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Why Do Countries Develop Harm Reduction Programs?

A Mixed Methods Approach

Jonathan Brozdowski

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ABSTRACT

This thesis investigates why and how countries develop drug harm reduction programs today. Though they began as a controversial set of ideas challenging global drug policy's dominant interdiction model, they have evolved over decades of mobilization around HIV and become a global social policy in many ways spearheaded by international organizations in its "medicalized" form. Drawing on understanding of complex multilateralism and the Advocacy Coalition Framework, this thesis uses an ordered probit regression analysis and a structured focused comparison of two countries to investigate harm reduction's development. Based on the dataset by Harm Reduction International (HRI) noting the presence or absence of seven programs in 165 countries, analysis found measures of participatory and egalitarian governance to be especially important. Kenya and Cameroon were chosen for case study through Mill's Method of Difference, as a deviant, successful case and as a typical, unsuccessful case, with substantial similarity in important factors except for the chosen variable of interest: civil society participation in government. It concludes that international involvement, civil society mobilization, and government cooperation with CSOs are especially important to harm reduction's development. In addition to being the first quantitative study and the first comparative case study on the specific factors that lead a country to develop harm reduction programs, this paper offers insight into global governance by showing how a global social policy can transcend national laws and be in some ways implemented by international actors.

Keywords: Harm reduction, Drug policy, Global social policy, Kenya, Cameroon

CONTENTS

TABLES

LIST OF ACRONYMS

ACRDR	Cameroon Association for the Harm Reduction for Drug Use among Young People
BTI	Bertelsmann Stiftung's Transformation Index
CAHR	Community Action on Harm Reduction
CAS	Complex Adaptive System
CSO	Civil Society Organization
DCR	Drug Consumption Room
EAP	East Asia and Pacific
ECA	Europe and Central Asia
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IO	International Organizations
IDU	Injecting Drug Use
QOG	Quality of Government
KANCO	Kenyan AIDS NGOs Consortium
MENA SA	Middle East and North Africa and South Asia
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NASCOP	National AIDS and STIs Control Program
NSP	Needle and Syringe Exchange Program
OBI	Open Budget Index
ODA	Official Development Assistance
OST	Opioid Substitution Therapy
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
SARS	Severe acute respiratory syndrome
SSA	Sub-Saharan Africa
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
UNDP	United Nations Development Program
UNODC	United Nations Office of Drugs and Crime

1. INTRODUCTION

The United Nations Office of Drugs and Crime (UNODC) estimated that 5.3% of the global population aged 15-64 used recreational drugs in 2018. Most of this population experiences few ill effects, and indeed benefit from occasional use of substances like cannabis and psilocybin mushrooms. The majority of drug-related harm stems from opioids like heroin; they are estimated to have caused two-thirds of the 585,000 people who died from drug use in 2017, more than half due to untreated hepatitis C (World Drug Report 2020). Although changes are ongoing, the dominant paradigm that governments have followed has been total prohibition and criminalization of use, a so-called "war on drugs." Global drug prohibition was led by the U.S. through the 20th century, affirmed through international treaties to which most every nation is a signatory, and perpetuated by the UNODC (Levine 2003). This has contributed to, among other things, $1 trillion in estimated costs for the U.S. government since President Nixon announced the war in 1971, 456,000 people presently serving time in prison on drug charges in the U.S. (Pearl 2018), and 115,000 organized crime homicides between 2007 and 2018 in Mexico (Calderón et al. 2019).

Harm reduction can be seen as a paradigm shift, in that it makes overall quality of life, and not cessation of drug use, the measure of successful drug policy ("Principles of Harm Reduction" 2019). Its broadest implications should entail an end to criminalization of use, careful government supply of drugs to ensure their safety and undermine criminal organizations, and addressing the harms linked to serious drug use, like domestic abuse and homelessness, rather than drugs themselves. But in its "medicalized" form, harm reduction refers to low-threshold health programs for active users. There are needle and syringe exchange programs (NSP), which limit the spread of infectious diseases like HIV and hepatitis by providing safe and clean equipment, primarily for heroin users, and opioid substitution therapy (OST) with prescription methadone, which prevents heroin withdrawal symptoms. Other important programs include supervised drug consumption rooms (DCR), which by providing a safe space for users, reduce overdoses, disease, and even crime in the surrounding community (Ng, Sutherland, and Kolber 2017); and peer distribution programs for naloxone, which reverses opioid overdoses. These programs have proven transformative in drug users' lives and extremely cost-effective in reducing healthcare and policing costs (Belani and Muennig 2008). They are especially needed now, as rates of drug use are greatly increasing worldwide ("Executive Summary, World Drug Report 2020" 2020).

But globally since 2012, progress on harm reduction has stalled (Harm Reduction International 2020). That year, a "foreign agent" law passed in Russia, which subjected NGOs that receive foreign donations or that engage in "political activity," loosely defined, to extensive audits and intervention into their internal affairs if they are registered. Subsequently, funding from international donors diminished, and many NGOs working on targeted HIV prevention for at-risk groups collapsed (Aasland and Meylakhs 2018). Other Central Asian countries have followed Russia's lead (Chaghouani 2018). At the same time,

the Global Fund to Fight AIDS, Tuberculosis and Malaria changed its criteria in 2014 such that, in many countries transitioning to middle-income status, harm reduction programs became ineligible for funding. Programs in Serbia and other former Communist countries shut down (Sarosi 2017a). In November 2018, Médecins Sans Frontières (MSF) called upon the Fund to make urgent changes to their policies for countries losing donor support, which face critical challenges in their healthcare systems (MSF 2018).

Given these pressures, it is crucial to understand what allows for the implementation of harm reduction programs. This thesis investigates two case studies in Sub-Saharan Africa, the region where harm reduction programs are just now getting off the ground. By examining their progress, we hope to capture an understanding of the present state of the movement globally. The paper will first introduce global social policy as the literature it speaks to. It will then briefly touch on the global fight against HIV, to provide context for harm reduction and introduce how programs have received attention and funding. Then, it situates harm reduction in global social policy through explaining the transnational networks and global governance that enables it. Only then will we review the literature on how harm reduction has been implemented. The paper will then summarize the core hypotheses and theory of this thesis, and go on to outline the research methodology used, by discussing the dataset examined, regressions undertaken, and logic for case selection. A results section follows, with both exploratory regression and ordered probit regression results explained. Thereafter the case studies of Kenya and Cameroon are introduced, with brief summaries of their respective political histories and their progress with drug policy. It will then discuss major lessons from their stories of the development of harm reduction and lack thereof, with special attention to the role of complex multilateralism and global advocacy coalitions. Finally, the discussion and conclusions follow, along with a word on the project's limitations.

2. LITERATURE REVIEW

2.1 The Advocacy Coalition Framework and Global Social Policy

The ACF is traditional public policy's straightforward method of explaining why a policy is implemented. It envisions policy subsystems wherein concerned actors from government, civil society, academia, technical areas like medicine, and potentially people from the private sector, cooperate as an advocacy coalition, compete against other coalitions, and work to influence government, the policy brokers. Policies generally result from external shocks to the system, events that bring attention, shift what had been a stable parameter, and catalyze action. Policy reform can be seen as a process driven by actors promoting their beliefs and seeking as many allies as possible (Jenkins-Smith and Sabatier 1994; Nwalie 2019). The ACF most effectively describes policy environments in which there is a single sovereign power, one strong but pluralistic national government to be influenced. Harm reduction's introduction to some advanced democracies like Switzerland does follow this narrative. But two factors

limit the usefulness of this framework to harm reduction as implemented today: its international character, and as will be discussed later, its disrespect for national law.

Global social policy has attempted to challenge traditional public policy's long 'methodological nationalism' (D. Stone and Ladi 2015), by including analysis on the roles of transnational and supranational forces and connections. One of its core concepts or frameworks is 'complex multilateralism,' which largely follows in the footsteps of liberal institutionalist international relations (IR) theory. While recognizing the importance of inter-state bargaining, scholars like Deacon and Stubbs (2013) believe global institutions exhibit autonomy and can effect change through global social policy prescriptions. There can therefore be thought to be an emergent global governance. Global public policy scholars like Deacon have focused on the policies promulgated by international organizations (IOs) like the World Bank and World Health Organization (WHO). Inside them, and also in international non-governmental organizations (INGOs), national governments, universities, and other organizations, "global policy advocacy coalitions" operate. These groups mobilize across borders and on global fora to shift global discourse and policy. In absence of a global government, global policies "normally require cooperation from state organizations at the national or local level to be implemented" (Orenstein 2005, 178). One could argue that even national policies can be global insofar as they are "co-determined" by global policy actors (Orenstein 2005), increasingly interlinked on the global scale as domestic policy communities are (Cerny 2001). But harm reduction has evolved further. Stone and Ladi (2015) wrote on the administrative practices and processes that are "delivering" global policies, creating transnational administration in some issue areas, though of course with regional variation. When there is a great deal of "regulation, management, and implementation" occurring across state boundaries, one might think of a policy as substantially determined by international actors (D. Stone and Ladi 2015). While harm reduction cannot be considered as "governed" internationally as gas flaring, its implementation in some countries does resemble transnational administration in some ways. The next section on HIV shows why. While harm reduction principles originated in the early 70s as activists fought against the dominant interdiction paradigm, it took until the HIV epidemic for political leaders to actually support harm reduction interventions, when increasing cases of HIV among people who inject drugs (PWID) allowed coalitions to mobilize around NSP and OST.

2.2 Human Immunodeficiency Virus

While many issue areas of global public policy struggle for attention and funding, infectious disease control has not. It was the original purpose of the WHO (Deacon 2007, 68), and though for many years it more ambitiously worked towards health system strengthening, donor cutbacks in the 1990s shifted focus back on disease interventions (Ingram, Diestelhorst, and Ntiabang 2007, 86). This was in large part due to HIV, which Ingram believed constituted the great modern moral challenge to the contemporary global order (Ingram, Diestelhorst, and Ntiabang 2007, 87). Activists effectively

mobilized around the great differences in life expectancy in wealthier and poorer states due to discrepancies in anti-retroviral therapy (ART) availability. Observing the ways the epidemic forced the connection between public health and clinical medicine, catalyzed advocacy, allowed for activists to collaborate with researchers, created transnational alliances, ignited a debate on the globally inequitable WTO agreement Trade-Related Aspects of Intellectual Property Rights (TRIPS), one might say HIV "invented global health" (Brandt 2013).

Most importantly for our discussion, the Global Fund emerged out of it in 2002. It was originally designed as a giant funding stream outside the control of the UN system, and thought to have innovative mechanisms that would successfully allocate resources to where they are needed most in the world (Deacon 2007: 124). The many billions promised by states have not materialized, and it has not strengthened countries' public health system as much as hoped. Instead, like the WTO, it has focused more narrowly on vertical, disease-related measures (Dräger, Gedik, and Dal Poz 2006). It functions with a bureaucracy that reviews grant applications developed through a national Country Coordination Mechanism (CCM) that must include representation from different sections of society, including government, CSOs, and healthcare professionals. This enables it to respond to local needs and offers an important platform for collaboration between government and civil society, as we will see in Cameroon. Today, the Global Fund the largest funder of both HIV services and harm reduction in the world. And harm reduction NGOs' success often depends on their relationship with it and other international organizations. The next section discusses how IOs, INGOs, foreign aid, and other international networks enable harm reduction.

2.3 Harm Reduction as a Global Social Policy

Many issue areas have considerable representation at the international level, and it is difficult to clearly define what might make one issue a global social policy that is substantially determined by international actors. There are three elements notable to harm reduction: its strong INGOs that shape its global advocacy coalition, complex multilateralism and international funding, and transnational evidence-building that enables local acceptance.

Harm reduction activists have mobilized in networks transnationally since the beginning of the movement. Early practices in England and the Netherlands were crucial connections for the advocates of harm reduction in Switzerland in the 1990s (Kübler 2001). Informal networks of experts gradually formalized, culminating in HRI in 1996, and thereafter other important active networks and NGOs like the International Drug Policy Consortium and the International Network of People Who Use Drugs (Abdool 2016). Today, harm reduction NGOs are well mobilized transnationally. There are large advocacy and expert organizations like Harm Reduction International and Mainline International, a very large implementing organization in Médecins du Monde (MdM), and the massive Open Society

Foundations, with its 20 billion USD endowment. These organizations now form a substantial global advocacy coalition that works for harm reduction implementation worldwide.

Harm reduction advocates have had to mobilize transnationally partially because national governments have traditionally not given them a proper platform, because prohibition has been the defining paradigm of state law. The Commission on Narcotic Drugs (CND) has invited all UN members annually to discuss the evolution of global drug policy, and it is a fairly democratic international affair. But in 2011, an alternative Global Commission on Drug Policy was organized with former government officials and nonstate actors to declare the failure of the war on drugs and call for its ending. This orchestrated, multi-stakeholder partnership pursued "alternative thinking within a state-dominated space" (2015, 880). Alimi argued that this massive conference was an attempt at global public policymaking without state governments. Harm reduction's international advocacy networks have thus grown to resemble global governance.

The next important transnational element is complex multilateral arrangements, which provide platforms and funding for harm reduction. The WHO was the first major multilateral body to endorse the principles of harm reduction in 1986. Other UN agencies showed hesitancy initially, like UNAIDS. But by the new century, harm reduction was firmly a part of global discourse, discussed at the UN General Assembly. In 2004, an eight-year EU drugs strategy was adopted which explicitly supported harm reduction. EU member states, along with aspiring ones, dutifully developed programs. Foreign aid from especially from the Dutch government has also helped programs develop; the Asian Harm Reduction Network was founded back in 1996 with their support. They have gone on to fund large initiatives like the 2011 Community Action on Harm Reduction (CAHR) program, which provided funding for study visits, community mobilization, and harm reduction programs in China, India, Indonesia, Kenya, and Malaysia. US foreign aid has also been "key to securing resources and support" in East Africa, especially since the U.S. President's Emergency Plan For AIDS Relief (PEPFAR) endorsed harm reduction in 2010 (Abdool 2016). USAID, the CDC, and of course the Global Fund (mostly funded by the U.S.) have also provided a great deal of support. International agencies have also had significant agenda-setting power. It was not always used for good; some have argued that the UNODC was uninterested in harm reduction because it was funded by countries hostile to it ("The United Nations and Harm Reduction" 2005). But the UNODC and UNAIDS became vocal advocates over the 2000s, playing important roles in "shaping the policy debate" in Africa (Abdool 2016).

Transnational mobilization has also been essential for gathering evidence needed for policy implementation. McCann and Temenos (2015) argue that cross-city or inter-place networks are crucial to the spread and operation of DCRs as public health services, because they provide evidence for both skeptical officials and inexperienced practitioners. Rhodes et al. (2016) also recognized the importance of an "evidence-making intervention" in Kenya's introduction of OST, in the ways OST had to manifest

locally, in a new context, convinced the public of its usefulness, and convince other East Africans of its applicability to their region. The realities of particular local social history and politics surrounding the controversial policy mean that policies cannot simply be serially reproduced and implemented by international actors (Horvath 2004). The interaction of the local and the global is defining for harm reduction.

Strong local activism and mobilization are of course necessary to start programs, sensitize resistant groups in society, build connections with many stakeholders, and pressure the government to accept harm reduction. Harm reduction's domestic fight is quite suited to the ACF, because there are many different harms associated with drug use, and advocates must work with actors from all these sectors to ensure drug users receive care and consideration. Police harass drug users, judges throw them in jail, and health services are insufficient to keep them well. So as Thomson (2013, 115) pointed out, "law enforcement, criminal justice, the health sector, and civil society organizations" must all work together.

3. THEORIES OF IMPLEMENTATION

Cross-country comparisons of why harm reduction programs are implemented have generally been done by harm reduction NGOs and activists. They tend to take a historical perspective from an NGO's vantage point, describing how enterprising NGOs with close ties to a community works within the confines set by the government, seeks international sources of funding, and eventually government support (Varentsov 2016). As international and regional NGOs like AFEW International try to support and advise local NGOs on how to move forward, this perspective makes sense (Dąbkowska and Wildschut 2018). But in absence of proper theory- or data-driven research, they do not capture the core explanatory factors. Explanations that go beyond the political and financial developments mentioned might touch on cultural and social movement evolutions. Activist Péter Sárosi categorized the "main factors shaping and framing harm reduction" as broadly the cultural, political, and funding environments in which NGOs operate. He concludes that "in the end, the success of harm reduction as a movement depends on the larger context of social justice movements, the state of democracy, and the existence of a strong civil society" (Sarosi 2017b).

Case studies on individual countries' movements are instructive but often idiosyncratic. The literature reviewed here might be divided into how democratic countries developed harm reduction in the 1980s and 1990s, how China and Iran developed in the early 2000s, and how the rest of the world has developed thereafter. The early stories of harm reduction reflect pluralistic democratic governance, developed without IO or INGO assistance but with a large role for their democratic institutions. China and Iran's stories reflect the policymaking of more "enlightened" authoritarian governments. More contemporary success stories from poorer countries involve substantial government engagement with both IOs and NGOs.

Four separate studies have examined the development of harm reduction in Switzerland (Kübler 2001; Uchtenhagen 2010; Csete and Grob 2012; Khan et al. 2014). Kübler notably uses the ACF complemented by the social movement concepts of mobilizing structures and political opportunity structures. Uchtenhagen attributes success in implementing harm reduction to the Confederation facilitating communication between researchers and other stakeholders and the Swiss direct democratic system, and Khan et al. add to this emphasis on the facilitating factors of the visibility and magnitude of the heroin problem, the HIV epidemic, and tolerance of semi-legal nongovernmental initiatives that led to official policy change.

In Ireland, Butler and Mayock (2005) attribute success to a network of civil servants and healthcare professionals working for gradual and covert changes in drug policy since the mid-80s, without any serious public dialogue. They describe this ambiguity as "an Irish solution to an Irish problem," particular to Irish political culture, with negative effects on attitudes towards drug users. In Denmark, Houborg and Frank (2014) use Kingdon's Multiple Streams framework and Callon's concepts of 'framing' and 'overflowing' to describe drug consumption rooms (DCRs) as ultimately resulting from a new social-democratic government in 2012, which re-interpreted Denmark's obligations under international treaties. Several NGOs illegally establishing DCRs over the years did not lead to policy change, but they did shift discourse and focus in the debate. In Argentina, Epele and Pecheny (2007) cited the HIV epidemic in the 1990s as influential in changing the dominant paradigm of repressive drug policies. Harm reduction programs started by NGOs were gradually recognized by public health officials, who placed them in city-level HIV policy strategies before the national Ministry of Health launched its own program in 2003.

In Iran, Razzaghi et al. (2006) attributed success to the famously influential Ministry of Health coordinating with health authorities from the prison department and judicial authorities, informed advocacy among senior policymakers that led to a national harm-reduction committee, and NGOs in advocacy and execution of programs. In China, Reid and Aitken (2009) attribute harm reduction development to senior officials' reaction to the SARS epidemic in 2003, which catalyzed interest in controlling HIV as well. They charted harm reduction acceptance through legislation, government meetings, ministries' initiatives, and provincial action.

In Afghanistan, Maguet and Majeed (2010) cite the main factors as a strong evidence base, especially from Iran, and urgency created by the worsening security situation in 2005 that threatened Médecins du Monde (MdM), the key implementing agency. There was a notable absence of organized opposition. In Malaysia, Narayanana, Vicknasingamb, and Robson (2011) cite NGOs as leading the transition to harm reduction. After government disappointment with failing to meet the UN Millennium Development Goal on HIV in 2005 and the WHO's warning about Malaysia's HIV epidemic, NGOs were able to engage and overcome an influential Muslim lobby, begin a partnership with the state, bring academics and

medical practitioners into advocacy, and implement programs. In Tanzania, Ratliff et al. (2016) applied the complex adaptive system framework to explain how harm reduction developed. Examining the non-linear dynamics, self-organization, and coevolution characteristics of complexity, they explained harm reduction as the emergent product of interaction among many actors. The CDC and WHO were noted as crucial actors advocating for HIV prevention among PWID, bringing the UNODC on board. Ultimately, PEPFAR provided the funding to implement programs.

Rather than researching the successful introduction of harm reduction, Spicer et al. (2011) documented the struggles faced by civil society advocates in their ongoing efforts to establish programs in Georgia, Kyrgyzstan, and Ukraine. They reported advocates' understanding of the policy context that inhibits them: weak governance, political change and instability, economic and political interests (in continued criminalization of drug use), and government marginalization of civil society. They additionally documented internal factors that contribute to CSO strength or weakness: legitimacy, access to evidence, resources and financing, connections with the administration, collective action, and leadership and communication. These elements mirror much of what activists in Cameroon described.

What emerges from these case studies most clearly is the role of NGOs, central to every story except that of China and Ireland. Self-organizing NGOs start up programs, notably without government permission in Switzerland and Denmark, and it is up to governments to allow them to operate or help them to flourish. The magnitude of the drug problem was cited as an important element in four stories, with high visibility of drug use in central Zurich, large-scale heroin use in Iran and Afghanistan, and rising HIV rates in Malaysia. One barrier discussed was conservative religious beliefs in Malaysia and Ireland. Muslim groups stood in the way in Malaysia, as we will see in Kenya. But clerics in Iran were actually quite supportive from early stages. Conservative Roman Catholic values were mentioned as barriers in Ireland, alongside negative views of abortion. In Afghanistan, Malaysia, and Tanzania, IOs and INGOs played a prominent role, in advocacy, agenda-setting, and implementation. That these countries' governments were receptive to international involvement was important.

However, it seems literature on harm reduction implementation is more of an answer to *how* harm reduction develops, rather than *why*. It is difficult to conceive of this question when examining one case, as causality can only be properly considered in single cases through process tracing, which none of these studies carried out. The question of why is better addressed cross-nationally, when one can examine whether factors important to one story appear in the other. As a biased selection of positive cases, these studies also do not provide the best evidence for what inhibits harm reduction. One might imagine that these countries were relatively less interested in supply interdiction methods and more committed to their populations' general welfare, but it is not easy to tell.

Based on these case studies, six simple hypotheses were chosen to test with regression analysis. Harm reduction quality would increase with greater:

1. Government engagement with civil society
2. Magnitude of the drug problem
3. Acceptance of liberal values, like positive attitudes towards homosexuality
4. Government engagement with international organizations
5. Government commitment to welfare
6. And with lesser government emphasis on supply interdiction measures

This paper investigates how harm reduction is implemented today, using global social policy's concepts of global advocacy coalitions and complex multilateralism. It pays special attention to the roles of IOs, transnational experts, and the Global Fund in countries' harm reduction movements. Examining the ways harm reduction can be implemented without government permission but with heavy involvement of providing agenda-setting, funding, guidance, and implementation, it argues harm reduction is substantially determined by transnational administration and domestic advocacy coalitions.

4. METHODOLOGY

This thesis combines quantitative and qualitative analysis to research why and how countries develop harm reduction. It began with an exploratory ordinary least squares (OLS) regression analysis of 164 countries' harm reduction quality with numerous variables of interest, the results of which served as the basis for case selection. Kenya and Cameroon investigated using desk research and key informant interviews with about seven activists, service providers, and government representatives in each country. Finally, an ordered probit analysis was conducted to test the six hypotheses mentioned. This type of regression is more suitable than OLS to the harm reduction score, as it is not continuous variable.

The harm reduction score that serves as this regression analysis's dependent variable is based on Harm Reduction International (HRI) data. The organization is authoritative in the field, with researchers that assess the quality of harm reduction programs in 165 countries every two years in their Global State of Harm Reduction report. In it, each country is rated from 0 to 7 based on the table, "Countries or territories employing a harm reduction approach in policy or practice" (K. Stone and Shirley-Beavan, 2018). It indicates the presence or lack of seven elements of harm reduction:

1. Explicit supportive reference to harm reduction in national policy documents
2. At least one needle and syringe exchange (NSP) operational
3. At least one opioid substitution program (OST) operational
4. At least one drug consumption room (DCR) operational
5. At least one naloxone peer distribution program operational

6. OST in at least one prison
7. NSP in at least one prison

A country with none of these programs, like Japan, was rated 0, whereas one with all of them was rated 7 (only Canada, Germany, and Spain).

Almost all countries in the world are included in HRI's table, except those in which injecting drug use (IDU) has not been reported (according to Degenhardt et al. 2017). While some African countries are missing from the table due to a lack of reliable data on the scale of drug use, they have been included in this paper's analysis based on the advice of Sam Shirley-Beavan, a research consultant at HRI, who assured that these countries do not have any of the seven elements mentioned.

The scores are an imperfect method for measuring the quality of a country's harm reduction services. Most obviously, they note the presence of a single program, which does not indicate whether there is sufficient coverage across the country. This creates an obvious bias in favor of larger countries, like the U.S.; its score of 6 hides the fact that there is significant regional variation in program accessibility. This is accounted for using the logarithm of population as a control. Another point to note is that scores indicate the presence of programs, whether they are provided by nonprofits or government. But because these programs are often controversial and tacit permission to operate is difficult enough to achieve, scores can still be seen as measuring government approval. Finally, analysis is limited by the use of data from a single year rather than longitudinally. The Global State of Harm Reduction 2018 was the first of their biennial reports to include most every country based on a comprehensive review by Degendhardt et al. (2017). that noted every country with documented IDU.

The independent variables chosen should be explained here so Table 4.1 below can be understood. One proxy was chosen to measure each. The full summary statistics and correlation matrices between them can be found in Appendix 1. They came from Varieties of Democracy (V-Dem) dataset, the UNODC's Annual Report Questionnaire (ARQ), the World Values Survey, and the United Nations Development Program (UNDP). V-Dem's CSP index is based on the question, "Are major CSOs routinely consulted by policymakers; how large is the involvement of people in CSOs; are women prevented from participating; and is legislative candidate nomination within party organization highly decentralized or made through party primaries?" V-Dem's egalitarian component is a measure of the extent to which the "egalitarian" principle is achieved, meaning "rights and freedoms of individuals are protected equally across all social groups; resources are distributed equally across all social groups; and access to power is equally distributed by gender, socioeconomic class and social group" (Coppedge et al. 2020). The measure of liberal values is from the WVS's 2017-2020 survey of roughly 1,500 people in each of 71 countries, where respondents were asked to report on a 1-10 scale the justifiability of homosexuality. Government engagement with IOs is measured by, as a percent of the country's gross national income

(GNI), the net official development assistance (ODA) received. This is a very imperfect measure. In order to improve it slightly, five countries with net negative ODA were removed, as negative values would not indicate a lesser amount of international engagement and investment. It more likely indicates the country is more committed to IOs by paying back the assistance they received.

Table 4.1 Hypotheses and their proxy variables

Hypothesis	Variable	Abbreviation
1. Govt engagement with CSOs	V-Dem civil society participation index	VDm_CSP
2. Measure of the drug problem	Prevalence of PWID (% of total pop)	PrvPWID
3. Liberal values	WVS Justifiable: Homosexuality	WVS_HsJ
4. Govt engagement with IOs	Net ODA received (% of GNI)	Net_ODA
5. Govt commitment to welfare	V-Dem egalitarian component index	VDm_Ega
6. Govt emphasis on interdiction	Prison population (per 100,000 people)	PrsnPop

For the case studies, most similar cases were chosen with divergent values on the dependent variable and the main variable of interest: civil society participation in government. First a deviant case was sought, with a higher harm reduction score than important variables would otherwise predict. Once a few cases were selected (among them Malaysia and Macedonia), other countries were examined with similar per capita GDP, healthcare spending, welfare quality, and cultural values. With substantially similar scores in most every important factor in this dataset except for civil society participation in government, Kenya and Cameroon are quite suitable for isolating the effect of that variable. A few other variables are offered for context: United Nations Development Program's (UNDP) Human Development Index (HDI); Bertelsmann Stiftung's Transformation Index (BTI) measuring welfare quality; and the ethnic fractionalization rate by Alesina et al. (2003), which based on ethnic, linguistic and religious groups in 190 countries, and it reflects the probability that two randomly selected people from a given country will belong to different groups. It is notable that their ethnic fractionalization rates are virtually identical, putting them in the top 5% of countries. With Kenya's recent steady successes since 2012 and Cameroon's presently active fight to move from its current score of 0, there is much to learn from these cases.

Table 4.2 Quantitative comparison of Cameroon and Kenya

Country	Score	GDP per capita	HDI	Healthcare Spending % GDP	BTI Welfare Score	V-Dem Egalitarian Comp	ODA as % of GNI	V-Dem Partip Comp	Ethnic fraction	Prison Pop
Cameroon	0	1,452	0.55	5.1	4.5	0.59	3.54	0.23	0.86	125
Kenya	4	1,595	0.58	5.2	4.5	0.46	3.17	0.55	0.86	103
Mean	2	14,630	0.71	6.7	5.0	0.61	5.84	0.49	0.44	164

5. REGRESSION RESULTS

Quantitative analysis started with an extensive exploratory multiple regression analysis, the full results of which can be found in the appendices. A wide variety of variables were selected to measure the magnitude of the drug problem, government service provision, democratic tendencies of the government, and societal values. Strong correlations were observed between harm reduction and many factors, controlling for GDP per capita and population. The main lessons drawn from this analysis were the apparently great importance of measures of participatory government, healthcare spending as a percent of GDP, and cultural values like religiosity. Kenya and Cameroon were chosen primarily based on these factors. Based on last year's HRI data, the magnitude of the drug problem did not seem so significant, but subsequent reanalysis with 2020 data showed that both prevalence of PWID and the HIV rate among them correlate significantly internationally. The importance of egalitarian policy also increased with 2020 V-Dem and HRI numbers. Other regressions run later showed strong correlations with measures of wealth and well-being, notably the HDI, along with gender inequality, though unfortunately time was insufficient to explore this further.

The proper theory-driven quantitative results follow. In terms of significance levels, one asterisk indicates $p < .1$, two if $p < .05$, and three if $p < .01$. The variables presented have been normalized for comparison between them. The "z" in front of them indicates that regressions were run using the variables' z scores. The covariance and correlation matrices of these coefficients in ordered probit model are found in the appendices.

Table 5.1 Ordered probit regression results

	(1) Score b/se	(2) Score b/se	(3) Score b/se	(4) Score b/se	(5) Score b/se	(6) Score b/se	(7) Score b/se
Score							
zVDm_CSP	0.434***	0.373***	0.233*	0.259*	0.075	-0.076	-1.236***
	(0.10)	(0.10)	(0.14)	(0.14)	(0.17)	(0.23)	(0.40)
zlogGDPpc		0.567***	0.548***	0.642***	0.441***	0.028	-1.737**
		(0.10)	(0.12)	(0.13)	(0.16)	(0.38)	(0.75)
zlogPop		0.348***	0.219	0.268*	0.377**	0.160	-0.644
		(0.12)	(0.14)	(0.14)	(0.15)	(0.22)	(0.45)
zPrvPWID			0.228**	0.343***	0.309***	0.013	-0.160
			(0.11)	(0.11)	(0.11)	(0.16)	(0.25)
zPrsnPop				-0.354***	-0.307**	-0.091	-0.317
				(0.12)	(0.12)	(0.16)	(0.30)
zVDm_Ega					0.438**	0.767***	1.856***
					(0.22)	(0.29)	(0.58)
zWVS_HsJ						0.080	0.373
						(0.27)	(0.51)
zNet_ODA							-2.171
							(1.62)
/							
cut1	-0.335***	-0.314***	-0.951***	-0.977***	-0.924***	-1.208***	-1.387
	(0.10)	(0.12)	(0.17)	(0.18)	(0.18)	(0.32)	(0.92)
cut2	0.029	0.103	-0.523***	-0.531***	-0.462***	-0.738**	-0.480
	(0.10)	(0.12)	(0.16)	(0.16)	(0.17)	(0.30)	(0.92)
cut3	0.186*	0.286**	-0.257*	-0.251	-0.172	-0.407	-0.104
	(0.10)	(0.12)	(0.15)	(0.16)	(0.16)	(0.29)	(0.92)
cut4	0.442***	0.584***	0.144	0.186	0.274*	-0.000	0.291
	(0.11)	(0.12)	(0.15)	(0.15)	(0.16)	(0.28)	(0.91)
cut5	1.038***	1.281***	0.992***	1.142***	1.239***	1.117***	2.398**
	(0.12)	(0.14)	(0.16)	(0.18)	(0.19)	(0.30)	(1.02)
cut6	1.625***	1.990***	1.759***	1.943***	2.049***	1.801***	3.262***
	(0.16)	(0.20)	(0.22)	(0.23)	(0.24)	(0.34)	(1.10)
cut7	2.287***	2.807***	2.594***	2.854***	2.972***	2.696***	
	(0.26)	(0.31)	(0.33)	(0.35)	(0.36)	(0.45)	
pseudo R-sq	0.038	0.107	0.095	0.132	0.142	0.104	0.234
N	156	155	103	102	102	62	29

Table 5.2 Ordinary least squares regression results

	(1) Score b/se	(2) Score b/se	(3) Score b/se	(4) Score b/se	(5) Score b/se	(6) Score b/se	(7) Score b/se
zVDm_CSP	0.781***	0.599***	0.327	0.346	0.066	-0.132	-1.160**
	(0.17)	(0.15)	(0.22)	(0.22)	(0.26)	(0.37)	(0.44)
zlogGDPpc		0.937***	0.867***	0.929***	0.610**	0.024	-1.415
		(0.15)	(0.19)	(0.18)	(0.24)	(0.59)	(0.84)
zlogPop		0.506**	0.252	0.299	0.463**	0.115	-0.588
		(0.20)	(0.23)	(0.22)	(0.23)	(0.34)	(0.55)
zPrvPWID			0.378**	0.506***	0.441**	-0.005	-0.029
			(0.18)	(0.17)	(0.17)	(0.25)	(0.34)
zPrsnPop				-0.468***	-0.379**	-0.069	-0.313
				(0.17)	(0.17)	(0.25)	(0.39)
zVDm_Ega					0.668**	1.162**	1.814***
					(0.32)	(0.45)	(0.62)
zWVS_HsJ						0.051	0.484
						(0.42)	(0.62)
zNet_ODA							-2.143
							(2.01)
_cons	2.130***	1.996***	2.816***	2.749***	2.630***	2.998***	2.548**
	(0.16)	(0.16)	(0.21)	(0.20)	(0.20)	(0.40)	(1.14)
R-sq	0.124	0.319	0.299	0.379	0.405	0.322	0.509
N	156	155	103	102	102	62	29

The probit model suggests that there are several factors that each contribute to harm reduction strength. V-Dem's measures for egalitarian policies seems to matter over and above the others, but prevalence of people who use drugs and prison population seemed to matter too. Overall, it seems government commitment to societal welfare matters the most to harm reduction, mediated by the size of the drug

problem and the government's emphasis on interdiction methods. Given the fairly low r-squared, this model is not an especially strong predictor of harm reduction quality, but it is not an insignificant one either.

Civil society participation in government did not matter as much as expected, and indeed negatively correlated in the final model, but this can probably be safely ignored given the low number of countries involved. Despite the correlations between liberal values and harm reduction, views of homosexuality did not seem important; indeed, the variable detracted from the model's explanatory power, based on the r-squared. This suggests that liberal values are co-occurring in countries with stronger harm reduction, but they are not contributing to harm reduction success.

Rather than correlating positively with harm reduction as a sign of greater government openness to international aid and IO involvement, net ODA as a percent of GNI actually negatively correlates with harm reduction. This correlation disappears with GDP per capita and population size controls, but it is still interesting to note. A high ODA probably reflects more that a country needs a great deal of assistance and cannot easily afford harm reduction programs.

6. CASE STUDIES

6.1 Introducing the Case Studies

As mentioned, Kenya and Cameroon were chosen based on their extremely similar GDPs per capita, government healthcare spending, BTI welfare score, and ethnic fractionalization rates; and rather similar HDIs, net ODA received, and prison population. The main differentiating variable was the measures of civil society's participation in government. With last year's data, measures of the magnitude of the drug problem did not significantly correlate internationally, and so it was not seen as a problem that there were no published estimates of prevalence of PWID or the HIV rate among them in Cameroon.

Unfortunately, the World Values Survey does not have data on Kenya or Cameroon, so it is difficult to see how these countries compare with the rest of the world. But the Afrobarometer measures some relevant dimensions for this analysis, yielding some interesting results. Though WVS indicators for self-reported political activism did not correlate significantly worldwide, they could be seen to mediate the effect of CSO participation in government. Despite the Cameroonian government accepting much less citizen involvement in governance, Cameroonians report being more civically involved. This suggests even more that government willingness to allow citizen participation is crucial for harm reduction; it is not that Kenyan citizens are more engaged, but that their government engages them more. Otherwise, there does seem to be more religious harmony and less restrictive views of women in Kenya. But views of homosexual people are similarly poor, suggesting that Kenyans and Cameroonians are not dissimilar in attitudes towards marginalized groups like drug users.

Table 6.1 Afrobarometer Comparison of Kenya and Cameroon

Percent of people that indicated the following answers	Mean in Africa	Kenya	Cameroon
Joined others in your community to request action from government in the past year ("Yes, several times" or "Yes, often")	15.0%	18.0%	21.7%
Got together with others to raise an issue in the past year: ("Yes, several times" or "Yes, often")	35.8%	36.5%	48.9%
People of a different religion as neighbors ("Somewhat like" or "Strongly like")	51.2%	65.8%	47.5%
Homosexuals as neighbors ("Somewhat like" or "Strongly like")	6.3%	2.9%	2.1%
"When jobs are scarce, men should have more right to a job than women" ("Strongly Disagree" or "Disagree")	53.3%	62.7%	57.5%

Until 2000, Kenya and Cameroon had similar political trajectories. The transitions from their founding presidents to their successors brought about a swift disintegration of political stability and attempted consolidation of authoritarian rule. Both countries stagnated economically in the mid-1970s through mid-1990s under lower commodity prices, corruption, and Structural Adjustment Programs. In 1989, Jean-François Bayart described Cameroon and Kenya as both affected by a "reciprocal assimilation of elites," or the "progressive emergence of a widespread alliance of different regional, political, economic and cultural segments of the social elite" (1993). With an extremely small middle class and a captured upper class, there was little space for political development in either country. But in the early 1990s, there was some opening up to democracy in both countries. While this was a brief moment in Cameroon, it was not in Kenya; this laid the groundwork for harm reduction years later.

The following sections attempt to identify the three most important factors that contribute to harm reduction success: civil society mobilization, international involvement, and government cooperation with NGOs.

6.2 Political History of Kenya

While Kenya was largely democratic at the time of its independence in 1964, the banning of an opposition party in 1969 and amendment of the constitution in 1982 ensured it was a one-party state under the Kenya African National Union (KANU). Kenya's first president, Jomo Kenyatta, had struggled to consolidate power throughout his time in office, and his successor in 1978, Daniel arap Moi, proved willing to resort to authoritarian measures to maintain control. Western powers had long supported the capitalist-friendly regime in contrast to its socialist-leaning neighbors in Tanzania and Ethiopia. But their support increasingly became tied to calls for reform, and their financial assistance was sought after economic stagnation since 1973. Some cite their influence as the sole factor behind the December 1991 constitutional amendment that reinstated multiparty elections. Opposition parties fought

amongst each other, partially through Moi's control, until 2002 when Moi decided to not seek reelection. Instead of KANU's candidate, Uhuru Kenyatta (son of Jomo Kenyatta), Mwai Kibaki became president. He brought greater democratic openness for Kenya, which ultimately afforded NGOs greater freedom to operate and influence the government (Apondi 2020). Kibaki's administration experienced a corruption scandal in 2005, and there was a great deal of violence surrounding the 2007 presidential election. Call for reforms ultimately resulted in a referendum, which in 2010 brought a new constitution with "devolution" or decentralization of power, from the presidency and national government to the country's local governments. Some believe devolution brought more problems, with decentralization of responsibilities but not the budget to match, and with lessened national but increased regional corruption (Abuya 2020). But Kenya's former Chief Justice believes devolution and the new constitution are central to Kenya's still-fragile democracy (Mutunga 2020).

Despite the questionable quality of democracy in Kenya, the government has apparently welcomed CSOs to a great extent. Unlike other less-than-democratic governments that fear CSOs, Kenya has allowed them to grow and welcomed their contribution to service provision and governance. Between 1990 and 2004, the number of NGOs registered in Kenya increased from 400 to nearly 3,000 in 2004. This was largely due to international influence: in 2005, 91% of the $213 million NGO reported raising came from international sources (Brass 2012). This funding came from private foundations as well as traditional donors, following the neoliberal emphasis in the 1990s on funding NGOs rather than governments. In 1998, Julie Hearn wrote of a "donor-sponsored 'NGO-isation' of Kenyan society (1998). As the government assented to calls for reform, they also reformed their institutions. USAID's population and health program in Kenya was its largest in sub-Saharan Africa in the mid-1990s; with this funding and other channels, they encouraged the Kenyan government to restructure healthcare, favoring private over public hospitals, thereby giving NGOs greater influence. The health sector might be the area most "captured" by NGOs, but their influence extends beyond it. In Jennifer Brass's article, "Blurring Boundaries: The Integration of NGOs into Governance in Kenya," she describes how governance of service provision has become a "complex, intertwined affair" where the government welcomes NGOs to sit on national policymaking committees, integrates their plans and budgets into national policy, and learns from NGOs' participatory, accountable approach (2012). This greater role for NGOs is relevant in many African countries, but it seems pronounced in Kenya. Devolution has subsequently allowed NGOs to be integrated into local governance arrangements, becoming involved in District Development Committees, making District Development Plans.

6.3 History of Drug Use and Harm Reduction in Kenya

There is a long history of alcohol, tobacco, khat, and cannabis consumption in Kenya, but heroin first surfaced along the coast in the 1980s. At that time, "brown sugar" heroin was common, which can be "chased" by inhaling the vapors of small quantities heated on a spoon. But it was replaced in the mid-

1990s by “white crest” heroin, which cannot be chased as it will burn; the user instead injects it, giving them a stronger high (Beckerleg 1995). IDU therefore only became common around this time (Beckerleg, Telfer, and Hundt 2005). In response, outreach for drug users began with the Omari Project opening in Malindi in 1995, with Muslim Education and Welfare Association (MEWA) in 2001 and the Reach Out Centre Trust in 2003 in Mombasa, and the Nairobi Outreach Services Trust (NOSET) in 2004. Today they remain the four harm reduction-focused NGOs in Kenya (Badhrus 2020).

Surveys of drug use started to come out in 2003 and 2004, by The Omari Project, the UNODC, the WHO, and by the National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA, established 2001). In early 2005, the US embassy began trainings for outreach to users, to inform them of the dangers of needle sharing, how to clean needles and syringes, and how to inject themselves properly. While the UNODC pushed for NSP and OST at this time, NACADA and other government bodies resisted (Badhrus 2020). Especially in response to a demographic health survey in 2008 that found a third of new HIV infections were coming from the key populations of MSM, PWID, and sex workers, a unit was established within the Ministry of Health specifically for them (Ayon 2020).

Beginning December 2010, there was a heroin shortage after a government crackdown on supply, upon which many drug users died (Mital et al. 2016). A number of politicians, including a woman vying for an MP position, brought media attention and created awareness around the heroin crisis (Badhrus 2020). In 2011, the Kenyan AIDS NGOs Consortium (KANCO) secured funding from a Dutch Ministry of Foreign Affairs program, Community Action on Harm Reduction (CAHR), which began with a baseline study and advocacy training. With the grant, KANCO organized a visit to visit harm reduction programs in Malaysia, Tanzania, and Mauritius with a roughly 15-person delegation including the head of the National AIDS and STIs Control Programme (NASCOP within the Ministry of Health), senior officials from the National AIDS Control Council, and regional Ministry of Health officials from major heroin-affected areas (Ayon 2020).

With encouragement from their international partners, KANCO decided to fund an NSP pilot in December 2012, though they had received express government direction not to. Within a few months, the program sparked controversy in the media and the broader public (Kamenderi 2020). UNAIDS officials privately expressed concern that they would “jeopardize the entire HIV discourse” in Kenya (Kalama 2020). After internal communications involving the Office of the President and the Ministry of Health, and a tense meeting between KANCO and the government called by the Kenyan Red Cross (the Principle Recipient of the Global Fund grant in Kenya), the government decided by February 2013 to accept the program and write NSP into official guidelines. Meanwhile, MEWA hosted a debate with the regional director of the Ministry of Health, NACADA, a well-known psychiatrist, three HIV positive former drug users, and an influential imam who was against NSPs. By embracing debate with the religious figures, advocates were able to shift public opinion in favor of the program (Badhrus 2020).

In December 2014, KANCO facilitated an introduction of OST in Nairobi and coastal cities, with the help of PEPFAR, the Center for Disease Control (CDC), USAID, the University of Maryland, and the UNODC (Rhodes et al. 2016). The design of OST involved policy officials and clinicians making field-visits to treatment programs in Tanzania and elsewhere with the express purpose to design their own (Rhodes 2018). Subsequently in 2015, the CAHR program ended and the Global Fund provided enough to expand coverage.

Today, the government supports harm reduction services, although opinions differ on whether OST programs are mostly funded by the government (Apondi 2020) or still mostly funded by donors like PEPFAR (Ayon 2020). At the Ministry of Health, there is a coordination point for all the NGOs working in harm reduction, along with a technical working group that regularly meets to discuss what is and is not working for drug users. Advocates from KANCO and Voices of Community Action and Leadership (VOCAL-Kenya) maintain contacts within Parliament that routinely consult them on issues related to drugs. Unfortunately, harm reduction is still not formally supported by legislation, but instead Ministry of Health programming, which means it remains vulnerable to the president's whims, for example (Apondi 2020). But Kenya is now seen to be a harm reduction leader in the region.

6.4 Civil Society Mobilization in Kenya

Civil society mobilization is crucial for two main reasons: building advocacy coalitions and sensitizing the public to harm reduction so they can take advantage of a moment of heightened awareness of the drug problem (the external shock discussed by ACF). Advocacy coalitions are key to civil society's strength. Small, on-the-ground CSOs like MEWA play a crucial role in mobilizing drug users through the provision of basic services. They earn the community's trust over time and help build awareness in a community. They can establish connections with local police and religious figures, creating a receptive space for harm reduction in a given city. But it takes larger NGOs to influence higher-level government and secure funding for the leap to harm reduction. The organizations most important in lobbying government and securing funding for programs were those dedicated to HIV. KANCO performed this work with legal help from the Kenya Legal and Ethical Network on HIV and AIDS. These NGOs were particularly strong perhaps because, back in the 1990s, the Kenyan government itself did not respond to HIV, and NGOs came in to fill the gap. These NGOs for years laid groundwork for harm reduction, in their research, contribution to government programs, and networks. However, it is important to note that the studies cited as most influential and the initial funding received were explicitly focused on harm reduction; it was not a simple outgrowth of HIV programs (Kalama 2020).

A moment of heightened societal awareness of drug use can lead to greater emphasis on supply reduction measures and greater criminalization of drug use, as we will see in Cameroon. This is why civil society mobilization over years is crucial. Activists must gain sufficient voice to influence public opinion when

the moment arises. When it does, it is useful to have evidence that demonstrates the scale of the problem. A few factors increased Kenya's awareness: the first were the studies done by the many HIV-related NGOs in the country. The HIV prevalence rate among PWID is a clear indication that NSP is needed. The success in reducing HIV broadly in Kenya brought attention to the pocket where it was still increasing: IDUs. The second factor that increased awareness were other studies on drug use, some of which were commissioned by NACADA, some of which were done by independent researchers. Finally, the last factor was the 2012 heroin shortage in Mombasa, which was widely cited by interviewees as a catalyst, an event around which activists and politicians mobilized.

Through lobbying Parliament, the Ministry of Health, NASCOP in particular, and through outreach to communities, media, and police, advocates built support for programs in numerous ways (Apondi 2020). Several activists routinely mention the importance of creating "champions," meaning both charismatic former drug users to influence the media and friends in Parliament to shape legislation. Strategic allies in decision-making places like the Ministry of Health proved crucial, and their participation in the site visit to Mauritius was helpful in making them strong advocates (Kalama 2020).

6.5 International Involvement in Kenya

International funding seems key to starting harm reduction programs everywhere. Local NGOs already providing harm reduction services seem to need international funding to expand and prove their worth before the government will consider helping. In Kenya, funding came from the Ministry of Foreign Affairs of the Netherlands, perhaps the world's leader in quality harm reduction services. Thereafter, the Global Fund and PEPFAR stepped in. International harm reduction NGOs also proved crucial in providing guidance. NSP started with technical support from the London School of Hygiene and Tropical Medicine and Alliance Public health from Ukraine, policy advocacy from the International Drug Policy Consortium, and assistance mobilizing drug users from the International Network of People who Use Drugs (Ayon 2020). And after their success in Kenya, KANCO received a grant to advocate for harm reduction at the East African Community, which has since released expressed support for harm reduction in 2019 (following in the footsteps of the Southern Africa Development Community (SADC) and the Economic Commission of West African States (ECOWAS)). The global advocacy coalition grows and continues on to influence other governance structures.

6.6 Kenyan Government Cooperation with NGOs

The most important factor in developing harm reduction programs seems to be government willingness to cooperate with NGOs. The reasoning behind this cooperation, which grew to what Bernice Apondi calls a "partnership" working hand-in-hand today, lies in the political developments discussed in a previous section: increasing democratic openness. Since the last years of Moi, there has been "ballooning democratic space," which increased significantly as Kibaki engaged civil society more

(Abuya 2020). Civil society was able to grow by earning the government's trust over years. Now, bills in parliament related to drug policy are designed with substantial NGO input. MPs listen to their advice, and have withdrawn proposals they were about to introduce based on the counsel of harm reduction advocates.

6.7 Political History of Cameroon

In 1966, Cameroon became a one-party state under President Ahmadou Ahidjo's Cameroon National Union. After Ahidjo resigned in 1982, Prime Minister Paul Biya took the presidency. Conflict with Ahidjo and an attempted coup in 1984 convinced him to reduce democratic space he briefly allowed upon taking office. The economy benefited the discovery of petroleum in the 1970s and investment in agriculture with oil money that allowed Cameroon to become a breadbasket for its neighbors, but subsequent declining commodity prices, failed large infrastructure projects, and corruption took their toll in the 1980s. Real gross GDP per capita had risen from 500 USD in 1970 to 1,200 USD in 1986, but then fell back to 500 USD by 1994. This seriously eroded the state's authority, and many refused to pay taxes (Fonjong 2007, 42). The growth of political parties, social movements, and NGOs resulted from this economic instability and perceived illegitimacy of the state (Vubo 2009).

According to Forje, civil society was "passive or captive and weak from 1st September 1966" when political parties were banned "to 26 May 1990" when six civilians were killed by security forces at the inaugural rally for the Social Democratic Front (1999). Vubo (2009). similarly begins his discussion of civil society in Cameroon with the 1991 Tripartite Talks between the government, opposition party, and civil society actors, which were specifically chosen by the regime to avoid "troublesome elements" (2009, 23). All civic associations were previously coerced into the national party, the Cameroon People's Democratic Movement (CPDM). But the First Freedom of Association Law was passed in December 1990, which researchers credit as helping NGOs proliferate (Fonjong 2007; Vubo 2009), though at the same time, the government's strict control over them. The government retains the right to dissolve NGOs, and they moreover require that all meetings intended to be held in public places, or in a place open to the public, be declared in advance. Largely due to these structures, though NGOs were originally linked to political movements, after the 1990–1993 crisis years, most NGOs have come to be apolitical (Vubo 2009, 23).

In the first presidential election in 1992 since other political parties were made legal, the Social Democratic Front led by John Fru Ndi was narrowly defeated (Abia et al. 2016). Student and worker's union activism through mid-1990s resulted in some adjustments, like greater press freedom and a slightly stronger National Assembly, but no substantial change (Forje 1999). Flawed elections with decreasing voter turnout were subsequently held in 1997, 2004, 2011, and 2018, all delivering victories to Biya. Since Southern Cameroon joined the country in 1961 and it adopted a federal system, many

believe the government has disenfranchised English speakers and gradually centralized. From late 2016, major Southern Cameroonian cities became "ghost towns" every Monday, as separatist militias encouraged people to refrain from economic activity. This "Anglophone crisis" has occupied much of the political system's attention, but it seems CSOs have gained strength in Southern Cameroon through it. Government resources are often rejected in the region, and the government has been forced to work with CSOs more. Despite the uncertainly caused by this, over the past decade, there has been a slow advancement of democracy, respect for human rights, and civic space in the whole country (Chamango 2020).

Unfortunately, it seems the vast majority of NGOs today are weak, with poor organizational structures (Mbuagbo and Neh 2003), "weak mobilization, a narrow territorial base" (Vubo 2009), severely limited funding (Fonjong 2007), "plagued by corruption, inefficiency, tribalistic tendencies, and no clear-cut development mission" (Tanga and Fonchingong 2009). Neo-patrimonialism and ethnicism limit civil society's ability to mobilize towards democratic culture, according to Fonchingong and Gemandze (2009). These researchers judge NGOs harshly, and one interview subject blamed NGOs' problems on Cameroonians: staff not working hard, lacking transparency, not gaining the credibility they need to attract funding (Sinda 2020). Indeed, the problem of briefcase NGOs (existing mainly on paper so entrepreneurs can support themselves) is occasionally cited (Chamango 2020; Nkwi 2006).

But the root cause of low capacity seems to be the government's interference, the "tense environment" in which they operate (Mbianke 2020). The government can be debilitating. In some places, NGOs cannot receive external financing without government permission (Fonjong 2007). This incentivizes corrupt deal-making with officials interested in their funding; and indeed, local governments do occasionally have to compete with NGOs for some funding streams. These problems reflect similar complaints documented by Spicer et al. (2011), with the acrimonious relationship between state and civil society. One interview subject felt they are only called upon when the government needs something from them, and they do not provide any support in return; they felt NGOs were seen as "slaves to the government." There is "no friendship. Only interest," where each might try to take advantage of the other financially.

6.8 History of Drug Use in Cameroon

The most commonly used substances, in descending order, are cannabis, tramadol, cocaine, and heroin (Ndi Ndukong 2020). Unfortunately, there have been few studies on illicit drug use in Cameroon. The largest study of drug use in Cameroon was done decades ago, as a rapid assessment by the UNODC, which documented IDU but did not carry specific data about it (Wansi et al. 1996). In 2011, a study of 1,200 high school students found 5% of them had taken drugs; of them, 65% reported having tried heroin, 57% cocaine, and 10% cannabis (Endong 2011). While there has never been a published, peer-

reviewed study of the number of PWID in Cameroon, nor the HIV rate among them, the organization Empower Cameroon estimated roughly 500 PWID in the country in 2018. PEPFAR Cameroon had an Integrated Biological and Behavioral Surveillance (IBBS) survey among PWID and transgender people in their 2018-2022 programming cycle, which may yet happen. It also stated a desire to increase their outreach and testing for PWID that began in 2018.

In Cameroon there are two notable harm reduction organizations, Empower Cameroon (led by Ndi Ndukong Titus) and the Cameroon Association for the Harm Reduction Related to Drug Use among Young People (ACRDR) (led by Ndeme Bebegue Melanie). Empower Cameroon was started in 2015, perhaps the first ever association for drug users in the country (Ndi Ndukong 2020). As a "cultural organization" of PWUD, they are presently focused on mobilizing drug users. Since 2018, they have started to hold conferences involving government representatives on drug policy reform and healthcare.

Recently, there has been greater government recognition of the drug problem. In 2018, Cameroon's Anti-Drug National Committee published their estimates that 21% of the population have tried illicit drugs, and 10% are frequent users (Oyekunle 2019). In June of 2019, the government publicly incinerated more than 35,000 kilograms of drugs, 18,603 kilograms of which was heroin (Dembele 2019). This is about the median amount seized by countries' police forces in 2016 (UNODC 2016). In January 2020, an incident gained national attention involving a 15-year-old student killing his mathematics teacher while reportedly on an illegal drug. President Biya subsequently called for collective action (Emmanuel 2020), and since, Ndeme reported she has been able to begin conversations about drugs with the government. So far, this has only resulted in the beginning stages of collaboration on an evolving project with the Ministry of Health. The overall government response to the increased attention was emphasis on interdiction measures, with increased policing and gendarmerie in schools. The Cameroonian government's approach to drug users is criminalization. By law, someone arrested for using drugs can receive medical assistance and lawyer to represent them, instead of jail time or a fine, a judge can send the person to a treatment center. Unfortunately, such a center does not exist (Ndi Ndukong 2020).

6.9 Civil Society Mobilization in Cameroon

Overall, the harm reduction associations in Cameroon are not extremely well established. They are still quite young and focused on mobilizing drug users, and especially in the days of COVID-19, providing them any kind of support can be a challenge. Drug users are still hesitant to organize; they did not show up to a town hall ACRDR organized with the head of social services in Douala. These organizations have also not been able to establish strong connections with other NGOs in the country. ACRDR has been sending people living with HIV to GTR Littoral Cameroun (Groupement Technique Régional de lutte contre le VIH) and especially mothers to the Cameroon National Planning Association for Family Welfare, but these connections are not political. In contrast to the hostile environment the Cameroonian

government creates for many NGOs, it seems they have a good working relationship with some NGOs focused on HIV. There is more support and funding for them (Mbianke 2020). They seem content in their relationship with the government, and not mobilizing with drug users because the HIV epidemic is more concentrated around other key populations. Meanwhile, ACRDR and Empower Cameroon do not seem to be coordinating with one another, perhaps due to poor personal relationships.

6.10 International Involvement and Government Cooperation with NGOs in Cameroon

It seems major international funders are not terribly active in Cameroon. When asked why, activists pointed to the government and NGOs themselves. One interview subject reported that a representative from Save the Children UK said they would like to be more involved, but the government of Cameroon is not "responsible enough," and they would not trust money would be spent as promised. International donors will fund large Western NGOs operating in Cameroon, but very rarely will a Cameroonian NGO benefit. ACRDR and Empower Cameroon are additionally not very well-connected with international harm reduction organizations. Ndeme has this year began reaching out to large nonprofits to find one that might conduct a proper survey of PWID.

The Global Fund has been more active, creating a platform for collaboration between government and civil society. Their committee serves as the primary way Empower Cameroon has cooperated with the government and attempted to secure funds for harm reduction programs. But they are vulnerable, as the funding request goes through the Ministry of Health, and the government is the primary recipient of GF money, ultimately sending NGOs their cheques. Drug users were first considered among the "key populations" vulnerable to HIV in 2017 (Ndi Ndukong 2020). In June 2020, their request to the Global Fund included items for a NSP, OST, IBBS, and funds for a center from which to operate. That the government allowed this to be included was encouraging, but the likelihood of approval is middling. But Empower Cameroon and ACRDR are least starting to hold meetings with the National Committee for the Fight Against Drugs and the Ministry of Health as of this year.

7. DISCUSSION AND CONCLUSIONS

Harm reduction can be seen in many different ways. Based on quantitative analysis, it might be viewed as largely a function of how interested the government is in their citizens' well-being, with greater chances if the IDU population is greater and the government is less interested in criminalization. Harm reduction can also be understood as a global social policy propagated through an international coalition of actors working in complex multilateral arrangements. But as seen in Kenya and Cameroon, success is also largely determined by civil society actors' ability to connect with these forces. In Kenya, experienced professional advocates that worked many years in the fight against HIV were able to start harm reduction programs fairly quickly after taking interest. They leveraged connections with

government officials, secured international funding, and worked through small community-based drug rehabilitation and treatment centers to implement initial programs. But they were so aided by global actors providing funding, guidance, and implementation of programs that one might view the global advocacy coalition as working through the local one. It is difficult to reconcile these views.

Examining Cameroon, one is struck by all local advocates do not have: funding even enough for the country's first clinic, connections with other local NGOs (let alone international ones), a conducive environment for advocacy, or any proper relationships with officials. But it is interesting to observe their strategy. They invite officials to conferences, organize sporting events and concerts for themselves and for their communities, and they place a great deal of hope in international actors, especially the Global Fund. Harm reduction ultimately gets off the ground when activists are able to reach them. What enables them to is great domestic mobilization, reaching those individuals in medicine, law enforcement, and criminal justice that will accept the subtle paradigm shift to harm reduction, and government willingness to cooperate, respecting them enough to allow them to start programs.

8. LIMITATIONS

With more time, this thesis would have used more advanced statistical methods to investigate HRI's scores more. The exploratory regression analysis showed some surprising correlations with gender inequality, a rather high correlation with the HDI, and many cultural values like self-expression, though there was significant regional variation. Further analysis might have revealed brought interesting insights into the values that underpin harm reduction.

This thesis took a rather top-down approach, conceiving of harm reduction through the large IOs and NGOs that propagate it. As a social movement, the story of harm reduction should also be told though the stories of grassroots activists that mobilize individual drug users and must work years to establish even basic treatment centers, as ACRDR and Empower Cameroon are today. Additionally, the thesis's research method involved reviewing literature largely written by Western academics interested in international organizations as forces for good, rather than more critically examining them through neocolonial or neoliberal lenses. The qualitative research method of mostly interviewing activists was additionally limiting, as they reproduce the narrative of harm reduction resulting from their efforts and the government's responsiveness to them. Without access to higher-level government officials, this thesis was not able to incorporate understanding of the idiosyncratic interests of and connections with powerful people that affect the outcome of harm reduction activism.

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APPENDIX 1. SUMMARY STATISTICS AND MATRICES FOR VARIABLES

Appendix Table 1.1 Summary Statistics

stats	Score	VDm_CSP	VDm_Egal	PrevPWID	PrsnPop	WVS_HsJs	Net_ODA
N	165	172	172	104	188	72	134
mean	2.054545	.6806453	.6089826	.3656023	163.5691	4.146389	5.842854
sd	2.144916	.2205205	.2154578	.4444864	122.6012	2.350129	8.728926
min	0	.054	.101	.0065506	9	1.27	.0090432
max	7	.986	.948	2.3	671	9.03	60.51865

Appendix Table 1.2 Covariance matrix of coefficients of ordered probit model

	Score							
e(V)	zVDm_CSP	zlo~DPpc	zlogPop	zPrvPWID	zPrsnPop	zVDm_Ega	zWVS_HsJ	zNet_ODA
Score								
zVDm_CSP	0.1601							
zlogGDPpc	0.1655	0.5668						
zlogPop	0.0264	0.1428	0.2058					
zPrvPWID	0.0297	0.0749	0.0378	0.0647				
zPrsnPop	0.0365	-0.0321	-0.0097	-0.0140	0.0900			
zVDm_Ega	-0.1690	-0.2819	0.0090	-0.0534	-0.0252	0.3356		
zWVS_HsJ	-0.0778	-0.0993	-0.0422	0.0117	-0.0543	0.0624	0.2578	
zNet_ODA	0.2089	0.7775	0.3026	0.1308	-0.0233	-0.4798	0.0626	2.6223

Appendix Table 1.3 Correlation matrix of coefficients of ordered probit model

	Score							
e(V)	zVDm_CSP	zlo~DPpc	zlogPop	zPrvPWID	zPrsnPop	zVDm_Ega	zWVS_HsJ	zNet_ODA
Score								
zVDm_CSP	1.0000							
zlogGDPpc	0.5496	1.0000						
zlogPop	0.1456	0.4180	1.0000					
zPrvPWID	0.2916	0.3911	0.3271	1.0000				
zPrsnPop	0.3040	-0.1422	-0.0709	-0.1829	1.0000			
zVDm_Ega	-0.7292	-0.6464	0.0341	-0.3621	-0.1452	1.0000		
zWVS_HsJ	-0.3829	-0.2599	-0.1833	0.0907	-0.3564	0.2120	1.0000	
zNet_ODA	0.3225	0.6378	0.4119	0.3175	-0.0480	-0.5114	0.0762	1.0000

APPENDIX 2. EXPLORATORY MULTIPLE REGRESSION ANALYSIS

Data were collected from numerous sources, primarily compiled by the UNODC, the UN Development Program (UNDP), the Quality of Government (QOG) Standard Dataset 2019, and the World Values Survey (WVS). One ordered probit analysis and several ordinary least squares (OLS) regressions were run between numberous variables and harm reduction scores. In the first table, regressions were run while controlling for logarithm of the country's population. In all others, the regressions were run when controlling for logarithm of per capita GDP and logarithm of total population. For each regression, the first row shows the coefficient of the primary variable, next the standard error in parentheses, and the finally the r-squared, or Stata's "pseudo r-squared" for the probit regressions. One asterisk indicates $p < .1$, two if $p < .05$, and three if $p < .01$. Regressions were run regionally according to standards set by the World Bank: Europe and Central Asia (ECA), Sub-Saharan Africa (SSA), East Asia and Pacific (EAP), and then the Middle East and North Africa together with South Asia (MENA SA) because of similarities in results and because neither region was large enough on its own for statistical significance. Latin America and the Caribbean is left out of the tables, because levels of IDU are quite low in the region (Stone and Shirley-Beavan 2018), and few variables correlated with harm reduction there. It is still included in global analysis, along with North America.

As seen in the table below, the variable that correlated most strongly with harm reduction was the UNDP's Human Development Index. Its four component parts follow it. Globally, the more wealth a country has, the more harm reduction services it provides. This relationship appears to be very strong, but regional analysis casts doubt on this, with the significance of several variables dwindling. So that we do not find the difference between wealthy and poor countries, or the difference between Europe (where harm reduction is strongest) and the rest of the world, it is important to examine regional correlations in order to find the difference between societies that do and do not accept harm reduction programs.

Appendix Table 2.1 Wealth

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
logGDPpc	0.8835***	1.5699***	0.7732*	1.2211***	0.7455	-0.611
	(0.1450)	(0.2355)	(0.4488)	(0.4364)	(0.6208)	(0.5915)
	0.0666	0.2153	0.0606	0.1872	0.0545	0.0394
logPopulation	0.2736**	0.4470**	0.204	-0.0651	0.7299***	0.5677
	(0.1065)	(0.2011)	(0.3958)	(0.3135)	(0.2350)	(0.4003)
	0.0117	0.0294	0.0057	0.0012	0.2784	0.0718
HDI	5.2105***	8.1436***	5.7175*	8.1713***	2.4475	1.0119
	(0.6736)	(0.9148)	(2.9248)	(2.0164)	(2.5844)	(2.7680)
	0.1251	0.3511	0.0836	0.333	0.2974	0.0767
Life Expectancy at birth	0.0973***	0.1570***	0.1590***	0.1198***	0.0592	0.0821
	(0.0135)	(0.0190)	(0.0519)	(0.0400)	(0.0570)	(0.0757)
	0.1092	0.3183	0.1775	0.2094	0.3027	0.1135
Expected years of school	0.2487***	0.4065***	0.1645	0.2299*	0.2528**	0.127
	(0.0334)	(0.0476)	(0.1082)	(0.1142)	(0.1051)	(0.1327)
	0.1152	0.3337	0.0543	0.1103	0.4167	0.1046
Mean years of school	0.2479***	0.3999***	0.304	0.2605***	0.09	0.0518
	(0.0324)	(0.0442)	(0.1876)	(0.0890)	(0.1195)	(0.1277)
	0.122	0.3581	0.0606	0.2068	0.2875	0.0779
GNI per capita	2.45E-5***	4.28E-5***	3.07E-5**	1.67E-4***	9.96E-7	-1.1E-5
	(4.59E-6)	(7.99E-6)	(1.36E-05)	(3.71E-5)	(1.47E-5)	(1.36E-5)
	0.0616	.1775	.1062	.3801	.2701	.0963
Secondary Enrollment	0.0259***	0.0430***	0.0162	0.0295**	0.0374**	0.0034
	(0.0037)	(0.0053)	(0.0133)	(0.0116)	(0.0149)	(0.0185)
	0.1116	0.3296	0.0398	0.212	0.414	0.0951
Inequ-adj edu index	3.6901***	6.1195***	3.1374	4.5432***	2.089	1.3519
	(0.4740)	(0.6481)	(2.4595)	(1.6049)	(2.4357)	(2.1013)
	0.1239	0.3827	0.0404	0.2215	0.2071	0.0633
Inequ-adj Life Expect	4.5354***	7.1939***	7.6772***	6.7869***	2.3672	2.2944
	(0.5959)	(0.8147)	(2.3817)	(1.8620)	(2.6364)	(3.0969)
	0.1184	0.343	0.1923	0.2819	0.271	0.0917

There is some evidence to support that harm reduction correlates with the magnitude of the problem, measured by the number of PWID and the HIV rate among them. But analysis here is limited by the lack of longitudinal data; countries like the Netherlands that have successful used harm reduction

programs to mitigate these problems are reducing the strength of this correlation. If the harm reduction score is taken to represent the quality of the government response to drugs as an individual health problem, the lack of correlation with volume of heroin seized hints that this is not an appropriate measure of the magnitude of a society's drug problem.

Measures of drug prohibition approach offer somewhat contradictory lessons. The negative correlation between incarceration rate and harm reduction supports the idea that states are choosing between criminalization and healthcare for drug users. But the positive correlation between harm reduction and high numbers of police shows that these programs can coexist alongside a prohibitionist approach. Police are often seen as the "foot soldiers of the drug war," a major barrier to harm reduction (Castillo 2018). Additionally, some have argued that the UNODC was largely uninterested in harm reduction because it was funded by countries hostile to it (Transnational Institute 2005). Of course, countries may not preach what they practice, but this does not appear true based on this data, except in East Asia and the Pacific (EAP). Japan, South Korea, and Singapore, with their scores of zero, contribute generously to the UNODC's general purpose fund.

Appendix Table 2.2 Measures of the drug problem

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
Prevalence PWID	0.4480*	0.7685*	-0.5418	1.0636	3.5202	1.4089
	(0.2368)	(0.3973)	(0.5073)	(1.1350)	(2.6352)	(3.1551)
	0.0879	0.2836	0.0803	0.512	0.2908	0.1012
HIV rate PWID	0.0062	0.0108	0.0137	0.0378*	0.0015	-0.0209
	(0.0074)	(0.0134)	(0.0181)	(0.0204)	(0.0602)	(0.0208)
	0.0476	0.159	0.0682	0.5382	0.0949	0.1022
HCV rate PWID	0.008	0.0152*	0.009	0.0222	-0.002	-0.0105
	(0.0051)	(0.0085)	(0.0123)	(0.0170)	(0.0803)	(0.0215)
	0.0389	0.1352	0.0773	0.5547	0.3667	0.0939
Adult HIV prevalence	-0.0376	-0.0519	-0.0825	0.019	0.4417	-0.2383
	(0.0300)	(0.0413)	(0.9910)	(0.0279)	(2.1153)	(1.8173)
	0.0974	0.2873	0.1058	0.2326	0.0752	0.2873
Ethnic Fraction	0.0147	-0.3164	2.5225*	0.2417	1.1289	-1.2295
	(0.4000)	(0.6523)	(1.4774)	(1.1260)	(1.3671)	(1.4927)
	0.093	0.2724	0.1266	0.243	0.3211	0.1233
log of Total Police	0.0915	0.1397	1.7368**	1.9805	-2.0441	-2.6596
	(0.2920)	(0.5300)	(0.6809)	(1.0863)	(2.3026)	(4.5440)
	0.093	0.2749	0.2673	0.499	0.264	0.148
log kg Heroin 2016	0.0867	0.1418	-0.0856	0.2969	0.4355	0.0849
	(0.0672)	(0.1258)	(0.1433)	(0.5947)	(0.5272)	(0.2759)
	0.0381	0.1415	0.1303	0.485	0.1743	0.081
Prison Pop	-0.0014*	-0.0024*	-0.0102***	0.0006	0.0044	0.0041
	(0.0008)	(0.0013)	(0.0022)	(0.0022)	(0.0030)	(0.0041)
	0.1055	0.3026	0.3871	0.2213	0.3484	0.1232
log UNODC Gen Purpose	-0.0333	-0.0614	0.2792**		-0.5601***	0.0864
	(0.0617)	(0.1086)	(0.1378)	(0)	(0.1637)	(0.2585)
	0.0928	0.2712	0.1458	0	0.5367	0.081
log UNODC Total Contribution	0.0235	0.058	0.2544**		-0.0832	0.1499
	(0.0501)	(0.0848)	(0.1246)	(0)	(0.1829)	(0.2234)
	0.0927	0.2719	0.1469	0	0.3072	0.0937

Harm reduction is indeed correlated with health, with especially strong correlations with the health expenditure, which can be read as measuring the government's commitment to health. That the dependency ratio also correlates well is understood as reflecting both the age pyramid of more developed countries that have harm reduction and also that longevity is provided by good healthcare. EAP again belied expectations by showing negative correlation between hospital beds and harm reduction, demonstrating stronger healthcare in more prohibitionist states. Overall, health seems important, but the correlations are not terribly strong, beyond the percent of GDP spent on health.

Strong correlations worldwide with gender was a surprise. Both gender outcomes and attitudes seem to reflect on a country's interest in harm reduction. But strangely these results were not seen much in regional analysis, suggesting that part of the results might be coming from harm reduction being stronger

and patriarchal norms being weaker in ECA compared to the rest of the world. The clear exception to this is the strong correlation with the percent of women 15 years and older with an account at a financial institution or with mobile money-service provider. This suggests female independence is associated with harm reduction. That general violence against women correlated while intimate partner violence suggests that the connection is not so much about gendered roles in relationships so much as the safety of women in general.

Appendix Table 2.3 Measures of health

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
log Health Expend	2.1228***	3.4502***	6.5692***	0.6875	1.3717	5.5096***
	(0.5391)	(0.7941)	(2.0582)	(1.3313)	(1.3328)	(1.6996)
	0.1214	0.3494	0.2416	0.2258	0.3164	0.3791
Physicians per 10,000	0.0521***	0.0860***	0.0152	0.1742**	0.0693	0.0567
	(0.0093)	(0.0135)	(0.0275)	(0.0648)	(0.0569)	(0.0413)
	0.1538	0.426	0.0725	0.3631	0.3288	0.1441
Hospital Beds per 10,000	0.0092**	0.0178**	-0.0066	-0.0323	-0.0273**	0.0245
	(0.0041)	(0.0073)	(0.0127)	(0.0300)	(0.0117)	(0.0369)
	0.0977	0.283	0.0718	0.2582	0.4308	0.0934
Infant mortality rate	-0.0228***	-0.0385***	-0.0730*	-0.0260**	-0.0373	-0.0175
	(0.0080)	(0.0121)	(0.0388)	(0.0127)	(0.0387)	(0.0323)
	0.1079	0.3138	0.1356	0.3103	0.3125	0.0879
M-d Poverty Ind	-6.0139***	-7.7001***	-41.6054	-3.6546*	-3.2984	3.1515
	(1.6097)	(1.9857)	(74.4479)	(1.8082)	(11.3402)	(9.7276)
	0.0817	0.2144	0.3364	0.3108	0.3229	0.2924
Dependency Rate	0.0584***	0.1069***	0.0503*	0.1775***	-0.0527	0.1111**
	(0.0105)	(0.0147)	(0.0296)	(0.0542)	(0.0568)	(0.0394)
	0.1461	0.4493	0.1236	0.4151	0.2858	0.306
IIAG Healthcare Rating	0.0521**	0.0467**		0.0559***		0.2315
	(0.0238)	(0.0190)	(0)	(0.0188)	(0)	(0.1498)
	0.1402	0.2945	0	0.388	0	0.803
F Mortality Non-com	-0.0009	-0.0022	-0.0094**	-0.0021	-0.0018	-0.0055
	(0.0008)	(0.0014)	(0.0035)	(0.0014)	(0.0033)	(0.0035)
	0.0914	0.2749	0.1944	0.2748	0.2659	0.1636
M Mortality Non-com	0.0008	0.0012	-0.0047**	-0.0011	-0.0026	-0.0041
	(0.0006)	(0.0010)	(0.0018)	(0.0016)	(0.0028)	(0.0031)
	0.0925	0.2693	0.1881	0.2312	0.2845	0.1391
Gender Inequ Ind	-6.0311***	-9.0815***	-8.8909**	-4.4855	-1.2534	-3.6269
	(1.0105)	(1.3482)	(3.9451)	(2.8531)	(4.6434)	(3.8397)
	0.1474	0.4183	0.1556	0.275	0.1699	0.0989

Examining the facets of democracy according to V-Dem, harm reduction seems clearly correlated, with egalitarian and participatory principles mattering most across all regions (except, again, in EAP).

"Polyarchy" is V-Dem's measure of electoral democracy, which is taken into account in all four other indices listed here, but not in the components that follow. Whereas the egalitarian component measures the achievement of equal protection of rights and freedoms and equal distribution of resources across all social groups, the participatory component measures "engagement in civil society organizations, direct democracy, and subnational elected bodies" (QOG). As harm reduction programs require that citizens care for those on the margins of society, and they are often implemented starting with grassroots efforts, this makes sense. EAP is a clear outlier here, which is discussed more later.

Appendix Table 2.4 Core V-Dem Indices

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
V-Dem Polyarchy	1.5690***	2.7048***	5.6226***	2.8559**	0.163	4.1227**
	(0.4297)	(0.6783)	(1.2169)	(1.0903)	(2.2480)	(1.5270)
	0.1069	0.3248	0.3711	0.3571	0.1535	0.2918
VD Liberal Dem	1.7905***	3.0347***	5.8141***	3.3085***	0.3086	4.4458**
	(0.4473)	(0.6992)	(1.1139)	(1.0788)	(2.5459)	(1.7426)
	0.1118	0.3364	0.4232	0.3966	0.154	0.2737
VD Participatory Dem	2.1105***	3.7243***	5.8756***	4.1179**	2.0051	5.8897**
	(0.5550)	(0.8789)	(1.4929)	(1.6622)	(2.7218)	(2.1516)
	0.109	0.333	0.3092	0.3449	0.181	0.2964
VD Deliberative Dem	1.6713***	2.7398***	5.5852***	3.2530***	-0.3743	4.4174**
	(0.4408)	(0.7030)	(1.1491)	(1.0321)	(2.4282)	(1.7988)
	0.1088	0.3219	0.3923	0.4043	0.1545	0.2621
VD Egalitarian Dem	2.4263***	4.0127***	6.6379***	3.8092***	0.6164	5.2235**
	(0.5201)	(0.7845)	(1.3639)	(1.2566)	(3.0297)	(2.0766)
	0.1225	0.3637	0.3929	0.3935	0.1555	0.2694

meaning countries have worse harm reduction in places where programs like education and healthcare are designed to benefit everyone.

Appendix Table 2.5 V-Dem egalitarian indices

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
VD Egalitarian Comp	2.8205*** (0.5743) 0.1275	4.2207*** (0.8299) 0.3627	5.8695*** (1.7245) 0.2607	2.8548** (1.0747) 0.3604	0.5987 (3.9852) 0.1545	3.7686** (1.8121) 0.2177
VD Soc group equ civil liberty	0.3676*** (0.0827) 0.1188	0.5850*** (0.1261) 0.3467	1.0591*** (0.2495) 0.3373	0.2445 (0.2010) 0.2538	-0.1958 (0.4964) 0.1614	0.4581* (0.2669) 0.1777
VD Soc class equ civil liberty	0.4452*** (0.1044) 0.1162	0.7086*** (0.1586) 0.3408	1.2981*** (0.3342) 0.3045	0.5574** (0.2311) 0.3394	-0.267 (0.5545) 0.1654	0.5398 (0.3153) 0.1772
VD % pop weak civil liberties	-0.0113* (0.0066) 0.0645	-0.0186* (0.0111) 0.1966	-0.0334** (0.0157) 0.1591	-0.0186 (0.0153) 0.2539	-0.004 (0.0352) 0.1833	-0.0177 (0.0267) 0.1853
VD Power by gender	0.3569*** (0.0962) 0.1079	0.6016*** (0.1485) 0.3269	1.0727*** (0.2808) 0.2986	0.3721 (0.2574) 0.2672	1.1124* (0.5350) 0.3334	0.5009 (0.3232) 0.1607
VD Power by social group	0.4090*** (0.0875) 0.1235	0.6136*** (0.1271) 0.3534	0.8798*** (0.2685) 0.2492	0.3573** (0.1661) 0.3179	0.1234 (0.4061) 0.1581	0.6251** (0.2662) 0.2493
VD Power by class	0.2014** (0.0897) 0.0917	0.3559** (0.1488) 0.2813	0.5029* (0.2769) 0.1312	0.4360** (0.1819) 0.3382	-0.2462 (0.8151) 0.1581	0.2908 (0.3297) 0.1057
VD Partic or public goods	0.2330*** (0.0870) 0.0956	0.3180** (0.1394) 0.2789	0.5846** (0.2529) 0.1672	0.172 (0.1781) 0.2414	-0.9908 (0.6574) 0.2585	0.5601* (0.2924) 0.1992
VD Means-test v. univ policy	0.2194** (0.1039) 0.0907	0.3347** (0.1657) 0.2737	0.5592 (0.3369) 0.1211	0.2149 (0.2054) 0.2451	-1.5410*** (0.5198) 0.4535	0.5501 (0.3955) 0.1456
VD Educational equality	0.3373*** (0.0935) 0.1063	0.5292*** (0.1449) 0.3143	0.4443 (0.2829) 0.1156	0.3796* (0.1895) 0.3063	0.2061 (0.4713) 0.1633	0.0976 (0.4314) 0.0787

The participatory component is comprised of four indices, civil society participation, direct popular vote, elected local government power, and elected regional government power. Only the sub-components for civil society participation were explored further, due to the others' relatively low correlation and less theoretical connection to harm reduction. Among them, CSO consultation seems to matter most. The Bertelsmann Stiftung's Transformation Index (BTI) variable generally reflects the same finding, that the participation of civil society in the political process is important. The Open Budget Index (OBI) variables measure how transparent and accessible the government's budget deliberation process and results are. But as the higher correlation between the two OBI numbers shows, public engagement is not itself more important for harm reduction than a more holistic measure of government accountability. In EAP, Gender seems to matter in both political power and in women's participation in civil society. Direct popular vote also proved important.

Appendix Table 2.6 V-Dem participatory indices

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
VD Participatory Comp	1.8525*** (0.5384) 0.1042	3.2697*** (0.8611) 0.3188	3.7871** (1.4410) 0.1927	1.9916 (1.4329) 0.2638	3.437 (2.4956) 0.243	4.2348** (1.7793) 0.253
VD Civil Society Part	1.6924*** (0.4508) 0.1085	2.7161*** (0.7001) 0.3214	5.6704*** (1.0974) 0.4187	1.8726 (1.2283) 0.2722	2.3192 (2.4345) 0.1987	3.2207** (1.4291) 0.238
VD Direct Popular Vote	1.4460** (0.6868) 0.0905	2.9456** (1.1990) 0.2827	-0.0195 (1.5616) 0.066	1.9007 (3.1423) 0.2281	8.1684** (3.7426) 0.3475	3.9759 (3.4443) 0.1253
VD Elected local gov power	0.6326** (0.2742) 0.1013	1.0993** (0.4443) 0.3097	1.7044** (0.7336) 0.1681	0.1902 (0.6312) 0.2562	0.8073 (1.1752) 0.173	2.7087*** (0.8475) 0.3693
VD Elected region gov power	0.2866 (0.2308) 0.0853	0.5149 (0.4004) 0.2622	0.8206 (0.6511) 0.0986	0.4465 (0.6463) 0.2308	-0.0461 (1.0201) 0.1534	0.146 (1.0827) 0.0774
VD CSO Consult	0.3488*** (0.0844) 0.1139	0.5134*** (0.1303) 0.3233	0.9967*** (0.1974) 0.4087	0.2413 (0.2067) 0.2512	-0.2545 (0.6466) 0.1614	0.7050** (0.2987) 0.2506
VD CSO Part Env	0.2778*** (0.0901) 0.0999	0.4815*** (0.1432) 0.3058	1.0555*** (0.2332) 0.3627	0.1884 (0.2281) 0.2356	0.6225 (0.3979) 0.2656	0.5189 (0.3105) 0.173
VD CSO Women Part	0.4418*** (0.1245) 0.1057	0.7719*** (0.1957) 0.3234	1.0563*** (0.3657) 0.2149	0.7692** (0.3463) 0.3236	1.5863* (0.8325) 0.3099	0.4447 (0.3497) 0.135
BTI Civil Society Partip	0.1586*** (0.0503) 0.0374	0.2572*** (0.0774) 0.1246	0.3572*** (0.0892) 0.5675	0.3590*** (0.1034) 0.4305	0.0676 (0.2550) 0.1513	0.1774 (0.1915) 0.2732
OBI Score	0.0211*** 0.0055 0.1023	0.0326*** 0.00085 0.3128	0.0083 0.0252 0.0275	0.0233** 0.0092 0.3842	-0.0042 0.0349 0.0829	0.0261 0.0241 0.2844
OBI Public Engage	0.0149 (0.0094) 0.0686	0.0301* (0.0169) 0.2357	0.0257 (0.0252) 0.0621	0.0347 (0.0290) 0.2633	0.0143 (0.0458) 0.0904	0.0715 (0.0753) 0.2696

Appendix Table 2.7 Cultural values 1

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
WVS Addict Neighbor	-0.0032	-0.0008	-0.0962	0.0335	-0.0841	-0.1137
	(0.0135)	(0.0274)	(0.0563)	(0.0323)	(0.1384)	(0.0804)
	0.0264	0.0926	0.1697	0.9742	0.1627	0.379
WVS Neighbor w AIDS	-0.0007	-0.0027	-0.0711***	0.0148	-0.0239	-0.018
	(0.0057)	(0.0112)	(0.0231)	(0.0228)	(0.0334)	(0.0374)
	0.0228	0.0945	0.4299	0.9624	0.1357	0.245
WVS Sex Work	-0.1592	-0.2509	0.9901*	-0.1534	0.1836	
	(0.2047)	(0.3734)	(0.5450)	(0.7622)	(1.1299)	(0)
	0.0394	0.1505	0.2453	0.9486	0.1833	0
WVS Homosexuality Just	0.1443	0.3026	0.8195***	-0.0848	0.4645	0.8645
	(0.1058)	(0.2027)	(0.2588)	(0.7684)	(0.6368)	(1.1493)
	0.0316	0.1314	0.4433	0.9472	0.1384	0.2784
WVS Importance God	-0.2866***	-0.5076***	-0.6121**	-0.1649	-0.282	-1.1708*
	(0.0960)	(0.1626)	(0.2659)	(0.2853)	(0.5297)	(0.5767)
	0.0857	0.2952	0.3135	0.9599	0.2323	0.5129
WVS Importance Religion	-0.7893***	-1.3758***	-1.3062	-0.4506	-0.8321	-3.4019**
	(0.2718)	(0.4653)	(0.8651)	(0.7905)	(1.9267)	(1.4525)
	0.0778	0.2639	0.1936	0.9596	0.2145	0.5143
WVS Religion v Science	-0.7406***	-1.3767***	-1.0255	0.4591	0.1	-3.7889***
	(0.2733)	(0.4652)	(1.1706)	(1.9668)	(2.6650)	(0.9202)
	0.0727	0.2641	0.1162	0.9493	0.1782	0.7289
WVS Surviv / Self-exp Ind	0.309	0.7683	1.9853*	0.9117	0.4554	0.807
	(0.3655)	(0.6817)	(1.0605)	(2.8663)	(1.3445)	(2.8786)
	0.0615	0.2225	0.2354	0.9514	0.6374	0.2347
WVS Tradition / Ration Ind	1.0882***	1.8983***	2.3186**	-0.054	-1.9715	3.4713
	(0.3773)	(0.6237)	(0.9905)	(1.1132)	(2.0922)	(1.9161)
	0.1023	0.3371	0.3172	0.9467	0.7095	0.4731
WVS Choice	2.8829**	5.6060**	8.0705**	-1.0504	4.7822	12.5894
	(1.2812)	(2.2243)	(2.9678)	(7.2725)	(7.1088)	(8.4689)
	0.0684	0.2143	0.4398	0.9476	0.2615	0.3838
WVS Autonomy	5.1433***	8.6921***	-0.1734	0.8861	4.0254	14.8757**
	(1.8439)	(3.1222)	(5.7667)	(4.1611)	(18.1509)	(4.8318)
	0.0552	0.2331	0.1212	0.9488	0.1879	0.6192

The first two variables are the percent of people who, when faced with the question, "On this list are various groups of people. Could you please mention any that you would not like to have as neighbors?" selected "drug addicts" and "people with AIDS." The next variable is a 1-10 response to "Please tell me for each of the following statements whether you think it can always be justified, never be justified, or something in between, using this card" as participants were asked about homosexuality. The derogatory term "addict" probably contributed to the former's lack of correlation anywhere. It is interesting that stigmatization against AIDS only mattered in Europe and Central Asia (ECA), but it correlated quite significantly there, along with a larger percent of people believing that homosexuality was "justifiable." Similarly, sex work being seeing as justifiable correlated significantly there. Religiosity proved especially important in MENA SA.

The next variable is the percent of people who responded "*disagree*" to the statement "Men have more right to a job than women" when jobs are scarce. The next variables are responses to "How important is God in your life," rated 1-10, and "Whenever science and religion conflict, religion is always right," rated 1-4. These variables had particularly high correlation in MENA SA.

The next four variables are indices. The "traditional values versus secular-rational values" and "survival values versus self-expression values" are composite variables based on responses to other WVS questions. Whereas traditional values emphasize religion, parent-child ties, deference to authority, and national pride, secular-rational values reflect the opposite, and see divorce, abortion, euthanasia and suicide as more acceptable. Survival values emphasize economic and physical security, while self-expression values emphasize environmental protection, democratic participation, gender equality, and tolerance of foreigners and queer people (World Values Survey 2019). They highlight differences between countries according to the Inglehart-Welzel Cultural Map, grouping them into African-Islamic, Latin-American, South Asia, Confucian, Baltic, Orthodox, Protestant Europe, Catholic Europe, and English-Speaking. The Choice index is a composite based on responses to questions related to homosexuality, abortion, and divorce acceptability. The Autonomy index is a composite of responses to: "Here is a list of qualities that children can be encouraged to learn at home. Which, if any, do you consider to be especially important? Please choose up to five" and respondents tended to choose 'independence' and 'determination / perseverance,' and not to choose 'obedience' or 'religious faith.' Next, there are the separated individual percent of respondents who chose 'imagination,' 'self-expression,' 'thrift: saving money and things,' and 'tolerance and respect for other people.'

The Choice index is a composite based on responses to questions related to homosexuality, abortion, and divorce acceptability. The Autonomy index is a composite of responses to: "Here is a list of qualities that children can be encouraged to learn at home. Which, if any, do you consider to be especially important? Please choose up to five" and respondents tended to choose 'independence' and

‘determination / perseverance,’ and not to choose ‘obedience’ or ‘religious faith.’ The choice index significantly correlated in ECA, while the autonomy index significantly correlated in MENA SA.

Propensity to be more civically active did not matter much, except in ECA. There, membership in mutual aid and political parties did not correlate, but propensity to demonstrate and petition the government did. Worldwide, the correlations for independence, imagination, and self-expression were surprising. By contrast, the values that proved significant in EAP.

Appendix Table 2.8 Cultural Values 2

	All Pb	All OLS	ECA	SSA	EAP	MENA SA
WVS Memb Mutual Aid	-0.0069	-0.0046	0.1818	0.0089	0.0331	0.1033
	(0.0136)	(0.0274)	(0.1111)	(0.0243)	(0.0630)	(0.0977)
	0.024	0.094	0.2116	0.9529	0.1034	0.1034
WVS Memb Political Party	-0.0094	-0.012	0.1041	-0.1396	-0.0275	0.1261
	(0.0098)	(0.0179)	(0.0906)	(0.1289)	(0.0316)	(0.0743)
	0.0368	0.1366	0.1462	0.9754	0.1673	0.1673
WVS Joined Demonstrate	-0.003	0.0021	0.0783**	-0.0171	0.0081	-0.0336
	(0.0099)	(0.0186)	(0.0361)	(0.0531)	(0.0545)	(0.0606)
	0.0447	0.1723	0.3028	0.9516	0.2477	0.2477
WVS Signed Petition	0.0057	0.0144	0.0535*	0.0035	0.0309	0.0126
	(0.0067)	(0.0129)	(0.0300)	(0.0282)	(0.0268)	(0.0623)
	0.0262	0.115	0.2332	0.9473	0.2321	0.2321
WVS Child Quality: Indep	0.0205**	0.0396**	0.0217	-0.0286	-0.0337	0.0639
	(0.0101)	(0.0195)	(0.0312)	(0.0470)	(0.0803)	(0.0499)
	0.0423	0.1615	0.1001	0.961	0.0887	0.3681
WVS CQ: Tolerance	0.0165	0.0331	-0.0314	-0.019	0.1283**	-0.0392
	(0.0129)	(0.0251)	(0.0522)	(0.0578)	(0.0387)	(0.0448)
	0.0306	0.1235	0.093	0.9517	0.6685	0.2969
WVS CQ: Imagination	0.0314**	0.0641**	0.0375	0.0165	0.1779*	0.1949**
	(0.0144)	(0.0273)	(0.0577)	(0.0269)	(0.0802)	(0.0656)
	0.0453	0.1818	0.0965	0.9612	0.4844	0.6548
WVS CQ: Obedience	-0.013	-0.0236	0.0078	-0.0098	0.0371	-0.0559
	(0.0083)	(0.0165)	(0.0349)	(0.0318)	(0.0892)	(0.0322)
	0.0342	0.1286	0.0741	0.9512	0.0884	0.4546
WVS CQ: Expression	0.0244**	0.0451**	-0.0427	-0.0326	0.1141	0.1007**
	(0.0106)	(0.0203)	(0.0324)	(0.0595)	(0.0851)	(0.0379)
	0.0479	0.1734	0.1677	0.9589	0.2782	0.6121
WVS CQ: Faith	-0.0142**	-0.0255**	-0.0264	-0.0085	-0.0355	-0.057
	(0.0064)	(0.0120)	(0.0286)	(0.0260)	(0.0476)	(0.0394)
	0.0462	0.1674	0.1211	0.9517	0.1415	0.3993

APPENDIX 3. LIST OF INTERVIEW SUBJECTS

Reychad Abdool, MD, former Senior Regional HIV Adviser in Africa

Timothy Abuya, Associate I of the Reproductive Health Program, Population Council

Calleb Angira, Director, Nairobi Outreach Services Trust (NOSET)

Bernice Apondi, Policy Manager, Voices of Community Action and Leadership-Kenya (VOCAL-Kenya)

Sylvia Ayon, Program Manager, Key Populations and Field Operations at Kenya AIDS NGOs Consortium (KANCO)

Abdalla Badhrus, Program Manager, Community Harm Reduction Program, Muslim Education and Welfare Association (MEWA)

Blaise Chamango, Director, Human IS Right

Mlewa Kalama, Director of Programs, Kenya AIDS NGOs Consortium (KANCO)

Morris Kamenderi, Principle Research Officer, Research and Policy Development, National Campaign Against Drug Abuse (NACADA)

John Kimani, Director, Kenya Network of Persons Using Drugs (KeNPUD)

Mbianke Livancliff, Coordinator of Health Programs, Disease Prevention and Control, Value Health Africa-Cameroon

John Muteti, Director, Research and Policy Development, National Campaign Against Drug Abuse (NACADA)

Ndeme Bebegue Mélanie, Founder, Cameroon Association for the Harm Reduction Related to Drug Use among Young People (ACRDR)

Ndi Ndukong Titus, Founder, Empower Cameroon

Leontine Sinda, MD, Founder, Saint Leonard Health and Research Foundation