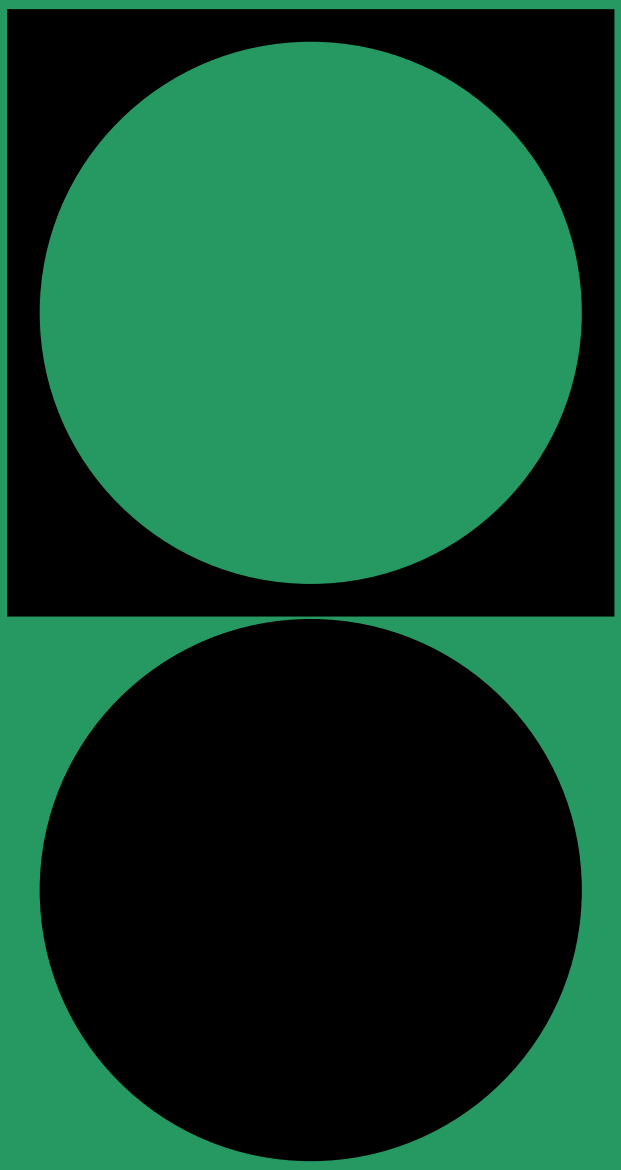
REGIONAL OVERVIEW: MIDDLE EAST AND NORTH AFRICA



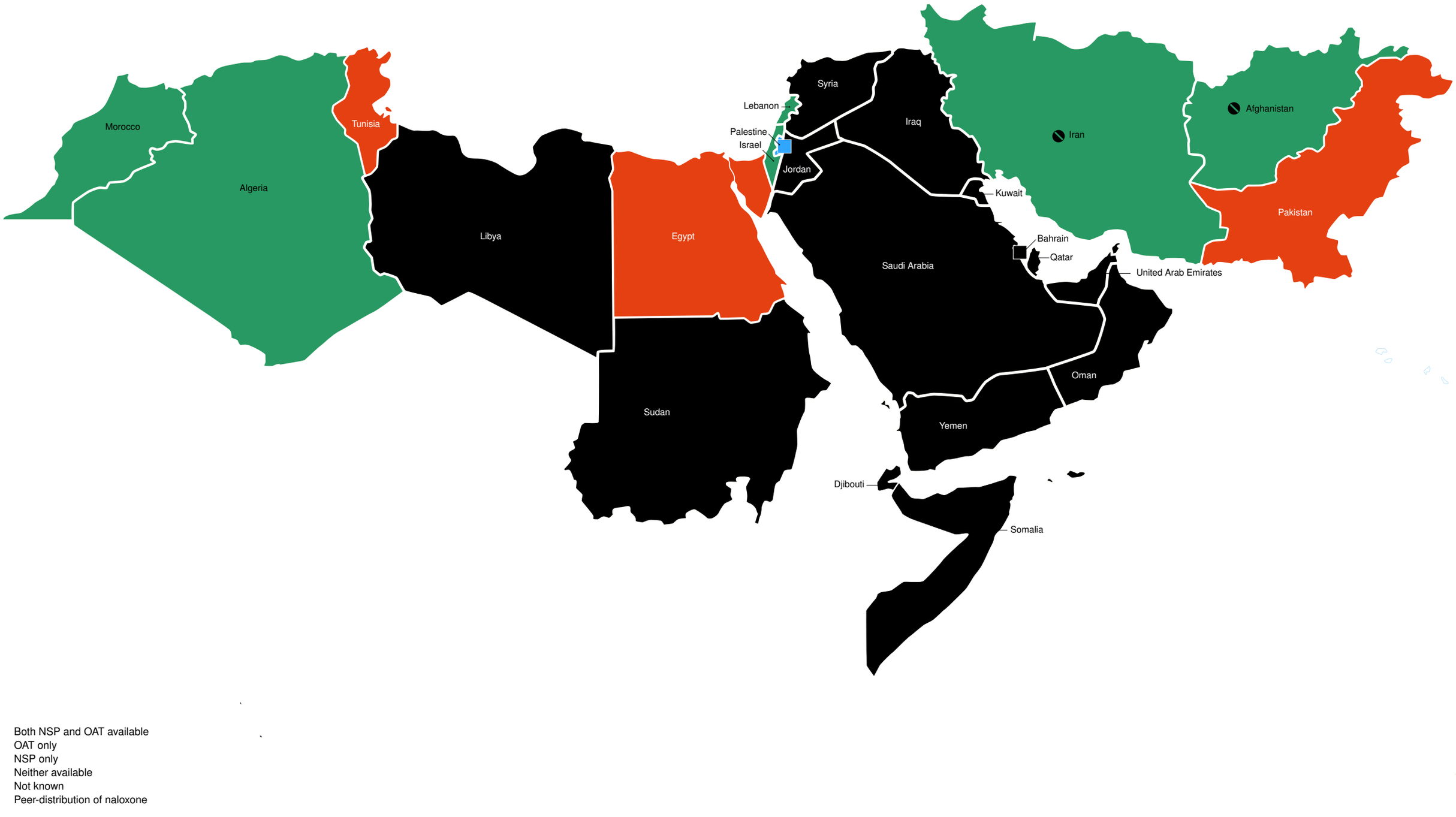
THE GLOBAL STATE
OF HARM REDUCTION 2022

HARM REDUCTION INTERNATIONAL

TABLE 6 EPIDEMIOLOGY OF HIV AND VIRAL HEPATITIS, AND HARM REDUCTION RESPONSES IN THE MIDDLE EAST AND NORTH 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]
Afghanistan[h]	57,207	3.1[3]	37.3[3]	3.7[3]	✓	✓	✓	×	×
Algeria	17,000	1.1	nd	nd	✓	✓ M	×	×	×
Bahrain	nd	4.6	nd	nd	×	×	×	×	×
Djibouti	nd	nd	nd	nd	×	×	×	×	×
Egypt	nd	3.8	49.5	13.5	✓	×	×	×	×
Iran	177,000	4.3	39.4	5.9	✓	✓ M B	✓[i]	×	×
Iraq	nd	nd	nd	nd	×	×	×	×	×
Israel	nd	nd	nd	nd	✓[1]	✓[1]	×	×	×
Jordan	nd	nd	nd	nd	×	×	×	×	×
Kuwait	nd	0.8	12.3	0.4	×	×	×	×	×
Lebanon	9,500	0.3	22	1.6	✓	✓ B	×	×	×
Libya	2,000	89.6	86.1	nd	×	×	×	×	×
Morocco	31,500	6.4	38.1	nd	✓	✓ M	×	×	×
Oman	nd	11.8	75.5	nd	×	×	×	×	×
Pakistan	497,000	30.9	54.5	7.9	✓	×	×	×	×
Palestine	nd	0	41.7	6.3	×	✓ M	×	×	×
Qatar	nd	nd	nd	nd	×	×	×	×	×
Saudi Arabia	nd	9.8	63	7.7	×	×	×	×	×
Somalia	nd	nd	nd	nd	×	×	×	×	×
Sudan	nd	0	nd	nd	×	×	×	×	×
Syria	nd	0	3.3	0.5	×	×	×	×	×
Tunisia	nd	3.1	17.2	2.7	✓	×	×	×	×
United Arab Emirates	nd	nd	nd	nd	×	×	×	×	×
Yemen	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.[2]
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=methadone.
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.
h Data on harm reduction service availability, which already represents a decline from previous reports, has been disputed by other sources, some of which report a collapse of harm reduction services in many parts of Afghanistan.
i While these services are reportedly available, civil society organisations report that they may be inaccessible in practice.


Morocco
Algeria
Tunisia
Libya
Egypt
Sudan
Lebanon
Syria
Palestine
Israel
Jordan
Iraq
Kuwait
Saudi Arabia
Bahrain
Qatar
United Arab Emirates
Iran
Afghanistan
Pakistan
Oman
Yemen
Djibouti
Somalia
Both NSP and OAT available
OAT only
NSP only
Neither available
Not known
Peer-distribution of naloxone

NSPs, OAT AND DCRs SINCE 2020

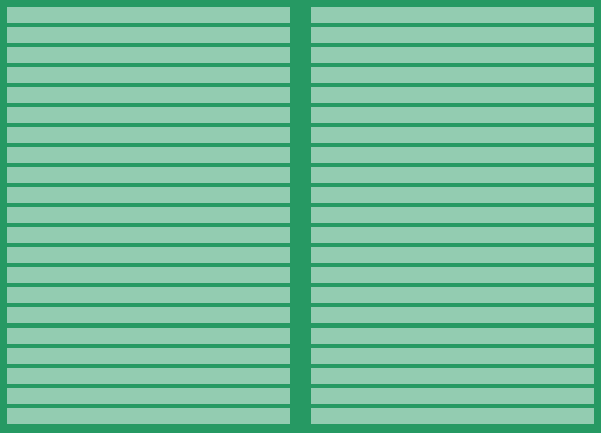
9 countries (38%) in the Middle East and North Africa provide **needle and syringe programmes** (no change from 2020)

7 countries (29%) in the Middle East and North Africa provide **opioid agonist therapy** (+1 since 2020, Algeria)

No country in the Middle East and North Africa provides **drug consumptions rooms** (no change from 2020)

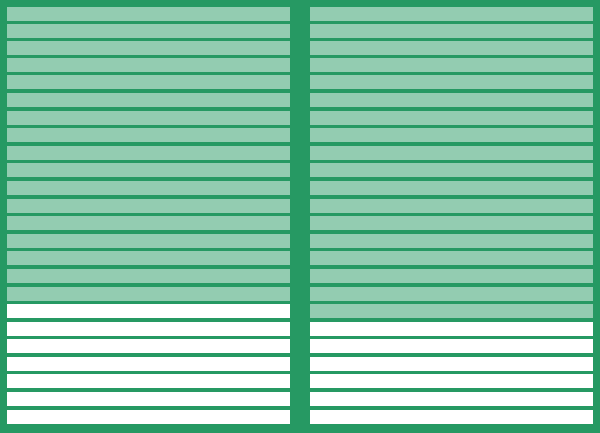
HARM REDUCTION IN PRISONS

2020 2022



No country in the Middle East and North Africa provides **needle and syringe programmes** in prisons (no change from 2020)

2020 2022



6 countries in the Middle East and North Africa provide **opioid agonist therapy** in prisons (-1 since 2020, Jordan)

ECONOMIC, HUMANITARIAN AND POLITICAL CRISES HAVE NEGATIVELY IMPACTED HARM REDUCTION IN THE MIDDLE EAST AND NORTH AFRICA

REGIONAL OVERVIEW

AUTHORS:
SANDRA HAJAL and **ELIE AARAJ**

INTRODUCTION

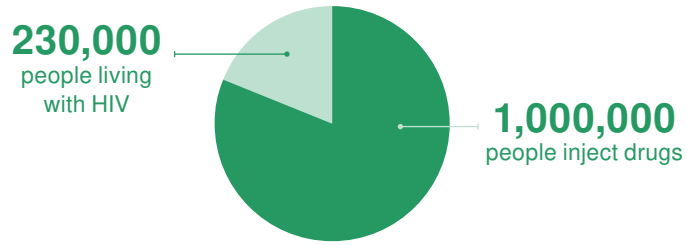
The Middle East and North Africa (MENA) region continues to experience conflicts, crisis, economic disturbances, political unrest, and the movement of refugees from Iraq, Palestine, Syria and Yemen.[4] All these factors have increased the general burden on public health systems, and affected drug use, HIV and harm reduction programmes in particular.[5,6] Environmental disasters related to the climate crisis, including the flooding in Pakistan in September 2022, have also put significant pressure on health services, including harm reduction.[7,8]

The latest data shows that around one million people in MENA inject drugs and 230,000 people are living with HIV.[2,9] On average, around 16,000 people are diagnosed with HIV every year in the region.[9] But only 43% of people living with HIV are on antiretroviral therapy (ART), and only 25% of pregnant women have access to antiretroviral medicines to protect their health and prevent mother-to-child transmission of HIV.[9] Despite evidence of the effectiveness of harm reduction interventions in promoting the health and rights of people who use drugs, these interventions remain limited in MENA region due to social, cultural, legal and economic challenges. In addition, data on drug use remains scarce in the majority of countries.[2] In some countries, research on drugs, populations most affected by HIV, HIV prevalence and many other important indicators are either non-existent or not comparable with other data because of a lack of research methods standardisation. In addition, most countries in the region lack human and financial resources to conduct regular research activities.[2]

NEEDLE AND SYRINGE PROGRAMMES (NSPs)

NSPs continue to be available in Afghanistan, Algeria, Egypt, Iran, Israel, Lebanon, Morocco, Pakistan and Tunisia. No countries in the region

More than 1 in 5 people who inject drugs in Middle East and North Africa are living with HIV



have newly implemented or closed programmes since 2020.[2,10–19]

Since 2020, Algeria has initiated OAT with methadone, operated by civil society organisations with government funding. With the support of the United Nations Office on Drugs and Crime (UNODC) and the Middle East and North Africa Harm Reduction Association (MENAHRA), Egypt and Pakistan have also been able to start the preparation and implementation of OAT, although these programmes are not yet fully operational. The preparatory work has included drafting standard operating procedures and protocols, training service providers, setting up a reporting system and importing the needed medication.[7,10–15,20] OAT continues to be available in Afghanistan,[j] Iran, Lebanon, Morocco and Palestine. But Lebanon is facing major challenges in providing OAT due to the country's ongoing economic and financial crisis (exacerbated by the COVID-19 pandemic and the Port of Beirut explosion in August 2020 – see Spotlight: Lebanon's OAT Shortage, page 103).[2,10,11,16–19] Since 2019, Lebanon has experienced a dramatic collapse in the most basic of services, including period health. There have been shortages of most medications in pharmacies and hospitals and prices have increased considerably.[21] As of 2020, OAT was available to people in prisons in Afghanistan, Iran, Lebanon, Palestine and Morocco.[2,11,16–19] However, in Lebanon it is only available for people who began treatment before incarcertion.[1]

Lockdowns related to the COVID-19 pandemic hindered the accessibility of both NSPs and OAT. Healthcare providers and clients were forced to stay at home, and service delivery centres were closed for periods of time before re-opening, progressively increasing their working hours to return to their previous schedules.[11] Flexibility and innovative service delivery methods (for example, home deliveries, increased take-home doses and outreach deliveries) have all been implemented in Afghanistan, Egypt, Lebanon, Morocco and Tunisia. A World Health Organization rapid assessment, published in late 2020, found almost all countries in the region included substance use programmes as part of their considerations in response to the COVID-19 pandemic, but only around half of all substance use programmes were classified as essential services. Only in Bahrain and Iran were psychosocial services for substance use reported as being fully funded during the COVID-19 pandemic.[22]

No drug consumption rooms (DCRs) are currently available in the region, and the overall response to drug overdose is highly underdeveloped.

HIV AND VIRAL HEPATITIS

HIV testing and treatment is available in the majority of countries. However, coverage and accessibility remains a challenge, especially for people who inject drugs, LGBTQI+ people, sex workers, people in prisons and people who are refugees.[2,10,13,18] Moreover, budget cuts, the decision by the Global Fund to Fight AIDS, Malaria and Tuberculosis (the Global Fund) to phase out funding in Egypt and Jordan from 2023, and the prioritisation of funding for humanitarian and emergency responses have dramatically affected civil society organisations that provide HIV services to people who inject drugs, resulting in major decreases in service delivery.[2,10,12–19]

"HIV testing and treatment is available in the majority of countries. However, coverage and accessibility remains a challenge, especially for people who inject drugs, LGBTQI+ people, people who sell sex, people in prisons and people who are refugees."

j As mentioned above, data on harm reduction services in Afghanistan is disputed, and the situation remains volatile following the Taliban offensive in spring 2021.

In the past two years, the expansion of HIV programmes in prisons has continued in Egypt, Morocco, Sudan, and Tunisia.[20] Rapid situational assessments of HIV and risk behaviours (including drug use) were carried out in prisons in Egypt, Sudan and Tunisia, a prison health strategy was launched in Morocco, and the first prison HIV programme was initiated in five prisons in Sudan.[20]

People who use drugs are at heightened risk of HIV and hepatitis C due to injecting drug use, sexual risk behaviours, inequalities, displacement and stigma. Approximately 30.5% of people who inject drugs in MENA are estimated to be living with current hepatitis C infection, and 4.1% are estimated to be living with HIV.[1]

WOMEN WHO USE DRUGS

Women still experience major gaps in access to harm reduction and treatment services.[2,10] This also applies to women who are partners of men who inject drugs, who need additional services to prevent and treat HIV and viral hepatitis.[23] In countries where harm reduction centres are concentrated in urban areas, some women find it hard to access these centres due to limited mobility or child care responsibilities that conflict with opening hours, and also face the barrier of stigma.[11] Iran and Tunisia currently offer gender-sensitive harm reduction programmes, with services tailored to the needs of women who use drugs and their children, although in Iran there are reports that these services are under threat from conservative actors and funding cuts, leading to two such services closing since 2020.[7,11] Tunisia has established Jasmin Space, a centre exclusively for women who inject drugs and their children, which offers tailored services.[11] Sex workers, LGBTQI+ people and refugees also face challenges in accessing harm reduction programmes due to discriminatory policies and stigmatisation from the general community and healthcare providers.[11]

CIVIL SOCIETY IN MENA

The Middle East and North Africa Network of/for People who Use Drugs (MENANPUD) was established in 2011. It is a community-led network of people who use drugs in MENA whose mission is to support peers, promote the health and wellbeing of people who use drugs, defend the rights of people who use drugs, reduce stigma, discrimination and criminalisation and promote harm reduction services. Since it began, MENANPUD has been supported, financially and technically by MENAHRA.[10,11] In 2021, MENANPUD started the process of officially registering as a non-governmental organisation in Lebanon and launched its first five-year strategy. Members received training to support them in NGO governance, proposal writing, social media, communications, advocacy and many other topics. Members have organised several awareness and advocacy campaigns in their respective countries and through the global *Support. Don't punish* campaign.[10,11]

POLICY AND FUNDING DEVELOPMENTS

Drug use remains criminalised in most countries in the region, and eight states retain the death penalty for certain drug offences (Bahrain, Egypt, Iran, Iraq, Kuwait, Palestine, Saudi Arabia and the United Arab Emirates). In Iran, at least 131 people were executed for drug-related offences in 2021, a 42% increase from 2020. The criminalisation of drugs continues to contribute to overcrowding in the region's prisons, with an attendant increased risk of health issues.[7,24]

There is limited domestic funding for harm reduction, which means services are not scaled up and there is limited availability of medication, commodities and other needed materials. Civil society organisations lead advocacy efforts to push for harm reduction approaches, programme implementation[2,10] and increased domestic and international funding. Civil society organisations also conduct local advocacy to initiate new programmes or bring about legal reforms.

Harm reduction for people who inject drugs is explicitly mentioned in the national policies of 14 out of 24 countries (Afghanistan, Algeria, Bahrain, Egypt, Iran, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Syria and Tunisia).[2,10–20] However, in many countries the political support for harm reduction remains limited. Many governments do not consider HIV and harm reduction to be high priorities, which makes it difficult to adopt an evidence-based, health-based response to drugs.

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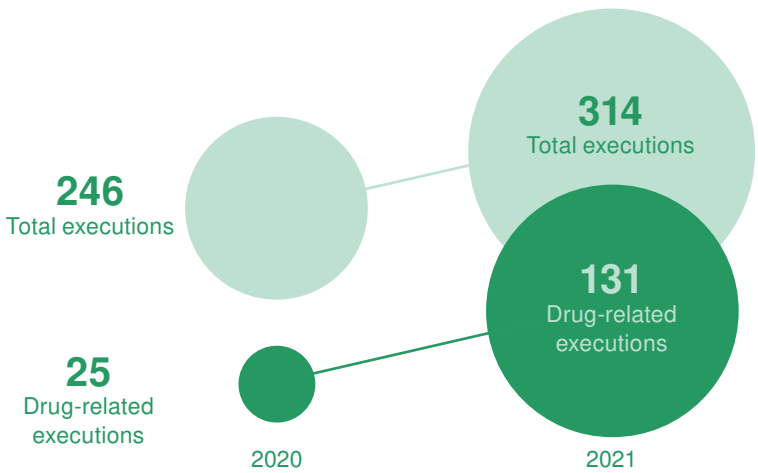

SPOTLIGHT

LEBANON'S OAT SHORTAGE

Since 2019, Lebanon has witnessed a dramatic financial crisis exacerbated by the increased economic strain of the COVID-19 pandemic and worsened by the massive explosion in Beirut port in August 2020. Human Rights Watch reported that in 2021, 80% of people in Lebanon did not have access to basic human rights and a decent standard of living, including health, education, adequate housing and electricity.[27] Since 2019, the Lebanese pound was devalued against the US dollar, resulting in increased prices and a shortage of basic goods. In addition, the Lebanese authorities and Bank of Lebanon ended subsidies for many essential items, including medication, which led to shortages and a significant increase in prices. The crisis also affected the country's OAT programme. The programme began in 2012 and sits in the Ministry of Public Health (MoPH). People who need OAT are usually prescribed buprenorphine by a psychiatrist in a private setting or by a civil society organisation. The medication is dispensed in three government hospitals pharmacies in three regions in Lebanon.

In September 2021, without prior notice, the MoPH informed all civil society organisations and psychiatrists of an imminent buprenorphine stock-out, with a maximum of one month of supply left. Service providers were urged to decrease clients' dosages to 8mg per day to buy time to find a solution. They were also asked to stop enrolling people to the OAT programme.

Stakeholders involved in the implementation of OAT programmes (civil society organisations AJEM, SIDC and Skoun; private psychiatrist and clinic organisation Reset; the Lebanese Psychiatric Society; the National Mental Health Programme; MENANPUD and MENAHRA) launched an emergency action plan to address the situation. The action plan included:

- Revising the dosages of around 1,200 clients and limiting the intake of new clients to extend limited supplies of OAT medications and avoid abrupt cessation for current clients.
- Securing and receiving authorisation from the Lebanese Psychiatric Society to use an expired stock of medication for the next three months.
- Dedicating a small fund (secured by Skoun) to support services for people willing to undergo detoxification.
- Advocating with international donors to receive funds to buy new stocks of medication (secured by MENAHRA and Skoun).
- Advocating with the Minister of Health and the Bank of Lebanon to secure subsidies to import OAT medication.
- Developing an overdose prevention action plan and securing 2,600 doses of naloxone.

The action plan was implemented, and MENAHRA and Skoun were able to mobilise funds to secure around eight months of medication. The Bank of Lebanon provided approval to continue partial support for OAT medication. This allowed new clients to be enrolled and existing clients to resume the dose on which they were stable. In addition, MENAHRA and partners liaised with Harm Reduction International and engaged Ethypharm, a UK-based pharmaceutical company and producer of buprenorphine, to donate a supply of buprenorphine to mitigate the impact of low stocks. Following extended negotiations and procedures, Ethypharm and MENAHRA were able to successfully import a donation of 6,946 packs of buprenorphine tablets in May 2022.[28] Notwithstanding these wins, the current stock is unsustainable and NGOs are not receiving regular updates from the MoPH regarding stock availability. Civil society organisations that deliver OAT report a risk of further shortages.[10,16]

Civil society organisations that provide OAT report that this instability has led to:

- people on OAT experiencing withdrawals and in some cases using illicit drugs;
- increased overdoses;
- increased mental health problems;
- and stress for clients, caregivers and families.

Civil society responded by increasing support and counselling sessions for people who use drugs. They also increased services so they could see clients more frequently and monitor people's mental health and any high-risk behaviours. Staff in civil society organisations experienced increased burnout due to the stressful nature of the situation.

The collaboration, fast response and pooling of donations and support among civil society organisations engaged in harm reduction secured the OAT medication needed to avert a significant crisis.

The Lebanese government must prioritise OAT as an essential medication to ensure the sustainability of programmes and reduce the country's reliance on international donors. It also needs to increase domestic funding and support for civil society organisations working in the fields of drug use and harm reduction. These organisations tend to be excluded from humanitarian, emergency and domestic funding, yet they are supporting some of the most vulnerable people in Lebanon who are unable to access or afford medication.

SPOTLIGHT

L'ESPACE LES JASMINS: A SPACE OF OUR OWN

According to limited available data, around one in five (19%) people who inject drugs in the world are women.[1] In Tunisia, the number of women who inject or use drugs has grown over recent years. Women who use drugs are greatly underserved by the Tunisian state, and tend to be even more overlooked than their male counterparts in terms of services, research, support programmes and access to harm reduction.[29] In 2015, during community meetings organised by the Tunisian Association against Sexually Transmitted Diseases and AIDS, women who inject drugs called for their own exclusive space as well as tailored social assistance and support for their children.

In response, civil society actors renewed their focus on gender-responsive harm reduction services. L'Espace les Jasmins, a space exclusively for women who inject drugs and their children, was launched on International Women's Day in March 2016. It offers a range of services for women in vulnerable situations and forms part of the harm reduction response to hepatitis C and HIV among women who inject drugs. Women who inject drugs – who are often experiencing the double stigma of being a woman who uses drugs as well as marginalisation and rejection from family and wider society – use the space for socialising and sharing experiences. The centre's goal is to improve the availability, accessibility, acceptability and quality of combined prevention, health, social and legal services for women who inject drugs.

The services the centre provides are high quality, relevant, targeted and continuous. These services include:

- distribution of kits that include condoms, lubricants and syringes;
- distribution of hygiene kits that include shampoo, wipes, towels, toothbrush and toothpaste, underwear, socks and soap;
- anonymous and free HIV, hepatitis C and syphilis screening;
- psychological and psychiatric support;
- support from an addiction specialist doctor, available weekly;
- legal support and advice;
- support for income-generating activities;
- hairdressing and other free beauty services;
- space for children, with educational games, swings and painting;
- and educational support for children, including private lessons, day-care and school supplies.

L'Espace les Jasmins now receives 368 women and 90 children every month. The centre's main source of funding comes from the Solidarité SIDA programme of the Mayoralty of Paris.

The main challenges L'Espace les Jasmins encounters are:

- advocacy for a comprehensive, holistic and integrated approach to harm reduction services, taking into consideration the role of gender;
- support for minors and provision of legal support;
- legal support for staff (for example, if they are arrested for carrying drug paraphernalia);
- advocacy with decision-makers for a better legal framework to support women who inject drugs;
- and introduction of an OAT programme for women who inject drugs.

L'Espace les Jasmins remains one the few centres that provides harm reduction services for women who use drugs in MENA.

SPOTLIGHT

THE RISE AND FALL OF HARM REDUCTION IN AFGHANISTAN

Afghanistan remains the world's leading supplier of opium; and the drug has been consumed there since ancient times.[30] Driven by decades of armed conflict, deterioration of security, economic stagnation and unsterile injection drug use, Afghanistan is vulnerable to increasing HIV infections and other blood-borne infections.[31]

Despite the violence, disorder and insurgency that marks the country's sociopolitical landscape, as well as the 'drug-free' paradigm that characterises its overall drug strategy, Afghanistan has been a rare example in the region of successful harm reduction implementation. Harm reduction programmes were implemented in the country following the fall of the Taliban in 2001, with support from donors and civil society organisations. By 2010, up to 28 NSP sites were operational.[32] In February 2010, the first methadone programme was launched, initially supporting 71 people.[33] In fact, such was the optimism toward the continued success of harm reduction interventions, one proponent from a harm reduction programme in Kabul declared: "Let us make a bet [that] Afghanistan could be a place of positive concern and interest in the future for the next generation of harm reduction!"[31]

This optimism would seem to have been vindicated during the following decade, which saw the scaling up of various harm reduction programmes, albeit largely due to international support. By 2012, there were a reported 19 NSPs in the country as well as one OAT site.[34] By 2020, there were 24 NSP sites and 8 OAT sites, and the country had become one of very few that implemented peer distribution of naloxone.[35] During the COVID-19 pandemic, the government and NGOs adjusted their responses to include provisions for take-home methadone and distributed harm reduction kits containing sterile needles, syringes, condoms, and medicines for sexually transmitted infections, among other products.[36]

But progress stopped when the Taliban returned to power in August 2021. In April 2022, the Taliban banned all forms of drug production and consumption, including that of opium, despite the drug's lucrative contribution to the national economy.[37] Reports from Kabul describe the collapse of harm reduction services in five provinces that previously relied on government funding to provide such services, resulting in staff going unpaid, a lack of harm reduction kits, a shortage of medicines and other medical equipment, and the shutdown of HIV prevention services.[38] As of August 2022, only eight NSP sites were operational and nine OAT sites (including four in prison).[39,42] Moreover, the Taliban has enabled the arbitrary arrest, detention and violent treatment of people associated with drugs[38]—in many ways mirroring what transpired during the previous Taliban regime, under which responses included 'maiming' the hands of people who use drugs.[40]

Left without a source of income from the opium trade, journalists report that "millions have joined the ranks of the impoverished," and people who use drugs can now be seen "living in parks and sewage drains, under bridges and on open hillsides" of Kabul.[41] The case of Afghanistan suggests political stability is a necessary precondition for the sustainability of harm reduction efforts, and that progress in any form should not be taken for granted, given its contingency on whoever is in power.

k This section was researched and written by Gideon Lasco.

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42. Another correspondent working in harm reduction provided slightly different figures: 14 NSP sites and eight OST sites (the same number from the GSHR 2020). It is worth noting that the correspondence from ANPASH qualified that, apart from the eight operational NSP sites, six more were supposedly awaiting funding from The Global Fund for reprogramming; however, it is unclear whether those six sites had already been restarted at the time of writing.