



Regional Overview

2.8 Middle East and North Africa



Middle East and North Africa

Table 2.8.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in the Middle East and North Africa

Country/ territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response	
					NSP ^a ■	OST ^b ■
Algeria	nk	nk	nk	nk	✗	✗
Bahrain	nk	55.8 ^{(1)c}	nk	nk	✗	✗(M) ^d
Egypt	31,000 ^{(2)e}	6.5–6.8 ⁽³⁾	49.4 (35.8–63) ⁽⁴⁾	13.5 (10.9–16) ⁽⁴⁾	✓9 ⁽⁵⁾	✗
Iran	200,000 ⁽⁶⁾	13.8 ^(6, 7)	50.2 (34.5–65.9) ⁽⁴⁾	17.3 (3.7–30.9) ⁽⁴⁾	✓580 ^{(6)f}	✓75,983 (M, B, O) ⁽⁶⁾
Iraq	34,673 ^{(8)g}	nk	nk	nk	✗(P)	✗
Israel	nk	nk	67.6 ⁽⁴⁾	2.8 ⁽⁴⁾	✓5 ^{(9)h}	✓(B, M)
Jordan	nk	6 ⁽¹⁰⁾	nk	nk	✓2 ⁽⁵⁾ⁱ	✗
Kuwait	nk	0 ⁽¹¹⁾	54 ^{(11)j}	nk	✗	✗
Lebanon	3,114 ⁽¹²⁾	1 ⁽¹³⁾	52.8 ⁽¹⁴⁾	nk	✓2 ^{(5)k}	✓ ^l
Libya	7,206 ^{(8)m}	87 ⁽¹⁵⁾ⁿ	94 ⁽¹⁵⁾	5 ⁽¹⁵⁾	✗	✗
Morocco	18,500 ⁽¹⁶⁾	11.4 ⁽¹⁷⁾	57 ⁽¹⁸⁾	nk	✓4 ⁽¹⁹⁾	✓6 ⁽¹⁹⁾
Oman	nk	3.8 ^{(20)o}	nk	nk	✗	✗
Palestine	nk	0 ⁽³⁾	nk	nk	1 ⁽²¹⁾	✗
Qatar	nk	nk	nk	nk	✗	✗
Saudi Arabia	10,000 ⁽²²⁾	3.5 ^{(23)p}	49.8 (14.1–85.4) ⁽⁴⁾	49.8 (14.1–85.4) ⁽⁴⁾	✗	✗
Syria	10,000 ⁽²²⁾	nk	60.5 ⁽⁴⁾	60.5 ⁽⁴⁾	✗	✗
Tunisia	9,000 ⁽¹⁷⁾	3 ⁽¹⁷⁾	nk	nk	✓3 ⁽²⁴⁾	✗
United Arab Emirates (UAE)	nk	nk	nk	nk	✗	✗ ^{(25)q}
Yemen	nk	nk	nk	nk	✗	✗

nk = not known

^a All operational needle and syringe exchange programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers. (P) = pharmacy availability.

^b Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.

^c People who inject drugs are reached only through post-rehabilitation or prison programmes (n=244), which may not be representative of the total number of people who inject drugs.

^d Although methadone is available for people who inject drugs in Bahrain, it is for detox purposes only.

^e Sub-national data based on greater Cairo (30,000) and Menia (1,000). At the time of reporting there was no national estimate for Egypt.

^f 580 refers to free state welfare organisation NSP provision and does not include needles and syringes that can be purchased at pharmacies.

^g Figure based on a literature review between 1998 and 2005.

^h Figure relates to the number of cities that operate NSPs in Israel, rather than the number of sites.

ⁱ Figure relates to the two known organisations providing NSPs in Jordan, rather than the number of sites.

^j Figure based on a sub-sample of 98 people who inject drugs in a treatment centre.

^k Figure relates to the two known organisations providing NSPs in Lebanon, rather than the number of sites.

^l OST available only in the private sector.

^m Figure based on a literature review between 1998 and 2005.

ⁿ Figure based on sub-national data from Tripoli and Benghazi.

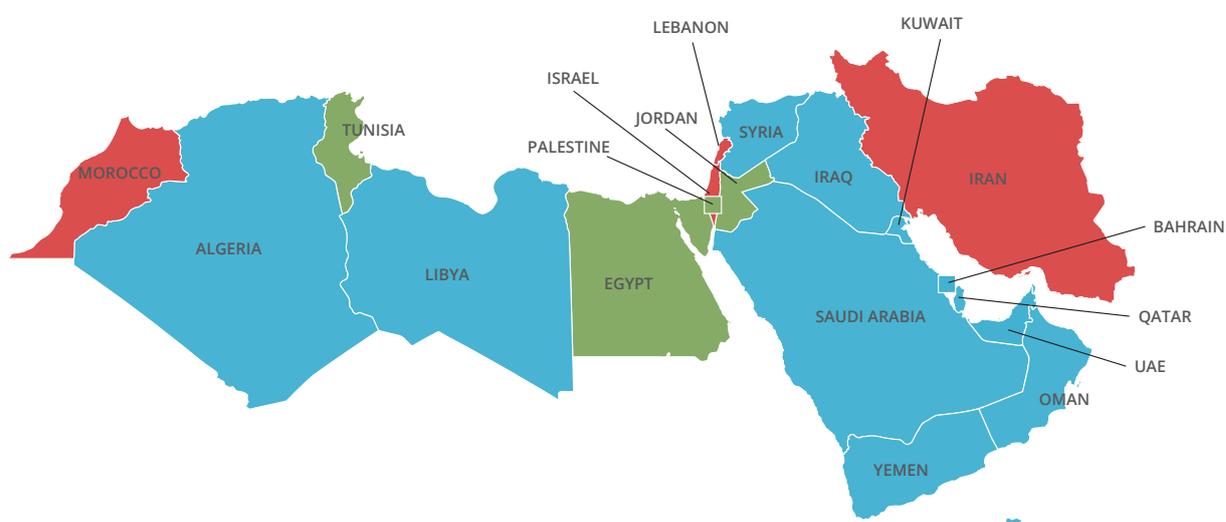
^o Figure based on facility-based mandatory testing and not on representative bio-behavioural surveys.

^p 2013 data from three detoxification centres in Riyadh, Jeddah and Daman, which may not be representative of the total number of people who inject drugs.

^q Although OST is available for people who inject drugs in UAE, it is for detox purposes only and only available at the National Rehabilitation Centre in Abu Dhabi.



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



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

Harm reduction in Middle East and North Africa

Overview

People who inject drugs, men who have sex with men, and female sex workers remain the most affected groups in terms of HIV, hepatitis C and hepatitis B in the Middle East and North Africa (MENA) region.⁽¹⁷⁾ Newly identified HIV infections have increased in MENA by 31% since 2001.⁽²⁶⁾ From an estimated 240,000 (150,000–320,000) people living with HIV, 57% of all new adult infections are among people who inject drugs.⁽²⁷⁾

Within MENA, the number of people who inject drugs ranges between 299,000 and 1,128,000,⁽²⁸⁾ the wide range highlighting the uncertainty around current estimates of population size. In most countries, population size estimates are infrequently updated and there is a lack of bio-behavioural data. Instead, there is an over-reliance on HIV case reporting and detoxification-facility-based surveillance on HIV, viral hepatitis and tuberculosis (TB) among this group.⁽²⁹⁾

New data on injecting drug use have emerged in some countries. The UNODC conducted a population size estimate of key populations in Egypt in 2014,⁽³⁰⁾ and the Middle East and North Africa Harm Reduction Association (MENAHR) collaborated with the National AIDS Program in Lebanon to undertake a size estimation, risk behaviour assessment and disease prevalence study among people who inject drugs.⁽¹²⁾

Iran remains the only country in the region to have consistently scaled up harm reduction services. However, coverage levels of NSP provision are still considered low by UN standards. Morocco, the second country in the region to implement a nationwide harm reduction strategy after Iran,⁽³¹⁾ has seen a steady increase in the number of people who use drugs in the north of the country over the last two decades.⁽¹⁹⁾ Harm reduction services have not yet been sufficiently scaled up to meet the increasing need.⁽⁵⁾

In Saudi Arabia, although harm reduction services are not yet in existence, the National AIDS Program is working on implementing a project to improve access to services for people who use drugs.⁽³²⁾ However, it is unclear whether any of these services will include NSP or OST. At present, services for people who use drugs consist only of rehabilitation centres, an approach not recommended as a first line of treatment for people who use/inject opioids.⁽³³⁾

There have been some indications of harm reduction implementation progress in the region since *Global State 2014*. The United Nations Office on Drugs and Crime (UNODC) has convened a National Opioid Substitution Therapy Taskforce in Egypt, commissioning a feasibility study to select, approve and procure the most appropriate controlled substances for piloting OST. At the time of reporting, the pilot programme was pending government approval.⁽³⁴⁾ Three organisations in Egypt have also been provided with funds through MENAHR to implement NSP outreach.⁽³⁵⁾ Jordan had planned to scale up NSP outreach. However, harm reduction activities in Jordan during 2015 slowed down considerably due to governmental restrictions on external funding to NGOs, with money released only in the summer of 2016.⁽⁵⁾

The most common response to drug use in the region is detoxification and rehabilitation, requiring the involvement of psychiatrists and physicians. Drug-related services in over half of the MENA countries are all abstinence-based, with no availability of evidence-based harm reduction initiatives such as the implementation of NSP and OST.⁽³⁶⁾ Punitive responses to drug use are among the most extreme seen globally. Of the 549 reported executions for drug offences carried out around the world in 2013, the majority were in Iran and Saudi Arabia.⁽³⁷⁾ Iran executed 367 people for drug-related offences in 2014; however, this number is likely to be an underestimate.⁽³⁷⁾

While there is no evidence to suggest that the death penalty for drugs serves as a deterrent to drug offences, the extremely punitive environment certainly hampers the extent to which harm reduction services can be delivered. Civil society reports that many people are often frightened to approach harm reduction services as they have experienced high levels of stigma, including frequent episodes of verbal and physical abuse by wider society and law enforcement figures, and a refusal of housing and employment as a result of being identified as someone who uses drugs.⁽⁵⁾

Few harm reduction services are tailored for women,⁽³⁸⁾ and further attention is required to ensure an appropriate response in the region to the health and social needs of women who inject drugs.⁽³⁹⁾ A regional capacity-building workshop on gender equality in harm reduction services was held in September 2015 by the Harm Reduction Consortium, comprising seven of the



leading international and regional harm reduction, drug policy and drug user networks. A number of civil society organisations from the MENA region participated in discussions on how to incorporate gendered services in harm reduction, and a manual entitled *Integrating Gender-Specific Services to Harm Reduction Programs in the MENA Region* has been developed and is awaiting publication. The manual includes a compilation of recommendations on how to address the gaps in providing harm reduction services to women, such as advocating for laws that specify access to services for females, and the recruitment of female outreach workers.⁽³⁵⁾

Ongoing conflicts in MENA countries have led to large numbers of internally displaced, refugee and migrant populations in the region, and there is a need to explore the extent to which injecting drug use occurs among these groups and to establish the required harm reduction response.⁽³⁹⁾ More than half of the world's refugees are located in Pakistan, Iran, Jordan and Lebanon,⁽³⁶⁾ which are also countries that sit along key drug-trafficking routes. These factors are a challenge to the fostering, implementation and scale up of harm reduction in the region.⁽³⁶⁾

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

Within the MENA region, NSPs are available only in Israel, Egypt, Jordan, Iran, Lebanon, Morocco, Palestine and Tunisia. However, even where available, these services continue to fall short of need. Only in Iran, where unsafe injecting drug use continues to be the greatest contributor to HIV incidence, is NSP provision substantial, with 580 sites across the country.⁽⁶⁾ NSP provision has steadily increased over the last five years, with coverage going from 26 to 35 syringes per person who injects drugs per year in 2012,⁽²⁴⁾ to 44 to 60 syringes in 2015. However, this is still considered to be low coverage by UN standards.⁽⁶⁾ In 2015, 81.5% of people who inject drugs reported using sterile injecting equipment,^(6, 7) with specific NSP sites, together with pharmacy provision, believed to contribute to relatively low unsafe injecting in the country.⁽⁶⁾ In total, 10,136,060 free sterile needles and syringes were provided to people who inject drugs in 2015 via the state welfare organisation.⁽⁶⁾

Since 2014, MENAHRA has financially supported organisations involved in NSP provision in Egypt, Jordan

and Lebanon via the Global Fund regional grant. In Egypt, MENAHRA worked with two organisations, Friends of HIV+ and the Friends Association, to provide 21,235 and 19,972 sterile needles and syringes respectively between July and December 2015.⁽⁵⁾ UNODC also assisted with increased coverage of NSP provision in the Luxor and Alexandria governorates, distributing 4,000 syringes between April and June 2015.⁽⁴⁰⁾ In Lebanon, Soins Infirmiers et Développement Communautaire (SIDC) reached a total of 176 people who inject drugs with NSP services in 2015, distributing a total of 89,523 needles and syringes.⁽⁵⁾ Skoun, a smaller NGO in Lebanon, also provided NSP outreach, distributing a total of 480 needles and syringes in the same year.⁽⁵⁾ In Jordan, both Forearms of Change Center to Enable Community (FOCCEC) and Friends of Development and Investment Society (FDIS) delivered NSP through outreach and fixed sites in 2015, delivering 63,396 and 80,368 sterile needles and syringes respectively.⁽⁵⁾

UNODC, in close partnership with civil society organisations, continues to provide comprehensive HIV services for people who inject drugs through drop-in centres and outreach programmes in Palestine (specifically the West Bank and Gaza). In 2015, 456 people who inject drugs benefited from harm reduction services, with 22,790 needles distributed and 1,396 information, education and communication materials given to beneficiaries.⁽⁴⁰⁾ In Morocco, 238,946 syringes were provided to people who inject drugs (80 per person who injects drugs per year) during 2014, considered low coverage by UN standards.⁽¹⁹⁾ In Israel, where NSPs operate in five cities, a total of 214,777 sterile needles and syringes were distributed in 2015.⁽⁹⁾

Although the primary mode of HIV transmission in Bahrain is unsafe injecting drug use, there is still no NSP provision in the country and people are often arrested for possession of syringes.⁽¹⁾ In Jordan, FDIS and FOCCEC organised a stakeholders' meeting in Amman to raise awareness of the benefits of NSP as a vital harm reduction service, and to disseminate the positive impact of the NSPs running in Jordan across the wider regional community.

There continues to be a complex interplay between political, legal and social commitments to harm reduction initiatives for people who inject drugs in the MENA region. Many countries, such as Bahrain, Kuwait, Qatar, Algeria, Saudi Arabia, UAE, Yemen and Iraq, continue to offer only abstinence-based detoxification services for people who use drugs, ignoring the individual and public health benefits a harm reduction approach could bring.

[†] According to the 2012 revised WHO, UNODC and UNAIDS target-setting guide, less than 100 syringes distributed per person who injects drugs per year is considered low coverage (100 to 200 is medium coverage and more than 200 is high coverage).

Opioid substitution therapy (OST)

Five countries in the region provide OST: Iran, Israel, Lebanon, Morocco and Palestine. However, many of the OST services fall short of need.

Iran presently runs the largest OST service in the region, but even its coverage levels are only just considered high by UN standards, with 41.2% of people who had injected drugs in 2014 in receipt of OST.⁽⁷⁾ Iran has since continued expansion of its OST programme, going from 4,275 sites in 2014 to 5,983 sites in 2016.⁽⁶⁾ According to UNAIDS, Morocco has also expanded its OST provision, enrolling 628 people who inject drugs onto its methadone programme during 2014.⁽¹⁹⁾ Despite this increase in provision, OST continues to have long waiting lists in both Morocco and Iran, with additional barriers in Morocco such as limited geographical coverage, restrictive prescription and delivery regulations for methadone (limited to a psychiatrist or physician specialising in drug use) as well as a lack of high-dosage buprenorphine.⁽³⁶⁾

Global State 2014 reported no OST in Egypt. Since then, however, UNODC convened a National Opioid Substitution Therapy Taskforce, commissioning a feasibility study to select, approve and procure the most appropriate controlled substances for piloting OST.⁽³⁴⁾ A pilot OST programme is now pending approval in Egypt.⁽³⁵⁾

Following the first pilot of methadone maintenance treatment (MMT) in Ramallah, Palestine, which was initiated in May 2014, the Ministry of Health opened its first permanent OST site in Ramallah.⁽⁴⁰⁾ Prior to its inception, the UNODC conducted a one-week specialised training course on OST for 15 healthcare service providers in the Ministry of Health. The training covered all aspects of a diversified, accessible and quality drug dependence treatment service, including opioids and other drugs, maintenance treatment (the medicines, the evidence, effective practices – such as evaluation, initial dose and management of dose – and tapering procedures), clinical care detoxification, dual diagnosis and relapse prevention. By the end of September 2015, 65 people had benefited from this new harm reduction service.⁽⁴⁰⁾

Viral hepatitis

There continues to be little data on the prevalence of viral hepatitis among people who inject drugs in countries within the MENA region. However, since *Global State 2014*, the hepatitis response in the region has entered a nascent stage, with some countries beginning to offer rapid screening for the hepatitis B

and C viruses, alongside HIV screening.⁽⁵⁾ In Jordan, for example, rapid screening as part of outreach programmes for people who inject drugs became available in August 2014. In Lebanon, rapid hepatitis C testing is available at voluntary counselling and testing centres and via outreach programmes for people who use drugs.⁽³⁵⁾

The World Health Assembly adopted the Global Health Sector Strategy on Viral Hepatitis 2016–2021 in May 2016. This strategy includes the term 'key populations' and highlights the need for a tailored response to tackling hepatitis among these groups.⁽⁴¹⁾ Within this framework, there is an action plan for WHO's Eastern Mediterranean Regional Office to focus its support on establishing national leadership and coordination in hepatitis control, and on collecting and analysing strategic information to guide the response, including the revision of policies. This work will also seek to strengthen services for the prevention and treatment of hepatitis by setting prevention, diagnosis and treatment targets for people who inject drugs; to collect and disseminate data; to promote policy dialogue to address barriers to harm reduction; to increase access to affordable medicines; and to monitor and evaluate the response for people who inject drugs.⁽⁴¹⁾

In light of the increasing hepatitis C epidemic, Egypt launched the first domestically funded national free treatment programme for hepatitis C in the region in 2015.⁽⁴²⁾ This treatment is for people who are co-infected with HIV, but it is unclear how accessible the service is for people who inject drugs.⁽⁵⁾

At the end of 2014 the Lebanese Ministry of Health invited MENAHRA to collaborate in the roll out of a national hepatitis B vaccination programme for people who inject drugs. In April 2015 they held a training day for NGOs who were interested in participating. The aim of the training was to present the hepatitis B vaccination project elements to the participants and to review the developed documentation and evaluation tools. In August 2015, the project protocol was sent to the NGOs involved in order to begin implementing the project. Later that year 840 hepatitis B tests and 500 hepatitis C tests were distributed to the organisations.⁽³⁵⁾

Although many countries in the region report hepatitis diagnostics and treatment availability to people who inject drugs (Bahrain, Egypt, Oman, Iraq, Iran, Kuwait, Qatar), it is clear that the lack of testing for people who inject drugs, problematic structures regarding referrals, stigma and inaccessibility of services, plus limited government support for this population, continue to

⁵ The 2012 revised WHO, UNAIDS and UNODC target-setting guide categorises OST coverage levels as follows: low coverage is less than 20%, medium coverage is between 20% and 40% and high coverage is more than 40% of opioid-dependent people who inject drugs on OST.



pose great barriers to eliminating the hepatitis C virus among people who inject drugs.

Amphetamine-type stimulants (ATS)

Use of amphetamine-type stimulants appears to be increasing in certain countries in the region, with injecting becoming more prevalent. For example, among those who had injected within the last month in Iran, 20.7% had mostly used methamphetamine, with 21.1% injecting.^(6,7) Captagon, an ATS, has seen an increase in use in many countries in the Middle East, in particular Lebanon, Saudi Arabia and Syria.⁽⁴³⁾

Although an increase in ATS use is reported, only Iran has prepared a guideline, yet to be published, for the integration of ATS harm reduction strategies into current harm reduction initiatives in the country, which is in the piloting phase.⁽⁵⁾ In Bahrain, training has been put in place for a national drug information expert team to update the previously conducted drug situation assessment in order to provide a more accurate picture of the recent emergence of ATS in the country.⁽⁴⁰⁾

Tuberculosis (TB)

There is very little data on TB among people who inject drugs in countries in the MENA region. Although the WHO recommends diagnosis and treatment of TB as an integral component of the harm reduction package, targeted TB services for people who inject drugs are rarely in place. Within the region, only Morocco,⁽¹⁸⁾ Oman⁽²⁰⁾ and Iran (by referral only)⁽⁶⁾ document the availability of TB diagnosis and treatment for people who inject drugs.⁽⁴²⁾ However, TB screening targeting people who inject drugs is not evidenced.

Antiretroviral therapy (ART)

According to a report from UNAIDS, there are very low rates of HIV testing among people who inject drugs in the MENA region.⁽⁴⁴⁾ Many countries in the region are yet to offer harm reduction services, and where HIV testing and treatment for people who inject drugs is integrated or linked with harm reduction programmes, a lack of proper coordination between services reduces the effectiveness of such initiatives.⁽⁵⁾

There are some examples of good practice, however. In Iran, 68 facilities out of 269 offering ART also have OST services in place, with a further 142 sites linking clients with OST services if requested.⁽⁶⁾ Capturing the number of people who inject drugs who have received HIV testing and treatment is often complex, and data are not disaggregated by population. However, Iran reported

that 2,404 people who inject drugs were on ART in 2013.⁽⁶⁾ In 2015 SIDC in Lebanon provided testing for HIV, HCV and HBV to 217 people who inject drugs and FOCCEC in Jordan reached 146 people with the same tests.⁽⁵⁾ UNODC, in close partnership with civil society organisations, also continued to provide comprehensive HIV services for people who inject drugs in drop-in centres and outreach programmes in Palestine.⁽⁴⁰⁾

Although ART provision is available to all in the MENA region, civil society reports that people who use drugs have been marginalised and stigmatised within HIV treatment settings, which discourages service access and utilisation. Further reported barriers include weak referral systems to clinics providing care and treatment after HIV diagnosis and the geographical distance people are required to travel to get to ART sites. Many people who inject drugs in the region are deemed ineligible for ART due to a requirement for detoxification prior to initiating treatment.⁽⁵⁾

Harm reduction in prisons

There are approximately 625,413 prisoners in the MENA region,⁽⁴⁵⁾ one-third of whom are reported to be incarcerated on drug-related charges.⁽⁴⁶⁾ Considering that conviction and punishment of people who use drugs is the primary approach for combating illicit drug use in the region,⁽⁴⁶⁾ with countries like Bahrain even arresting people for simply possessing syringes,⁽⁴⁷⁾ these figures are not very surprising. Injecting drug use in prison has been documented in several MENA countries, including Iran, Lebanon, Morocco, Oman, Palestine and Syria.^(48,49) A recent study on HIV and HCV prevalence and incarceration-related risks in three Palestinian governorates, for example, found that 83.6% of a sample of 288 people who inject drugs had spent time in prison, with nearly half reporting that they had injected while in prison.⁽⁴⁹⁾

Unsafe injecting drug use is considered the main mode of HIV and HCV transmission among prisoners in the MENA region.^(48,49) A recent review synthesising all available data on HIV and HCV in MENA prisons found a median HIV prevalence among incarcerated populations of 0.01% in Egypt, 2.5% in Iran, 0% in Iraq, 0.1% in Jordan, 0.05% in Kuwait, 0.7% in Lebanon, 18.0% in Libya, 0.7% in Morocco, 0.3% in Oman, 0% in Palestine, 1.2% in Saudi Arabia, 0.04% in Syria, 0.05% in Tunisia and 3.5% in Yemen. Although very few countries in the region had data on HCV in prisons, a median prevalence of 23.6% was found in Egypt, 28.1% in Lebanon, 37.8% in Iran, 1.5% in Syria and 23.7% in Libya.⁽⁴⁸⁾

[†] This number does not include Palestine, where there are still no prisoner estimates available.

While these findings highlight the need to implement comprehensive harm reduction services in MENA prisons, the regional response continues to be weak. Since *Global State 2014*, Iran has reportedly ceased to provide NSPs in prisons, regrettably signifying the end of prison-based NSP provision in the region. OST continues to be available in more than 50% of Iranian prisons,⁽⁵⁰⁾ although with around 43,500 prisoners accessing OST in 2014, coverage still remains inadequate.⁽⁶⁾ Dwindling focus on, and support for, harm reduction, both in prisons and in the broader community, has been identified as an emerging concern in Iran, with the expansion of harm reduction services currently under serious threat due to severe financial constraints.⁽⁶⁾

More encouragingly, OST has reportedly been initiated in Nador and Al Hoceima prisons in Morocco,⁽¹⁸⁾ and OST pilots (accessible only to prisoners who were prescribed OST prior to their arrest) were launched in some Lebanese prisons.^(5, 51) OST is also reported to be available in some Israeli prisons.⁽⁵²⁾

Testing for HIV, which is often mandatory, and ART are reported to be provided to prisoners in just over one-third of the region's countries, including Egypt,⁽⁴²⁾ Iran,⁽⁶⁾ Israel,⁽⁹⁾ Lebanon⁽¹³⁾ Libya,⁽⁵³⁾ Morocco⁽⁵⁾ and Saudi Arabia⁽³²⁾. The provision of HCV diagnosis and treatment, however, is much more infrequent, reportedly only available to prisoners in Egypt, Kuwait, Lebanon and Oman.^(5, 11) TB diagnosis and treatment within prisons is also scarce throughout the region. Evidence of diagnosis and treatment of TB in prisons could be found only in Egypt (limited), Iran, Kuwait (limited), Morocco, Lebanon and Oman. It is not known whether these services are available in other countries. Condoms are available to prisoners in Egypt, Iran (limited to conjugal visits), Lebanon and Morocco only.⁽⁵⁾

Overdose

Data on fatal and non-fatal overdose remain extremely limited in the region. The availability of naloxone (a highly effective opioid antagonist that reverses the effect of overdose) is restricted to hospitals in most MENA countries, and so remains unavailable for peer distribution.⁽⁵⁾

In Lebanon, civil society organisations have taken action to end hospital reporting of overdose cases to the police – a practice that is known to deter people witnessing an overdose from calling emergency services. Skoun and MENAHRA conducted a nationwide campaign to change hospital policies that prevent people from seeking help when in need.⁽⁵⁾ Following these advocacy efforts,

the Ministry of Health in Lebanon issued an official statement to all hospitals requesting that they refrain from reporting any overdose case to the police.⁽⁵⁴⁾

Policy developments for harm reduction

As noted in *Global State 2014*, very few countries in the region make explicit mention of harm reduction in their national strategies. Only Egypt,⁽⁵⁵⁾ Iran,⁽⁶⁾ Morocco,⁽¹⁸⁾ Syria⁽⁵⁶⁾ and Tunisia⁽³⁾ specifically mention harm reduction for people who inject drugs. Iran's national guideline promotes the inclusion of people who inject drugs in all aspects of a comprehensive package of HIV services.⁽⁶⁾ Lebanon's updated national strategic plan notes a focus on most-at-risk populations, including people who use/inject drugs.⁽³⁵⁾ Algeria,⁽⁵⁷⁾ Jordan⁽¹⁰⁾ and Saudi Arabia⁽³²⁾ all mention high risk or key populations, but without specific reference to harm reduction for these groups. The national HIV strategy for Libya is currently being redrafted.⁽⁵³⁾

In 2014 Oman took steps towards updating its national AIDS strategy, but the new document, finalised in June 2016, will include no explicit mention of key populations or harm reduction.⁽²⁰⁾ However, Oman's national strategies for drug use control and prevention for 2016 to 2020 and for HIV/AIDS control and prevention specifically mention harm reduction.⁽²⁰⁾ In addition, the national narcotic law in Oman has been updated and guidelines to deal with psychoactive substances in health institutions and pharmacies have recently been established.⁽⁵⁾ In November 2015, the WHO also developed a harm reduction protocol with a focus on MMT in the country.⁽⁵⁾ Thanks to the national strategies for drug use control and prevention and for HIV/AIDS control and prevention, there has also been an increase in voluntary testing and counseling in the Muscat region of Oman.⁽⁵⁾

In 2015 UNODC, in collaboration with the WHO, translated two key guidelines into Arabic: the guidelines for countries to set targets for universal access to HIV prevention, treatment and care for people who inject drugs,⁽⁵⁸⁾ and the guidelines for the psychosocially assisted pharmacological treatment of opioid dependence.⁽⁵⁹⁾ Both will help to fill existing technical gaps and open new windows of opportunity for evidence-based harm reduction and drug treatment services.⁽⁵⁾ In Iran, based on identified barriers during a recent assessment on HIV testing and treatment, policy changes have been made to enable the integration of HIV treatment and care within OST sites.⁽⁶⁰⁾

^u Based on the national AIDS strategy for the Syrian Arab Republic developed in 2011. Given the ongoing state of conflict in the country, this information has not been updated.



Civil society and advocacy developments for harm reduction

Civil society networks and organisations in the region continue to play a consistent and vital role in advocating and implementing harm reduction approaches. MENAHRA has played a long-standing role as the regional harm reduction network, and its advocacy, capacity building, development of publications and other tools and support for harm reduction service delivery across 20 countries has continued since *Global State 2014*.

MENAHRA led the civil society engagement in the recent high-level processes of the United Nations General Assembly Special Session (UNGASS) on the drugs in April 2016 and at the UN High-Level Meeting on HIV in June 2016. In October 2015 MENAHRA participated in the Regional Dialogue on Drug Policy and HIV, contributing to ongoing national and regional discussion in advance of UNGASS.⁽⁶¹⁾ In an effort to highlight the rights of drug users to policy makers in the region, MENAHRA also developed and disseminated four position statements to coincide with different occasions in 2015: The International Day Against Drug Abuse and Illicit Trafficking on 26 June,⁽⁶²⁾ World Hepatitis Day on 28 July,⁽⁶³⁾ International Drug Users Day on 1 November⁽⁶⁴⁾ and World AIDS Day on 1 December⁽⁶⁵⁾. Unfortunately, political commitment and support for harm reduction by country representatives within the region during the UNGASS process was absent.

MENAHRA works closely with civil society partners throughout the region, as well as other regional bodies that cover harm reduction in their remit. Between 8 and 10 December 2015 in Beirut, Lebanon, MENAHRA and the Regional Arab Network Against AIDS (RANAA) convened a regional dialogue meeting to consult stakeholders on current regional and national harm reduction needs and priorities.⁽³⁵⁾

MENAHRA also coordinated the ‘Support Don’t Punish’ campaign action within the region (please see report overview for further information on the campaign). Thirteen countries in the region took part: Bahrain, Egypt, Iran, Jordan, Kuwait, Lebanon, Morocco, Pakistan, Palestine, Saudi Arabia, Syria, Tunisia and UAE. Activities included theatre acts, video messages from key harm reduction decision makers and activists, seminars and position statements.⁽⁵⁾

In Egypt, 15 civil society organisations are part of the Network of Associations for Harm Reduction, established

in 2010 to strengthen collaborations among harm reduction service providers and to reduce the stigma and discrimination faced by key populations.⁽⁴²⁾ The Middle East and North Africa Network of People who Use Drugs (MENAPUD), a regional network of people who currently use or formerly used drugs, was initiated, with support from MENAHRA, in 2011. In 2014, funds were secured via the MENAHRA Global Fund grant to appoint a coordinator and MENAPUD is currently working to facilitate its registration as an NGO.⁽³⁵⁾

Religious leaders have significant influence on the acceptance of harm reduction practices in many countries within the MENA region. A regional advocacy meeting on harm reduction was held for religious leaders in December 2012. It issued a declaration on the rights to health and harm reduction for people who use drugs. The regional religious leaders group contributed to the development of guidelines for religious leaders on harm reduction during 2014 and 2015.⁽³⁵⁾

Funding developments for harm reduction

The Global Fund continues to be one of the most significant financial contributors to harm reduction in MENA. MENAHRA, principal recipient of the regional harm reduction grant in the MENA region, is approaching the end of its round 10 Global Fund grant, which aimed to strengthen civil society to advocate for a more conducive environment for implementing harm reduction in 13 countries in the region.⁽⁵⁾ Thus far, this grant has assisted harm reduction programming and advocacy in Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Palestine, Syria and Tunisia.⁽⁵⁾ In 2016, within the context of the Global Fund’s new funding model, MENAHRA and RANAA submitted a joint concept note for further funding, bringing together the two regional organisations in an effort to provide complementary advocacy, research and services in the region for people who inject drugs, men who have sex with men, sex workers and people living with HIV.⁽³⁵⁾ If successful, the regional grant will fund harm reduction initiatives for these key populations from 2017 to 2019.

In Iran, with the highest population of people who inject drugs in the region, the Global Fund grant covers the majority of the harm reduction programmes in the country, currently delivered via outsourcing to private or non-government sectors.⁽⁶⁾ This grant will end in 2018. While Iran is one of the few countries in the region where the national government invests in harm reduction, the extent of current investment is unclear.⁽⁶⁾

Given the high numbers of people who inject drugs in the country, the imperative for Global Fund financial support to be extended via the new funding model is clear.

National government funds also go towards harm reduction in Oman and Morocco.⁽¹⁸⁾ Although the Global Fund has consistently funded harm reduction in Morocco, the head of state, King Mohammed VI, recently funded a harm reduction building through the Mohammed V Foundation.⁽³⁶⁾

Investment by national governments in harm reduction is negligible in most MENA countries, with the vast majority of harm reduction funds coming from international donors.⁽⁵⁾ In Egypt, for example, the Global Fund (through a national grant and via MENAHRA), the Drosos Foundation, FHI 360 and UNODC have assisted harm reduction services and advocacy efforts.⁽⁴²⁾

Although it is widely acknowledged that harm reduction funding in the region falls far short of need, evidencing the amount spent is challenging and requires dedicated research. In light of this, MENAHRA, with funding from UNODC, is piloting an investment tracking tool for harm reduction in two countries (Morocco and Egypt) between 2015 and 2016. This tool, developed by Harm Reduction International, has been used in other regions and will serve to illustrate spend versus need, increasing evidence-based advocacy for continued funding for vital harm reduction programmes. There are presently plans to expand the investment tracking tool project into three other countries (yet to be identified) in the region during 2017 with funding from the Robert Carr Foundation.⁽³⁵⁾



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