2.7 SUB-SAHARAN AFRICA

ANGOLA
BENIN
BOTSWANA
BURKINA FASO
BURUNDI
CABO VERDE
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
COMOROS
CONGO (DEMOCRATIC REPUBLIC OF)
CONGO (REPUBLIC OF)
CÔTE D'IVOIRE
DJIBOUTI
EQUATORIAL GUINEA
ERITREA
ESWATINI
ETHIOPIA
GABON
THE GAMBIA
GHANA
GUINEA
GUINEA-BISSAU
KENYA
LESOTHO
LIBERIA
MADAGASCAR
MALAWI
MALI
MAURITANIA
MAURITIUS
MOZAMBIQUE
NAMIBIA
NIGER
NIGERIA
RWANDA
SÃO TOMÉ AND PRÍNCIPE
SENEGAL
SEYCHELLES
SIERRA LEONE
SOMALIA
SOUTH AFRICA
SOUTH SUDAN
SUDAN
TANZANIA
TOGO
UGANDA
ZAMBIA
ZIMBABWE

TABLE 2.7.1:

Epidemiology of HIV and viral hepatitis, and harm reduction responses in sub-Saharan Africa

Country/territory with reported injecting drug use[1]	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[2]	OAT[3]	Peer distribution of naloxone	DCRs[4]
Angola	nk	nk	nk	nk	x	x	x	x
Benin	nk	2.2[1]	nk	nk	✓[2]	x	x	x
Burkina Faso	nk	nk	nk	nk	x	✓[3]	x	x
Burundi	nk	nk	nk	nk	x	x	x	x
Cameroon	nk	nk	nk	nk	x	x	x	x
Cabo Verde	nk	nk	nk	nk	x	x	x	x
Central African Republic	nk	nk	nk	nk	x	x	x	x
Chad	nk	nk	nk	nk	x	x	x	x
Congo (Democratic Republic of)	160,000[1]	13.3[4]	nk	nk	x	x	x	x
Côte d'Ivoire	500[4]5	3.4[1]	1.8[4]	10.5[4]	x	✓1[5]	x	x
Djibouti	nk	nk	nk	nk	x	x	x	x
Eswatini	nk	nk	nk	nk	x	x	x	x
Ethiopia	nk	nk	nk	nk	x	x	x	x
Gabon	nk	nk	nk	nk	x	x	x	x
Gambia	nk	nk	nk	nk	x	x	x	x
Ghana	6,314[6]	nk	40.1[4]	nk	x	x	x	x
Guinea	nk	nk	nk	nk	x	x	x	x
Kenya	30,500[4]	18[7]	16.4[4]	5.4[4]	✓19[8]	✓7[8,9]	x6	x
Lesotho	2,600[10]	nk	nk	nk	x	x	x	x
Liberia	457[11]7	3.9[12]8	nk	nk	x	x	x	x
Madagascar	15,500[4]	4.8[4]	5.5[4]	5[4]	x	x	x	x
Malawi	nk	nk	nk	nk	x	x	x	x
Mali	nk	5.1[13]9	nk	nk	✓[14]	x	x	x
Mauritius	11,667[15]	45.5[4]	97.1[4]	6.%[4]	✓46[16]10	✓42[16] (M,B)	x	x
Mozambique	29,000[4]	46.3[4]	67.1[4]	nk	✓1[17]	x	x	x
Niger	nk	nk	nk	nk	x	x	x[18]	x
Nigeria	80,000[39]	3.1[4]	2.3[19]	6.7[4]	✓3[20–22]	x	x	x
Rwanda	2,000[4]	nk	nk	nk	x	x	x	x
Senegal	1,324[23]11	9.4[4]	39.3[4]	nk	✓4[24,25]	✓1[24]	x	x
Seychelles	2,560[26]12	12.7[26]	76[26]	1[26]	x	✓13	x	x
Sierra Leone	1,500[4]	8.5[1,4]	nk	nk	✓[27]	x	x	x
Somalia	nk	nk	nk	nk	x	x	x	x
South Africa	76,000[4]	14.2[4]	54.7[28]14	5[29]	✓5[30]	✓<11[30] 15(M,B,B-N)	x16	x
Tanzania	30,000[31]17	15.5[7]	57[32]	1.1[4]	✓[4]	✓6[33]	x	x
Tanzania (Zanzibar)	3,000[34]	11.3[35]	25.4[35]	5.9[35]	x	✓[36]	x18	x
Togo	2,500[4]	nk	nk	nk	x	x	x	x
Uganda	3892[37]	17-20[38]19	nk	nk	x	x	x	x
Zambia	nk	nk	nk	nk	x	x	x	x
Zimbabwe	nk	nk	nk	nk	x	x	x	x

nk = not known

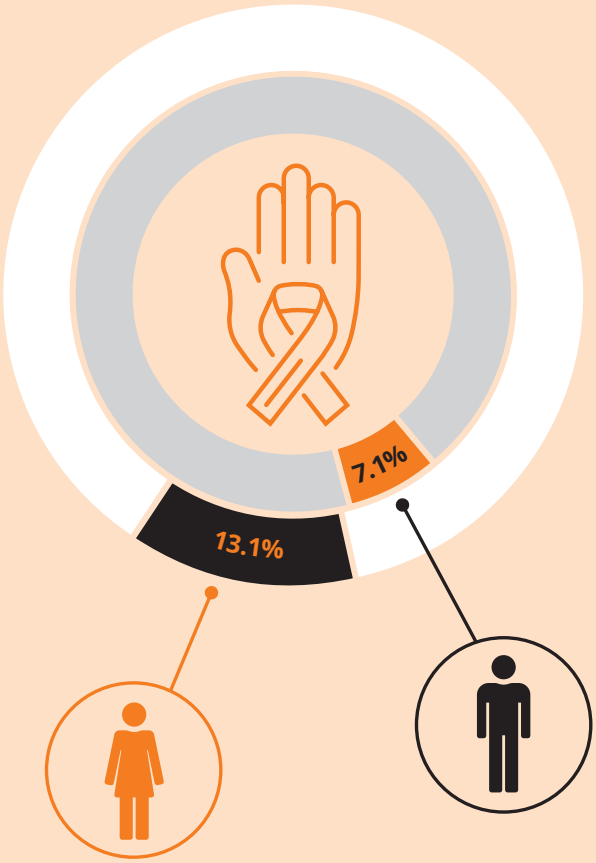
1 The countries included in this table are those with reported injecting drug use according to Larney et al., 2017. No evidence of injecting drug use was found in: Botswana, Central African Republic, Comoros, Equatorial Guinea, Eritrea, Guinea Bissau, Mauritania, Namibia, Congo (Republic of), São Tomé and Príncipe, or South Sudan.[1]
2 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.
3 Opioid agonist therapy (OAT), including methadone (M), buprenorphine (B) and any other form (O) such as morphine and codeine.
4 Drug consumption rooms, also known as supervised injecting sites.
5 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.
6 Naloxone is available at harm reduction sites in Kenya but can be administered only by trained healthcare personnel.
7 Based on sub-national data from six cities in three counties of Liberia.
8 Based on sub-national data from Grand Cape Mount, Grand Bassa, Grand Gedeh, Gbarpolu, Lofa, Montserrado, Margibi, Nimba and River Gee.
9 Based on sub-national data for Bamako only, with a sample size of 39.
10 35 sites managed by the Ministry of Health and Quality of Life (Government of Mauritius), 11 sites managed by the NGO Collectif Urgence Toxida.
11 Based on sub-population data from Dakar only.
12 Total number of people using heroin estimated to be 4,318, with 2,560 using injection as the chosen route of administration.
13 OAT offered by the Agency for the Prevention of Drug Abuse and Rehabilitation, believed to be an abstinence-oriented programme.
14 N=940 people who inject drugs in Cape Town, Durban and Pretoria. Data from 2017.
15 OAT is available in four cities: Cape Town, Durban, Johannesburg and Pretoria (eight sites in Pretoria).
16 Naloxone available for administration by first responders/emergency healthcare workers.
17 Figure is believed to be an underestimate nationally, but locally adequate in selected sites.
18 Naloxone available for administration by first responders/emergency healthcare workers.
19 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 2.7.1:
Availability of harm reduction services

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

2.7
Harm reduction in sub-Saharan Africa

HIV PREVALENCE IN PRISONS



IN WEST AND CENTRAL AFRICA, HIV PREVALENCE AMONG WOMEN IN PRISON IS ESTIMATED AT 13.1%, COMPARED WITH 7.1% AMONG MEN IN PRISON.

30% of people who inject drugs in the region are estimated to be living with HIV.

THE NUMBER OF PEOPLE WHO INJECT DRUGS IS ESTIMATED TO BE BETWEEN

560,000 AND **2.7 MILLION**

A RANGE THAT DEMONSTRATES THE PAUCITY OF DATA.

HIV IN THE REGION

51% ON ANTI-RETROVIRAL THERAPY

AS OF 2018, ONLY 51% OF ALL PEOPLE LIVING WITH HIV IN WEST AND CENTRAL AFRICA RECEIVED ART, WHICH MEANS THAT AROUND 2.5 MILLION PEOPLE LIVING WITH HIV IN THE REGION NEEDED TREATMENT BUT WERE NOT RECEIVING IT.

1. Overview

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Most countries in sub-Saharan Africa have poor collection and availability of data on drug use and the health of people who use drugs, and harm reduction services for people who inject drugs are limited. Injecting drug use is reported in 38 of 49 countries in sub-Saharan Africa, and the number of people who inject drugs is estimated to be between 560,000 and 2.7 million, a range that demonstrates the paucity of data.[39] Most people who report injecting drugs in sub-Saharan Africa are male, ranging from 66% in northern Nigeria to 93% in Nairobi, Kenya.[40]

The most commonly injected drugs in the region are opioids, followed by cocaine and tranquilizers.[41] Until now across the region, cocaine and heroin have been commonly used, with cocaine use highest in West, Central and Southern Africa, and heroin consumption concentrated along the East African coast (particularly in Kenya, Mauritius, Seychelles, South Africa and Tanzania).[41]

Drug use is criminalised in most sub-Saharan African countries, and people who use drugs are the target of law enforcement operations. Government policies on psychoactive drugs reflect a political preference for controlling drug supply. National and regional drug policies, influenced by the United States, UN conventions and other states' interests, often limit resources for harm reduction on the grounds that they condone drug use.[42] However, in West Africa in particular, there has recently been a movement towards more evidence-based and humane policy responses.[42]

Only a few countries in the region have implemented harm reduction programmes, particularly in the public sector. For example, needle and syringe programmes (NSPs) exist in ten countries in the region (Benin, Kenya, Mali, Mauritius, Mozambique, Nigeria, Tanzania, Senegal, Sierra Leone, South Africa and Tanzania), while opioid agonist therapy (OAT) is available in nine territories (Burkina Faso, Côte d'Ivoire, Kenya, Mauritius, Senegal, Seychelles, South Africa and Tanzania, as well as in Zanzibar). Although regional data is limited, country surveys among people who inject drugs suggest high HIV prevalence.[43]

Overall, just under a third (30%) of people who inject drugs in the region are estimated to be living with HIV and the same population is estimated to have accounted for 2% of new HIV infections in the region in 2019.[1,44] As noted above, data collection in the region is poor and therefore these estimates should be used with caution. Although there is progress with harm reduction programmes in the region, the overarching theme is one of implementation gaps and barriers, including limited programmes for women who use drugs, criminalisation of drug use, and limited legal and policy provisions to support programmes.

> *Needle and syringe programmes (NSPs) exist in ten countries in sub-Saharan Africa, while opioid agonist therapy (OAT) is available in nine countries.*

2. Developments in harm reduction implementation

2.1 NEEDLE AND SYRINGE PROGRAMMES (NSPs)

Since the *Global State of Harm Reduction 2018*, there has been some progress in initiating NSP programmes in sub-Saharan Africa, with NSPs now operational in Benin, Nigeria and Sierra Leone. However, the NSPs which commenced in 2018 in Uganda are no longer operational. In total, NSPs exist in sub-Saharan Africa across ten countries (Benin,[2] Kenya, Mali, Mauritius, Mozambique, Nigeria, Senegal, Sierra Leone, South Africa, and Tanzania), an increase of one since 2018.[45] In Benin, the NSP was initially implemented in certain communities with a high concentration of people who inject drugs, but since 2018 has been extended to the entire country through a programme supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). Currently, people who inject drugs enrolled in the programme receive ten syringes per month.[2] In Nigeria, three pilot sites are now operational with support from the federal government.[20–22] The Uganda Harm Reduction Network in 2018, with support from the Global Fund, piloted an NSP reporting distribution of 2,244 syringes to 120 people who inject drugs over a period of eight months from January to September 2018.[46] However, due to limited funding, the pilot programme was never scaled up, and the activity closed in 2019 at the end of the regional Global Fund grant.

Senegal remains a model example of successful implementation of harm reduction, showcasing positive collaboration between different state bodies and agencies, which resulted in the launch of West Africa's first harm reduction centre in 2014. The centre continues to operate outreach activities for NSPs within communities of people who inject drugs.[47] Since March 2019, the Sierra Leone Youth Development and Child Link (SLYDCL) has run the country's first NSP and plans to scale up its activities nationally and include people in prison once the results of the survey among people who inject drugs provides updated population size estimates. The National AIDS Secretariat in Sierra Leone advocates for the inclusion of harm reduction training into the mainstream police academy curriculum, with the aim of reducing police interference in NSP provision.[27]

Since the beginning of 2017, ARCAD Santé Plus in Mali has implemented a harm reduction programme focusing on injecting drug use in the districts of Bamako and Sikasso and financed by the Global Fund. Given the difficult context in Mali, an important component of the project is aimed at creating an enabling environment, including addressing political, legal, clinical and social barriers. The successful implementation to date has paved the way for harm reduction to be included in the funding request from Mali to the Global Fund for the 2021 to 2023 cycle.[20][14]

Despite these examples of achievements and the demonstrated effectiveness of NSP programmes in sub-Saharan Africa, coverage remains inadequate. Of the countries that have NSPs, the majority provide less than the World Health Organization (WHO) recommendation of 300 syringes per person who inject drugs per year.[48,49] The risk of acquiring HIV through sharing of injecting equipment is high among the people who inject drugs in sub-Saharan Africa. Many HIV prevention programmes in the region have deprioritised injection risks in their public awareness communications, perceiving injected drug use to be uncommon.[50] The reality is that a large proportion of people who inject drugs regularly share equipment, and research carried out in Nigeria revealed that only 25% of people who inject drugs know that sharing of syringes carries the risk of HIV transmission.[50]

In Nigeria, in 2019, the government committed to piloting needle and syringe programmes after advocacy from the health sector and civil society organisations.[51] Pilots have been implemented in three states in 2020, but the coverage and extent is unclear.[20, 21]

Criminalisation, legal restrictions on young people, and stigma and discrimination were reported as key barriers to effective NSPs. Additionally, people who inject drugs rely chiefly on civil society organisations for harm reduction services, which often operate in hostile environments. Funding for NSP programmes is insufficient, largely due to lack of political will and support. For example, in May 2018 in Durban, South Africa, the NSP was closed due to concerns of insufficient stakeholder consultation and the systems available for waste management of unsterile injecting equipment.[53] While this service was reinstated in late June 2020 and has seen a significant increase in the total number of clients, programme staff have struggled to locate the previous cohort of clients that had accessed the service before its closure.[20] The reform of obstructive laws and policies – along with greater funding and other

20 ARCAD Santé Plus (formerly a Global Fund sub-recipient) became the principal recipient for implementation.

support for community-based organisations – would greatly enhance HIV prevention among people who inject drugs in the region.[7]

NSP delivery in many countries across the region adopts a peer-led approach to distribute syringes and collect unsterile equipment. However, a challenge with the peer-led approach is that it is often supported by international donors, and once donor funding ends, national governments do not fill the funding gap.[53]

2.2 OPIOID AGONIST THERAPY (OAT)

In sub-Saharan Africa, OAT services are available in Burkina Faso, Côte d'Ivoire, Kenya, Mauritius, Senegal, Seychelles, South Africa and Tanzania (as well as in Zanzibar). Despite the unstable legal and policy environment in the region, there has been an incremental increase in countries or territories with OAT services from eight in 2018 to nine in 2020. The government has steadily expanded access to OAT in Kenya since 2014, although still only an estimated 10% of people who inject drugs are reached.[53]

The commonly used opioid agonist medications in the region are methadone, buprenorphine and buprenorphine-naloxone combinations. Where OAT exists, it is generally provided only through direct observation therapy in treatment settings, with the exception of South Africa and Tanzania where OAT is also provided in take-home doses (though only in a small-scale pilot in Tanzania). OAT services in sub-Saharan Africa are offered primarily in public general hospital settings, for example in Kenya and Tanzania, OAT is offered in public and national referral hospitals.[32,54] However, there remain some cases of private drug treatment centres in Kenya and South Africa.[32,54]

Since 2018, in Burkina Faso, methadone is listed as an essential medicine and delivered at the addictology unit at the Centre Hospitalier Universitaire Yalgado[3] in the capital city of Ouagadougou. In Dakar, Senegal, the drop-in clinic CEPIAD offers free OAT. In Uganda, the President's Emergency Plan for AIDS Relief (PEPFAR) pledged to support programmes for people who inject drugs.[46] Uganda now has plans in place for setting up its first ever OAT programme, likely to use both methadone and buprenorphine-naloxone combination.

OAT remains unavailable in Zimbabwe and Nigeria, despite significant populations of people who inject drugs and high HIV prevalence in both countries. However, the Nigerian government began processes in March 2019 to develop guidelines on the use of methadone for drug treatment and has also created a national task force on harm reduction.[55] In Mali, ARCAD Santé Plus is advocating for the introduction of OAT, backed up by data from a pilot project launched in 2017.[14] OAT is not yet available in Niger; however, the national pharmaceutical laws do provide a legal framework for the use of agonists such as methadone and naltrexone.[18] Sierra Leone aims to address drug use by using a holistic approach focusing on HIV prevention, including OAT implementation. However, while there is growing political support for harm reduction measures in Sierra Leone, there is no domestic funding for this work which is currently wholly supported by the Global Fund.[27]

Despite advances in OAT programming, relevant policy and OAT advocacy lag behind in South Africa. The South African Addiction Medicine Society has developed OAT guidelines, and new National Department of Health OAT guidelines are currently in development to be aligned with the new National Drug Master Plan.[20] OAT medications are still not included on the essential drug list for use at the primary care level. Even with the third five-year South African National Strategic Plan on HIV, Sexually Transmitted Infections and Tuberculosis (2017–2022), OAT is not included.[56]

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

While some African countries, notably Nigeria and South Africa, are the site of manufacture of ATS such as methamphetamine, these substances are largely manufactured for export.[57] Prevalence of amphetamine and methamphetamine use across Africa is less than 0.5% according to the United Nations Office on Drugs and Crime (UNODC), while cocaine use is even less prevalent (0.2%).[58] National-level data is completely absent for most countries. In Nigeria, the use of amphetamines and MDMA is prevalent

among young people, negligible among older people and less prevalent among women and girls.[13] Overall, the estimated prevalence of use of amphetamines is 0.2%.[59]
A significant proportion of people who inject drugs in South Africa use methamphetamine or cocaine, and use is especially high in Cape Town.[60,61] One three-city cross-sectional survey in the country found that 28% of people who inject drugs had injected methamphetamine or ATS in the last month, compared with 86% who had injected heroin.[60] Stimulant injection is associated with more frequent injection and therefore higher prevalence of risk behaviours (such as using equipment multiple times or for multiple people) and higher risk of HIV and hepatitis transmission.[62] NSPs are the primary harm reduction service for this population in South Africa. Since 2017, TB/HIV Care in Cape Town and Durban has offered Contemplation Groups as a part of their harm reduction programming. The sessions with these groups focus on providing room for reflection on drug use, and creating and strengthening identities separate from drug use among people who use drugs. Qualitative evaluation has found that the groups succeed in allowing participants an opportunity to manage their drug use, increase harm reduction practices and rebuild relationships according to their needs and experiences.[63]

The emergence of new psychoactive substances (NPS) and the counterfeit drug trade is also an issue in the region. WHO estimates that as many as 100,000 deaths per year in Africa could be due to counterfeit prescription medication not intended for recreational use. The total demand in West Africa for amphetamines, cocaine, opiates and prescription opioids is projected to more than double by 2050, from roughly 185 metric tons in 2018.[59]

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

Overdose, overdose response and DCRs have remained the same as reported in the *Global State of Harm Reduction 2018*. Naloxone use in overdose management has been reported in some parts of sub-Saharan Africa, including South Africa and Kenya[45] and only in hospitals in Tanzania. In South Africa, projects have trained peers and staff in overdose and prevention management, but naloxone itself remains only accessible through prescription or medical first responders.[20] Civil society actors continue to advocate for the inclusion of naloxone in all public harm reduction programmes.[20] In the Democratic Republic of the Congo, Mauritius, Nigeria, Senegal, Seychelles, Uganda and Zimbabwe, naloxone is reportedly unavailable.[64]

2.5 HIV AND ANTIRETROVIRAL THERAPY (ART)

HIV prevalence among people who inject drugs in sub-Saharan Africa is approximately 56%, though up-to-date and robust data is scarce.[65] National prevalence estimates among people who inject drugs vary considerably, for example from 3.1% in Nigeria to 45.5% in Mauritius.[66] In 2017, it was estimated that roughly 6.5% of people who inject drugs in West and Central Africa are living with HIV.[67] This variation demonstrates the urgent need for accurate and representative data on HIV among people who use drugs in the region.

This geographic variation in HIV prevalence may be related to gender inequality within settings and the degree of overlap between injection drug use and sex work. There is a higher HIV prevalence among women who inject drugs, who are two to ten times more likely to be living with HIV than men who inject drugs in Nigeria, South Africa and Tanzania.[43,68]

As of 2018, only 51% of all people living with HIV in West and Central Africa received ART, which means that around 2.5 million people living with HIV in the region needed treatment but were not receiving it.[69] As of June 2020, Benin, Burkina Faso, Burundi, Cape Verde, Côte d'Ivoire, Chad, Guinea, Guinea-Bissau, Liberia, Mauritania, Mali, Niger, Sierra Leone and Togo had all introduced supportive policies relating to HIV testing and treatment.[1]

ART coverage in West and Central Africa is below that of East and Southern Africa, which has attained 67% coverage. The low coverage in the West and Central sub-regions is attributed to various factors, mainly conflict within the region, other epidemics such as Ebola, and the fact that a high proportion of people do not know their HIV status. This situation is further exacerbated by the lack of national and international political will, weak healthcare systems and lack of support for community-based and community-led

organisations.[70] As a result of low testing, low ART coverage and issues with treatment retention, in 2018, an estimated 39% of people living with HIV in West and Central Africa achieved viral suppression. However, as few people can access a viral load test, the real picture on viral suppression is uncertain.[69]

Where harm reduction services exist in sub-Saharan Africa, HIV services, including HIV testing and access to ART, have been integrated. OAT services have been used as sites for HIV testing and ART delivery for people who inject drugs. Additionally, ART services are provided in outreach settings for hard-to-reach populations, including people who inject drugs. Despite the efforts to make services available to people who inject drugs in the region, the performance of ART services has been affected by client loss to follow-up and poor adherence outcomes, especially for those who fall in and out of the OAT programme[71].

2.6 HARM REDUCTION IN PRISONS

Prisons are a high-risk environment for HIV transmission due to widespread drug use and a lack of availability of sterile injecting equipment, tattooing with homemade and unsterile equipment, and high-risk and non-consensual sex. UNAIDS estimates that people in prison worldwide are on average five times more likely to be living with HIV compared with adults who are not imprisoned, while WHO estimates the difference to be even higher.[72,73] A systematic review released in 2018 found that recent incarceration was associated with an 81% increase in HIV risk and 62% increase in hepatitis C risk.[74] Due to overcrowding, as well as stress, malnutrition, drug use, and violence, the immune system may be further weakened, rendering people living with HIV more exposed to other health complications.[74–76] Despite this, HIV prevention programmes are rarely made available within prison settings and many people in prison with HIV are unable to access ART.[75,77]

Reported HIV prevalence among people in prisons in sub-Saharan Africa ranges between 2.3% in Ghana and 27% in Zambia, though data among this population is likely to be largely unreliable.[77–79] Women in prison are more affected, experiencing HIV prevalence that is almost double that of men. For example in West and Central Africa, HIV prevalence among women in prison is estimated at 13.1%, compared with 7.1% among men in prison.[80]

In sub-Saharan Africa, the punitive response to drug use remains dominant, and people who use drugs continue to be harshly criminalised. Three countries in the region (Mauritius, Kenya and Seychelles) offer OAT services in prison settings. In Kenya, one magistrate in Mombasa County offers alternatives to prison for people convicted of minor offences. [81] This has legal basis through the Kenya Community Service Orders Act (1998), which established a diversion scheme that enables Kenya Probation and Aftercare Services (KPAS) to assess people convicted of a drug use offence. The initial assessment when a person is referred to KPAS also includes a comprehensive familial and social component. On the basis of that report, a magistrate has the flexibility to refer the person to a drug dependence treatment facility.

In Uganda, the Uganda Harm Reduction Network has an ad hoc arrangement with the police in Kampala to divert certain cases of drug use to them for alternative support rather than incarceration.[71] Evidence indicates that people who use drugs who have been incarcerated for non-injected drug use transition to injecting drug use during incarceration and continue to inject after release. Prisons in the country have limited ART and HIV testing services[82].

3. Policy developments for harm reduction

Ten countries across the region - Côte d'Ivoire, Kenya, Mali, Mauritius, Mozambique, Senegal, Seychelles, South Africa, Tanzania and Uganda - have incorporated harm reduction into their national HIV strategic plans. In addition to these ten countries, since 2018, the East African Community (EAC) with support from the Global Fund (through Principal Recipient Kenya AIDS NGO Consortium (KANCO) together with Sub-Recipients), has developed a regional policy for harm reduction. This led to the development of the EAC Regional Policy on Prevention, Management, and Control of Alcohol, Drugs and Other Substance Use.[83]

The African Union continues to demonstrate a strong commitment to addressing drug use in the region by facilitating the availability of a wide range of evidence-based treatment options, including OAT. For the first time, the new African Union Plan of Action on Drug Control and Crime Prevention for 2019-2023 calls for harm reduction services and alternatives to imprisonment to be made available. It includes a commitment to review and harmonise drug policies across the region and to the continuous support of international research and data collection processes.[84]

A national task force has been formulated in Nigeria to develop policies as the government has started to show some signs of embracing harm reduction. However, the majority of sub-Saharan African countries continue to focus on supply reduction and criminalisation of drug use.

In South Africa, the long-awaited National Drug Master Plan 2019-2025 began to be implemented at the national and regional level from July 2020. The part of the plan focused on the health sector includes commitment to harm reduction services under its strategic goals.[20,85]

4. Funding developments for harm reduction

While harm reduction measures are most often relatively inexpensive and demonstrably cost-effective, one of the most important barriers to harm reduction initiatives is nonetheless a lack of sustainable funding.[86] This forces programmes to reduce capacity or prevents them from opening at all. The Global Fund remains the driving force behind the introduction and financing of harm reduction programmes in West and Central Africa.[27,87]

In Sierra Leone, the Global Fund committed to continue their support for the implementation of harm reduction programmes focusing on NSP and the use of naloxone to combat overdoses for the 2020-2022 period.[27] In Senegal, the Global Fund finances the CNLS (Conseil National de Lutte contre le Sida) CEPIAD harm reduction centre.[87]
In some countries, domestic investment is increasing for HIV key population programming, which includes people who inject drugs. For example, in Kenya OAT is budgeted through the national domestic budget.[8,9]

Women who use drugs in East Africa

A persistent gap in harm reduction programming in East Africa is the lack of programmes designed to address the specific needs of women, taking into account the unique challenges they face. With the number of women who use drugs increasing across the region, they also face more serious consequences from co-infection with diseases such as HIV, hepatitis C and B and other sexually transmitted infections. In some cases, women who use drugs may also be members of other key populations. For example, an urban study in Kenya found that 48.7% of women who inject drugs in low-income urban settings engaged in sex work as their main source of income.[88] Despite these factors, women-led civil society organisations advocating for the rights of women who inject drugs are uncommon, the notable exceptions being the South African and Tanzanian networks of people who use drugs. Some services have emerged to meet the needs of women who use drugs. Community-based programmes for women who inject drugs exist in South Africa and Kenya. The Muslim Education and Welfare Association is a Kenyan civil society organisation that provides quality HIV prevention, treatment, care, support services, socio-economic rehabilitation, reintegration and human rights-based and gender-sensitive services for people who use drugs. To date, the services have been scaled up to include provision of shelter to homeless women who inject drugs and are experiencing homelessness and their children, as well as engaging women in health education and economic empowerment activities.

Despite these developments and growing research over the past decade on the structural factors that shape HIV among people who inject drugs, it is difficult to find sex-disaggregated data on drug use. Population-based studies of people who use drugs rarely include women, making it difficult to estimate prevalence of drug use among them. Special efforts are needed to systematically include women in studies on substance use, and gather comprehensive age and sex-disaggregated data. This is particularly true among women who use drugs in rural communities.[20]

In its plans to establish the country's first OAT site in a public mental health facility with support from PEPFAR, the Ugandan government supported the Uganda Harm Reduction Network to conduct an assessment of the perspectives of women who inject drugs. Focus group discussions and key informant interviews with women who use and inject drugs revealed that many women between 16 and 32 years old had first used drugs with the assistance of an intimate partner.[71] Many women also reported that they engaged in sex work. Women expressed a desire to engage with drug and health services, but noted that they were discouraged from doing so because of the stigma they experience as women who inject drugs.

During a 2016 study among people who use drugs in Uganda,[46] one respondent reported that women who inject drugs who are experiencing homelessness and those who are sex workers were particularly vulnerable to both violence and HIV transmission, and that programmes do not provide services that meet their unique needs, including night outreach and offering food and shelter. For example, women who inject drugs experiencing homelessness who have families and babies have no adequate services available to them.[46]

> *Women who inject drugs who are experiencing homelessness and those who are sex workers were particularly vulnerable to both violence and HIV transmission, and programmes do not provide services that meet their unique needs.*

Opportunities to end the War on Drugs in Africa

The Global Fund is the primary funder of harm reduction programmes in Africa, but implementation is limited by national policies. As a result, harm reduction policies and programmes are severely lacking in West and Central Africa. The main obstacle remains the 'war on drugs', the prohibitionist approach that governments promote over more humane, evidence-based policies.

An exception to this pattern is Senegal, where the CEPIAD centre has created an environment favourable to people who use drugs by providing free OAT and NSPs.[89] Integrating harm reduction into national health strategies, and treating drug use as a public health issue, has allowed Senegal to begin to implement more effective drug policies.

The African Union Plan of Action on Drugs and Crime for 2019-2023 offers a unique opportunity to African countries to incorporate harm reduction in national policy frameworks. For the first time, the words 'harm reduction' were explicitly included in the plan. The plan also covers 'alternatives to punishment'. The ground-breaking inclusion of harm reduction and harm reduction-based health centres for people who use drugs paves the way for governments and policy-makers to develop and implement harm reduction measures by including these in their respective national drug control masterplans.

The West Africa Commission on Drugs has developed a Model Drug Law for West Africa, a tool for policy makers to advocate for evidence-based drug laws in the region.[90] The Model Drug Law contains legislative provisions and commentary incorporating the obligations of the three UN drug control treaties. It also takes into account the outcomes and commitments from the 2016 United Nations General Assembly Special Session on the World Drug Problem and the ECOWAS Drug Action Plan to Address Illicit Drug Trafficking, Organized Crime and Drug Abuse in West Africa (2016-2020).[90,91] It seeks to promote the protection of public health as the overriding priority of drug policy, and includes recommendations for the implementation of needle and syringe programmes, opioid agonist therapy and the decriminalisation of drug possession where there is no intent to manufacture, traffic, sell or supply.[90]

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