

Regional Overview

2.8 Middle East and North Africa



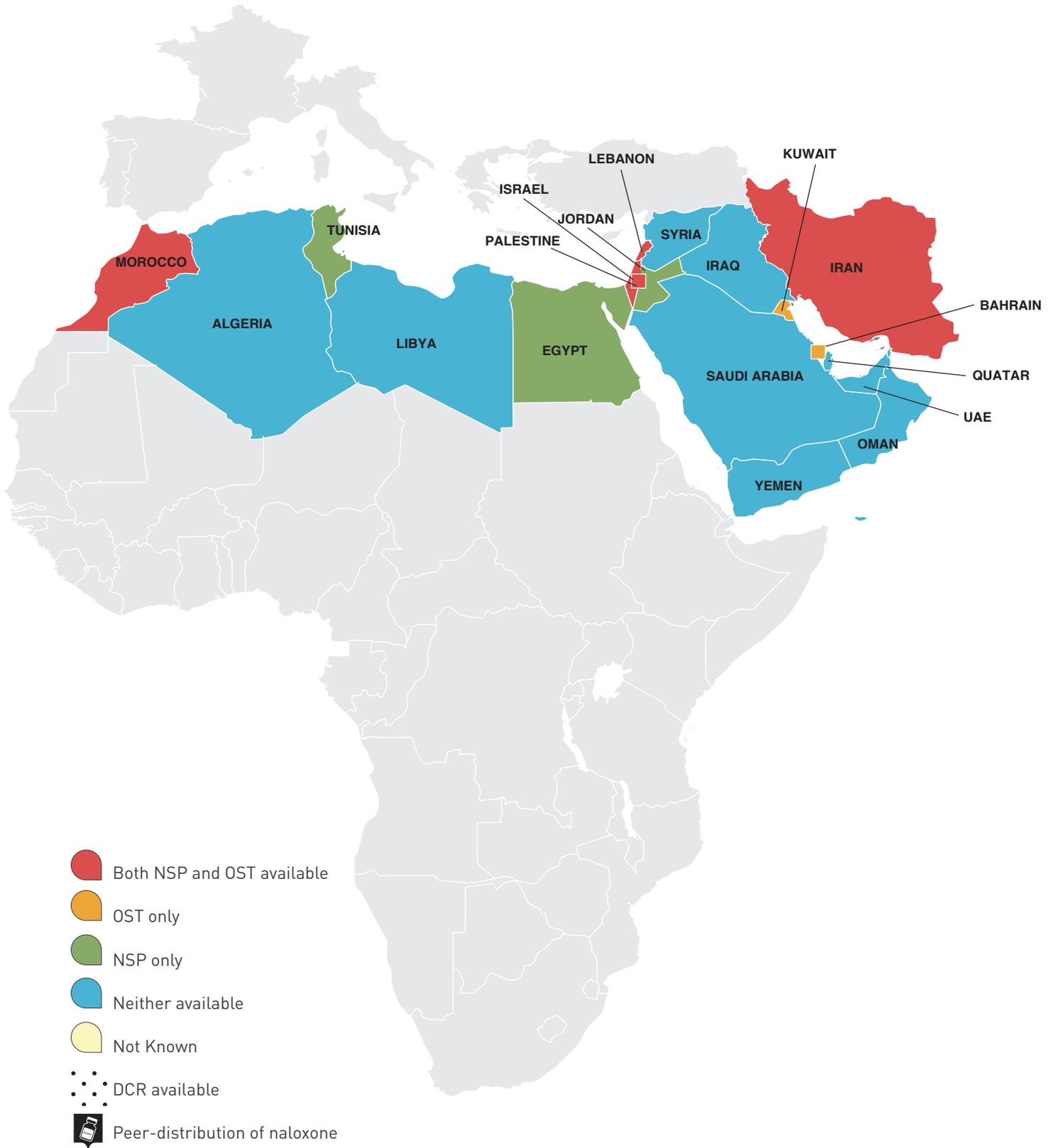
Table 2.8.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in the Middle East and North Africa

Country/territory with reported injecting drug use ^a	People who inject drugs ^{b(2)}	HIV prevalence among people who inject drugs(%) ^{c(2)}	Hepatitis C (anti-HCV) prevalence among people who inject drugs(%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response			
					NSP ^d	OST ^e	Peer-distribution of naloxone ⁽¹⁾	DCRs ^f
Algeria	21,050	6.5	nk	nk	x ^g	x	x	x
Bahrain	2,000	3.9 ⁽⁴⁾	nk	nk	x ⁽²⁾	✓ ^{h(5)}	x	x
Egypt	93,000	2.4 ⁽⁶⁾	nk	nk	✓(9) ⁽²⁾	x	x	x
Iran	185,000 ⁽⁷⁾	13.8 ⁽⁸⁾	52.2 ⁽⁷⁾	30.9 ⁽⁹⁾	✓(580) ⁽²⁾	✓(7,016) ⁽²⁾	x	x
Iraq	18,750	0.6	nk	nk	x	x	x	x
Israel	nk	nk	45.3 ⁽¹⁰⁾	5 ⁽¹¹⁾	✓(5) ⁽¹²⁾	✓ ⁽¹³⁾	x	x
Jordan	4,240	0.6	nk	nk	✓(10) ⁽²⁾	x	x	x
Kuwait	3,510	0.6	nk	2 ⁽¹¹⁾	x	✓(1) ⁽²⁾	x	x
Lebanon	3,200	0.9 ⁽⁶⁾	28 ⁽⁹⁾	2 ⁽¹⁴⁾	✓(2)	✓(10) ⁽²⁾	x	x
Libya	6,800	87.1 ⁽⁸⁾	94.5 ⁽¹⁵⁾	4.5 ⁽¹⁵⁾	x	x	x	x
Morocco	3,000-18500 ^(2,6)	7.1 ⁽⁶⁾	57 ⁽¹⁶⁾	nk	✓(6) ⁽²⁾	✓(7) ⁽²⁾	x	x
Oman	4,110	0.6	nk	4.8 ⁽¹¹⁾	x	x ⁽³⁾	x	x
Palestine	5,000	nk	40.3 ⁽⁹⁾	0.6 ⁽¹⁷⁾	✓(2) ⁽²⁾	✓(1) ⁽²⁾	x	x
Qatar	2,220	0.6	nk	nk	x	x	x	x
Saudi Arabia	10,000	3.5 ⁽¹⁸⁾	77.8 ⁽¹⁰⁾	7.7 ⁽¹⁹⁾	x	x	x	x
Syria	10,000	nk	40.8 ⁽⁹⁾	0.5 ⁽²⁰⁾	x	x	x	x
Tunisia	11,000	3.9 ⁽⁸⁾	29.1 ⁽⁹⁾	3.0 ⁽¹¹⁾	✓(25) ⁽²⁾	x	x	x ^k
United Arab Emirates	9,250	0.6	nk	nk	x	x ⁽²⁾	x	x
Yemen	7,030	0.6	nk	nk	x	x	x	x

nk – not known

- a There have been reports of injecting drug use in every country in the region according to Larney et al. in 2017.⁽¹⁾
- b As accurate data on estimates in the MENA region is scarce, unless otherwise referenced, numbers represent extrapolations made according to estimations from similar country contexts by the Middle East and North Africa Harm Reduction Association (MENAHRRA).⁽²⁾
- c HIV prevalence in Algeria, Iraq, Jordan, Kuwait, Oman, Qatar, United Arab Emirates and Yemen are made by MENAHRRA according to similarities with other countries where national estimations are unavailable.⁽²⁾
- d 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.
- e Number of opioid substitution therapy (OST) sites.
- f Drug consumption rooms, also known as supervised injecting sites.
- g Civil society organisations in Algeria are reported to distribute needles and syringes; however, purchasing needles and syringes from pharmacies is difficult because some pharmacists refuse to sell them to people who inject drugs or do not have sufficient stocks in remote places.⁽³⁾
- h Bahrain has begun piloting OST programmes.⁽⁵⁾
- i NSPs were widely available within the governorate of Minya in 2014 to 2016 by two local civil society organisations, through funding from MENAHRRA; however, these programmes have been halted since mid-2016 due to governmental disapproval.⁽³⁾
- j Currently there is no OST programme in Oman; however, OST has recently been included in national policy documents. During the past two years, many OST advocacy campaigns and training workshops have been conducted. Financial constraints are one of the main barriers in delaying the implementation of OST.⁽³⁾
- k In 2017, it was reported that several safe injection sites were operated by a civil society organisation in Tunisia, including a site exclusively serving women. However, it is unclear if these services are still in operation.
- l OST is available in the United Arab Emirates for detoxification only.

Map 2.8.1: Availability of harm reduction services



Harm reduction in the Middle East and North Africa

Overview

In a recent systematic review, injecting drug use was reported in every country in the Middle East and North Africa region.^[21] There are an estimated 349,500-437,000 people who inject drugs in the region,^[2,10] 96.2% of whom reportedly use opioids as their main drug (compared with 14.2% for stimulants).^{m[10]} Heroin is the most commonly used substance in the region (used by an estimated 63.9% of people currently using drugs), followed by cannabis (46.2%)ⁿ and cocaine (32.8%).^[23] While use of amphetamine-type substances has long been established in the Middle East, recent evidence indicates that use is increasing in certain countries (such as Jordan and Syria) and that use is increasingly prevalent in North Africa.^[24]

Despite the prevalence of drug use in the region, the implementation of needle syringe programmes (NSPs) remains extremely low, with between one and four needles distributed per individual per year in the region. The provision of opioid substitution therapy (OST) is also low (see table 2.8.1). The Middle East and North Africa is one of just two regions in the world where AIDS-related deaths continue to rise. It is estimated that 57% of all new adult HIV infections in the region are among people who inject drugs.^[25] Nevertheless, access to harm reduction services, including HIV testing and treatment, is lacking among people who use drugs or inject drugs in the region.^[2] This lack of harm reduction and health services for people who use drugs is at risk of being further aggravated by the absence of positive changes in investment and political commitment to harm reduction in the region.^[26]

Harm reduction services in the region are predominately provided by civil society across the region, with governments playing a small role in some countries.^[23] Five countries (Israel, Iran, Lebanon, Morocco and Palestine) have incorporated harm reduction strategies into the national HIV frameworks, and eight countries (Algeria, Bahrain, Egypt, Jordan, Libya, Oman, Syria and Tunisia) refer to people who inject drugs as populations requiring specific health services.^[2] There is an absence of robust data on people who use drugs living with HIV and accessing antiretroviral therapy.^[21] There have also been large cut backs and closures of harm reduction services in some countries: Egypt and Oman have ceased to provide harm reduction services since 2016,^[2] and Jordan has been forced to severely restrict service provision due to an ongoing funding crisis.^[3]

Countries in the region are faced with substantial challenges which impair their ability to effectively implement national HIV prevention programmes, including a drastic decline in HIV and harm reduction funding exacerbated by the fact many countries in the region rely on singular funding sources.^[27] Other challenges for addressing blood-borne diseases among people who use drugs include an absence of effective surveillance systems, a paucity of quality and accessible services, and prevailing stigma and discrimination. Regional instability caused by the ongoing civil wars in Iraq, Libya, Syria and Yemen also contribute to communities' access to quality lifesaving harm reduction services.^[27]

This fragile socio-political environment has caused unprecedented mass movements of people across and beyond the region, with growing cohorts of refugees, internally displaced people and migrants subsisting in poor living conditions that have an impact on their mental and physical health. The UN Office on Drugs and Crime (UNODC) reports this has precipitated an increase in drug consumption and trafficking, and the region has seen a rise in income generation through the production and selling of drugs.^[24,28] In addition to this regional socio-political instability, the Middle East and North Africa Harm Reduction Association reports that gender disparity and engendered cultural norms lead to women in the region, especially women who use drugs, being less likely to access health services.^[23] There is also a paucity of HIV and harm reduction services for people who use drugs in closed settings, such as those in displacement camps and in prison contexts.^[29] Experienced or anticipated stigma are also reported as barriers to accessing health care for people who use drugs, particularly in Egypt, Morocco and Tunisia.^[23]

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

All 19 countries in the region are reported to be home to populations of people who inject drugs, but the provision of NSPs is inconsistent. Despite having been first introduced in the region over 15 years ago, NSPs are still only available in eight countries, and no new countries have implemented NSPs since the *Global State of Harm Reduction 2016*. Where they exist, NSPs have seen some growth. Tunisia and Jordan

m The regional proportion of people who inject drugs reporting opioids or stimulants as their main drug does not account for polydrug use and may be based on varying methodologies.^[10]

n Cannabis consumption is thought to be widespread in the region and this figure may represent an underestimate due to underreporting.^[22]

have seen the greatest expansions in NSP service provision since 2016. Jordan began implementing NSPs in five governorates in 2013, and as of 2018 has expanded to include a further 10.^[2] Morocco and Palestine also increased the number of NSP sites in each country.^[30] Unfortunately, due to ongoing challenges, Egypt's NSP programme ceased in 2016.^[2]

In Iran, there is evidence supporting the effectiveness of access to sterile syringes in reducing syringe sharing practices and syringe reuse among people who inject drugs.^[31] With 580 state-supported NSP sites across the country, Iran is an outlier in the region;^[2] elsewhere NSPs remain remarkably limited in scope and coverage, and there is little governmental support and public acceptability.^[3]

Challenges to NSP provision in the region include limited funding, poor political commitment and support, protracted bureaucratic procurement processes and regional instability.^[2] The Middle East and North Africa remains the region with the lowest NSP coverage globally (0.5 syringe/people who inject/year).^[32] Pharmacies continue to be the most accessible source of sterile syringes, particularly in Iran, Jordan and Tunisia,^[33] though there are legal barriers and communities report persistent stigmatisation of people who inject drugs from pharmacy staff in many countries.^[34] With the exception of Iran, and to a lesser extent Morocco, there is a lack of a supportive legal and socio-cultural environment for NSPs, and the possession of syringes by people who inject drugs can often lead to prosecution.^[35]

Opioid substitution therapy (OST)

Opioid substitution therapy as harm reduction is currently provided in at least seven countries in the region, with methadone distributed in Iran, Israel, Morocco and Palestine, and buprenorphine provision in Iran, Israel, Kuwait and Lebanon.^[2,13] Prior to 2010, Iran and Israel were the only countries in the region which provided OST for people who use opioids.^[2,13] Since that time, Morocco (in 2010), Lebanon (in 2012), Palestine (in 2014) and Kuwait (in 2015) have initiated OST.^[2] Since 2016, Bahrain has launched an OST pilot.^[5] OST has also been available in the United Arab Emirates since 2012; however, it is only available for detoxification at the National Rehabilitation Centre and is not available to foreign workers, who make up the majority of the population.^[2,22] Oman is also currently considering moves to initiate OST service provision.^[3]

Iran incorporated OST into its national policy in 2003 and is leading the way in service provision, with over 7,000 centres providing OST to more than 650,000

people who use drugs.^[2,36] In 2011, Lebanon adopted a take-home buprenorphine pilot programme; however, provision is limited to authorised psychiatrists working within pre-registered treatment settings. The results of the evaluation of the first pilot in Lebanon supported expanding the access to buprenorphine in Lebanon and other Middle Eastern and North African countries, and is an encouraging step towards continued service provision for people who use drugs.^[5]

The availability of publicly funded low-threshold methadone maintenance therapy services in Iran has increased through Ministry of Health drop-in centres since the *Global State* last reported. Methadone, buprenorphine and tincture of opium are used for opioid maintenance treatment in Iran; coverage of OST has also increased since 2016.^[3] The main barriers to OST in the country include geographical obstacles for people in rural settings and costs incurred with accessing the service, although since 2010 insurance coverage for OST services has been provided for in national law.^[3] Since 2014, the Iranian Drug Control Headquarters has allocated funding to implement insurance for opioid substitution therapy services.^[3]

In Lebanon, three new OST prescribing centres have opened: one in the Bekaa, one in Beirut and one in a coastal town near Tripoli.^[3] Although coverage is increasing, imposed weekly urine screening tests for people who use drugs dissuade many from accessing the service.^[3]

Legal and political constraints limit the provision of OST in many parts of Palestine, with a paucity of services available in the West Bank and the Gaza Strip, and extremely limited psychosocial services supporting adherence to the programme.^[3] In the United Arab Emirates, potential challenges and obstacles for adherence to OST for eligible people who use drugs include concerns about being forced into diversion programmes, poly-substance use (particularly the high levels of benzodiazepines), unstable housing conditions and geographical barriers.^[3]

Amphetamine-type stimulants (ATS), cocaine and its derivatives, and new psychoactive substances (NPS)

Although there is a lack of robust data on the variety of drugs used within the Middle East and North Africa, polydrug use is prevalent. Among people currently using drugs, the most commonly used drugs include heroin (in Egypt and Morocco), cannabis (mostly in Lebanon, followed by Tunisia and

Morocco) and cocaine (especially in Morocco and Lebanon).^[23] Other types of drugs being consumed include MDMA (predominately in Lebanon), methamphetamine (with the highest usage reported in Iran and Lebanon) and benzodiazepines in Tunisia.^[23,37] Use of tramadol and Tamol in Egypt are also continuing or emerging trends.^[23] Prescription drugs were used by 22.7% of people who drugs in the region.^[23] Lebanon has witnessed an increase in the use and sale of synthetic cannabinoids.^[38] Use of khat, a natural stimulant with a long history of use in the region, is reportedly increasing in countries such as Yemen, Oman and Saudi Arabia.^[39]

Fenethylamine, a stimulant commonly referred to by the brand name Captagon, is the Arabian Peninsula's most consistently consumed narcotic substance,^[40] particularly in Saudi Arabia where use is reported to be high among young men.^[41] Captagon is reported to be easily accessible, and available in e-commerce within the United Arab Emirates, Syria, Iraq and Turkey, and widely available on the darknet.^[41]

Globally, there is a lack of harm reduction services that are responding to the needs of people who use ATS and NPS, and the Middle East and North Africa is no exception. Iran piloted a number of programmes to support people who use ATS and NPS in 2014/2015; for example, needle and syringe programmes for people who use ATS, safer methamphetamine use kits and education about drug use.^[42] An evaluation of this programme published in 2017 found that harm reduction services focused on people who use ATS improved health outcomes for this population.^[42]

Overdose, overdose response and drug consumption rooms (DCRs)

Although there continues to be little available data on overdose in the Middle East and North Africa, there have been some positive developments addressing overdose since the *Global State of Harm Reduction 2016*. Lebanon, in part influenced by effective advocacy by civil society, has continued to demonstrate a commitment to overdose prevention. This has included lobbying healthcare providers not to report patients to law enforcement when they access health services for drug overdose symptoms.^[3]

Availability of naloxone, an opioid antagonist capable of reversing the effects of overdose, is reported to be low across the Middle East and North Africa. Overdose prevention programmes are being carried out in Algeria, Egypt, Palestine and Tunisia in formal medical settings; however, access in all countries is reported to be minimal, and often limited to information and education rather than medical

assistance.^[3] Syria supports one facility capable of addressing overdose with naloxone; however, this service is heavily over-burdened and under-funded.^[3] There were no reported peer-distributed naloxone programmes in the Middle East and North Africa region at the time of reporting.

Overdose prevention programmes are not available (the main barrier being regulations and national instability) in Jordan, Libya, Oman and Morocco, although Morocco has started discussions on developing an overdose response framework.^[3] In the United Arab Emirates, overdose prevention programmes are not currently available; however, harm reduction advocates are currently lobbying to make naloxone kits available to emergency and first responder staff, as well as family members of people who inject drugs.^[3]

Viral hepatitis

Although the HIV prevention and treatment response in the Middle East and North Africa has been expanded in the last several years, viral hepatitis, particularly hepatitis C, continues to be a neglected public health concern. An estimated 48.1% of people who inject drugs in the region are positive for hepatitis C antibodies, with hepatitis transmission associated with unsafe injecting practices such as sharing needles and syringes.^[10] Since the *Global State of Harm Reduction 2016*, the World Health Organization Regional Office for the Eastern Mediterranean conducted a questionnaire survey to review the status of the viral hepatitis response programme in the 22 countries of the region. Findings from the survey demonstrated that although 21 countries were implementing (or at the least considering developing) prevention and care interventions for hepatitis C, actual delivery of testing and treatment was limited in scale and scope, and service provision inconsistent across the countries.^[43] Even though 13 of the 22 countries reported as having a strategy for the prevention and control of viral hepatitis, baseline data on hepatitis C is lacking, and therefore effective strategies for reducing the disease burden among people who use drugs and for increasing service coverage have not been fully developed.^[43] In those countries already implementing national hepatitis programmes, coverage of screening/diagnostic testing and treatment continues to be insufficient.^[43]

Injecting drug use is the main route of transmission for hepatitis C in Egypt, Iran, Iraq, Libya, Morocco, Saudi Arabia, Tunisia, Yemen, Kuwait, Qatar and Syria, with prison populations and those in closed settings particularly at risk.^[44] Although the risk has

been identified, coverage of treatment options in the region remains low. Across the region, direct-acting antivirals (DAAs) have been referred to in viral hepatitis treatment protocols and made available to the public, yet the costs (borne either by national health insurance mechanisms or by the individual) are generally prohibitively high. In Lebanon, for instance, although hepatitis C testing and treatment services are available, the procurement of costly DAAs is intermittent, which impacts upon effective treatment adherence and many patients must cover the costs of supplementary laboratory tests themselves.^[3] Libya experiences similar challenges, with shortages of treatment and costly laboratory tests having a negative impact on patient uptake and retention.^[3]

A dearth of robust data at the country and regional level, and a lack of awareness contributes to a lack of political commitment and domestic investment in viral hepatitis responses.^[43]

Tuberculosis (TB)

Although there is limited data specifically on TB incidence among people who use drugs, testing and treatment of tuberculosis has been mainstreamed into public health services across the region. In many instances this has occurred as part of the HIV response, including in Bahrain,^[45] Iran^[46] and Algeria.^[3] In Morocco, the Ministry of Health allocates an annual budget for the national tuberculosis programme to provide free health services to all TB patients, including people who use drugs.^[47] The TB response programme in Jordan is implemented under a grant from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The Jordanian Ministry of Health's national TB programme is partially integrated into general health services, and operates at the central, district and peripheral levels.^[3]

HIV and antiretroviral therapy (ART)

Antiretroviral therapy is officially widely available to all people living with HIV across the region, including people who use drugs, and provision is integrated into traditional HIV services.^[3] In the Middle East and North Africa, as in other regions, there is little data on the numbers of people who use drugs currently on ART. Regional instability and a number of local-level security concerns negatively affect adherence among people who use drugs.^[23] A 2017 systematic review covering the WHO Eastern Mediterranean region^o estimated that 26% of people who inject

drugs living with HIV had been diagnosed as such, 11% of these were on ART, and 44% of these were virally suppressed.^[48] In a 2017 regional survey conducted among people who use drugs accessing ART and other harm reduction services, it was reported that three quarters of the participants believed that services in public healthcare settings were not stigma-free; and that they were subjected to discrimination, with the majority from Pakistan (88.5%), followed by Afghanistan (85%), Morocco (84.6%), Tunisia (83.3%) and Egypt (73.7%).^[23]

Along the HIV cascade of care, alarming levels of treatment drop-out result from: high levels of stigma; discrimination and mistreatment from healthcare providers; the lack of privacy and anonymity, and breaches in confidentiality when accessing the medicine; and the absence of collaboration and communication among service providers, especially with regard to people living with HIV co-infected with viral hepatitis or other infectious conditions.^[23] As reported in the *Global State of Harm Reduction 2016*, Iran continues to be an example of good practice, including scaling up the number of antiretroviral centres and satellite centres, including ensuring service provision in prison contexts.^[49] Despite this, overall coverage of ART in Iran is estimated to be low at 19%, mainly due to a lack of access to treatment for people who inject drugs.^[6,50] The country is currently developing pilot projects integrating antiretroviral therapy into OST services.^[50]

Harm reduction in prisons

In 2016, there were an estimated 625,413 people imprisoned across the Middle East and North Africa (excluding Palestine), a 5% increase on the figure for 2010.^[51] Of these, 225,624 (36%) were in Iran, 76,000 (12%) were in Morocco and 62,000 (10%) were in Egypt.^[51] One third of all incarcerated people are reported to be imprisoned for drug-related charges.^[3] Punitive drug control continues to be the primary approach for addressing drug use in the region, with countries like Bahrain arresting individuals purely for possessing needles or syringes.^[3]

Drug use is reportedly highly prevalent in prison contexts in the Middle East and North Africa (including in Lebanon, Morocco, Oman, Palestine and Syria) and, due to the lack of needle and syringe programmes, so too is unsafe injecting drug use.^[3] While high levels of unsafe injecting drugs should precipitate a scale-up of harm reduction programmes in prisons, the regional response continues to be weak.^[3] OST is available in prisons

^o This region includes Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Syria, Tunisia, the UAE and Yemen. It also includes Afghanistan, Djibouti, Pakistan, Somalia and Sudan, which are covered by other chapters in this report.

in five of the 19 countries in the region: Iran, Israel, Lebanon, Morocco and Palestine.^[3,6,13] In 2016, 49,785 people received OST in prison in Iran and 6,000 prisoners were enrolled in the therapy in Israel.^[6,13] In Palestine, daily journeys are reportedly made by prison authorities to take prisoners to receive methadone, though the number of people enrolled in prison OST appears to be small.^[3] In both Lebanon and Morocco, OST services exist in prison, but are reported to be largely inaccessible.^[3] In Morocco, only seven people received OST while in prison in 2016; in Lebanon, OST is only available to people who were enrolled before entering prison.^[3]

No country in the region currently provides NSPs in prisons.^[3]

A UNODC programme under the Regional Programme in the Arab States (2016-2021) was developed to prevent drug use and treat drug use disorders, while also including provisions to prevent and treat HIV among prison populations.^[3,52] The UNODC-led programme now reaches over 40,000 prisoners and prison staff with HIV/AIDS prevention, treatment, care and support services.^[3] This cohort includes 10,000 prisoners in three Egyptian prisons (Fayoum, Wadi AlNatroon and Borg Al-Arab); 18,000 prisoners in five Moroccan prisons (Oukacha, Tangier, Tetouan, Salé and Nador); and 15,000 prisoners and juvenile detainees in six adult and juvenile prison facilities in Tunisia (adult prisons at Mornaguia, Borj El Amri, La Manouba and Le Kef; juvenile centres at El Mourouj and El Mghira).^[3] During 2017, around 1,000 prisoners were screened for HIV, hepatitis B and hepatitis C (though this represents only around one in 40 of the total population of the programme prisons).^[3,51] In the same year, approximately 1,900 prisoners were tested for tuberculosis.^[3] Although Iran is celebrated for its harm reduction response in prisons, there is a serious lack of gender balance in the approach, with women accounting for only 4% of methadone treatment participants in prison, according to data from 2012.^[53] Condoms are reportedly accessible to prisoners in Iran and Tunisia.^[3]

Women who use drugs

Recent estimates state that women account for one third of people who use drugs globally.^[54] Yet women who use drugs have less access to harm reduction services and are at higher risk of HIV infection than men.^[55] In the Middle East and North Africa region, given the already

scarce base of harm reduction programmes and policies, gender-sensitive harm reduction services have received little attention. Research on drug use and related health issues in the region rarely produces gender-disaggregated data.^[56]

In 2013, the Middle East and North Africa Harm Reduction Association (MENAHR) conducted a study on women who use drugs, which confirmed that they face marginalisation and are disadvantaged with regards to accessing harm reduction services.^[57] Many women have negative experiences in utilising harm reduction services, such as breaches of confidentiality and stigmatisation. When attempting to access health or social services, many were denied due to discrimination or having limited ability to pay for services. Acknowledging this, discussions on gender-specific services for countries in the region have been initiated by MENAHR and practical guidelines for advocacy for women who use drugs were published in 2017.^[56] A small number of emerging practices for women do exist in countries of the region:

- **IRAN:** Civil society engagement and research activities in Iran increasingly shed light on the particular needs of women who use drugs and advocate for more gender-sensitive services.^[42,58] The civil society organisation Khaneh Khorshid offers a list of services that seek to provide harm reduction services, including provision of OST; HIV prevention workshops; medical and legal aid services; and referrals to medical centres, employment agencies and educational institutions. Khaneh Khorshid currently provides methadone treatment to over 100 women and provides ancillary services to more than 600 women annually.^[58]
- **LEBANON:** The Inter-Ministerial Substance Use Response Strategy 2016-2021 aims to ensure gender-sensitive services and calls for targeted interventions for women to address their specific needs. It further acknowledges that gender-disaggregated data on substance use is lacking.^[59]
- **TUNISIA:** The first safe injection sites were established by a civil society organisation in Tunisia,^p of which one specifically works with women who use drugs. It is the first reception centre for women who use drugs in the region, and provides a safe place that protects women who inject drugs with health and dignity.^[60]

p In 2017, it was reported that several safe injection sites were open. However, it is unclear at the time of writing if these services are still in operation.

Despite the positive developments in some countries in the region, an emphasis on gender-specific service provision is still lacking and in many countries the needs of women who use drugs are not addressed adequately. A scale-up of gender-sensitive harm reduction in the region is much needed.^[56] In order to ensure that women who use or inject drugs are reached by harm reduction interventions, service providers, programme developers and policy makers should acknowledge women's particular vulnerabilities and tailor interventions to their needs. Depending on the context, gender-sensitive harm reduction may include, but must not be limited to: targeted education and awareness for women about drug use and its related harms; tailored harm reduction services for women, including women-only drop in centres; female counsellors; and female condom distribution, as well as psychological services and safe places for women drug users who are victims of violence in the region.^[56]

Policy developments for harm reduction

Despite the evidence that drug use is a major issue in the Middle East and North Africa region, with preventable adverse health and social effects, many countries in the region lack an adequate evidence base of epidemiological, qualitative and sociological data on drug use, key populations and related health consequences.^[22,61] Barriers to research on harm reduction are not only created by the lack of funding, but also by the particular socio-cultural, economic, policy-related and political situations in each country.^[61,62] While some countries allow for harm reduction interventions to protect a person's physical and mental wellbeing (for example Israel, Iran, Lebanon and Morocco), others continue to apply a punitive approach against people who use drugs and deny harm reduction service provision.^[61,62] Criminalisation and entrenched stigma associated with drug use in Middle Eastern and North African countries negatively impacts upon research into harm reduction, drug use and its adverse effects, and contributes to the exclusion of people who use drugs from national surveillance programmes. For example, Bahrain, Iraq, Kuwait, Libya, Oman, Qatar, Saudi Arabia, Syria and the United Arab Emirates have limited, or lack completely data on key populations at risk of HIV, including people who use drugs.^[62]

Since the *Global State of Harm Reduction 2016*, there have been a number of policies addressing the health and harm reduction needs of people who use drugs in the region. Harm reduction has been referenced in: the Iranian National AIDS Strategy for 2015-2019, which works towards the maintenance of HIV prevalence at less than 15% among people who inject drugs; the 2016-2020 National AIDS Strategy in Lebanon, which includes a commitment to NSP and OST, along with naloxone by 2019;^[3] Morocco has included efforts for increasing HIV education, and distribution of syringes and condoms in policy documents since 2016; Palestine has been piloting methadone maintenance programmes;^[3] Saudi Arabia's National AIDS Strategic Plan prioritises HIV screening, counselling and treatment;^[3] and Tunisia made reference to OST and NSP for the first time in their 2015-2018 National AIDS Strategy.^[49]

After years of designing drug policies that have mainly focused on eliminating drug use, drug policy reform is becoming a mainstream discussion in Morocco.^[63] The Authenticity and Modernity, and Al Istiqlal political parties have introduced parliamentary bills to legalise the medical and industrial use of cannabis.^[63] In Yemen, civil society reports that there have been no new policy developments, due to the ongoing conflict.^[3]

While Iran has served as a model for other countries in the region in its implementation of harm reduction policies and deployment of peer-education programmes and NSPs,^[64] continued criminalisation of people who inject drugs, manifested by punitive laws, incarceration and prohibitions on harm reduction, have a detrimental impact upon access to harm reduction services in the country. These negative effects include decreased access to NSPs, increased risky behaviours of sharing used injecting materials, and an increased HIV and hepatitis C prevalence among people who use drugs.^[29]

Civil society and advocacy developments for harm reduction

Since 2007, the Middle East and North Africa Harm Reduction Association (MENAHRRA), a network of knowledge hubs and civil society organisations focusing on harm reduction strategies, has led civil society advocacy efforts in the region. MENAHRRA's mission is to improve the quality of life of people who use drugs through advocacy, capacity building and technical assistance, and by serving as a resource centre in the region.^[65] The Middle East

and North Africa Network of People who use Drugs (MENANPUD) is also active, and acts as a support group of activists concerned with harm reduction and the rights of people who use drugs.^[66]

Civil society continues to lead advocacy efforts for the promotion and sustainability of harm reduction services for people who use drugs in the region. In addition to MENAHRA, in 2016/2017, the MENA H Coalition was launched, which aims at limiting the spread of HIV, promoting harm reduction interventions, and mitigating stigma and discrimination in the Middle East and North Africa.^[66] In early 2018, the MENA H Coalition formally announced its interest in applying for the Multi-Country Request for Proposals launched by the Global Fund to address the “Sustainability of services for Key Populations in the MENA region”.^[67]

The global Support. Don't Punish campaign is a popular platform for harm reduction advocates in the Middle East and North Africa. In 2017 and 2018, the campaign was rolled out in a number of countries, including Lebanon and Yemen, and by the Forearms of Change Centre in Jordan.^[3,68] The Forearms of Change Centre also runs a peer-based network of people who use drugs in the country.^[3]

Civil society organisations contribute greatly to reducing stigma towards people who use drugs and advocating for the continuation and scaling up of harm reduction services, even in increasingly hostile environments. Progress can be seen in Morocco, Tunisia, Algeria and Lebanon, where civil society voices are gaining momentum.^[69] In the past few years, multiple regional platforms and networks have been established or grown, such as the Regional/ Arab Network Against AIDS and a regional chapter of the International Treatment Preparedness Coalition advocating for access to HIV treatment.^[69]

Funding developments for harm reduction

Despite increasing efforts to advocate for the establishment of harm reduction policies and programmes, people who use drugs in the Middle East and North Africa region remain highly vulnerable and lack access to health and social services.^[2] A fundamental barrier to the effective and sustainable implementation of harm reduction in the region is the scarcity of funding for harm reduction.^[3] In most countries, interest in allocating resources to harm reduction is non-existent at national government level.^[3] This is exacerbated by a tremendous decline in international donor funding in recent years. The Global Fund, for instance, spends only around 8%

of all its investments in the Middle East and North Africa region.^[3,70] The lack of funds and support for harm reduction has forced the closure of some established programmes, such as needle and syringe programmes in Egypt and Jordan.^[3]

The International Organization for Migration is implementing a regional grant to provide TB, HIV and malaria services in Jordan, Lebanon, Syria and Yemen; however, the majority of these funds are directed at support for displaced people.^[70] In Palestine, there is a lack of donor interest, leading to severe shortages in funds allocated for prevention of harm and treatment of drug use; the Ministry of the Interior in Gaza stated, “there is no support from donor agencies and no-one considers this area a priority”.^[71]

A number of extenuating factors impact upon the availability and distribution of funds for harm reduction work in the Middle East and North Africa. Services are understaffed in Oman, Saudi Arabia and Syria, and as a result these countries have been forced to downsize their harm reduction plans.^[49] Civil society organisations report there is insufficient collaboration between research groups, non-governmental organisations, the government and private clinics, which results in a lack of data and limited distribution of harm reduction resources.^[49] This is especially present where there are many groups working without cohesion, like in Lebanon. MENAHRA report that there is poor resource allocation, availability or mobilisation in Algeria, Bahrain, Kuwait, Lebanon, Palestine, Morocco and Yemen.^[49] Political challenges and punitive drug policies work against the provision of funding for services for people who use drugs in Qatar, Bahrain, the United Arab Emirates, Saudi Arabia and Kuwait. Budget advocacy tends to be largely driven by civil society in other regions, meaning that in countries with little or no meaningful freedom for civil society organisations working for harm reduction (such as Kuwait, Bahrain, Oman, Qatar, Yemen, Iraq and the United Arab Emirates), there is a lack of a strong voice to encourage investment in harm reduction.^[49]

The discontinuation of harm reduction efforts is particularly alarming in light of rising AIDS-related deaths in the Middle East and North Africa and regional estimates that indicate more than 50% of all new HIV infections among adults occur among people who inject drugs.^[25] In the absence of any change to the lack of funding and evidence, the current situation paints a bleak future for the health of people who use drugs in the region. Political commitment, regional collaboration and investment are fundamental to increase and sustain harm reduction service availability and accessibility.^[26]

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