2.4 MIDDLE EAST & NORTH AFRICA

ALGERIA
BAHRAIN
EGYPT
IRAN
IRAQ
ISRAEL
JORDAN
KUWAIT
LEBANON
LIBYA
MOROCCO
OMAN
PALESTINE
QATAR
SAUDI ARABIA
SYRIA
TUNISIA
UNITED ARAB EMIRATES
YEMEN

TABLE 2.4.1:

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

Country/ territory with reported injecting drug use	People who inject drugs	HIV prevalence among people who inject drugs (%)	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)	Harm reduction response			
					NSP[1]	OAT[2]	Peer distribution of naloxone	DCRs[3]
Algeria	nk	1.1	nk	nk	✓	x	x	x
Bahrain	nk	4.6	nk	nk	x	x	x	x
Egypt	nk	2.6	51.8	nk	✓	x	x	x
Iran	22,000	14	52	4.4	✓	✓	x	x
Iraq	nk	nk	nk	nk	x	x	x	x
Israel	nk	nk	nk	nk	✓	✓	x	x
Jordan	nk	nk	nk	nk	x	x	x	x
Kuwait	nk	nk	12.3	0.4	x	x	x	x
Lebanon	nk	0.0	23.4	1.2	✓	✓	x	x
Libya	2,000	89.6	94.2	nk	x	x	x	x
Morocco	3,000	9.6	46.2	nk	✓	✓	x	x
Oman	nk	11.8	48.1	nk	x	x	x	x
Palestine	nk	0.0	41.4	nk	x	✓	x	x
Qatar	nk	nk	69	nk	x	x	x	x
Saudi Arabia	nk	9.8	nk	nk	x	x	x	x
Syria	nk	0.0	40.8	nk	x	x	x	x
Tunisia	nk	3.5	21.7	nk	✓	x	x	x
United Arab Emirates	nk	nk	nk	nk	x	x	x	x
Yemen	nk	nk	nk	nk	x	x	x	x

nk = not known

1 All operational needle and syringe programme (NSP) sites, including fixed sites, vending machines and mobile NSPs operating from a vehicle or through outreach workers.
2 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
3 Drug consumption rooms, also known as supervised injecting sites.

MAP 2.4.1:
Availability of harm reduction services

- Both NSP and OAT available
- OAT only
- NSP only
- Neither available
- Not known
- DCR available
- ⊗ Peer-distribution of naloxone

2.4
Harm reduction in the Middle East and North Africa

7
NEEDLE AND SYRINGE PROGRAMMES

5
OPIOID AGONIST THERAPY

0
DRUG CONSUMPTION ROOMS

0
PEER DISTRIBUTION OF NALOXONE

AN ESTIMATED

200,000

PEOPLE

WHO INJECT DRUGS LIVE WITH **CHRONIC HEPATITIS C** IN THE MENA REGION

HIV

ALTHOUGH THE MENA REGION IS ESTIMATED TO HAVE ONE OF THE LOWEST HIV PREVALENCE RATES IN THE WORLD (<0.1%), HIV/AIDS-RELATED DEATHS REMAIN HIGH.

<0.1%

HIV PREVALENCE RATES

8000

2020

AIDS-RELATED DEATHS

The COVID-19 pandemic has affected implementation of harm reduction programmes. The pandemic has drastically impacted the quality and delivery of harm reduction services, and stakeholders are struggling to ensure sustainable services during this period.

1. Overview

Author:
Sandra Hajal
Middle East and North Africa Harm Reduction Association

Author: Elie Aaraj
Middle East and North Africa Harm Reduction Association

Despite the well documented health and social impacts of substance use in general and injecting drug use specifically, harm reduction interventions remain very limited in the Middle East and North Africa (MENA) region. Only six countries implement needle and syringe programmes (NSPs) - Algeria, Egypt, Iran, Lebanon, Morocco, and Tunisia - and four provide opioid agonist therapy (OAT) services as part of harm reduction - Iran, Lebanon, Morocco and Palestine.[3–17] Even in countries where NSPs and OAT are provided, accessibility and coverage remain a challenge, due to lack of funding, legal issues, stigma and discrimination, criminalisation of drug use, lack of political commitment. Overdose response is minimal and limited to only two countries - Lebanon and Morocco.[4,18–20] No drug consumption rooms (DCRs) are currently available in the region nor programmes specific to the use of amphetamine-type stimulants (ATS).

People who inject drugs are identified as a vulnerable group to HIV and hepatitis C infection and remain underserved by social and health interventions.[21,22] Although the MENA region is estimated to have one of the lowest HIV prevalence rates in the world (<0.1%), HIV/AIDS-related deaths remain high (8000 in 2020) and only 38% of people living with HIV have access to antiretroviral therapy (ART).[23] When it comes to hepatitis C, estimates state that the MENA region has the highest prevalence of hepatitis C infection globally, with around 20% of the people living with hepatitis C infections residing in the MENA region.[2] In addition, in 2020, it was estimated that there are more than 200,000 people who inject drugs living with chronic hepatitis C with one third of these localised in Iran.[2]

Civil society organisations, with minimal input from governments, lead implementation of harm reduction programmes in the region, with the exception of Iran.[4–6,24,25] These organisations are mainly reliant on international funding and in the past few years have suffered from multiple budget cuts and termination of many programmes (for instance, all NSPs have been progressively closed in Palestine and Jordan since 2016).[8,9,16,26]

The past two years have seen a major expansion in harm reduction programmes in prisons in Egypt, Morocco and Tunisia, with the support of the United Nations Office on Drugs and Crime (UNODC) in an effort to tackle the high morbidity and mortality of HIV and limit its impact in closed settings.[13,27,28] ART is widely available to any person testing positive, however many barriers for HIV testing still exist and civil society organisations providing HIV services to people who inject drugs have also been affected by budget cuts which have led to significant decreases in services.[3,4,7,8,15,29,30] The MENA region is considered to have low or intermediate incidence of tuberculosis (TB), and TB services have been mainstreamed into public health services with acceptable accessibility and coverage.[31,32]

Multiple governments (Algeria, Iran, Lebanon, Palestine, and Morocco) have adopted new policies, leaning towards a less punitive approach to drug use, however it is still criminalised in many countries in the region.[3–7,9,33,34]

Many countries in the region have been scaling up their HIV and hepatitis C response, however the impact is still insufficient and challenged by multiple barriers. The COVID-19 pandemic has affected implementation of harm reduction programmes. The pandemic has drastically impacted the quality and delivery of harm reduction services, and stakeholders are struggling to ensure sustainable services during this period.

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

NSPs have been implemented in the region for the past twenty years. However, in the past couple of years many countries have ceased or decreased the number of sites delivering NSPs due to multiple challenges, mainly financial difficulties.

Algeria, Egypt and Morocco are the only countries reporting some improvements in the last two years. Reporting systems, advocacy, leadership, coverage of NSPs and acceptability were highlighted and improved.[3,4,24,30] No changes occurred with NSPs in the same period in Iran and Tunisia.[5,6,17,34] Lebanon reported a decrease in service delivery due to limited funding and resources;[7] in Palestine and Jordan NSP services stopped completely due to limited funding and lack of political commitment.[8,9] Only one civil society organisation, Soins Infirmiers et Développement Communautaires (SIDC), is currently providing an NSP in Lebanon through clinic and outreach work.[7] NSPs are still not available in Bahrain, Qatar, Syria and Yemen due to political and legal barriers.[11–13,25,35] People who inject drugs in most of these countries struggle to access sterile injecting equipment. In Bahrain, for instance, pharmacies refuse to sell sterile syringes to people who inject drugs and their only access to syringes is through hospital waste or through buying unsterile syringes from diabetic patients.[11]

The number of syringes distributed per year per person who inject drugs remains far below 300, which is the World Health Organization (WHO) target for the elimination of hepatitis C. Morocco and Iran report coverage to be less than 100 syringes per person per year, and represent the highest coverage in the region.[4,10,36] In Morocco, barriers to NSPs include the distribution of injecting equipment unsuited to the needs of older people who require different syringe sizes than the ones distributed; self-stigma of people who refuse to identify themselves as people who inject drugs; and the preference of users to alternate between injecting and sniffing which results in major variations in the total number of syringes distributed on a period of time.[4] Regional barriers to accessibility and coverage of NSPs are common across all countries. Structural challenges include legal barriers, criminalisation of drug use and possession, a lack of political commitment and a lack of social acceptability. Operational challenges include a lack of funding opportunities; limited capacities of service providers (mainly civil society organisations); a lack of unified reporting systems resulting in inconsistencies in reporting (e.g. duplications); and difficulties in issuing grants or contracts to the civil society organisations for the delivery of NSP services.[10,11,13,14,34]

2.2 OPIOID AGONIST THERAPY (OAT)

OAT as a harm reduction intervention is provided in Iran (using methadone, buprenorphine and tincture of opium), Lebanon (buprenorphine and buprenorphine-naloxone), Morocco (methadone), and Palestine (methadone and buprenorphine).[4–7,9,14–17,29] The Ministry of Health in Syria and civil society organisations in Yemen reported the availability of OAT only in detoxification units.[12,25]

A major development in the region is the development of a pilot OAT programme in Egypt. In 2019, the UNODC and WHO worked with the General Directorate of Mental Health and Addiction and National AIDS Programme of Egypt to review and update the OAT feasibility study conducted by UNODC in 2014, with the possibility of beginning a pilot programme.[10,13]

Other developments in the past two years have been seen in Iran, Lebanon and Morocco. Since 2018, Lebanon has been scaling up OAT services with two dispensing units (to provide buprenorphine or buprenorphine-naloxone) opened in Bekaa and Mount Lebanon, and two additional centres for multidisciplinary follow-up and prescriptions (Bekaa and Kesrouan areas) are also offering OAT. Fifty-eight psychiatrists are currently licensed to provide OAT in Lebanon, with three psychiatrists receiving their licence in the past two years. Psychiatrists have received authorisation to provide buprenorphine and buprenorphine-naloxone, which was introduced in addition to buprenorphine to limit injection practice among patients.[14] According to the Lebanese Ministry of Public Health, eligible patients for OAT need to be seen and diagnosed with opioid use disorder by an authorised psychiatrist and followed by a multidisciplinary team including the psychiatrist, a psychotherapist, a registered nurse and a social worker. Patients are also required to follow up weekly and have a regular negative urine test to be able to receive their medications, that they pay for out-of-pocket,[14,29] from

a dispensing unit in a government hospital. The current procedures (regular follow-up, urine tests, prescriptions) are an extremely high financial cost to patients. Civil society organisations are requesting that the Ministry of Public Health revise the frequency of these procedures and their relative cost.[7,14]

Three new OAT centres were opened in Morocco in an effort to improve coverage, geographical distribution of services and long waiting lists.[4] However, many cities in Morocco remain underserved. People who inject drugs are often forced to travel long distances to reach OAT services and in some instances they even relocate to be close to service centres.[4] The main challenges faced in Morocco with regards to OAT are long waiting lists and lack of qualified and trained staff (e.g. to prescribe and follow up) which hinders the quality of service offered.[4]

In Iran, where already close to one million people are receiving various OAT modalities,[17] the number of people on OAT has slightly increased since 2018. The government of Iran established an integrated national database for registration of all OAT patients which has improved monitoring of clinics and limited duplication of cases.[5] Insurance coverage for OAT was expanded. Initially, it was only available through government centres which offer a small proportion of OAT in Iran. From 2020, the Ministry of Health increased insurance coverage to selected private sector clinics where patients usually pay out-of-pocket.[6] The current barriers and challenges faced by OAT in Iran are mandatory registration, fear of breach of confidentiality, stigma and discrimination, daily dispensing of methadone in first months, limited accessibility in rural areas, and a lack of gender-specific services.[5,6]

Palestine is still offering OAT with methadone with minimal follow up and counselling.[9] Buprenorphine was recently introduced as an alternative.[16] Algeria, Bahrain and Jordan have not yet introduced OAT mainly due to legal barriers, technical barriers related to methadone import and storage and lack of resources.[3,4,8,10–13,30]

Only six countries implement needle and syringe programmes (NSPs) - Algeria, Egypt, Iran, Lebanon, Morocco, and Tunisia - and four provide opioid agonist therapy (OAT) services as part of harm reduction - Iran, Lebanon, Morocco and Palestine.

2.3 AMPHETAMINE-TYPE STIMULANTS (ATS) AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Amphetamine-type stimulants are the second most common type of illegal substances used globally and usually vary according to different regions and contexts. According to the World Drug Report 2019, the most used types of ATS in the MENA region were methamphetamine (crystal and tablet form), MDMA, stimulant NPS,[4] and cocaine.[38] The estimated last year prevalence of cocaine use among adults in the region was around 70,000 accounting for 0.02% of the population. Estimates of amphetamine and ecstasy use are not available.[38] Harm reduction services for ATS and NPS are still lacking. Civil society actors across the region reported that established harm reduction services are not tailored to the needs of people who use stimulants and NPS.[3,4,6,12,14,15,17,34]

Most of the global amphetamine trafficking remains concentrated in the MENA region with 51% of the global seizures happening in this region.[38] Most of the seized fenethylline (an amphetamine commonly known by the brand name Captagon) was produced in Lebanon and Syria.[39] In fact, since 2011, the unstable situation in Syria seems to have impacted the illicit drug trade; amphetamine production and trading have economically fuelled the war in Syria with huge economic gains.[40]

4 Stimulant NPS are drugs with similar effects to amphetamine, cocaine, and MDMA, which result in increased alertness, energy, confidence, and sociability, and suppression of appetite and fatigue (e.g. mephedrone, methylone, α-PVP)[37].

2.4
OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

Drug consumption rooms are still not available in the region due to legal, cultural and structural barriers. Drug use is still criminalised in most of the MENA countries and people who inject drugs often face high levels of stigma and discrimination. Public acceptance and funding challenges are also among the cited barriers for the implementation of DCRs.[3–14,16,17,25]

In the MENA region, naloxone is available in medical, emergency or treatment settings only and not in a take-home form, except in Iran where naloxone programmes are available and operational all over the country and take-home naloxone is easily available however not many people make use of the programme.[3–6,16,17,26]

When it comes to overdose, only two countries have seen developments since 2018: Morocco and Lebanon. Morocco conducted international consultations in their efforts to develop a National Overdose Framework.[4] Overdose prevention materials were also prepared and service providers were trained on overdose prevention and emergency interventions in 2019.[15] Lebanon highlighted the need to develop an overdose prevention framework in its Inter-Ministerial Substance Use Response Strategy 2016-2021.[18] Advocacy efforts by civil society organisations in Lebanon continued into 2020. An assessment conducted in 2018 by Skoun, a Lebanese civil society organisation, found that more than 60% of hospitals reported overdose cases to the police despite a statement issued by the Ministry of Public Health asking healthcare facilities not to report these types of cases.[19] Following the results of this assessment and consistent lobbying, the Ministry of Public Health issued a second statement in 2019 to reinforce the first statement and push hospitals and health professionals to refrain from reporting overdose cases. Consequently the Ministry of Interior Affairs also issued a statement asking law enforcement officers not to intervene in cases of overdose.[20] Small scale educational overdose programmes prepared by civil society organisations are also available in Lebanon but with minimal coverage.[7]

Reporting overdose cases to law enforcement was also mentioned as a main barrier to health seeking in Bahrain, where people who inject drugs or their friends would not seek emergency care because of fear of imprisonment.[11]

2.5
HIV AND ANTIRETROVIRAL THERAPY (ART)

In 2020, UNAIDS estimated that 240,000 persons are living with HIV in the MENA region, however, only 130,000 know their status.[23] Only 38% of people living with HIV are receiving ART and around 8000 individuals died of an AIDS-related disease in 2018.[23] Few countries have effective HIV surveillance systems and data is lacking in many of them. In 2018, the HIV prevalence among people who inject drugs was highest in Iran (9.3%), Morocco (7.1%) and Tunisia (6%), and lowest in Kuwait, Lebanon, Oman and Syria (around or below 1%).[23] Although all countries except Bahrain reported availability of HIV testing (including for people who use drugs), the number of persons not knowing their status remains high.[3–17,24,25,30,34,35] In addition, HIV prevention programmes are not usually tailored for people who use drugs, therefore coverage and accessibility to HIV testing for this population remains low.[10,17] Iran and Lebanon reported occasional shortages in rapid testing kits at civil society organisations targeting people who use drugs. In Bahrain, voluntary counselling and testing is not available, and testing (without counselling) is mandatory for people entering prisons or addiction treatment centres.[11] The main barriers for HIV testing among people who use drugs are related to the costs of testing including travel, missed work days, and programmes not geographically reaching people who use drugs.[4,9,10,12,15,17,34]

Antiretroviral therapy is still widely available and free of charge for anybody testing positive for HIV, including people who inject drugs across the region. However, data on numbers of people who inject drugs receiving ART remains scarce.[3,10,30,41] The main issues for non-adherence to ART for people who use drugs are stigmatisation and recurrent substance use relapse which results in missed doses and appointments, and in some countries ineligibility for ART.[7,15,17] Morocco was the only country in which civil society reported the integration of ART within OAT services. Once they test positive, people who use drugs receive priority to be included in the OAT programme before starting ART, in order to improve adherence. During the treatment, patients can receive multiple support interventions ranging from medical follow-up, transportation costs and individual accompaniment, if needed.[4]

2.6
HARM REDUCTION IN PRISONS

The availability of harm reduction services in prisons varies across countries, despite the fact that people who use drugs make up approximately one third of all people in prison in the MENA region.[27] The negative impact of the prison environment on morbidity and mortality of HIV is well evidenced, however the regional harm reduction response in prisons remains weak and fragmented.[27] Most of the MENA countries still criminalise drug possession and authorities are focusing on drug control and prohibition instead of the health and wellbeing of people in prisons.[28]

Even though some countries in the MENA region implement NSPs in the community, none provide NSPs in prisons. People who are on OAT prior to incarceration in Jordan, Lebanon, and Morocco can continue their treatment when in prisons. In Iran, OAT programmes in prisons are large and comprehensive, and methadone can be initiated inside the prison setting.[4,6,7]

In Egypt, UNODC launched the "Prison HIV Project" in collaboration with the Ministry of Interior in 2019. The project includes the expansion of the UNODC Prison Health Programme from three prisons to seven including, for the first time, a women's prison. The services included are voluntary counselling and testing; hepatitis B and C and TB prevention and treatment; and sexual and reproductive health services.[13] This project is also implemented in Morocco and Tunisia and addresses the gender gap and limited services delivered to women in prisons (see box, p.124). Since 2018, Morocco has also established OAT units in five prisons that are under this project. However, methadone is only available for people who had initiated OAT prior to being incarcerated.[4,15] All other interventions are available for everyone in all prisons in Morocco even if they were not initiated before incarceration (treatment of HIV, sexually transmitted infections and TB).[4,13] In addition to the methadone treatment programme in prisons for men and women, Iran provides HIV testing, ART, hepatitis C and TB services.[6] Other countries such as Algeria, Bahrain, Jordan, Lebanon, Syria and Yemen offer HIV and viral hepatitis testing and treatment inside prisons with variable coverage and accessibility.[3,7,8,11,12,25,29] For instance, in Bahrain, HIV and hepatitis C testing are mandatory upon incarceration, however no counselling is provided. Hepatitis C treatment is not available to people in prison in Bahrain, however ART is provided.[11]

3.
Policy developments for harm reduction

Historically, countries in the MENA region have adopted conservative and punitive drug policies. Drug use and drug possession are criminalised in all of the countries in the region.[42] However, there have been policy developments in some countries towards a less punitive approach to drug use. A new Palestinian law was passed reframing drug use as a health issue rather than a criminal justice issue.[9] The same message was highlighted in the Inter-Ministerial Substance Use Response Strategy for Lebanon (2016-2021) and all five ministries launching this strategy agreed on including harm reduction as an essential theme under the services to be ensured within implementation.[18] In addition, a group of civil society organisations in Lebanon presented an amendment of the substance use law to the Lebanese parliament in an effort to reorient the national policy into a more humanitarian and public health approach.[7,14] In Algeria, the government issued the new National Strategic Plan for drug use (2020-2024) and included new harm reduction actions with people who inject drugs.[3] In 2017, the Iranian Parliament approved the addition of an amendment to the Drug Control Law for the purpose of converting the death penalty to imprisonment for some drug-related crimes.[5] Civil society in Morocco is advocating for changes of punitive laws regarding drug use.[4]

However, multiple discriminatory laws exist in the region and often hinder people who use drugs from accessing services. These discriminatory laws include compulsory parental consent for people under 18 who are accessing services, and other laws limiting people in the area of employment via criminal background checks.[3,7,9,30] In Iran, the police usually refer people who use drugs and experiencing homelessness to compulsory residential treatment facilities which contributes to further marginalisation of people who use drugs.[6] In Jordan, people who use heroin receive mandatory HIV testing, and drug tests are also conducted prior to being offered employment in the public sector.[8]

Iran and Lebanon reported using technology in the surveillance of the OAT service provision at the Ministry of Public Health (Iranian Drug Abuse Treatment Information System and OST Information System), with the aim of monitoring the OAT programmes and avoiding duplications.[6,14]

HIV, viral hepatitis and TB in prisons: From advocacy to policy reform and implementation[13]

In 2016 UNODC initiated HIV, viral hepatitis and TB prevention, treatment, voluntary confidential counselling and testing services, and sexual and reproductive health (SRH) projects in prison settings in three countries (Egypt, Morocco, and Tunisia).

Since 2018, UNODC has trained 470 professionals including 365 men and 105 women from the General Directorate of Prisons, Ministries of Health, and civil society organisations in Egypt, Morocco and Tunisia with 21 rounds of workshops. The participants included medical officers, nurses, social workers, and civil society organisation outreach teams working both at the community level and in closed settings. The workshops were facilitated by expert consultants and UNODC Global Prison and HIV Coordinators and covered a variety of subjects including:

- HIV testing and counselling;
- Delivering HIV prevention services to people who inject drugs, and people who use stimulants and a r e living in closed settings;
- Viral hepatitis among people who use drugs and living in closed settings;
- Tuberculosis;
- The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules);
- The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (The Bangkok Rules);
- Occupational safety and health procedures related to HIV;
- Women's health in prisons.

During this period, almost 3,336 people in prison (male and female) received individual and group counselling sessions on safe injecting practices, HIV, hepatitis B and C, adverse consequences of drug use, symptoms of sexually transmitted infections, safe sex and condom use, HIV testing, TB and personal hygiene.

UNODC-trained medical professionals delivered HIV and viral hepatitis voluntary counselling and testing services to 15,000 people in prison, and 24,000 people in prison were screened for tuberculosis. A total of 800 male and female prison staff were vaccinated against hepatitis B.

EGYPT: Through established voluntary counselling and treatment centres, the project is covering 27,000 people in prison (male and female) at Fayoum, Wadi Al-Natroon, Borg Al-Arab, Gamasa, Merg, Minia, and Qanater regions.

MOROCCO: All prisoners have access to HIV testing and counselling services including 21,000 people in prison (male and female) in five major prisons of Morocco namely Oukacha, Tangier, Tetouan, Salé, and Nador, implemented through civil society organisations.

TUNISIA: Around 10,000 people in prison (male and female) and juvenile detainees in Mornaguia, Borj El Amri, La Manouba, Le Kef El Mourouj, and El Mghira centres are covered under this project with comprehensive HIV prevention, treatment, and care services. Civil society organisations will also work in partnership to provide training activities on prevention of HIV, sexually transmitted infections, TB and substance use to prison officers and inmates (Mornaguia, Borj El Amri, La Manouba and Le Kef) as well as in two juvenile rehabilitation centres (El Mourouj and El Mghira centres).

As a result of UNODC advocacy in the region, the provision of HIV prevention, treatment and care for people who use drugs and living in closed settings was added to the national HIV strategies of Egypt, Morocco, and Tunisia.

The UNODC Prison Health Project covers 7,000 females in prison in Egypt, 2,000 in Morocco and around 400 in Tunisia.

During the COVID-19 pandemic, UNODC organised virtual training for prison staff and contributed to the procurement of personal protective equipment for prisons and prison health staff in Egypt, Morocco and Tunisia. UNODC also worked on developing and translating education materials on COVID-19 and prevention methods for persons who use drugs and persons living in closed settings. The material is currently available in English, French and Arabic and distribution started in Algeria, Morocco, Egypt, Morocco, and Tunisia.

4. Funding developments for harm reduction

One of the main challenges faced by countries in the MENA region with regards to harm reduction is funding. Almost all countries, except Morocco, reported decreased funding since 2018. The main international donors reported by stakeholders supporting harm reduction are the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), and the Drosos Foundation. Funding is also channelled via the Middle East and North Africa Harm Reduction Association, UNODC, the UN Development Programme and UNAIDS.[3,4,6–10,24,25,29,30] Unfortunately, these funding sources have decreased their support in most countries.

In Yemen, the Global Fund had secured a budget to support harm reduction activities for 2016-2022, however this budget was reallocated for emergency support due to the unstable situation and conflicts in the country.[25] Similarly in Palestine, the Global Fund and UNODC have reshuffled their funding towards refugees and humanitarian aid. As a result, harm reduction interventions were cancelled except for OAT, which is funded by the Korea International Cooperation Agency.[9] Since 2018, the Drosos Foundation stopped funding harm reduction in Tunisia and the Global Fund stopped its harm reduction and HIV funding in Iran. However, advocacy efforts were quite successful in Iran, resulting in the inclusion of treatment interventions (including opioid agonist maintenance treatments with methadone, buprenorphine and opium tincture) in the health insurance package.[5,6,17] Government funding in Iran has increased since 2018, however the increase has not been proportionate to the inflation occurring in the country.[17] No funds are available in Bahrain due to major legal barriers which results in the near total absence of harm reduction services.[11]

In Algeria, the Ministry of Health has not secured a budget for harm reduction, however health services are offered for free in the public facilities for everyone including people who use drugs. The Global Fund is supporting civil society organisations to deliver integrated services for HIV and people who use drugs. The budget allocated for the year 2018-2019 was USD 430,000 and currently amounts to USD 114,000 for 2020-2022. It will be extremely difficult for civil society organisations to continue providing these services after 2022 as international funding is decreasing and domestic funding is not available.[3,33]

The case is the same in Lebanon, where multiple international donors have decreased or stopped their funding since 2018 and domestic funding is not available. The National Lebanese Drug Observatory fund was also stopped in 2019.[14,29]

In Morocco, funding is more sustainable. International donors are supporting civil society organisations working on harm reduction along with national funding mainly from the Mohammed V Foundation for Solidarity. This local foundation supported the construction of most addiction treatment centres along with their human resources, equipment, ART and TB treatment and others. No budget cuts are reported for the coming years.[4,15]
Competing priorities for government budgets have resulted in the deprioritisation of harm reduction as a crucial part of health services.

> *One of the main challenges faced by countries in the MENA region with regards to harm reduction is funding. Almost all countries reported decreased funding since 2018.*

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