Regional Overview

2.9 Sub-Saharan Africa

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]
Burkina Faso[d]	nk	nk	nk	nk	✗	✗
Côte d'Ivoire	nk[(1)e]	nk[(1)f]	nk	nk	✗	✗
Ghana	6,314[(2)g]	nk	nk	3.1[(1)]	✗	✗
Kenya	18,327[(3)]	18.3[(3)]	51.4 (42.2–60.6)[(4)]	6.4[(4)]	✓13[(5)]	✓5[(5)]
Liberia	nk	3.9[(6)]	nk	nk	nk	nk
Malawi	nk	nk	nk	nk	✗	✗
Mauritius	11,677[(7)]	44.3[(7)]	96.5[(8)]	6.7[(8)]	✓49[(7)]	✓18[(7)]
Mozambique	2,204[(9)h]	50.3–73.1[(10)]	61.7–77.3[(9)]	32.1–36.4[(9)]	✗	✗
Nigeria	19,000[(11)]	3.4[(11)]	nk	nk	✗	✗
Senegal	1,324[(12)i]	9.1[(13)]	38.85[(12)]	nk	✓	✓(1)[(14)]
Seychelles	346[(15)]	5.8[(15)]	53.5[(15)]	0.1[(15)]	✗	✓(1)[(15)]
South Africa	75,000[(16)j]	14[(16)]	nk	nk	✓3[(16)]	✓(M,B)[(K)]
Tanzania	30,000[(17,18)]	35[(18)]	28[(19)]	nk	✓5[(20) l,m]	✓3(M,O)[(20)]
Uganda	nk	nk[(21)]	nk	nk	✗	✗
Zanzibar	nk	11.3[(22)]	nk	nk	✗	✗

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] Global State of Harm Reduction 2014 reported that Burkina Faso had one OST site in operation. This information was incorrect and has therefore been omitted from this 2016 report.

[e] Estimates based on sub-national data from Abidjan, there are believed to be 3,521 drug users who had used heroin and/or cocaine (both injecting and non-injecting) in the past year (see Overview below).

[f] Estimates based on sub-national data from Abidjan, the HIV prevalence rate among people who inject drugs is 5.2%, but this is based on a sample size of 57 (see Overview below).

[g] Estimates based on sub-national data in four areas: Accra, Tema, Cape Coast and Sekondi-Takoradi.

[h] Estimates based on median Integrated Biological and Behavioral Surveillance (IBSS) findings conducted in Maputo and Nampula, which looked at lifetime injecting.

[i] Estimates based on sub-national data from the Dakar region referring to people who use injectable drugs inclusive of heroin and cocaine.

[j] In late 2015 a stakeholder meeting hosted by the South African National AIDS Council to review the estimates on people who inject drugs, based on expert consultation and the available data, revised the previous estimate of 67,000 to 75,000.

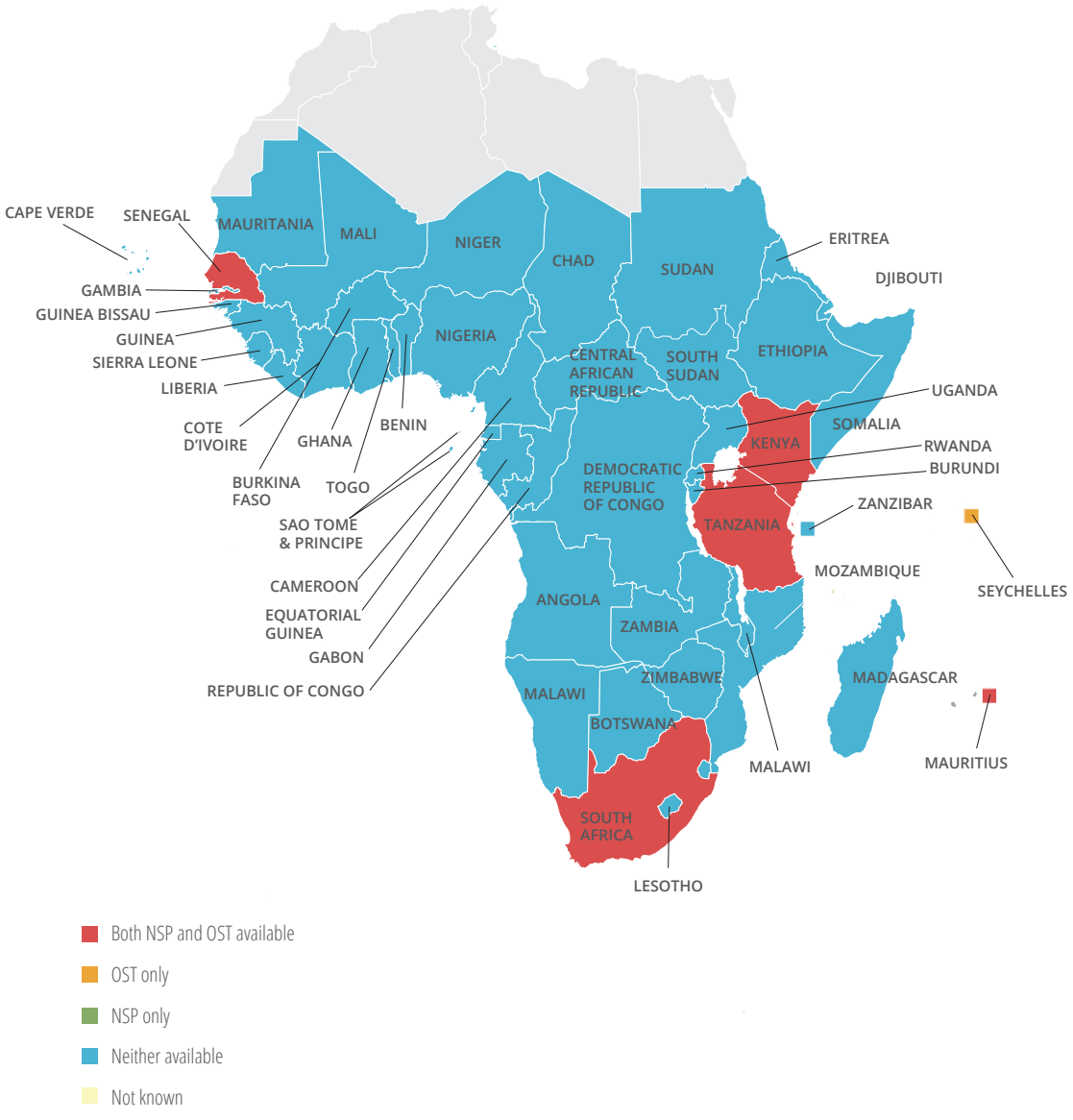
[k] It is not possible to put a figure on the exact number of OST sites in operation within South Africa as OST is also available in private clinics and government hospitals (the latter use it for detoxification only).

[l] Médecins du Monde and its partner NGO Mukikute are the only two NGOs implementing NSPs in Dar es Salaam through five fixed sites and 56 outreach sites with the support of external donors.

[m] NSPs operate in five fixed sites in three districts (Temeke, Llala and Kinondoni). Outreach workers also provide NSP in 107 hotspots within the three districts.

[n] Based on a study conducted in Kampala in 2012, HIV prevalence among people who inject drugs was 16.7%, but this is based on a sample size of 54 (see Overview below),

Map 2.9.1: Availability of needle and syringe programmes (NSP) and opioid substitution therapy (OST)



Harm reduction in Sub-Saharan Africa

Overview

An estimated 25.6 million people are living with HIV in the region of sub-Saharan Africa. UNAIDS reports substantial gains against HIV in the region since 2010, including a decline in the number of new HIV infections. This decline is most marked in eastern and southern Africa, where HIV incidence was 4% lower in 2015 than it had been in 2010, with 40,000 fewer people becoming HIV-positive. Similarly, coverage of antiretroviral treatment (ART) doubled in the region between 2010 and 2015, meaning that over half of those in need now receive HIV treatment.[23]

The proportion of new HIV infections attributed to unsafe injecting drug use is relatively small compared with that in other regions: 0.4% of new HIV infections in western and central Africa, and 2% in eastern and southern Africa.[23][o] In real terms, however, these proportions, which are based on a dearth of data and believed to be underestimates, add up to tens of thousands of people whose acquisition of HIV via unsafe injecting could have been prevented through the provision of harm reduction services. Indeed, new research on drug injecting from several countries in the region illustrates the potential for rapid expansion of the HIV epidemic through unsafe injecting and clearly shows the urgent need for harm reduction implementation and scale-up. For example, research has shown that between half and three-quarters of the people who inject drugs in Mozambique are living with HIV,[10] and over three-quarters are living with the hepatitis C virus (HCV).[9]

Since the *Global State of Harm Reduction 2014,* there has been an increase in international donor support for harm reduction activities in several countries in the region. This support covers essential academic research, advocacy and civil society strengthening as well as the establishment and implementation of programmes. Sub-Saharan Africa is likely to be the only region experiencing an increase in harm reduction funding, as the wider context is one of donor retreat from investment in middle-income countries in favour of directing support towards low-income countries. It is vital to note, however, that although harm reduction funding may be increasing, it is still supporting advocacy and programming in only a handful of the 54 countries that make up the African Union.

More research on injecting drug use has begun to emerge from the region, some of which was featured in a special issue of the *International Journal of Drug Policy* on sub-Saharan Africa in 2016.[p] A handful of countries do operate harm reduction services, although some of these are still in their infancy and operate on a small scale. After a long period of political rejection of harm reduction services, Kenya now has both NSP and OST facilities, with its NSP service being steadily scaled up over the last decade to 13 NSP sites in operation. Since the *Global State 2014,* five OST sites are now in operation where previously there were none.[5] According to the National AIDS and STI Control Programme data from 2014 to 2016, 20 needles and syringes are distributed per person who injects drugs per year in Kenya. This provision is still significantly below internationally recommended standards, but it is a step forward in Kenya's harm reduction response.

For the first time since the inception of the *Global State of Harm Reduction* report in 2008, information has become available on injecting drug use in Côte d'Ivoire, where, thanks to international donor support, the NGO Médecins du Monde (MdM) is working with local partners to develop harm reduction strategies for people who use drugs. As the primary form of heroin and cocaine consumption is smoking, MdM, alongside local partners, distributes information on safer pipe smoking to ensure people do not have to share equipment. They also provide medical care and support, including HIV testing.[24] In a study involving 450 people who use drugs in Abidjan, Côte d'Ivoire, almost all respondents (98.2%) reported consuming heroin, with 12.7% reporting injecting. Only one respondent noted that he had shared a syringe.[1] Civil society reports that syringes are available from pharmacies at low cost and without a medical prescription, but states the need for a harm reduction strategy to be put in place.[24]

In Kampala, Uganda, a study conducted in 2012 found that 16.7% of people who inject drugs tested positive for HIV.[21] In Ghana, a study estimated that 6,000 people were injecting drugs, and highlighted the sharing of needles as well as the use of discarded injecting equipment found in hospital waste.[2, 25, 26] In Nigeria, a study undertaken in 2010 found that HIV prevalence rates among people who inject drugs ranged from 3% to 9.3%,[27] with 72% of respondents residing in the Federal Capital Territory reporting sharing needles.[27] Despite these findings, and the clear and urgent need

[o] In terms of HIV prevalence among people who inject drugs, many of the figures cited in Table 2.9.1 often stem from sub-national data and should therefore be viewed with caution.

[p] The *International Journal of Drug Policy's* special issue on sub-Saharan Africa (published in April 2016) is available from: www.ijdp.org/issue/S0955-3959(16)X0004-7.

they illustrate, harm reduction interventions have yet to be implemented in the Côte d'Ivoire, Nigeria, Ghana, Mozambique or Uganda.

Although there has been progress in expanding the harm reduction response in some countries, there remains a predominantly punitive response to drug use in the region, with incarceration of people who use drugs on the rise.[28] Through continued civil society advocacy, academic research and international donor support, knowledge and awareness of harm reduction is increasing in several countries and pushes against the tide of negative and stigmatising attitudes and policies towards drug use. As in other regions, political and financial support for harm reduction is often precarious.

Changes in the political landscape can have a direct impact on the provision of harm reduction services. For example, a change in government in Mauritius in late 2014 resulted in a severe scaling down of the national harm reduction response. *Global State 2014* reported on Mauritius's unique place in the region as a leader in harm reduction, with political and financial support from the national government for the provision of both NSPs and OST. Since then, the new government has moved OST distribution away from the health service to police stations with daily fixed times for people who use drugs to attend, and the number of needles and syringes that NGOs are able to provide has been greatly restricted[29] Tanzania's 2015 change in government has also led to a stagnation of the harm reduction services available, with OST programmes in the country accepting no new clients.[5, 16]

Policies that greatly restrict the implementation of harm reduction remain in place in many countries in this region, despite a regional call by the African Union for harm reduction scale-up.[30] In Nigeria, for example, there continues to be no harm reduction policy or programme that is nationally approved,[31] even though the national policy for the control of viral hepatitis called for these essential services to be implemented.[32] In Uganda, the government is reluctant to amend certain sections of the Anti-Narcotics Act, which provides for long custodial sentences for non-violent drug-related offences.[33]

Since *Global State 2014*, there have been some significant developments in South Africa in relation to harm reduction research, policy and practice. Although the scale-up of harm reduction services remains slow, these programmes are now recognised by the Departments of Health and Social Development and by the Central Drug Authority as essential.[16, 34] The implementation of new NSP sites in different parts of the country is evidence of this positive step forward.[16,34] Political acceptance for harm reduction approaches is a welcome and an important progression, particularly in light of reports of high levels of the sharing of injecting equipment among people who inject drugs in South Africa.[35]

Although harm reduction services are improving in some countries in sub-Saharan Africa, it is clear that there is still discordance between the levels of HIV and HCV among people who inject drugs and the adequacy of service provision. Significant structural barriers in the form of drug policy, criminal laws, law enforcement and political priorities remain firmly in place for harm reduction in much of the region. Even where NSP and OST services are operating, people who use drugs often feel stigmatised and discriminated against when seeking out HIV testing and treatment, with a lack of integrated service provision for this key population group.[16, 29, 34, 36, 37] In addition, as in other regions, HCV treatment remains beyond the grasp of the vast majority of people (both people who use drugs and those who do not) due to its exorbitant costs. Many of the newer HCV direct-acting antivirals are not widely registered in the region, causing additional barriers.[16, 38]

Civil society organisations and drug user networks are attempting to overcome many of the structural hurdles in place and are steadily gaining a stronger voice within the political landscape of drug policy and harm reduction. In Senegal, the first association of people who use drugs, Health Life Hope (SEV), has begun advocating for a risk reduction rather than a punitive approach to drug policy in the country.[14] In South Africa, advocacy efforts preceded the launch of three NSP sites,[16] and two drug user networks were formed in Cape Town and Pretoria in 2015.[34]

With planned further research on injecting drug use in certain countries in the region emerging (from government departments, civil society groups and academics), continued funding from multilaterals such as the Global Fund, a growing civil society movement, the inclusion of drug user networks in the discourse, and umbrella advocacy groups (such as the West African Harm Reduction Network and the East Africa Harm Reduction Network) forming across territories, it is hoped that harm reduction will continue to gain strength in sub-Saharan Africa. However, it must be noted that in the majority of countries in the region there continues to be a rejection of harm reduction approaches, and further work on advocacy and awareness is essential.

Developments in harm reduction implementation

Needle and syringe programmes (NSPs)

As illustrated in Table 2.9.1, only five countries (of the 54 countries that make up the African Union) provide NSP services for people who inject drugs: Kenya, Mauritius, Senegal, South Africa and Tanzania.

Kenya estimated HIV prevalence rates for people who inject drugs, between May and December 2012, as 14.5% in Nairobi and 20.5% in the coastal regions, with a reported 23% of people in Nairobi sharing needles.[39] In 2012 the Kenyan government announced the initiation of NSPs in the country, resulting in ten newly operational sites by 2014 reaching 4,500 people who inject drugs[40] The model used combined fixed-site NSPs alongside NSP outreach.[41] Prior to the inception of this service, UNAIDS estimated that 51.6% of people reported using sterile injecting equipment.[3] In 2016 the Community Action on Harm Reduction (CAHR) project found that 88.8% of people reported using sterile needles,[42] which is suggestive of the NSPs' success. Given these figures, the Global State can now report Kenya's consistent scaling up of NSP site provision, with civil society reporting up to 12,000 people who inject drugs accessing these services.[5] This rise in harm reduction service provision is thanks to both national and international advocacy efforts in the country, alongside increased international donor funding and government support (both political and financial).[5]

Global State 2014 reported on a planned harm reduction demonstration project in South Africa, due to begin in Cape Town, Durban and Pretoria.[43] This project, an initiative of the US Centers for Disease Control and Prevention, was established in 2014 by civil society organisations (TB/HIV Care Association and OUT LGBT Wellbeing) and provided over 400,000 needles and syringes within its first year of operation, alongside HIV testing and links to care for key populations in these areas. Thanks to this project there are now three NSPs operating in South Africa and, for the first time, a sub-district of the Department of Health in the Western Cape provided a consignment of needles. The only NSP that operated previously (for men who have sex with men (MSM) and funded by Aids Fonds) came to an end in 2014. The beneficiaries of this service have been referred to the new NSPs in operation.[16]

Although injecting is not reported to be the main form of heroin use in Tanzania, with many people smoking *cocktail* (cannabis, tobacco and heroin), unsafe needle sharing is commonplace among those who do inject,[44] and HIV and HCV prevalence rates among people who inject drugs are estimated to be 51.1% and 75.6% respectively.[45] Smoking is also more commonplace than injecting in Senegal. However, amongst people who inject drugs in Senegal, HIV and HCV prevalence rates are lower, at 9.4% and 38.85% respectively.[12] In Tanzania, Médecins du Monde and its partner NGO Mukikute are the only two NGOs implementing an NSP service in Dar es Salaam, with five fixed sites and 107 mobile outreach units.[20] Senegal's NSP services began in 2011 in the Dakar region and are provided through the NGO Centre de Prise en Charge Intégrée des Addictions de Dakar (CEPIAD).[37] Given the rise in drug use in Tanzania, and the clear need of people who inject drugs in both Tanzania and Senegal, there is a definite requirement for further implementation of harm reduction services in these countries.[12, 14, 44] It seems that there has not been a major expansion of services in either Tanzania or Senegal since 2014.[14, 20] Civil society in Senegal reports that NSP implementation and scale have been hampered by the lack of aregulatory framework for the sustainability and safety of both NSP workers and those in receipt of the service.[14]

Despite the increasing number of NSP sites in sub-Saharan Africa, coverage remains extremely low, with many countries where injecting is known to occur not providing this essential service.[q] The government of Nigeria does not politically support the provision of NSPs as a service for people who inject drugs. However, NGOs working in the field do try to provide sterile syringes.[31] Needles are reported to be widely available at pharmacies and medicine stores,[46] but it is unclear how accessible pharmacy provisions are to people who inject drugs. In the Seychelles, it has been found that high percentages of people who inject drugs practice unsafe injecting behaviour,[15] but an NSP service is yet to be established.

In those countries where NSP sites do exist, there is often intense social stigma around injecting drug use and the use of the programmes. For example, people accessing NSPs in South Africa may be subjected to multiple rights infringements, including harassment, arrest without cause and the confiscation of and breaking of injecting equipment by police.[16]

NSP sites in Mauritius, although still operational and financially supported by both the government and the Global Fund, are restricted by a fixed quota of 30,000 needles per month.[29] This restriction has emerged since a new government came to power in December 2014,

[q] Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Côte d'Ivoire, Djibouti, Ethiopia, Gabon, Gambia, Ghana, Guinea, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Seychelles, Sierra Leone, Somalia, Togo, Uganda, Zambia, Zanzibar, Zimbabwe.

even though the number of people who inject drugs in the country is increasing.[29] Previously the provision of injecting equipment was responsive to need. However, due to the lack of materials provided by the Ministry of Health, provision has now been restricted to a quota of five syringes per person per visit, falling vastly short of the requirement for this population.[29]

Women, health and harm reduction

Women who inject drugs often experience disproportionately higher levels of negative health outcomes[19, 47] and face a greater risk of HIV than their male counterparts. This disparity has been documented in various countries:

- In Senegal, HIV prevalence among female drug users was found to be over four times that of male drug users (13.0% and 3.0% respectively).[12]
- In Tanzania, HIV prevalence rates reach 71% among women who inject drugs,[48] over four times higher than the national HIV prevalence estimate for all people who inject drugs (15.5%).[17]
- In Nigeria, women who inject drugs were found to have higher HIV prevalence rates than men in all four states surveyed, aside from the Federal Capital Territory.[27]

In South Africa, NSPs are still experiencing challenges in reaching women who inject drugs with their services[16] To ensure that services are well-equipped to reach women who inject drugs, service providers, including medical institutions providing HIV testing and treatment, must gain the trust of women who inject drugs. This trust can be established via the medium of women peer workers, multiple encounters and making personal connections with women who inject/use drugs.[48]

In Kenya, NSP services are using community-based outreach enabling access to equipment for women who do not wish to be seen seeking services.[5, 40, 49] Women who inject drugs have played a significant role in the development and implementation of harm reduction services in the CAHR project.[42]

It has also been suggested that interventions directed towards sexual risk reduction in combination with harm reduction should be used for women who inject drugs.[50] This approach recognises the link that may exist in some settings between heroin use, HIV and low condom use during sex work, serving to further increase the risk for women.[27]

Opioid substitution therapy (OST)

As with NSP, the majority of countries in sub-Saharan Africa with reported drug use have not yet introduced OST programmes (see Table 2.9.1 and Map 2.9.1). OST remains largely unavailable, with only six countries in the region implementing this as a public service.

In Kenya, OST was introduced outside of private providers in December 2014.[51] Although the scale of this service is small at present, three fixed sites have been initiated within two years in hospitals in Nairobi, Malindi and Mombasa, and two further independent sites were launched in 2016.[5] Mathematical modelling has shown that approximately 10% coverage of OST over a five-year period could reduce the HIV incidence among people who previously injected drugs by between 5% and 10%, and if coverage attains 40% the reduction could reach 20%.[51] Since the inception of the OST programme in 2014, 1,100 people have enrolled in this service.[32] However, in-depth interviews with people who inject drugs in Kenya show that while some are able to access the programmes successfully, others report hardship, stigma and the challenge of discrimination by clinic staff.[52]

In South Africa, the small pilot project in the Western Cape has been joined by a government-funded and NGO-run OST site in Cape Town, providing buprenorphine-naloxone to people who inject opiates[16, 53] The city of Tshwane in Gauteng has entered into an agreement for OST to be made available at selected primary healthcare centres, and an OST demonstration project is at the planning stage in Durban, with political support from the provincial Department of Health.[16] These are important developments within South Africa, where, until recently, OST provision was largely limited to the private sector.

Tanzania continues to have the largest government-run OST programme in sub-Saharan Africa. The first OST clinic offering methadone was launched in February 2011 at the Muhumbili National Hospital in Dar es Salaam[54] and the programme continues to operate from three OST sites.[20] Since the change of government in 2015, however, no new clients have been accepted onto the OST programme.[5, 16]

In Senegal, OST has also been established in a medical centre in Dakar. There has also been a greater focus on

mapping injecting drug use in Senegal in recent years, with early findings showing that heroin is the most popular drug of choice, but it is often smoked rather than injected.[12] These findings illustrate the urgent need to scale up OST availability for people who use (including those who smoke) opiates.

In Mauritius, under the new government elected in 2014, OST distribution has been moved from the health service to police stations, with daily fixed times (6.00 to 8.00 am) for people who use drugs to attend.[29] OST from government-supported services is available only to people who had initiated treatment prior to the inception of new policies in January 2015, including those on maintenance therapy before that date.[29] Instead, Suboxone and Naltrexone are available, but selection criteria for this new treatment are uncertain[29] The retreat from a well-established and government-supported harm reduction programme encompassing 52 NSP sites and 16 OST sites is of international concern. Mauritius, which had been a harm reduction champion in the region, is now facing an increase in HIV and HCV infection among the estimated 10,000 people who inject drugs there.[55]

Viral hepatitis

Data on the extent to which people who inject drugs are affected by hepatitis C (HCV) in sub-Saharan Africa remain extremely limited. From the estimates available, it is clear that the prevalence of HCV is very high among people who use drugs when compared with national estimates. HCV prevalence among people who inject drugs in the Kinondoni municipality of Dar es Salaam, Tanzania is reported to be 75.6%,[45] over 2.5 times higher than the national average of 28.0%.[19] The Integrated Biological and Behavioral Surveillance Survey (IBBS) in Mozambique, a study undertaken between October 2013 and March 2014 in the Maputo and Nampula districts, showed HCV screening results for a sample of people who inject drugs to be 77.3%[9] In preliminary studies in Dakar, Senegal in 2011, HCV prevalence in this population was 38.85%.[12]

The lack of availability of HCV testing and treatment is partly due to the prohibitive cost to both the service provider and the service user. In Tanzania, the cost of treatment for HCV is over €10,000 per patient,[56] rendering it beyond the reach of most people. In Mauritius, HCV testing is available for people who inject drugs. Although it is estimated that 97% are living with the HCV affordable treatment remains unavailable.[29] In South Africa, HCV testing is limited to less accessible facilities in the form of regional hospitals, and there is a dearth of data on the burden of viral hepatitis among people who inject drugs. To combat the lack of data, civil society organisations and academia are working together to conduct a cross-sectional survey in South Africa, recruiting 1,200 people who use drugs in Cape Town, Pretoria and Durban and using a range of HCV testing modalities to develop recommendations for local guidelines on HCV testing and treatment.[16]

An initiative is under way to allow low- and middle-income countries to avoid the exorbitant cost of HCV treatment. In sub-Saharan Africa and other regions, Gilead (the pharmaceutical company that has developed medicine suitable for treating HCV) is working with regional partners to introduce the low-cost generic Sovaldi® (one of the new HCV treatment drugs recommended by the World Health Organization) for use in low- and middle-income countries.[57] Even with these initiatives, however, it is thought that the medicines will still be very expensive.

Tuberculosis (TB)

TB prevalence rates in sub-Saharan Africa are extremely high, with 28% of the world's cases found in this region[58] 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 is a great paucity of data regarding TB prevalence and treatment access among people who inject drugs.

Whilst the majority of those who have been diagnosed will not develop active TB, people who use, and particularly those who inject, drugs, together with prisoners, are more vulnerable to progressing to active TB due to increased HIV co-infection and the poor prison conditions in some countries.[59] A study from Côte d'Ivoire, for example, found that people living in the *fumoirs* (crowded spaces where heroin and cocaine are smoked, often located in urban slums) were nearly nine times more likely to have TB, with almost half of the participants also having been incarcerated at least once[1]

The criminalisation of drug use, which is inextricably linked with the intense social stigma and discrimination faced by people who use drugs in the region, often leads to poor health-seeking behaviours and deters individuals from accessing TB services.

Antiretroviral therapy (ART)

It is not clear to what extent people who inject drugs have benefited from the dramatic recent scale-up of ART access in sub-Saharan Africa. Data on the numbers of

people who inject drugs receiving ART within the sub-Saharan Africa region are sparse. In the Seychelles, for example, it is reported that 63% of people who inject drugs have ever had a HIV test,[15] but it is unclear how many receive ART.

Enrolling people who inject drugs into ART programmes is imperative, and integrated services serve to enable access. However, a study conducted in Tanzania concluded that people receiving OST often had to wait weeks to receive their test results, and ART initiation was conducted off-site, creating an additional barrier to seeking essential HIV treatment.[60] Clients described the increased stigmatisation they felt at the HIV clinic due to their drug use, with women experiencing even greater levels of stigma due to assumptions of sex work with drug use and HIV.[60] Although integrated care is the recommended gold standard by the World Health Organization (WHO),[61] it is often not in place and poor linkages between harm reduction service providers and HIV testing and treatment services create further barriers for people who use drugs to access treatment.

Civil society reports from Mauritius, Nigeria and South Africa echo these challenges on ART access. While HIV testing and treatment are services that are available to all in principle, the criminalisation of drug use, coupled with experienced or perceived risk of stigma and discrimination in healthcare settings, act as deterrents to service access.[16, 29]

In Uganda, ART coverage is hoped to be increased to 50% and eventually to 80% over time, and to include people who use drugs.[62] However, no tailored service for this key population is available, and civil society report that people who use drugs face violence and police harassment at clinics.[33]

Over the course of the CAHR project between 2011 and 2015, the number of people who inject drugs in Kenya who registered for ART went from 6% at baseline to 54%.[42] This finding illustrates the positive impact of investing in an integrated harm reduction service provision approach for people who use drugs.

Harm reduction in prisons

Punitive drug policies and law enforcement contribute to a high proportion of people who inject drugs in sub-Saharan Africa being incarcerated. A study involving people who inject drugs in the Seychelles found that just over half had been arrested in the previous twelve months.[15] In a study of people who use drugs in Dakar, Senegal, a history of incarceration was reported by 61.9% (n=506), with 29.2% acknowledging that they consumed drugs whilst in prison.[12]

High-risk injecting practices in prisons in the region may be a significant contributor to accelerating HIV transmission.[63] Yet the only country to implement harm reduction services in prison is Mauritius. Methadone maintenance treatment (MMT) was available in prisons in Mauritius when the *Global State* last reported in 2014. However, since the change of government in 2014, this service has been limited to those who already received OST prior to incarceration. New prisoners seeking OST are now offered either buprenorphine or naloxone.

Kenya, Uganda, Tanzania, Seychelles, Mauritius and South Africa all provide HIV testing and ART for prisoners. Access to ART, TB diagnostics and treatment and condoms in South African correctional facilities has reportedly improved since *Global State 2014*, following the prioritisation of these services by government in recent years.[16] However, HCV testing and treatment remains unavailable. In Mauritius, HIV testing is compulsory within the prison setting, with ART being provided to those who require it. TB testing and treatment are also provided. HCV testing is available, but there is currently no treatment for this, and condoms are not made available.[29] HIV and TB testing and treatment are also available in prisons in Tanzania, but HCV diagnostics and treatment are not.[20]

There is no HIV, HCV, TB testing or treatment available in Nigerian prisons, and condoms are not made available to prisoners.[31] Indeed, it appears that only South Africa and Lesotho distributes condoms in prisons.[71] It is clear from the few studies available that harm reduction services in prisons are greatly needed.

Overdose

There continues to be a dearth of data on the prevalence of and response to overdose in the sub-Saharan Africa region. The latest data from Kenya indicate that, in 2011, approximately 58% of people who injected drugs reported knowing at least one person who had experienced a fatal overdose, and the overdose cases were 83% to 90% higher in Nairobi than in the coastal areas.[64]

Naloxone, a highly effective opioid antagonist used to reverse the effects of opioid overdose, is reportedly available only in Kenya and Tanzania, via health clinics and outreach sites as part of the state health system. Peer distribution of naloxone has been discussed and advocated for in both Kenya and Tanzania, but has not yet been implemented.[5, 20]

Overdose prevention, in the form of training in behavioural change is available in South Africa as part of

NSP and HIV prevention services, but naloxone is yet to be established as a part of the response.[16]
In Mauritius, there is a distinct lack of knowledge and training regarding overdose prevention and no naloxone provision, in spite of the established harm reduction programme.[29]

Policy developments for harm reduction

Although harm reduction implementation is increasing in some countries in the region of sub-Saharan Africa, it is clear that punitive drug policies and a lack of political will still form significant barriers to the implementation and success of a harm reduction approach to drugs. For example, in late 2014 Uganda's parliament passed the Narcotics Law which when implemented, will result in much longer sentences for those convicted of drug-related offences in the country.[65]

Harm reduction was previously endorsed in the Tanzanian *National Strategy for Noncommunicable Diseases, 2009–2015*.[66] This policy is currently being revised with input by civil society organisations, although it is uncertain whether harm reduction will be mentioned in the new strategy.[20] In Nigeria, where there are no formal active harm reduction services, there remains a mention of harm reduction within the national hepatitis policy,[67] but not in the country's HIV/AIDS strategy or drug control master plan (2015–2019). Similarly, harm reduction has not been included in any of Uganda's national policies, despite a significant need for these services.[33]

South Africa's *National Drug Master Plan 2013–2017*[68] and *National Strategic Plan on HIV, STIs and TB 2012–2016*[69] both make explicit reference to harm reduction, highlighting the gradual endorsement of these services for people who use drugs in South Africa.

Despite advances in some countries, policies in much of the region continue to focus on supply reduction and the criminalisation of people who use drugs, overshadowing any harm reduction response or even demand reduction response. However, the African Union, in its common position for the United Nations Special Session (UNGASS) on the drugs, committed to achieving a balanced and integrated approach among supply reduction, demand reduction and harm reduction.[30]

Civil society and advocacy developments for harm reduction

Civil society organisations have been increasingly active in sub-Saharan Africa, both in implementing harm reduction services and in working to increase awareness of the need for harm reduction. This mobilisation has led, in some countries, to increased levels of support for harm reduction interventions.

In South Africa, civil society organisations were supported by local government to host a Drug Policy Week in Cape Town in 2016, bringing together over 80 representatives of national, provincial and local government, academia and civil society as well as participants from western and southern Africa and the Indian Ocean islands for three days of presentations and deliberations on drug policy reform. The initiative resulted in the creation of a website to share drug policy information among all participants[r] and increased levels of support for harm reduction interventions[16] Advocacy efforts also preceded the three NSP site launches in South Africa, and a series of discussions and workshops with law enforcement officials have since taken place covering issues relating to NSP provision.[16, 34] In April 2016 the Central Drug Authority and the South African National AIDS Council met to discuss a joint strategy around HIV prevention and treatment for people who use drugs, where explicit support for NSP and OST services was highlighted. Although drug user networks do not exist in the country at present, the TB/HIV Care Association is supporting the establishment of two networks, in Pretoria and Cape Town, with input from both the International Network of People who Use Drugs (INPUD) and CoAct.[34]

South Africa also hosted the 21st International AIDS Conference in July 2016 in Durban. The extent to which this event could serve as a platform to raise awareness and promote harm reduction in the region and beyond was minimised by a distinct absence of harm reduction and drug-related presentations in the main programme. In the fringes of the conference, the drug user and harm reduction networking zone in the Global Village[s] ran around 40 sessions, which included presenters from Nigeria, Kenya and South Africa discussing harm reduction, drug policy and the situations faced by people who use drugs in these countries.[t]

The Tanzanian Network of People who Use Drugs (TaNPUD) is working to secure small but vital improvements in harm reduction provision, but is as

[r] See www.sadrugpolicy.com.
[s] Convened by The Urban Futures Centre at Durban University of Technology, in partnership with TB/HIV Care Association in the Global Village with financial support from the AIDS and Rights Alliance for Southern Africa (ARASA).
[t] The programme for the drug user and harm reduction networking zone is available at: www.sadrugpolicyweek.com/news/pwud-harm-reduction-zone-aids2016.

yet not attached to any broader network such as the East African Harm Reduction Network.[20]

The Ugandan Harm Reduction Network (UHRN) is also continuing to advocate for the implementation of harm reduction programmes. It sits on the Key Populations Technical Working Committee, alongside the Ministry of Health, to advance the response to issues faced by people who use drugs.[33] UHRN also sits on the Most At Risk Populations (MARPS) Steering Committee at the Uganda AIDS Commission (UAC), which monitors HIV/AIDS programming in the country. Although at present no harm reduction initiatives operate in Uganda, UHRN's participation in these forums is a positive step forward.

Since *Global State 2014*, a Civil Society Coalition on Drugs has formed in Nigeria, and now advocates for national drug policy reform. YouthRISE has also been undertaking advocacy efforts involving young people who use drugs in Nigeria.[30]

In 2014 the Africa Key Population Experts Group was formed. At its third meeting in 2015, the group agreed on a strategic framework that noted the importance of the development of monitoring and evaluation tools for key populations in the region, and advocated for the meaningful inclusion of key populations.[70] With several national and regional Global Fund grants including harm reduction components, harm reduction for people who use drugs is now firmly on the agenda in Global Fund Country Coordinating Mechanisms. The East African Harm Reduction Network and the East and Southern Africa Regional Harm Reduction and Drug Policy Group also serve as regional platforms for harm reduction discussions and the sharing of policy and practice from across the differing countries. The West African Harm Reduction Network, consisting of 42 civil society organisations, issued a statement ahead of UNGASS calling for the acceptance of harm reduction.[37]

Funding developments for harm reduction

Multilateral agencies and international donors still provide the majority of harm reduction funding in sub-Saharan Africa, with the Global Fund being the largest contributor, as in other regions. In 2015 the East African Harm Reduction Network obtained a grant from the Global Fund to implement harm reduction interventions and improve advocacy efforts in Burundi, Ethiopia, Kenya, Mauritius, Seychelles, United Republic of Tanzania (mainland and Zanzibar) and Uganda.[29]

Nigeria was approved for a Global Fund grant for harm reduction advocacy and service implementation in 2015 and received US$8 million. However, it is unclear how these funds have been disbursed in the country and the extent to which they have gone towards harm reduction programme planning and services. Prior to receiving the grant, the Nigerian Agency for the Control of AIDS requested that these funds be diverted to sexual transmitted infections (STI) prevention programmes as it was not in support of harm reduction. Such a diversion of funds runs contrary to harm reduction need and represents a tragic missed opportunity to increase harm reduction awareness and implement services.[31]

In South Africa, civil society will receive funding from the Global Fund through the South African National AIDS Council's work to implement harm reduction for people who inject drugs in four metropolitan areas.[16] This funding will provide support until 2019. Funding has also been provided by Mainline, through Bridging the Gaps, which will also run until 2019. The Open Society Foundations and AmfAR (The Foundation for AIDS Research) have funded policy, human rights and advocacy work in the country. US government grants via PEPFAR (US President's Emergency Plan for AIDS Relief)/CDC (Centers for Disease Control and Prevention) have included people who inject drugs in their key population prevention programmes in South Africa, which will run from 2016/17 to 2021/22; the scope and specific funding allocations are yet to be announced.[34]

Through the Global Fund grant, and via the Kenya AIDS NGOs Consortium (KANCO), UHRN is implementing a three-year project on HIV and harm reduction in eastern Africa, which aims to build policy support and technical capacity for harm reduction interventions.

Although harm reduction is beginning to receive financial support from national governments in South Africa,[16] Senegal,[37] Tanzania and Mauritius, programmes are still largely dependent on international donor support. The Mauritian government, for example, provides only 25% of current funding for harm reduction, with the remaining 75% covered by the Global Fund.[29] In Tanzania, the Elton John AIDS Foundation (EJAF) funding that supported MdM's harm reduction efforts in Dar es Salaam came to an end in May 2016. It is unclear how services in the country will be affected by this development, and whether other donors will provide money for much needed harm reduction services in the country.[20]

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