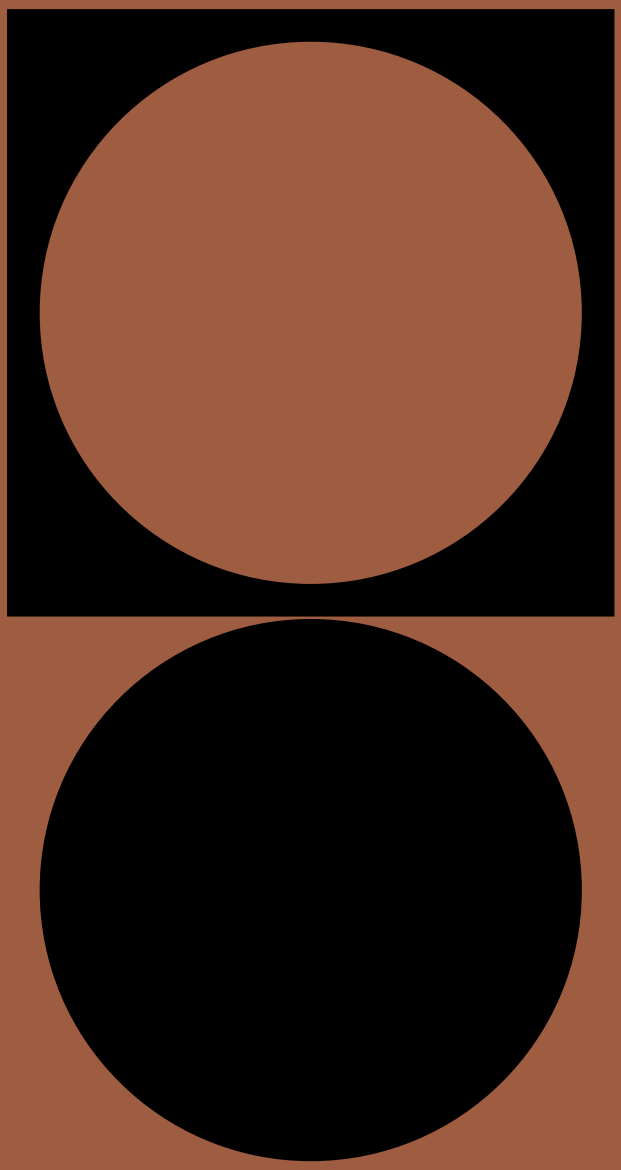
REGIONAL OVERVIEW: EASTERN AND SOUTHERN AFRICA



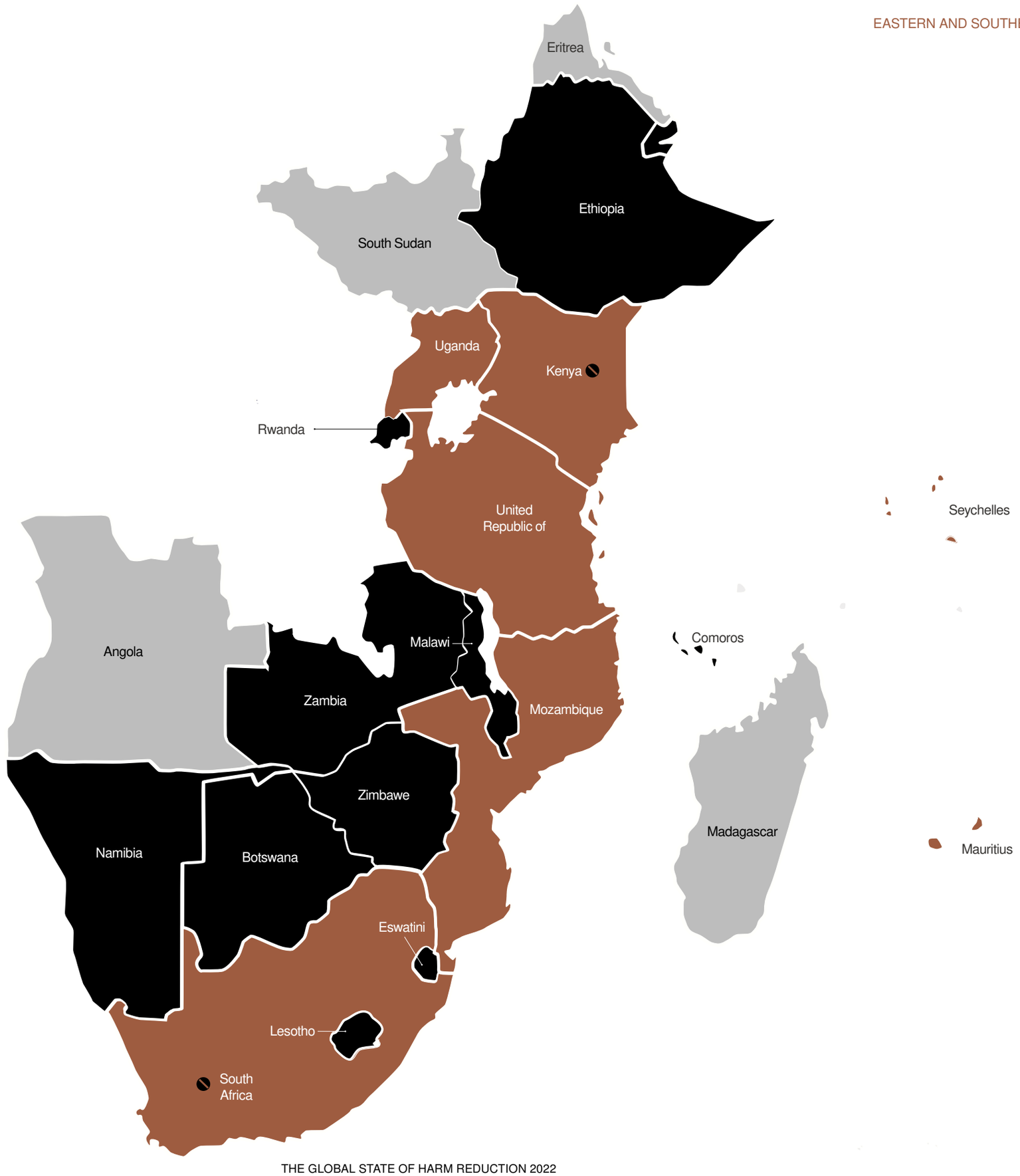
THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

TABLE 3 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN EASTERN AND SOUTHERN AFRICA

Country/territory	People who inject drugs[a]	HIV prevalence among people who inject drugs (%)[a]	Hepatitis C (anti-HCV) prevalence among people who inject drugs (%)[a]	Hepatitis B (anti-HBsAg) prevalence among people who inject drugs (%)[a]	Harm reduction responses[b]				
					NSP[c]	OAT[d]	Peer distribution of naloxone[e]	DCR[f]	Safer smoking equipment[g]
Angola	nd	nd	nd	nd	nd	nd	nd	×	nd
Botswana	nd	5.1	nd	nd	×	×	×	×	×
Comoros	nd	nd	nd	nd	nd	nd	nd	×	nd
Eritrea	nd	nd	nd	nd	nd	nd	nd	×	nd
Eswatini	1,279[2]	nd	nd	nd	×	×	×	×	×
Ethiopia	139,500	6.3	3.4	5.1	×	×	×	×	×
Kenya	36,000	11.3	20	3.9	✓	✓ M B	✓	×	×
Lesotho	1,279	nd	nd	nd	×	×	×	×	×
Madagascar	18,500	4.5	5.6	5.3	nd	nd	nd	×	nd
Malawi	nd	nd	nd	nd	×	×	×	×	×
Mauritius	12,000	32.3	90	3.5	✓	✓ M	×	×	×
Mozambique	33,000	35.5	43.6	24.2	✓[3]	✓ M	×	×	×
Namibia	nd	nd	nd	nd	×	×	×	×	×
Rwanda	2,000	9.4	nd	nd	×	×	×	×	×
Seychelles	2,000	12.6	79.1	0.3	✓[4]	✓ M	×	×	×
South Africa	82,000	17.9	54.7	5	✓	✓ M	✓	×	×
South Sudan	nd	nd	nd	nd	nd	nd	nd	×	nd
Uganda	9,500	17[5]	2[6]	8.4[5]	✓	✓ M B	×	×	×
United Republic of Tanzania	30,000[7]	35[7]	23.1	6.9	✓	✓ M	×	×	×
Zambia	26,840	24[8]	nd	nd	×	×	×	×	×
Zimbabwe	nd	nd	nd	nd	×	×	×	×	×

a Unless otherwise stated, data is from Degenhardt et al (under review).[1]
b Data sourced in *Global State of Harm Reduction* survey responses, unless otherwise stated.
c At least one needle and syringe programme operational in the country or territory, and the number of programmes (where data is available)
d At least one opioid agonist therapy programme operational in the country or territory, and the medications available for therapy. B=buprenorphine, M=methadon.
e At least one naloxone distribution programme that engages people who use drugs (peers) in the distribution of naloxone and naloxone training, and facilitates secondary distribution of naloxone between peers.
f At least one drug consumption room (also known as safe consumption sites among other names) operational in the country or territory, and the number of facilities.
g At least one programme in the country or territory distributing safer smoking equipment to people who use drugs.


Eritrea
Ethiopia
South Sudan
Uganda
Kenya
Rwanda
United Republic of
Angola
Malawi
Zambia
Mozambique
Zimbawe
Namibia
Botswana
Eswatini
Lesotho
South Africa
Seychelles
Comoros
Madagascar
Mauritius
Both NSP and OAT available
OAT only
NSP only
Neither available
Not known
Peer-distribution of naloxone

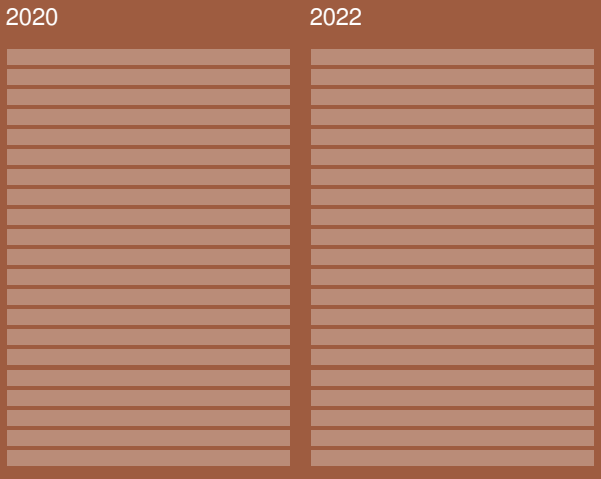
NSPs, OAT AND DCRs SINCE 2020

7 countries (33%) in Eastern and Southern Africa provide **needle and syringe programmes** (+2 since 2020, Uganda and Seychelles)

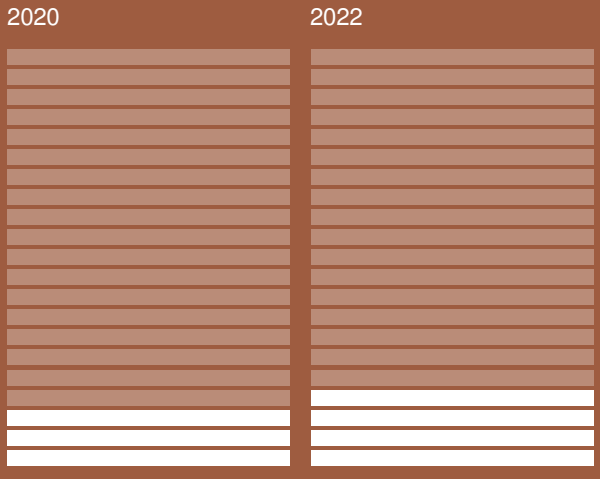
7 countries (33%) in Eastern and Southern Africa provide **opioid agonist therapy** (no change from 2020)

No country in Eastern and Southern Africa provides **drug consumptions rooms** (no change from 2020)

HARM REDUCTION IN PRISONS



No country in Eastern and Southern Africa **provides needle and syringe programmes** in prisons (no change from 2020)



4 countries (19%) in Eastern and Southern Africa provide **opioid agonist therapy** in prisons (+1 since 2020, Tanzania)

THERE ARE NO FORMAL HARM REDUCTION PROGRAMMES FOR STIMULANTS OR NEW PSYCHOACTIVE SUBSTANCES IN EASTERN AND SOUTHERN AFRICA

REGIONAL OVERVIEW

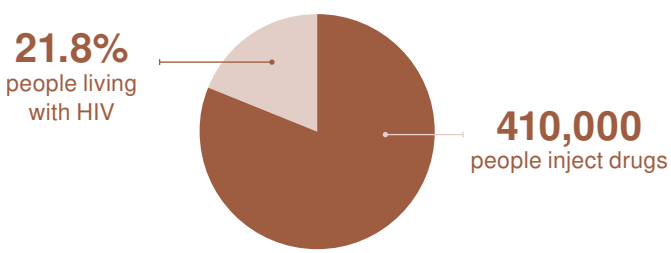
AUTHOR:
WANGARI KIMEMIA

INTRODUCTION

A rough estimate from incomplete surveys indicates there are about 410,000 people who inject drugs in Eastern and Southern Africa, 21.8% of whom are living with HIV.[9,10] In recent years, available data from the region shows an increase in heroin use,[11,12] injecting drug use, and increased HIV and hepatitis infections among people who inject drugs.[13] Eastern and Southern Africa is characterised by repressive criminal laws, high estimated transmission rates of HIV and viral hepatitis among people who inject drugs,[14] and an absence of essential health services.[3,13,15] Punitive policies, minimal data, lack of political will, limited funding, stigma, and discrimination are among the main challenges hampering the implementation of harm reduction services in the region.

Generally, poor data is damaging to countries' abilities to make good policies and data-driven decisions.[16] One of the challenges that researchers encounter when conducting studies in Eastern and Southern Africa is that data on HIV and drug use is poor: it either does not exist or it lacks validity and reliability.[17] In large part, this is driven by the criminalisation and stigmatisation of drug use, which pushes people who use drugs into hidden spaces and discourages people from disclosing their drug use to researchers and healthcare providers.[9] As long as such punitive laws and policies persist, it will be difficult to obtain accurate national estimates of drug use patterns. Evidence from other countries on the effectiveness and cost-effectiveness of harm reduction, alongside co-operation and information sharing between countries and rapid, localised assessments of needs, can provide a reliable basis for the implementation of essential harm reduction services in Eastern and Southern Africa.[18]

More than 1 in 5 people who inject drugs in Eastern and Southern Africa are living with HIV



"One of the challenges that researchers encounter when conducting studies in Eastern and Southern Africa is that data on HIV and drug use is poor: it either does not exist or it lacks validity and reliability. In large part, this is driven by the criminalisation and stigmatisation of drug use, which pushes people who use drugs into hidden spaces and discourages people from disclosing their drug use to researchers and healthcare providers"

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

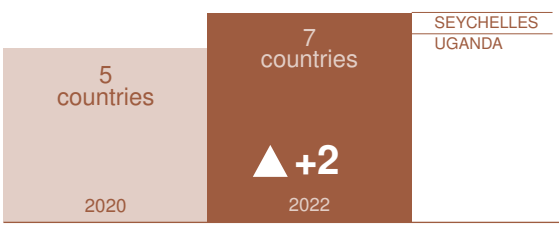
Of the 20 countries in the region, NSPs are operational in only 7 (Kenya, Mauritius, Mozambique, Seychelles, South Africa, Tanzania, and Uganda). This marks an increase of two countries since 2020 (Seychelles[a4] and Uganda, which initiated an NSP in 2018 and ended the programme in 2019, then resumed it in 2021[19]). Even in countries where NSPs exist, they are insufficiently accessible to the people that need them and are often disrupted.[3]

OPIOID AGONIST THERAPY (OAT)

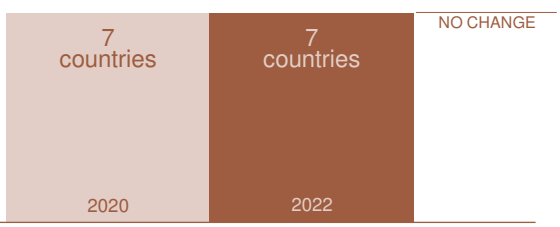
OAT remains limited in the region, with programmes in only seven countries (Kenya, Mauritius, Mozambique, Seychelles, South Africa, Tanzania, and Uganda). This is an increase of two countries since 2020 (Mozambique[3] and Uganda[19] – Uganda opened its first OAT programme in October 2020[20]). Methadone is used in all seven countries, while buprenorphine is also used in Kenya, Mauritius, South Africa, Tanzania and in clinical trials in Uganda.[19] Zambia does not implement OAT, and methadone is not registered or available.[21] In South Africa, advocacy efforts led to methadone being added to the essential medicines list, but the high price of methadone limits access to OAT.[22] In August 2022, after sustained civil society advocacy, pharmaceuticals company Umsebe Healthcare announced a significant reduction in the price of methadone for healthcare providers from late 2022[23] (not yet implemented at the time of this report).[24]

The approach to OAT is broadly regimented and has taken place primarily within medical settings,[25] generally administered as directly observed therapy (DOT).[26] The DOT approach has been associated with high, avoidable costs. For example, in Kenya the actual cost of acquiring methadone comprises only 10% of the total cost; 86.4% funds personnel costs, and the remaining 4% funds recurrent, non-personnel costs, mainly dispensing cups.[27]

Needle and Syringe Programmes (NSPs)



Opioid Agonist Therapy (OAT)



a In Seychelles, NSPs have been available since 2016, but this was unreported in previous editions of the *Global State of Harm Reduction*.

DOT is associated with reduced retention of clients on treatment[28] and increased vulnerability of people who use drugs to COVID-19 in high prevalence areas, for example, because people have to leave their houses to travel to receive it.[29]

The COVID-19 pandemic has led to alternatives to DOT being explored. For example, Kenya introduced take-home doses, mobile van dispensing and buprenorphine.[30] During Ramadan, organisations in Kenya moved to 'moonlight dispensing' so people who were fasting during the day could still access OAT.[30] Tanzania and Uganda have also introduced initiatives for take-home doses.[28,30,31]

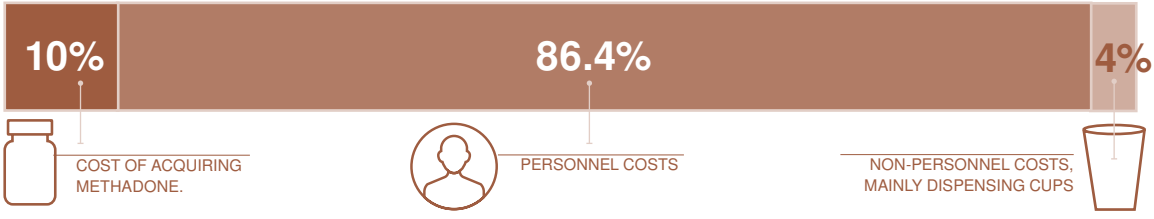
STIMULANTS AND NEW PSYCHOACTIVE SUBSTANCES (NPS)

Cocaine and methamphetamine use have increased in the region since 2020.[11,32] South Africa is now estimated to be one of the largest methamphetamine consumer markets in the world[3], and significant methamphetamine markets also exist in Botswana, Eswatini, Kenya, Lesotho, Malawi, Mozambique, Uganda, Zambia and Zimbabwe.[33] Civil society in Zimbabwe reports increased popularity of crystal methamphetamine.[3] Mauritius is experiencing an increase in the use of NPS, notably synthetic cannabinoids and synthetic cathinones.[34] No civil society informants reported formal harm reduction programming for stimulants or NPS (for example, no stimulants prescription programmes or the distribution of safer smoking kits), although civil society organisations in South Africa have been distributing safer stimulant kits since 2020 on an ad hoc basis.[35]

OVERDOSE, OVERDOSE RESPONSE AND DRUG CONSUMPTION ROOMS (DCRs)

There is a lack of data on overdose and drug-related deaths in Eastern and Southern Africa, and no country has national data on either issue.[3,36] One small study in Dar-es-Salaam, Tanzania found that 34% of a sample of women who use drugs had experienced an overdose.[37] Two countries in the region have at least one naloxone peer distribution programme: Kenya and South Africa.[22,38,39,40,41] However, these are all small programmes with minimal reach and accessibility. For example, although a peer-run outreach programme has distributed a small number of intramuscular naloxone in South Africa, it remains a prescription-only medication and no nasal naloxone is available in the country.[42] No country in the region reported having a drug consumption room.

The cost of directly observed therapy for OAT in Kenya



HIV AND ANTIRETROVIRAL THERAPY (ART)

Eastern and Southern Africa is still heavily affected by HIV, and is home to approximately 54% of all people living with HIV in the world.[10] New HIV infections declined by 44% from 2010 to 2021 in the general population, but HIV prevalence among people who inject drugs is estimated at 21.8%, compared with 6.2% among the general population.[10] Criminal laws undermine efforts to reach and engage people who use drugs in national HIV responses.[10] Indeed, civil society actors and researchers report that stigma and discrimination is a major barrier for people who use drugs when it comes to accessing HIV-related services.[40,41,43,44,45,46,47] Other barriers to HIV care include a lack of facilities in rural areas, which means people have to travel long distances to access treatment, which is time-consuming and expensive.[42] People who are experiencing homelessness also struggle to store medication safely.[48]

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HARM REDUCTION IN PRISONS

NSPs are not available in any prison in the region, and only five countries (Eswatini,[47] Kenya,[49] Mauritius,[50] Seychelles and Tanzania) provide OAT in prisons. All countries reportedly provide HIV testing and treatment inside prisons, although there are many documented barriers to access, particularly for women who use drugs, including humiliating and punitive treatment.[51] Viral hepatitis testing and treatment is largely unavailable, and no country has data on drug-related deaths in prisons. Moreover, no country provides naloxone in prison or has a naloxone-on-release programme.

WOMEN WHO USE DRUGS

Women who use drugs are still largely left out of research and service delivery.[51,52,53] In Mozambique, data on women who use drugs is virtually non-existent; a 2015 report indicated that women who use drugs are extremely vulnerable and lack access to healthcare, legal support, and sexual reproductive health rights and services.[3] This is despite the fact that women who use drugs in the region may be more vulnerable to HIV, for example through involvement in the sex industry.[54,55]

Research in South Africa has found that women who use drugs face many additional barriers to accessing harm reduction services, including stigma, sexual and physical violence, harassment from law enforcement and a lack of tailored services.[51,53,56] New programmes supported by the Dutch Ministry of Foreign Affairs' Love Alliance grant and the United Nations Office on Drugs and Crime are being implemented in the country to improve access to HIV and sexual and reproductive health services for women who use drugs through the training of community healthcare workers.[42]

PUNITIVE DRUG POLICIES AND LIMITED FUNDING

Ten countries in Eastern and Southern Africa make explicit, supportive reference to harm reduction in national policy documents (see Table 3, page 60). The East African Community Regional Policy on Alcohol, Drugs and Substance Abuse aims to scale up harm reduction programmes in the East African Community states (Burundi, Democratic Republic of the Congo, Kenya, Rwanda, South Sudan, Tanzania and Uganda).[57] In South Africa, NSPs are included in the *South African National Strategic Plan on HIV, Tuberculosis and STIs 2017-2022*, and activists, including the South African Network of People who Use Drugs, are providing input into the renewed plan for 2023 to 2025.[35,58]

In Mauritius, the provision of sterile needles and syringes is explicitly permitted by the HIV and AIDS Act of 2006.[59] Research from Kenya suggests that the lack of a legal framework for harm reduction results in de-prioritisation of harm reduction programmes in domestic budgets.[60]

POSITIVE DEVELOPMENTS

For the first time, Uganda has included people who inject drugs as a key population in the National HIV *Strategic Plan 2020/21 to 2024/25*.[61] Guidelines for access to HIV services for people who use drugs and a draft standard operating procedure for police on interacting with people who use drugs have also been developed.[19] A diversion strategy for people who use drugs has been adopted by the police, and 85 law enforcement officers had been trained on its implementation by March 2022.[62]

In 2020, Kenya revised its OAT guidelines to include take-home doses and buprenorphine.[30] Moreover, Kenya amended its Narcotics, Drugs and Psychotropic Substances Act to decriminalise drug paraphernalia, differentiate in law between amounts for use and amounts for trafficking, reduce imprisonment for personal cannabis possession from 10 years to no more than 5 years, and introduce an option of a fine of not more than 100,000 Kenya Shillings (about USD 850) for personal cannabis possession.[63]

NEGATIVE DEVELOPMENTS

Governments in the region continue to promote policies associated with a failed prohibitionist approach to drugs.[64] Kenya has introduced penalties for law enforcement officers who aid offences through 'concealing the commission of any offence' and has also made it mandatory to disclose information about offences.[63] Civil society in Kenya fear that the amendments will be exploited by law enforcement to target people charged with low-level drug crimes.[65] Zimbabwe's public health policies do not take into account drug use or identify people who use drugs as a key population.[3] In Mozambique, 'inciting drug use' and 'abandoning drug use paraphernalia in a public place' are crimes. In March 2022, the local government in Maputo, Mozambique banned syringe distribution in the community, motivated by complaints about syringes being left in public spaces, though the ban was lifted in mid-2022.[3] In South Africa, drug testing in schools is permitted by law; drug testing is permitted in work places when it is referenced in employment contracts or in a substance use policy.[3,42]

FUNDING GAP

There is strong political commitment across the region to address HIV, and most countries have adopted ambitious targets to expand HIV programmes and increase domestic funding for these programmes.[10] But adequate funding for harm reduction remains a major challenge, and countries still rely on international donors.[60] PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) are the main harm reduction donors in the region.

Domestic funding for harm reduction varies across the region. The governments of Seychelles and Mauritius fund national OAT programmes.[66] In Kenya, during the 2016-2017 financial year, the government contributed 25% of the total spending on HIV but only 8% of this funding went toward HIV prevention (including, but not limited to, harm reduction).[15] In South Africa, apart from one programme in the city of Tshwane, no other harm reduction services are funded by the national government.[3,67] In Uganda, no domestic funding was provided for harm reduction in 2017, 2018 and 2019; all services were funded by international donors.[68] The sustainability of harm reduction programmes in Tanzania also depends on international funding.[69]

Civil society reports that these funding gaps greatly hamper the scale up of harm reduction in the region.[19,24,40,44]

Support don't Punish in front of a prison in Mauritius. L'Initiative sida, tuberculose and paludisme.

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