism, individualism, autonomy, incrementalism, and accountability without termination (Hawk et al. 2017, 4).

Initial harm reduction interventions focused on the mitigation of HIV transmission among people who inject drugs (Hawk et al. 2017, 1; Seddon 2020, 1–6). However, because in many contexts, people who use drugs also experience social disadvantage, including poverty, homelessness, social exclusion and a range of health and social service access inequities, contemporary views of harm reduction incorporate a social justice framework. These highlight the social context in which drug use takes place and the need to reduce those harms along with drug use-related harms (Pauly 2008, 8).

A harm reduction approach supports individual goal-setting in the management and treatment of harmful substance use (Hawk et al. 2017, 4). It differs from traditional substance use disorder treatment interventions, where the emphasis is on abstinence as the goal of treatment (Paquette, Daughters, and Witkiewitz 2022, 2). Thus, while traditional approaches can be punitive, often involuntarily discharging people who use substances from treatment (Paquette et al. 2022, 2), harm reduction interventions support clients to meet their substance use and wellness-related goals.

In relation to opioid dependence, treatment approaches that focus on abstinence have suboptimal treatment outcomes. Research shows that most people with opioid dependence resume opioid use within six months of undergoing detoxification (WHO 2009, 7). Abstinence-focused interventions that are unsupportive of opioid substitution maintenance therapy have been shown to contribute to people leaving care, re-connecting with the illegal drug markets, homelessness, unemployment and poor health (Dennis, Rhodes, and Harris 2020, 7). On the flip side, research shows that a harm reduction approach enables service providers to support individuals whose substance use treatment goal is abstinence (Dennis et al. 2020, 4).

South African Context

Historically, South Africa has embraced a prohibitionist drug policy and abstinence-based drug dependence treatment (Scheibe et al. 2017, 199). The National Drug Master plan 2013–2017 did not include harm reduction as it is internationally understood, and stated that harm reduction could be “achieved, for example, by treatment, aftercare and re-integration of substance abusers/dependents with society” (Department of Social Development 2013, 29). The current National Drug Master Plan (2019–2024) forefronts social protection and access to healthcare services over conviction and punishment (Department of Social Development 2019, 44–45). This national response to drug policy reflects the global shift towards evidence-based public health and social justice approaches to drug use (Department of Social Development 2019, 44–45). It references the WHO package of harm reduction interventions, which is also recommended in the South African National Strategic Plan on HIV, TB and STIs 2017–2022 (South African Government and South African National AIDS Council 2017, 67).

Recent drug and HIV policy reforms have been informed by emergent epidemiological information. A national HIV household survey in 2012 found that 0.3% of people aged 15 years and older had used an opiate in the previous three months (Peltzer and Phaswana-Mafuya 2018, 3). More recent evidence describes a significant increase in opioid use over the past decade. For example, the proportion of people accessing drug treatment services for opioid use disorders across 83 drug treatment centres increased from 16% in 2012 to 20% in 2017 (Harker et al. 2020, 5). Similarly, data from a private medical aid scheme (n=1,251,458) showed that between 2011 and 2020, there was a 12% annual increase in the incidence of opioid-related disorders (Tlali et al. 2022, 5).

Additionally, the burden of blood-born viruses among people who inject drugs has been documented as being significant. In 2019, the HIV prevalence among people who injected drugs was estimated at 21%, and hepatitis C virus prevalence at 55% (Scheibe et al. 2019, 6). In 2020, an estimated 82 500 people injected drugs in the country; mostly heroin (UNAIDS Key Population Atlas 2022). Policy reform has also been influenced by increasing recognition of the scope of human rights violations, media stereotyping, stigma and exclusion experienced by people who use drugs and their effects on health service access (Shelly et al. 2017, 40–47).

The City of Tshwane and the Community Oriented Substance Use Programme

Although the full extent of heroin use is not known, limited available evidence points to a large and growing problem in the City of Tshwane. From the 2012 National Household Survey, an estimated 93 157 people aged 15–65 years or 0.4% of the City of Tshwane population had used an opiate in the previous three months (Peltzer and Phaswana-Mafuya 2018, 3; Statistics South Africa 2011). In 2017, a biobehavioural survey and population size estimation estimated HIV prevalence at 58.4% and hepatitis C virus prevalence at 94.1% among an estimated population of 4 514 people who injected drugs in the City of Tshwane (University of California San Francisco, Anova Health Institute, and National Institute for Communicable Diseases 2018, 10).

In 2016, the City of Tshwane collaborated with the University of Pretoria to create a public health response to the growing need to address harms related to drug use. Together, they initiated the Community Oriented Substance Use Programme (COSUP), South Africa’s first publicly funded community-based harm reduction programme (Scheibe et al. 2020a, 1).

Between 2016 and 2021, COSUP set up 17 service sites in four of the city’s seven regions, from which multi-disciplinary teams of community and healthcare providers deliver a range of services. Services include health and psychosocial assessments; brief interventions; psychosocial interventions; needle and syringe services (distribution of needles and syringes, collection and destruction of used equipment, as well as counselling on safer injecting); opioid substitution therapy and testing; and referral for other medical conditions (Scheibe et al. 2020a, 2–6). See *Harm Reduction in Practice: The Community Oriented Substance Use Programme in Tshwane* (Scheibe et al. 2020a) for more detail on COSUP.

The scale and scope of COSUP’s work between May 2016 and June 2021 included: 10 645 people who use drugs accessed services; 675 908 sterile needles were distributed; 1 812 people were initiated on OST; 292 family interventions were conducted; 25 sports and reading clubs were established; 2 907 COSUP clients were enrolled in skills development programmes through a network of 343 community-based organisations; over 1 000 health science and social work students received training in harm reduction, and 159 community outreach awareness campaigns were initiated from 19 schools (COSUP 2020, 26–27; COSUP 2021, 5–11). During the Covid-19 hard

lockdown, 1 076 homeless and displaced people were assessed and initiated on OST to manage withdrawal symptoms and for maintenance (Scheibe et al. 2021, 20). These documented programmatic outputs notwithstanding, stakeholder perceptions of COSUP are unknown. The aim of this study, therefore, was to understand stakeholders' perspectives of COSUP's effectiveness to change the well-being of people who use drugs, drug-related service accessibility, family relationships and community re-integration of people who use drugs in Tshwane. It also sought to explore stakeholders' preferred approach to addressing drug-related harms in the city.

The next section outlines the methodology employed for this study. It is followed by the study's main findings and a discussion of these in relation to the local and international context, as well as their implications for organisations and service providers in health and social services.

Methods

Design and Setting

Data were collected using a self-designed, quantitative cross-sectional survey that was administered to stakeholders in and around COSUP service delivery sites in the City of Tshwane Metropolitan Area (Tshwane) in Gauteng Province, South Africa.

Population

The study population comprised four stakeholder segments: 1) people directly involved in the delivery of COSUP services, including COSUP employees (medical professionals, social workers and outreach workers) as well as students in training in these professions; 2) people in governmental, not-for-profit or community-based organisations who provided services to, interacted with or made referrals to COSUP, including local government officials, health and welfare service providers, law enforcement and private security personnel; 3) family members of COSUP clients; and 4) community members living in the vicinity of COSUP sites. Individuals from any segment of the stakeholder population in each of the four regions who were aged 18 years or older were eligible to participate in the study. Current or past COSUP clients were excluded from the study.

Sample Size and Sampling

The study set out to purposively recruit 480 participants on the assumption that each fieldworker would recruit and complete 40 interviews over a two-month period, in addition to other work commitments. This number was deemed feasible in light of available resources and time for implementation. No sample size calculation was done. Participants were purposively sampled in an attempt to include a diverse set of COSUP stakeholders in relation to their roles and geographic location.

Data Collection

Data were collected by 12 COSUP employees (seven social workers, one peer educator, three community health workers, and one professional nurse) using a purposively designed 24-question quantitative survey. Sociodemographic data included stakeholder group, gender (male; female; trans or gender diverse; prefer not to say), and age (1–24; 25–39; 40–59; 60+). Familiarity with COSUP was assessed on a five-point Likert scale from not familiar to extremely familiar. Perceptions of COSUP's effectiveness were assessed using statements with categorical options (agreed, disagreed or neutral). COSUP's effectiveness was assessed in relation to: 1) client well-being; 2) access to substance use services; 3) family relationships; and 4) community integration. One question assessed participants' belief of the best approach to address harmful drug use, presenting four approaches and definitions (harm reduction; abstinence; criminal justice, or other). Perspectives on the future of COSUP were also obtained (sustained; expanded; reduced; or discontinued). The survey tool was piloted prior to implementation.

For the purposes of fieldwork, COSUP's coverage area was divided into three zones, with each zone having a designated team of fieldworkers and a manager. The managers, with support from a researcher, conducted face-to-face fieldworker training that involved didactic information and role-play. The managers observed and certified field workers' ability to inform participants about the study, obtain informed consent and complete the survey using an electronic device.

Recruitment

Each fieldworker developed a personalised recruitment plan focusing on different geographical areas. Lists of potential participants were developed based on various stakeholder roles: COSUP employees; students; referral organisations; local government; family, and broader community members; or stakeholders. Fieldworkers identified and made appointments with stakeholders on an individual basis. The survey was administered by them face-to-face or virtually (Zoom[®], San Jose, California). Some were self-administered by respondents. Collected data were electronically captured and stored on Qualtrics[®] (London, England). On occasion, when there were breaks in electricity supply and/or internet network failure, fieldworkers used paper-based surveys that were subsequently captured onto Qualtrics[®]. Participant recruitment took place between November and December 2021.

Data Analysis

Responses of consenting participants who had some familiarity with COSUP were analysed. Participants were stratified into being either somewhat familiar (combining those reporting to be slightly and moderately familiar) or very familiar (combining those reporting to be very and extremely familiar) with COSUP. Frequencies and proportions were used to describe the captured demographic data and responses for the 24 survey questions, by level of familiarity (somewhat familiar and very familiar) and as a total.

Ethical Considerations

Ethical approval was obtained from the University of Pretoria’s Health Sciences Research Ethics Committee (reference number 310-2020). Participation was voluntary, and no remuneration was provided. Informed consent was captured via the electronic or paper-based tool, as appropriate. The City of Tshwane’s Department of City Strategy and Organisational Performance authorised the inclusion of public servants from that department to participate.

Findings

A total of 371 respondents were approached, and 363 respondents consented to participate. Of the eight people who declined to participate, one had no knowledge of COSUP, six cited time constraints, and one did not respond. Twenty-five respondents were excluded from the analysis as they were not familiar with COSUP (figure 1).

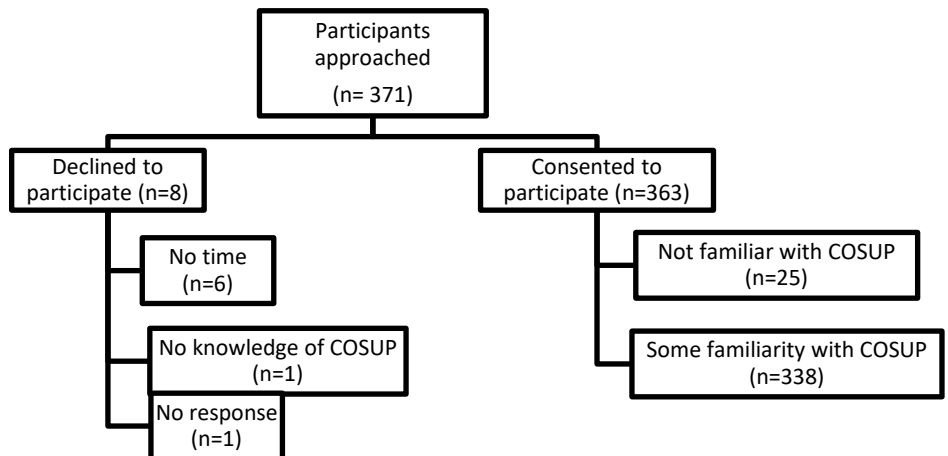


Figure 1: Study participant flow

Overall, 54.7% (185/338) of participants reported to be very familiar with COSUP. Participants included a range of stakeholders, including community outreach workers (18.1%, 61/388); psychosocial service providers (17.8%, 60/388); medical healthcare providers (13.3%, 45/388); and COSUP client family members and/or caregivers (11.8%, 40/388). Self-reported levels of familiarity were similar across most stakeholder roles. Exceptions included outreach workers, among whom 82% were very familiar with COSUP, and students/interns and educators, among whom 83.9% and 80% were somewhat familiar with COSUP, respectively. Most (68.1%, 230/338) participants were females, with similar proportions of participants by gender being somewhat and very familiar with the programme. More than half of study participants were in the age range 25–39 years (52.4%, 177/388). Most participants in the 18–24-

year age group (81.3%, 13/16) described themselves as somewhat familiar with COSUP, while older participants (40–60 years of age) described themselves as being very familiar (58%, 78/134) (table 1).

Table 1: Selected study participant characteristics

	Familiarity with COSUP	Somewhat familiar with COSUP		Very familiar with COSUP		Total	
		N	153	185	338		
		n	%	n	%	n	%
Role	Community outreach worker	11	7.2	50	27.0	61	18.1
	Psychosocial service provider	28	18.3	32	17.3	60	17.8
	Medical health care provider	23	18.3	32	17.3	45	13.3
	Family member/caregiver	18	11.8	22	11.9	40	11.8
	Law enforcement	16	10.5	14	7.6	30	8.9
	Civil society organisation (manager/worker)	12	7.8	13	7.0	25	7.4
	Student/ intern	17	11.1	6	3.2	23	6.8
	Educator	12	7.8	3	1.6	15	4.4
	Government official	5	3.3	8	4.3	13	3.9
	Community Member	2	1.3	4	2.2	6	1.8
	Other	8	5.2	6	3.2	14	4.1
	Pastor/Face-based organisation	1	0.7	5	2.7	6	1.8
Drug and related service role^		91	42.5	123	57.5	214	63.3
Gender	Females	103	67.3	127	68.7	230	68.1
	Males	49	32.0	55	29.7	104	30.8
	Transgender/ other	0	0	0	0	0	0
	Missing	1	0.7	3	1.6	4	1.2
Age	18–24	13	8.5	3	1.6	16	4.7
	25–39	79	51.6	98	53.0	177	52.4
	40–59	56	36.6	78	42.2	134	39.6
	60+	5	3.3	6	3.2	11	3.3

Note: ^ Includes participants that are community outreach workers, psychosocial and medical service providers, students and participants from civil society organisations linked to COSUP

Table 2 sets out responses to statements about the influence of COSUP on clients, service delivery and broader community issues relating to drug use in Tshwane among participants who were somewhat or very familiar with COSUP.

Most respondents (91.7%, 310/338 of all respondents and 97.3%, 180/185 of respondents who were very familiar with COSUP) agreed that COSUP had increased access to drug treatment and harm reduction services in Tshwane.

Over 80% of participants thought that COSUP had improved the well-being of COSUP clients, changed stakeholders' attitudes towards people who use drugs, improved networking among stakeholders providing services to people who use drugs, and increased service provider willingness to work with and support people who use drugs.

Across all variables, participants who were more familiar with COSUP were more likely to agree with statements supporting positive results of COSUP, compared to those who were less familiar with the programme.

Higher levels of agreement with statements around the positive influence of COSUP were most marked (differed by 20% or more) between those with greater familiarity of COSUP than those with less familiarity in relation to the influence of COSUP on reducing heroin use among clients (88.1% vs 68.0%); the reduction in criminal activity (65.4% vs. 41.8%); and increased access to skills development programmes (82.2% vs 56.2%), respectively.

Fewer than 60% of participants agreed that COSUP had participated in activities for schoolgoers, helped reduce criminal activity, or improved media portrayal of people who use drugs in Tshwane.

Analysis of stakeholder perspectives by participant roles showed a similar picture. For example, 90% of COSUP client family members and caregivers (n= 40) agreed that the programme increased re-integration with the family, even though only 55% of all family members and caregivers were very familiar with COSUP. Also, only 60% (18/30) of security sector respondents (police, law enforcement and private security) and 55% (22/40) of COSUP family members and caregivers agreed that COSUP had contributed to reducing crime.

Table 2: Participant perspectives on influence of COSUP on clients, service delivery organisations and the community

Familiarity with COSUP	Somewhat familiar		Very familiar		Total	
	n=153		n=185		n=338	
	N	%	n	%	n	%
Influence of COSUP on clients, service delivery and communities						

Improved well-being	121	79.1	173	93.5	294	87.0
Reduced heroin use	104	68.0	163	88.1	267	79.0
Reduced drug-related health risks	108	70.6	156	84.3	264	78.1
Improved family relationships	106	69.3	161	87.0	267	79.0
Supported community re-integration	108	70.6	159	86.0	267	79.0
Increased access to drug treatment and harm reduction services	130	85.0	180	97.3	310	91.7
Raised awareness of drug-related services availability	109	71.2	161	87.0	270	79.9
Participated in activities for schoolgoers	59	38.6	110	59.5	169	50.0
Increased access to participate in skills development programmes	86	56.2	152	82.2	238	70.4
Reduced criminal activity	64	41.8	121	65.4	185	54.7
Helped homeless people who use drugs during Covid-19 pandemic	107	69.9	163	88.1	270	79.9
Improved networking among stakeholders	113	73.9	170	91.9	283	83.7
Changed views towards people who use drugs	118	77.1	175	94.6	293	86.9
Increased service provider willingness to work with and support people who use drugs	109	71.2	167	90.3	276	81.7
Improved media portrayal of drug use	46	30.1	110	59.5	156	46.2
Improved substance use service organisations view of people who use drugs	109	71.2	159	86.0	268	79.3
Improved service delivery for people who use drugs	83	54.3	140	75.7	223	66.0

In terms of participants' views on the best response to take towards addressing harmful drug use in the city, over two-thirds of all study stakeholders (69.2%, 265/388) and 71% (151/214) of stakeholders from the drug use service and related sectors favoured a harm reduction approach. Respondents who were less familiar with COSUP, however, were more inclined to favour abstinence-based approaches (22.9% vs. 14.6%). Ten people, including four from law enforcement, regarded a criminal justice approach to be the best response to addressing drug use-related problems in the city (table 3).

Most participants (78.4%, 265/388) agreed that COSUP should expand its footprint and services according to demand. Only a few felt that COSUP services should be reduced (n=4) or discontinued (n=3) (table 3).

Table 3: Participant perspectives on best responses to drug use and the future of COSUP

Familiarity with COSUP	Somewhat familiar	Very familiar	Total
	n=153	n=185	n=338

	n	%	n	%	n	%
Best response towards drug use						
A criminal justice approach	5	3.3	5	2.7	10	3.0
A harm reduction approach	98	64.1	136	73.5	234	69.2
An abstinence approach	35	22.9	27	14.6	62	18.3
No response provided	15	9.8	17	9.2	32	9.5
Future of COSUP						
COSUP services should be discontinued	2	1.3	1	0.5	3	0.9
COSUP should expand its footprint and services according to demand	115	75.2	150	81.1	265	78.4
COSUP should reduce its footprint and services	2	1.3	2	1.1	4	1.2
COSUP should sustain its footprint and services	22	14.4	18	9.7	40	11.8
Other	11	7.2	11	6.0	22	6.5
No response provided	1	0.7	3	1.6	4	1.2

Limitations

Participants in this study were purposely sampled. This may have led to the selection of respondents who were more likely to look favourably on COSUP, as they may have had an existing relationship with COSUP or the fieldworkers. The use of stakeholder recruitment plans may also have contributed to fieldworkers selecting participants who were more easily accessible and more likely to respond to requests for participation. Additionally, some of the participants may have known the fieldworkers, and this may have led to information bias. COSUP clients were not included in the study to minimise a potential beneficiary bias. Fieldworkers were not able to reach all segments of the stakeholder population due to limited access to transport and mobile data, the impact of Covid-19 on work routines, as well as familiarity with government and provincial officials. While the findings of this study may not be generalisable, they do provide valuable insight into stakeholder perceptions of COSUP in the City of Tshwane.

Discussion

This cross-sectional survey among stakeholders familiar with COSUP found that most participants perceived the programme to have improved client well-being, reduced heroin use and reduced drug-related health risks. They also perceived it to have positively impacted broader social well-being, including family relationships and integration with the community. These findings confirm WHO (2019) as well as local research findings (Scheibe et al. 2020b, 6) that harm reduction-based approaches, which

include OST, reduce heroin use and improve well-being among people with heroin dependence.

The study corroborates our earlier research among social workers and healthcare providers involved in the Covid-19 response in Tshwane, which reported the value of OST as part of harm reduction and treatment for people with opioid dependence (Marcus et al. 2020, 3–6; Scheibe et al. 2021, 1–11). The study found evidence that stakeholders noticed an increased awareness of drug-related service availability, skills development opportunities and inter-organisational networking in the context of COSUP implementation.

Harm reduction is also a movement for social justice, built on a belief in, and respect for, the rights of people who use drugs (Hawk et al. 2017, 4). Harm reduction includes influencing and advocating for inclusive and non-stigmatising services for people who use drugs (Hawk et al. 2017, 4). Stakeholder responses point towards an improvement in willingness to work with and support people who use drugs, which suggests a reduction in stigma towards people who use drugs. The benefits of harm reduction, in particular of OST, go beyond blood-borne infections, to include a reduction in all-cause mortality and improved social functioning (WHO 2022, 30). The COSUP programme domains assessed and responses received confirm COSUP's positive influence on health and social inclusion.

These findings would likely be similar for an integrated community-oriented, abstinence-based programme that is based on human rights (WHO and UNODC 2020, 7–14). Similarly, programmes that enable supportive attitudes and understanding of people who use drugs and stigma reduction, should be expected of any model of care that follows principles of good drug use dependence treatment (WHO and UNODC 2020, 7–14). This said, there are several notable differences between COSUP, as a harm reduction intervention, and abstinence-based programmes. Although not measured in this assessment, in COSUP, abstinence from drugs is neither prioritised nor assumed to be the goal of people accessing services (Hawk et al. 2017, 4). Also, accountability without termination is encouraged, which means that people may continue to access services should they not achieve their health or drug-using goals or should they make harmful health decisions (Hawk et al. 2017, 4). By contrast, in abstinence-based settings, access to sterile injecting equipment is rarely available, increasing the risk of harm for people who inject drugs. Similarly, in many abstinence-based OST programmes, urine drug testing is used to police and exclude or withdraw services from people with concurrent illicit opioid use (Keeney and Saucier 2010, 29).

Stakeholders view COSUP as having had less effect in schools, within the media and on crime, which reflects both the focus of the intervention and the complexity of social settings. As a health and social intervention in community settings, the programme concentrated on harmful substance use among people who were out of school and over the age of 18. COSUP interventions to equip educators with knowledge and skills to

deal with substance use in 19 schools were likely constrained by the presence of abstinence-focused programmes being run in schools, and the fact that the Department of Education's policies around drug use prevention and school safety do not include harm reduction (Department of Basic Education 2013; Department of Basic Education, UNICEF, and Centre for Justice and Crime Prevention 2016).

Stakeholder perceptions of COSUP having limited positive influence on broader societal perspectives around drug use are unsurprising, given the limited resources available to the programme, its focus on health and social service delivery, the short time frame, and the limited scale of its operations. The majority of participants considered harm reduction to be the best way to manage harmful drug use in the city, and most thought that COSUP should continue and expand the coverage of its services. These findings align with stakeholders' overall positive perspectives on the effects COSUP interventions had across the assessed domains. The fact that most of the respondents who favoured abstinence-based models were people who were less familiar with COSUP, suggests that they may not have experience or a full understanding of harm reduction, COSUP, or the limited effectiveness of abstinence-based interventions. Overcoming the assumptions and ideology that underly differences in opinion about abstinence-based and harm-reduction approaches is likely to be best addressed practically through pragmatism, individualism and incrementalism. In other words, it is possible to simultaneously provide services to reduce the harms of substance use and support people who opt for abstinence as their long-term treatment goal.

Although support for criminal justice approaches to address harmful drug use was limited to a few study participants, largely from law enforcement, this finding points to the ongoing need to share global and local evidence around the harms and costs of punitive approaches (Jürgens et al. 2010, 476–479) and the benefits of supportive, health and human rights-based approaches in local contexts (Scheibe et al. 2016, 1–4).

Implications for Practice

Our study suggests that a harm reduction approach, which uses evidence-based interventions, is acceptable to and supported by a range of stakeholders. The analysis shows that support for this approach is greater among people who are exposed to its programmatic application. Also, the limited support for punitive approaches to substance use provides an opening for engagement around policy reform to address the consequences of the criminalisation of drug use. Given the weak understanding of harm reduction among public service, social work and healthcare professionals in South Africa and the region, there is also an urgent need to ensure that harm reduction and evidence-based treatment are integrated into university programmes as well as the continuous professional development training of those already working in the field.

Conclusion

In this study, the majority of stakeholders favoured a harm reduction approach to substance use in the City of Tshwane. They perceived COSUP, a community-based programmatic intervention, to have increased awareness of available services, reducing the harms and improving the well-being of people who use drugs, particularly people with opioid use disorders. The study's findings add to a growing literature on the perceived benefits and support for a harm reduction approach among a range of stakeholders. The study provides additional insights that support the scale-up of recommended practice, as well as the implementation of newer approaches included in the National Drug Master Plan 2019–2024. The study highlights the need for additional research into the use of harm reduction approaches in schools, and broader efforts to address misconceptions of harm reduction and the limitations of abstinence-based and criminal justice approaches to managing harmful drug use. An impact evaluation of the COSUP programme would add an additional dimension to stakeholder perspectives.

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