National Harm Reduction Guidelines for PUD (Persons who use and inject drugs)

December 2025

Ghana

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Abbreviations

DACF	District Assembly Common Fund
FDA	Food and Drugs Authority
GHS	Ghana Health Service
ICESCR	International Covenant on Economic, Social and Cultural Rights
MOH	Ministry of Health
NACOC	Narcotics Control Commission
NACP	National HIV/STI Control Program
NGO	Non-Governmental Organization
NSP	Needle and Syringe Program
OAT	Opioid Agonist Therapy
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WAPCAS PLUS	Ghana-West Africa Program to Combat AIDS & STI
WHO	World Health Organization

Glossary of Terms

Good Samaritan Laws	Legal protections that encourage people to call for emergency help during an overdose or other drug-related crisis by reducing fear of arrest or prosecution; they are designed to save lives rather than to change criminal law broadly.
Persons who use drugs	Refers to individuals who consume psychoactive substances.
People who inject drugs	Refers to people who use needles or other injecting equipment to administer psychoactive substances.

Executive Summary

Purpose

This guideline provides a pragmatic, rights-based national framework to reduce blood-borne infections, prevent fatal overdoses, and improve health and social outcomes for people who use drugs in Ghana. It translates global evidence into operational standards for Needle and Syringe Programmes (NSP), Opioid Agonist Therapy (OAT), and overdose prevention (naloxone), and sets out community engagement, monitoring, and a financially sustainable scale-up plan across primary to tertiary care.

Context and Urgency

Ghana's drug markets are diversifying with increasing opioid and stimulant use and rising injection in urban and peri-urban areas. Local data show higher HIV and HCV prevalence among people who use drugs and people who inject drugs than the general population. Legal reforms (Narcotics Control Act 2020; Public Health Act 851) enable a health-centred response, but persistent stigma, punitive policing, weak surveillance, limited naloxone and OAT access, and fragile financing hinder impact. Pilot NSP/OAT activities have demonstrated feasibility and demand.

Priority Interventions

- **NSP:** Low-threshold provision of sterile injecting equipment, safe disposal, basic wound care, condoms, and hygiene kits; hybrid delivery (fixed sites, mobile outreach, peer distribution) and clear referral pathways to testing, vaccination and social services.
- **OAT:** Methadone or buprenorphine for opioid dependence with medically supervised induction, maintenance, psychosocial support, take-home policies tied to stability, and prison continuity.
- **Overdose prevention:** Community take-home naloxone, SCARE ME overdose response training, post-overdose observation, and linkage to care; include naloxone on essential medicines lists and protect lay responders legally.

Enablers and Safeguards

- **Legal and human-rights alignment:** Implement Act 1019 and Public Health Act protections; train law enforcement; adopt Good Samaritan and confidentiality safeguards.
- **Community and peer leadership:** Meaningful people who use drugs involvement, peer remuneration, and stigma-reduction campaigns.
- **Supply chain and workforce:** Central procurement with buffer stocks, forecasting, multidisciplinary teams, and routine training.
- **Integration:** Embed harm reduction into HIV/TB, mental health, and primary care to maximise reach and cost-efficiency.

Monitoring and Accountability

A concise M&E package defines core indicators (coverage, commodities, OAT retention, naloxone reversals, rights incidents), DHIMS2 reporting, quarterly data quality audits, sentinel surveillance for HIV/HBV/HCV among people who use drugs, and CQI cycles to guide scale-up.

Financing and Scale-Up Roadmap

A three-phase plan (pilot → integration → sustainability) combines donor seed funding with domestic financing (government budget lines, NHIS inclusion, DACF, earmarked levies), CSR and private partnerships. Early efficiency measures include task-shifting, pooled procurement and service integration.

Expected Outcomes

Scaled, rights-centred harm reduction will reduce HIV/HBV/HCV transmission among PWID, cut overdose deaths, improve linkage to health and social services, and strengthen public-health resilience while advancing long-term cost savings. Immediate multisectoral commitment is required to move from pilots to national scale.

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The Technical Working Group provided subject-matter expertise, drafted technical sections, and guided clinical and programmatic recommendations.

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Disclaimer
The views expressed in this guide are those of the authors and contributors and do not necessarily reflect the official policies of the supporting organisations

Signed on behalf of the project team,

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CHAPTER 1: Introduction

Introduction

The concept of harm reduction emerged in the late 20th century as a pragmatic public health response to the spread of blood-borne infections among people who inject drugs (PWID). Early pilot programmes in Australia and Europe introduced needle-and-syringe programmes (NSPs) to curb HIV transmission, rapidly followed by opioid agonist therapy (OAT) in the 1990s. Over the past three decades, the scope of interventions has broadened to include take-home naloxone, hepatitis C treatment, peer outreach, and comprehensive psychosocial support. Today's harm reduction framework is enshrined in WHO and UN guidelines and recognized as an essential component of global health security.[1]

Harm reduction reached Africa later than Europe and North America but has steadily gained traction over the past two decades. Initial pilot activities and advocacy began in the mid-2000s, with more visible programme expansion across Southern and Eastern Africa during the 2010s; by the early 2020s a growing number of countries in West and Central Africa had begun pilot needle-and-syringe programmes, opioid agonist therapy pilots, and community naloxone initiatives as part of HIV/hepatitis prevention and overdose response efforts.[2] Regional momentum accelerated after 2015 through technical support, donor investment and advocacy by civil society, and continues to be driven by evidence from pilot sites and growing recognition of the public-health imperative.[3]

West Africa's programme rollout has been gradual and largely pilot-led, with Ghana among countries moving from advocacy to operational pilots (NSP/OAT) in the early 2020s—illustrating a recent but important shift from policy debate to implementation in the region.2 3

Harm reduction strategies have transformed the global response to infectious diseases and overdose. Robust evidence demonstrates that when communities have access to sterile injection equipment, substitution therapy, and emergency overdose reversal, new HIV infections can fall by more than 50 percent and drug-related deaths decline dramatically. These interventions are cost-effective, strengthen primary health systems, and contribute directly to the Sustainable Development Goals by promoting health, reducing inequities, and saving lives.

Despite this scientific consensus, people who use drugs often face intense stigma and discrimination. Deep-seated moral judgments, community ostracism, and provider bias drive many individuals underground, away from life-saving services. Stigmatizing language and behaviours fueled by decades of criminalization discourage service uptake and can perpetuate cycles of infection and social exclusion.

Legal frameworks in many countries continue to treat drug use as a criminal offence rather than a health issue. Possession of syringes is frequently classified as evidence of drug use and opioid agonist therapy remains restricted to hospitals, excluding community or peer-led delivery. Absence of Good Samaritan protections and confidentiality safeguards further deters bystanders from calling for emergency assistance during overdoses.

In Ghana, these challenges underscore the urgent need for a national guideline that translates global best practices into our local context. By aligning existing laws with international standards, addressing stigma head-on, and laying out clear operational steps, this document provides a roadmap for scaling up harm reduction services. It is designed to unite policymakers, health-care providers, law enforcement, and

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1 WHO consolidated harm reduction guidance and WHO naloxone/overdose guidance.

2 Global State of Harm Reduction — West and Central Africa regional overview, Harm Reduction International.

3 Africa harm reduction progress/pilot summaries, African Harm Reduction Association (AHRA), and related regional reports.

community stakeholders around a shared vision: a Ghana where harm reduction is embraced as a cornerstone of public health and human rights.

Purpose, Scope, and Principles of the Guideline

This guideline provides pragmatic, rights-based, public-health. evidence -based harm reduction strategies aimed at reducing the health, social, and economic harms associated with drug use in Ghana It is intended for health professionals, programme managers, policymakers, civil society, and community-based organisations engaged in drug use prevention, treatment, and care.

People who use drugs (injecting and non-injecting), adolescents and young adults, women (including pregnant/post-partum), people in detention, and individuals with co-occurring mental health needs.

The principles underpinning this guide include non**-punitive access**, **confidentiality**, **youth and gender responsiveness**, **integration** with HIV/hepatitis/mental health services, **peer involvement**, and **phased scale-up** driven by local epidemiology.

Rationale for Harm Reduction in Ghana

Ghana is at a critical juncture in its public health response to drug use. The traditional perception of a drug market dominated by domestically sourced cannabis is being fundamentally challenged by a significant epidemiological shift. The UN Office on Drugs and Crime (UNODC) World Drug Report, 2024, highlights an "alarming diversification" of drug markets across Africa.[4] The region is increasingly becoming a key transit hub for substances such as cocaine, heroin, and methamphetamine, leading to a rise in their use within local populations. This diversification is exacerbating existing public health challenges and requires a strategic pivot in policy and intervention. While Ghana has made a landmark legislative shift with the passage of the Narcotics Control Act, 2020 (Act 1019), a significant gap persists between this progressive policy and its on-the-ground implementation.

The health consequences of the evolving drug-use landscape are stark and provide a compelling public-health justification for a national harm-reduction strategy. Local studies in Ghana report concentrated burdens among people who use drugs (PWUD) and people who inject drugs (PWID): one recent situational assessment found HIV prevalence of 2.5% among PWUD and 10.9% among PWID, and HCV prevalence of 5.9% among PWUD and 19.9% among PWID—substantially higher than the national adult HIV prevalence (~1.2%). International evidence shows people who inject drugs face a many-fold higher risk of HIV than the general adult population, injecting drug use accounts for an appreciable share of new HIV and HCV infections globally, and a large proportion of HCV-related mortality is attributable to injecting drug use. Together, these data rebut the longstanding professional view that needle-and-syringe programmes are unnecessary in Ghana: even with a modest absolute number of PWID, the high concentration of blood-borne viruses in this population makes targeted harm-reduction services an essential, evidence-based public-health priority. The 2024–2025 pilot NSP in Accra demonstrates feasibility and policy progress and offers an immediate opportunity to design a data-driven, nationally scalable response.20

Ghana's drug policy landscape is in a state of dynamic transformation. The passage of the Narcotics Control Act 2020 (Act 1019) is a pivotal development that signals a significant philosophical shift in the country's approach to drug use. Act 1019 calls for drug use to be primarily addressed as a public health issue, and promotes alternatives to incarceration, bringing Ghana’s legal framework closer to international best practices on human rights and public health. Despite the new law, there continues to be evidence of violence and arbitrary arrests for drug use. This contradiction between policy and practice indicates that legal reform alone is insufficient to create a supportive environment for harm reduction.

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[4] UNODC World Drug Report 2024 and Harm Reduction International (Global State of Harm Reduction).

Epidemiology of Drug Use: Global, Sub-Saharan Africa, and Ghana

Global

According to the UNODC World Drug Report 2024, an estimated 296 million people worldwide used drugs in the past year, a 23% increase over the past decade. Drug use is rising fastest in low- and middle-income countries, driven by urbanization, youth demographics, and shifting drug markets. Cannabis remains the most used drug globally. Opioids (including heroin and synthetic opioids like fentanyl) are responsible for the most drug-related deaths. Amphetamines and cocaine use is increasing in several regions. Globally, an estimated thirteen million people inject drugs, and this remains a major driver of bloodborne infections, overdose deaths, and other harms. People who inject drugs account for roughly 10% of new HIV infections globally; pooled estimates indicate HIV prevalence among PWID is around 10–12% globally, HBV prevalence around 7–9%, and HCV prevalence commonly reported between ~40–50% (viremic HCV), with lower pooled HCV estimates reported for parts of Africa .[5] [6] [7]

People who use drugs face a greater risk of these blood-borne infections due to the sharing of unsterile paraphernalia and equipment, the low availability and/or accessibility of prevention, treatment, and care services, as well as between drug use and higher-risk sexual behaviors.

Global reviews estimate HIV prevalence among PWID at roughly 10–15% and HCV seroprevalence frequently exceeds 40%.67 Worldwide drug-related deaths exceed half a million per year with opioids accounting for the majority of these fatalities.[8] [9]

Access to naloxone and community overdose response programmes remains limited in many countries despite evidence that take-home naloxone reduces fatal overdoses.[10] [11]

Sub-Saharan Africa

According to the Global Harm Reduction report (2024/25) by Harm Reduction International, most countries in sub-Saharan Africa have poor collection and availability of data on drug use.

Estimates of people who inject drugs in Africa are imprecise; published ranges for the region span 560,000 to 2.7 million, reflecting limited surveillance and wide uncertainty. Although overall prevalence in sub-Saharan Africa has historically been lower than in some other regions, recent studies, and national reports document rapid increases in use—especially among youth and in urban and peri-urban settings. Growing trafficking and transit routes across East, West and Southern Africa have expanded local availability of heroin, stimulants, and non-medical opioids, driving new patterns of local consumption and injecting practices.[12] [13]

Cannabis is the most widely used illicit drug in Africa, with lifetime or past-year use estimates in some subregions commonly cited in the single-digit to low-teens range.[14] Non-medical use of tramadol and other pharmaceutical opioids is widespread in West Africa. Heroin use and injecting have risen in coastal and urban centres, particularly along established trafficking routes in East and Southern Africa and increasingly

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5 UNAIDS. HIV and people who inject drugs — Thematic briefing note, 2024 Global AIDS Update.

6 World Health Organization. People who inject drugs — WHO overview.

7 Grebely J, et al. Epidemiology of injecting drug use and HCV prevalence among PWID.

8 UNODC — World Drug Report (global drug-related deaths, trends).

9 WHO — Opioid overdose fact sheet (global deaths and role of opioids.

10 Harm Reduction International — Global State of Harm Reduction (coverage of naloxone and program availability).

11 WHO/UNODC — Guidance on community overdose prevention and naloxone distribution (evidence on effectiveness and implementation gaps).

12 PLOS Global Public Health — Prevalence and patterns of substance use in West Africa: systematic review and meta-analysis (2024).

13 Global Initiative Against Transnational Organized Crime (GI-TOC) — Illicit drug markets analyses for Eastern, Southern and West Africa.

14 UNODC World Drug Report 2025.

in parts of West Africa including Ghana and Côte d'Ivoire.[15] [16] Recent UNODC reporting estimates roughly 1.2 million people who inject drugs (PWID) in Africa, while country and regional surveys indicate a notable proportion of people who use drugs are young (including adolescents and older teenagers), underscoring urgent prevention and service needs.[17]

Across sub-Saharan Africa, HIV prevalence among people who inject drugs (PWID) varies widely by country and setting, commonly reported between about 10% and 30% in site-level or country estimates; HCV seroprevalence in urban PWID cohorts frequently exceeds 40% and can reach higher levels in concentrated epidemics.7 Most countries in the region do not have comprehensive national harm-reduction policies; coverage of needle-and-syringe programmes (NSP), opioid agonist therapy (OAT) and naloxone distribution remains very limited, with many OAT and naloxone activities currently restricted to pilot projects, civil-society initiatives or donor-funded programmes.[18]

Ghana

In Ghana there are no estimates of the total number of psychoactive substance users. The Ghana Narcotics Control Board (NACOB) estimated in 2014 that 50,000 young people between the age of 12 to 35 years, are psychoactive substance users of which 35,000 are from the Junior High/ Senior High schools and Tertiary institutions. Adolescents and young adults are a primary and increasingly vulnerable group for drug use in Ghana. A 2024 study on adolescents aged ten -17 years in Ghana found a substance use prevalence of 12.3% (Kyei-Gyamfi, et al., 2024). This same study reported that adolescents and young adults showed notable levels of use and early initiation in multiple studies. Another study from the Northern Region reported a lifetime substance use rate of 62.3% among high school students (Mohammed, et al., 2024). Motivators for initiation included curiosity, peer influence, desire to enhance social status, cope with stress with influence from social media, peer use, and engagement in paid work for some (Darko & Glozah, 2025). A 2021 survey also found that 54.1% of boys in Junior High School (JHS) and Senior High Schools (SHS) used drugs especially cannabis (Consultative Committee to Combat Drug Menace (Schools, 2024). The prevalence and patterns of drug use vary across different regions and demographics within Ghana. Geographically, the coastal belt shows a higher prevalence of substance use among adolescents compared to the middle and northern belts which may be due to greater access in the coastal areas. The coastal, urban, and peri-urban areas are particularly affected by this menace due to West Africa's role as a transit corridor for international trafficking whose supply routes contribute to local availability (UNODC, 2024; Emmanuel, Akinsolu, Abodunrin, & Ezechi, 2024). The Narcotics Control Commission (NACOC) reported that the three northern regions accounted for more than 50% of reported drug use in Ghana (Mohammed, et al., 2024). Gender differences are reflected in males being more likely to engage in substance use than females as a study in 2024 found that 15.8% of male adolescents reported substance use compared to 8.8% of females. This gender disparity was attributed to societal norms that normalize substance use more among men (Kyei-Gyamfi, et al., 2024).

Cannabis is the most used illicit drug, with lifetime use estimates of 8–10%. Non-prescribed tramadol use has escalated, especially among youth, transport workers, and laborers. Heroin use is increasing in urban centers such as Accra, Kumasi, and coastal towns, with growing reports of injection.[19]

There are an estimated 10,000–20,000 people who inject drugs in Ghana[20], though precise figures remain uncertain because of stigma and the absence of a national size-estimation survey. Injected substances

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15 PLOS Global Public Health — Prevalence and health consequences of nonmedical use of tramadol in Africa (systematic scoping review, 2024).

16 ENACT/WENDU policy brief — West Africa trends and trafficking impacts (policy brief, 2024).

17 Frontiers in Psychiatry — Substance use among young people in sub-Saharan Africa: systematic review and meta-analysis (2024).

18 UNODC — Implementing opioid agonist therapy operational tool (2022).

19 PLOS Global Public Health qualitative study on tramadol in Ghana.

20 PLOS One situational assessment (Guure et al., 2024).

reported in national and local studies include heroin, tramadol, and pethidine. Injections frequently occur in informal urban settlements with limited access to sterile equipment or clinical care. [21]Recent national surveys and field studies report a median age in some cohorts around 37 years; most respondents (≈68%) report smoking as their primary route of use, about 20% report snorting or oral consumption, and polydrug use is common.[22] Local programme and research reports indicate heroin, cocaine and tramadol are prominent in injection networks, with men more likely to report heroin, cocaine and tramadol use and women reporting higher proportions of cocaine use in some samples.

HIV prevalence among people who inject drugs is estimated to be 2–5 times higher than the general population, whilst HCV prevalence may exceed 30% in some cohorts.[23]

Overdose deaths are underreported but rising, linked to opioid injection and the lack of naloxone access. Ghana lacks a national harm reduction strategy, though pilot NSP and OAT programmes are emerging. Naloxone is not widely available, and OAT medications (methadone and buprenorphine) are not yet included in the Ghanaian essential medicines list, despite being included as essential medicines by the World Health Organization (WHO). Surveillance systems for drug use and overdose are weak, with no national size estimation study for PWID.

[21] Global Initiative report on Ghana drug use.
[22] Kyei-Gyamfi et al., Substance Abuse Treatment, Prevention, and Policy (2024).
[23] UNAIDS thematic brief on PWID.

CHAPTER 2: Policy and Legal Framework

Overview

This chapter summarizes the legal, constitutional and human-rights foundations for harm reduction in Ghana, highlights gaps between law and practice, outlines socio-cultural and structural barriers, and describes current interventions and key actors.

Ghana's legal and constitutional framework provides a basis for harm reduction.

Legal and Policy Basis

Key Domestic Instruments

- **Narcotics Control Commission Act, 2020 (Act 1019):** The Narcotics Control Commission Act, 2020 (Act 1019) provides the primary legal basis for a health- and rights-centred drug policy in Ghana. The Act reframes drug use and dependence as public-health issues and empowers the Narcotics Control Commission to develop guidelines for harm-reduction services, including needle-and-syringe programmes (NSP) and other public-health interventions. Under Section 2(1) the Act mandates that drug use and dependence be treated as public-health concerns, establishing a legal basis for prevention, treatment, rehabilitation, social reintegration, and harm-reduction programming rather than purely punitive measures. It aligns Ghana's policy direction with global harm reduction standards endorsed by the UNODC, WHO, and African Union Plan of Action on Drug Control.24

  Section 10(b) enables the Commission to establish committees, including a Special Committee on Harm Reduction, providing institutional backing for NSP, opioid agonist therapy, overdose prevention, and community outreach.

  Section 112 authorises the Minister for the Interior, on the Board's recommendation, to make legislative instruments to operationalise these provisions, creating a clear regulatory route to draft SOPs, standards, and enforcement mechanisms for harm-reduction services.

- **Public Health Act, 2012 (Act 851):** The Public Health Act, 2012 (Act 851) provides a clear statutory mandate to protect population health and underpins harm-reduction programming in Ghana. While the Act does not name "harm reduction" explicitly, its focus on disease prevention, public education, safety regulation and access to quality health services creates a lawful basis for non-punitive, evidence-based interventions that reduce transmission of blood-borne viruses (HIV, HBV, HCV) and prevent drug-related fatalities. Interpreting Act 851 in support of harm reduction enables state institutions to design and implement prevention, treatment, rehabilitation, and community-based outreach measures that minimise health and social harm while protecting broader public health.
- **1992 Constitution of Ghana:** "The 1992 Constitution of the Republic of Ghana enshrines fundamental human rights that apply to all persons, including people who use drugs. It guarantees equality before the law and freedom from discrimination, affirms the right to dignity and protection from torture or degrading treatment, and secures rights to personal liberty and fair trial. Under the Constitution, the State is obligated to safeguard the welfare of all people and to promote access to healthcare. Taken together, these provisions support treating drug dependence as a public-health and human-rights issue rather than a solely criminal matter, and they provide a constitutional basis for humane, non-coercive harm-reduction policies and programmes.

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[24] African Union Plan of Action on Drug Control and Crime Prevention (2019–2023).

Regional and International Obligations

Ghana is party to core international human-rights instruments that enshrine the right to the highest attainable standard of physical and mental health, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Universal Declaration of Human Rights (UDHR), the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

Under Article 12 of the ICESCR the State must take measures to prevent, treat and control epidemic and occupational disease; General Comment No. 14 by the UN Committee on Economic, Social and Cultural Rights clarifies that this includes ensuring equal access to health care and non-discrimination for marginalised groups such as people who use drugs. Regionally, the African Charter on Human and Peoples' Rights (to which Ghana is a party) similarly protects the right to the highest attainable standard of health and equality before the law. African Commission resolutions on the right to health and protection from violence and discrimination further underscore State obligations to ensure unobstructed, non-discriminatory access to life-saving health care, including evidence-based harm-reduction services for people who use drugs.[25] [26] [27] [28] [29]

Implementation Gap

Despite progressive laws, enforcement practices — including arrests, searches, detention, and occasional violence — continue to occur and deter people who use drugs from seeking health services. These contradictions reflect institutional culture, gaps in accountability and limited law-enforcement training in public-health approaches. Legal reform alone is therefore insufficient to create a supportive environment for harm reduction; a national strategy must include a substantial, resourced programme to reorient and train law-enforcement and related personnel in rights-respecting, public-health policing approaches. Without a fundamental shift in enforcement practice, the risk of violence, arbitrary arrest and harassment will continue to deter people who use drugs from accessing the services Act 1019 aims to provide.[30] [31]

Human-Rights and Ethical Obligations

- **Equality and non-discrimination:** Guarantee access to health services for people who use drugs and people who inject drugs on equal terms.
- **Right to health and life:** Implement evidence-based interventions that prevent HIV, HBV, HCV, and overdose fatalities.
- **Freedom from cruel, inhuman, or degrading treatment:** Prohibit abusive policing or custodial practices; prioritise health-centred alternatives.
- **Confidentiality and informed consent:** Safeguard client privacy
- **Participation and accountability:** Involve PWUD, peer networks and civil society in design, oversight, and monitoring.

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25 International Covenant on Economic, Social and Cultural Rights (ICESCR) — full text.
26 UN Committee on Economic, Social and Cultural Rights — General Comment No. 14.
27 Universal Declaration of Human Rights (UDHR) — full text.
28 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) — full text.
29 African Charter on Human and Peoples' Rights — full text.
30 Challenges of Effective Policing in Ghana (overview of policing practice and operational gaps).
31 innovative Harm Reduction Programs and Police Partnerships (examples of police–health collaboration and training models).

These obligations require monitoring legal compliance, documenting rights violations and integrating safeguards into programme standards.

Sociocultural and Structural Barriers

Beyond law and policy, the path to a national harm-reduction strategy in Ghana is primarily a socio-cultural challenge. A principal structural barrier is deeply-rooted moralistic stigma that frames drug use as a moral failing or sin rather than a treatable health condition. The dominant religious and moral narratives predispose policymakers, communities, and service providers to favour punitive or abstinence-centred responses and to view harm reduction as implicitly condoning drug use. That stigma drives victim-blaming, reduces political appetite for harm-reduction funding, and directly suppresses service uptake: people who use drugs commonly avoid health services out of fear of discrimination, harassment, or exposure.

The problem is therefore not only legal but institutional and cultural. A credible national strategy must include a substantial, resourced pillar to shift social norms and reorient institutions: public communications that reframe drug dependence as a health issue, sustained faith-leader and community engagement, stigma-reduction training for health and social service staff, and large-scale, mandatory training and accountability reforms for law enforcement

Current Interventions and Actors

- **Civil Society Organisations:** NGOs and CSOs (including WAPCAS Plus and partner networks) have initiated a nascent harm reduction movement in Ghana.
- **Drop-in Centres (DICs):** Six DICs launched offering integrated, low-threshold services: HIV/STI testing, TB screening, wound care, psychosocial support, hygiene kits for women who use drugs and Needle and Syringe Programme (NSP) kits.
- **Stakeholder Engagement:** stake holder engagement included WHO, UNAIDS, NACOC, Ghana AIDS Commission (GAC), Ghana Police Service, National AIDS control program (NACP), People who use drugs community representatives and multiple civil society organisations (CSOs)—showing political and cross-sectoral buy-in at the pilot stage.
- **Other Actors:** Vision for Alternative Development (VALD), Recovery in Africa and peer networks contribute prevention, recovery, and community support functions.

CHAPTER 3: Harm Reduction Overview

Definition: Harm reduction is a pragmatic, person-centered set of policies and services that reduce the health, social and legal harms associated with drug use. Its primary goals are to **keep people alive, prevent disease, reduce acute harm (including overdose), and create pathways to improved wellbeing and social reintegration**. Interventions range from safer-use supplies (needle and syringe programmes), safer-behaviour education, risk-reduction services (drug checking), and overdose response (naloxone).

Harm reduction does not require abstinence as a precondition for support.

Key Evidence and Public-Health Benefits1

- **Needle and Syringe Programmes (NSPs)** reduce HIV and hepatitis C transmission by preventing reuse and sharing of injecting equipment; NSPs also function as low-threshold points for testing, condoms, and referrals.
- **Opioid Agonist Therapies (OAT)** (methadone, buprenorphine) reduce injecting frequency and overdose risk, decrease acquisitive/criminalised behaviours, and improve retention in HIV care and antiretroviral therapy adherence.
- **Naloxone Distribution and Community Overdose Training** reduce fatal overdoses when combined with rapid referral and linkage to services.
- **Integrated Packages** that combine NSPs, OAT, HIV/STI testing and treatment, hepatitis vaccination, mental-health, and social support produce **synergistic gains**: fewer blood-borne infections, improved chronic-disease management, reduced emergency-service use and better social stability.
- **Policy and Legal Environments** strongly influence coverage and outcomes: supportive, health-oriented laws increase impact; punitive approaches increase stigma, discourage service use, and worsen health outcomes.

International Policy and Guidance

- **WHO, UNAIDS32 and UNODC** consistently endorse evidence-based harm reduction (NSPs, OAT, naloxone, comprehensive packages) as essential to HIV/hepatitis prevention and as central to the right to health.
- The **UN System Common Position on Drugs (2018)**[33] cautions that criminalisation of personal drug use increases health risks, drives stigma and risky practices, and undermines HIV prevention and treatment.
- The **International Narcotics Commission Board (INCB)** and other UN bodies have urged member states to prioritise health, human rights, and development over punishment and to ensure access to treatment and life-saving services for people who use drugs.
- The **African Union 2019–2023 Plan of Action** called for harm reduction services and alternatives to imprisonment, signalling regional political commitment to scale evidence-based interventions.

Global evidence is unequivocal: harm reduction saves lives, is cost-effective, reduces healthcare costs, and does not increase drug use.

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[32] UNAIDS — Harm reduction and HIV prevention resources.

[33] UN System Common Position on Drugs (2018).

Relevance to Ghana: Health, Legal and Service Implications

Why harm reduction matters for Ghana:

- **Epidemic Control:** Cost-effective prevention of HIV and viral hepatitis, reducing the long-term burden on national health systems.
- **Bridge to Services:** Low-threshold sites (drop-in centres, outreach) engage marginalised people and link them to TB screening, ART, primary care, mental-health, and social supports.
- **Social Stability:** Reduced drug-related harms and mortality support family wellbeing and community safety.

Legal and Policy Enabling Environment

- **Narcotics Control Commission Act, 2020 (Act 1019) and Public Health Act, 2012 (Act 851)** provide a legal basis to treat drug use as a public health issue, authorise alternatives to custodial sentences and support health–law enforcement collaboration. These statutes enable diversion to treatment, health-sensitive policing, and scale-up of evidence-based services.
- **Law Enforcement Engagement:** Training police to facilitate access to services, implementing diversion pathways and adopting protocols that protect human rights reduces stigma and prevents avoidable harm.

Human Rights and Service Quality Principles

Core principles to guide implementation:

- **Right to Health and Non-Discrimination:** Ensure services are available to all people who use drugs without exclusion or stigma.
- **Confidentiality and Informed Consent:** Maintain client privacy and respect autonomy in care decisions.
- **Gender, Age and Needs Responsiveness:** Provide women-specific spaces and services; integrate sexual and reproductive health and GBV support; design services appropriate for young people.
- **Mental-Health and Psychosocial Support:** Include counselling, peer support groups, and formal referral pathways.
- **Participation and Accountability:** Involve people who use drugs, peer networks and community stakeholders in programme design, delivery, and oversight.
- **Workforce Capacity and Continuous Training:** Train health workers, outreach staff and police on non-judgmental, evidence-based practice and human-rights obligations.
- **Policy and Legal Monitoring:** Identify and reform laws and regulations that limit access or criminalise service engagement.

CHAPTER 4: Harm Reduction Interventions

Purpose and Scope

This chapter describes the core harm reduction interventions recommended for Ghana, explains delivery options and minimum standards, and shows how services should be integrated across the country's tiered health system. It focuses on three priority interventions: Needle and Syringe Programmes (NSP), Opioid Agonist Therapy (OAT, also called OST), and Overdose Management (naloxone). Each section sets out the rationale, who should be eligible, essential components, delivery modes, linkages, and suitability by health-system level.

NSP, OAT and naloxone distribution are proven, complementary interventions. In Ghana, implementing them through peer-led, low-threshold models and integrating them across CHPS → health centre → district → regional systems will reduce infections and deaths, improve treatment access, and strengthen public-health outcomes. Success requires clear SOPs, trained staff and police, reliable supply chains, domestic financing, and active engagement of people who use drugs.

Why these interventions matter:

- NSPs, OAT and naloxone distribution are evidence-based measures that reduce HIV, HBV, and HCV transmission, prevent fatal overdose, and improve engagement with health and social services.
- They are low-threshold, rights-centred interventions: no abstinence is required, and services must protect confidentiality and dignity.
- In Ghana, these interventions align with recent legal reform and with regional/global public-health guidance; practical pilots show high demand and feasibility.

Needle and Syringe Programmes (NSP)

NSPs supply sterile injecting equipment, safe disposal, basic wound care and health education, and function as referral hubs to testing, vaccination and social supports.

Purpose and Scope

- To reduce transmission of HIV, HBV, and HCV among people who inject drugs.
- To provide sterile equipment, safe disposal, and linkage to health and social services.
- To engage people who use drugs, some of whom may not be otherwise engaged with any relevant health or social services.

Eligibility and Access

- All people who inject drugs.
- No requirement for treatment or abstinence; anonymous access permitted.

Core Components (Minimum Standards)[34] [35]

- Range of sterile equipment preferred locally (needles/syringes, filters, sterile water, swabs, tourniquets, mixing vessels, pipes, etc.).
- Puncture-proof return/disposal boxes and safe sharps collection.
- Condoms and basic hygiene kits.

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[34] UNODC NSP practical guide.
[35] WHO harm reduction guidance.

- Counselling, brief health screening and formalised referral protocols to HIV/HBV/HCV testing, ART, TB screening, wound care and social support.
- Recordkeeping for service delivery, commodity stock, and basic coverage indicators.

Such paraphernalia is provided free of charge to reduce the risks of HIV and hepatitis infections with unsterile equipment. NSPs also include mechanisms for the safe return and disposal of used needles and syringes and other injecting equipment.

Delivery Modes (Recommended Hybrid Model)[34][35]

- Fixed sites (drop-in centres, health facilities) for counselling, testing and clinical services.
- Mobile units/vans for neighbourhoods with dispersed needs.
- Outreach/backpack distribution by trained peer workers for hard-to-reach groups.
- Pharmacy partnerships and vending machines as adjuncts to improve access and anonymity.

Suitability by Health Level

- **CHPS/Outreach:** Basic distribution, education, referrals.
- **Health Centres/Polyclinics:** Regular exchange, counselling, linkage.
- **District/Regional Hospitals:** Supervision, supply hub, training.
- **Tertiary Sites:** Protocol development, research, and training.

Opioid Agonist Therapy (OAT)

OAT is the standard treatment for opioid dependence. It reduces illicit opioid use, overdose risk and harms associated with injecting, and improves retention in care and social functioning.

OAT uses licensed opioid medicines – primarily methadone or buprenorphine – to treat opioid dependence, reduce illicit opioid use, prevent overdose, and improve health and social outcome and retain clients in care.

Purpose and Scope

- To provide safe, evidence-based medical treatments for opioid dependence, primarily using methadone or buprenorphine.
- To reduce illicit opioid use, prevent overdose, and improve health and social outcomes.

Eligibility and Access

- Adults diagnosed with opioid dependence (per national/ICD-10/DSM criteria).
- Voluntary entry with informed consent; no exclusion for HIV, pregnancy, or co-occurring substance use.

Core Components (Minimum Standards)[36]

- Medical assessment, baseline testing (HIV/HBV/HCV), and psychosocial assessment.
- Clinician-supervised induction and dosing with individualized titration.
- Maintenance dosing with adherence support, psychosocial counselling, and social referrals.
- Clear policies on take-home doses tied to stability criteria. Regular dosing under supervision, with take-home doses for stable patients to enable them to adhere to OAT as part of their usual daily schedules.
- Trained multidisciplinary teams (doctors, nurses, pharmacists, counsellors, peer workers).

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[36] WHO — Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence (methadone, buprenorphine).

- Naloxone and overdose awareness and response training should be provided for everyone receiving an OAT prescription.

Service Models and Placement

- Low-threshold models that prioritise easy entry and retention are preferred.
- Delivery options: specialised OAT clinics (district/regional hospitals), integrated models at ART clinics or polyclinics, and links to community-based providers for follow-up.
- Prison and pre-release programmes must ensure continuity of care.

Operational Safeguards

- Standard operating procedures for induction, dose adjustment, and management of diversion.
- Routine monitoring (retention, urine testing if used, adverse events).
- Link OAT to HIV care, TB services, mental-health care, and social support.
- Inclusion of methadone and buprenorphine on the essential drug list

Suitability by Health Level

- **CHPS:** Screening and referral.
- **Health Centres:** Initiation of low-dose OAT with clinical oversight where feasible.
- **District Hospitals:** Full initiation, maintenance, and psychosocial services.
- **Regional/Tertiary:** Complex case management, training, and research.

Overdose Management and Naloxone Distribution

Naloxone is a safe, effective opioid antagonist that reverses opioid overdose. Community distribution combined with brief, practical training for peers, families, outreach workers and first responders markedly reduce fatal overdoses.

Purpose and Scope

- To prevent fatal opioid overdoses by training people at risk, their networks and other likely 'first responders' to recognize and respond to an overdose, including with the use of naloxone.
- To prevent deaths from opioid overdose through timely recognition and response.
- To ensure naloxone is widely available at community, primary, secondary, and tertiary levels.

Target Groups and Access

- People who use opioids, their peers and families, outreach workers, health workers and first responders.
- Lay distribution through Take-Home Naloxone (THN) and peer networks is essential.

Core Elements (Minimum Standards)[37]

- Overdose recognition and response training using the SCARE ME sequence (see below).
- Naloxone kits (intranasal for community use, injectable ampoules for facilities where cost or supply makes that preferable).

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[37] WHO naloxone/overdose guidance and fact sheet.

- Post-overdose pathway: observation for at least 2 hours (longer after long-acting opioid exposure), linkage to OAT/NSP/HIV services, psychosocial support, and documentation.
- Legal protections for lay responders (Good Samaritan provisions).

Service Delivery Models

- **Take-Home Naloxone Programmes:** Distribute kits through OST clinics, NSPs, drop-in centres, and emergency departments.
- **Peer-to-Peer Training and Distribution:** Empower experienced peers to train and distribute kits within their networks.

Recognition of Overdose[38]

- **Signs:** Unresponsiveness, slow or absent breathing, pinpoint pupils, cyanosis.
- **The following opioid overdose triad should be observed:**
  - Pinpoint pupils
  - Unconsciousness
  - Respiratory depression (bradypnoea) (< 10 breaths per minute or 1 breath every 5s)

SCARE ME: Practical overdose response steps for training and job aids.

- **S** — Stimulate the person (shout, rub sternum) to try to rouse them.
- **C** — Call for medical help (and emergency services) immediately.
- **A** — Airway: open the airway and check for obstruction.
- **R** — Rescue breathing: provide rescue breaths if the person is not breathing adequately.
- **E** — Evaluate breathing and response continuously.
- **M** — Muscular injection or intranasal administration of naloxone per kit instructions; repeat every 2–3 minutes as needed.
- **E** — Evaluate and support: continue monitoring, provide additional naloxone if required, keep the person on their side once breathing and wait for emergency responders; link to services.

Naloxone Administration37

Community/Primary Care:

- IM injection: 0.4–0.8 mg, repeat every 2–3 minutes as needed.
- IN spray: 2–4 mg, repeat every 2–3 minutes as needed.

Secondary/Tertiary Care:

- IV administration if available.
- Continuous monitoring, repeat dosing or infusion if long-acting opioids are involved.

Post-Overdose Care37 38

- Observe for at least two hours (longer for methadone overdoses).
- Link to OAT, NSP, HIV/HBV/HCV testing, psychosocial support.

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[38] WHO — Community management of opioid overdose: practical guidance on naloxone distribution and training (policy/operational points).

Suitability by Health Level

- **CHPS:** Community training and basic naloxone kit distribution; local SCARE ME education.
- **Health Centres/Polyclinics:** Overdose response, initial observation, and referral into care.
- **District/Regional/Tertiary:** Advanced resuscitation, monitoring, supply hubs, and training centres for SCARE ME and naloxone programmes.

Integration, Linkages, and Systems Requirements

Referral Pathways

- Establish formal referral agreements between NSPs, OAT clinics, CHPS, HIV/TB services, mental-health, and social protection agencies. Use standard referral forms and a simple service map/database.

Workforce and Peers

- Employ and remunerate peer workers; provide ongoing training and psychosocial support. Train health staff and law-enforcement focal points on human-rights, confidentiality, and non-stigmatising care.

Supply Chain and Commodities

- Central procurement with buffer stocks for needles, OAT medications, and naloxone; simple forecasting templates and monthly monitoring.

Financing and Sustainability

- Integrate core services into the national health budget.
- Leverage donor funding for scale-up phases.
- Develop transition plans to reduce donor dependency.

Community Engagement and Stigma Reduction

- Implement public education campaigns that reframe drug use as a health issue. Engage religious and community leaders, and involve PWUD in programme design, governance, and monitoring.

Practical Phased Rollout

1. **Pilot:** One urban and one peri-urban site combining NSP, naloxone distribution and referral to OAT.
2. **Scale-up:** Replicate successful pilot models to regional hubs; formalise procurement and workforce pipelines.
3. **Consolidation:** Integrate into routine primary health services, expand prison continuity programmes, and embed monitoring in national health information systems.

CHAPTER 5: Community Engagement in Harm Reduction

Purpose and Scope

This chapter defines principles, structures, and practical steps for meaningful community engagement in harm reduction programming. It describes who should be involved, how to design participatory processes, phased implementation, roles and responsibilities, monitoring, sustainability, and risk mitigation. The guidance preserves people-centred practice, protects rights, and supports programme sustainability.

Why Community Engagement Matters

- Builds trust between health teams and people who use drugs (PWUD).
- Reduces stigma and discrimination and increases uptake of services.
- Mobilises local resources and social support.
- Empowers PWUD as agents of change and improves program relevance, acceptability, and sustainability.

Core Strategies

Strategy	Description	Examples of Activities
Community Dialogue and Sensitization	Inform and discuss drug use and harm reduction with stakeholders and the public	Town-hall meetings; radio slots; school sessions
Peer Involvement	Recruit and train people with lived experience to deliver messages and services	Peer educators distributing needles, naloxone; peer outreach
Partnerships with Community Structures	Collaborate with chiefs, faith leaders, NGOs and CSOs	Joint outreach campaigns; advocacy meetings
Capacity Building	Train community members and leaders to support harm reduction	Training for health volunteers, peer trainers
Advocacy and Rights Awareness	Promote human rights and reduce stigma; encourage enabling local policy	Community dialogues on inclusion; rights workshops

Community Engagement Process (Practical Steps)[39]

1. **Mapping and Stakeholder Identification:** Chiefs, youth groups, women's associations, faith leaders, PWUD networks, health workers, police, and local NGOs.
2. **Sensitization and Education:** Introductory awareness sessions tailored to audiences (leaders, families, service providers).
3. **Participatory Planning:** Co-design priorities, targets and service modalities with people who use drugs representatives.

[39] WHO/UNAIDS community engagement guidance.

4. **Joint Implementation:** Support peer-led outreach, mobile clinics, drop-in centres, and community distribution (e.g., naloxone, NSP).
5. **Feedback and Monitoring:** Collect routine community feedback, hold public review meetings, and adapt programmes responsively.

Guiding Principles[40]

- **Meaningful Participation:** "Nothing for us without us" — involve PWUD at every stage.
- **Respect for Rights and Dignity:** Confidentiality, voluntariness, and non-discrimination.
- **Inclusivity:** Represent women, youth, people in detention and other marginalised sub-groups.
- **Local Leadership and Ownership:** Build community champions and embed roles in local structures.
- **Evidence-Based Action:** Use data and community input to guide decisions.
- **Partnership and Transparency:** Multi-sector collaboration with open feedback and accountability.

Implementation Framework

Component	Objective	Key Activities	Expected Outputs
A. Community Assessment & Mapping	Identify needs, actors, drug-use patterns	Mapping, network ID, attitude assessment	Baseline data; stakeholder map
B. Stakeholder Mobilization & Sensitization	Build local support	Sensitization sessions; media engagement	Increased awareness; buy-in
C. Capacity Building & Empowerment	Strengthen peer/community skills	Train peer educators; overdose response; counselling	Skilled community workforce
D. Participatory Planning & Co-Design	Ensure community shapes services	Advisory groups; planning workshops	Locally owned action plans
E. Service Delivery & Community-Led Actions	Implement responsive services	Peer outreach; naloxone/NSP distribution; referrals	Accessible, trusted services
F. Communication, Advocacy & Stigma Reduction	Shift public attitudes and policy	Anti-stigma campaigns; testimonials	Enabling environment

[40] Harm Reduction International peer resources.

G. Monitoring, Evaluation & Learning (MEL)	Track progress and adapt	Community indicators; participatory reviews	Continuous improvement

Roles and Responsibilities

Actor	Roles
Ministry of Health/GHS	Policy, technical guidance, mainstreaming into health systems
District Health Teams	Local management, supervision, reporting
Community Leaders/Traditional Authorities	Mobilisation, cultural mediation, advocacy
Civil Society/NGOs	Training, advocacy, outreach, service delivery support
Peer Networks/PWUD Associations	Peer education, outreach, feedback, and co-design
Families/Religious Groups	Supportive care, reintegration, stigma reduction
NACOC	Lead public education; coordinate sensitization and law-enforcement engagement
Law Enforcement Agencies	
FDA	Provide the regulation of the approved medical products including medical devices to be administered for use and ensure the accessibility and availability of harm reduction drugs esp. naloxone, methadone or buprenorphine and avoid illicit or unapproved substances.

Phased Implementation

Phase	Duration	Key Milestones
1. Preparation & Assessment	Months 1-3	Mapping, baseline survey, stakeholder ID
2. Engagement & Capacity Building	Months 4-6	Sensitization, peer training, partnerships
3. Implementation	Months 7-18	Outreach, NSP/naloxone/OAT referrals, advocacy
4. Monitoring & Scale-Up	Months 19-24+	Evaluation, documentation, expansion

Sustainability Measures

- Institutionalise community engagement in district health plans and budgets.

- Develop local champions and formal peer-led structures with remuneration/stipends.
- Integrate harm reduction activities into existing CHPS and primary-care platforms.
- Mobilise domestic resources and align donor contributions with a transition plan.

Risk Mitigation

Risk	Mitigation
Community Resistance/Stigma	Ongoing sensitization; engage trusted leaders early
Resource Constraints	Integrate into existing programmes; leverage partners
Weak Coordination	Establish multi-sectoral technical working groups
Policy/Legal Barriers	Targeted advocacy: link programme benefits to public health goals

Expected Outcomes

- Greater uptake of harm reduction services and improved health outcomes for PWUD.
- Reduced stigma and stronger community support systems.
- Enhanced collaboration across health, social and justice sectors.
- Durable, locally led harm reduction programmes.

CHAPTER 6: Monitoring, Evaluation and Learning

Purpose

Provide a concise, intervention-focused M&E framework to track implementation, quality, outcomes, and rights-related safeguards for the three priority interventions in this guideline: Needle and Syringe Programmes (NSP), Opioid Agonist Therapy (OAT), and Overdose Management (naloxone). The framework supports evidence-based decision making, accountability, resource mobilisation and adaptive learning.

Objectives

1. Measure coverage, quality, and outcomes of NSP, OAT and naloxone interventions at national and sub-national levels.
2. Ensure routine, reliable reporting and data quality so policy and programme managers can optimise delivery and scale-up.
3. Monitor human-rights protections and law-enforcement interactions that affect access and uptake.
4. Generate learning for operational improvement, scale-up decisions, and budget planning.

Scope and Use

- Apply to all programmes delivering NSP, OAT and overdose prevention across CHPS → health centre → district → regional → tertiary levels.
- Intended users: MoH/GHS, NACP, NACOC, implementing NGOs, district health teams, donor partners, and peer networks.
- Reporting cadence aligns with programme cycles: monthly operational, quarterly management, annual strategic.

Data Collection Methods (Intervention Focus)

- **Routine Service Records:** Client registers, commodity stock cards, OAT dosing logs, naloxone distribution, and incident reports.
- Facility and outreach reporting into DHIMS2 (or agreed national platform) with standard module fields for NSP/OAT/overdose.
- Periodic surveys and sentinel surveillance for HIV/HBV/HCV among PWID and clients in OAT.
- **Qualitative Methods:** FGDs, key-informant interviews and client exit interviews to assess access, stigma, and acceptability.
- **Special Assessments:** DQAs, supply-chain audits, adherence/retention studies, and costing exercises.
- **Data Triangulation:** Cross-check programme data with hospital records, police complaint logs and national survey outputs.

Core Data Governance and Quality Measures

- Standard operating procedures and indicator definitions manual for NSP, OAT and naloxone modules.
- Role-based access and encryption for sensitive data; anonymisation for client-level exports.
- Routine Data Quality Assessments (DQAs) quarterly, with corrective action plans.
- Spot checks and unannounced supervision visits for verification.

- Partners submit quarterly progress reports within 15 days of quarter end: final reports within 90 days of project close.

Indicator Framework: Priority Indicators (Tailored to Interventions)

Clinical and Service Delivery Indicators (Monthly/Quarterly)

No.	Indicator	What it Measures	Data Source	Frequency	Lead
1	Number of unique clients reached by NSP	NSP coverage and reach	NSP client registers; outreach forms	Monthly/Quarterly	NGOs/MoH
2	Needles/syringes distributed and returned	Commodity distribution and safe disposal	Stock cards; exchange logs	Monthly	Supply Chain/NGOs
3	Number of clients enrolled on OAT	Scale and uptake of OAT	OAT clinic registers	Monthly/Quarterly	OAT clinics/MoH
4	OAT retention at 3/6/12 months (%)	Treatment continuity and program quality	OAT cohort follow-up records	Quarterly/Annual	MoH/OAT clinics
5	Number of naloxone kits distributed (community/facility)	Availability and reach of overdose prevention	Distribution logs	Monthly/Quarterly	NGOs/MoH
6	Reported overdose reversals (naloxone use)	Immediate lifesaving impact	Incident reports; outreach reports	Quarterly	NGOs/MoH
7	% of facilities (PHC/district) with functional NSP/OAT/naloxone stocks	System readiness and integration	Facility assessments; supervision checklists	Monthly/Annual	Supply Chain/GHS

Human Rights, Law Enforcement, and Access Indicators (Quarterly/Annual)

No.	Indicator	What it Measures	Data Source	Frequency	Lead
HR1	Number of complaints/reported human-rights violations	Protection, redress, and accountability	CHRAJ, Legal Aid, CSO logs	Quarterly	CHRAJ/NACOC

	against PWUD and resolved (%)				
HR2	Number of law enforcement personnel trained on harm reduction and human rights	Enabling law-enforcement environment	Training reports	Bi-annual	NACOC/Police
HR3	% of PWUD reporting decreased stigma/improved service access	Client-reported access barriers	KAP survey/client interviews	Annual	WAPCAS/NACP

Programme Coverage, Community Engagement & Financing (Annual/Quarterly)

No.	Indicator	What it Measures	Data Source	Frequency	Lead
C1	Number of community engagement events with PWUD networks	Community mobilisation and ownership	Community reports	Quarterly	NGOs/District Teams
C2	Number of peers-led organisations active and supported	Strengthening peer systems	NGO registry; partner reports	Annual	MoH/Registrar
C3	Total domestic and external funds allocated to harm reduction	Financial sustainability	Budget and expenditure reports	Annual	MoH/MoFEP
C4	% of harm reduction budget from domestic sources	Transition to sustainable financing	National budget data	Annual	MoH/MoFEP

Notes on indicator use:

- *Disaggregate by sex, age group, and geography where feasible; flag women-specific uptake and outcomes.*
- *Adopt unique client identifiers for longitudinal tracking where privacy safeguards permit.*
- *Define clear numerator/denominator rules in the indicator manual to avoid double-counting (e.g., unique NSP visitors per month).*

Monitoring Activities and Reporting Flows

- Facility/outreach teams → monthly upload to DHIMS2 (NSP/OAT/naloxone module).
- District review meetings monthly to validate data and resolve stock or human-resource issues.
- Quarterly multi-stakeholder review (MoH, FDA, NACOC, NACP, CSOs, donors, peer reps) to assess progress against targets and approve corrective actions.
- Annual strategic review and public report with epidemiological indicators (HIV/HBV/HCV trends, overdose mortality).

Data Quality Assurance (Operational Steps)

1. Standardised data collection tools and training for all staff and peers.
2. Weekly supervisor review of registers; monthly reconciliation of stock cards and commodity consumption.
3. Quarterly DQAs: completeness, accuracy, timeliness, and consistency check with documented corrective plans.
4. Periodic external verification (independent audits or partner field visits) at least annually.

Learning, Adaptation, and CQI

- Embed Continuous Quality Improvement (CQI) cycles at facility and district levels: plan → do → study → act.
- Quarterly knowledge-sharing workshops to surface operational challenges (retention, diversion, procurement) and disseminate solutions.
- Peer learning exchanges between pilot sites (urban/peri-urban) before national scale-up.
- Maintain a short learning brief after each quarter summarising key lessons and adaptations.

Governance, Roles, and Accountability

- District M&E focal points to ensure timely submission and local validation.
- Implementing partners accountable for primary data quality and timely reporting; MoH/GHS responsible for national consolidation and public reporting.

Minimal Recommended Dashboards/Outputs

- Monthly operational dashboard: clients reached, commodities dispensed/stock status, naloxone reversals.
- Quarterly management dashboard: retention rates (OAT), coverage by district, HR incidents, and training coverage.
- Annual public brief: national coverage, epidemiological trends, financing, and key recommendations.

CHAPTER 7: Financially Sustainable Plan for Implementing Harm Reduction Strategies in Ghana

Introduction

In Ghana, the implementation of harm reduction strategies requires a **financially sustainability plan** that ensures continuity across all levels of care: community, primary, secondary, and tertiary.

A financially sustainable harm reduction program in Ghana requires **strategic integration, diversified financing, and strong accountability mechanisms**. By combining domestic resource mobilization, donor support, private sector engagement, and community participation, Ghana can build a resilient harm reduction system that protects public health, reduces stigma, and ensures equitable access to services at all levels of care.

This plan outlines a **multi-pronged financing and resource mobilization framework** that leverages domestic, donor, and private sector contributions, while embedding harm reduction into existing health and social protection systems for long-term sustainability.

Guiding Principles for Financial Sustainability

- **Integration into National Health Financing:** Align harm reduction with Ghana's Universal Health Coverage (UHC) roadmap and National Health Insurance Scheme (NHIS).
- **Diversified Resource Base:** Avoid over-reliance on donor funding by mobilizing domestic resources, private sector partnerships, and innovative financing.
- **Efficiency and Accountability:** Ensure transparent use of funds through monitoring, evaluation, and reporting mechanisms.
- **Equity and Accessibility:** Prioritize underserved populations, ensure services are available at all levels of care.

Cost Components of Harm Reduction Implementation

To ensure sustainability, the following cost categories must be considered:

- **Programmatic Costs:** Procurement of needles, syringes, methadone/buprenorphine, naloxone, test kits, and educational materials.
- **Human Resources:** Training and retention of health workers, peer educators, and community outreach staff.
- **Infrastructure:** Establishment of drop-in centres, integration into existing health facilities, and mobile outreach units.
- **Monitoring & Evaluation:** Data systems, reporting tools, and operational research.
- **Advocacy & Community Engagement:** Campaigns to reduce stigma and promote uptake of services.

Resource Mobilization Strategy

Domestic Resource Mobilization

- **Government Budget Allocation:** Advocate for a dedicated harm reduction budget line within the Ministry of Health and Ghana Health Service. Also advocate for yearly forecast and estimates of buprenorphine, methadone or naloxone to be readily available with the Food and Drugs Authority.
- **NHIS Integration:** Include OST, overdose management, and HIV/HCV testing under NHIS benefit packages.

- **District Assemblies Common Fund (DACF):** Leverage local government funds for community-level harm reduction interventions.
- **Sin Taxes and Earmarked Levies:** Allocate a percentage of revenue from alcohol, tobacco, and sugary drink taxes to harm reduction programs.

Donor and Development Partner Support

- **Global Fund, PEPFAR, UNODC, WHO:** Continue leveraging international partners for initial scale-up, technical assistance, and catalytic funding.
- **Blended Financing:** Use donor funds to de-risk and attract private sector investment in harm reduction supply chains (e.g., local methadone production).

Private Sector Engagement

- **Corporate Social Responsibility (CSR):** Partner with telecoms, banks, and extractive industries to fund community outreach and education.
- **Health Insurance Companies:** Encourage private insurers to cover harm reduction services.
- **Pharmaceutical Partnerships:** Negotiate reduced pricing or local production of methadone, buprenorphine, and naloxone. Encourage reduced pricing of medical devices intended to monitor patients for opioid-induced respiratory depression and help healthcare specialists tailor opioid administration (including community naloxone kits-intranasal sprays etc.).

Community and Civil Society Contributions

- **Community-Based Financing:** Encourage local NGOs and CBOs to mobilize small grants and in-kind contributions.
- **Faith-Based Organizations:** Engage churches and mosques in stigma reduction campaigns and service delivery support.

Sustainability Mechanisms

Integration into Existing Health Systems

- Embed harm reduction services into primary health care, HIV/TB clinics, and mental health services to reduce duplication and costs.
- Train existing health workers rather than creating parallel structures.

Cost-Efficiency Measures

- Bulk procurement of commodities through pooled purchasing mechanisms.
- Use digital platforms for training, monitoring, and reporting to reduce recurrent costs.

Capacity Building and Local Ownership

- Strengthen local NGOs and CBOs to deliver services sustainably.
- Build capacity for local methadone/naloxone production to reduce dependency on imports.

Monitoring, Evaluation, and Accountability

- Establish a **national harm reduction financing dashboard** to track expenditures, outcomes, and gaps.
- Annual financial and programmatic audits to ensure accountability and maintain donor confidence.

Phased Implementation Plan

Phase	Timeframe	Key Activities	Financing Approach
Phase 1: Pilot & Scale-Up	Years 1-2	Pilot NSP, OST, overdose prevention in selected regions	Donor + Gov't seed funding
Phase 2: Integration	Years 3-5	Integrate services into NHIS, expand to all regions	Domestic financing + CSR
Phase 3: Sustainability	Years 5+	Local production of commodities, full NHIS coverage, diversified financing	Domestic + private sector