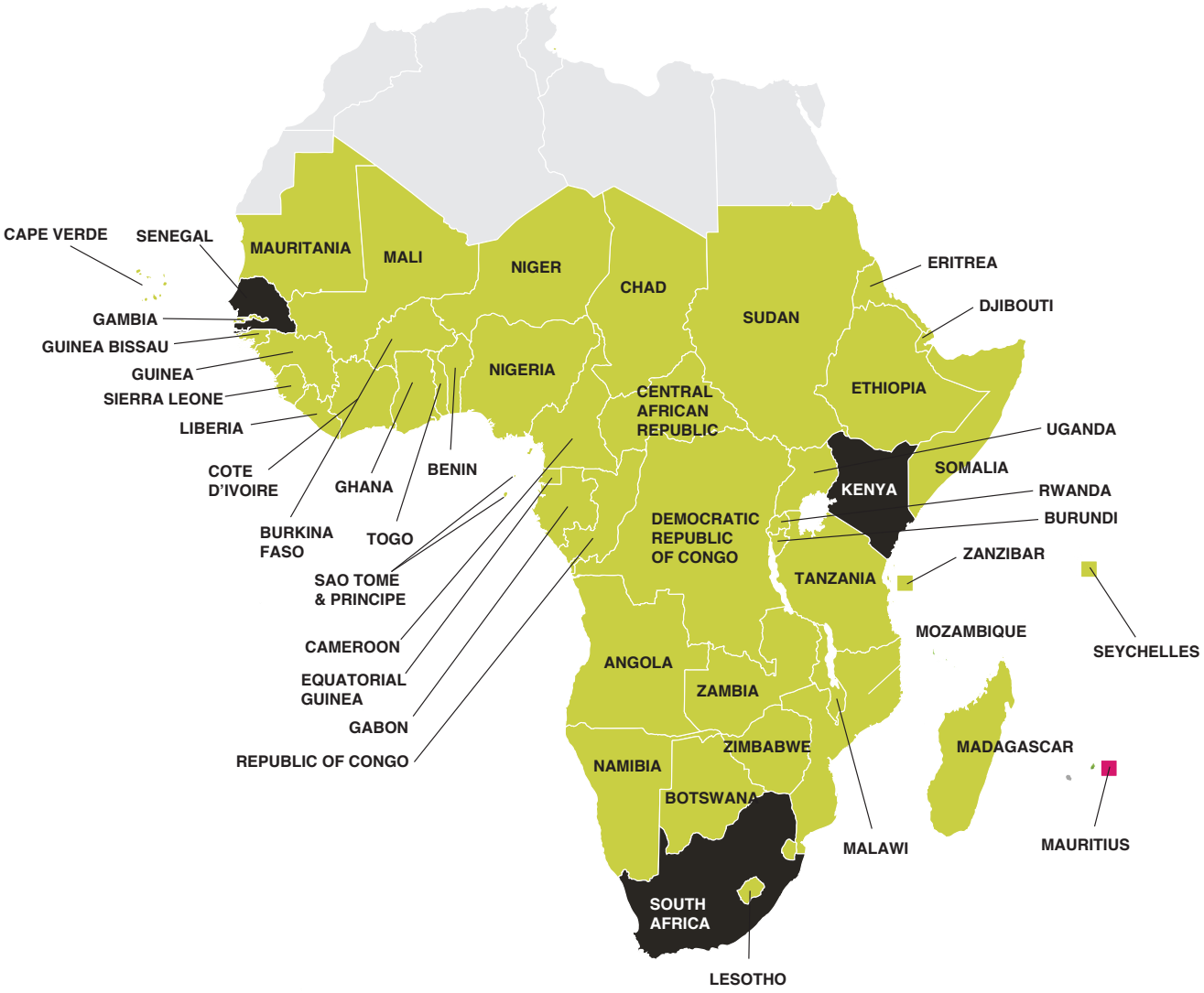
2.9 Regional Update: Sub-Saharan Africa



Map 2.9.1: 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 2.9.1: Harm Reduction in Sub-Saharan 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]
Cote D'Ivoire	nk	nk	x	x
Djibouti	nk	nk	x	x
Gabon	nk	nk	x	x
Ghana	nk	nk	x	x
Kenya	130,748[d]	42.9%	x (P)	✓[e](M,O)
Malawi	nk	nk	x (P)	x
Mauritius	17,500	9.8%[f]	✓(39) (P)	✓(14) (M,O)
Nigeria	nk	5.5%	x	x
Senegal	nk	nk	x	✓ (B,O)
Sierra Leone	nk	nk	nk[g]	x
South Africa	262,975[h]	12.4%	x (P)	✓(6) (M,B)
Uganda	nk	nk	x	x
Tanzania	nk	nk	x (P)	x
Zambia	nk	nk	x	x

nk = not known

a The countries included in the table are those which have reported injecting drug use (IDU) and/or NSP or OST according to the latest UN Reference Group systematic reviews. However, IHRA data collection in 2007/8 also found IDU reports in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Ethiopia, Gambia, Guinea, Liberia, Mali, Mozambique, Niger, Rwanda, Seychelles, Somalia, Togo, Zanzibar and Zimbabwe.
b 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.
c The number in brackets represents the number of operational OST programmes, including publicly and privately funded clinics and pharmacy dispensing programmes. (M) = methadone, (B) = buprenorphine and (O) = any other form (including morphine, codeine).
d The UN Reference Group offers a range of 30,264 to 231,231, illustrating the uncertainty around the numbers of people who inject drugs in the country.
e Methadone maintenance treatment is available on a very limited basis from private clinics only.
f In 2009, a surveillance survey found an HIV prevalence of 47.4% among people who inject drugs, but this study has not yet been made publicly available.
g While the UN Reference Group includes Sierra Leone among the countries with NSP, this has been disputed by a UNODC representative in the region and so is listed here as not known.
h Researchers in South Africa find this figure to be too high, stating that the country has around 100,000 heroin users and about one-fifth of them at most inject.

Harm Reduction in Sub-Saharan Africa

Sub-Saharan Africa remains the region most heavily affected by HIV, accounting for 67% of new HIV infections worldwide.[3] The majority of new HIV infections occur through heterosexual intercourse, but recent epidemiological evidence attributes an increasingly significant role to injecting and non-injecting drug use in driving many national epidemics.[3] In addition, since 2008 more studies have identified the role of non-injecting drug use (e.g. methamphetamine smoking) in facilitating sexual transmission, particularly among youth in South Africa.[4 5]

Although less extensively studied than other key populations, people who inject drugs in Sub-Saharan Africa appear to be at high risk of HIV infection. Injecting has now been reported in the majority of the forty-seven Sub-Saharan states and there are indications that HIV prevalence is high among injecting populations. Although systematic figures do not exist for the majority of states, estimates derived from three countries in the region (South Africa, Mauritius and Kenya) suggest that 221,000 (range 26,000 to 572,000) people who inject drugs are living with HIV in the region.[i 1] In countries where estimates are available, reported HIV prevalence among people who inject drugs ranges from 5.5% in Nigeria to 42.9% in Kenya.[1]

Since 2008 few additional countries have adopted key harm reduction interventions as part of their HIV response. Mauritius remains the only country with established needle and syringe programmes (NSPs).[j] Opioid substitution therapy (OST) is also available in Mauritius and to a lesser extent in South Africa, Senegal and Kenya.

There is potential for injecting drug use to exacerbate epidemics in countries where HIV prevalence is already high and to expand epidemics rapidly in countries that have remained relatively less affected. Mauritius stands out as a case in point, where HIV prevalence among people who inject drugs has come to dominate the HIV epidemic in a short time span: 92% of new HIV infections were attributed to injecting drug use in 2005.[6] Experiences from Asia and Eastern Europe also illustrate the importance of timely interventions to mitigate the rapid escalation of epidemics among both key populations and the general population.

While there has been some increase in research involving vulnerable populations such as people who inject drugs in Sub-Saharan Africa, substantial evidence gaps remain.[3] The lack of data on drug use and HIV in the region continues to be a barrier to a clear understanding of the epidemic and hinders efforts to reduce HIV and other harms among drug-using populations.

Developments in harm reduction implementation

Needle and syringe exchange programmes (NSPs)

Mauritius remains the only country in the region with established NSPs. In 2008 it was reported that there were three sites in the country,[7] however, service provision has been substantially scaled up since then. In 2010 the official programme operates mainly through community-based outreach, using two mobile services to distribute injecting equipment to thirty-one sites. An additional eight fixed sites are run by non-governmental organisations (NGOs). Together, these services distribute sterile injecting equipment and condoms to nearly one in three people who inject drugs in the country.[8]

Unpublished data from the WHO indicates the existence of NSPs in Sierra Leone. However, data on the number of sites and extent of coverage are lacking,[2] and this information has been disputed by a UNODC representative in the region.[9]

While there are indications that sterile injecting equipment is available to purchase from pharmacies in some countries, it is clear that, outside Mauritius, most people who inject drugs in the region lack adequate access to sterile needles and syringes. Research suggests that needle and syringe sharing is common among males and females who inject in the region.[10 11]

As highlighted in 2008, women who inject drugs in the region are at increased vulnerability to HIV infection.[7] It is reported that many female injectors are also sex workers and therefore may be at increased risk of sexual HIV transmission.[6] Extremely risky practices, such as 'flashblood,'[k] continue to be reported among women who inject in Tanzania and Zanzibar.[10 12] Research from six African countries indicates that women who inject drugs in Sub-Saharan Africa are at the greatest risk of HIV infection, with an HIV prevalence rate two to ten times higher than among male injectors.[10]

Opioid Substitution Therapy (OST)

Opioid substitution therapy (OST) remains generally unavailable across Sub-Saharan Africa. Scale-up of OST in Mauritius has been steady since 2008, but services are still limited. Very limited OST is also available in South Africa, Kenya and Senegal.[2]

In Mauritius, it is estimated that 2,000 people, including 150 women, are receiving methadone maintenance treatment (MMT) from fourteen sites – a notable expansion in service coverage compared with the 400 people who were accessing MMT through seven sites in 2008.[7 8]

In South Africa, buprenorphine is provided as substitution therapy in approximately six drug treatment facilities. As these are privately operated facilities, the associated cost continues to make this service unobtainable to many individuals who use opiates. The South African Medicines Control Council has recently approved the registration of methadone in a form suitable for MMT.[2]

i The estimates for Sub-Saharan Africa should be viewed with considerable caution as the prevalence estimates were derived from three out of forty-seven countries in the region (South Africa, Mauritius and Kenya).

j NSP has also been reported in Sierra Leone, however, this has been disputed by a UNODC representative in the region and the source of the report is yet to be published.

k *Flashblood* refers to a dangerous blood-sharing practice that carries a very high probability of HIV transmission. One user draws blood back into the syringe after injecting heroin and then passes the syringe on to a peer who injects the 3 to 4 ml of blood.

In Kenya, MMT is accessible on a very limited basis in private clinics only. Its provision in public health facilities is prohibited by current government policy.[2]

In Senegal, buprenorphine has become available for opioid maintenance treatment, but data on the extent of coverage is absent.[2]

A lack of political will, legislation prohibiting the prescription of methadone and buprenorphine and weak health care systems in many countries remain major barriers to the introduction and scale-up of OST services across Sub-Saharan Africa.

While the harm reduction response is extremely limited in this region, some countries are reaching small numbers with detoxification and abstinence-based services; these include Mauritius, South Africa, Ghana, Zambia, Kenya, Sierra Leone, Malawi, Tanzania and Nigeria.[2 7]

Antiretroviral therapy (ART)

Since HIV infection in the region occurs predominantly via sexual transmission, most HIV interventions have not been targeted at people who use drugs. Data on HIV prevalence and on HIV and AIDS prevention and treatment services for people who inject drugs remain very limited. In Kenya, despite the number of voluntary counselling and testing sites (854) and centres providing antiretroviral treatment (731), only thirty-eight people who inject drugs are reported to be receiving ART.[2]

Policy developments for harm reduction

In most Sub-Saharan African countries, drug policy continues to focus on supply reduction and criminalisation of users. However, there is a growing awareness in several countries of the need to address HIV and drug use. National drug and/or HIV policies have been targeted at people who use drugs and harm reduction in a few instances, including in Kenya, Tanzania (and Zanzibar) and Mauritius.

The new Kenyan strategic plan for AIDS from 2010 to 2013 explicitly covers harm reduction services, including OST and NSPs.[13] Kenyan legislation will need to be amended in order to make the provision of such services possible. The Kenyan Ministry of Medical Services is developing a drug dependence treatment protocol that will include the provision of OST to opiate users.[9]

As part of Tanzania's national strategic plan on substance use and HIV and AIDS for 2007 to 2011, reported on in the 2008 Global State of Harm Reduction report,[7] the government is presently planning to introduce a pilot OST programme.[9]

In 2008 the Indian Ocean Commission, representing five Indian Ocean island states (Mauritius, Madagascar, Reunion, Seychelles and the Comoros) initiated discussions on the introduction of harm reduction policies. The 6th Colloquium on HIV in the Indian Ocean, with a theme of harm reduction, was held in Mauritius in November 2008, and talks continued at the First Conference on Harm Reduction in October 2009 in the same country.

Despite these policy amendments in some countries, law enforcement and criminalisation remain the dominant responses to drug use and people who use drugs in Sub-Saharan Africa. Even in Mauritius, which has the most developed harm reduction response in the region, there have been moves to reintroduce the death penalty for drug trafficking, especially for the importation of buprenorphine, provoking a strong reaction from national and international advocates.[14] Increased advocacy efforts to raise awareness around the urgency of responding to HIV and drug use among policy makers and health care providers are essential to bolster political support for harm reduction in the region.

Civil society and advocacy developments for harm reduction

Although civil society organisations (CSOs) with a focus on people who use drugs remain few in number, in the past two years some CSOs have worked alongside international organisations to advocate for the introduction and scale-up of harm reduction in the region.

The Sub-Saharan African Harm Reduction Network (SAHRN) was established in 2007 to increase the awareness of the need for a public health response to drug use and the adoption of a harm reduction approach in the region. SAHRN is building its membership and attempting to reach wider audiences through regular newsletters and through a website launched in early 2010: www.sahrn.net. In addition, the network has participated in various global conferences, including the XVII International AIDS Conference in Mexico in August 2008, Harm Reduction 2008 and 2009 in Barcelona and Bangkok respectively and the 1st Regional Middle East and Africa Harm Reduction Conference in Beirut in May 2009.

The Sub-Saharan African region held its first conference on harm reduction in 2009, organised and hosted by a Mauritian consortium of NGOs. The event was attended by representatives from all the Indian Ocean island states, along with participants from Mauritius, Kenya, Tanzania, Zanzibar and Mozambique. Community representatives, including people receiving MMT and people living with HIV from the host country, also played a prominent role at the conference.[8]

As in other regions, civil society organisations are responding to HIV and drug use in the absence of government programmes. In a number of countries where harm reduction services are limited or difficult to access, NGOs provide some outreach, HIV risk reduction information and health services for people who use drugs. For instance, in Kenya, in the absence of government programming, the Nairobi Outreach Services Trust, the Muslim Education and Welfare Association, the Omari Project and the Reachout Centre Trust all provide services to people who use drugs in the cities of Mombasa, Malindi and Nairobi, some since the mid-1990s.[9 10] There is an urgent need to strengthen advocacy on these issues and to begin bridging the service provision gap for people who use drugs. This requires increased support from government, donors and international organisations, including NGOs and multilateral agencies.

Multilaterals and donors: Developments for harm reduction

Existing prevention and care measures for people who use drugs in Sub-Saharan Africa are mainly supported by international donors and multilateral agencies. UNODC (as part of the Joint UNAIDS Team in Kenya and the UNAIDS Regional Support Team in Eastern and Southern Africa), WHO and UNICEF provide technical assistance to harm reduction initiatives in the region. Also since 2008, the Open Society Institute has begun supporting programmes to increase access to justice for people who use drugs in both Kenya and Tanzania.[15]

UNODC has played a key role in harm reduction scale-up in Mauritius and in sharing these experiences at the regional level. In 2009 the Mauritian Ministry of Health and the National AIDS Secretariat, assisted by UNODC and other agencies, successfully mobilised over US$3 million for the period 2009 to 2013 from the Global Fund to Fight AIDS, Tuberculosis and Malaria.[16] This programme will provide essential support to harm reduction interventions and services for high-risk groups, including people who inject drugs.[16]

In October 2009 the WHO and the UNODC offices in the region funded a surveillance survey in Mauritius to estimate the prevalence of injecting drug use and of HIV amongst the injecting population. The final report will be released in April 2010. A similar survey is planned in the Seychelles with the financial assistance of the UNODC and the Indian Ocean Commission.[8]

Since the majority of resources are directed towards heterosexual HIV transmission, most countries in Sub-Saharan Africa have limited institutional and technical capacity to address the issue of drug use and injecting effectively. Most countries are far from implementing the comprehensive package of interventions advocated by UNODC, UNAIDS and WHO to reverse the epidemic and reduce drug-related harms.[17] Multilateral agencies' continued focus on harm reduction, as well as increased support for key regional and local partners, including civil society and organisations of people living with HIV and who use drugs, is necessary for the development of a comprehensive response in the region.

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