Regional Overview
Sub-Saharan Africa

Availabilty 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 SUB-SAHARAN AFRICA

<table>
<thead>
<tr>
<th>Country/territory with reported injecting drug use</th>
<th>People who inject drugs</th>
<th>Adult HIV prevalence amongst people who inject drugs</th>
<th>Adult HCV prevalence amongst people who inject drugs</th>
<th>Harm reduction response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>1,000</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Guinea</td>
<td>10 registered cases</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Kenya</td>
<td>0.3% of the male population</td>
<td>68–88%</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Malawi</td>
<td>0–29³⁴</td>
<td>0³</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Mauritius</td>
<td>17,000–18,000¹</td>
<td>nk</td>
<td>95%⁶</td>
<td>✓ ✓</td>
</tr>
<tr>
<td>Niger</td>
<td>1,000</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Nigeria</td>
<td>5,000</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Somalia</td>
<td>1,000</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>South Africa</td>
<td>16,000⁷</td>
<td>1–20%⁸</td>
<td>7%⁹</td>
<td>X ✓</td>
</tr>
<tr>
<td>Sudan</td>
<td>37,628⁹</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Tanzania</td>
<td>2,200¹⁰</td>
<td>nk</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Zambia</td>
<td>6.7% of people accessing drug treatment¹¹</td>
<td>&lt;1%¹²</td>
<td>nk</td>
<td>X X</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>3.1% of adult drug using population¹³</td>
<td>26.2%¹⁵</td>
<td>22%¹³</td>
<td>X X</td>
</tr>
</tbody>
</table>

nk = not known

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**Legend:**
- **NSP:** Needle and Syringe Program
- **OST:** Opioid Substitution Therapy
- **HIV and HCV programmes targeted towards people who inject drugs:**
  - Largely non-existent in the region. Targeted HIV programmes, or drug treatment programmes referring people to HIV services, exist in Burkina Faso, Kenya, Mauritius, Mozambique and South Africa.

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**Notes:**
- a Due to difficulties in information gathering in the region, there are gaps in some of the data. These are particularly related to three East African countries (Madagascar, Rwanda and Ethiopia) and several Central and West African countries.
- b Injecting drug use has also been reported in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Cote D’Ivoire, Djibouti, Ethiopia, Gambia, Liberia, Mali, Mozambique, Rwanda, Senegal, Seychelles, Sierra Leone, Togo, Uganda, and Zimbabwe. In the following countries, as yet there have been no official reports of injecting drug use: Botswana, Burundi, Central African Republic, Chad, Comoros, Democratic Republic of the Congo, Republic of the Congo, Equatorial Guinea, Guinea-Bissau, Gabon, Lesotho, Madagascar, Malawi, Namibia, Niger, Rwanda, and Sao Tome and Principe.
- c 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.
- d A recent rapid assessment found small numbers of people who inject drugs but none testing positive for HIV.
- e This figure was coded ‘D’ by the Reference Group to the United Nations on HIV and Injecting Drug Use, indicating a lack of technical information to support the estimate. Country progress reports from north and south Sudan state that injecting drug use is not an issue in the country.
Over 754 million people live in the forty-seven countries that make up Sub-Saharan Africa.14 Countries in this region almost exclusively populate the lowest thirty on the human poverty index. The wealthiest countries are South Africa and Gabon.15 The vast majority of states are severely affected by poverty, many are politically unstable and several are currently in conflict or post-conflict situations. Swahili (or Kiswahili) is the most widely spoken non-European language, and there are over 2,000 local languages. English, French and, to a lesser extent, Portuguese are spoken in some countries.

**DRUGS IN THE REGION**

**Cultivation, production and transhipment**

Cultivation and production in Sub-Saharan Africa is mostly limited to cannabis and khat, which is legal in some parts of Africa. Much of the cannabis and khat is grown and consumed locally, for example in Tanzania20 and Kenya.7

In the past decade, West Africa in particular has become a major through-route for drug trafficking from Latin America to Europe. UNODC reports that thirty-three tons of cocaine have been seized in West Africa since 2005, a huge increase over prior figures, and more than had ever been seized in Sub-Saharan Africa previously.13 The largest seizures in 2007 occurred in Senegal, Mauritania, Guinea-Bissau, Cape Verde, Benin, Ghana, Guinea and Nigeria. Although trafficking cocaine via West Africa adds mileage to the transit route, poverty, political instability, weak law enforcement, corruption and, in some cases, conflict or post-conflict situations render the area ideal for drug trafficking.

As well as transit by air and sea, evidence suggests that the already established cannabis transit route from Morocco to Europe is now also being used to transport cocaine, with people travelling overland from West Africa to Morocco. A recent UNODC report highlighted the increasing cocaine trafficking in Guinea-Bissau, a country with linguistic ties to Brazil and Portugal, two important countries on global cocaine transhipment routes. The report indicated that the value of the drugs trade may be as high as the country’s entire national income.17 UNODC estimates that about 27% of the cocaine that entered Europe in 2006 transited African countries.19

Drug trafficking is also reported in several countries in East and Southern Africa, including Kenya (although drug trafficking is believed to have reduced there in recent years) and South Africa, which provides the most lucrative cocaine market in Sub-Saharan Africa.18 Heroin enters Southern Africa largely through the ‘Maputo Corridor’ (from Maputo, Mozambique to Pretoria, South Africa), which functions as a conduit for heroin coming from Tanzania via Mozambique.19 Heroin trafficking from Afghanistan via East and West African countries to North America is also reported. Some seizures have been made in recent years, but these are very small in comparison to those made in other areas of the world.22

**Drug use**

There are limited data on the nature of drug use in Sub-Saharan Africa, apart from South Africa. In most countries, tobacco, alcohol and cannabis appear to be the most widely used substances. Data in West Africa show cannabis as the primary drug of use among people accessing treatment services.23 However, use of cocaine, heroin and methamphetamine has been reported in several countries. In Nigeria, heroin, cocaine and cannabis are the most commonly used drugs.20 ‘Mandrax’, a combination of methaqualone and antihistamine that has been prescribed as a sleeping tablet, is the second most commonly used drug in South Africa after cannabis.21 Increased use of methamphetamine (locally known as ‘tik’) is also reported, particularly among adolescents in Cape Town.22 Solvent use is reported in Uganda23 and khat, also known as ‘mairungi’, is widely used in Kenya and other East African countries.24

**Alcohol**

Recorded alcohol consumption is highly varied across Sub-Saharan Africa. Nine countries (Chad, Comoros, Guinea, Mali, Mauritania, Niger, Senegal, Sudan and Somalia) have some of the lowest levels of alcohol consumption in the world, and Somalia is one of only six countries globally with alcohol consumption recorded at zero. However, Burundi, Nigeria, Swaziland and Uganda have extremely high levels of alcohol consumption. Uganda has the highest recorded per capita rate of consumption in the world at 19.47 litres of pure alcohol. In addition, Gabon, Swaziland, Tanzania and Uganda have very high beer consumption levels.

Alcohol consumption is generally lower in East Africa (with the exception of Uganda) than in West and Southern Africa.25 However, there is substantial unrecorded alcohol consumption in the region, including numerous home-brewed drinks and illicit alcohol. In East Africa, ‘over 90% of alcohol consumed according to some estimates is unrecorded’.26 In the Democratic Republic of the Congo, home-made liquor is becoming more widely consumed than beer, as the latter is expensive and often in limited supply.

There are also many countries that have high rates of adult lifetime abstinence, including Mali (95.6%), Mauritania (97.5%) and Senegal (94.4%).

At least nine countries (Benin, Comoros, the Republic of the Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea-Bissau and Togo) do not have age restrictions on alcohol purchases, and licences are not required for producing or selling all or some types of alcohol in Ethiopia, Gabon and Angola.28

**Cocaine**

Cocaine is becoming increasingly available in Sub-Saharan Africa, largely due to the growing involvement of some countries in cocaine trafficking. Cocaine use is reported in several countries, including Burkina Faso, Ghana, Guinea, Kenya, Nigeria, Senegal, Sierra Leone, South Africa and Togo. Senegal and Guinea are seeing an increase in cocaine use and it is stable in both Nigeria and Burkina Faso. The use of crack cocaine has been reported in Nigeria, Ghana, Côte d’Ivoire and Gambia.

Cocaine use is most common in South Africa, where use has markedly increased in the past decade. In 2006, over 10% of people accessing drug treatment (including for alcohol use) named cocaine as the primary drug of use.27

**Heroin**

Heroin first reached Sub-Saharan Africa in the 1980s, but was in limited supply for many years. The less-refined, brown heroin was the most commonly available until recent years, and was mostly inhaled, known as ‘chasing the dragon’. With increased heroin trafficking in the past decade, the arrival of white, more-refined heroin (which cannot be ‘chased’) and lower prices, mean that the drug is now much more accessible and local consumer markets...
have been established. It is estimated that in Africa (including North Africa), 0.2% of the population use opiates. This is almost exclusively heroin use, particularly in Sub-Saharan Africa.

Involvement in the trafficking of Asian heroin to consumer countries has led to increased availability and use of the drug in a number of countries, including Kenya, Mauritius, Mozambique, South Africa and Tanzania (including Zanzibar). It is reported that heroin is either injected, or smoked with cannabis and tobacco (known as ‘cocktail’ in Kenya29 and ‘pinch’, ‘unga’ or ‘nyaope’ in South Africa). In Durban, South Africa, young people use low-grade heroin and cocaine mixed together, known locally as ‘sugars’. In Mozambique, heroin is reported to be more commonly used than cannabis, according to treatment centre data.

Treatment demand for heroin use is high in Tanzania (32.7% of all treatment demand), Mauritius (58%) and Mozambique (54.7%). In South Africa, heroin treatment demand rose from less than 1% to 7% of all treatment demand (including alcohol) between 1996 and 2006.27

Injecting drug use surveillance systems, estimates of the number of people who inject drugs are only available for thirteen countries and territories. However, according to the UNODC, injecting drug use is present in seventeen West African countries, and anecdotal evidence also suggests that it is present, albeit very rare, in Djibouti. However, very limited information on the extent and nature of injecting drug use in this area is available. It is reported to be increasing in many countries in the region, including Somalia. In Nigeria, the most commonly injected drugs are heroin, cocaine, a combination of heroin and cocaine (known as ‘speedball’) and pentazocine. In Liberia, cocaine and heroin are injected, but widespread poverty prohibits most from affording the drugs.

Drug-related harms

**HIV and AIDS**

Globally, Sub-Saharan Africa is the region hardest hit by HIV and AIDS. An estimated 22.5 million people are living with the virus in the region, 61.5% of whom are women. Southern Africa is particularly affected, and there are eight countries (Botswana, Lesotho, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) with national adult HIV prevalence exceeding 15%.

The latest UNAIDS report indicates that in many countries, HIV prevalence is stable or showing small declines, most noticeably in Kenya and Zimbabwe. The report also highlights a ‘shift towards safer behaviour’ in some countries.27

Studies and anecdotal evidence suggest that injecting drug use, though very varied in the region, is increasing in some parts of at least nine countries (Ethiopia, Kenya, Mauritius, Rwanda, Somalia, South Africa, Tanzania, Uganda and Zambia), and that heroin is the most commonly injected drug. Sudan and Mauritius are reported to have the largest numbers of people who inject drugs at 37,878 and 17,000 to 18,000 respectively. However, the Sudanese estimate is likely to be overstated, and injecting drug use was not mentioned in recent country progress reports to UNAIDS from north and south Sudan. Half of all people using drugs in Mauritius are reported to use heroin, and the overwhelming majority of those inject the drug.

Kenya has widespread injecting drug use in the capital city Nairobi and in the coastal areas of Mombasa, Kisumu and Nakuru. All of these lie along major highway routes to the Democratic Republic of the Congo and Sudan. Tanzania (including Zanzibar) has considerable injecting drug use. It has also been reported in Uganda and more recently in the Seychelles, but there are very limited data on these countries.

Injecting drug use is also evident in several Southern African countries, but again there are limited data to illustrate its trends or extent. In Mozambique, the most commonly injected drugs are heroin, cocaine and methamphetamine. In Zambia, heroin and, to a lesser extent, diazepam injecting are reported.

In South Africa, heroin is the most commonly injected drug. However, the injecting of other opiates, as well as to a lesser extent amphetamine-type stimulants (ATS) and cocaine, are reported. Injecting drug use is increasing in Pretoria and Johannesburg, but decreasing in the Western Cape. Of those accessing treatment and reporting heroin as their primary drug of use in three areas, 11%, 33% and 42% respectively reported injecting.

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Map 9.2: Number of people who inject drugs in Sub-Saharan Africa

**Injecting drug use**

Due to a lack of drug use surveillance systems, estimates of the number of people who inject drugs are only available for thirteen countries and territories. However, according to the UNODC, there are at least twenty-seven countries in Sub-Saharan Africa where injecting drug use has been reported in the past five years. In addition, there are reports of injecting in Guinea, Niger, Zimbabwe and Djibouti.

Although most new HIV diagnoses are attributable to sexual transmission, the influence of injecting drug use is increasing in many countries. Where data are available, they suggest HIV prevalence among people who inject drugs to be high. Due to a lack of available injecting equipment and low awareness levels of the associated risk, needle and syringe sharing is common practice.

In Tanzania, it has been reported that when sharing injecting equipment, people will clean the syringe by flushing it with water until no blood appears to be left.38 ‘Flashblood’, a practice posing enormous risk of blood-borne virus transmission, has been reported both in Tanzania and Zanzibar. This process involves a recent heroin injector drawing his or her blood into a syringe for someone else to inject, in an effort to relieve withdrawal symptoms when heroin is unobtainable.38,39

National estimates of HIV prevalence among people who inject drugs are only available in Kenya (66–88%),38 Zanzibar (26%),39 South Africa (1–20%)40 and Zambia (<1%).40 In Mauritius, in 2005, 90% of HIV diagnoses were attributable to injecting drug use, in sharp contrast with the figure of 7% just four years earlier.1 There are also subnational estimates available which illustrate the severity of the situation in several African cities. In the capital city of Tanzania, Dar es Salaam, HIV prevalence among people who inject drugs has been reported as 42%.41 In Mombasa, Kenya, prevalence rates of 49.5% were found among those who inject drugs.42

Several studies from various countries illustrate that women who use drugs (both injecting and non-injecting) are more vulnerable to HIV transmission than men. HIV prevalence rates among women injecting drugs were found to be particularly high in Zanzibar (40%),39 Tanzania (65% in Dar es Salaam),38 Nigeria29 and Kenya (where six out of every seven female injectors are living with HIV).40

Many studies also report that a large proportion of women who use drugs engage in sex work. In a recent South African study, female sex workers reported engaging in sex work in order to support their drug use, but they also engaged in drug use in order to cope with sex work. A number of the women reported injecting drugs. Female sex workers who reported using drugs were also found to be at risk of sexual violence, further increasing their risk of HIV.43

While the response to drug use and HIV must target all those affected, particular attention must be paid to women and the interplay between drug use, sex work and HIV transmission in Sub-Saharan Africa.

Increasingly, studies are linking HIV transmission with non-injecting drug use in this region.44,45 For example, HIV prevalence is elevated among people who use drugs and alcohol in Malawi (25.5%), where the most common drug use includes alcohol (including traditional brews such as ‘chibuku’ and ‘kachasu’) and cannabis, known locally as ‘chamba’.46 In Kenya and Zanzibar, HIV prevalence was found to be 6.3% and 4.1% respectively among non-injecting drug users.2,11

Map 9.3: HIV prevalence among people who inject drugs in Sub-Saharan Africa

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Map 9.3: HIV prevalence among people who inject drugs in Sub-Saharan Africa
A meta-analysis of twenty African studies found an association between alcohol use and positive HIV serostatus. In Zimbabwe, where approximately one-quarter of the adult population is living with HIV, drinking in ‘beerhalls’ was associated with unprotected sex. Researchers are also beginning to investigate the potential link between methamphetamine use (known locally as ‘tik’) and HIV transmission in South Africa.

The existing evidence on non-injecting drug use and HIV transmission is explored further in section 3 of this report.

Hepatitis C virus (HCV)

According to WHO data in 1999, national HCV prevalence was high in the Central African Republic (4.5%), Chad (4.8%), the Democratic Republic of the Congo (6.4%), Gabon (6.5%) and Zimbabwe (7.7%). Very high estimates were reported in Guinea (10.7%), Burundi (11.1%) and Cameroon (12.5%).

There is very limited information available on HCV among people who inject drugs in the region. In Mombasa, Kenya, HCV prevalence is reported at 70% among people who inject drugs. In Zanzibar, HCV prevalence was found to be elevated among both people who inject drugs (22%) and those who use non-injecting drugs (15%). Rates were also higher overall among females using drugs (21.7%) than among males (15.1%). The same study found HIV and HCV co-infection among 40% of people who use drugs (both injecting and non-injecting).

Drug use and its related harms in prisons

UNODC estimates that 668,000 people are incarcerated in the region, with female prisoners making up between 1% and 6% of the total prison population. Botswana and South Africa have the highest imprisonment rates in the region at 329 and 342 per 100,000 in the adult population respectively. South Africa has the largest reported prison population in the region at between 157,402 and 159,961 people.

Two countries, Sudan and the Democratic Republic of the Congo, have the death penalty for drug offences in their legislation. Although the majority of countries in the region have mandatory sentencing for drug offences, in some Southern African countries there are alternatives to incarceration, including diversion programmes (Botswana, Malawi, Namibia and South Africa) and fines (Namibia and Swaziland). Compulsory drug treatment is in place in several Southern African countries (Angola, Lesotho, Namibia, South Africa and Swaziland).

Conditions in most African prisons are extremely poor, with severe overcrowding, poor maintenance and living conditions, poor nutrition and lack of health care. Although there is a lack of available data on the history of drug use among prison populations, a recent UNODC report indicated that injecting in prisons is likely to be rising in several countries (Cape Verde, Côte d’Ivoire, Guinea, Kenya, Mauritius, Nigeria, Senegal and Tanzania).

A review of HIV prevalence among prisoners found only five countries had data available on injecting drug use in prisons, reporting it to be very limited (Cote D’Ivoire and Zambia) or non-existent (Mozambique, Niger and South Africa). Despite this, existing data suggest high prevalence rates among African prisoners compared to the general adult populations. A review of HIV in prisons found prevalence rates higher than 10% in the national prison populations of South Africa and Zambia, as well as in some prisons in Burkina Faso, Cameroon, Cote D’Ivoire, Gabon, Malawi and Rwanda. Nearly one-third of new HIV infections in Mauritius in 2005 were among prisoners.

Table 9.2 consolidates the available data, some of which is over ten years old and most of which is taken from random sampling and therefore may not be representative of the national prison population. This exemplifies the lack of recent and reliable information in this area.

Table 9.2: HIV prevalence rates in prisons in Sub-Saharan Africa

<table>
<thead>
<tr>
<th>Country</th>
<th>HIV prevalence rate among prisoners</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>11%</td>
<td>1999</td>
</tr>
<tr>
<td>Cameroon</td>
<td>12%</td>
<td>2005</td>
</tr>
<tr>
<td>Cote D’Ivoire</td>
<td>28%</td>
<td>1993</td>
</tr>
<tr>
<td>Djibouti</td>
<td>6.1%</td>
<td>n/a</td>
</tr>
<tr>
<td>Malawi</td>
<td>60–75%</td>
<td>n/a</td>
</tr>
<tr>
<td>Nigeria</td>
<td>9%</td>
<td>2004</td>
</tr>
<tr>
<td>Rwanda</td>
<td>14%</td>
<td>1993</td>
</tr>
<tr>
<td>Senegal</td>
<td>2.7%</td>
<td>1997</td>
</tr>
<tr>
<td>South Africa</td>
<td>45%</td>
<td>2006</td>
</tr>
<tr>
<td>Uganda</td>
<td>8%</td>
<td>2002</td>
</tr>
<tr>
<td>Zambia</td>
<td>27%</td>
<td>1999</td>
</tr>
</tbody>
</table>

n/a = not available

There are no available data on HCV prevalence rates in prisons.

THE RESPONSE

Harm reduction services

Needle and syringe exchange programmes (NSPs)

The only country with an official NSP is Mauritius, where, since 2006, three NSP sites have been operating and distributing injecting equipment via community-based outreach. There are plans to increase the number and coverage of NSPs in Mauritius, but a lack of human resources and funds make this a challenge. In addition, while the possession of injecting equipment without a prescription is still illegal, fear of arrest will continue to be a significant barrier to people accessing this service.

In at least thirteen countries in the region sterile injecting equipment can be purchased from pharmacies. In South Africa, bleach and alcohol swabs are also available at pharmacies. However, even in cases where it is affordable, pharmacists may not be willing to sell syringes to people they suspect of injecting drugs. In South Africa, where pharmacy sales are more widespread than most other countries, problems are associated with the judgmental attitude of pharmacists towards ‘heroin junkies’, as well as the difficulties of accessing equipment late at night. In Malindi, Kenya, non-governmental organisations (NGOs) worked

* Angola, Botswana, Burkina Faso, Kenya, Lesotho, Malawi, Mozambique, Namibia, the Seychelles, South Africa, Swaziland, Tanzania (including Zanzibar) and Uganda.
with pharmacists to ensure that they would not refuse sales of injecting equipment to people injecting drugs. In Nigeria, one study found that 70% of people who inject drugs reported being able to obtain sterile syringes, mostly from pharmacies but also from friends and drug dealers.

There are several hurdles to overcome in order to introduce or increase NSPs in communities where injecting occurs. There is a need for increased surveillance to add to existing information on the extent and nature of injecting drug use in the region. All sectors must recognise the importance of early intervention in order to mitigate the impact of injecting. Lessons must be learnt from other resource-limited settings in which NSPs are available. In addition, support from relevant bodies on the development of new, as well as the reform of existing, legislation and policy is required.

Treatment for drug dependence

In general, opioid substitution therapy (OST) is not available in Sub-Saharan Africa. Mauritius and South Africa are the only two countries in which OST is prescribed for maintenance therapy. In Mauritius, the volume of OST prescribing has steadily increased since the initiation of the programme, and there are now reported to be 400 people receiving OST from seven sites. South Africa is the only other country where OST is available for maintenance therapy, but this is not widely accessible and there is currently no legislation to accommodate OST provision. A few private facilities provide OST, many of which are inaccessible to people who use opiates due to prohibitive expense.

In general, the provision of OST in Sub-Saharan Africa is impeded by legislation prohibiting the prescription of methadone and buprenorphine, a lack of political will, as well as weakened health-care systems in many countries.

A small number of countries provide OST for detoxification purposes, including Uganda, Somalia, Botswana (mostly used for alcohol detox) and South Africa. In South Africa, methadone and buprenorphine are both available for detoxification. However, methadone is only available as a syrup (Physeptone), which has high sugar content, contains alcohol and must be taken in large quantities. Buprenorphine is a preferred option, but is expensive and therefore not accessible to everyone. Detoxification involves three to seven days of OST prescription from standalone outpatient units, such as 'K-TOX' in Cape Town. Other opiate detoxification units are housed in government hospitals in Cape Town, Pretoria and Johannesburg. In Kenya, tranquilisers and painkillers are used to relieve withdrawal symptoms during detoxification.

Other (non-OST) drug treatment is available in several countries to varying extents. South Africa and Kenya appear to have the most extensive treatment provision, with 9,412 people accessing 72 sites in South Africa, and Kenya being reported as the country with the most drug treatment services in East Africa. In Nigeria, a broad range of drug treatment is available, including treatments that are religious-based and those offered by traditional healers. However, a study in Lagos highlighted that people who used drugs had difficulties accessing these due to prohibitive cost. Mauritius, Uganda and Zanzibar also offer treatment for drug use.

Throughout the rest of the region, there are very few dedicated drug treatment or rehabilitation services outside of psychiatric services. There is also a great amount of stigma associated with being a drug user and accessing these services. Most countries have fewer than ten drug treatment sites. In Namibia, for example, in 2004, only fifty-four people in the country received drug treatment.

In Uganda, a 32-bed drug treatment centre has been established within the national mental hospital but, in general, drug treatment is limited. Somalia has one outpatient treatment centre and Sudan has three psychiatric wards providing drug treatment. Limited drug treatment is available in Burkina Faso and to a lesser extent in Liberia, where a rehabilitation centre that was destroyed during the fifteen-year civil war has not yet been renovated and there is a lack of trained staff to work on drug treatment. In Swaziland, it is reported that there is no dedicated drug treatment or rehabilitation centre but some provision for drug treatment is offered in psychiatry services.

Aside from the obvious lack of coverage of OST and non-OST drug treatment services, a number of further barriers are reported for people who inject drugs in accessing these services. These include prohibitive cost of treatment or travel, inappropriateness of services (for example those targeted at alcohol use rather than injecting drug use) and stigma and discrimination. The predominant view is that people who use drugs are criminals and not necessarily in need of, or deserving of, treatment. While the recent Kenyan country progress report highlighted the need for de-stigmatisation of ‘rehabilitated drug users’ and support for them to find work by issuing ‘certificates of good conduct’ after a period being clean, increased efforts are necessary to reduce stigma that affects people currently using drugs.

Targeted HIV prevention, treatment and care

Throughout the region, civil society, government and international organisations are involved in the provision of HIV prevention, treatment and care. Although far from reaching the target of ‘universal access’, HIV interventions in the region have increased dramatically in recent years, with considerable support from international donors. As HIV transmission is predominantly via heterosexual sex, the response has not traditionally been targeted towards those who inject drugs. Data on the extent to which people who inject drugs have access to HIV services are very limited.

Interventions targeting people who inject drugs with HIV prevention, treatment and care are reported in at least five countries (Burkina Faso, Mauritius, Mozambique, Kenya and South Africa). In Mauritius, it is reported that 10% of people who inject drugs accessed voluntary HIV counselling and testing (VCT) in the last twelve months. Many received information on HIV and AIDS through radio and television and participated in a seminar on HIV and AIDS. Condom distribution is also reported to have recently increased.

In South Africa, information and awareness programmes run by government and civil society that address the link between drug use and HIV are in the early stages of implementation. PEPFAR has also provided the Medical Research Council in South Africa with funding for an international rapid assessment response and evaluation. The target populations are people who use drugs (injecting and non-injecting), including sex workers and men who have sex with men (MSM). The project involves research which will inform an intervention phase working with various NGO/CBO service providers in the field of drug treatment and HIV services to build capacity, strengthen networks and facilitate community outreach to increase the reach and competency of services.
In Mozambique, one NGO works on increasing access to HIV services for people who inject drugs. In Burkina Faso, there are reported to be some programmes reaching people who inject drugs with STI prevention, limited condom distribution, and information, education and communication (IEC) programmes.

In 2004, a PEPFAR grant allowed the UNODC to support the implementation of community-based outreach programmes for people who inject drugs in Kenya. There is now a national Working Group on Prevention of HIV among Drug Users guiding policy and programming on HIV and drug use, and significant efforts are being made to increase uptake of VCT among people who use drugs. NGOs in Nairobi and in several coastal towns offer psychosocial and peer support outreach, self-help groups, harm reduction education and VCT, and refer clients to antiretroviral treatment (ART) clinics and other services.

There are no data available to indicate the numbers of people who inject drugs that are receiving ART, although it is reported that some provision is occurring in South Africa.

Several barriers exist that impede the access of people who inject drugs to essential HIV services. In many countries, for example Lesotho, Malawi, Swaziland and Zimbabwe, access to VCT, ART and other services is limited in general, and is likely to be even less available to marginalised groups. Surveillance systems are few, and as such there is a lack of evidence on the extent of injecting drug use and HIV, discouraging many countries, for example, Mozambique, Namibia and Swaziland, from prioritising this during service design and delivery. Further barriers include a lack of awareness of HIV risk behaviours, harm reduction and drug treatment services, distance to services and cost of transport, severe stigma and discrimination associated with both drug use and HIV, fear of arrest or harassment, and a lack of confidentiality at both HIV and drug treatment services.

A consultation with people who inject drugs in Kenya revealed that few VCT sites are ‘drug-user friendly’, and that IEC materials for people who use drugs are ‘inadequate’. In South Africa, interviews with people who use drugs (including those who inject, MSM and sex workers) indicated that access to VCT was problematic due to their lack of knowledge of VCT sites, long waiting times and cancellation of appointments in public centres, and the expense associated with private facilities. People who use drugs also felt stigmatised.

In several countries the provision of ART is still limited, for example in Djibouti (600 people), the Seychelles (199 people), Somalia (200 people) and Sudan (800 people). Even in countries such as Zambia and Zimbabwe where ART is more available, in practice it is easier for some groups (for example government officials, teachers, mothers and civil servants) to gain access to the treatment than others. In South Africa, while ART is provided, recent studies show that vulnerable people who use drugs have limited knowledge about the treatment.

A country progress report from Kenya’s National AIDS Control Commission admitted that people who inject drugs had been ‘neglected’ in the national response to HIV, along with MSM and migrant populations. The report highlights the intention to respond to HIV among people who use drugs in 2008, stating that they, along with other marginalised, criminalised groups had ‘been excluded from care, treatment and prevention strategies, policy and programmes’.

**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. South Africa was the only country found to have HCV testing and treatment in place, which in theory could be accessed by people who inject drugs, although there is no information to illustrate the extent to which this is occurring.

**Harm reduction in prisons**
In general, prison health care in Sub-Saharan Africa is very limited. There are no prisoners in the region with access to either prison needle and syringe exchange (PNEP) or OST. HIV prevention, care and treatment services are very limited in prisons throughout the region.

VCT is available in prisons in at least ten countries (Botswana, Kenya, Lesotho, Malawi, Mauritius, the Seychelles, South Africa, Tanzania, Uganda and Zambia) but to varying extents. For example in Botswana and Mauritius, VCT is available to most prisoners. However in Malawi, there is just one pilot VCT site operating in Zomba Central prison.

The availability of condoms also varies widely. For example, they are available in some prisons in Lesotho and the majority of prisons in South Africa, but distribution is prohibited in Botswana as it is believed they would promote sexual behaviour in the prisons (condoms are only distributed to prisoners upon release from prison or parole).

ART is available in some prisons in at least eight countries: Botswana (302 people receiving ART), Kenya, Lesotho, the Seychelles, South Africa (2,323 people receiving ART), Tanzania, Uganda (100 people receiving ART) and Zambia. Prevention of mother-to-child transmission (PMTCT) and STI testing and treatment are also reported to be available in Botswana’s prisons. Treatment of opportunistic infections is reported to be available in a small number of Ugandan prisons.

In Zambia, a number of NGOs support HIV prevention and care programmes in prisons. In South Africa, NGOs and research initiatives focus on HIV within prisons and provide harm reduction information for prisoners using drugs. Information on the availability of HCV testing and treatment within prisons is unavailable for most countries in the region. As HCV services are very rare in place outside prisons across the region (with the exception of South Africa), it is unlikely that prisoners will have access to them.

**Policies for harm reduction**
Until recently, HIV policy and practice mainly focused on sexual and vertical (mother-to-child) HIV transmission, as these are the main routes of transmission in the region. However, a number of policies have been developed in recent years which prioritise, or make reference to, responding to HIV and drug use.

For example, Zanzibar has a Five-year National Strategic Plan on Substance Use and HIV and AIDS (2007–2011), and the Tanzanian National Drug Control Policy (2007) identifies responding to HIV infection among people who use drugs as critical to the response. In addition, the Mauritian National Multisectoral HIV/AIDS Strategic Framework (NSF) 2007–2011 includes two objectives on reducing HIV transmission among people who inject drugs and prisoners. It sets targets of 80% of people who inject drugs and all prisoners having access to HIV prevention services by 2011.
Many HIV action frameworks in the region (Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) include mention of human rights, and those in South Africa, Zambia and Zimbabwe also include mention of injecting drug use. However, South Africa has the only drug policy in the region which includes mention of a specific harm reduction intervention, in this case OST.

In some countries, policies have become redundant following years of conflict (for example in Liberia) and in others, further investigation is needed to ascertain whether policies are in place and to establish their content.

At the regional level, the recently released African Union Plan of Action on Drug Control and Crime Prevention (2007–2012) prioritises within it ‘Regional and National capacity building and training to enhance prevention and care of substance abuse and related HIV and AIDS’ as well as requiring ‘Member States to conduct training in harm reduction, drug abuse treatment and rehabilitation, and provide services for drug dependent individuals, including street children and child soldiers’.

In October 2007, the Sub-Saharan African Harm Reduction Network (SAHRN) was formed. A meeting held in Nairobi, Kenya brought together NGOs, researchers and UN representatives from eleven African countries to discuss drug use and the reduction of its related harms in the region. During the meeting, the lack of appropriate policies, and/or the political will to create and implement them, were cited as significant barriers to promoting harm reduction in the region.

The overarching objective of SAHRN is to create a conducive environment for harm reduction in Sub-Saharan Africa, through advocacy, information sharing and networking. An initial scoping report revealed that there are very few civil society organisations in the region currently focusing on harm reduction policy and advocacy at the national level. Current data suggest that these are limited to Cameroon, Liberia, Mauritius, Nigeria, South Africa and Zambia. However, it is hoped that the formation of SAHRN will bring new opportunities for researchers and NGOs to engage in harm reduction policy at the regional and international levels.

**Multilateral support for harm reduction**

There are clearly numerous challenges to the establishment of harm reduction interventions such as OST and NSP in the resource-poor countries of Sub-Saharan Africa, where poverty affects the majority of the population and health system infrastructures are often already struggling to cope with numerous health issues, including generalised HIV epidemics. Support from both international donors and multilateral agencies will be integral to the response in this region. Currently, few, if any, multilateral agencies support or actively contribute to the initiation or scaling up of NSP or OST services in the region. However, a number have some focus on increasing access to drug treatment as well as HIV prevention, care and treatment for people who use drugs and for prisoners.

With the exception of South Africa, there are no drug user organisations in the region. In South Africa, the drug user organisation was established in the early 1990s and is currently less active than it has been in the past. 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 stifles 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.

The UNODC has three offices covering Sub-Saharan Africa: one each in West/Central Africa, East Africa and Southern Africa. In 2001, a UNODC Africa-wide initiative was launched to develop national capacity in drug demand reduction and treatment. In Kenya, a PEPFAR grant allowed UNODC to support the development of community-based outreach for people who use drugs. The UNODC has also had an increased focus on HIV within prisons in Sub-Saharan Africa, releasing a report on the issue and hosting a regional meeting in Mombasa, Kenya in 2007.

In addition, funding from the World Bank has enabled the Tanzanian government to establish a programme focusing on HIV and drug use. Other technical and financial support for programmes on HIV and drug use comes from UNAIDS, WHO and UNICEF.

While recognising the importance of these initiatives, multilateral agencies are failing to promote, or provide support for, harm reduction approaches such as NSP and OST in the region. There is now increasing evidence of the contribution of injecting drug use to HIV and HCV epidemics in the region and experiences from elsewhere illustrate the importance of timely intervention to mitigate the rapid escalation of epidemics among key populations and the wider population. In Sub-Saharan Africa, injecting drug use could exacerbate epidemics in countries where HIV prevalence is already very high, as well as rapidly expanding epidemics in countries which have so far remained relatively less affected.

An increased focus from multilateral agencies is necessary in order to provide government and civil society with the necessary support and guidance on how to respond to the challenges faced. This will perhaps require different approaches to those used in other settings. For example a recent article suggested that supporting and expanding community-based efforts would be paramount to an effective response. Efforts to curb injecting among people who use drugs in the region may also be part of the harm reduction response to reduce the ‘potential for drug driven HIV to exacerbate the heterosexual epidemic’.