



2.9 | Regional Update **Sub-Saharan Africa**



Table 2.9.1: Epidemiology of HIV and Viral Hepatitis, and Harm Reduction Responses in Sub-Saharan Africa

Country/territory with reported injecting drug use ^a	People who inject drugs ^b	HIV prevalence among people who inject drugs (%) ^b	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%) ¹	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%) ¹	Harm reduction response ^c	
					NSP ^d	OST ^e
Côte D'Ivoire	nk	nk	nk	nk	✗	✗
Djibouti	nk	nk	nk	nk	✗	✗
Gabon	nk	nk	nk	nk	✗	✗
Ghana	nk	nk	40.1	nk	✗	✗
Kenya	49,167 ²	18.3 ²	51.4 (42.2–60.6)	6.4	✗	✓ (M,O) ^f
Malawi	nk	nk	nk	nk	✗ (P)	✗
Mauritius	9,253 (5,699–10,444) ³	47.4 ³	97.3 ³	9	✓ (52) (P)	✓ (16)(M,O)
Nigeria	nk	4.2 ⁴	nk	nk	✗	✓
Senegal	nk	9.2 ⁴	nk	nk	✗	✓ (B,O)
Seychelles	1,671 (673–1,706) ⁴	5.8 ⁹	53.5	0.1	✗	✗
Sierra Leone	nk	nk	nk	nk	nk	✗
South Africa	67,000 ⁵	19.4 ⁴	nk	nk	✓ (1)(P) ⁵	✓ (6)(M,B)
Uganda	nk	nk	nk	nk	✗	✗
Tanzania	25,000–50,000 ⁶⁸	42 ⁶⁸	22.2	3.8	✓ (1) (P)	✓ (1)
Zambia	nk	nk	nk	nk	✗	✗

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, HRI data collection in 2007/08 also identified 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 Unless otherwise stated, data are sourced from Mathers B et al. for the Reference Group to the UN on HIV and Injecting Drug Use (2008) Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review, Lancet, 372(9651):1733–1745.

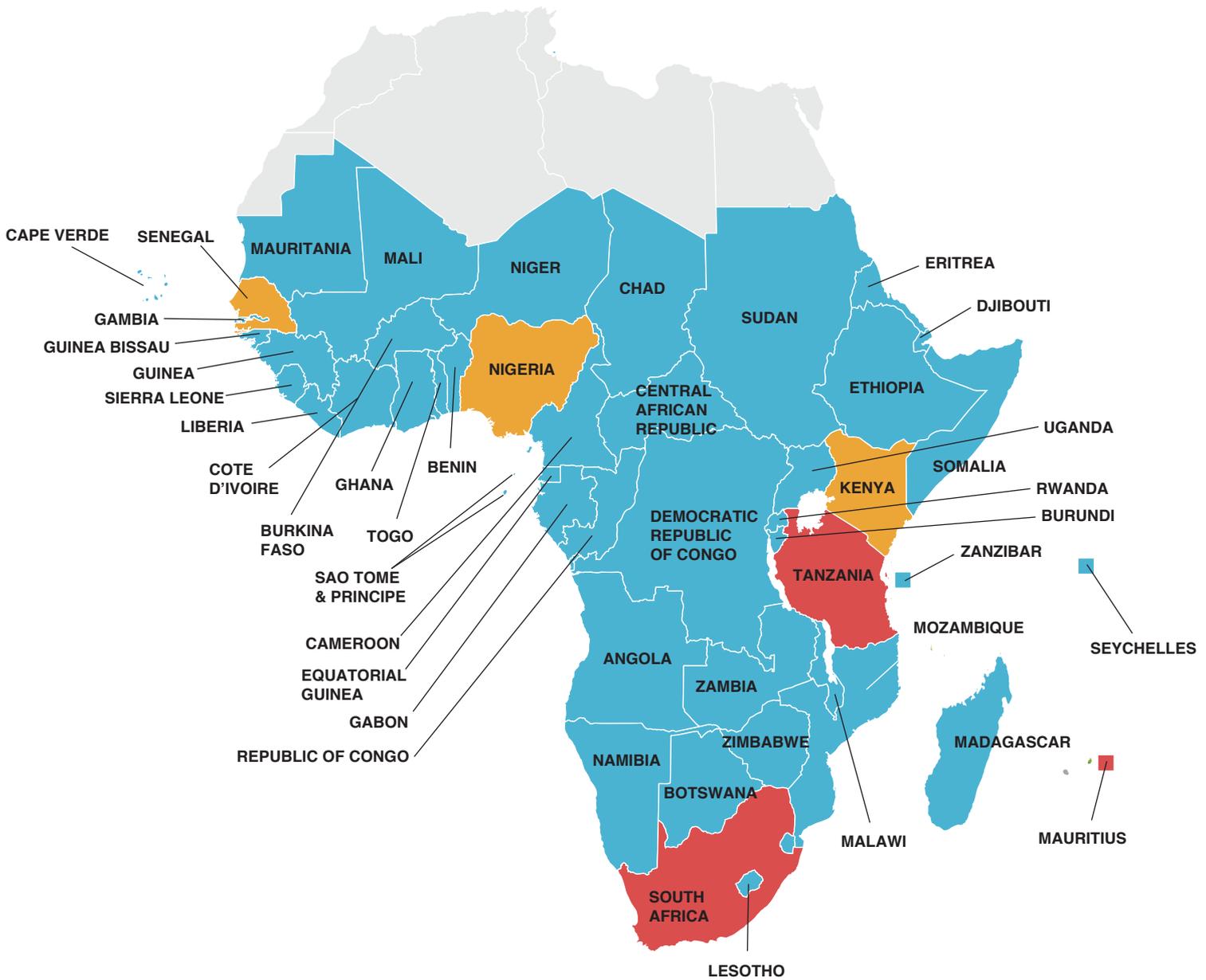
c Unless otherwise stated, data on NSP and OST coverage are sourced from Mathers B, Degenhardt L, Ali H, Wiessing L, Hickman M, Mattick RP, Myers B, Ambekar A & Strathdee SA for the Reference Group to the United Nations on HIV and Injecting Drug Use (2010) HIV prevention, treatment and care for people who inject drugs: A systematic review of global, regional and country level coverage, Lancet, 375(9719):1014–28.

d 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.

e 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, (O) = any other form (including morphine and codeine).

f Methadone is available on a very limited basis from private clinics only.

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

Harm Reduction in Sub-Saharan Africa

Available estimates suggest that there may be 1,778,500 people who inject drugs (PWID) in sub-Saharan Africa (range: 534,500–3,022,500).⁶ Among them, an estimated 221,000 (range: 26,000–572,000) may be living with HIV.⁶ However, since this estimate is based on only 13 out of 47 countries in sub-Saharan Africa, it is likely that current figures underestimate the true extent of injecting drug use (IDU) and HIV among injecting populations in the region. In 2009, the prevalence of IDU across the region was estimated at 0.2% in the general population.⁷

Available estimates of HIV prevalence among PWID in sub-Saharan Africa range from 4.2% in Nigeria to 51.6% in Mauritius, among a small number of countries for which data exist (see Table 2.9.1).³ Unsurprisingly, HIV prevalence among PWID is higher than in the general population; for example, in 2011 HIV rates among PWID in Zanzibar were approximately 25%, compared to less than 1% among the general population.⁸ Significant proportions of PWID in Kenya, Tanzania, Mauritius, Mozambique and South Africa engage in high-risk injecting practices, including sharing of needles, syringes and other injecting paraphernalia.^{9–11}

The growing number of PWID in sub-Saharan Africa has been closely associated with the emergence of many African countries as key transit points in the global trafficking of heroin, cocaine and other drugs.^{7,13} For example, the Indian Ocean coastal regions of Tanzania and Zanzibar are situated on the path of multiple trafficking routes.⁷ South Africa and several countries in Western Africa likewise act as key transit points for cocaine trafficking routes from Latin American producers.⁷ Ineffective border controls, limited cross-border and regional cooperation and deficiencies in the criminal justice systems allow for relatively easy access to heroin from Afghanistan, Thailand, India and Pakistan.⁵⁸

Sub-Saharan Africa remains significantly behind global efforts to implement and scale up harm reduction interventions as part of a comprehensive HIV response for PWID. Existing needle and syringe exchange programmes (NSPs) have been scaled up in Mauritius, and new programmes have been established in South Africa and Tanzania. In South Africa, provision is small-scale, based in Cape Town only and targeted specifically at men who have sex with men (MSM), whereas in mainland Tanzania the opioid substitution therapy (OST) programme is backed by the government and has been in operation since February 2011.

Existing interventions are largely restricted to major cities and coastal regions where IDU appears to be more concentrated.⁹ Although anecdotal evidence suggests that IDU may also occur in rural areas and smaller towns,¹⁴ existing programmes in Kenya and Tanzania are focused in and around Mombasa, Nairobi and Dar es Salaam.⁹ In all cases, the scale of existing

services remains far below estimates needed to reverse the HIV epidemic among this population.¹⁵

There are substantial evidence gaps on the epidemiology of HIV and viral hepatitis among PWID, particularly for Central and Western African countries. Since 2010 there have been attempts to address the dearth of population-based studies among PWID and injecting-related HIV infection in the sub-Saharan Africa region,⁹ with bio-behavioural surveillance projects now being conducted in the major drug consumption cities of Nairobi and Mombasa in Kenya.¹⁰ However, even in East and Southern African countries that conduct surveillance, these assessments are not conducted regularly enough to track trends in IDU and HIV. As a result, in most countries there is still insufficient understanding of the size and distribution of key affected populations, rendering calculations of intervention needs and coverage very challenging.¹⁶ Further investigation is urgently needed to understand the extent to which existing interventions effectively meet the needs of PWID to determine the scale of the response required.¹⁷

Major legal and policy barriers, including criminalisation of people who use drugs (PWUD), present significant barriers to accessing existing programmes where these do exist, and exacerbate unsafe injecting practices and HIV transmission among PWID.^{7,18} Although there has been an increasing awareness of the need to address IDU-related HIV in the region since 2010, approaches in many countries continue to focus on supply reduction and law enforcement rather than public health.

Developments in harm reduction implementation

Needle and syringe programmes

Provision of NSPs in sub-Saharan Africa is limited to isolated efforts by non-governmental organisations (NGOs) in a small number of countries. In June 2012 the Kenyan government announced that it will begin distributing sterile needles and syringes to PWID across the country.¹⁹ At the time of writing, the proposed NSP was still in the early phases of discussion, and potential implementation sites in Kenya had yet to be identified.²⁰ A small NSP programme was launched in Cape Town, South Africa in August 2010 as part of Health4Men, a project providing free sexual health care to MSM.²¹ However, its reach remains limited to a small number of MSM. There are plans to open a second site in Gauteng in South Africa.²¹ In late 2010 Médecins du Monde-France (MdM-F) initiated the first NSP site in Tanzania, in the Temeke district of Dar es Salaam.⁸ Although still in the early stages of development with a relatively small reach, by September 2011 the MdM team had made contact with 1307 PWID, distributing a total of 32,700 needle and syringes.

The number of operational NSP sites in Mauritius, the first country in the region to implement NSPs, was scaled up from 39 sites in 2010 to 52 sites in 2012.⁵ Despite increases in the number of sites, coverage of existing NSP services in Mauritius remains low compared to international coverage targets,¹⁵ with 30 syringes distributed per PWID per year.^{22g} Some NGOs in Seychelles distribute needles, syringes and other injecting equipment sporadically; however, these efforts are not officially recognised or accounted for by government authorities.²³

In countries where data are available, sharing of injecting equipment among PWID appears to be common. In Nigeria, the percentage of PWID reported to have used sterile equipment for their last injection has decreased over the past two years, from 89.2% in 2010 to 70.8% in 2012.²⁴ More than a third of the 540 participants in a Kenyan study reported sharing injecting equipment with close friends or primary sex partners.² Reasons for sharing injection equipment included lack of personal needles when required (23%), difficulty in accessing new needles or cost (17%), pressure from peers (14%) and being in prison (2%).² HIV prevalence was six times higher (30%) among those that reported ever having shared needles and syringes than among those that never shared (5%), and 47% reported sharing a needle or syringe in the past month.² In South Africa, 86% of PWID reported sharing needles and syringes, with some reporting re-using injecting equipment up to 15 times.²⁵

Legal barriers and social stigma present major barriers to accessing sterile injecting equipment, often forcing PWID to hide injecting equipment and engage in unsafe injecting.¹⁰ ²⁶ Even in places where it is legal to purchase needles and syringe, fear of discrimination or disapproval from the community often deters individuals from accessing the services they need.⁵ In a study from Kenya, an average of 31% of respondents reported having been confronted by the police or having injecting equipment confiscated by law enforcement authorities within the past six months.² The threat of arrest for possessing residual traces of heroin in the syringe barrel when returning used injecting equipment remains a significant deterrent to those seeking to access NSP facilities.²⁷

An emerging concern is the overlap between the injecting and sexual networks of several key populations at higher risk of HIV, including PWID, MSM and sex workers. Research from South Africa highlighted a significant intersection between IDU and high-risk sexual practices.²⁸ A 2010 study of 509 MSM in Zanzibar reported that 60% used a needle after someone else had used it, with 68% passing a needle on to someone else after injecting.⁵⁸ Effective responses to overlapping high-risk behaviours require both the mainstreaming of harm reduction services within broader HIV prevention services

as well as the inclusion of population-specific needs, such as those of women or MSM, within existing harm reduction programmes. It is unclear whether and to what extent such integrated services are available in countries within this region.

As in other parts of the world,²⁹⁻³⁰ women who inject drugs in the region experience disproportionately higher levels of negative health outcomes compared with their male counterparts.^{2, 8, 31} Though fewer in number compared with their male counterparts, women who inject drugs have consistently higher HIV prevalence than male injectors.¹⁰ In a 2011 Kenyan study, HIV prevalence was 47% among women injectors compared with 17% among male injectors.¹⁰ Flashblood,^h which has previously been documented among women who inject drugs in Tanzania and Zanzibar,³² is now also evident along the Kenyan coastal towns of Mombasa and Malindi,³³ indicating cross-border influences of drug consumption trends among countries in the same geographical region.

Opioid substitution therapy

OST remains largely unavailable throughout sub-Saharan Africa (see Table 2.9.1). Tanzania is the only country in the region that has initiated an OST programme since 2010, in addition to the program already operating in Mauritius.¹⁷ Located within Muhimbili University Hospital, Tanzania's OST programme began operating in February 2011.⁸ Although the outreach capacity of the existing single facility is limited, 175 PWID received treatment through this programme as of September 2011.⁸ Plans to open an additional site were in progress at the time of writing.

Limited OST services are available in South Africa and Senegal, but there is very limited government support. In South Africa, legal restrictions for using methadone for substitution therapy have been lifted, and buprenorphine is also available for substitution, only in the private health sector.³⁴ This effectively limits access to these medicines for the vast majority of people who use opiates who are not covered by private health insurance and cannot afford the medicines.⁵ Despite evidence that access to OST could prevent 14% of new HIV infections projected to occur in Nairobi between 2010 and 2015,³⁵ methadone for detoxification is only available in one clinic on a very limited basis.

Antiretroviral therapy

In December 2010, an estimated 5,064,000 people were receiving antiretroviral therapy (ART) in the sub-Saharan Africa region. This represented almost half of the people living with HIV that were eligible for ART. Coverage differed significantly between Eastern and Southern Africa (56%) and West and Central Africa (30%).³¹

g If the 4728 clients on Methadone Maintenance Therapy are excluded from the calculation, the number of syringes distributed per PWID per year would be 60.

h Flashblood is high-risk practice that involves blood-sharing by injecting the blood of the person who got the main hit to experience some of the effect of the drug.

National reporting to WHO in 2010 on the availability of HIV prevention, treatment and care services for PWID revealed that only nine out of thirty-five reporting sub-Saharan African countries had services in place providing ART to PWID.³¹ There remain very limited data on the numbers of PWID that may be accessing ART within the region. The Reference Group to the UN on HIV and Injecting Drug Use reported that thirty-eight PWID in Kenya and 138 PWID in Mauritius were receiving ART in 2008. These estimates were equal to less than 1% of HIV-positive PWID in Kenya and 1.1% (range 0.4–9.2%) of HIV-positive PWID in Mauritius receiving ART.¹⁷ The global average, according to the UN Reference Group was 4% of HIV-positive PWID receiving ART.¹⁷ Despite the significant caveats on these calculations,ⁱ it is clear that the response to HIV among PWID is much further developed in Mauritius than in the rest of the region. While more data are necessary to accurately assess the situation, with an absence of targeted HIV interventions for PWID, along with substantial barriers to accessing health care services,³⁶ the overwhelming majority of PWID eligible for ART in sub-Saharan Africa are currently unlikely to receive it.

Where services providing ART are available to PWID, there are significant factors which may impede service access. These include, but are not limited to, institutionalised stigma and discrimination against PWID within health care systems, a perceived or real lack of confidentiality and subsequent fear of health care professionals reporting drug use to the police, as well as treatment providers refusing access to ART on the basis of drug use.³⁶

Viral hepatitis

The prevalence of hepatitis C (HCV) among the general population in sub-Saharan countries varies but is generally high.³⁷⁻³⁸ Similarly, the majority of countries in the region have considerable hepatitis B (HBV) epidemics among the general population.³⁹

There is a paucity of available data on viral hepatitis among PWID across sub-Saharan Africa. In the five countries where estimates are available, HCV prevalence may be significantly higher than HIV prevalence among PWID. Estimates were available for Tanzania (22.2%), Ghana (40.1%), Mauritius (97.3%), Kenya (51.4%, range 42.2–60.6%)¹ and Seychelles (53.5%)⁴⁰ (see Table 2.9.1). In a Tanzanian study, HCV prevalence was 28% among PWID compared with 2% in their non-injecting peers.⁸ Data on HBV among PWID are similarly limited, with estimates only available for four countries: Tanzania (3.8%), Kenya (6.4%), Seychelles (0.1%) and Mauritius (9%).¹ For many countries in the region, the failure to acknowledge the existence of PWIDs continues to thwart systematic surveillance efforts to monitor viral hepatitis and other IDU-related harms among this population.

ⁱ Not all HIV-positive people who inject drugs will be eligible for ART. The calculation of the ratio of PWID receiving ART is based on the UN Reference Group (C grade) estimate of 130,748 PWID in Kenya and an estimated HIV prevalence of 42.9% among them. More recent data suggests both the number of PWID and the HIV prevalence among PWID to be significantly lower (see Table 2.9.1).

While the cost and quality of HCV treatment regimens may change in the near future, at present the cost and complexity of treatment delivery pose substantial barriers to implementation in high-prevalence, low-resource settings.^{1,41} The significance of viral hepatitis among populations engaging in IDU needs considerably more recognition in the region. Targeted messaging for hepatitis prevention must be integrated within comprehensive HIV prevention and treatment services.⁵⁸ There are indications that such services may be developed in Zanzibar, where plans include the establishment of integrated HIV/viral hepatitis facilities that will target key affected populations.⁵⁸

Tuberculosis

Tuberculosis (TB) prevalence in the sub-Saharan region is notably high. Where available, TB rates per 100,000 in the population were reported to be highest in South Africa (981) and Zimbabwe (633), with Mozambique (544) and the Democratic Republic of Congo (327) also reporting substantial rates.⁴² South Africa currently reports the third highest TB burden in the world, with TB incidence having increased by 400% over the past fifteen years.²⁵ An estimated 80% of South Africa's population are currently infected, and TB/HIV co-morbidity is estimated to reach 60% among people living with HIV.²⁵ While the majority of people infected with TB will not develop active TB disease, PWUD and prisoners are more vulnerable to progressing to active TB disease.⁴²

Although integrated TB/HIV testing and treatment is beginning to emerge in South Africa²⁵ and other parts of the region, there are no known interventions specifically targeting PWID. The challenges posed by TB/HIV co-infection among PWID are intensified by incarceration, with TB prevalence amongst prison populations much higher than prevalence in the general population.⁴³ High rates of TB in prisons are further exacerbated by overcrowding, poor sanitation, late diagnosis, inadequate treatment of infectious cases, high transfer rates and gaps in continuity of care upon release.

Overdose

Data on the prevalence of and responses to overdose in sub-Saharan Africa are extremely scarce. Available data indicate that risk of overdose is high in some parts of the region. For instance, overdose cases in Kenya are estimated to be 83–90% higher in Nairobi than in the coastal areas, and approximately 58% of PWID in Kenya reported knowing at least one person who had experienced a fatal overdose.¹⁰

Naloxone, a highly-effective opioid antagonist used to reverse the effects of overdose, has been approved and is available for the management of overdose in hospital emergency departments in Tanzania.⁹ However, in the context of significant stigma and criminalisation of PWID, who may be reluctant to access services for fear of being reported, managing overdose remains a challenging feat in countries

in the region.⁴⁴ Community distribution of naloxone through peers is unknown to operate in any countries within the region.⁴⁴ Given the paucity of data available on this issue, further investigation is required to better understand the extent of overdose in countries in sub-Saharan Africa and to expand access to overdose prevention programmes that include peer distribution of naloxone among PWID, their families and communities.

Harm reduction in prisons

Criminalisation of drug use and possession and drug-related crime contribute to a high proportion of PWID among sub-Saharan African prison populations.¹⁰ Anecdotal evidence suggests that prison settings may be contributing considerably to accelerating HIV transmission due to the high availability of drugs and the lack of sterile injecting equipment.⁷

IDU has been documented in prisons in Côte d'Ivoire, Mauritius, Kenya and Ghana.¹⁰ Kenyan prisons are predominantly populated by adult males, with a significantly smaller number of female and juvenile inmates.⁴⁵ Drug trafficking and trading in prison is reported to be common, with drugs often brought in by inmates attending court dates or by security officers either supplying the drugs or facilitating their entry.² HIV prevalence in the Kenyan prison population is 8.2% compared with a national prevalence of 6.4%, and is significantly higher (19%) among female inmates than among male inmates (6%).⁴⁵

Access and take-up of testing services is limited, particularly for TB and viral hepatitis. Approximately 77% of Kenyan inmates reported ever being tested for HIV, 23% for TB and less than 2% for viral hepatitis.⁴⁵ In neighbouring Uganda, HIV prevalence in the prison population is nearly twice as high as the national prevalence in adults.⁴⁶ Where data are available, a high percentage of PWID report sharing injecting equipment while incarcerated. The overwhelming majority of PWID (81%) surveyed in Nairobi and coastal provinces in Kenya report having been previously incarcerated.² Approximately 7% reported injecting drugs while in prison, and of these, 61% reported sharing needles or syringes.²

NSP and OST are not implemented in any prisons in the sub-Saharan Africa region. Although Nigerian government objectives outline a commitment to increased access for PWID to a full range of harm reduction measures, planned services in prisons are limited to drug treatment, telephone hotlines and drop-in centres for providing information and referrals.⁴⁷

Policy developments for harm reduction

Progress in terms of the development of a conducive policy environment for harm reduction remains limited across the region, with a few exceptions. Harm reduction is mentioned in the Tanzanian National Strategy for Non-Communicable Diseases (NCD) 2009–2015, with key objectives on the most-at-risk populations outlined in the National Multisectoral Strategic Framework on HIV/AIDS.⁴⁸ In Kenya the recently launched national HIV strategy similarly denotes a national response to emerging evidence of changing epidemiological dynamics, affirming universal access to HIV prevention, treatment, care and support.⁴⁶ Recent steps have also been taken to increase the engagement of provinces, districts and local communities in HIV service planning across the country.⁴⁶ Ongoing strategic objectives in Mauritius include dialogue and sensitisation with the Anti-Drug Smuggling Unit to improve the running of the NSPs, advocacy for the decriminalisation of the distribution and carrying of syringes, the implementation of harm reduction programmes in prisons and the implementation of awareness-raising programmes in the community to mitigate stigma and discrimination.²²

Despite these advancements, for the majority of countries in the region, relevant policies continue to focus on supply reduction and the criminalisation of PWUD, impeding efforts to implement evidence-based harm reduction interventions.² For instance, despite progress with the implementation of the first NSP in Tanzania, the possession of needles is still illegal across some jurisdictions.^{8, 49} Although HIV-related discrimination is now prohibited in Kenya, national legislation and policy fail to offer legal protection for certain key populations.⁴⁶ Furthermore, although reference to harm reduction appears in Nigeria's National Policy on HIV and AIDS,⁵⁰ the country's National Drug Law Enforcement Agency (NDLEA) continues to focus on supply control and demand reduction via seizures and arrests. PWID are routinely harassed, raided and detained in already overcrowded prisons in the attempt by the NDLEA to control drug availability.⁴⁷

While there is an increasing awareness of the need to address IDU-related HIV in region, as can be seen above, drug policy continues to focus on supply reduction and rely on law enforcement rather than public health approaches, with very few exceptions. Progress toward the overhaul of current drug policies and regulations in favour of harm-reduction-based strategies is impeded by the lack of political will and support. Increased advocacy efforts are essential to strengthen political support for public health and human-rights-based approaches to addressing HIV related to IDU in the region.

Civil society and advocacy developments for harm reduction

Although civil society organisations (CSOs) with a focus on PWID and harm reduction are limited in number within the region, there has been a marked increase in the number of local CSOs working alongside international organisations to advocate for the introduction and/or scale-up of harm reduction services since 2010.

In the continuing absence of local government support for harm reduction, regional CSOs remain the main advocates for harm reduction. A meeting of civil society groups was held at a pre-conference event during the 16th International Conference on AIDS and Sexually Transmitted Infections (STIs) in Ethiopia in December 2011. Among the outputs of this meeting was the formation of a sub-regional harm reduction and drug policy network to be hosted by Kenya AIDS NGOs Consortium (KANCO). The objectives of the network include strengthening links between local harm reduction networks in sub-Saharan Africa, promoting awareness and facilitating the adoption of harm reduction initiatives across the continent. The network will continue to work together with national harm reduction networks and organisations in Uganda and Kenya, as well as focal points in Tanzania, Mauritius, Nigeria and Ethiopia.

There are a number of newly formed national networks in the region including those based in Kenya and Uganda. Formed in January 2011 by current and former PWUD based in Kampala, the Ugandan Harm Reduction Network (UHRN) is a national non-profit organisation that works to promote the health of individuals and communities affected by drug use. UHRN engages in advocacy, information sharing and dissemination and capacity-building, and seeks to act as a coordinating body for member associations representing marginalised groups in the country. Similarly the Kenyan Harm Reduction Network was formed in 2011 and is made up of harm reduction organisations that aim to advocate for a harm reduction approach to drug use and drug policy.

Other new initiatives include those in the Seychelles; while key groups are still not directly targeted in national prevention programmes, NGOs have attempted to become more proactive in addressing the specific needs of key populations at higher risk of HIV, including PWID.²³ Moreover, several programmes in Zanzibar are currently being developed to strengthen and extend the capacity of the public health system, community-based organisations and associated peer-education initiatives.⁵⁸

In June 2012 INPUD developed and led capacity-building workshops for drug user advocates in Kenya as part of the CAHR project, and in Tanzania in partnership with MdM. The overall aim of the workshops was to determine existing and potential platforms for PWUD to input into the development,

implementation and evaluation of programming and decision-making around national-level services and policy that impact upon PWUD. Activities included information dissemination around harm reduction, training in drug user organising and capacity-building to deliver peer education. As a result of these workshops, national drug user networks were founded in each country.⁵¹

The region held its second harm reduction conference in 2011, hosted by Collectif Urgence Toxida (CUT), a network of NGOs and individuals working in the field of drug use and HIV/AIDS mainly in Mauritius and the Indian Ocean. The conference was attended by participants from all of the Indian Ocean states as well as Kenya, Tanzania, Zanzibar, Mozambique and Morocco, among others. The theme of the conference was 'Towards a client-centred approach' and aimed to engage the participants in dialogue around the improvement of the quality of harm reduction services delivered in Mauritius. Importantly, the conference emphasised the human rights and public health principles that underscore harm reduction.

Multilaterals and donors: developments for harm reduction

Multilateral agencies and donor NGOs provide the majority of HIV/AIDS spending in sub-Saharan Africa. The German Society for International Cooperation (GIZ) provides technical assistance to exchange initiatives in parts of the region including Mauritius, Sierra Leone and Kenya.

Open Society Foundations, through the International Harm Reduction Development Program (IHRD) and the Open Society Initiative for Eastern Africa (OSEA), has supported organisations working with PWUD in Kenya and Tanzania to increase knowledge and capacity on harm reduction, health and human rights protections. Support has included: study visits for NGO representatives to harm reduction programmes in Africa (Mauritius) and North America; support for legal empowerment, including legal aid, paralegal training and NGO support for PWUD at police stations, in pre-trial detention and in prisons; training on naloxone provision, needle exchange and harm reduction basics; presentations and participation at national, regional and international conferences and advocacy to increase awareness of harm reduction principles, decrease rights abuses, secure national and international funds for harm reduction, and network with other community organisations working with PWUD.

The short-lived 2009 US Congressional decision to allow the use of federal funds for NSPs and subsequent revisions to HIV prevention guidance from the President's Emergency Plan for AIDS Relief (PEPFAR)⁵² represented an opportunity to expand and develop existing harm reduction interventions and to rally support for evidence-based approaches targeting PWID.⁹ However, the reinstatement of the ban on the use of US

federal funds for NSPs⁵³ in December 2011 greatly undermined burgeoning efforts to expand harm reduction in the region.

The Global Fund to Fight AIDS, Tuberculosis and Malaria explicitly supports harm reduction as part of its commitment to fund evidence-based, cost-effective interventions.⁵⁴ However, of the 55 countries and territories supported by the Global Fund since its inception, only three African countries with generalised HIV epidemics – Burundi, Kenya and Nigeria – were included (see Table 2.9.2).⁵⁵

Table 2.9.2: Approved Global Fund investments targeting people who inject drugs in sub-Saharan Africa, Round 1 (2002) to Round 10 (2010)⁵⁶

COUNTRY / TERRITORY	TOTAL (US\$)	
Burundi	600,000	*
Cape Verde	700,000	*
Kenya	1,900,000	*
Madagascar	1,300,000	*
Mauritius	1,500,000	*
Nigeria	1,300,000	*
Zanzibar	500,000	‡
TOTAL	7,800,000	

Notes

Figures are rounded. Data are correct as of March 2012. Data are based on detailed grant budgets submitted to the Global Fund and may not reflect actual expenditures.

* Figure includes projections for future years of grants that have not yet been formally committed.

‡ Zanzibar, a semi-autonomous part of Tanzania, receives separate grants from the Global Fund.

Despite the major concerns posed by IDU-related HIV in these epidemiological settings,^{7, 31} no funds were allocated for PWID in countries with generalised epidemics in past rounds, a situation largely influenced by limited technical support, advocacy and political commitment in most settings in the region.⁵⁷ Since 2010 the dedicated funding reserve for HIV proposals that focus on most-at-risk populations created as part of Round 10 includes funding support to implement harm reduction programmes planned in Kenya.⁵⁵ In total, the Global Fund has provided US\$7.8 million for harm reduction programmes targeting PWID in the region.

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