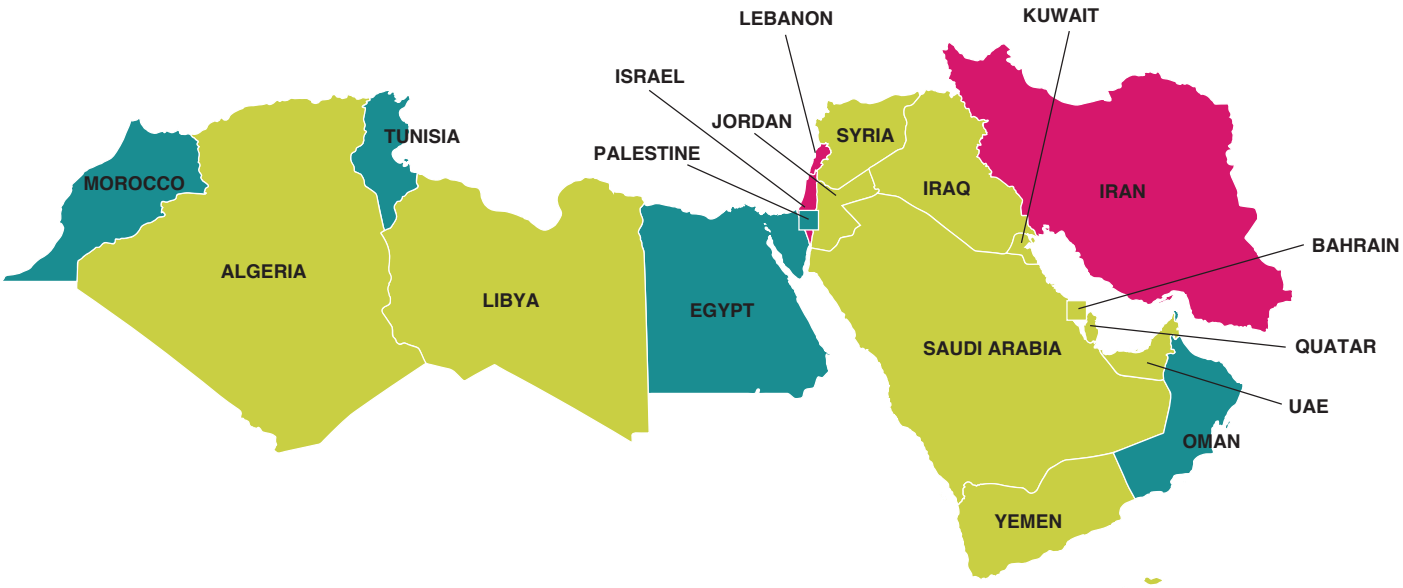
2.8 Regional Update: Middle East and North Africa



Map 2.8.1: Availability of needle and syringe exchange programmes (NSP) and opioid substitution therapy (OST)

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

Table 2.8.1: Harm Reduction in the Middle East and North Africa

Country/territory with reported injecting drug use[a]	People who inject drugs[1]	Adult HIV prevalence amongst people who inject drugs[1]	Harm reduction response[2]	
			NSP[b]	OST[c]
Algeria	nk	nk	x	x
Bahrain	nk	0.3%	x	x
Egypt	nk	2.55%	✓(2) (P)	x
Iran	180,000	15%	✓(428–637) (P)	✓(680–1,100) (B, M)
Iraq	nk	nk	x (P)	x
Israel	nk	2.94%	✓	✓(B,M)
Jordan	nk	nk	x (P)	x
Kuwait	nk	nk	x	x
Lebanon	nk	nk	✓(1–5) (P)	✓(1) (B)
Libya	1,685	22%	x	x
Morocco	nk	nk	✓(2–3) (P)	x[c]
Oman	nk	11.8%	✓(1)	x
Palestine	nk	nk	✓(1)	x
Qatar	nk	nk	x	x
Saudi Arabia	nk	0.14%	x	x
Syria	nk	0.3%	x (P)	x
Tunisia	nk	nk	✓(6)	x
United Arab Emirates (UAE)	nk	nk	x	nk[d]
Yemen	nk	nk	x (NP)	x

nk = not known

a The number in brackets represents the number of operational NSP sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = needles and syringes reported to be available for purchase from pharmacies or other outlets and (NP) = needles and syringes not available for purchase; where this is not referred to it is not known.
b The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone and (B) = buprenorphine.
c Methadone was approved for use in November 2009 and OST pilot sites are due to begin prescribing in June 2010.
d The UN Reference Group reports that there are three NSP sites in the country, but this has been disputed by civil society in the region and so is reported here as not known.

Harm Reduction in the Middle East and North Africa

The marginalised and criminalised populations of men who have sex with men and people who inject drugs remain most affected by HIV in this region. Latest estimates from the Reference Group to the UN on HIV/AIDS and Injecting Drug Use indicate that there are over 300,000 people who inject drugs in the Middle East and North Africa (MENA) region.[1 3] Injecting drug use is driving HIV epidemics in Iran, Bahrain and Libya and contributing to those in several other MENA countries. However, data availability is extremely poor as weak monitoring systems hamper efforts to gain a true picture of the region's drug-related epidemics.

Better surveillance is needed to inform responses in the MENA region. While some monitoring systems have improved in recent years (e.g. in Syria, Morocco and Lebanon), across the region there has been a reluctance to focus on stigmatised and criminalised populations such as people who inject drugs. There is an over-reliance on passive rather than active surveillance, which may result in both injecting drug use and HIV being under-reported.[3] Local and national monitoring systems urgently require strengthening in order to inform targeted responses to drug-related HIV epidemics in the region.[4]

Pilot harm reduction programmes are operating in several MENA countries. Since 2008 Tunisia has introduced pilot needle and syringe programmes (NSPs). Iran remains the only country in the region where access to both NSPs and OST has been dramatically scaled up. Despite positive developments and increases in service provision since 2008, a large proportion of people who inject drugs in the region do not have access to these key interventions.

Some significant recent developments for harm reduction policy and advocacy indicate a growing understanding of the need for action in the region. In October 2009 a resolution from the WHO Regional Committee for the Eastern Mediterranean called for rapid scale-up of harm reduction services to prevent hepatitis B and C epidemics among people who inject drugs. While government action on harm reduction remains slow and perhaps reticent (with the exception of Iran), the engagement of states (via country coordinating mechanisms) in the development of a Round 9 Global Fund proposal with a focus on harm reduction demonstrated an acceptance of the need for an increased response.

Another important development, particularly for civil society, was the first Regional Conference on Harm Reduction, which was held in Lebanon in November 2009. The event provided a vital opportunity for sharing experiences and raising awareness of key issues with policy makers and the media. Despite strong civil society in parts of the region, and some important contributions from the Middle East and North African Harm Reduction Association (MENAHRA), restrictions on the functions of non-governmental organisations in several countries continue to limit the harm reduction response.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Eight MENA countries have operational NSPs. Tunisia became the latest addition when its first pilot NSP was introduced in June 2008, and now has six operational sites. Morocco has increased its service provision and several NSPs are now operating in the northern areas of Tangiers, Tetuan, Nador and Hoceima, through both fixed and mobile units.[5] In these areas, respondent-driven sampling suggest that between 5% and 15% of heroin users are injecting.[5] Lebanon, reported to have very small-scale service provision in 2008, may now have up to six NSPs.[2] The most significant scale-up has occurred in Iran, which reportedly had 170 NSPs in 2008 and now has between 428 and 637 sites.[2 6] However, this still equates to an average of only 2.5 NSP sites per 1,000 people who inject drugs.[2]

Estimates of NSP service coverage are scarce in the region. A lack of information on the numbers of people who inject drugs, as well as poor monitoring of services, impedes coverage calculations in several countries. Iran, which undoubtedly has the highest coverage, distributes an average of only 41 syringes per person per year,[2] much lower than the UN recommended target of 200 syringes per person per year.[7] Services are estimated to reach just 28% of the total number of people who inject drugs in Iran.[2]

Government reports on progress towards universal access targets indicate that distribution per person per year equates to 6.7 syringes in Morocco and less than one syringe in Oman.[8] Information is available on the numbers of people who inject drugs accessing NSPs per year in Lebanon (600–800), Morocco (611, mostly in Tangiers) and Tunisia (680).[2] Reports from Tunisia indicate that 268 clients accessed the service regularly (twice a week or more) and 412 used the service less frequently.[2] Estimates are also available on the number of syringes distributed per year in Lebanon (>2,000), Morocco (44,696), Oman (2,400) and Tunisia (5,924).[2]

Research in the region suggests that people who inject drugs commonly share needles and that the need to scale up access to sterile injecting equipment remains urgent.[4]

Opioid substitution therapy (OST)

Some provision of OST is reported in three MENA countries – Iran, Israel and, to a limited extent, Lebanon.[2] In Morocco, five sites (two residential and three drop-in centres) are due to pilot methadone maintenance therapy (MMT) in June 2010. By April 2010 methadone had been ordered and prescribing guidelines and procedures prepared.[5] While the UN Reference Group reports that three OST sites were operating in UAE, no further details on service provision is available and the existence of sites has been disputed by civil society in the region.[5] Although the number of sites operating in Israel is not clear, it is estimated that between 530 and 570 people receive buprenorphine or methadone as substitution therapy in the state. In Lebanon, there is no legal framework for OST provision, but 112 clients are reported to be receiving buprenorphine as substitution therapy from one centre.[2]

The most extensive OST coverage is in Iran, where the number of sites has increased since 2008 from 654 to between 680 and 1,100 in 2010.[2 6] These are in public and private treatment centres,

as well as drug intervention centres and prisons. Overall, there are estimated to be 4.3 OST sites per 1,000 people who inject drugs in Iran.[2] Data indicate that in one year an estimated 108,000 people received methadone or buprenorphine as substitution therapy in the country; an increase on 2008, when it was reported that in one year 60,000 people received methadone and 6,500 received buprenorphine.[2 6] A crude calculation suggests that for every 100 people in Iran who inject drugs, there are fifty-two people receiving OST.[2] However, particularly in Iran, the significant numbers of opiate smokers (rather than injectors) receiving OST must be taken into consideration when interpreting that figure.

Also in Iran, a comprehensive service for female drug users has been operating in Tehran since 2007. Run by the Iranian National Centre on Addiction Studies (INCAS) and funded by the Drosos Foundation, the service has been providing women with non-judgmental, professional and culturally sensitive harm reduction services; this meets an identified gap as previously most OST and NSP services were tailored to men. In 2009 over 140 women had attended the service and forty-five were receiving MMT.[9]

Antiretroviral therapy (ART)

Estimates of the number of people who inject drugs receiving ART in the region are limited to Iran, where 580 injectors are reported to be accessing HIV treatment.[2] This is a considerable increase on the 125 current or past injectors reported in 2008.[6] Another crude calculation reveals that this is the equivalent of two in every 100 people who inject drugs living with HIV.[2 e] Through a Global Fund programme in Egypt, a total of 371 people were reported to be receiving ART in 2009, but it is not clear whether this includes people who use drugs.[10]

Policy developments for harm reduction

In 2010 Iran, Israel, Lebanon and Morocco include harm reduction as part of their national policies on HIV and drugs. In accordance with Morocco's national harm reduction policy, regulations were amended in 2009 to allow methadone to be prescribed as substitution therapy. Oman has examined the policy and programmatic factors that may be barriers to the introduction of harm reduction measures. Research in drug-using behaviours in Bahrain has been conducted in order to prepare for programme implementation.[11]

At the regional level, Ministries of Health echoed calls made at the 52nd WHO Eastern Mediterranean Region Committee Meeting in 2005, by issuing another resolution in 2009 calling for the rapid scale-up of harm reduction services for people who inject drugs. This time it was specifically in response to growing epidemics of viral hepatitis among this population (see Chapter 3.1 for more on viral hepatitis).[12]

In 2009 MENAHRA, in conjunction with WHO's Eastern Mediterranean Regional Office (EMRO) and the UNODC Middle East and North Africa Regional Office (MENARO), submitted a regional proposal to the Global Fund Round 9, which focused heavily on the introduction and scaling up of harm reduction in the region. While unsuccessful in securing funds, the proposal did gain approval from most country coordinating mechanisms in the region, indicating support (albeit reluctant in some cases) for harm reduction.

e This figure must be interpreted with caution as not every person who injects drugs living with HIV will be in need of ART.

Harm reduction and Islam

Equally as important as government support in some countries, synonymous with it in others, is the endorsement of a harm reduction approach by religious leaders. The rapid scale-up of NSPs and OST (both in the community and in prison settings) in Iran was possible precisely because it was considered to be an essential response within the context of Islam. A recent review investigating harm reduction responses in Islamic countries around the world (including several that have readily adopted it, e.g. Iran, Malaysia and Indonesia) found that it was an approach that 'does not violate shariah law', but instead 'follows Islamic principles' and 'provide[s] a practical solution to a problem that could result in far greater damage to the society at large if left unaddressed'.[13] This important paper explores the basic guidelines in the Quran and the Sunnah (Prophetic traditions) that support NSPs and OST. It concludes that resistance to harm reduction in some Islamic countries (e.g. Libya, Tunisia, Syria and Jordan) is due to ideologies that have so far resulted in responses to drug use that are primarily criminal justice oriented.[13]

Many MENA countries where injecting drug use is reported have not identified injecting drug use as an HIV risk factor in their policy documents or articulated a need for a harm reduction response. Several legal and regulatory barriers, and a general government resistance to change, are significant obstacles to harm reduction implementation. Despite the adoption of a public health approach to drug use in several countries in the region, drug-related offences still result in severe penalties, including the death penalty in the majority of MENA states. [f 14]

Civil society and advocacy developments for harm reduction

Middle Eastern and North African civil society organisations (CSOs) have been actively advocating for harm reduction during the past two years. A major barrier to increasing services in the region has been the lack of awareness and understanding among all stakeholders of the need to address HIV and other health-related harms associated with injecting drug use.[6] Facilitating exchange of ideas and experiences, MENAHRA held the first Regional Conference on Harm Reduction in November 2009 in Beirut, Lebanon. It brought together over 200 policy makers, religious leaders, civil society representatives, frontline workers and researchers to discuss harm reduction for the first time.

MENAHRA was launched in 2007 with technical support from WHO and IHRA and funds from the Drosos Foundation. In 2008 the network developed a strategic framework with three- and five-year targets attached, prioritising activities in MENA countries based on public health need for harm reduction interventions and on openness to the harm reduction approach.[15]

MENAHRA has increasingly proved to be a catalyst for civil society mobilisation around harm reduction advocacy and service

f The following countries have the death penalty for drug offences in legislation, although some have not carried out executions for drug offences in recent years: Iran, Saudi Arabia, Egypt, Syria, Yemen, Libya, Kuwait, Iraq, Oman, UAE, Bahrain and Qatar. In 2009 the intention to use the death penalty for drug offences was announced in Gaza.

provision in the region. To date, the network has directly funded five partner CSOs in Iran, Pakistan, Afghanistan, Egypt and Tunisia. MENAHRA's sub-regional knowledge hubs in Morocco, Lebanon and Iran have reached over 1,500 civil society representatives, media workers, religious leaders and policy makers through seminars, site visits and training workshops on issues such as harm reduction key interventions, proposal writing and advocacy. The network regularly shares harm reduction news with over 550 contacts, works with media to increase awareness of harm reduction and participates in international events such as the UN Commission on Narcotic Drugs (2008 and 2009) and the International Harm Reduction and AIDS Conferences. In May 2009 MENAHRA became an officially registered association in Lebanon.

MENAHRA led the development of the harm reduction focused proposal to the Global Fund Round 9. Although the bid was ultimately unsuccessful, the process was extremely useful in strengthening the capacity of CSOs in the region to prepare a complex multi-country proposal, in planning and prioritising activities over five years in the region with CSOs and UN agencies (UNODC and WHO) and in engaging country coordinating mechanisms on the issue of harm reduction.

In Tunisia, the civil society organisation ATL MST/SIDA led a participatory community assessment to find out more about the risks faced by people who inject drugs and to inform harm reduction programming in the country. This assessment was used as an advocacy tool and enabled ATL MST/SIDA to implement Tunisia's first harm reduction pilot programme.[16]

Despite these achievements, overall, civil society involvement in HIV prevention, treatment and care for people who use drugs remains weaker in the Middle East and North Africa than it is in other regions. There is an essential role for international and regional organisations, including multilateral agencies, in strengthening and building civil society in the MENA region to advocate for and implement harm reduction.

Multilaterals and donors: Developments for harm reduction

Several multilateral agencies and donors supported and participated in the first Regional Conference on Harm Reduction, including the Council of Europe, GTZ, the Drosos Foundation, the Global Fund, UNAIDS, the Pompidou Group, UNODC and WHO.

As in other regions, the Global Fund is a significant source of financial support for harm reduction programmes. For example, a programme in Morocco (recently highlighted as a success story) has reached 400 people who inject drugs in its pilot stage and aims to significantly expand service provision of OST and NSPs (including in pharmacies and prisons) as well as to increase access to hepatitis C treatment.[10] Harm reduction activities are being funded by the Global Fund in Egypt (e.g. peer outreach and the establishment of drop-in centres). There are also plans to reach people who inject drugs through Global Fund programmes in Jordan and Palestine (in the latter, programme activities have been delayed due to conflict).[10]

UNODC MENARO is actively supporting harm reduction activities in several countries in the region (including Morocco, Lebanon, Jordan and Egypt) through its regional programme: Promoting Best Practices and Networking for Reducing Demand for and Harm from Drugs. The European Commission funds the programme and the Trimbos Institute, Netherlands, is a programme partner, particularly supporting the development of harm reduction outreach programmes.

WHO EMRO is also a key supporter of harm reduction in the region, providing technical support to civil society through its direct involvement in MENAHRA and other initiatives.

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