Regional Overview
2.9 Sub-Saharan Africa

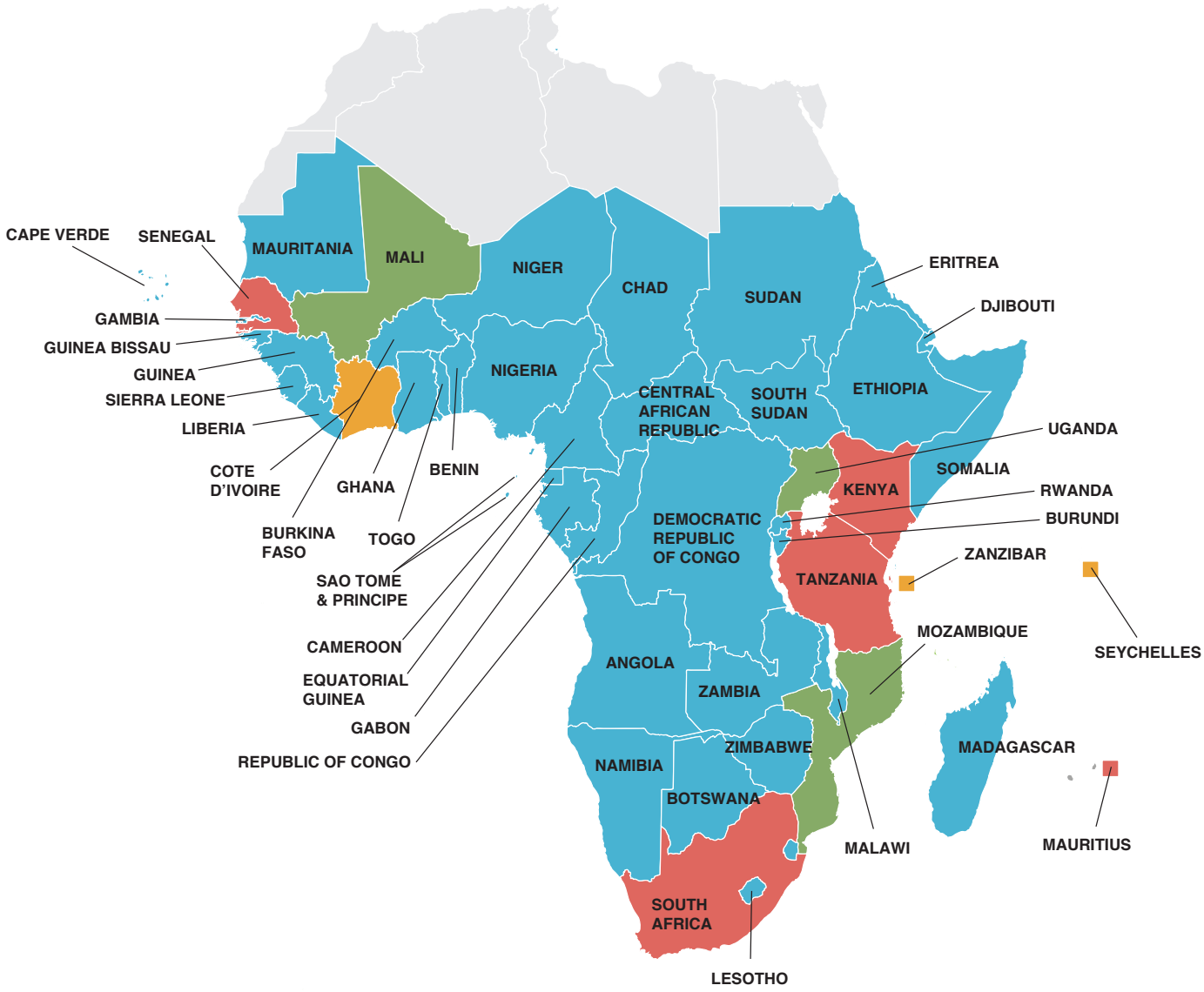
Table 2.9.1: Epidemiology of HIV and viral hepatitis, and harm reduction responses in Sub-Saharan Africa

Country/territory with reported injecting drug use[a]	People who inject drugs	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[b]	OST[c]	Peer-distribution of naloxone
Benin	nk	5.1[1]	nk	nk	x	x	x
Burkina Faso	nk	nk	nk	nk	x	x	x
Burundi	nk	nk	nk	nk	x	x	x
Côte d'Ivoire	500[1]d	5.3[1]	1.8[1]	10.5[1]	x	✓[12]	x
Democratic Republic of the Congo	3,500[1]	13.3[1]e	nk	nk	x	x	x
Ghana	6,314[3]	nk	40.1%[1]	nk	x	x	x
Kenya	30,500[1]	42[1]	16.4[1]	5.4[1]	✓19[12]	✓7[4,5]	x[f]
Lesotho	2,600[6]	nk	nk	nk	x	x	x
Liberia	457[7]g	3.9[8]h	nk	nk	x	x	x
Madagascar	15,500[1]	4.8[1]	5.5[1]	5%[1]	x	x	x
Malawi	nk	nk	nk	nk	x	x	x
Mali	nk	5.1[9]i	nk	nk	✓[1]	x	x
Mauritius	11,667[10]	45.5[1]	97.1[1]	6.1[1]	✓46[11]j	✓42[11](B, M)	x
Mozambique	29,000[1]	46.3[1]	67.1[1]	nk	✓1[12]	x	x
Nigeria	44,515[9]	3.4[13]	5.8[1]k	6.7[1]	x	x	x
Rwanda	2,000[1]	nk	nk	nk	x	x	x
Senegal	1,324[14]l	9.4[1]	38.9[1]	nk	✓5[15,16]	✓1[15]	x
Seychelles	2,560[17]m	12.7[17]	76[17]	1[17]	x	✓n	x
Sierra Leone	1,500[1]	8.5[1]	nk	nk	x	x	x
South Africa	76,000[1]	14.2[1]	54.7[18]o	5[19]nk	✓4[20]	✓<11[20]p (M, B, B-N)	x[q]
Tanzania	30,000[21]r	35[22]	57[23]	1.1[1]	✓	✓6[24]	x
Tanzania (Zanzibar)	3,000[25]	11.3[26]	25.4[26]	5.9[26]	x[1]	✓[27]	x[s]
Togo	2,500[28]	nk	nk	nk	x	x	x
Uganda	nk	17-20[29]t	nk	nk	✓2[30]	x	x
Zambia	nk	nk	nk	nk	x	x	x
Zimbabwe	nk	nk	nk	nk	x	x	x

nk – not known

a The countries included in this table are those with reported injecting drug use according to the 2008 United Nations Reference Group systematic review and/or with operational NSPs or OST at the time of data collection. HRI also found data on injecting drug use in Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Djibouti, Ethiopia, Gabon, Gambia, Guinea, Malawi, Mali, Niger, Rwanda, Sierra Leone, Somalia, Togo, Zambia and Zimbabwe, but did not find verified data to include on these countries.
b 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.
c Opioid substitution therapy (OST), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
d For people who use drugs this number is believed to be between 6,000 to 10,000 people, with smoking rather than injecting more widely practised.
e For Kinshasa.
f Naloxone is available at harm reduction sites in Kenya but can be administered only by trained healthcare personnel.
g Based on sub-national data from six cities in three counties of Liberia.
h Based on sub-national data from Grand Cape Mount, Grand Bassa, Grand Gedeh, Gbarpolu, Lofa, Montserrado, Margibi, Nimba and River Gee.
i Based on sub-national data for Bamako only, with a sample size of 39.
j 35 sites managed by the Ministry of Health and Quality of Life (Government of Mauritius), 11 sites managed by the NGO Collectif Urgence Toxida.
k Based on sub-population data from 2010.
l Based on sub-population data from Dakar only.
m Total number of people using heroin estimated to be 4,318, with 2,560 using injection as the chosen route of administration.
n OST offered by the Agency for the Prevention of Drug Abuse and Rehabilitation, believed to be an abstinence-oriented programme.
o N=940 people who inject drugs in Cape Town, Durban and Pretoria. Data from 2017.
p OST is available in four cities: Cape Town, Durban, Johannesburg and Pretoria (eight sites in Pretoria).
q Naloxone available for administration by first responders/emergency healthcare workers.
r Figure is believed to be an underestimate nationally, but locally adequate in selected sites.
s Naloxone available for administration by first responders/emergency healthcare workers.
t Figure relates to people who use drugs, but women who inject drugs appear disproportionally affected by HIV with more than double the prevalence at 45%.

Map 2.9.1: Availability of harm reduction services



- Both NSP and OST available
- OST only
- NSP only
- Neither available
- Not Known
- DCR available
- Peer-distribution of naloxone

Harm reduction in Sub-Saharan Africa

Overview

Since the previous iteration of this report in 2016, sub-Saharan Africa has seen some progress in harm reduction policy and services in selected countries. Explicit support for harm reduction is now contained in national policy documents in 10 countries as opposed to seven in 2016, and needle and syringe exchange programme (NSP) services have been established in Uganda, Mali and Mozambique, which brings the total number of countries operating an NSP in the region to eight. The number of countries with some opioid substitution therapy (OST) provision has increased since 2016, with the addition of Zanzibar (see Table 2.9.1) having a service operating since 2015, and a new OST service having been established in August 2018 in Abidjan, Côte d'Ivoire. *The Global State of Harm Reduction* now also reports on more countries than ever in the region that have demonstrable advocacy efforts for harm reduction or with established programmes in place.

In a systematic review published in 2017, evidence was found of injecting drug use in 36 countries in the region,[u] with a broad-ranging estimate of people who inject drugs numbering between 645,000 and 3 million.[1] Reliable information on drug use in sub-Saharan Africa is, however, limited. Due to differing methods for calculating prevalence of blood-borne diseases among people who use drugs, with figures often stemming from sub-national data, the numbers cited in Table 2.9.1 should be viewed with caution. Although harm reduction services are generally found to be lacking, after an extended period of political rejection of harm reduction, some change has been observed in the region during the last five to 10 years, with epidemiological research being undertaken, pilot programmes and endorsements of harm reduction found in government policies. There has also been programmatic scale up of harm reduction services in a select few sub-Saharan African countries.

Since the last iteration of the *Global State*, the first East African harm reduction conference was held in Nairobi, Kenya in early 2018 and attracted approximately 600 participants from 20 countries. The event, co-hosted by the Kenya AIDS NGO Consortium (KANCO) and the Kenyan Ministry of Health, also saw the Cabinet Secretary for Health (Kenya) formally launch the Eastern Africa Harm Reduction Network.[5] A decade ago this conference would have been hard to imagine, and donor support for harm reduction activities in selected countries has assisted greatly with these changes. For example, Kenya now appears as one of the champions of harm reduction in the continent, steadily upscaling its harm reduction services over the last three to five years. Some politicians and policy makers voiced opposition to the criminalisation of drug use and urged a move towards drug use being treated as a public health issue.[31] Civil society mobilisation in the region has led to increased levels of support for harm reduction interventions, public awareness of what harm reduction is and in some instances to the initiation of services, such as pilot NSPs in Uganda.[30]

In November 2016, a civil society organisation in Senegal – Alliance Nationale des Communautés pour la Santé (ANCS) – became the principal recipient of a Global Fund regional grant programme which aims to: produce strategic information about people who use drugs; support countries to create harm reduction programmes and policies; advocate for harm reduction-friendly laws; create advocacy tools for harm reduction; and, build capacity for actors in the sector, including people who use drugs.[32] Importantly, the project calls for the establishment and necessity of a favourable environment for harm reduction interventions.[33] The programmes are due to operate in five countries (Côte d'Ivoire, Cape Verde, Burkina Faso, Guinea-Bissau and Senegal) in the coming years, all of which at the time of reporting had either no or very limited harm reduction services.[15,32]

Although increases in harm reduction services and support have been achieved, there are also examples of regression in the region. In 2014, the *Global State of Harm Reduction* reported a scale-up in both NSP and OST services in Tanzania.[34] In 2018, although there has been an increase in OST interventions outside Dar es Salaam, NSPs remain limited and accessibility is low.[24] The understanding of harm reduction interventions appears entwined within an abstinence-based approach in Tanzania under the current government, and demonstrates little focus on the health and wellbeing of people who use drugs.[24] As endorsed by the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the Joint United Nations Programme on HIV and AIDS (UNAIDS), the UN General Assembly, the Economic and Social Council, the UN Commission on Narcotic Drugs, the UNAIDS Programme Coordinating Board, the Global Fund and the President's Emergency Plan For AIDS Relief (PEPFAR), a comprehensive package of harm reduction interventions has been scientifically

u Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Ethiopia, Gabon, Gambia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritius, Mozambique, Niger, Nigeria, Rwanda, Senegal, the Seychelles, Sierra Leone, Somalia, South Africa, Swaziland, Togo, Uganda, Tanzania, Zambia and Zimbabwe.

demonstrated to support the prevention and spread of HIV and the reduction of other harms.[35] NSPs in particular are based on strong evidence for their effectiveness in the prevention of HIV[36,36,37] and hepatitis C,[36-39] and are known to lead to a reduction in injecting risk behaviours, such as the sharing of equipment.[39] NSPs are also cost-saving when compared with the total lifetime cost of treating a person with HIV.[40]

An inclusive approach: the necessity for gender-sensitive harm reduction services

Since 2012, the Muslim Education and Welfare Association (MEWA) in the coastal region of Kenya has partnered with Mainline, an organisation which implements harm reduction programmes in different parts of the world. The partnership's focus was on improving access to quality HIV prevention, treatment, care, support services, socio-economic rehabilitation, reintegration and human rights for people who use drugs. Starting in 2017, the project added a specific focus to deliver inclusive, rights-based and gender-sensitive services which were more accessible for women.[41]

Women who inject drugs often experience disproportionately high levels of negative health outcomes,[42,43] with studies often illustrating a much higher HIV prevalence rate among women who inject drugs than their male counterparts. [44,45] Women are often less inclined to seek harm reduction services due to multiple stigmas (such as external gender-related stigma, internal self-stigma, stigma from others living with HIV),[46] which has clear implications for their health.[47-49] Examples of this disparity have been reported in the Democratic Republic of the Congo, where drug use appears much more taboo among women than men,[50] and in Mauritius, where women remain a hidden population.[51,52] These attitudes are similarly echoed all over the region.[5,20,24,30,50]

To ensure women and girls are not left behind, the joint project in Kenya aims to strengthen and build capacity of established drop-in centres and NSPs; distribute condoms; improve screening, diagnostics and treatment of diseases and infections; improve HIV testing and counselling; and improve outreach. It also aims to provide expert harm reduction training to female drug users to form a "train the trainer" model of peer-to peer support, and information and assistance on accessible services.[41] The hope is that this approach, although currently implemented only in the coastal region, will eventually be taken up nationally and investment in it increased.[41,53]

Nigeria continues to be politically resistant to harm reduction interventions, even given the high lifetime prevalence of use of drugs such as heroin (63%) and cocaine (70%) among people who inject drugs, and unsafe practices such as the sharing and reuse of needles.[16,54] In the Seychelles, the harm reduction response has also fallen short, leading to the potential for a public health crisis. Between 2011 and 2017, HIV prevalence among people who injected drugs in the country increased from 5.8% to 12.7% and HCV prevalence from 53.5% to 76%.[17] Zanzibar, where one harm reduction service is in operation, has an HIV prevalence among people who inject drugs of 11.3%.[26] Although the hepatitis C prevalence rate is lower than other countries in the region (25.4%), both are likely to rise without a range of harm reduction interventions in place for this population.[26] The Democratic Republic of the Congo lacks many of the WHO-recommended harm reduction interventions.[35] Meetings between harm reduction advocates in the country and the ministers of health and security have not yet resulted in improvements to the implementation of essential services.[50]

Prevalence and patterns of drug use also vary across the region and, as Table 2.9.1 highlights, there remains a serious need to close the gap in harm reduction services and healthcare provision in sub-Saharan Africa for those at risk of blood-borne viruses, such as people who inject drugs, particularly in reference to hepatitis C. Research is assisting with this in some countries. For example in South Africa, between August 2016 and December 2017, 1,165 people who use drugs (including 941 people who inject drugs) were recruited across three cities (Cape Town, Durban and Pretoria) to assess prevalence of HBV, HCV and HCV-HIV co-infection. The study found that hepatitis C prevalence (virological confirmation) ranged from 29-73%, with up to 29% of people who inject drugs in Pretoria found to be co-infected with HIV and HCV.[18]

Even in the countries in the region which have established harm reduction services, significant structural barriers to uptake by people who use drugs persist. As one study participant in Durban notes, "Drug prohibition laws, stigmatisation and heavy-handed policing have all led to low levels of help or health seeking behaviour, distrust of the health system and little faith in the interventions that are available among [a] low-income community

of people who use drugs",[55] and there remains limited access to legal services for this population.[20] Mauritius and Tanzania have taken regressive steps in harm reduction-related policy, reducing and/or limiting access to comprehensive harm reduction services in recent years.[52]

Although harm reduction services are improving in some countries in sub-Saharan Africa, it is clear that there continues to be discordance between levels of HIV and hepatitis C among people who inject drugs and the availability of harm reduction services. Laws, policies and practices are inextricably linked to the effectiveness of a country's response to epidemics and the ability of people who use or inject drugs to gain access to HIV prevention, treatment and care services.[56] People who use drugs often feel stigmatised and discriminated against when seeking HIV testing and treatment, with a lack of integrated service provision for this population.[20,24] In addition, as in other regions, hepatitis C treatment remains beyond the grasp of the vast majority of people (both those who use drugs and those who do not) due to its cost. People also identified a low sense of self-worth, previous negative health care service experiences, a sense of hopelessness and long waiting times as contributing barriers to accessing hepatitis care.[19]

There is a great need in this region, as in others, for stability of harm reduction in policy, programming and security of its funding, such that these will not be undone by a change in government. Harm reduction is not a moral question, but an evidence-based, established public health approach which works.[57-61] The effectiveness of abstinence-based rehabilitation treatments has been refuted anecdotally in the region, with one harm reduction focus group in South Africa finding that every participant had at one time or another been enrolled in some form of rehabilitation centre, only to return to illicit opioid use on departure.[55] Human Rights Watch has also reported that abusive and unregulated rehabilitation centres which violate international human rights laws are operating across the region.[58,62]

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

NSPs in sub-Saharan Africa have been newly implemented in three countries since the *Global State of Harm Reduction* last reported in 2016 – Mali, Uganda and Mozambique – bringing the total number of countries now implementing this service in the region to eight. In September 2017, the Ugandan Ministry of Health approved pilot NSPs run by the Uganda Harm Reduction Network (UHRN), in partnership with Community Health Alliance Uganda, in two designated health facilities in one district of Uganda (Kampala).[29,30]

At the time of writing, there are four NSP sites in four cities in South Africa (Cape Town, Pretoria, Johannesburg and Port Elizabeth), an increase of one since the *Global State* reported in 2016, with the City of Tshwane (Pretoria) planning to expand its services to eight locations in the future.[20] In Kenya, thanks to an increase of funding from the Global Fund, NSPs have also increased, going from 13 to 19 since 2016.[63] In Senegal, the Alliance Nationale des Communautés pour la Santé (ANCS) implement a syringe programme based in Dakar,[32] and provide psychosocial and health specialists who can accompany and support people who use drugs when using the service.[32] Four further NSP sites are also operational, two in Dakar, one in Mbour and one in Kaolack.[16]

NSP sites in Mauritius, although still operational and financially supported by both the government and the Global Fund, remain restricted to a fixed quota of 30,000 needles per month.[51,64] The restriction, implemented by the government that came to power in 2014, inhibits service providers (who cannot respond to need) and is harmful, given the increasing number of people who inject drugs in the country.[51,52,64] People under the age of 18 do not have access to harm reduction programmes and, with paraphernalia illegal under the Mauritius Dangerous Drugs Act, young and old may be arrested for the simple possession of a syringe.[52] In Kenya, although NSP services fail to reach everyone who needs them, approximately 135 needles per person who injects drugs per year are distributed, a substantial increase since 2015.[65] A guideline for young people and harm reduction is currently in development in Kenya to enable better access to this group in the future.[5] Some NSPs in South Africa and Mauritius also solicit feedback on people's experience of the services to inform future improvements.[20,51,52]

Despite some increases in the region, coverage of existing NSP services remains disproportionately low compared to international targets.[35] In Tanzania, NSP provision remains poor, and high-risk behaviours such as needle sharing and the

practice of flashblood[v] have been reported, with an estimated 15.6% of people who inject drugs practising flashblood and 14.2% sharing a needle with another at last injection.[66] As previously noted, the approach taken in the country is predominantly abstinence-based in nature and therefore much-needed NSP services are not yet being scaled-up to the same extent as OST.[24] Tanzania is one of the main routes of entry for heroin in sub-Saharan Africa[67,68] and there is relatively high opioid use in the region.[21] There is poor access to screening services for blood-borne viruses such as HIV and viral hepatitis for people who inject/use drugs.[67] There is therefore an urgent need for significant increase in coverage of NSP, along with better integrated healthcare services for people who use/inject drugs and a strengthening of counselling on safe injecting and safe sex practices.[66]

NSP provision is currently unavailable in Zimbabwe.[69] However, the Zimbabwe Civil Liberties and Drug Network (ZCLDN) is currently working with the Parliamentary Committee on Health and HIV to table a motion to introduce harm reduction services, including NSP, in the country.[69] One of the major challenges to initiating NSP has been the lack of reliable data on injecting drug use. Civil society groups, such as the ZCLDN, point to evidence of injecting drug use and a clear need for these harm reduction services.[69] The Seychelles also has no NSP provision in free harm reduction services, but needles and syringes are available for purchase from pharmacies. From recent data, however, pricing appears as a barrier to the safe use of needles, with 41% of respondents (n=142) reporting unsafe injecting practices.[17] Given the rising rates of HIV and hepatitis C among people who use drugs in the Seychelles, harm reduction measures such as NSP are urgently called for.[17,70]

Nigeria remains politically resistant to the implementation of NSPs, even though unsafe practices such as the sharing and the reuse of needles is high.[13,71] Needles and syringes are sold at pharmacies, but people who inject drugs are often asked undesirable questions and worry about criminal repercussions. Coupled with this are the behavioural norms of needle sharing as a sign of trust or brotherhood, and new practices, such as the shared purchase of pre-loaded syringes by several people, leading to the sharing of a single syringe.[71] Civil society organisations in the country, such as YouthRISE, continue to advocate for the initiation of NSPs as an essential harm reduction service.[16]

In all countries where NSP sites exist (Kenya, Mali, Mauritius, Senegal, South Africa, Tanzania and Uganda and Mozambique), barriers to access remain, including social stigma, geographic coverage (often sites are restricted to urban areas with no mobile sites operational) and harassment/rights infringements by law enforcement, such as the confiscation of syringes/needles.[20]

Opioid substitution therapy (OST)

A total of seven countries in sub-Saharan Africa have OST services freely available for people who use/inject opioids (see Table 2.9.1). Zanzibar has offered this service since 2015 and Côte d'Ivoire since August 2017.[2,27] Similarly to NSPs, the majority of countries in the region have yet to introduce OST programmes. Where it exists, OST is provided in the form of methadone or buprenorphine, depending on the country, predominantly in directly observed treatment settings. Take-home dosing has been successfully implemented in South Africa, and is beginning on a small scale in Tanzania in the municipality of Temeke.[20,24]

Tanzania established its first methadone clinic at the Muhimbili National Hospital in Dar es Salaam in 2011, followed by a second clinic in Mwananyamala and an additional site in Dar es Salaam.[72] Since then, there has since been significant scale-up of OST outside Dar es Salaam, including the Mbeya and Mwanza regions, with political endorsement to scale up OST in other regions of Tanzania, beginning with Dodoma in late 2018.[24] Although the scale-up of services is welcome, the primary focus remains on injecting drug use; people who smoke rather than inject, particularly women, find access to OST more challenging.[68] There are also regular drug checks for people attending the clinics. The continuation of OST is dependent on negative results for illicit drug use, and an abstinence-oriented culture is dominant.[24] Zanzibar began implementing OST in 2015, offering methadone (doses ranging from 8mg-295mg), and had enrolled approximately 415 people into the programme at the time of reporting.[27] In early 2017, the Ministry of Health in Côte d'Ivoire approved the first OST programme in the country; the first unit was established in August 2018 in Abidjan.[2]

In the last iteration of the *Global State* in 2016, the city of Tshwane (Pretoria) in Gauteng, South Africa had entered into an agreement for OST to be made available at selected primary healthcare centres, with an OST demonstration project at the planning stages in Durban. In 2018, these programmes are

v Flashblood is a high-risk blood-sharing practice that carries a very high probability of viral transmission. A person who has recently injected draws blood back into the syringe post-injection and passes the syringe to a peer, who injects the 3ml to 4ml of blood in turn.

operational; 606 people were enrolled in OST as part of the city-funded low-threshold programme in Pretoria, and approximately 50 new people entered the service each month.[20] At the time of reporting, there were over 11 OST projects being implemented in four cities (Pretoria, Cape Town, Durban and Johannesburg) in South Africa for people who use opioids.[20] However, one of the main barriers to accessing substitution treatment remains the cost of medication (with no generic products available), since the services are not subsidised.[20] There have also been limited discussions with the National Department of Health in respect of determining appropriate budgets for OST; however, at the time of publication there was no clear call for a harm reduction-specific budget to offer free or subsidised care.[20]

In Kenya, OST was introduced by non-private providers in December 2014; since then there has been a steady increase in provision and support for further roll-out of OST services by USAID and the US Centers for Disease Control and Prevention, with seven OST clinics now open.[5] Further scaling up of this service is needed. Although many people who use drugs are keen to access OST programmes, at the time of reporting they were reaching less than 10% of people who inject drugs in the country.[63] Barriers to accessing substitution therapy include lengthy distances for people to travel to receive daily dosages and limited uptake by people living with disabilities.[5]

In 2016, under the newly elected Mauritian government, OST distribution was moved from health facilities to police stations, with daily fixed times and reduced hours (from 6.00 to 8.00 am) for people who use drugs to attend, with considerable negative impact on access to services. Methadone was also replaced with buprenorphine and naltrexone.[73] Successful advocacy by a Mauritian network of civil society organisations, Collectif Urgence Toxida, resulted in the reintroduction of methadone in 2017.[52] In the first half of 2018, distribution continued to be carried out at police stations and at the aforementioned fixed hours. However, in July 2018 the health minister of Mauritius announced that OST distribution would revert to primary healthcare settings with times of distribution to be reviewed.[52] The restrictions placed around OST in Mauritius highlight the retreat from previously well-established services in this country.

OST is available in Senegal, funded by several partners including the Global Fund and Expertise France, yet coverage is limited.[33] In 2016, the Centre de Prise en Charge Intégrée des Addictions de Dakar (CEPIAD) had enrolled 425 people in OST, carried out more than 3,000 consultations and offered a full range of services, including medical, psychological and social services plus daily methadone therapy, as well as activities such as gardening, literacy, theatre and art therapy.[33] There is hope for the service to be scaled-up, with take-home methadone available and a decentralised community service reaching beyond Dakar, yet these plans are funding-dependent. At present, women who use drugs make up only 10% of people coming to CEPIAD, and methods are still being explored to adapt services to meet their needs.[33]

OST remains unavailable in Zimbabwe. Opioids for detoxification are only available in rehabilitation clinics or by referral to mental health services.[69] Making harm reduction services available in the country would be an important step toward respecting the health-related and human rights of people who use drugs, and enabling access to opioids as a harm reduction measure. The Zimbabwe Civil Liberties and Drug Network is currently working with the Parliamentary Committee on Health and HIV to table a draft motion to introduce essential harm reduction services, including OST, to Zimbabwe.[69]

After long-term advocacy activities in Uganda, PEPFAR (through the US Centers for Disease Control) is due to incorporate elements of OST in Uganda's Country Operational Plan 2018 budget.[30] In Côte d'Ivoire and Mozambique, the respective Ministries of Health have announced plans to launch OST.[12,33] Although OST services are not available in the Democratic Republic of the Congo, it is believed that opioids may be available for substitution therapy via clandestine methods. However, further research is needed to understand need and subsequent harm reduction provision.[50]

In the Seychelles, OST is offered by the Agency for the Prevention of Drug Abuse and Rehabilitation, yet this appears linked to an abstinence-oriented approach rather than a harm reduction approach. In a recent report it was noted that there is an urgent need to pursue and scale-up harm reduction programmes in the country, particularly given the rising rates of HIV and hepatitis C among people who inject/use drugs. [17]

As indicated in Table 2.9.1 and Map 2.9.1, Nigeria still lacks OST services. However, [16,74] in 2018 the Ministry of Health began a consultation on the development of guidelines on the use of methadone for drug rehabilitation treatment. The health minister has also set up a task force to advise on the implementation of harm reduction in the country.[16]

Human rights violations and Stepping Up in South Africa

Human rights violations of people who use drugs are often unreported, underreported, or ignored. The Step Up Project, which has provided needle and syringe programmes and other core HIV services to people who inject drugs in South Africa, has consulted intensively with people who use drugs in order to better understand their lived realities and needs.[75] In 2016, 683 violations were recorded in Cape Town, Durban and Pretoria, 81% of which involved the illegal removal of unused injecting equipment.[75]

The Step Up Project emphasises the value of reporting violations and the way in which recording violations can contribute to positive changes in the environment.[75] An example of this was evidenced in Pretoria, where people who use drugs reported increased harassment, arrests and assaults by South African Police Services (SAPS) and members of the local Community Police Forum (CPF). When approached by members of the Step Up team, SAPS and CPF members reported that increased policing actions against people who inject drugs were motivated by concerns around the incorrect disposal of injecting equipment. Service users acknowledged this problem and Step Up implemented an adapted needle and syringe service based on needle exchange at the location in lieu of the regular distribution of full harm reduction packs (although these were still supplied where necessary), reducing the number of inappropriately discarded needles in the community. This measure, combined with informing SAPS and CPF that Step Up team members would be recording human rights violations, is believed to have led to a reduction in human rights violations in the area.[75] This is a small but significant example of the ways in which communication, understanding, respect and persistence can effect necessary changes for both people who inject drugs and the broader community.

Amphetamine-type stimulants (ATS) and new psychoactive substances (NPS)

Although injecting drug use is believed to be relatively low in some of the countries in the region, inhalation of substances like crack or heroin has been documented as quite commonplace in parts of West Africa.[33] With respect to broader amphetamine-type stimulant (ATS) and new psychoactive substances (NPS) use, evidence points to increases seen elsewhere around the globe[76] (please see ATS and NPS sections in other regional chapters).

A study of healthcare workers in Kenya found 8.8% had used cocaine, 6.4% ATS and 5.4% hallucinogens.[77] Methamphetamine laboratories have been discovered in Nigeria, and civil society organisations report a growth in the use of ATS.[74] Anecdotal evidence suggests there has been an increase in the use of NPS in Mauritius, with more seizures being carried out by the anti-drug and smuggling unit in the country.[52] Cocaine and its derivatives are available in Zimbabwe, but the drug is expensive and therefore access is limited.[69] Although there is no available data on NPS, sources note a rise in use in the Zimbabwean market where these substances are popular with younger people. In the capital's two major psychiatric referral hospitals, a high prevalence of substance-related psychiatric conditions has been noted by local doctors with the emergence of NPS.[69,78] Although ATS use is prevalent in South Africa, there is very little data outside detoxification treatment numbers. A study in Cape Town found over 90% of people who inject drugs screened for OST (n=<70) reported concurrent heroin and methamphetamine injecting.[20,79] Yet the response to ATS in all countries is almost exclusively abstinence-based, and resistance to harm reduction stands as a major barrier for people who use stimulants.[24,30,52,80]

Perhaps in light of the reported increase, Expertise France is financing six long-terms projects in West Africa (and South East Asia) to respond to new modes of drug consumption.[33] Given the reported increase in the whole region, there is a great need for research and development of harm reduction services specific to ATS and NPS.

Viral hepatitis

As seen in Table 2.9.1, data on the extent to which people who inject drugs are affected by hepatitis C (HCV) in the region remain extremely limited. From the estimates it is clear that the prevalence of hepatitis C in this population is high among people who use drugs when compared with national estimates.[9] It appears that Kenya is the only country in the region where treatment for hepatitis C is available free of charge, through funding from both the Global Fund and UNITAID, for small pockets of people who inject drugs.[5] At the time of publication, the treatment programme was available to 200 individuals as part of a research project; however, the Global Fund plans to assist 1,000 people into treatment by the end of 2019.[5] For the majority of people with limited access to these programmes, hepatitis C treatment remains expensive, often forming an insurmountable barrier, particularly for people who inject drugs and who are most vulnerable to the virus.[5]

In South Africa, National Hepatitis Guidelines and a National Hepatitis Action Plan are under development and will include a focus on people who inject drugs.[20] At time of publication, hepatitis C testing was not included in existing harm reduction programmes in South Africa, and direct acting antivirals (DAAs) were not formally registered with the South African Health Products Regulatory Authority. Treatment is therefore limited to two tertiary hospitals in the public sector, and there is limited awareness surrounding hepatitis C and poor linkages to care.[81] A study undertaken in three locations in South Africa (Cape Town, Durban and Pretoria) among 940 people who inject drugs found hepatitis C prevalence (virologically confirmed) at 44%; 224 people in the study who used drugs but did not inject had hepatitis C prevalence of 8%.[81] The high hepatitis C prevalence among people who inject/use drugs highlights an urgent necessity for expanded community-based services that are accessible and appropriate for key populations.[81,82] The findings also support a comprehensive care package of needle and syringe exchange programmes, opioid substitution and DAA therapy.[82]

In Tanzania, hepatitis B and C testing have recently been integrated into OST services, with more comprehensive care packages available for people who inject drugs.[24] However, hepatitis C treatment is inaccessible to much of the population due to the price of treatment, and diagnostic tests often have recurrent stock-outs.[24] With hepatitis C rates significant among people who inject drugs in the country (22% reported in 2010 in Zanzibar,[83] 27.7% reported in 2013 in Dar es Salaam[84] and 57% reported in Tanzania as a whole[23]), integrating hepatitis treatment into OST clinics should be considered with urgency.

In Uganda, Senegal, Zimbabwe, Zambia, Mauritius, South Africa and Nigeria, a lack of availability and accessibility of hepatitis C testing and treatment was reported for people who use drugs.[16,20,30,32,52,69,74] The cost of treatment remains the principal barrier; however, punitive laws and fear of reprisals often deter people who use drugs from accessing hepatitis C testing and treatment services.[69]

Tuberculosis (TB)

In 2016, an estimated 10.4 million people fell ill with TB around the world, 25% in Africa.[85] With TB deaths among those infected at approximately 82% in this region, a long way away from the WHO sustainable development goal of 10%, it is clear that TB prevention and treatment remain to be comprehensively addressed.[85] Sub-Saharan Africa, although witnessing a marginal decline in overall incidence (in 2016, 254 cases per 100,000 population per year as opposed to 263 in 2014), is estimated to have nearly double the TB global incidence of 140 per 100,000.[86]

Although TB testing and treatment are available to everyone in principle, they remain out of reach for much of the population in practice, and there continues to be a paucity of data regarding TB prevalence and treatment access among people who inject drugs. Whilst the majority of those who have been diagnosed may not develop active TB, people who use/inject drugs, together with prisoners, are more vulnerable to progressing to active TB due to increased HIV co-infection and poor prison conditions in many countries.[87]

In 2016, South Africa accounted for the largest share of people newly enrolled in HIV care who began TB preventive treatment, and it has been noted by WHO for its strong efforts in this area.[85] TB diagnosis and treatment is available in South Africa and Nigeria, but often services also place emphasis on abstinence as a condition for treatment, which restricts access.[16,20] With this in mind, in 2016 one sub-acute TB hospital in Cape Town shifted from running an abstinence-based intervention to implementing a harm reduction approach. This included the development of a new screening tool, a "contemplation group" for patients and harm reduction practice guidelines for staff. The aim of the programme is to assist patients to adhere to TB treatment, regardless of substance use. Over the first six months of the project, attendance in the contemplation group improved from 13% to 42%, highlighting how a harm reduction approach can be made practical and acceptable in a short space of time. However, acceptance of the programme has been varied among hospital staff, and long-term mentoring and support for hospital staff in harm reduction was recommended to improve their understanding of a harm reduction approach.[88]

The lack of available access to TB services for people who use drugs can also be seen in Uganda.[30] TB programmes are often more accessible when integrated into other services, such as harm reduction sites or HIV testing and treatment facilities. TB diagnostics and treatment are available in integrated services in Zimbabwe,[69] Senegal,[32] South Africa[20] and Kenya.[5]

In Tanzania, TB testing and treatment are integrated into OST services, but there remain challenges and a lack of resources in providing care to the population of people who use drugs in a friendly and non-judgmental way.[24] The criminalisation of

drug use, often linked with intense social stigma and discrimination faced by people who use drugs in the region, can lead to poor health-seeking behaviours.[49] Given the high rates of TB in sub-Saharan Africa, urgent action is needed to address the gaps in service provision.

Antiretroviral therapy (ART)

Data on the number of people who inject drugs receiving ART within the sub-Saharan Africa region are sparse. It is believed that HIV testing and treatment for people who inject drugs in Kenya reached approximately 68% of people who inject drugs registered in harm reduction services.[5,89] Yet adherence can be problematic, with missed appointments and a lack of follow-up care.[5]

In South Africa, Tanzania and Senegal, ART is widely available in mainstream public health services. However, there are few key population-specific ART services in existence, and criminalisation continues to contribute to non-disclosure of drug use to service providers.[20,24,32] Mandatory drug testing for people who inject/use drugs currently inhibits people from accessing ART in the current HIV prevention policy in Uganda.[30] HIV testing and treatment services in Nigeria are often located some distance from where people who are using drugs reside, so although ART is provided free of charge at government facilities, there are some associated costs for registration and laboratory tests which form another barrier to service uptake.[16]

To protect confidentiality and privacy, HIV data systems in South Africa do not routinely collect data on key population type.[20] Enrolling people who inject/use drugs into ART programmes is imperative, and integrated services which enable access should be increased in all countries in the region.

Overdose, overdose responses and drug consumption rooms

There are no drug consumption rooms or safer injecting facilities in sub-Saharan Africa and no peer-distribution naloxone programmes in operation at time of publication. Naloxone, a highly effective opioid antagonist used to reverse the effects of an overdose, is available outside hospitals in Kenya at harm reduction sites.[5] However, although harm reduction sites have access to naloxone, it can only be administered by medical personnel, which causes challenges for community groups and outreach.[5]

Naloxone can also be administered only by first responders and healthcare workers in South Africa[20] and Tanzania.[24] The existing harm reduction services in South Africa have trained peers and staff in overdose and prevention management, but there are occasional national stock-outs.[20] Formulations of naloxone other than injection (e.g. intranasal) have not yet been registered in South Africa, which further limits the life-saving support that first responders can provide.[20] In 2016, naloxone was added to the List of Essential Medicines in Tanzania, but can be stored and administered only in hospitals and specific medical facilities that have an emergency or specialised unit, meaning access is extremely limited.[24]

Naloxone is reportedly unavailable in the majority of countries listed in Table 2.9.1, including Mauritius,[52] Zimbabwe,[69] Senegal,[32] Nigeria,[16] the Seychelles,[17] Democratic Republic of the Congo[50] and Uganda.[30] The barriers preventing overdose programmes from operating were primarily noted to be prohibitive drug laws and restrictions on who is eligible to administer the drug.[24,30,52] In the Democratic Republic of the Congo, alongside many other countries in the region, advocacy efforts are in place to lobby for access to naloxone, and the necessity for drug and overdose training.[50]

A systematic review in 2014 found between 83-100% survival rates post-naloxone treatment, demonstrating that non-medical bystanders trained in community opioid prevention techniques are effectively able to administer the life-saving treatment.[57] It is widely acknowledged that people using drugs, their families, friends and people nearby who have access to naloxone form the most effective line of defence against opioid overdose; ensuring ease of access to this medicine is paramount.[90]

Harm reduction in prisons

Despite some momentum around decriminalisation in recent years, the response to drugs remains predominantly punitive in sub-Saharan Africa. In 2014, the West Africa Commission on Drugs called for the decriminalisation of both drug use and possession for personal use, presenting evidence of the ways in which criminalisation negatively impacts on health and social problems, and places undue pressure on the criminal justice system.[91] Since then, Ghana is poised to become the first country in the region to decriminalise the personal possession and use of all illicit drugs, replacing dated punitive legislation with an approach which addresses drug use as a public health issue. However, how this would work in practice is unknown.[92]

Research indicates that prisoners are more likely to be exposed to blood-borne viruses in the prison setting,[93,94] and reports of injecting drug use in

prisons are found worldwide.[95] The effectiveness of prison NSPs in challenging this has been demonstrated,[96] yet no countries in sub-Saharan Africa implement NSP harm reduction services in prisons and places of detention. Only three countries in the region provide OST in the prison setting: Mauritius, Kenya and the Seychelles.[w] In 2016, the *Global State* reported that, since the change of government in Mauritius in 2014, OST had been limited to those who already received it prior to incarceration. Thanks to lobbying by groups such as Collectif Urgence Toxida, OST in the form of methadone can now be initiated in three of the six prisons on the island.[52] Given that illicit drugs have been reported in all six prisons,[97] a scaling up of OST services and implementation of further harm reduction measures (such as NSP provision) is recommended, particularly given that 85% of people who inject drugs have reported being arrested by police in Mauritius.[11] In Kenya, only people who had received methadone maintenance prior to being incarcerated are given access to off-site OST centres by prison wardens.[5] However, the extent of ease of access to OST services in prisons for people who use opioids in all three countries is unclear.

Prison population rates vary considerably across sub-Saharan Africa. The median prevalence of incarceration for West African countries is 52 people per 100,000, whereas in Southern Africa it is nearly quadruple the figure at 188.[98] With the highest per-capita incarceration rate in the world, greater even that that of the United States, the Seychelles has 799 people imprisoned per 100,000.[98] Perhaps because of these figures, the Seychelles replaced its 1990 drug law with a new Misuse of Drugs Act in 2016 and convened a special tribunal to review sentences for drug offences.[99] The updated act is aimed at providing more effective measures in relation to drug use, and promoting treatment, education and rehabilitation.[99] This may result in a reduced number of people incarcerated for drug offences over time; however, the Seychelles remains extremely limited in its harm reduction approach, both in the community and in prisons (see Table 2.9.1). Without an appropriate public health-centred harm reduction response in the Seychelles, HIV and hepatitis C prevalence will continue to rise.[17]

UNAIDS estimated that 56-90% of people who inject drugs will be incarcerated at some stage in their lives[100] and drug use in the prison setting is widely documented.[95] A study involving people who use drugs in Dakar, Senegal found that 29.2% had consumed drugs whilst in prison.[14] People who inject drugs are also most vulnerable to overdose on release from prison,[101-104] yet naloxone is reportedly unavailable to prisoners post-release in every country in the region.[5,16,20,24,30,32,50,52,64,69,74] The provision of good-quality and accessible harm reduction, both inside and outside prisons, is a binding human rights obligation,[105] one which sadly remains unmet in sub-Saharan Africa.

HIV testing and treatment (using ART) and TB testing and treatment are available within prison settings, in theory, in all countries in the region. However, in some countries it has been noted that these services have limited reach and coverage,[30] stocks of essential medicines are often in short supply or arrive late[50] and access to ART through prison hospital/treatment centres can be difficult.[16,32,69] Although ART is available in South Africa to those who have been charged with any criminal offence, there appears to be limited access to HIV and ART services.[20] Put simply, failing to provide access to essential medicines in a timely way contravenes states' obligations to respect and protect the health and bodily integrity of people who are imprisoned, and in extreme circumstances, the very right to life of these people.[106,107]

As noted previously and evidenced in Table 2.9.1, hepatitis C prevalence among people who inject drugs is high. Similarly to naloxone availability, all countries in the region lack hepatitis C treatment in prisons.[5,16,20,24,30,32,50,52,64,69,74,108] Condom distribution is reportedly available in prisons only in Uganda (but with limited reach and coverage),[30] and in Lesotho and South Africa.[20]

In sub-Saharan Africa, the punitive response to drug use remains dominant, and people who use drugs continue to be harshly criminalised. It is clear that meeting international human rights obligations must be urgently prioritised in sub-Saharan African prisons, and that national, regional and international prison monitoring mechanisms should systematically examine issues relating to harm reduction during their prison visits.[109] One example of a progressive approach can be seen in Kenya, where a magistrate based at the Shanzu court in Mombasa offers people who use drugs a harm reduction alternative. People can be referred to the Muslim Education and Welfare Association (MEWA) rather than being imprisoned for drug-related crimes, where they are offered rehabilitation, psychosocial support, OST or support groups.[110]

w In Kenya this is an off-site OST service not operating within the prison. In the Seychelles, the extent or accessibility of OST services for people in prison is unclear.

Policy developments for harm reduction

Despite progress in the implementation of harm reduction services in some countries in the region, for the majority of sub-Saharan Africa a continued focus on supply reduction in drug policy and the criminalisation of drug use overshadows these efforts.

Harm reduction is now explicitly referenced in policy documents in 10 countries in the region,[x] and noted in regional guidance.[27] Tanzania endorsed harm reduction in its national HIV strategy, and harm reduction is present in a number of new policies, such as the National Guideline for Comprehensive Package of HIV Interventions for Key and Vulnerable Populations.[24,111] Although people who use drugs are recognised as a key population by the Tanzanian government, and included in upcoming policies on HIV and hepatitis C, coverage of services does not meet the WHO recommended levels in practice.[24]

Harm reduction is mentioned in various policy documents in South Africa, including the draft South African Hepatitis Guidelines, the draft South African Hepatitis Action Plan, and the South African National Strategic Plan on HIV, TB and STIs (2017-2021).[112] Significant advocacy efforts have also gone into including references to harm reduction in the updated South African National Drug Master Plan, which is currently in development. In Kenya, harm reduction is endorsed in national policy guidelines on HIV, and a multi-country Eastern African Harm Reduction Policy was in development at the time of publication; it is expected to include explicit reference to harm reduction.[5,30] The Kenya AIDS NGO Consortium, through support from a Global Fund regional grant, took leadership in the development of the sub-regional policy group on harm reduction at the East African Community (EAC) level.[5] The EAC is a regional intergovernmental organisation comprised of six countries (Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda) and at the time of publication the policies outlined were due to be delivered to the EAC council of ministers for further recommendation and approval.[5]

Harm reduction is not explicitly mentioned in national policies or strategies at present in Uganda. However, harm reduction issues have been submitted to policy makers establishing the new draft HIV prevention Action Plan for Uganda.[30] PEPFAR, through its linking agency the US Centers for Disease Control and Prevention, has committed to allocate a budget for the development of policy guidelines for the delivery of harm reduction interventions in Uganda.[30]

As previously noted, much of sub-Saharan Africa continues to follow a predominantly punitive approach to drug policy. The African Union, in its common position for the United Nations Special Session (UNGASS) on drugs, committed to achieving a balanced and integrated approach among supply reduction, demand reduction and harm reduction.[113] At time of reporting, Ghana was the only country in the region poised to decriminalise the personal possession and use of illicit drugs.[92]

Civil society and advocacy developments for harm reduction

Civil society organisations continue to be active in sub-Saharan Africa, both in implementing harm reduction services and lobbying for the need for harm reduction where it does not exist and/or where services are extremely limited. This mobilisation has led to increased levels of support for harm reduction interventions, public awareness of what harm reduction is through campaigns such as Support. Don't Punish[115] and in some instances the initiation of services, such as pilot NSPs in Uganda.[30]. The East African Harm Reduction Conference was held in Nairobi, Kenya in early 2018 and attracted approximately 600 participants from 20 countries. The event, co-hosted by the Kenya AIDS NGO Consortium and the Kenyan Ministry of Health, also saw the Kenyan cabinet secretary for health formally launch the Eastern African Harm Reduction Network.[5,52] Through the African Union, members of the Southern African Development Community have also been vocally supportive of harm reduction in various forums,[69] and civil society organisations in Kenya report better engagement in government budget-making processes for harm reduction.[5]

In South Africa, the second South African Drug Policy Week (SADPW) 2017, co-hosted by the South African National AIDS Council, brought together various stakeholders and people who use NSP and OST services to participate in discussions of the National Drug Master Plan development process.[20] The Southern African Network of People Who Use Drugs (SANPUD) was also established.[20,69] In September

x As far as we are able to ascertain, harm reduction is explicitly referenced in government policy documents in Ghana, Kenya, Mauritius, Tanzania (including Zanzibar), Zambia, Nigeria, South Africa, the Seychelles and Senegal.

2017, Mauritius also held its Third International Conference on Harm Reduction.[52]

In Nigeria, a national civil society stakeholders meeting on harm reduction was held for the first time in 2017. The meeting involved the Ministry of Health and the National Drug Law Enforcement Agency, which had in the past stood against harm reduction, with a national harm reduction coalition being formed at the time of publication.[16] A drug user network was also established in Nigeria in 2017, known as the Drug Harm Reduction Advocacy Network, and linked to the International Network of People who Use Drugs (INPUD).[16,74] This drug user network joins a plethora of others in the region, some of which are attached to the broader East Africa Harm Reduction Network,[y] including SANPUD (also linked to INPUD), [20] Drug Users of Gauteng, Drug Users of Cape Town, Drug Users of Durban,[20] the Mauritian Network of People who Use Drugs,[51,52] Drug Users Network Seychelles (DUNS), the Burundi Network of People who Use drugs (BAPUD), Santé Espoire et VIE (SAVE) in Senegal,[32] the Tanzanian Network of People who Use Drugs (TANPUD),[24] the Zanzibar Network of People who Use Drugs, the Kenya Network of People who Use Drugs[5] and five drug user-led groups in Zimbabwe, including the Zimbabwe People who Use Drugs group which formed in 2016.[69] The Zimbabwe Lawyers for Human Rights group has also assisted members of the Zimbabwe Civil Liberties and Drug Network at country level to understand their rights.[69] In April 2018, a Harm Reduction Association was also established in the Democratic Republic of the Congo, although limited to harm reduction advocacy work at time of publication.[50]

In 2017, YouthRISE Nigeria led the We Are People campaign, which focused on the human rights of people who use drugs and the need for harm reduction services. In 2018, YouthRISE aims to work together with the United Nations Office on Drugs and Crime (UNODC) to organise training for civil society organisations in the country on harm reduction.[16,74] Civil society organisations, such as UHRN in Uganda, are also helping to shift the trend from arrest and detain to arrest and refer to harm reduction by engaging with police officers and stations on the principles of harm reduction.[30]

Funding developments for harm reduction

As reported in previous iterations of the *Global State*, much of the funding for harm reduction in sub-Saharan Africa stems from multilateral agencies. In 2017, civil society organisations in South Africa received funding from the Global Fund through the South African National AIDS Council's work, with the monies used to support the continuation of services in Cape Town and the scale-up of two new NSPs in Port Elizabeth and Johannesburg, and two small OST programmes.[20] Although the Global Fund is supporting harm reduction in the region and South Africa more specifically, there is currently evidence of the government prioritising harm reduction funding.

There have been limited discussions with the South African National Department of Health on the appropriate budget for OST, but at the time of publication there are no reports of plans for a harm reduction-specific budget. Funding from PEPFAR of services for people who inject drugs through the Centers for Disease Control and Prevention has been reduced, with no additional funding from USAID in the latest round of key population funding.[20] Mainline, a Dutch NGO, has been complementing PEPFAR and Global Fund harm reduction funding through a programme of work called Bridging the Gaps in South Africa, focused on OST and psychosocial services in three cities and drop-in centres.[53] The Open Society Foundations (OSF) fund advocacy initiatives in East and West Africa.[20] Harm Reduction International's 10 by 20 campaign[z] was presented at the 2017 South African Drug Policy Week.[20]

Although more than 90% of funding in South Africa comes from international donor support, the City of Tshwane has allocated 4-5 million Rand (US$300,000 to $375,000) to harm reduction funding, specifically for OST and sterile injecting equipment/harm reduction packs, as part of a three-year agreement with the University of Pretoria. The programme aims to develop and implement a response to drugs that is not prohibitionist in nature.[20]

In Kenya, the United States government contributed an estimated US$5.5 billion through PEPFAR between 2004-2017 to the national AIDS response.[115] Small pockets of government funding are being used to support OST programmes in Kenya; however, the majority of funding continues to come from international donors.[5] Through donor support, such

y Kenya, Uganda and South Africa.
z The 10 by 20 campaign calls on governments to redirect 10% of law enforcement funding to harm reduction by 2020.

as that of the Global Fund, UNITAID, International HIV/AIDS Alliance, PEPFAR, USAID and Mainline via Bridging the Gaps, harm reduction services in the country have increased, including for OST, NSPs, naloxone and hepatitis C provision; but the last only to a small extent at time of publication.[5,53] In the next two to three years, the Global Fund grant (which is the primary funding to have sustained and scaled-up harm reduction programming and advocacy in Kenya) will come to an end. There is some concern that without a strong transition process and greater commitments by governments, the positive changes in Kenya, Uganda, Tanzania, Zanzibar, the Seychelles and Mauritius may be lost.[5] At present, in Kenya, OST coverage still reaches only 9% of people who use opioids, and more resources are needed to support and scale-up all nine of the WHO recommended interventions in the country.[63]

The Global Fund have supported pilot NSPs in Uganda in 2018, with the hope to scale-up to more sites with Global Fund assistance in the future.[29] The Partnership to Inspire, Transform and Connect the HIV response (PITCH), supported by the International HIV/AIDS Alliance, is also contributing to harm reduction initiatives in Uganda.[30] In Tanzania, harm reduction funding comes from a variety of sources.[24] OST clinics and the provision of methadone are supported primarily by the Centers for Disease Control and PEPFAR, with some support from the Tanzanian government. Funding for the NSPs running in Dar es Salaam comes from the French NGO Médecins du Monde (MdM) with support from Agence Française de Développement (AFD) and harm reduction advocacy is mainly funded through the Global Fund, with monies also coming from the Open Society Initiative for East Africa (OSIEA) and UN agencies.[24] For the first time, pilot NSP activities have been integrated into the recent Global Fund grant in Tanzania.[24] Due to limited resources and a lack of understanding regarding the principles of harm reduction in the country, health services which aim to address drug users' needs often lack financing, and there is an extremely limited government budget dedicated to the care of people who use drugs.[24]

In Senegal, harm reduction continues not to be a priority for the government.[32] ANCS, which is one of the main implementers of harm reduction in the country, receives funding from the Global Fund, the International HIV/AIDS Alliance and the Open Society Initiative for West Africa (OSIWA). The Global Fund grant will end by 2020/2021, and efforts must be made to ensure alternative funding is secured before then.[32] Similarly in Nigeria, which is yet to implement harm reduction programmes, over 80% of funding for the national HIV/AIDS programme comes from international donor contributions.[16]

The only country in the region that breaks the mould is Mauritius, where the government supports approximately 70% of harm reduction services and the Global Fund provides approximately 30%.[52] In the rest of sub-Saharan Africa, government domestic investment in harm reduction is poorly documented and there remains a heavy reliance on international donors; a reliance that risks the sustainability of the harm reduction response and leaves services in a precarious situation.[115]

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