# Regional Overview
## Middle East and North Africa


### AVAILABILITY OF NEEDLE AND SYRINGE EXCHANGE PROGRAMMES AND OPIOID SUBSTITUTION THERAPY

- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known

# HARM REDUCTION IN MIDDLE EAST AND NORTH AFRICA

| Country/territory with reported injecting drug use | People who inject drugs[b 1] | Adult HIV prevalence amongst people who inject drugs[2] | Adult HCV prevalence amongst people who inject drugs[3] | Harm reduction response | | |
|---|---|---|---|---|---|---|
| | | | | NSP | OST | HIV and HCV programmes targeted towards people who inject drugs[a] |
| Algeria | 40,961 | nk | nk | X | X | Limited targeted HIV prevention |
| Bahrain | 674 | nk | 81%[4] | X | X | X |
| Egypt | 88,618 | 0.6%[b,5] | nk | ✓ | X | X |
| Iran | 240,000[6] | 12%[6] | 35%[6] | ✓ | ✓ | Targeted VCT, condom distribution, limited IEC and STI prevention, 125 people who inject drugs are receiving ART [7] |
| Iraq | 34,673 | 0 | nk | X | X | X |
| Israel | 9,000[2] | 1–3%[8] | 54% | ✓ | ✓ | Targeted HIV programmes exist. 12% of the total ART recipients are people who inject drugs[9] |
| Jordan | 4,850 | 4.2%[c] | nk | X | X | X |
| Kuwait | 4,100 | 0 | nk | X | X | X |
| Lebanon | 3,300 | 7.8% | 5%[d] | ✓ | ✓ | Limited targeted HIV prevention |
| Libya | 7,206 | 0.5–59.4% | nk | X | X | X |
| Morocco | 18,500 | nk | nk | ✓ | X | Limited targeted HIV prevention |
| Oman | 500–1,000[10] | 14%[10] | 31.1%[10] | ✓ | X | Limited targeted HIV prevention |
| Palestine | 1,850 | nk | nk | ✓ | X | X |
| Qatar | 1,190 | nk | nk | X | X | X |
| Saudi Arabia | 23,600 | nk | 69%[4] | X | X | X |
| Syria | 6,000 | 0.3%[c] | 60.5% | X | X | X |
| Tunisia | 13,163 | 0.3%[c] | nk | X | X | X |
| UAE | 4,800 | nk | nk | X | X | X |
| Yemen | 19,700 | nk | nk | X | X | X |

nk = not known

a These services include, amongst others, voluntary HIV testing and counselling; HIV prevention, treatment and care; hepatitis C testing and treatment; STI prevention and treatment; information, education and communication.
b Among males who inject drugs.
c Figure previous to 1998.
d Non-national estimate – capital city.

Over 309 million people live in the Middle East and North Africa,[11] a region comprising eighteen countries and the Occupied Palestinian Territories (hereafter referred to as Palestine). Economically it is a very diverse region, ranging from wealthier nations such as Israel, United Arab Emirates (UAE) and Saudi Arabia, to poorer nations such as Yemen.[12] A number of countries are currently or have recently been affected by conflict, and the region remains politically important largely due to the export of oil and oil-related products. The majority of the region's population follows Islam, and the most widespread languages are Arabic (varying in dialect across different countries) and French (in North Africa).

# DRUGS IN THE REGION

## Cultivation, production and transhipment

Morocco is the world's foremost producer of cannabis resin and remains the main source of the drug for the consumer market in Western Europe.[13] Khat, an amphetamine-like stimulant, is cultivated in Yemen predominantly for domestic use, which is widespread. There are recent reports of impoverished farmers in southern Iraq beginning to cultivate opium poppy fields.[14]

Many Middle Eastern and North African countries form part of the opiate trafficking routes originating in Afghanistan, the world's foremost opiate-producing country. Political instability in conflict-affected countries, strong black-market trade routes and easy access by air, land and sea are all factors which increase the ease of drug transhipment in the region. Iran is the country most affected by drug smuggling as it provides a corridor into the Middle East and North Africa, Central Asia or Western Europe. Iran sees 68% of the world's opium seizures.[13] To a lesser extent, Oman and UAE are beginning to experience more drug smuggling, with heroin destined for Europe and North America via East and West Africa.[15]

## Drug use

Information on drug use is limited as surveillance of this kind is not established in many countries. Reported alcohol consumption rates across the region suggest very low usage,[16] with zero official consumption in three countries (Kuwait, Libya and Saudi Arabia), and per capita consumption below one litre of pure alcohol per year for all but five of the others. The exceptions are Bahrain (2.63 litres), Israel (1.99), Lebanon (4.13), Oman (1.32) and UAE (2.75). Data were unavailable for Palestine.

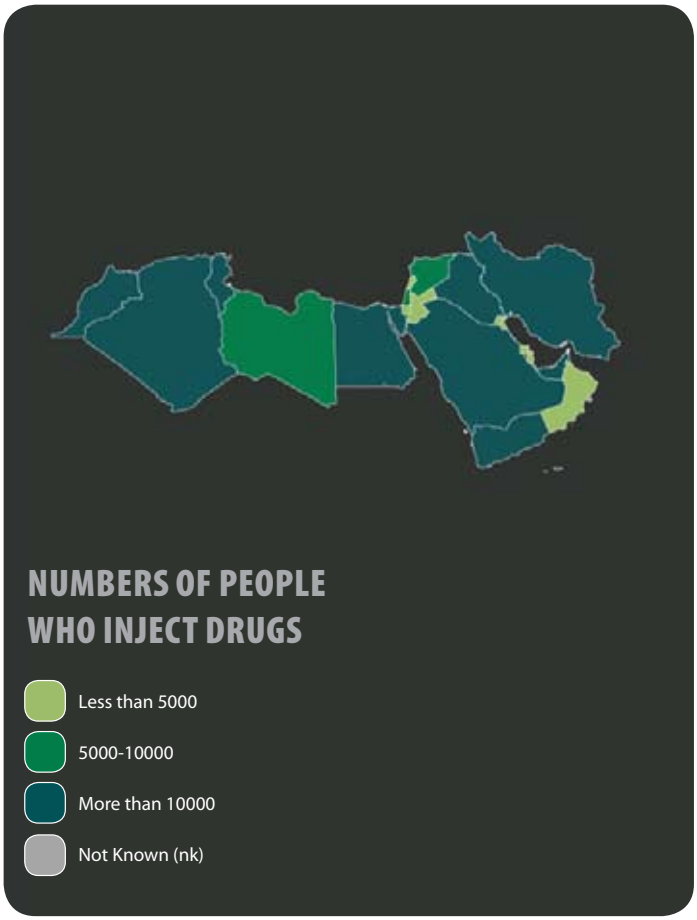
These low consumptions rates may be due to the majority Muslim populations, high levels of self-reported abstainers across the region and the common policy responses such as bans on alcohol consumption for Muslim residents or total prohibition with severe penalties (in Iran, for example, death sentences have been imposed).[17] However, the figures may also reflect under-reporting due in part to the stigma associated with alcohol use in the region.[18]

Cannabis or hashish smoking is reported to be the most prevalent drug use in the region. The use of Khat is highly prevalent in Yemen, and to a lesser extent in other countries of the Arabian Peninsula.[19] Cocaine use is reportedly increasing in Morocco, but as yet cocaine injecting is not reported. In Israel, the use of cocaine, LSD, amphetamine and tranquilisers is reported.[13] Opiate use is reported in many countries, and is prevalent in Iran, where over 1.2 million people smoke, inject or ingest opiates.[13] Non-injecting drug use has not been highlighted as linked to the transmission of either HIV or HCV in Middle Eastern and North African countries.

### *Opiates*

There has been a considerable increase in the number of people who use opiates in recent years, best documented in Iran, where opium smoking has historical and traditional roots dating back to Ancient Persia. The fall of the Taliban in neighbouring Afghanistan, and the political instability that followed, allowed for a rise in opiate production. As a result, Iran has seen an increase in the availability of both opium and heroin. Over 1.2 million people (2.8% of the population) are reported to use opiates in the country.[13]

In Iran and surrounding countries, opium smoking is considered medicinal by many people, and where public health systems have been disrupted by war and conflict it provides an easily attainable remedy for illness. Heroin is also easily available in many countries.




Map 8.2: Numbers of people who inject drugs in the Middle East and North Africa

### *Injecting drug use*

The country in the region with the highest number of people who inject drugs is Iran, where the latest estimate places the number of injecting drug users at 185,000.[1] However, a national research centre has suggested this figure to be low, and estimates there to be approximately 240,000 people injecting, based on averaging data from multiple sources.[6] After Iran, the countries in the region with the largest numbers of people injecting drugs are Egypt (88,618), Algeria (40,961) and Iraq (34,673).[1]

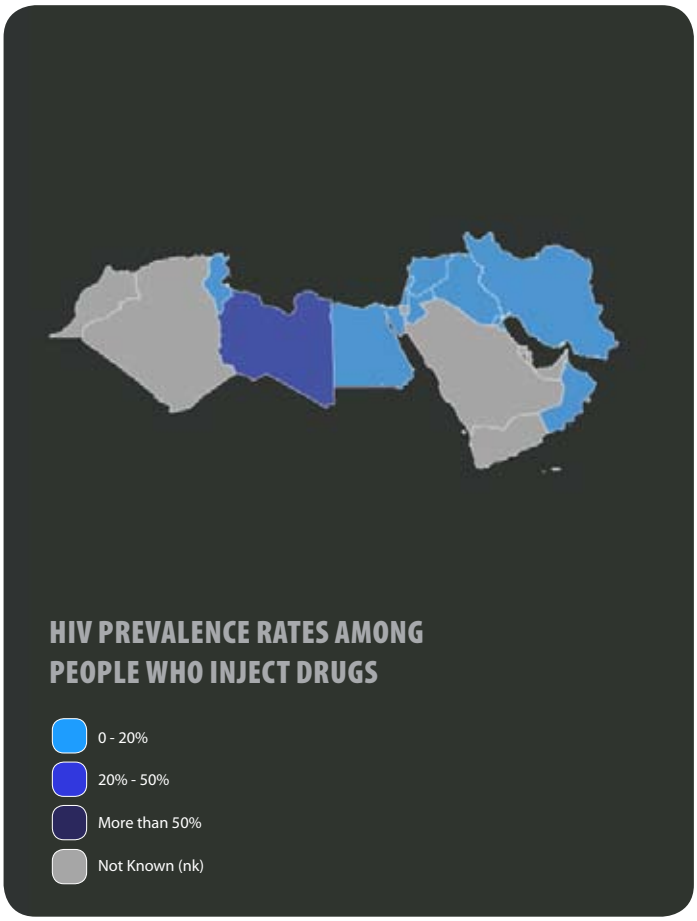
The overwhelming majority of Iranians who inject drugs are males living in urban areas and more than half are above thirty years of age.[20] Similarly, in Oman, it is reported that over 90% of people who

inject drugs are male. Disaggregated information is not available in any other countries in the region.

Heroin is the most commonly injected drug in every country in the region, although it is not the only substance injected. In Iran, for example, there are also reports of buprenorphine, opium and benzodiazepines being injected, although these are much rarer than heroin injecting. In Oman, there are rare cases of barbiturates being injected. In Palestine, tranquilisers are sometimes injected. In Qatar and UAE, the injection of heroin and other opiates is reported. In Syria, diazepam is an injected drug.[10]

Injecting drug use is increasing in several countries. For example, sources in Kuwait identified a huge rise in both injecting and other drug use following the Iraq war.10 In Iraq itself, the status of injecting drug use is unclear as political instability and conflict have severely disrupted the health care system and surveillance mechanisms. Several factors in the country could contribute to an increase in drug use, including weaker border controls, potentially allowing more drugs to enter from neighbouring countries, as well as the beginnings of opium poppy cultivation in some areas.[14] Injecting drug use is also increasing in Bahrain, Egypt, Iran, Syria and Yemen.

Conflicting reports make it difficult to establish whether injecting drug use is increasing or decreasing in Saudi Arabia. The only countries where decreases in injecting drug use are reported are Lebanon and Morocco.[10]




Map 8.3: HIV prevalence among people who inject drugs in the Middle East and North Africa

## Drug-related harms

### *HIV and AIDS*

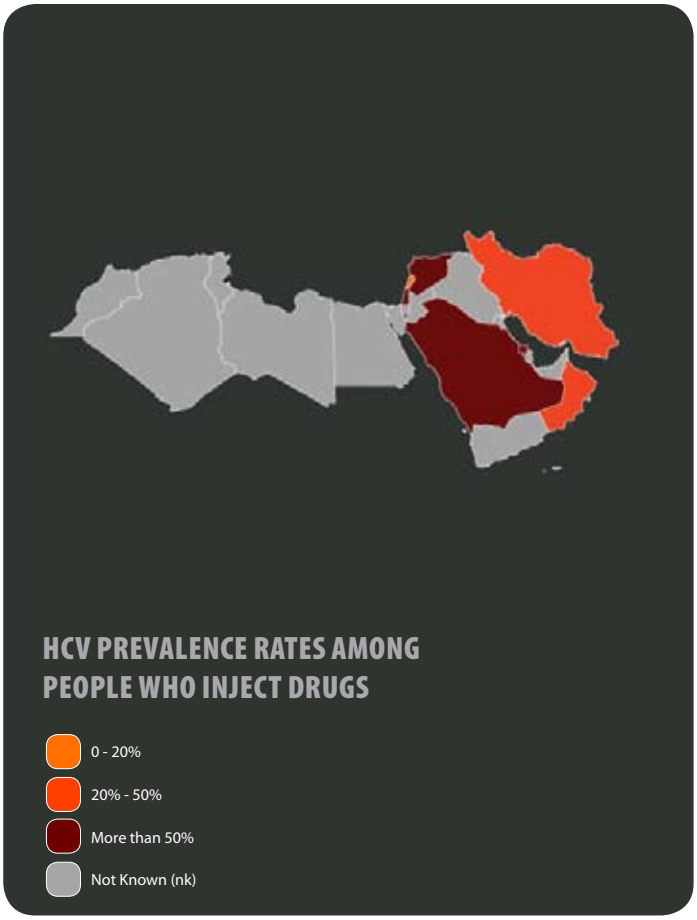
HIV and AIDS surveillance in the Middle East and North Africa is very limited. UNAIDS data show that HIV prevalence remains low; in 2006, the number of people living with HIV in this region was estimated to be 61,900.[21] Men who have sex with men and people who inject drugs, both highly criminalised populations in this region, are more affected by the epidemic. Injecting drug use is a significant route of HIV transmission in Iran and Libya, and has contributed to HIV epidemics in Algeria, Israel, Morocco, Syria and Tunisia.[22]

HIV prevalence rates among people who inject drugs are not available in six countries in the region, and those that are available are, in most cases, not very recent. Low HIV prevalence is reported among people who inject in Iraq (0%)[2] and Egypt (0.6% among males).[5] Higher prevalence is found in Iran (12%)[6] and Libya (up to 59.4%).[2]

Further insight into the extent to which HIV affects people who inject drugs can be gained from HIV case reporting. In Libya, for example, over 90% of HIV cases are attributable to injecting drug use. In Bahrain, this figure is reported to be 73%.[23] In Tunisia, 34% of reported HIV cases are attributed to injecting drug use.[24] This figure is lower in Algeria (18.4%),[24] Israel (16%),[25] Lebanon (8.5%)[26] and Morocco (5%).[4] Although the Egyptian National AIDS Program reports consistently low HIV prevalence rates, injecting drug use is a significant risk factor and is the mode of HIV transmission in 6% of cases.[27]

Across the region, injectors most affected by HIV are men who live in urban areas. In Palestine, those who return after travelling to other Arab and Western countries are reported to be more affected by HIV. Although HIV prevalence among people who inject drugs remains low in this region, several studies have found the sharing of injecting equipment to be common, for example in Algeria,[28] Lebanon[29] and Morocco.[30]

The paucity of information on injecting drug use and HIV in some countries could be attributed to low levels of HIV transmission among somewhat small numbers of people who inject drugs. However, government reluctance to commission research or publicise information on these two highly stigmatised issues may equally be masking the true extent to which people who inject drugs are affected by HIV.[10]




Map 8.4: HCV prevalence among people who inject drugs in the Middle East and North Africa

### *Hepatitis C virus (HCV)*

According to the WHO in 1999, national HCV prevalence was low in much of the region. Algeria, Iraq, Israel, Oman, Tunisia and UAE all had low HCV prevalence (less than 1%), while Jordan, Kuwait, Qatar, Saudi Arabia and Yemen had slightly higher HCV levels (between 1% and 4%). Egypt had the highest reported national HCV prevalence, regionally and globally, at 18.1%.[31]

Information on HCV prevalence among people who inject drugs is not available for most countries in the region,* but, where reported, the data reveal high levels of HCV. In particular, very high HCV prevalence is reported among people who inject in Bahrain (80%),[4] and high HCV levels are also reported in Iran (35%).[10]

Iranian research indicates that certain characteristics and behaviours are correlated with a positive HCV test, including being an older person who has been injecting for a number of years, having a history of imprisonment and men who report having had sex with other men.[32,33] Most HCV cases have been reported in large cities, in particular Iran's capital city Tehran.

* Algeria, Egypt, Iraq, Jordan, Kuwait, Libya, Morocco, Palestine, Qatar, Tunisia, UAE and Yemen.

## Drug use and its related harms in prisons

Iran, where there are estimated to be over 150,000 people incarcerated in 200 prisons (excluding juvenile facilities),[34] has the highest prison population in the region.[10] The country with the highest recorded imprisonment rate is UAE, and Iraq is reported to have the highest number of prison facilities (over 1,000).[34]

Drug-related crimes are reported to represent three-quarters of all crimes committed in Israel.[13] Libya is the only country for which there is an available estimate of the number of prisoners with a history of injecting drug use (approximately 60%).[35] However, as is the case in other regions where drug-related offences receive severe penalties, it is likely that a large proportion of prisoners are serving sentences for drug use as well as other drug-related offences.

Nine countries in the region impose the death penalty for drug-related offences. Executions for drug offences have taken place in Egypt, Iran, Kuwait and Saudi Arabia.[36] In Bahrain, Iran and Qatar, individuals receive mandatory sentences for drug offences. There are alternatives to custodial sentences for drug offences (12 countries)† and compulsory or coercive treatment is also used (13 countries).‡

In many countries, estimates of HIV prevalence within prisons are not available. Some estimates are not markedly different to reported national HIV prevalence rates, for example in Iran (2%), Lebanon (0.7%), Morocco (0.7% among male prisoners), Oman (0.2%) and Syria (0–0.2%).[35] However, evidence of increased HIV prevalence rates among prisoners has been reported in Yemen (26.5%),[37] UAE (18.4%, figure from 1998) and Libya, where anecdotal evidence suggests that HIV prevalence among people who inject drugs in prison may reach 60%.[35]

Data on hepatitis C prevalence among prisoners are only available for Iran,§ where the rate is reported to be 18.7%.[38,39] More research is necessary to establish the extent to which HCV affects prisoners in this region. This is particularly important in countries with extremely high national HCV prevalence such as Egypt.

# THE RESPONSE

## Harm reduction services

### *Needle and syringe exchange programmes (NSPs)*

NSPs operate in seven countries in the region: Iran, Israel, Oman, Morocco and small-scale syringe distribution is carried out in Egypt, Lebanon and Palestine.[40] In Morocco, civil society organisations are in the process of developing an NSP outreach strategy.[41] In Iran, an estimated 1.4 million needles and syringes were distributed by 120 NSPs and 150 peer outreach teams in 2007. Based on an estimated 240,000 people who inject drugs in the country, this equates to almost six syringes per person in 2007, which is insufficient.

Many people cannot or do not access NSPs for various reasons. These include limited access due to few outlets and outreach teams, lack of awareness of the risks associated with sharing injecting equipment, lack of awareness of available services, inconvenience of regular attendance at services as well as fear of

† Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Saudi Arabia and Tunisia.
‡ Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Morocco, Oman, Qatar, Saudi Arabia, Syria, Tunisia and UAE.
§ Estimate derived from two prison studies in 1999 and 2000 with a total of 567 prisoners.

becoming registered as someone who injects drugs and having this information shared with police. In Iran, those who are also receiving drug treatment from a Drug Intervention Centre (DIC) are given a card to show that they are accessing harm reduction services. This card can be used to protect from arrest for being an illegal 'addict'.[10]

In Israel, there are pilot NSPs in three major cities,[42] and Morocco and Oman both have one NSP site each. This is clearly not enough to reach the 9,000, 18,500 and 500–1,000 people who inject drugs in each country respectively. Even in Iran, where the number of NSPs has been increasing in recent years, there are still not enough to reach all those who need this service.

Several factors hinder the scale up of NSPs and other harm reduction interventions in the region. The NGO sector often plays a large role in NSP service delivery, but in Iran and Oman there are limited NGOs working with harm reduction in their remit. There are restrictive regulations that limit the extent to which NGOs and other actors can become involved in service provision in both these countries. In Iran, the NSPs in existence are reported to have difficulties in both attracting and maintaining staff. In general, there is limited awareness of injecting drug use and the effectiveness of harm reduction at the governmental level. It is not prioritised and, as a result, there are limited funds and capacity within national and provincial bodies for the implementation and monitoring of interventions.

In several countries (Egypt, Iran, Iraq, Jordan, Lebanon, Morocco and Syria), injecting equipment can be purchased from pharmacies, but, as in other regions, stigma and criminalisation of people who inject drugs may make this very difficult in practice. In Yemen, the sale of needles and syringes in pharmacies is prohibited. In Oman, despite the prohibition of pharmacy sale being lifted in 2003, no pharmacy actually sells injecting equipment.

### *Treatment for drug dependence*

Methadone is illegal in at least three countries (Jordan, Saudi Arabia and Syria) and regulatory barriers exist in most of the other countries in the region. Although some countries (Bahrain, Lebanon and Oman) use opioid substitution therapy (OST) in detoxification from heroin and other opiates, maintenance therapy is only available in Iran, Lebanon and Israel. Fifteen years ago, methadone maintenance treatment (MMT) was available in Oman, but this was discontinued following regulatory issues such as diversion and unsupervised prescription of take-home doses.[10] In Morocco, authorisation has recently been given for methadone to be used.[41]

Iran has the most extensive OST provision, which has been scaled up rapidly in response to a growing HIV epidemic among people who inject drugs. There are now estimated to be 654 OST sites in Iran, made up of 130 public and 350 private treatment centres, 120 drug intervention centres (DICs) and 54 prisons. In 2007, it was estimated that 18,500 people in public treatment centres, 20,000 people in private treatment centres, 7,000 people in DICs and 10,910 prisoners were receiving MMT. Approximately half of these people inject drugs; the majority of the remaining OST clients are heroin smokers, followed by opium takers and smokers.[10] A recent report estimated that there were 60,000 people receiving methadone and 6,500 receiving buprenorphine in Iran.[43] The provision of OST is so widespread and its necessity so ingrained that following the Bam earthquake in 2003 emergency supplies for survivors included methadone.

In Israel, methadone and buprenorphine maintenance therapy are available,[44] and it is reported that a pilot heroin prescription programme may be established.[45] Some longer-term clients receiving OST are given take-home doses of methadone, which means that daily attendance at a clinic or pharmacy is not necessary.[46]

OST is also available in Lebanon via one NGO-based OST site providing buprenorphine maintenance therapy to less than twenty clients.[47] The Lebanese government has plans to expand this service.

In the countries where OST exists, there are several barriers to accessing it. In Lebanon, in addition to the cost barrier (approximately USD60 per week) the scale of OST provision is so limited that very few people are able to benefit. In Iran, OST sites do not exist throughout the country and are therefore inaccessible to some due to distance, however the main barrier is reported to be cost. Two-thirds of treatment centres are private clinics and therefore charge a daily fee for dispensing OST. There is also a charge to receive treatment in public centres, although this is much lower. While there are limited places in the DICs that provide access to OST free of charge, they are often full to capacity. There is also a lack of awareness of OST and the availability of services among people who use drugs in the region, and it is reported that some people hold legitimate fears of confidentiality breaches at treatment centres.[10]

In Iran, although OST service provision has been rapidly scaled up in recent years, there are barriers to further increasing this coverage. These are reported to include a lack of interest among physicians and others in the health sector to work in the field of drug dependency; limited funds to subsidise OST provision for those who cannot afford to pay for it; limited capacity of national and provincial bodies for planning, implementing and monitoring interventions; and restrictive regulations that make it difficult for other sectors (including NGOs and academic institutions) to provide services.[10]

In countries where OST is not yet provided, there are several challenges to establishing these services and initiating a harm reduction approach. Many countries are poor, politically unstable and/or in conflict or post-conflict situations. As a result, many have relatively weak health-care services that require significant strengthening to enable provision of comprehensive harm reduction services. The predominant response to drugs in this region has been to tackle drug supply rather than the health implications of drug use and, as such, punitive law enforcement has been the dominant approach.

Establishing the extent of drug use and the harms related to drug use has not been prioritised by governments. As a result, there are very limited surveillance systems in place to monitor trends, which in turn renders planning the response difficult. In most countries in the region, drug use is considered an antisocial, immoral behaviour in opposition to religious beliefs, Therefore, drug dependence treatment, where it exists, promotes an abstinence-based approach rather than a harm reduction approach.

Other (non-OST) drug dependence treatment is available in at least sixteen countries. Iran has the highest number of people accessing non-OST treatment, estimated to be 100,000.[10] Algeria, Bahrain, Lebanon, Saudi Arabia[48] and Egypt[4] have all had over 1,000 people registered in drug dependence treatment at one time since 1998.

The form, location and extent of treatment choice vary within the region. For example, in Yemen it is reported that no specific drug treatment centre exists. Oman has one facility based in a psychiatric hospital unit, while Egypt, Morocco and Iran all have many non-OST drug treatment options. Most countries fall somewhere in between. In Iran, these include outpatient and inpatient detoxification with or without clonidine, herbal medicine, psychosocial approaches, twelve-step focused self-help groups and therapeutic communities.

Limited inpatient and outpatient detoxification and rehabilitation services within, or attached to, psychiatric hospitals are available in countries including Algeria, Bahrain, Iraq and Kuwait. Some of these services also include psychosocial support and counselling. In many countries, traditional models are being used for detoxification and long-term residential rehabilitation. This response is predominantly led by the mental health sector and overseen by law enforcement. In Bahrain, where one psychiatric hospital (Al-Moayyed) houses a drug rehabilitation centre, it is reported that any other hospital, health centre or private practitioner is prohibited from treating alcohol or drug use problems. A two-year detoxification and rehabilitation programme in UAE explicitly states that people living with HIV are not permitted to join the programme.[10]

### *Targeted HIV prevention, treatment and care*

Very few HIV programmes are designed to reach people who inject drugs in this region. They are largely limited to Algeria, Iran, Morocco and Oman, and they vary in scope. Although voluntary HIV counselling and testing (VCT) is available to people who inject drugs in at least seven countries, the extent to which they can access this service is unclear. In Iran, 7.4% of people who inject drugs are aware of their HIV status, and it is reported that legal, cultural and social restrictions limit VCT access for this key population.[10] In Algeria, it is reported that 15% of 'problematic drug users' are aware of their HIV status and that, in general, HIV prevention knowledge within this group (including people who inject drugs) is low.[28] In Algeria, Morocco and Iran, HIV prevention programmes specifically target people who inject drugs.

Across the region (where estimates are available), the number of people in need of antiretroviral therapy (ART) exceeds 12,900,* but information on the numbers receiving ART is very limited.[49] A WHO review reported that 225 people in Oman and 49 in Tunisia were receiving ART at the end of 2006,[49] and a recent country progress report states that 246 people are receiving ART in Lebanon.[29]

Although no country is reported to exclude people who inject drugs from receiving ART, information for most countries is not disaggregated to reflect the extent to which they have access to it. These data are only available for two countries. In Iran, 125 current or past injectors are receiving ART,[7] and in Israel, an estimated 12% of the total ART recipients are past or current injectors.[50] While access may be limited for people who inject drugs in some countries, the lack of data should not lead to the assumption that this is the case throughout the region. In Bahrain, for example, where most people living with HIV are past or current injectors, the majority of those who need ART are currently receiving it.[40]

Barriers to scaling up ART access for people who inject drugs in Iran include inadequate coverage of harm reduction services, which can provide referrals to ART providers, the need for increased VCT uptake, limitations of available ART medications, difficulties in reaching criminalised and stigmatised communities and concerns held by health providers on treatment adherence.

### *Targeted HCV prevention, treatment and care*

Information on the availability of HCV prevention, treatment and care programmes for people who inject drugs is very scarce in the region. Research has established that people who inject drugs have access to HCV testing in Iran and Oman and they are not excluded from HCV treatment provision in Iran.

## Harm reduction in prisons

Iran is the only country in which NSP is available in some prisons. In five out of a total of 200 adult prisons, prisoners can access clean injecting equipment from 'Triangular Clinics', but it is reported that this service is rarely used. Iran is also the only country in the region where OST is available, with 54 large prisons providing MMT to 10,910 prisoners at the end of 2007.[10]

Condoms are available in conjugal visit rooms in all Iranian prisons, and 88 prisons also provide condoms on request from 'Triangular Clinics'. The same 88 prisons also offer VCT. Continuation of ART therapy is possible in some prisons, but only in one prison in Iran can ART be initiated. Testing for hepatitis C is available in the forty larger Iranian prisons, but treatment is not available in any prisons in the region.

Non-OST drug dependence treatment is available in all prisons in Morocco and Iran. In seven countries (Egypt, Iraq, Jordan, Oman, Palestine, UAE and Yemen), no drug treatment is available in prisons. Information could not be obtained for the remaining countries.

### Drug policy shift in Iran

Prior to 1997, drug policy was strict in Iran, emphasising supply reduction and punishing drug use. This approach contributed to an increase in HIV among prisoners, particularly those who inject drugs. As much as 60% of prisoners were incarcerated due to drug convictions, and mandatory sentencing was the predominant approach. There was no alternative to imprisonment.

From 1997, Iranian government drug policies began to change. The current policy, while continuing a supply-reduction approach, also includes emphasis on harm reduction and drug treatment. The provision of harm reduction services, inside and outside prisons, and alternative facilities is now central to Iran's HIV response. This policy change was catalysed by advocacy and evidence from successful NGO and university-led harm reduction programmes, as well as close cooperation and common understanding between key stakeholders from various government departments. There is now a national harm reduction committee, which has representatives from various ministries, academic institutions and NGOs.[10]

* Data available for Egypt, Iran, Jordan, Lebanon and Morocco.

## Policies for harm reduction

In general, the majority of Middle Eastern and North African countries do not currently include harm reduction in government policy on HIV or illicit drugs. The majority of countries have HIV action frameworks, some of which include mention of injecting drug use (Algeria, Iran, Lebanon, Morocco and Oman) and human rights (Algeria, Iran, Jordan and Morocco).

All countries in the region have legislation on drugs, and national policies or strategies on illicit drugs exist in twelve countries (Bahrain, Egypt, Iran, Iraq, Jordan, Morocco, Oman, Qatar, Saudi Arabia, Syria, UAE and Yemen). Harm reduction is included in drug and/or HIV policy in Iran, Morocco and Oman (although in the case of Oman this is limited to education on harms associated with drug use). Iran, Morocco, Oman, Egypt and Lebanon have all shown support for harm reduction in international forums.

The Middle East and North Africa Harm Reduction Association (MENAHRA) was formed in 2007. This four-year regional project is an initiative of the WHO and IHRA, supported by the Drosos Foundation. It comprises three sub-regional knowledge hubs: the Iranian Centre for Addiction Studies in Iran, Soins Infirmiers et Developpement Communautaire (SIDC) in Lebanon and Ar-Razi hospital in Morocco.

MENAHRA aims to strengthen the role of civil society organisations in harm reduction in the region. It will provide direct support to civil society organisations to initiate or scale up harm reduction interventions, as well as supporting model programmes that demonstrate the feasibility of harm reduction services. In its first year, MENAHRA focused on capacity-building, advocacy and information-sharing and is committed to creating an environment which is conducive to the implementation of life-saving harm reduction interventions.

An initial scoping report revealed that there are very few civil society organisations in the region focusing on harm reduction advocacy at the national level; these are currently limited to Iran, Lebanon and Morocco.

There are no drug user organisations in the region. Drug use remains greatly hidden within communities and people who use drugs are often deterred from accessing any health services for fear of being stigmatised and, in some countries, arrested. This stigma also silences the voices of people who use drugs in the region. They are not empowered to advocate for better access to services, or to be involved in the planning, implementation and monitoring of treatment provision to ensure their needs are met.

## Multilateral support for harm reduction

Various initiatives of UNAIDS, WHO and UNODC focus on injecting drug use and HIV in this region, but multilateral support directly related to harm reduction policies or programmes is not extensive. Explicit support for harm reduction has come from WHO through the work of the Regional Advisory Panel on the Impact of Drug Use (RAPID), established in 2002, and the WHO Regional Committee for the Eastern Mediterranean (EMRO), which in 2005 passed a resolution on the 'substance use and dependence' in the region. This document urged member states to respond to 'the rise in injecting drug use in the Region' with a 'wide range of approaches and interventions' including 'harm reduction'.[51]

WHO EMRO has also been instrumental in the documentation of Iranian experiences in the rapid scale up of harm reduction programming and the promotion of this approach through regional advocacy. Along with WHO EMRO, the work of the UNODC Regional Office for the Middle East and North Africa (ROMENA) and UNAIDS contributes towards a conducive environment for harm reduction through support for drug use and HIV situation assessments, policy development and the design of interventions on HIV prevention, treatment and care for people who use drugs. A UNODC-supported project assessing HIV in prisons is planned for Algeria, Egypt, Jordan, Lebanon, Morocco and Palestine.[41]

At country level, several governments and civil society organisations are receiving support from multilateral agencies for initiatives related to HIV and drug use. For example, UNODC and UNAIDS, the World Bank, UNDP and WHO are providing technical and financial support to the government and/or civil society on activities related to harm reduction in Iran. Global Fund grants support the Iranian government and civil society to carry out HIV prevention, treatment and care work through harm reduction.

UNODC ROMENA is supporting governments and civil society on drug prevention, treatment and rehabilitation in several countries, including Algeria, Egypt, Jordan, Lebanon, Morocco and Palestine. For example, in October 2007, UNODC ROMENA launched 'Strengthening community resources in providing drug abuse treatment and rehabilitation for vulnerable groups in Jordan', which has among its objectives to increase access to community-based HIV prevention services for people who use drugs.[52] In Morocco, UNAIDS is supporting the development of harm reduction advocacy workshops.[41]

While the issues of injecting drug use and harm reduction are being raised in several countries in the region, increased implementation of essential interventions, including NSP and OST, is necessary to have an impact on the HIV and HCV epidemics among people who inject drugs in the Middle East and North Africa.

# References


1 Aceijas, C. et al (2006) Estimates of Injecting Drug Users at the National and Local Level in Developing and Transitional Countries, and Gender and Age Distribution. Sexually Transmitted Infections 82: 10–17.
2 Aceijas, C. et al (2004) Global Overview of Injecting Drug Use and HIV Infection among Injecting Drug Users. AIDS 18: 2295–2303.
3 Aceijas, C. and Rhodes, T. (2007) Global Estimates of Prevalence of HCV Infection among Injecting Drug Users. International Journal of Drug Policy 18(5): 352–358.
4 World Health Organization Regional Office for Eastern Mediterranean (2003) Preliminary Report on WHO/EMRO Questionnaire for Regional Situation Analysis on Drug Abuse, 2002.
5 Family Health International (2007) Egypt Final Report: April 1999 to September 2007. USAID's Implementing AIDS Prevention and Care (IMPACT) Project.
6 Rahimi-Movaghar, A. for the Epidemiology Department, Iranian National Center for Addiction Studies (2008) Estimations for Global State of Harm Reduction Reviewing and Using Multiple Sources.
7 Aceijas, C. et al (2006) Antiretroviral Treatment for Injecting Drug Users in Developing and Transitional Countries 1 Year before the End of the 'Treating 3 million by 2005. Making it happen. The WHO strategy' ('3by5'). Addiction 101(9): 1246–1253(8).
8 Chemtob, D. and Grossman, Z. (2004) Epidemiology of Adult and Adolescent HIV Infection in Israel: A Country of Immigration. International Journal of STD and AIDS 15: 691–696.
9 World Health Organization Regional Office for Europe (2007) HIV/AIDS Country Profiles for the WHO European Region: Israel.
10 Iranian National Center for Addiction Studies (2008) Global State – data collection response.
11 United Nations Development Programme. Basic Indicators for Other UN Member States 2007/2008 Report (data from 2004). http://hdrstats.undp.org/indicators/334.html (date of last access 27 February 2008).
12 United Nations Development Programme (2007) Human Development Report 2007/2008.
13 United Nations Office on Drugs and Crime (2007) World Drug Report.
14 Stop the Drug War (2007) Middle East: Opium Poppies Flower Again in Iraq. Drug War Chronicle 487.
15 European Monitoring Centre for Drugs and Drug Addiction (2007) Opioid Use and Drug Injection. http://www.emcdda.europa.eu/html.cfm/index41527EN.html (date of last access 5 April 2008).
16 World Health Organization (2004) Global Status Report on Alcohol 2004.
17 Amnesty International (2005) Iran: Death Penalty/Imminent Execution: Karim Fahimi, also known as Karim Shalo. http://www.amnesty.org/en/library/info/MDE13/069/2005 (date of last access 5 April 2008).
18 World Health Organization Regional Office for the Eastern Mediterranean (2006) Technical Paper on Public Health Problems of Alcohol Consumption in the Region.
19 Warfaa, N. et al (2007) Khat Use and Mental Illness: A Critical Review. Social Science and Medicine 65: 309–318.
20 Razzaghi, E. et al (1999) Final Report of the Rapid Situation Assessment of Drug Abuse in Iran. Iranian Welfare Organization and UNDCP.
21 UNAIDS (2006) Report on the Global AIDS Epidemic. Annex 2: HIV and AIDS Estimates and Data, 2005 and 2003.
22 UNAIDS (2007) AIDS Epidemic Update.
23 World Health Organization Regional Office for Eastern Mediterranean (2004) A Draft of the 5-Year Regional Strategic Planning on Substance Abuse 2005–2009.
24 Oppenheimer, E. et al (2003) Treatment and Care for Drug Users Living with HIV/AIDS. London: Imperial College.
25 UNAIDS (2006) Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Israel.
26 United Nations Office on Drugs and Crime and the Institute for Development, Research and Applied Care (2003) Substance Use and Misuse in Lebanon (The Lebanon Rapid Situation Assessment and Responses Study).
27 UNAIDS (2006) Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Egypt.
28 Algerian Ministry of Health (2006) Algerian Report on the Monitoring of the Declaration of Commitment of the United Nations General Assembly Special Session on HIV/AIDS (UNGASS, 2001) in December 2005.
29 Lebanon (2008) Narrative: UNGASS Country Progress Report.
30 World Health Organization and UNAIDS (2006) Fact Sheet for Middle East and North Africa.
31 World Health Organization (1999) Hepatitis C – Global Prevalence (Update). Weekly Epidemiological Record 74: 425–427.
32 Zamani, S. et al (2006) High Prevalence of HIV Infection Associated with Incarceration among Community-based Injecting Drug Users in Tehran, Iran. JAIDS 42(3): 342–346.
33 Amiri, Z.M. et al (2007) Prevalence of Hepatitis C Virus Infection and Risk Factors of Drug Using Prisoners in Guilan Province. Eastern Mediterranean Health Journal 13(2): 250–256.
34 International Centre for Prison Studies. Prison Briefs: Middle East/North Africa. http://www.kcl.ac.uk/depsta/law/research/icps/worldbrief/ (date of last access 6 January 2008).
35 Dolan, K. et al (2007) HIV in Prison in Low-income and Middle-income Countries. The Lancet Infectious Diseases 7: 32–41.
36 Lines, R. (2007) The Death Penalty for Drug Offences: A Violation of International Human Rights Law. London: International Harm Reduction Association.
37 Jenkins, C. and Robalino, D. (2003) HIV/AIDS in the Middle East and North Africa: The Cost of Inaction. Washington DC: World Bank.
38 Khamisipour, K. et al (2000) HIV, HCV, HBV and Syphilis Infections among High Risk Groups in Boushehr Province.
39 Salehi, M. et al (2001) HBsAg and Hepatitis C Infection Prevalence in Prisoners of Sistan and Baloochestan Province.
40 Hermez, J., World Health Organization Regional Office for Eastern Mediterranean – personal communication (March 2008)
41 Middle East and North Africa Harm Reduction Association (2007) Harm Reduction for the MENA Region. Newsletter 1, December.
42 Israeli Ministry of Health (2006) UNAIDS Monitoring the Declaration of Commitment on HIV/AIDS – Report from Israel.
43 International Harm Reduction Development Program (2008) Harm Reduction Developments 2008. Countries with Injection-driven HIV Epidemics.
44 Peles, E. et al (2008) Tricyclic Antidepressants Abuse, with or without Benzodiazepines Abuse, in Former Heroin Addicts Currently in Methadone Maintenance Treatment (MMT). European Neuropsychopharmacology 18(3): 188–193.
45 Middle East: Tel Aviv Seeks to Begin Heroin Maintenance Program. Drug War Chronicle 523. http://stopthedrugwar.org/chronicle/523/tel_aviv_proposes_heroin_maintenance_pilot_program (date of last access 14 March 2008).
46 Peles, E. et al (2008) Tricyclic Antidepressants Abuse, with or without Benzodiazepines Abuse, in Former Heroin Addicts Currently in Methadone Maintenance Treatment (MMT). European Neuropsychopharmacology 18(3): 188–193.
47 Mikdashy, N. (2008) Harm Reduction in Beirut: Skoun and Buprenorphine Substitution Treatment. http://www.menahra.org/index.php?option=com_content&task=view&id=84&Itemid=1 (date of last access 15 April 2008).
48 United Nations Office on Drugs and Crime Inter-country Team for the Middle East and North Africa (2003) Drug Abuse and HIV/AIDS in the Middle East and North Africa.
49 World Health Organization, UNAIDS and UNICEF (2007) Towards Universal Access: Scaling Up Priority HIV/AIDS Interventions in the Health Sector Progress Report, April 2007.
50 World Health Organization Regional Office for Europe (2007) HIV/AIDS Country Profiles for the WHO European Region: Israel.
51 World Health Organization Regional Office for Eastern Mediterranean (2005) Regional Committee for the Eastern Mediterranean – Resolution Agenda Item 5(c) Substance Use and Dependence.
52 Qatamish, N. and Jaradat, J., Hashemite Kingdom of Jordan (2008) UNGASS Country Report January 2006 to December 2007.