

HARM REDUCTION **ADVOCACY BRIEF FOR THE MIDDLE EAST AND NORTH AFRICA REGION**



MENA HRA

2021

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FOREWORD

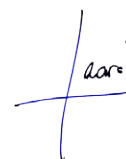
It is with great pleasure that we present to the harm reduction community, the first Advocacy Brief for the Middle East and North Africa (MENA) countries. This Advocacy Brief is a new contribution to regional literature, and has been conducted as part of the information and knowledge building services that MENAHRA aspires to offer to the decision makers, the civil society organizations and the scientific community in the region. I hope that this regional brief offers an added value to civil society organizations and decision makers in their efforts to scale up the harm reduction response.

MENAHRA aims to focus on building stronger advocacy and look forward to building a more conducive environment to ensure a better quality of life for people who use drugs in MENA.

This Advocacy Brief would not have been possible without the contribution and cooperation of a countless colleagues in the field. We extend our thanks to Dr. Marie Claire Van Hout and Ms. Patricia Haddad for cooperating with MENAHRA and effortlessly conducting this wide and comprehensive brief. We also would like to thank the Global Fund and Frontline AIDS, our Principle Recipient, for their support and for funding the development of this report. I would also like to thank my team at MENAHRA, for their commitment and energetic participation in reviewing and editing the report.

Last but not least, this report is dedicated to the community of people who use drugs and their families in the region in recognition of their suffering and resilience.

Sincerely,
Elie Aaraj

A handwritten signature in blue ink, appearing to read 'Aaraj', with a stylized flourish extending from the bottom left.

Executive Director
MENAHRA

ABOUT MENAHRA

In 2007, the WHO, in partnership with Harm Reduction International, initiated a five-year project for HIV/AIDS prevention and treatment targeted at PWIDs in the MENA region through the creation of MENAHRA. MENAHRA is the first network on injecting drugs harm reduction in the MENA, which aims to build capacity, availability, access and coverage of harm reduction services for PUD. In 2012, MENAHRA was established and registered as a regional NGO. It aims to improve the quality of life of PWUD through advocacy, capacity building, and technical assistance, and by serving as a resource centre in the region.

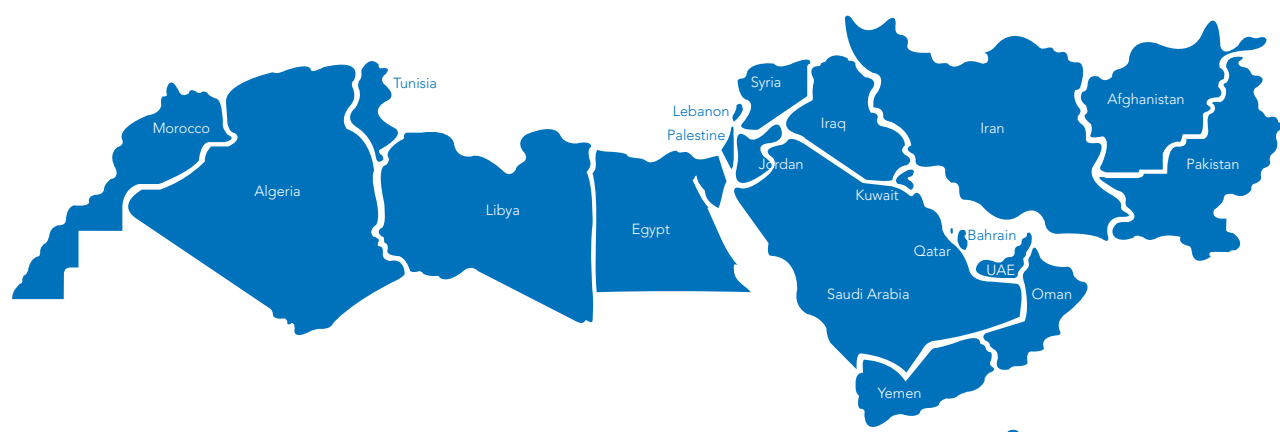
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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ATS	Amphetamine-Type Stimulant
BBS	Bio-Behavioral Survey
BBV	Blood-Borne Virus
BMT	Buprenorphine Maintenance Treatment
COVID-19	Corona Virus Disease 2019
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DCR	Drug Consumption Room
EMRO	Eastern Mediterranean Regional Office (World Health Organization)
FSW	Female Sex Worker
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
HTS	HIV Testing Services
IDU	Injecting Drug Use
IEC	Information Education Communication
KP	Key Population
MENA	Middle East and North Africa
MENAHRA	Middle East and North Africa Harm Reduction Association
MMT	Methadone Maintenance Treatment
MSM	Men who have Sex with Men
NASP	National AIDS Strategic plan
NGO	Non-Governmental Organization
NSP	Needle/ Syringe Program
OAT	Opioid Agonist Treatment
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
STI	Sexually Transmitted Infection
UAE	United Arab Emirates
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

BACKGROUND TO THE MENA REGIONAL AND COUNTRY ADVOCACY BRIEFS



The 2020 MENAHRA situation assessment has presented a comprehensive review on the situation and development of the harm reduction response of drug use and its harms in the Middle East and North African region during the timeframe 2010-2020. Key situational factors hamper the harm reduction prioritization and response in the region. The current situation of drug production, trafficking and consumption (including harmful use) is exacerbated by political and economic instability, protracted conflict in some countries, security issues, weak cross border cooperation, the relationship between weapons, human and drug trafficking, the absence of alternative livelihoods for drug producers, and migration and displacement of almost 11 million in the region. We present here an overview of the regional situation generated by the MENAHRA 2020 situation assessment followed by regional prioritisation and country specific data and advocacy briefs.

Surveillance

Surveillance and academic activity on drug use trends, size estimates of key populations and treatment characteristics, and BBV prevalence in community and prison settings differ per MENA country and in some countries remains scant or dated, making it difficult to assess extent and trends in the MENA region. This hampers advocacy for harm reduction and the development of effective evidence-based drug and public health policies at country and regional level.

Law Enforcement and Penal Settings

Over 600,000 people are deprived of their liberty in the MENA region, the vast majority of who are male and detained on drug related charges (Al-Shazly and Tinasti, 2016). Repressive and punitive approaches to drugs including corporal punishment and death penalty, criminalization, coercive drug treatment mandated by the courts and aggressive policing continue to discourage health care seeking by PWUD. Some countries have reported the rise in private drug treatment and rehabilitation centers using methods which are not evidence based. This reinforces marginalization and stigmatization of PWUD/PWID and perpetuates unsafe/high risk use of drugs in the region.

Eight out of 20 countries (Algeria, Jordan, Lebanon, Libya, Morocco, Qatar, Tunisia, and UAE) in the region have legislation that sanctions drug consumption, while six countries (Bahrain, Egypt, Iraq, Kuwait, Saudi

Arabia, Yemen) have legislation that focuses on drug possession for the purpose of consumption and does not sanction consumption itself. In only four countries (Afghanistan, Iran, Oman, Pakistan), the law allows possession of a specified amount of drugs, or classifies consumption as a non-criminal offense. Some countries now give precedence to prevention and treatment over punishment, however it is unclear as to when and for how long these are applied (for example Lebanon, Algeria, Libya, Yemen, Morocco, Tunisia, Qatar).

Iran, Libya, Qatar, Saudi Arabia, the UAE and Yemen traditionally use judicial corporal punishment (i.e. state-sanctioned beating, caning, or whipping of a person) for drug use, purchase or possession. The death penalty for drug offences continues to be prescribed in many MENA countries, including Bahrain, Egypt, Iran, Iraq, Kuwait, Libya, Oman, Qatar, Saudi Arabia, Syria, the UAE, Palestine, Gaza and Yemen. Countries reporting death sentencing for drug offences in 2018 include Bahrain, Egypt, Iraq and Oman (Girelli, 2019). There have however been some encouraging shifts, for example in 2019, the progressive MENAHRA initiative “Beirut Declaration” based on the Third Consultation Meeting on Law Enforcement and the Rights of People Living with and Affected by HIV¹ was signed and aims to promote the positive engagement of law enforcement agents in the HIV response in selected countries in the MENA region, and to create a common understanding and agreement between partners and participants on strategic human rights-based HIV programming and a roadmap to improve the legal environment in the region.

Drug Use Trends

Although the MENA region is primarily a drug trafficking and transit region, there are notable production and consumption trends in Captagon (commonly fenethylamine), opium, heroin, cannabis, ATS and Khat. Cannabis remains the most commonly used substance. Increased use of synthetic cannabinoids, ATS, and pharmaceutical drugs in a number of countries in the region has been observed through shifting trends of drug use. A concerning rise in synthetic cannabinoid use has been noted in Jordan, Kuwait, Egypt, and Palestine. ATS use has increased in Afghanistan, Kuwait, Iran, Iraq, Lebanon and Palestine. The rise in pharmaceutical drug use however, is the most widespread and noted among 15 of the 20 MENA countries (Afghanistan, Algeria, Egypt, Iran, Iraq, Jordan, Kuwait, Pakistan, Palestine, Qatar, Saudi Arabia, Syria, Tunisia, UAE, and Yemen). The World Drug Report 2020 has identified the trafficking and non-medical use of Tramadol and Captagon as one of the key challenges faced within the region. Pharmaceutical drug availability in community pharmacies strongly contributes to misuse, abuse and dependence on over the counter and prescription drugs in several MENA countries (for example Jordan, Libya, Egypt, Iraq, Lebanon, Yemen, Pakistan, Saudi Arabia, UAE, Morocco). These pharmaceutical drugs reported on include buprenorphine, benzodiazepines, pharmaceutical opioids (Tramadol), and amphetamines (Captagon). Moreover, in Lebanon, a rising trend in Salvia use among drug users has been noted. In the Golden Crescent (Afghanistan, Iran, and Pakistan), opioids (opium and heroin) remain the main drugs used. Khat also remains a main drug of use in countries of the Gulf (Oman, Saudi Arabia, UAE, and Yemen). Common drugs that are injected have been reported in eight countries of the region (Algeria, Bahrain, Jordan, Morocco, Oman, Pakistan, Palestine, Syria,) and include heroin primarily, as well as buprenorphine (Subutex®), amphetamines, cocaine, morphine, and AVIL.

Drug Injecting and related risk behaviours

The previous MENAHRA regional situation assessment (2017) estimated 887,000 PWID. Although data are relatively limited, there are several 2020 global estimates of the size of PWID in the MENA region, which however used different methods, and different definitions of the MENA region. In the MENA region, estimations of number of PWID were available through two recent global reviews tackling PWID age profiles and HCV prevalence respectively (Hines et al., 2020; Mahmud et al, 2020). One of the reviews presented PWID size estimates for only 5 of the 20 countries, while the other presented size estimates for all 20 countries. Estimates from both reviews, as well as age profiles of PWID, are presented in the comparative Table 1.

¹ <http://www.menahra.org/en/menahra-publications/publications/883-law-enforcement-and-the-rights-of-people-living-with-and-affected-by-hiv-beirut-declaration>

Table 1. 2019/2020 estimates and age profile of PWID in the MENA region per country

Countries	Estimated number of PWID	Source	Average age of PWID in years*
Afghanistan	139000 (88000 – 190500) 18820 (12435 – 23000)	(Hines et al_2020) (Mahmud et al_2020)	28.3 (21 – 32)
Algeria	40961 (26333 – 55590)	(Mahmud et al_2020)	30.0 (30 – 30)
Bahrain	1937 (1369 – 15506)	(Mahmud et al_2020)	-
Egypt	90809 (71485 – 119633)	(Mahmud et al_2020)	-
Iran	158000 (107000 – 209000) 185000 (135000 – 300000)	(Hines et al_2020) (Mahmud et al_2020)	32.7 (27 – 44)
Iraq	34673 (23115 – 46230)	(Mahmud et al_2020)	28.0 (28 – 28)
Jordan	4850 (3200 – 6500)	(Mahmud et al_2020)	-
Kuwait	4050 (1850 – 8750)	(Mahmud et al_2020)	-
Lebanon	3207 (1506 – 4908)	(Mahmud et al_2020)	29.5 (29 – 30)
Libya	2000 (1000 – 3000) 4446 (2948 – 5943)	(Hines et al_2020) (Mahmud et al_2020)	39.0 (39 – 39)
Morocco	30500 (15500 – 45500) 18000 (13500 – 22500)	(Hines et al_2020) (Mahmud et al_2020)	33.2 (31 – 39)
Oman	4250 (2800 – 5700)	(Mahmud et al_2020)	-
Pakistan	423000 (363000 – 482500) 117632 (89500 – 510000)	(Hines et al_2020) (Mahmud et al_2020)	30.5 (28 – 34)
Palestine	1850 (1200 – 2500)	(Mahmud et al_2020)	40.6 (39 – 43)
Qatar	1190 (780 – 1600)	(Mahmud et al_2020)	-
Saudi Arabia	16800 (11336 – 22264)	(Mahmud et al_2020)	40.0 (40 – 40)
Syria	8000 (5750 – 10250)	(Mahmud et al_2020)	32.0 (32 – 32)
Tunisia	11000 (8462 – 13750)	(Mahmud et al_2020)	34.6 (33 – 36)
UAE	4800 (3200 – 6400)	(Mahmud et al_2020)	-
Yemen	19770 (12710 – 26830)	(Mahmud et al_2020)	-

*** Average age profile as per Hines et al., 2020**

In countries where data were available from both global reviews (Afghanistan, Iran, Libya, Morocco, Pakistan), the large discrepancies in size estimations was noted in Afghanistan and Pakistan. Based on data reported in Mahmud et al., (2020), the average number of PWID in all 20 countries is estimated to be 592,045 (428,479 – 1,207,853). However, size estimates for Afghanistan and Pakistan reported by Hines et al (2020) were more consistent with another review reporting on frequency of IDU (Colledge et al., 2020). Taking into consideration these discrepancies, if the size estimates for Afghanistan and Pakistan were to be substituted for those from the Hines et al review (2020), the average estimated number of PWID in all 20 countries consisting of the MENA region may increase up to 1,017,593 (777,544-1,347,853). It is reported that the lowest percentage of PWID aged 25 years or younger residing in the MENA region (Hines et al., 2020). PWID age profile information was available for 12 of the 20 countries, with an average age of 33.2 years (range 28-40.6).

According to another review by Colledge et al. (2020) focusing on injecting frequencies, data was available for only eight countries. Yet another estimate is generated from this review, indicating the different estimates available for the region and emphasizing the need for a comprehensive and exhaustive size estimation study. In eight of the 20 countries (Afghanistan, Iran, Lebanon, Libya, Morocco, Pakistan, Palestine, Syria) that fall within the MENAHRA identified MENA region that are reported on in this document, an estimated number of 726,000 (range 561,000-905,500) PWID were found to be injecting at least once daily, while an estimated number of 47,000 (range 20,000-80,500) PWID were found to inject less than once daily (Colledge et al., 2020). The high number of PWID injecting on a daily or more frequency is largely attributed to the figures estimated for Pakistan, Iran, and Afghanistan, three countries that have some of the largest populations of PWID in the region.

Data for seven countries (Afghanistan, Egypt, Iran, Lebanon, Morocco, Pakistan, Tunisia) on use of sterile injecting equipment at last injection was reported by the UNAIDS through their AIDSINFO online platform. Reporting years ranged from 2014 to 2019. High risk was found in Egypt with only 31.5% PWID reporting use of sterile injecting equipment at last injection in 2015. Increased risk may have followed in later years due to halting of some NSPs in the country.

Afghanistan, Lebanon, Morocco, and Tunisia reported good figures of over 90% use of sterile injecting equipment at last injection, all of which still currently having running NSPs. However, these figures do not necessarily reflect that risk of contraction of HIV and HCV is decreased as they only report on “*last injection*”. Risky sexual behaviour among PWID was reported by only six countries, on condom use in last sexual intercourse. All six countries reported that less than 50% of PWID used condoms during last sexual intercourse.

Drug Treatment

Information related to drug dependence in the MENA region is mainly extracted from treatment related settings. Opioids are the primary drugs of use among clients that present to drug treatment centers, often in poly-drug use situations. Main opioids include heroin, opium, and pharmaceutical opioids such as buprenorphine and Tramadol. Other drugs of dependence include cannabis, amphetamines, ATS, tranquilizers, benzodiazepines, and cocaine. Use and injecting use of heroin, amphetamines, cocaine, morphine and buprenorphine are common in drug treatment patient populations in MENA. Co-morbidity with mental illness is of rising concern (for example in Afghanistan, Lebanon, Oman, Saudi Arabia). Emerging trends in co-morbidity with trauma related mental illness are observed, particularly in displaced populations and humanitarian settings. Approaches to opioid use disorder treatment vary from detoxification using methadone (most common; Bahrain, Saudi Arabia) to OAT (with BMT most common form of OAT) in the MENA region. Only Afghanistan, Iran, Kuwait, Lebanon, Morocco, Palestine, UAE currently provides OAT.

BBV: HIV, Hepatitis B and C

HIV prevalence remains low among the general population in countries of the MENA region. According to the current UNAIDS (2020) report, the HIV epidemic in the MENA region is still growing; however, the response has not been appropriate for the size of the problem (Global AIDS Update, 2020). UNAIDS reports an estimate of 20,000 (range 11,000-38,000) newly reported infections for 2019 in the region, figures that are 25% higher than new infections in 2010 (UNAIDS, 2020). The Global AIDS report (2020) reflects a rising trend relating to the HIV epidemic in the MENA region, with a 22% increase in new infections between 2010 and 2019, while AIDS-related deaths remain stable. Increases in new HIV infections of more than 20% since 2010 have occurred, including in Afghanistan (116%), Algeria (83%), Egypt (421%), Lebanon (44%), Pakistan (75%), Tunisia (29%), and Yemen (26%). In contrast, Iran, Libya, and Morocco report that annual new HIV infections have declined by more than 10% since 2010. In 2020, access to HIV testing, treatment and care in the MENA region is well below the global average, with only 52% of PLHIV aware of their serostatus, 38% accessing ART, and less than one-third virally suppressed (UNAIDS 2020).

Globally, an estimated 325 million people are living with chronic viral hepatitis infections (HBV: 257 million; HCV: 71 million). In the MENA region, 36 million people (HBV: 21 million; HCV: 15 million) are estimated to have chronic viral hepatitis infections (WHO, 2017). The WHO Eastern Mediterranean region, which comprises more or less the same countries as those covered by MENAHRA (with the exception Algeria and the inclusion of Sudan, Somalia and Djibouti), is reported to have the highest prevalence of HCV infection (2.3%) with incidence rates of 62.5 per 100,000 population. Main modes of transmission in the region have been identified as unsafe healthcare procedures followed by injecting drug use (WHO, 2017).

Convergence of Key Populations

There is considerable HIV incidence among PWID in the MENA region, with more than one third of HIV infections reported in 2019 attributed to PWID. Moreover, key populations and their sexual partners accounted for almost all new infections (approximately 97%) in the MENA region in 2019 (UNAIDS, 2020). Prevention and treatment programmes in many MENA countries are not reaching sufficient numbers of key populations at high risk of HIV infection. The estimated HIV incidence rate for 2017 among PWID ranged between 0.7% per person-year (ppy) in Tunisia and 7.8% ppy in Pakistan, with Libya being an outlier (24.8% ppy) (Mumtaz et al., 2018). According to a global systematic review by Larney et al. (2020), the highest HIV prevalence among

PWID was reported in Libya (89.6%), Pakistan (32.3%), Iran (14%), and Oman (11.8%). Countries in which HIV prevalence among PWID was reported to be between 5 and 10% included Saudi Arabia (9.8%) and Morocco (9.6%). Countries with a prevalence of less than 5% included Bahrain (4.6%), Afghanistan (4%), Tunisia (3.5%), Egypt (2.6%), and Algeria (1.1%); while two countries that reported zero HIV prevalence among PWID included Lebanon and Palestine.

Distribution of new HIV infections among key populations in the region in 2019 were estimated to be 43% among PWID, 23% among MSM, 19% among clients of sex workers and sex partners of other key populations, 12% among sex workers, and 3% among the general population. Patterns of new infections have changed between 2014 and 2019 and have seen an increase of new infections among PWID (28% of new infections in 2014), MSM (18% of new infections in 2014), CSW (9% of new infections in 2014); while there was a decrease of new infections among clients of CSW and sex partners of other key populations (41% of new infections in 2014), and the general population (4% of new infections in 2014) (UNAIDS, 2019; UNAIDS, 2020).

Global estimates of HCV in people with recent injecting drug use in the MENA region are 36.1 (29.2- 43.2), with the number of people living with HCV with recent injecting drug use are 126,000 (65,000 – 199,500) (Grebely et al., 2018). Pooled estimates of HCV in PWID stratified by populations' risk of exposure to HCV infection across MENA are 49.0 (range 43.8–54.3) and 6.6 (range 5.7–7.6) among populations of intermediate risk includes in prisoners (Chemaitelly et al., 2019)

Estimates in the region indicate that half the PWID have been infected with HCV, but with great variation in antibody prevalence across specific MENA countries (Mahmud et al., 2020). There is no community level data on people who no longer inject drugs, but who have contracted HCV. High rates of HCV of >35% are reported in PWID in Afghanistan, Egypt, Libya, Oman, Iran, Pakistan, Saudi Arabia, Palestine and Lebanon. Largest numbers of chronic HCV infection among PWID are found in Iran at 68,526 (45,252-121,475), and in Pakistan at 46,554 (22,815-168,797) (Mahmud et al., 2020). Egypt and Pakistan are facing generalized HCV epidemics, and host close to 80% of all HCV exposed and chronically infected individuals in the MENA region (Chemaitelly et al., 2019). HCV genotypes vary in the region, with genotype 3 most common in PWUD in Afghanistan, Iran and Lebanon; genotype 1, largely found in the Maghreb countries (Algeria, Morocco, Tunisia, and to some extent Libya); and genotype 4 in Libya, where extremely high rates are observed (up to 96% in the PWID population). HBV prevalence is a concern among risk groups, particularly PWID in Afghanistan, Iran, Kuwait and Lebanon. High prevalence of HBV among the refugees is observed in Iraq, Afghanistan and Libya.

Overlap and intersections are present among key populations, and underpins the importance of addressing the gaps in evidence to potentially inform future programming. Drivers of HIV and HCV among key populations include injecting drug use, partially intersecting with multiple and concurrent sexual partnerships, gender inequalities and violence, displacement, stigma and discrimination. Several countries had little or dated detail on key populations size estimates or recent prevalence of BBV; or relied on case finding among key populations (Afghanistan, Bahrain, Iraq, Kuwait, Egypt, Saudi Arabia, Syria, Qatar, and Tunisia).

Many MENA countries lack sufficient current evidence to determine size of key populations and BBV prevalence in key populations. This reflects the incompleteness of HIV and HCV strategic information systems in the MENA region (Global AIDS Report, 2019). Given that almost all new HIV infections are associated with key populations; this deficiency must be addressed so that more effective and focused programmes can be put into action. There is a strong possibility for hidden HIV epidemics in the MENA region among key populations. There is a complete lack of data on key populations other than PWID for four countries (Bahrain, Iraq, and Palestine, Qatar). Transgender information is almost non-existent, with size estimate and HIV prevalence available for only Pakistan, and HIV prevalence available for Iran. In terms of HCV prevalence among key populations other than PWID, no data was available. Only available prevalence estimations related to prevalence of HCV and co-infection with HIV from UNAIDS (2020), and even that platform had available prevalence rates for only sex worker and MSM populations from Afghanistan and Algeria; no data was available for transgender populations from any country.

Prisoners are an identified key population in the MENA region, however data, where available, is scant with low rates of HIV (0.6%-3.5%) in Afghanistan, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Palestine, Saudi Arabia, Syria, Tunisia, and Yemen), and HCV (1.7% -37.8%) in Afghanistan, Egypt, Lebanon, Pakistan, Iran, Syria and Libya) (Heijnen et al., 2016). Some countries are reporting a concern in the rise of BBV in prisons coinciding with a rise in incarceration (Afghanistan).

At country levels, the 2020 MENAHRA situation assessment indicates the presence of concerning rates of HIV and viral hepatitis transmission among **PWID** populations in Afghanistan, Algeria, Egypt, Lebanon, Iraq, Morocco, Palestine, Pakistan, Tunisia and Libya (extremely high at 87%); in **MSM** populations in Afghanistan, Algeria, Egypt, Lebanon, Iraq, Morocco, Yemen (no HCV data available), Pakistan, Tunisia and Libya; in **FSW/CSW** populations in Algeria, Iran, Lebanon, Iraq, Morocco, Pakistan and Libya; and in **refugee** populations in Afghanistan, Iraq, Lebanon and Libya (particularly HBV).

HIV testing and treatment cascade

The previous MENAHRA situation assessment in 2017 reported that HIV Testing Services (HTS) were reported to be widely available in 14 countries of the region; however, the coverage was low. In 2020, HIV testing is currently available in 18 countries of the region, with HTS reported to be available, including for PWUD (communications with focal points). However, the number of PLHIV who know their status in the region remains low. Prevention and treatment programmes in many MENA countries are not reaching sufficient numbers of key populations at high risk of BBV infection. UNAIDS (2020) have reported on a large gap in the first 90 of the cascade of PLHIV unaware of their status in countries of the region. HIV surveillance systems are not effective in most countries and data is lacking. Data regarding PWID who know their HIV status is scant with information available for only 8 countries (Algeria, Egypt, Iran, Kuwait, Morocco, Pakistan, Saudi Arabia, Tunisia) with rates of less than 50% PWID who know their status reported in 3 of those countries (Morocco, Pakistan, Tunisia). Strengthened political commitment is evident in a few countries, such as Algeria and Morocco, but the region's overall HIV response is well off-track and far from reaching the 90–90–90 targets (UNAIDS, 2019). Efforts are compounded by humanitarian emergencies due to the protracted emergencies in Libya, the Syrian Arab Republic, Yemen and elsewhere. Women and minors also represent a gap in the evidence, and are not sufficiently supported in community level harm reduction and treatment structures or in prisons. There is a strong possibility for hidden HIV and HCV epidemics in the MENA region among key populations, particularly PWID, MSM and CSW, and in prisons, with convergence into the general population via sexual transmission. High prevalence of HBV among the refugees/migrant populations from Syria, Palestine, Afghanistan and North Africa is also observed. Low levels of education, low BBV transmission knowledge, and stigma and discrimination compound their risk.

Moreover, the region is reported to have the lowest treatment coverage in the world, with more than 100,000 PLHIV in need of treatment but that are unable to access it (UNAIDS, 2020). Although ART is available free of charge for PLHIV in countries of the region, there is limited data regarding PWID receiving ART. To date, only Iran and Morocco have integrated ART within OAT services (*communication with focal points*).

Taking into consideration the gaps in the HIV testing and treatment cascade in the region in general, there are further barriers affecting PWUD, among other key populations, in terms of their access to HIV testing and treatment. Focal points in different countries that were consulted with have indicated that main barriers to HTS include stigma and discrimination, geographical and institutional centralization of HTS, difficulty in reaching PWUD, and confidentiality issues (*communications with focal points*).

Only ten countries have an updated 2018/2019 Global AIDS Monitoring Report (Iran, Afghanistan, Algeria, Egypt, Kuwait, Lebanon, Pakistan, Saudi Arabia, Tunisia, UAE). There are no updated 2018/2019 Global AIDS Monitoring reports available for Libya, Bahrain, Iraq, Jordan, Morocco, Palestine, Qatar, Syria, Yemen or Oman.

Harm Reduction

The ongoing humanitarian emergencies in the MENA region, conflict and economic migration, and internal/external displacement of large populations and the geographies of high risk behaviors and key populations in the MENA region, present massive challenges for public health systems in general, and HIV and drug use prevention, treatment and care programmes in particular. Whilst strengthened political commitment is evident in a few countries, such as Algeria and Morocco, the region's overall HIV response is well off-track and far from reaching the 90–90–90 targets (UNAIDS, 2019). Efforts are compounded by humanitarian emergencies due to the protracted emergencies in Libya, the Syrian Arab Republic, Yemen and elsewhere.

The 2020 MENAHRA situation assessment reports that the MENA region has witnessed a slow but steady increase in the harm reduction response among countries of the region in general, with some positive changes in harm reduction policy visibility, provision and coverage since 2016. The previous situation assessment in

2017 reported that harm reduction services were observed to have low coverage, and warranted scale up. Low political commitment, low prioritization of the HIV response, reduced funding and restrictions on the functions of NGO in some MENA countries hampers the harm reduction response.

Harm reduction policies

- Six out of 20 countries in the region (Iraq, Kuwait, Qatar, Saudi Arabia, UAE, and Yemen) do not have explicit harm reduction policies within their NASP or noted PWID as an important key population in their national plans.
- Fourteen countries have mention of harm reduction/PWID in national policy documents: seven countries adopting harm reduction policies in their NASP include Afghanistan, Egypt, Iran, Lebanon, Morocco, Oman, and Palestine; seven countries in which PWID are noted as important key populations in their national plans include Algeria, Bahrain, Jordan, Libya, Oman, Syria, Tunisia and Pakistan.

This is an improvement since the previous situation assessment (2017) which reported that six countries of the region (Afghanistan, Iran, Lebanon, Morocco, Palestine and Pakistan) had adopted harm reduction policies within their NASP.

NSPs

Current 2020 UNAIDS reports that although the number of countries providing NSP has increased, coverage remains insufficient. According to WHO EMRO, NSP coverage in the region (estimated to be around 25 syringes/PWID/year) remains below the Global 2020 and 2030 targets (200 syringes/PWID/year and 300 syringes/PWID/year respectively). Moreover, out of seven countries for which data was available, the highest reported distribution of syringes/PWID is in Afghanistan with a reported number of 112 syringes/PWID in 2019 (UNAIDS, 2020). Current coverage is unlikely to have an impact on HIV and HCV incidence among PWID.

- NSPs are available in 10 countries of the region (Afghanistan, Algeria, Egypt, Jordan, Iran, Lebanon, Morocco, Palestine, Tunisia, and Pakistan), with the recent addition of Algeria to the list of 9 countries reported in 2016. It has been reported that an NSP was set up in 2 regions of Algeria (Algiers and Annaba) in 2018-2019 as part of the implementation of the combined HIV prevention program with support from the Global Fund. There is also a planned scale-up to a third region (Oran) for 2020-2022.
- NSPs in some countries of the region (Egypt, Jordan, and Lebanon) have been reduced due to changes in funding priorities and although services are still available, there has been a decrease in coverage since 2016.
- Although the number of countries providing NSP has increased, coverage remains insufficient. According to WHO EMRO, NSP coverage in the region (estimated to be around 25 syringes/PWID/year) remains below the Global 2020 and 2030 targets (200 syringes/PWID/year and 300 syringes/PWID/year respectively). Moreover, out of seven countries for which data was available, the highest reported distribution of syringes/PWID is in Afghanistan with a reported number of 112 syringes/PWID in 2019 (UNAIDS, 2020). Therefore, current coverage is unlikely to have an impact on HIV and HCV incidence among PWID.

There is an increase since the previous situation assessment (2017) in number of countries with NSPs from nine to ten, but a decrease in NSP coverage since the 2017 MENAHRA situation assessment..

OAT

- Drug detoxification and abstinence treatment is most common (Afghanistan, Algeria, Bahrain, Egypt, Oman, Saudi Arabia, and Tunisia).
- OAT exists in seven out of 20 countries (Afghanistan, Iran, Kuwait, Lebanon, Morocco, Palestine, and

UAE). MMT in five countries (Afghanistan, Iran, Morocco, Palestine, UAE); and BMT in four countries (Iran, Kuwait, Lebanon, UAE). Iran uses opium tincture for substitution treatment.

- OAT developments since 2016 include the scaling up of services in Lebanon through two new dispensing units (Bekaa and Mount Lebanon governorates) and two additional centers offering OAT (Bekaa and Mount Lebanon governorates). Moreover, suboxone was recently introduced in an effort to limit injecting practices among beneficiaries of OAT that are using buprenorphine. Morocco is also scaling up OAT through the opening of three new centers to improve coverage and geographical distribution; however more efforts are needed in this area. Whereas in Iran, insurance coverage for OAT was expanded to include selected private sector clinics in addition to the previously covered governmental centers, in addition to the introduction of a national registration database for OAT to improve data management and quality.
- Five countries remain in the planning phase for OAT: Algeria, Egypt, Oman, Pakistan, and Tunisia.
- Endorsement of OAT in Pakistan by the Drug Regulatory Authority and Anti-Narcotic Forces and steps towards registering Methadone and Buprenorphine reached advanced stages during 2020.
- In Egypt, the government has requested support from WHO and UNODC to review the OAT feasibility study conducted by UNODC with the support of MENAHRA in 2014, as part of the plan for elimination of HCV in Egypt.

There is progress in OAT provision in the MENA region since the previous situation assessment (2017) in terms of scaling up of services within countries. However, the number of countries which reported that OAT existed remains the same in the 2020 situation assessment: Seven (Afghanistan, Iran, Kuwait, Lebanon, Morocco, Palestine, and UAE) with a further two countries planned (Oman and Pakistan). The 2020 situation assessment also shows that no change has been noted in terms of countries have implemented both essential harm reduction services in the form of combined OAT and NSP services since the previous situation assessment (2017), where the four countries implementing them remain the same (Afghanistan, Iran, Morocco and Lebanon).

Prisons

- OAT is available in prisons in Afghanistan, Iran, Lebanon, Morocco, and Palestine. In some countries for example as in Lebanon OAT is only available in prisons to those who were enrolled before entering prison.
- NSP is not available in prisons in any country of the region. Iran used to provide NSP services in prisons; however these programs have been halted.
- In Egypt, the UNODC Prison HIV project provided HIV, HBV and HCV counseling and testing services to inmates. The project also distributed needles, syringes and condoms to released inmates and their families. Therefore, although NSP is not technically available in prisons in Egypt, this step can be seen as an improvement in the provision of services for key populations.
- The previous MENAHRA situation assessment (2017) did not explicitly refer to condom programming in prisons, but did refer to condom programming in the community in Afghanistan, Egypt, Iran, Syria, Palestine, Morocco, Lebanon and Jordan. The 2020 MENAHRA assessment reports on progress in this setting with condom programming is reported in Iran, Egyptian and Algerian prisons.

There has been an increase in overdose prevention programming, from zero to two countries implementing naloxone through community distribution (Afghanistan and Iran) and with Morocco in the planning phases for community distribution. The previous situation assessment (2017) did not report on naloxone, and only referred to policy change in overdose prevention protocols in hospitals in Lebanon. There has been no progress regarding DCR in any country since the previous situation assessment (2017).

NGO Response

Civil society engagement and the work of NGOs is often the one of the drivers of the HIV and harm reduction response. In the MENA, it is often NGOs that are at the forefront of advocacy initiatives and service provision in the fields of HIV, harm reduction, and key populations. Moreover, PWID and other key populations are known to be more comfortable accessing services through non-governmental structures, as they remain to be criminalized populations in most countries of the region.

The previous situation assessment (2017) referred to NGOs working in HIV prevention and illustrated the range in involvement from none to drivers of the HIV response across MENA countries. There is no doubt that NGOs are the main actors in the implementation of HIV and harm reduction programs in the region, and therefore, there is a need to scale-up their role and provide support among countries in which their involvement and engagement is weak. Countries with the best examples of HIV and harm reduction responses in the region (such as Iran, Lebanon, Morocco, Pakistan, Tunisia) have an active number of NGOs who are primarily providing services to key populations and are involved in scaling up the response in coordination with governmental and other national stakeholders. In six countries out of the 20 (Iraq, Kuwait, Libya, Oman, Qatar, UAE), there is a non-existent to very limited role that NGOs play in the HIV and harm reduction response. Coincidentally, these countries do not provide comprehensive harm reduction programs that are tailored for key populations.

COVID-19

There is growing concern highlighted in the most recent World Drug Report (UNODC, 2020) of an increase in harmful patterns of drug use, whether through a switch to injecting or through more frequent injecting among users, as a result of the COVID-19 pandemic. Shortages of opioids due to COVID-19 restrictions, as well as a deteriorating financial situation as a result of these restrictions were among the concerns highlighted that may impact PWID. An increased risk of contracting COVID-19, as well as other diseases such as HIV and HCV, is presented with expected increases in IDU and sharing of injecting equipment as a result of drug shortages or safe injecting material shortages (UNODC, 2020). Civil society response to the pandemic in terms of maintaining harm reduction services has been very active. With lockdowns rendering closure of HTS, treatment and harm reduction service centers, the difficulty in reaching PWUD to ensure services are maintained increased. As a result, countries with available services swiftly adapted their services to ensure continuity. This included shifting counselling services to online platforms for psychosocial counselling, extending validity of OAT prescriptions, distribution of hygiene and personal protective equipment to PWUD and healthcare workers, distribution of harm reduction and safe injecting materials in larger quantities to decrease frequency of visits, as well as meeting other emergent needs (*communications with focal points*).

See [Table 2](#) on the following page for a regional harm reduction overview.

Table 2 MENA regional harm reduction overview.

Countries	Mention of harm reduction/ PWID in national policy documents	Availability of needle and syringe program	Needles and Syringes distributed per person who injected *	Availability of opioid agonist treatment
Afghanistan	HR policy adopted in NASP	Yes	112	MMT
Algeria	PWID noted as important KP in national plan	Yes	-	No
Bahrain	PWID noted as important KP in national plan	No	-	No
Egypt	HR policy adopted in NASP	Yes	1	No
Iran	HR policy adopted in NASP	Yes	43	MMT & BMT
Iraq	-	No	-	No
Jordan	PWID noted as important KP in national plan	Yes	-	No
Kuwait	-	No	-	BMT (integrated treatment program)
Lebanon	HR policy adopted in NASP	Yes	9	BMT
Libya	PWID noted as important KP in national plan	No	-	No
Morocco	HR policy adopted in NASP	Yes	109 (2018)	MMT
Oman	HR policy adopted in NASP & PWID noted as important KP in national plan	No	-	No
Pakistan	PWID noted as important KP in national plan	Yes	46 (2018)	No~
Palestine	HR policy adopted in NASP	Yes (limited)	-	MMT
Qatar	-	No	-	No
Saudi Arabia	-	No	-	No
Syria	PWID noted as important KP in national plan	No	-	No
Tunisia	PWID noted as important KP in national plan	Yes	49	No
UAE	-	No	-	MMT & BMT(integrated treatment program)
Yemen	-	No	-	No

Countries	Coverage of OAT % (year) *	Availability of drug consumption rooms	Availability of naloxone through community/peer distribution	Availability of OAT in prisons	Availability of NSP in prisons
Afghanistan	4.8 (2019)	No	Yes	Yes (1 prison)	No
Algeria	-	No	No	No	No
Bahrain	-	No	No	No	No
Egypt	-	No	No	No	Limited to released inmates & families
Iran	13.4 (2019)	No	Yes	Yes	No
Iraq	-	No	No	No	No
Jordan	-	No	No	No	No
Kuwait	-	No	No	No	No
Lebanon	49.7 (2015)	No	No	Yes	No
Libya	-	No	No	No	No
Morocco	42.3 (2018)	No	No	Yes	No
Oman	-	No	No	No	No
Pakistan	-	No	No	No	No
Palestine	-	No	No	Yes	No
Qatar	-	No	No	No	No
Saudi Arabia	-	No	No	No	No
Syria	-	No	No	No	No
Tunisia	-	No	No	No	No
UAE	-	No	No	No	No
Yemen	-	No	No	No	No

*Source: UNAIDS Info – data year most recent as of 2019 (aidsinfo.unaids.org)

~ Progress towards introducing OAT in 2020

MENA REGIONAL ADVOCACY BRIEF

KEY ACTIONS TO BE SUPPORTED



PRIORITY AREA 1: LAW AND SECURITY:

It is recommended for MENAHRA and international organizations to continue to support efforts for a revision of policies and legislation regarding the penalisation of drug use and promotion of regional and national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalisation of drug use.



PRIORITY AREA 2: EVIDENCE IN THE MENA REGION:

It is recommended for MENAHRA to support countries in ensuring that BBS, rapid assessment and service needs assessments are implemented regularly to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. This work can be supported via a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings.



PRIORITY AREA 3: STRATEGIC CHANGE IN THE HARM REDUCTION RESPONSE:

With technical assistance from MENAHRA and international organizations such as UNAIDS, WHO EMRO, UNODC, MENA Member States should build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and to cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration. There is a need to advocate for, scale-up the role of

NGOs and provide support among countries in which their involvement and engagement is weak. The lack of HIV & Harm Reduction Services funding plays a major role in the absence of services which has a direct impact on the risks, morbidity, mortality rate & the HIV/ Hepatitis C spread. It is recommended that MENAHRA, the UN family, the NGOs including the community led organizations to develop and implement a regional advocacy strategy to mobilize domestic resources precisely in national budgets.



PRIORITY AREA 4: NATIONAL STRATEGIES AND POLICIES PRIORITY:

It is recommended for MENAHRA to intensify advocacy and sensitization efforts with government partners, international organizations (UNAIDS, UNODC) and NGOs in Iraq, Kuwait, Qatar, Saudi Arabia, UAE, Yemen in order to achieve visibility of harm reduction and explicit reference to PWID/PWUD as key population in national HR/ NASP strategies. MENA countries are to be encouraged and supported to regularly update their Global AIDS reporting.



PRIORITY AREA 5: LEAVING NO-ONE BEHIND IN THE HARM REDUCTION AND BBV RESPONSE:

It is recommended for MENAHRA and international organizations that when planning or during scale up of harm reduction programmes to include not only PWID/PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.



PRIORITY AREA 6: NSP AND CONDOM PROGRAMMING:

It is recommended for MENAHRA and local partners to continue to lobby for initiation of NSP in Bahrain, Iraq, Kuwait, Libya, Oman, Qatar, Saudi Arabia, Syria, UAE and Yemen, and with increased operationalization with increased coverage, particularly in known hotspots, geographic areas containing converging key populations of PWID, CSW, MSM and migrants, and in prisons in Afghanistan, Algeria, Egypt, Jordan, Iran, Lebanon, Morocco, Palestine, Tunisia, and Pakistan. It is encouraging to see condom programming is reported in Iran, Egyptian and Algerian prisons with lessons learnt applicable to other MENA countries.



PRIORITY AREA 7: OAT PROGRAMMING:

It is recommended for MENAHRA and international organizations to continue to support countries in the OAT planning phase; Algeria, Egypt, Oman, Pakistan, and Tunisia to progress into community operationalization with strong monitoring, clinical audit and after care supports, in addition to supporting continued expansion for those countries actively providing OAT (Afghanistan, Iran, Kuwait, Lebanon, Morocco, Palestine, UAE). Consideration of MMT and BMT as treatment options is warranted, alongside prison and community continuum of care. Efforts to stimulate feasibility studies to support planning of OAT in the remainder countries is warranted (Bahrain, Iraq, Jordan, Libya, Qatar, Saudi Arabia, Syria, Yemen) to increase knowledge on evidence, efficacy and tackle concerns around diversion.



PRIORITY AREA 8: OVERDOSE PREVENTION:

It is recommended for MENAHRA and international organizations to continue to support countries in the planning of overdose prevention programming, and continued scale up in the existing three countries. Sensitization efforts are warranted to support initiation of DCR and naloxone in the MENA region.

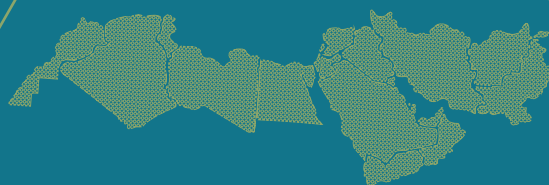


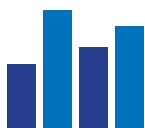
PRIORITY AREA 9: NGO AS KEY DRIVERS OF THE HARM REDUCTION RESPONSE:

It is recommended for MENAHRA and international organizations to support collaboration with government partners, and to scale-up the role of NGOs in the HIV and harm reduction response in all countries, and to provide support among countries in which their involvement and engagement is weak. MENAHRA should strengthen further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO.



HARM REDUCTION ADVOCACY BRIEF FOR AFGHANISTAN





WHAT IS THE CURRENT SITUATION IN AFGHANISTAN



DRUG USE

Afghanistan has an estimated total population of 38,042,000¹

The estimated number of PWID has been found to be highly variable among different meta-analysis studies, and ranges from an estimated 18,820 (12,435-23,000)² to as high as 139,000 (88,000-190,500)³!

Yet another study estimates that 1.6 million Afghans use drugs (mostly opium and heroin), the majority of which are male⁴

More comprehensive and updated national population size estimations for PWID are needed to determine and reach a consensus on realistic estimations!

Young PWID aged under 25 years account for 25.3% of the population with an average age of 28.3 years⁵!

Main drugs of use:

- Cannabis among men
- Opioids (opium, codeine, heroin) among women and children
- Benzodiazepines

Primary drugs of abuse among people in treatment: Opioids (heroin and opium) and cannabis

Injecting drug use:

- Prevalence of injecting drug use is estimated at 0.8% (0.5-1.09)⁶
- An estimated 109,500 (68,500-156,500) PWID inject on a **daily basis**, while another estimated 29,500 (11,500-53,000) inject less frequently⁷
- 94% of PWID reported the use of sterile injecting equipment during their last injection⁸

Unsafe injecting (shared needles and other injecting equipment) is the main transmission route of BBVs in Afghanistan

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 Rasekh et al., 2019

5 Hines et al., 2020

6 Larney et al., 2020

7 Colledge et al., 2020

8 UNAIDS Info, 2019



PLHIV AND KEY POPULATIONS

Estimated 7,200 (4,100-11,000) PLHIV, with an estimated 27% (11-92) PLHIV only aware of their status⁹

A large gap is noted in testing and awareness of PLHIV of their status although HIV testing is available throughout the country in six extension sites, but with low coverage

HIV prevalence among PWID is estimated at 4% indicating a concentrated epidemic¹⁰

Estimated HIV prevalence among SW (0.3%) and MSM (0.5%) is less concentrated¹¹

Estimated 0.6% median HIV prevalence among prisoners¹²

Estimated HBV prevalence of 6.6% among PWID in 2012¹³

Estimated 39,500 (23,000-60,000) PWID¹⁴ that are living with HCV

Estimated 4,360 (2,207-6,657) PWID¹⁵ that are chronically infected with HCV

Estimated 1.7% (1-4.6) HCV prevalence¹⁶ among prisoners

Injecting drug use is a driver of HIV among KPs in Afghanistan, and partially intersects with multiple and concurrent sexual partnerships, gender inequalities, and violence

Prisoners have been identified as KPs in Afghanistan due to unsafe injecting practices

Needle/Syringe programming efforts need to be introduced into prisons and scale up in the community to ensure high reported use of sterile injecting equipment to translate in the long run to decreased BBV among PWID



LAW ENFORCEMENT¹⁷

Drug Legislation: law allows possession of a specified amount of drugs

No reported information regarding mandatory treatment for drug useHarm reduction policy adopted in country NASP

9 UNAIDS Info, 2019

10 Larney et al., 2020

11 UNAIDS Info, 2019

12 Heijnen et al., 2016

13 World Drug Report – UNODC, 2020

14 Grebeley et al., 2018

15 Mahmud et al, 2020

16 Heijnen et al., 2016

17 Al-Shazly & Tinasti, 2016



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ NSPs available with estimated 112 needles/syringes distributed per PWID in 2019¹⁸
Double of the estimated 52 needles/syringes distributed per PWID in 2018!
- ✓ OAT available as MMT, including in 1 prison
Increase in OAT coverage from 3.2% in 2018 to 4.8% in 2019! Increase in OAT coverage from 3.2% in 2018 to 4.8% in 2019!¹⁹
- ✓ Naloxone community distribution available
- ✗ DCRs unavailable
- ✗ NSPs unavailable in prisons

Efforts in supporting combined prevention services of NSP and OAT have shown increases in estimated number of needles/syringes distributed per PWID and in percentage of OAT coverage

Harm reduction is funded by NGOs (such as OHRA) who are involved in advocating for KPs and providing screening, prevention and treatment services for HIV.

Challenges of the national HIV response include:

- Insufficient targeting of prevention
- Limited capacities for prevention, implementation and management
- Weak strategic information management, including absence of a comprehensive surveillance system on HIV and STIs and current reliance on data only available for KPs
- Weak community ownership and participation
- Insufficient scale up of treatment, care, and support

Scale-up of combined harm reduction interventions, including HCV services, with focus on increasing coverage of HIV testing services in collaboration with civil society and community actors in Afghanistan is needed to make progress towards the 90-90-90 targets

Introduction of NSP services into prisons and scale up of OAT in prisons can contribute to decreasing transmission of BBV among incarcerated PWID in Afghanistan, and make it a pioneer country in the region that is currently providing combined harm reduction prevention services in prison settings

¹⁸ UNAIDS Info, 2019

¹⁹ UNAIDS Info, 2019



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for the adoption of harm reduction policy in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

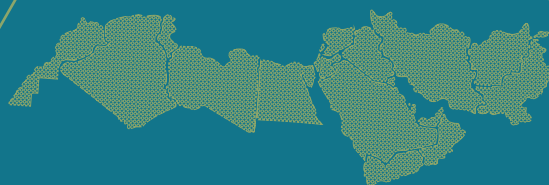
- Initiate sensitization on HCV and overdose within harm reduction programming
- Scale up of viral hepatitis prevention programming among youth and PWUD
- Scale up HIV testing services throughout the country, and increase sensitization on importance of testing to increase coverage and uptake
- Scale up OAT coverage to all prisons (currently available in 1 prison)
- Support sensitization and introduction of NSP in prison setting.
- Scale up existing naloxone programming through community/peer distribution.
- Continued provision of essential harm reduction services in the form of combined OAT and NSP services
- Continued support for the availability of NSP, with dedicated advocacy and measures to support the scale up of needles and syringes distributed per person who injected (currently 112/person; 2019).
- Consideration of MMT and BMT as treatment options is warranted, alongside prison and community continuum of care. Continue to support the availability and scale up coverage of OAT (currently 4.8%; 2019), specifically current provision of MMT, and expand choice to include BMT.
- Initiate sensitization around the evidence base of DCR
- Continued support for condom programming in community
- Focus efforts on tackling ATS, pharmaceutical and opioid use
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response

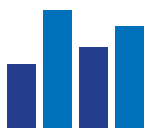
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities.

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM
REDUCTION
ADVOCACY
BRIEF
FOR ALGERIA





WHAT IS THE CURRENT SITUATION IN ALGERIA



DRUG USE

Algeria has an estimated total population of 43,053,000¹ with an estimated number of 40,961 (26,333-55,590) PWID².

Young PWID aged under 25 years account for 36.8% of the population with an average age of 30 years³!

Main drugs of use:

- Cannabis
- Psychotropic drugs (mainly sedatives)
- Opium

Common drugs injected: Subutex® and Heroin

Primary drugs of abuse among people in treatment: Cannabis and Amphetamines

Data on prevalence of injecting drug use in Algeria is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated 16,000 (15,000-17,000) PLHIV, with an estimated 76% (36-100) PLHIV aware of their status⁴, and an estimated 63.2% of PWID know their HIV status⁵

HIV prevalence among key populations calculated based on data from HTS centers⁶:

- PWID: 3.4%
- FSW: 4.2%
- MSM: 4.7%

Indicating a concentrated epidemic among these populations

Estimated HBV prevalence of 1.4% among PWID in 2018⁷

Estimated 14,220 (8,233-21,178) PWID⁸ that are chronically infected with HCV

Translating into an estimated 34.7% of PWID chronically infected with HCV

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 UNAIDS Info, 2019

6 Global AIDS Monitoring Report, 2018

7 World Drug Report – UNODC, 2020

8 Mahmud et al, 2020



LAW ENFORCEMENT⁹

Punitive legislation: Law differentiates between possession and consumption. Punishable by imprisonment between 2 months-2 years, and a fine.

Mandatory treatment: Law states prevention and treatment before penal measures making treatment basis of legal response to drug use. Sanctions are not enforced if and until treatment, which may include detoxification and rehabilitation, is refused.



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID noted as an important KP in the 2020-2024 NASP
- ✓ NSPs available
- ✗ OAT unavailable
- ✗ Naloxone community distribution unavailable
- ✗ NSP and OAT unavailable in prisons
- ✗ DCRs unavailable

Algeria is planning on introducing OAT in 2020 under the authorization of the 2016 Algerian National Strategic Plan for MMT provision, and is making progress on this issue

The Global Fund remains the sole funder of the combined prevention program for PWID which includes a package of services including information, support for screening and treatment services, condoms, lubricant and harm reduction equipment. **However, the country is in its transition period and there is a need to ensure sustainability of these services!**

NGOs are essential partners in the HIV response and involved in prevention efforts including condom distribution and psychosocial support for PLHIV and KPs.

Scale-up and introduction of comprehensive harm reduction interventions, including HCV services, in collaboration with civil society and community actors in Algeria can contribute further to the achievement of the 90-90-90 targets, making it a pioneer country in the region in this area

⁹ Al-Shazly & Tinasti, 2016



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Support the strengthened political commitment to tackle HIV with focus on key populations
- Continued support for the inclusion of PWID as key population in the national strategic plan, with advocacy for explicit mention of harm reduction in the plan
- Advocacy to ensure sustainability and possible scale-up of the combined prevention program for PWID post-transition
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and mandatory treatment
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

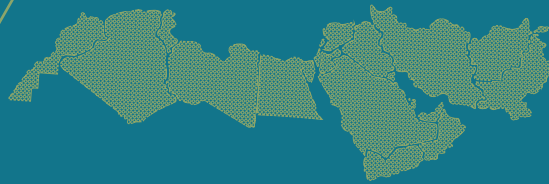
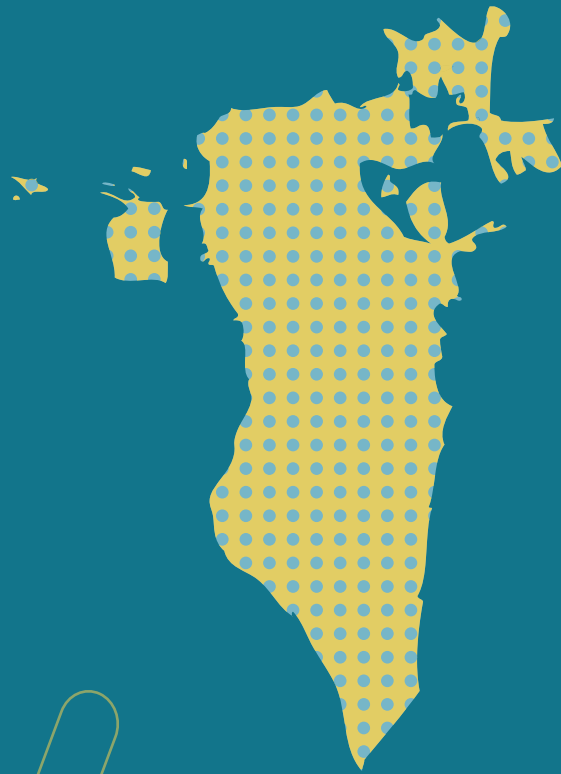
- Continued planning of OAT and achieve operationalization
- Initiate sensitization on highlighting HCV services within harm reduction programs
- Support sensitization and planning for OAT in the prison setting.
- Support sensitization and planning for NSP in prison setting.
- Support sensitization and planning for naloxone programming through community/peer distribution.
- Support sensitization and planning for operationalization of essential harm reduction services in the form of combined OAT and NSP services
- Ensure continued availability and scale up of NSP into a third region, with dedicated advocacy and measures to support reporting of needles and syringes distributed per person who injected (no data; 2019).
- Initiate sensitization around the evidence base of DCR
- Continued support for condom programming in the prison setting
- Focus efforts on tackling ATS, pharmaceutical and opioid use

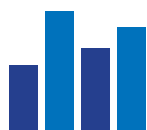
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug detoxification modalities.

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Continued regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM REDUCTION ADVOCACY BRIEF FOR BAHRAIN





WHAT IS THE CURRENT SITUATION IN BAHRAIN?



DRUG USE

Bahrain has an estimated total population of 1,641,000¹ with an estimated number of 1,937 (1,369-15,506) PWID².

The average age profile of PWID population is not known in Bahrain³, more research is needed to determine the characteristics of this population for informed programming

Common drugs injected: heroin, amphetamines, cocaine

Data on prevalence of injecting drug use in Bahrain is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV is unknown, and there is a lack of data on the progress towards the 90-90-90 targets⁴

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV on treatment, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

HIV prevalence among PWID is estimated at 4.6% indicating a concentrated epidemic⁵

Estimated HBV prevalence of 0% among PWID in 2018⁶

Estimated 672 (428-5,907) PWID⁷ that are chronically infected with HCV

Estimated HIV, HBV, and HCV prevalence among other KPs is not available⁸

Mandatory HIV and viral hepatitis testing is available at the addiction treatment hospital and for prisoners but not available at the community level

Needle sharing is reported anecdotally along with diversion of needles from hospital waste, emergency departments and purchasing from people with diabetes

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 Larney et al., 2020

6 World Drug Report – UNODC, 2020

7 Mahmud et al., 2020

8 UNAIDS Info, 2019



LAW ENFORCEMENT⁹

Punitive legislation: law does not sanction personal consumption but possession, procurement, or purchase of drugs for personal use is punishable with imprisonment of at least 6 months and a fine

Mandatory treatment: court may order admittance to hospital for treatment in addition to sanctions for possession. Completing treatment does not exempt offenders from their sentence and are sent to prison after release from treatment

Death sentences for individuals involved in drug trafficking and smuggling were confirmed in 2018¹⁰

Drug offenders that have completed their treatment are exposed to additional and renewed risks of relapsing due to sentencing to prison after treatment – advocacy for less punitive legislation, especially imprisonment after mandatory treatment is crucial!



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID noted as an important KP in the country NASP but has not been updated since 2010
- ✗ NSPs unavailable
- ✗ OAT unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Bahrain and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs

There are several active NGOs in the field of HIV that can become partners and pioneers in a harm reduction response in Bahrain.

⁹ Al-Shazly & Tinasti, 2016

¹⁰ Girelli, 2019

Introduction of harm reduction services in Bahrain in an evidence-based manner, coupled with increased generation of data and information, in collaboration with civil society and community actors presents an important opportunity in developing model programs to limit the spread of BBVs among KPs in general and PWID in specific



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Support for the development of an updated country NASP with continued inclusion of PWID as a key population
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and death sentences for drug offenses
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

- Initiate sensitization on HCV and overdose within harm reduction programming
- Support sensitization and planning for voluntary HIV testing in the community
- Support sensitization and planning for naloxone programming through community/peer distribution.
- Support sensitization and planning for operationalization of essential harm reduction services in the form of combined OAT and NSP services
- Support sensitization and planning for NSP in the community and in prisons
- Support sensitization and planning for OAT in the community and in prisons. Include feasibility studies to support planning.
- Initiate sensitization around the evidence base of DCR
- Focus efforts on tackling heroin, ATS, and cocaine use
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response

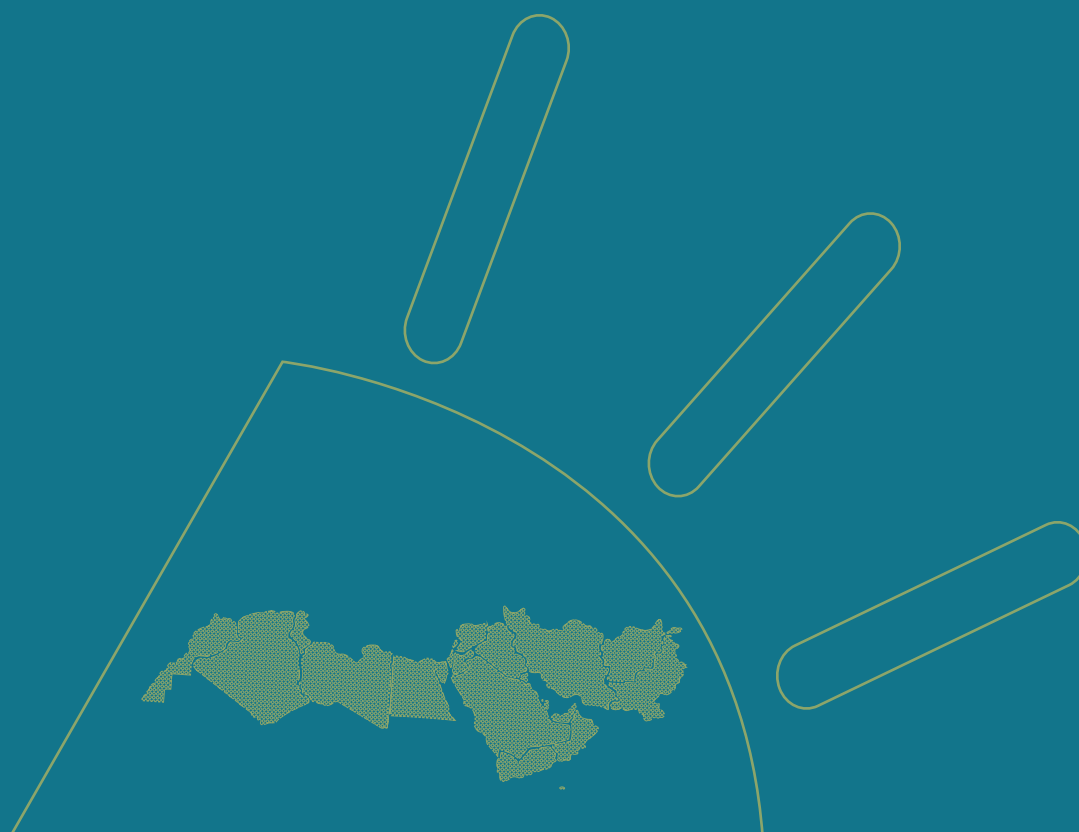
- If planning harm reduction programs ensure to include not only PWID/PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Include dual diagnosis support within drug detoxification modalities.

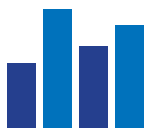
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR EGYPT





WHAT IS THE CURRENT SITUATION IN EGYPT



DRUG USE

Egypt has an estimated total population of 100,388,000¹ with an estimated number of 90,809 (71,485-119,633) PWID².

The average age profile of PWID population is not known in Egypt³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Captagon
- Pharmaceutical opioids (tramadol)
- Heroin

Primary drugs of abuse among people in treatment: Cannabis, opioids, and ATS

Data on common drugs injected and prevalence of injecting drug use in Egypt is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated 22,000 (20,000-24,000) PLHIV, and the percentage of PLHIV that are aware of their status is unknown; however, an estimated 95.4% PWID know their HIV status has been reported⁴

A large gap is noted in testing and awareness of PLHIV of their status, as well as reporting on this indicator

HIV testing is available through government led centers that have been trained to be user friendly

HIV prevalence among key populations:

- PWID: 2.6%⁵
- SW: 2.8%⁶
- MSM: 6.7%⁷

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 Larney et al., 2020

6 UNAIDS Info, 2019

7 UNAIDS Info, 2019

Estimated **HBV prevalence of 2.6% among PWID** in 2014⁸

Estimated **HCV prevalence of 37.1% among PWID**⁹

Estimated **32,997** (15,102-61,499) PWID¹⁰ that are chronically infected with **HCV**

Estimated **23.6%** (15.8-31.4) **HCV prevalence**¹¹ among **prisoners**

Prisoners have been identified as KPs with concentrated HCV epidemics in Egypt due to unsafe injecting practices that includes tattooing, injecting drug use, and sharing of non-sterile toiletries

Needle/Syringe programming efforts need to be introduced into prisons and scaled up in the community to ensure high reported use of sterile injecting equipment to translate in the long run to decreased BBV among PWID



LAW ENFORCEMENT¹²

Punitive legislation: law against possession, procurement, or purchase of drug, and cultivation of plants from which drugs can be extracted punishable by imprisonment between 3 to 15 years and a fine. Law does not include punishing PWUD if in possession of any quantity

Mandatory treatment: law states alternative of commitment to treatment instead of imprisonment and a fine. If treatment is not successful, remaining sentence time is served in custody

Legislation protecting PWUD confidentiality: law specifies confidentiality of data to workers in drug treatment centers. Any disclosure is punishable.

Death sentences for drug offenses were pronounced for 23 people in 2018, 1 of which was a foreign national¹³

Legislation indicates concern for PWUD and treatment, however further advocacy for policy change for clearer support for PWUD rights and removal of mandatory treatment and death sentencing is needed

8 World Drug Report – UNODC, 2020

9 Mahmud et al, 2020

10 Mahmud et al, 2020

11 Heijnen et al., 2016

12 Al-Shazly & Tinasti, 2016

13 Girelli, 2019



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ Harm reduction policy adopted in country NASP
- ✓ NSPs available with estimated 1 needles/syringes distributed per PWID in 2019¹⁴

NSP availability in prisons is limited to released inmates and families

- ✗ OAT unavailable, however a feasibility study has been completed
- ✗ Naloxone community distribution unavailable
- ✗ DCRs unavailable

Efforts for the operationalization of OAT in the country and scaling up of NSPs need to be enhanced to ensure availability of these services

Several NGOs have experience in providing condom promotion, HIV testing and counseling, and NSP for PWID in large cities, however have been limited in activity due to governmental restrictions. NGOs are active in advocating for harm reduction and drug user rights.

Scale-up of combined harm reduction interventions, including HCV services, with focus on increasing coverage of HIV testing services in collaboration with civil society and community actors in Afghanistan is needed to make progress towards the 90-90-90 targets

Introduction of NSP services into prisons and scale up of OAT in prisons can contribute to decreasing transmission of BBV among incarcerated PWID in Afghanistan, and make it a pioneer country in the region that is currently providing combined harm reduction prevention services in prison settings



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for the adoption of harm reduction policy in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and death sentencing for drug offenses

¹⁴ UNAIDS Info, 2019

- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

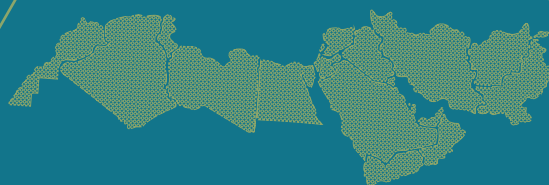
Harm reduction and treatment services and programming:

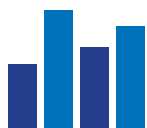
- Continue and scale up HCV efforts and advocate to integrate within harm reduction programming
- Continued support to ensure that HIV testing centers that are government-led remain user friendly to key populations, with support to introduce community led testing centers
- Scale up the BBV testing and counseling program in prisons
- Scale up condom programming in prisons
- Sensitize and plan for naloxone programming through community/peer distribution.
- Introduce NSP in prisons and scale up NSP for released inmates in the community
- Continued support for the availability of NSP, with dedicated advocacy and measures to support use of sterile injecting equipment (31.5%; use at last injection 2015), and scale up of needles and syringes distributed per person who injected (currently 1/person; 2019).
- Support continued planning for OAT provision in the community and in prisons.
- Initiate sensitization around the evidence base of DCR
- Focus efforts on tackling Captagon, ATS, pharmaceutical (Tramadol), synthetic cannabinoid and opioid use
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities.

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM REDUCTION ADVOCACY BRIEF FOR IRAN





WHAT IS THE CURRENT SITUATION IN IRAN



DRUG USE

Iran has an estimated total population of 82,914,000¹

The estimated number of PWID has been found to be variable among different meta-analysis studies, and ranges from an estimated 158,000 (107,000-209,000)² to 185,000 (135,000-300,500)³

Young PWID aged under 25 years account for 14.9% of the population with an average age of 32.7 years⁴

Main drugs of use:

- Opioids
- Cannabis
- ATS
- Methamphetamine
- Pharmaceutical opioids (tramadol)

Injecting drug use:

- Prevalence of injecting drug use is estimated at 0.28% (0.19-0.37)⁵
- An estimated 156,000 (108,500-208,000) PWID inject on a **daily basis**, while another estimated 1,000 (<500-3,000) inject less frequently⁶
- 73.4% of PWID reported the use of sterile injecting equipment during their last injection⁷

Unsafe injecting (shared needles and other injecting equipment) can become a main transmission route of BBVs in Iran, especially with the reported figure of 98.7% of PWID that inject on a daily basis

1 UN population division, 2019

2 Hines et al., 2020

3 Mahmud et al., 2020

4 Hines et al., 2020

5 Larney et al., 2020

6 Colledge et al., 2020

7 UNAIDS Info, 2019



PLHIV AND KEY POPULATIONS

Estimated 61,000 (34,000-120,000) **PLHIV**, with an estimated 37% (20-79) PLHIV only aware of their status⁸

A large gap is noted in testing and awareness of PLHIV of their status although HIV testing and counseling is available throughout the country

HIV prevalence among PWID is estimated at 14% indicating a concentrated epidemic⁹

Estimated **HIV prevalence** among SW at 2.1% is less concentrated¹⁰

Estimated **HBV prevalence of 3.6% among PWID** in 2011¹¹

Estimated **HCV prevalence of 52.6% among PWID**¹²

Estimated 52,000 (29,500-81,000) PWID¹³ that are living with **HCV**

Another study estimated 68,526 (45,252-121,475) PWID¹⁴ that are chronically infected with **HCV**

Estimated **37.8% (2.7-80.5) HCV prevalence**¹⁵ among **prisoners**

Recent positive shifts in decrease in prevalence rate of HIV among PWID, FSW, and prisoners has been observed, but harm reduction efforts need to be maintained to ensure further progress

The high coverage of harm reduction is currently not considered sufficient to prevent HCV transmission in Iran

Needle/Syringe programming needs to be re-introduced into prisons and scaled up in the community to ensure high reported use of sterile injecting equipment to translate in the long run to decreased BBV among PWID



LAW ENFORCEMENT¹⁶

Drug Legislation: drug possession for personal use and consumption are classified as non-criminal offenses

8 UNAIDS Info, 2019

9 Larney et al., 2020

10 UNAIDS Info, 2019

11 World Drug Report – UNODC, 2020

12 Mahmud et al, 2020

13 Grebeley et al., 2018

14 Mahmud et al, 2020

15 Heijnen et al., 2016

16 Al-Shazly & Tinasti, 2016



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ Harm reduction policy adopted in country NASP
- ✓ NSPs available with estimated 43 needles/syringes distributed per PWID in 2019¹⁷
- ✓ OAT available as MMT and BMT, including in prisons (coverage at 13.4% in 2019)¹⁸
- ✓ Naloxone community distribution available
- ✗ DCRs unavailable
- ✗ NSPs no longer available in prisons

Efforts in supporting combined prevention services of NSP and OAT need to be reinforced to increase number of needles/syringes distributed per PWID and percentage of OAT coverage

A large number of NGOs are active in the harm reduction and HIV response, however, an analysis of HIV/AIDS policy in Iran raised the importance of facilitating increased participation of NGO/CSO actors in the policy process¹⁹

Scale-up of combined harm reduction interventions, including HCV services, with focus on increasing coverage of HIV testing services in collaboration with civil society and community actors in Iran is needed to make progress towards the 90-90-90 targets

Re-introduction of NSP services into prisons and scale up of NSP and OAT in prisons and in the community can contribute to decreasing HIV and HCV prevalence among PWID in Iran, to reclaim its “forerunner” reputation in harm reduction in the MENA region

¹⁷ UNAIDS Info, 2019

¹⁸ UNAIDS Info, 2019

¹⁹ Khodayari-Zarnaq et al., 2019



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for the adoption of harm reduction policy in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use, and against death penalties for drug offenses
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

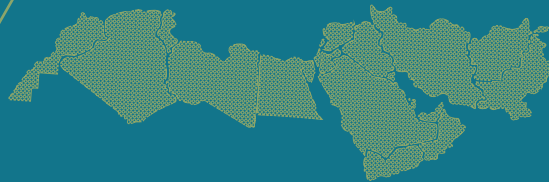
- Initiate sensitization on HCV and overdose within harm reduction programming
- Scale up of viral hepatitis prevention programming among youth and PWUD
- Scale up in outreach teams and harm reduction services for PWID
- Scale up OAT in all prisons
- Support the re-introduction of NSP in prisons
- Scale up existing naloxone programming through community/peer distribution.
- Continued provision of integrated ART within OAT services
- Continued provision of essential harm reduction services in the form of combined OAT and NSP services
- Continued support for the availability of NSP, with dedicated advocacy and measures to support the scale up of needles and syringes distributed per person who injected (currently 43/person; 2019).
- Continued support for and scale up of MMT, BMT, and opium tincture as treatment options is warranted, alongside prison and community continuum of care. Continue to support the availability and coverage of OAT (currently 13.4%; 2019),
- Initiate sensitization around the evidence base of DCR
- Scale up condom programming in all settings
- Focus efforts on tackling cannabis, synthetic cannabis, ATS, methamphetamine, pharmaceutical and opioid use

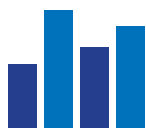
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities.

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM REDUCTION ADVOCACY BRIEF FOR IRAQ





WHAT IS THE CURRENT SITUATION IN IRAQ



DRUG USE

Iraq has an estimated total population of 39,310,000¹ with an estimated number of 34,673 (23,115-46,230) PWID².

Main drugs of use:

- Prescription drugs
- Alcohol
- Cannabis

Data on type and prevalence of injecting drug use in Bahrain is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV is unknown, and there is a lack of data on the progress towards the 90-90-90 targets³

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV on treatment, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

HIV and HBV prevalence among PWID are unknown^{4, 5}

Estimated 12,037 (7,227-17,612) PWID⁶ that are chronically infected with HCV

Estimated HIV, HBV, and HCV prevalence among other KPs is not available⁷

Although HIV testing services are reported to be widely available in the country, detecting HIV prevalence has been limited to case-finding in Iraq

Data on BBV prevalence of general population as well as key populations is severely lacking; concentrated efforts in research and evidence-based reporting are needed

1 UN population division, 2019

2 Mahmud et al., 2020

3 UNAIDS Info, 2019

4 Larney et al., 2020

5 World Drug Report – UNODC, 2020

6 Mahmud et al., 2020

7 UNAIDS Info, 2019



LAW ENFORCEMENT⁸

Punitive legislation: law does not sanction consumption but possession is punishable with imprisonment up to 15 years, or 3 years and a fine

Mandatory treatment: court may impose mandatory treatment up to 6 months in a health center assigned by the ministry as an alternative to custody if drug dependence is caused by a medical condition. If drug use is not a result of a medical condition, admission into treatment can be ordered but criminal sanctions will also be imposed

Four death sentences were imposed for drug offences in 2017⁹

Drug offenders that have completed their treatment are exposed to additional and renewed risks of relapsing if criminal sanctions are imposed during or after treatment – advocacy for less punitive legislation is crucial!



WHAT IS BEING DONE IN HARM REDUCTION?

- ✗ No mention of harm reduction or PWID in national policy documents
- ✗ NSPs unavailable
- ✗ OAT unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Iraq and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs

NGOs have a very limited role in Iraq, and therefore there might be a need to strengthen the civil society sector in order to improve the response

Introduction of harm reduction services in Iraq in an evidence-based manner, coupled with increased generation of data and information, in collaboration with civil society and community actors presents an important opportunity in developing model programs in the HIV and harm reduction response

⁸ Al-Shazly & Tinasti, 2016

⁹ Girelli, 2019



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Support sensitization of PWID and other key populations in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use, mandatory drug treatment, and death sentencing for drug offences
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

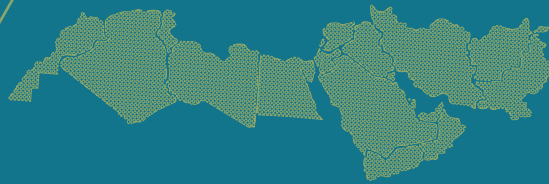
- Initiate sensitization on viral hepatitis prevention programming among youth and PWUD
- Continued support for HIV testing services, especially voluntary counseling and testing in the community
- Initiate sensitization on essential harm reduction services in the form of combined OAT and NSP services
- Focus efforts on tackling prescription drugs, synthetic cannabinoids, alcohol, and cannabis use

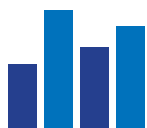
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Support sensitization of harm reduction evidence, policy and programming in the country, and conduct feasibility studies
- Support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR JORDAN





WHAT IS THE CURRENT SITUATION IN JORDAN



DRUG USE

Jordan has an estimated total population of 10,102,000¹ with an estimated number of 4,850 (3,200-6,500) PWID².

The average age profile of PWID population is not known in Jordan³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Synthetic cannabinoids
- Gabapentinoid
- Pregabalin

Primary drugs of abuse among people in treatment: amphetamines, opioids (heroin, pharmaceutical opioids, LSD

Common drugs injected: Heroin

Data on prevalence of injecting drug use in Jordan is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV is less than 500, and there is a lack of data on estimations of PLHIV who know their status⁴

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

HIV and HBV prevalence among PWID are unknown^{5,6}

Estimated 1,684 (1,001-2,476) PWID⁷ that are chronically infected with HCV

Estimated HIV prevalence among SWs and MSM are 0.5% and 0.2% respectively⁸

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 Larney et al., 2020

6 World Drug Report – UNODC, 2020

7 Mahmud et al., 2020

8 UNAIDS Info, 2019

HIV testing is available through governmental health centers throughout the country, and in one NGO in Amman at the community level



LAW ENFORCEMENT⁹

Punitive legislation: law punishes consumption, possession, or procurement for consumption, in addition to planting or purchasing any plant that produces drugs with imprisonment of 1-2 years and a fine

Mandatory treatment: law requires PWUD to voluntarily inform official authorities of a request for treatment before being caught by illegal activity

Drug law specifies confidentiality of identity and information related to PWUD in treatment



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID noted as an important KP in the country NASP
- ✓ NSP available (limited)
- ✗ NSP unavailable in prisons
- ✗ OAT unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

Harm reduction services in Jordan can be said to be non-existent with the exception of one limited NSP.

NGOs in Jordan are active in the HIV response and in key population programs. One NGO is specifically providing voluntary testing and counseling for HIV, HCV and HBV to PWID, as well as NSP services when possible.

Introduction of combined harm reduction services in Jordan in an evidence-based manner, coupled with increased generation of data and information, in collaboration with civil society and community actors presents an important opportunity in developing model programs to limit the spread of BBVs among KPs in general and PWID in specific

⁹ Al-Shazly & Tinasti, 2016



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for PWID as a key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and mandatory treatment

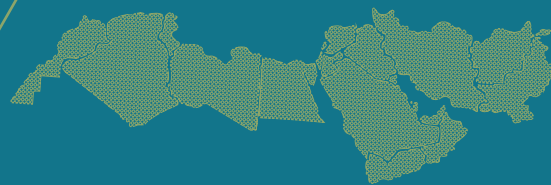
Harm reduction and treatment services and programming:

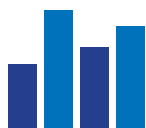
- Initiate sensitization on HCV and overdose within harm reduction programming
- Scale up voluntary HIV testing in the community
- Advocate for and sensitize for a range of harm reduction policies and programs spanning community and prison settings. Support for feasibility studies
- Scale up existing NSP and counter recent funding cuts
- Focus efforts on tackling synthetic cannabinoids, GABA drugs, amphetamines, pharmaceutical and opioid use

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM REDUCTION ADVOCACY BRIEF FOR KUWAIT





WHAT IS THE CURRENT SITUATION IN KUWAIT



DRUG USE

Kuwait has an estimated total population of 4,207,000¹ with an estimated number of 4,050 (1,850-8,750) PWID².

The average age profile of PWID population is not known in Kuwait³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Captagon
- Synthetic cannabinoids
- Methamphetamine
- Tramadol
- Heroin
- Ketamine
- Substances producing alcoholic effects

Primary drugs of abuse among people in treatment: opioids, cannabis, ATS, tranquilizers and sedatives, solvents and inhalers, cocaine

Data on type and prevalence of injecting drug use in Kuwait is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of **PLHIV** is 640 (580-700), with an estimated 67% (60-73) of PLHIV who know their status⁴, and an estimated 100% of PWID know their HIV status⁵

HIV prevalence among PWID is **unknown**⁶

Estimated **HBV** prevalence of 0.38% among PWID in 2017⁷

¹ UN population division, 2019

² Mahmud et al., 2020

³ Hines et al., 2020

⁴ UNAIDS Info, 2019

⁵ UNAIDS Info, 2019

⁶ Larney et al., 2020

⁷ World Drug Report – UNODC, 2020

Estimated 1,406 (578-3,334) PWID⁸ that are chronically infected with HCV

Estimated HIV and HCV prevalence among other KPs is not available⁹

HIV testing services have been introduced, with provision of anonymous rapid 4th generation HIV tests, counseling, and online services

Results of a recent cross-sectional study on 521 people admitted for drug treatment in hospital indicated high rates of HBV, HCV, and HIV among PWID compared to the general population¹⁰

High rates of injection equipment sharing have been reported in 2015, along with high sexual activity by stimulant users¹¹



LAW ENFORCEMENT¹²

Punitive legislation: law against possession, procurement, or purchase for personal consumption with imprisonment up to 10 years and a fine. No sanctions on PWUD who are not in possession of substances

Drug law specifies professional confidentiality for people in addiction treatment



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ BMT as integrated treatment program available
- ✗ No mention of harm reduction or PWID in national policy documents
- ✗ NSPs unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No comprehensive combined harm reduction services are available in Kuwait yet and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs

Steps towards implementation of NSP and extension of OAT using BMT, as well as introduction of PrEP and PEP have been progressing

NGOs are not active in the fields of HIV and Key Populations

8 Mahmud et al, 2020

9 UNAIDS Info, 2019

10 Altawalah et al., 2019

11 Kuwait MOH, 2015

12 Al-Shazly & Tinasti, 2016

Introduction of comprehensive and combined harm reduction services in Kuwait in an evidence-based manner, coupled with increased generation of data and information, presents an important opportunity in developing model programs to limit the spread of BBVs among KPs in general and PWID in specific



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Advocate to include PWID as key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use

Harm reduction and treatment services and programming:

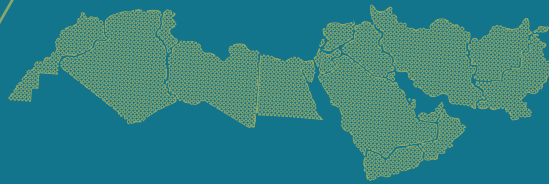
- Initiate sensitization on HCV within HIV and harm reduction programming
- Continued support for voluntary HIV testing and counselling in the community
- Support sensitization and planning for NSPs
- Scale up existing BMT coverage and expand the choice to include MMT
- Advocate for and sensitize for a range of harm reduction policies and programs spanning community and prisons settings. Support for feasibility studies
- Focus efforts on tackling synthetic cannabinoids, methamphetamines, pharmaceutical opioids and heroin use

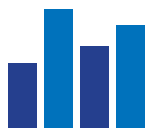
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR LEBANON





WHAT IS THE CURRENT SITUATION IN LEBANON



DRUG USE

Lebanon has an estimated total population of 6,856,000¹ with an estimated number of 3,207 (1,506-4,908) PWID².

Young PWID aged under 25 years account for 17.3% of the population with an average age of 29.5 years³!

Main drugs of use:

- Marijuana
- Hashish
- Heroin
- Cocaine
- ATS
- Synthetic drugs such as Captagon
- Salvia

Primary drugs of abuse among people in treatment: Opioids (heroin, pharmaceutical opioids), cannabis, cocaine, ATS, benzodiazepines

Injecting drug use:

- An estimated 2,500 (1,500-4,000) PWID inject on a daily basis, while another estimated 2,500 (1,000-3,500) inject less frequently⁴
- 98.5% of PWID reported the use of sterile injecting equipment during their last injection in 2014⁵

More studies and data generation are crucial to update population size estimations and explore current trends in use of sterile injecting equipment

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 Colledge et al., 2020

5 UNAIDS Info, 2019



PLHIV AND KEY POPULATIONS

Estimated 2,500 (2,200-2,800) **PLHIV**, with an estimated 91% (51-100) PLHIV aware of their status⁶; however estimates of PWID that know their HIV status are unavailable⁷

HIV prevalence among **PWID and SWs** is reported to be **0%**

HIV prevalence among **MSM** is estimated at **12%**, indicating a concentrated epidemic

HIV prevalence among **Prisoners** is estimated at **0.1%**

Estimated **HBV prevalence of 2% among PWID** in 2015⁸

HCV prevalence among **PWID** is estimated at **17.6% (10.5-25.2)**⁹

Estimated **565 (47-1,884) PWID**¹⁰ that are chronically infected with **HCV**

Estimated **28.1% (3.4-52.8) HCV prevalence**¹¹ among **prisoners**

Around 100 HIV testing centers operate throughout the country, with 87% of facilities providing on-site testing for viral hepatitis

Injecting drug use is a driver of HCV among PWID in Lebanon, and harm reduction efforts need to be maintained to decrease its spread and maintain the low HIV prevalence among PWID and SWs



LAW ENFORCEMENT¹²

Punitive legislation: Law punishes possession, procurement, or purchase of drugs for consumption with imprisonment between 3 months and 3 years and a fine. Punishment with the same sanction is applied for people that do not abide by court-imposed treatment procedures

Mandatory treatment: offender may ask for referral to the Drug Addiction Committee for follow-up and referral to treatment in lieu of penal measures

A reported decrease (~49%) of heroin users arrested in 2019 when compared to 2016 has been noted. Contributing factors include scaled up OAT implementation, and the decision by the legal authorities to refer addicts to treatment instead of prison¹³

6 UNAIDS Info, 2019

7 UNAIDS Info, 2019

8 World Drug Report – UNODC, 2020

9 Larney et al., 2020

10 Mahmud et al, 2020

11 Heijnen et al., 2016

12 Al-Shazly & Tinasti, 2016

13 Khalaf et al., 2019



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ Harm Reduction policy adopted in NASP
- ✓ NSPs available with estimated 9 needles/syringes distributed per PWID in 2019¹⁴
- ✓ OAT available as BMT, and in prisons but limited to people previously enrolled before incarceration
- ✗ Naloxone community distribution unavailable
- ✗ NSP unavailable in prisons
- ✗ DCRs unavailable

More than 50% of HIV programs for PWID are estimated to be provided by NGOs. NGOs are active in provision of harm reduction services, including OAT support services, and advocacy. NSP is provided by one NGO (SIDC) through a drop in center

Scale-up of combined harm reduction interventions in the community and in prisons, including community naloxone distribution, in collaboration with civil society and community actors in Lebanon is crucial in maintaining the noted progress of the response



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for the adoption of harm reduction policy in the country NASP, as well as the inter-ministerial mental health and substance use response strategy
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and mandatory treatment
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

¹⁴ UNAIDS Info, 2019

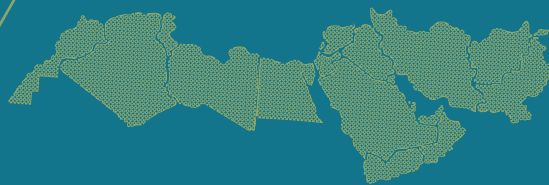
Harm reduction and treatment services and programming:

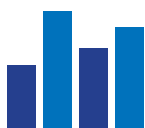
- Continue and scale up viral hepatitis services within harm reduction programs, through maintaining HBV and HCV testing and referral, and HBV vaccination programs for key populations
- Scale up OAT in all prisons, and include initiation of OAT within prisons
- Support sensitization for and introduction of NSP in prison setting.
- Continued support for overdose programming efforts that include initiation of naloxone programming through community/peer distribution.
- Continued support for HIV testing and counseling services in the community and in prisons
- Continued provision of essential harm reduction services in the form of combined OAT and NSP services
- Continued support for the availability and scale up of NSP, with dedicated advocacy and measures to support scale up of needles and syringes distributed per person who injected (currently 9/person; 2019).
- Continued support for the availability and coverage of OAT, specifically BMT (currently 49.7%; 2019), and expand choice to include MMT
- Initiate sensitization around the evidence base of DCR
- Continued support for condom programming in the community
- Focus efforts on tackling ATS, Captagon, Salvia, synthetic drugs, pharmaceutical and opioid use
- Introduce accurate and comprehensive sexual health and harm reduction education and promotion
- Ensure availability of PrEP for free to all key populations
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response
- When planning or during scale up of harm reduction programs ensure to include not only PWID/PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM REDUCTION
ADVOCACY BRIEF
FOR LIBYA





WHAT IS THE CURRENT SITUATION IN LIBYA



DRUG USE

Libya has an estimated total population of 6,777,000¹

The estimated number of PWID has been found to be slightly different among different meta-analysis studies, and ranges from an estimated 2,000 (1,000-3,000)² to an estimated 4,446 (2,948-5,943)³

Main drugs of use:

- Hashish
- Hallucinogens (ecstasy)
- Artane (trihexyphenidyl)
- Clonazepam
- Sleeping pills
- Tramadol

Main drugs of use:

- Prevalence of injecting drug use is estimated at 0.05% (0.01-0.10)⁴
- An estimated 1,000 (500-1,500) PWID inject on a **daily basis**, while another estimated 1,000 (500-1,500) inject less frequently⁵



PLHIV AND KEY POPULATIONS

Estimated 9,200 (8,300-10,000) PLHIV, however, the percentage of PLHIV that are aware of their status is **unknown**⁶

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

HIV prevalence among PWID is estimated at 89.6%⁷, the highest among countries in the region

Estimated HIV prevalence among MSM (3.1%) is less concentrated⁸

1 UN population division, 2019

2 Hines et al., 2020

3 Mahmud et al., 2020

4 Larney et al., 2020

5 Colledge et al., 2020

6 UNAIDS Info, 2019

7 Larney et al., 2020

8 UNAIDS Info, 2019

Estimated 18% HIV prevalence among prisoners⁹

Estimated HBV prevalence of 4.5% among PWID in 2010¹⁰

Estimated 1,500 (500-2,000) PWID¹¹ that are living with HCV

Estimated 2,949 (1,885-4,047) PWID¹² that are chronically infected with HCV

Estimated 23.7% HCV prevalence¹³ among prisoners

Although HIV testing services are available in the country, only a few facilities providing these services exist



LAW ENFORCEMENT¹⁴

Punitive legislation: law differentiates between possession and consumption. Both punished by imprisonment up to 2 years and a fine.

Mandatory treatment: court may order admission to treatment centers instead of criminal sanctions. Mandated treatment period is 6 months to one year



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID noted as an important key population in the country NASP
- ✗ NSPs unavailable
- ✗ OAT unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Libya and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to decrease HIV prevalence among PWID, as well transmission of other BBVs

NGOs have a very limited role in Libya, and therefore there might be a need to strengthen the civil society sector in order to improve the response

Introduction of harm reduction services in Libya in an evidence-based manner, coupled with increased generation of data and information, in collaboration with civil society and community actors presents an important opportunity in developing model programs in the HIV and harm reduction response

⁹ Heijnen et al., 2016

¹⁰ World Drug Report – UNODC, 2020

¹¹ Grebeley et al., 2018

¹² Mahmud et al., 2020

¹³ Heijnen et al., 2016

¹⁴ Al-Shazly & Tinasti, 2016



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continue to support inclusion of PWID as a key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use, mandatory drug treatment, and death penalty for drug offences

Harm reduction and treatment services and programming:

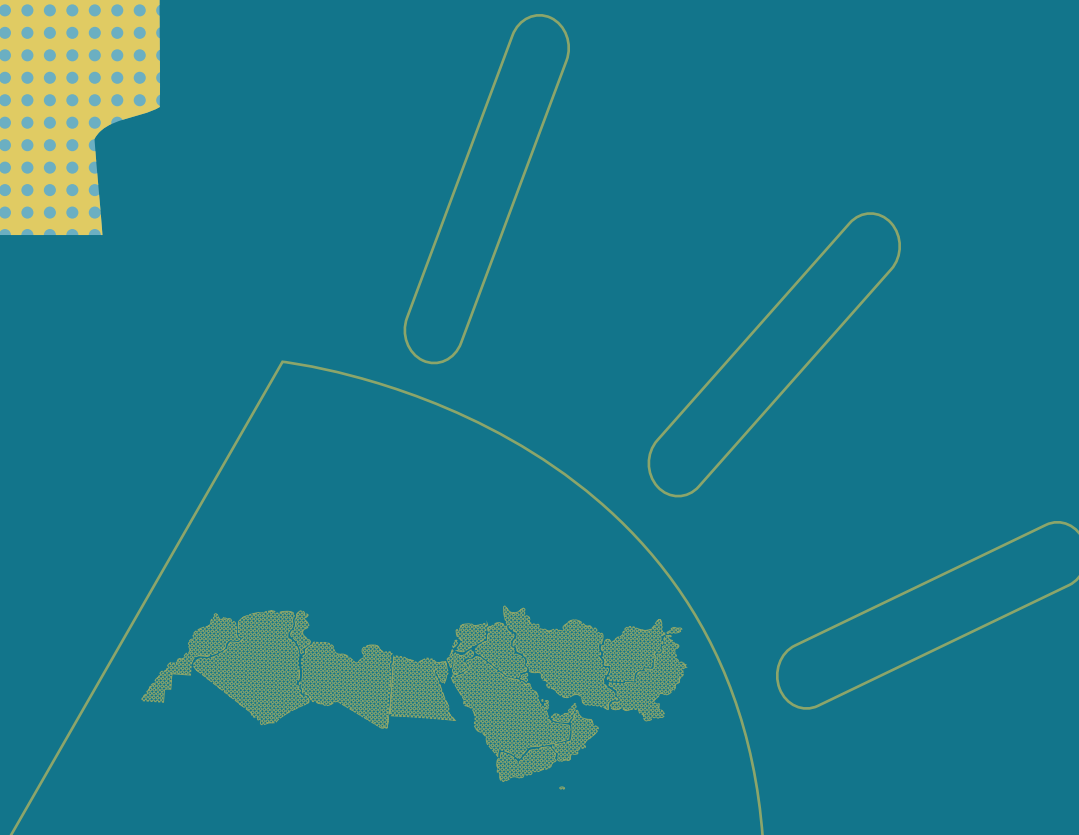
- Initiate sensitization on BBV risks and transmission for the local community
- Continued support for and scale up of HIV testing services, especially voluntary counseling and testing in the community
- Initiate sensitization on essential harm reduction services in the form of combined OAT and NSP services
- Focus efforts on tackling hash, pharmaceuticals such as Artane, benzodiazepines, and tramadol use

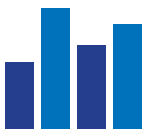
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Advocate and sensitize for a range of harm reduction policies and all harm reduction programs spanning community and prison settings. Support for feasibility studies.
- Advocate to support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR MOROCCO





WHAT IS THE CURRENT SITUATION IN MOROCCO



DRUG USE

Morocco has an estimated total population of 36,472,000¹

The estimated number of PWID has been found to be variable among different meta-analysis studies, and ranges from an estimated 18,000 (13,500-22,500)² to 30,500 (15,500-45,500)³

Young PWID aged under 25 years account for 6.9% of the population with an average age of 33.2 years⁴

Main drugs of use:

- Cannabis
- Amphetamines
- Ecstasy
- Psychotropic drugs

Primary drugs of abuse among people in treatment: cannabis, opioids

Injecting drug use:

- Common drugs injected: heroin
- Prevalence of injecting drug use is estimated at 0.13% (0.07-0.20)⁵
- An estimated 28,000 (14,500-42,500) PWID inject on a daily basis, while another estimated 2,500 (1,000-4,500) inject less frequently⁶
- 92.1% of PWID reported the use of sterile injecting equipment during their last injection in 2017⁷

Drug injecting has increased in the past twenty years, particularly in the north of Morocco⁸

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 Hines et al., 2020

5 Larney et al., 2020

6 Colledge et al., 2020

7 UNAIDS Info, 2019

8 Morocco MOH, 2015



PLHIV AND KEY POPULATIONS

Estimated 21,000 (17,000-28,000) **PLHIV**, with an estimated 77% (64-100) PLHIV aware of their status⁹, and an estimated 36.1% of PWID know their HIV status¹⁰

HIV testing and counseling is widely available throughout the country, maintenance of testing centers is crucial to maintain knowledge of status

HIV prevalence among PWID is estimated at 9.6% indicating a concentrated epidemic¹¹

Estimated **HIV prevalence among MSM at 5.9%** also indicates a concentrated epidemic, while prevalence among SW is less concentrated at 1.3%¹²

Estimated **HCV prevalence of 40.4%** among PWID¹³

Estimated **12,500** (5,500-21,000) PWID¹⁴ that are living with **HCV**

Estimated **6,718** (3,147-11,471) PWID¹⁵ that are chronically infected with **HCV**

A study observed that commercial heterosexual sex networks were the leading driver of the HIV epidemic, with half of HIV incidence but with a growing contribution for MSM¹⁶

Needle/Syringe programming need to be introduced into prisons and scaled up in the community to ensure high reported use of sterile injecting equipment to translate in the long run to decreased BBV among PWID



LAW ENFORCEMENT¹⁷

Drug Legislation: law punishes drug consumption with imprisonment between 2 months and 1 year with a fine. In some cases of drug consumption, only a fine is imposed.

Mandatory treatment: court may order treatment instead of sanctions. Treatment period not specified but follows doctor recommendations

Drug policy: the Moroccan government has practiced a policy of containment of cannabis cultivation, whereby no new areas are permitted, whilst permitting maintenance of existing areas in the Rif¹⁸. There was an observed decline in cannabis resin trafficking in Morocco in 2017 based on seizures and qualitative reporting¹⁹.

⁹ UNAIDS Info, 2019

¹⁰ UNAIDS Info, 2019

¹¹ Larney et al., 2020

¹² UNAIDS Info, 2019

¹³ Mahmud et al, 2020

¹⁴ Grebeley et al., 2018

¹⁵ Mahmud et al, 2020

¹⁶ Kouyoumjian et al., 2018

¹⁷ Al-Shazly & Tinasti, 2016

¹⁸ Afsahi, 2015; Blickman, 2017

¹⁹ UNODC World Drug Report, 2019; 2020



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ Harm reduction policy adopted in country NASP
- ✓ NSPs available with estimated 109 needles/syringes distributed per PWID in 2018²⁰
- ✓ OAT available as MMT, including in prisons (coverage at 42.3% in 2018)²¹
- ✗ NSPs unavailable in prisons
- ✗ Naloxone community distribution unavailable
- ✗ DCRs unavailable

Efforts in supporting combined prevention services of NSP and OAT need to be reinforced to increase number of needles/syringes distributed per PWID and percentage of OAT coverage

Continued scale up for OAT is warranted, particularly regarding geographic coverage for OAT where long waiting lists continue and scale up in prisons; peer based naloxone, providing services for minors, and addressing critical constraints which impede access to OAT; lack of high dosage buprenorphine; prescription and delivery regulations for methadone

NGOs are highly active in comprehensive harm reduction response, mostly thematic NGOs working on harm reduction and human rights, with representatives of PWUD in Morocco. The newly established network (2019) of all national actors involved in drug addiction field is called REMAD

The Global Fund, which will remain at least until 2023 is the most important donor for harm reduction programs in Morocco. There is a strategic work plan including a full harm reduction program 2018-2022 adopted by the Ministry of Health. At the legislative level, there has been no change or development in favor of PWUD or other key populations.

Scale-up of combined harm reduction interventions, including HCV services and community naloxone distribution, with focus on increasing coverage of HIV testing services in collaboration with civil society and community actors in Morocco are efforts that contribute to maintaining the flagship, evidence-based response that the country has been reputed to have

²⁰ UNAIDS Info, 2019

²¹ UNAIDS Info, 2019



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Support strengthened political commitment and continue to support the adoption of harm reduction policy in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and mandatory treatment
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

- Initiate sensitization on HCV within harm reduction programming
- Scale up OAT in all prisons
- Introduce NSP in prisons
- Continued support for HBV vaccination in prisons
- Further 2018 efforts on overdose prevention and training of community workers on naloxone use, by initiating naloxone programming through community/peer distribution.
- Support essential harm reduction services in the form of combined OAT and NSP services
- Continued support for the availability and scale up of NSP, with dedicated advocacy and measures to support the scale up of needles and syringes distributed per person who injected (currently 109/person; 2018).
- Continued support for the availability and coverage of OAT (currently 42.3%; 2018), specifically current provision of MMT, and expand choice to include BMT.
- Initiate sensitization around the evidence base of DCR
- Focus efforts on tackling cannabis, amphetamine, psychotropic drug use
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.

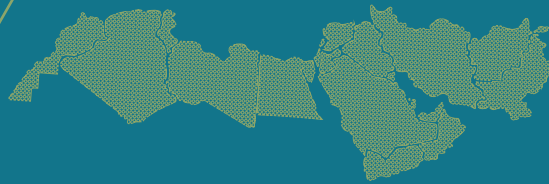
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities.

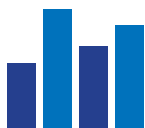
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR OMAN





WHAT IS THE CURRENT SITUATION IN OMAN



DRUG USE

Bahrain has an estimated total population of 4,975,000¹ with an estimated number of 4,250 (2,800-5,700) PWID².

The average age profile of PWID population is not known in Oman³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Khat
- Opiates
- Stimulants
- Cannabis
- Benzodiazepines
- Sedatives

Primary drugs of abuse among people in treatment: Opioids, cannabis, tranquilizers and sedatives, amphetamines, solvents and inhalants, hallucinogens

Common drugs injected: Heroin and morphine

Data on prevalence of injecting drug use in Oman is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated 3,200 (2,900-3,600) PLHIV, with an estimated 69% (53-84) PLHIV aware of their status⁴; however estimates of PWID that know their HIV status are unavailable⁵

HIV prevalence among PWID is estimated at 11.8% indicating a concentrated epidemic⁶

Estimated HBV prevalence of 4.82% among PWID in 2016⁷

Estimated 1,440 (864-2,103) PWID⁸ that are chronically infected with HCV

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 UNAIDS Info, 2019

6 Larney et al., 2020

7 World Drug Report – UNODC, 2020

8 Mahmud et al, 2020

HIV prevalence among **prisoners** is estimated at 0.2%

Estimated **HIV and HCV** prevalence among other KPs is not available⁹

For key populations, initiation of anonymous testing and counseling is a significant improvement towards early HIV diagnosis. There are plans by the Omani NAP to expand it to more areas in the near future



LAW ENFORCEMENT¹⁰

Punitive legislation: law allows possession of specified amount of drugs

Mandatory treatment: treatment period not specified

Legislation protecting PWUD confidentiality: drug law protects confidentiality of people in dependence treatment centers

However, there is a zero tolerance policy toward substance use and strict drug trafficking laws up to and including the death penalty¹¹



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ Harm reduction policy adopted, and PWID are noted as an important key population in the country NASP
- ✗ NSPs unavailable
- ✗ OAT unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Oman and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs

Oman has been given permission to trial an OAT service on a small scale, however the provision of MMT/BMT has not been reported to date. Opioid detoxification is available using Methadone.

NGOs have no role in the HIV response in Oman, however increasing collaboration between the NAP and civil society organizations has been recently observed.

⁹ UNAIDS Info, 2019

¹⁰ Al-Shazly & Tinasti, 2016

¹¹ Girelli, 2019

Introduction of harm reduction services in Oman in an evidence-based manner - as has been done in the country's best practice approach towards adopting a comprehensive national HIV response - coupled with increased generation of data and information, presents an important opportunity in developing model programs to limit the spread of BBVs among KPs in general and PWID in specific



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continue to support harm reduction policies and inclusion of PWID in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and death penalty for drug offenses

Harm reduction and treatment services and programming:

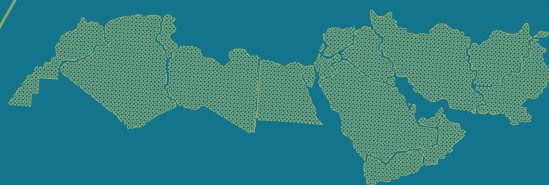
- Initiate sensitization on HCV within youth programs and general community
- Support sensitization and planning for voluntary HIV testing in the community
- Support the planning phase for OAT, and progress to initiation
- Advocate for and sensitize for a range of harm reduction policies and all harm reduction programs spanning community and prison settings. Support for feasibility studies.
- Focus efforts on tackling khat, hash, opiates, stimulants, and pharmaceuticals use

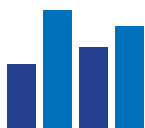
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Advocate to support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR PAKISTAN





WHAT IS THE CURRENT SITUATION IN PAKISTAN



DRUG USE

Pakistan has an estimated total population of 216,565,000¹

The estimated number of PWID has been found to be highly variable among different meta-analysis studies, and ranges from an estimated 117,632 (89,500-510,000)² to as high as 423,000 (363,000-482,500)³!

More comprehensive and updated national population size estimations for PWID are needed to determine and reach a consensus on realistic estimations!

Young PWID aged under 25 years account for 22.9% of the population with an average age of 30.5 years⁴!

Main drugs of use:

- Opioids (heroin, pharmaceutical)
- Cannabis

Injecting drug use:

- Common drugs injected: heroin and AVIL®
- Prevalence of injecting drug use is estimated at 0.37% (0.32-0.42)⁵
- An estimated 422,500 (364,000-483,500) PWID inject on a **daily basis**, while <500 (<500-500) are estimated to inject less frequently⁶
- 72.5% of PWID reported the use of sterile injecting equipment during their last injection in 2016⁷

Injecting drug use represents a major cause of HIV transmission in Pakistan, and with HIV highly prevalent among PWID

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 Hines et al., 2020

5 Larney et al., 2020

6 Colledge et al., 2020

7 UNAIDS Info, 2019



PLHIV AND KEY POPULATIONS

Estimated 160,000 (140,000-190,000) PLHIV, with an estimated 21% (19-24) PLHIV only aware of their status⁸, and an estimated 47.1% of PWID know their HIV status⁹

A large gap is noted in testing and awareness of PLHIV of their status although HIV testing is available throughout the country through field and mobile units with trained teams

HIV prevalence among PWID is estimated at 32.3% indicating a concentrated epidemic¹⁰

Estimated HIV prevalence among transgender individuals at 5.5%¹¹

Estimated HIV prevalence among SW (3.8%) and MSM (3.7%) is less concentrated¹²

Estimated 2% HIV prevalence among prisoners¹³

Estimated HBV prevalence of 27% among PWID in 2007¹⁴

Estimated 116,000 (<500-173,500) PWID¹⁵ that are living with HCV

Estimated 46,554 (22,815-168,797) PWID¹⁶ that are chronically infected with HCV

Estimated 15.6% (12.8-18.4) HCV prevalence¹⁷ among prisoners

The HIV epidemic is concentrated in key populations, and the National AIDS Control Program has reported primary concentration of HIV among PWID in 2019

Needle/Syringe programming efforts need to be introduced into prisons and scaled up in the community to ensure high reported use of sterile injecting equipment to translate in the long run to decreased BBV among PWID and other intersecting key populations



LAW ENFORCEMENT¹⁸

Punitive legislation: Drug use or possession for personal use is not an offense

Recent data indicates that out of 133 capital cases prosecuted under the Pakistani Control of Narcotic Substances Act, every single death sentence was pronounced primarily for possession-based offences, rather than trafficking or management of drug syndicates¹⁹

8 UNAIDS Info, 2019

9 UNAIDS Info, 2019

10 Larney et al., 2020

11 UNAIDS Info, 2019

12 UNAIDS Info, 2019

13 Heijnen et al., 2016

14 World Drug Report – UNODC, 2020

15 Grebeley et al., 2018

16 Mahmud et al., 2020

17 Heijnen et al., 2016

18 Al-Shazly & Tinasti, 2016

19 Girelli, 2019



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID noted as an important key population in country NASP
- ✓ NSPs available with estimated 48 needles/syringes distributed per PWID in 2018²⁰
- ✗ OAT unavailable, but with planned progress towards introduction in 2020
- ✗ Naloxone community distribution unavailable
- ✗ DCRs unavailable
- ✗ NSPs unavailable in prisons

Despite available harm reduction services in every district with drug use, more efforts are needed for enhanced coverage. Although 7,500 people are reached with clean needles through NSP every day in 5 districts of the country, efforts to reach PWID and their partners are hindered by stigma, discrimination, and policies which criminalize drug use and possession

NGOs are highly active in HIV and harm reduction response. With the withdrawal of the World Bank in 2010, the Global Fund has the main financier of HIV prevention activities targeting IDUs, with NGOs are the forefront of the harm reduction response.

Nai Zindagi is PR of the Global Fund grant. The first drug user network in Pakistan (DUNE) was launched in 2015 and is part of the Association of People Living with HIV (APLHIV) in Pakistan.

Pakistan's HIV response, designed using a high impact focused targeted approach to increasing coverage of HIV prevention, treatment, care, and support services is an important step

Introduction of OAT to ensure combined harm reduction interventions, including HCV services, with focus on increasing coverage of HIV testing services in collaboration with civil society and community actors in Pakistan can increase progress towards universal health coverage

²⁰ UNAIDS Info, 2019



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for the adoption of PWID as a key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

- Initiate sensitization on HCV and overdose within harm reduction programming
- Scale up of viral hepatitis prevention programming among youth and PWUD
- Scale up HIV testing services throughout the country, and increase sensitization on importance of testing to increase coverage and uptake
- Introduce NSP in prisons
- Support planning and initiation of naloxone programming through community/peer distribution.
- Continued support for the availability of NSP, with dedicated advocacy and measures to support the scale up of needles and syringes distributed per person who injected (46/person; 2018).
- Endorsement of OAT in Pakistan by the Drug Regulatory Authority and Anti-Narcotic Forces and steps towards registering Methadone and Buprenorphine reached advanced stages during 2020. Support continued planning and initiation of OAT spanning community and prison settings.
- Initiate sensitization around the evidence base of DCR
- Focus efforts on tackling opioids, pharmaceutical drugs, and cannabis
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.

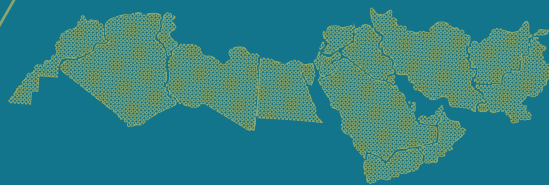
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities.

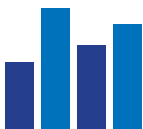
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR PALESTINE





WHAT IS THE CURRENT SITUATION IN PALESTINE



DRUG USE

Palestine has an estimated total population of 4,981,000¹ with an estimated number of 1,850 (1,200-2,500) PWID².

Main drugs of use:

- Synthetic drugs
- Cannabis
- Heroin
- Cocaine
- Prescription drugs such as tramadol

Injecting drug use:

- Common drugs injected are heroin and cocaine
- An estimated 2,000 (1,000-2,500) PWID inject on a daily basis, while another estimated 1,500 (500-2,000) inject less frequently³

More studies and data generation are crucial to update population size estimations and explore current trends in use of sterile injecting equipment



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV is **unknown**, and there is a lack of data on the progress towards the 90-90-90 targets⁴

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV on treatment, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

HIV prevalence among PWID is reported to be 0%

Estimated HBV prevalence of 0.6% among PWID in 2010⁵

1 UN population division, 2019

2 Mahmud et al., 2020

3 Colledge et al., 2020

4 UNAIDS Info, 2019

5 World Drug Report – UNODC, 2020

HCV prevalence among PWID is estimated at 31.2% (26.3-36.2)⁶

Estimated 542 (350-1,234) PWID⁷ that are chronically infected with HCV

Estimated HIV and HCV prevalence among other KPs is not available⁸

HIV testing centers are widely available in all districts in Palestine

Injecting drug use is a driver of HCV among PWID in Palestine, and harm reduction efforts need to be maintained to decrease its spread and maintain the low HIV prevalence among PWID

Incarceration was shown to increase the odds of being infected with HCV and ever tested for HIV. This indicates the need for harm reduction and BBV prevention in Palestinian prisons, and for alternatives to imprisonment to be considered.⁹



LAW ENFORCEMENT

No information is available regarding punitive legislation against drug use and mandatory treatment measures¹⁰

The death penalty can be imposed for drug offences only in the Gaza Strip¹¹



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ Harm Reduction policy adopted in NASP
- ✓ NSPs available in a limited manner
- ✓ OAT available as MMT, including in prisons
- ✗ Naloxone community distribution unavailable
- ✗ NSP unavailable in prisons
- ✗ DCRs unavailable

NGOs are the main providers of treatment and rehabilitation (Al Huda, Al Sadeq al Tayeb, Maqdese, SARC, Caritas). NSP and condom provision was initiated in the West Bank by local NGOs, but is currently not provided for with the exception of a small program in East Jerusalem.

⁶ Larney et al., 2020

⁷ Mahmud et al, 2020

⁸ UNAIDS Info, 2019

⁹ Štulhofer et al., 2016

¹⁰ Al-Shazly & Tinasti, 2016

¹¹ Girelli, 2019

Introduction of combined harm reduction interventions in the community and in prisons, including community naloxone distribution and HCV services, in collaboration with civil society and community actors in Palestine is crucial in accelerating the response



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continued support for the adoption of harm reduction policy in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate against criminalization and imposition of the death penalty for drug offences
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

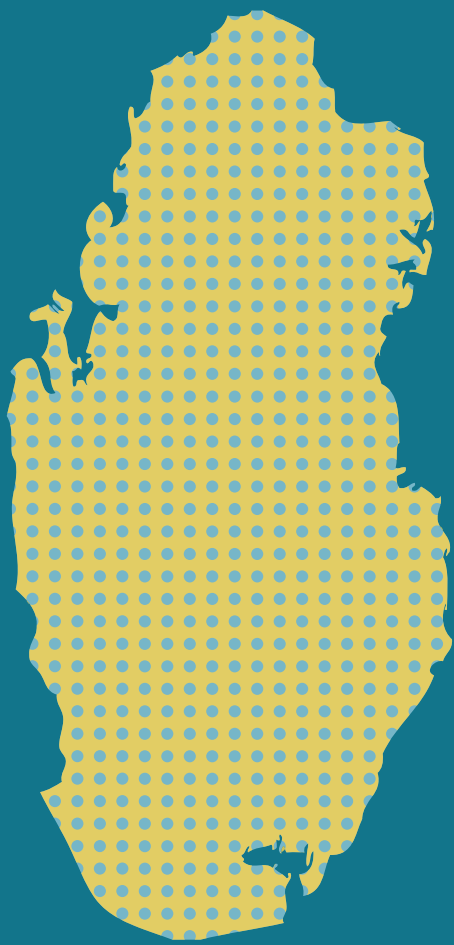
Harm reduction and treatment services and programming:

- Continue and scale up viral hepatitis services within harm reduction programs, with integration of HCV rapid testing
- Introduce NSP in prisons
- Continue to support and plan for naloxone programming through community/peer distribution
- Continued support for HIV testing and counseling services in the community and in prisons
- Continued support for the availability and scale up of NSP, with dedicated advocacy and measures to support scale up of needles and syringes distributed per person who injects
- Continued support for the availability and coverage of OAT in the community and in prisons, specifically current provision of MMT and expand choice to include BMT
- Initiate sensitization around the evidence base of DCR
- Focus efforts on tackling cannabis, heroin, cocaine, ATS, synthetic and pharmaceutical drug use
- Recognize convergence and include focus on specific risk groups such as prisoners, CSW, refugees, PWID, and MSM in the BBV and harmful drug response

- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Build on the successes achieved to date and develop sustainable models which include harm reduction as a human right, and cascade the efforts into the future by targeting HIV, viral hepatitis, risk behaviors and migration
- Include dual diagnosis support within drug treatment modalities

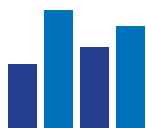
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR QATAR





WHAT IS THE CURRENT SITUATION IN QATAR



DRUG USE

Qatar has an estimated total population of 2,832,000¹ with an estimated number of 1,190 (780-1,600) PWID².

The average age profile of PWID population is not known in Qatar³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Opioids
- Cannabis

Data on type and prevalence of injecting drug use in Qatar is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV is unknown, and there is a lack of data on the progress towards the 90-90-90 targets⁴

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

HIV prevalence among PWID is unknown⁵

Estimated 413 (244-610) PWID⁶ that are chronically infected with HCV

Estimated HIV and HCV prevalence among other KPs is not available⁷

HCV testing and free treatment is available for all people in Qatar

Voluntary HIV testing is available in one center in Qatar

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 Larney et al., 2020

6 Mahmud et al., 2020

7 UNAIDS Info, 2019



LAW ENFORCEMENT⁸

Punitive legislation: law differentiates between possession and consumption. Consumption is punished with imprisonment of 1-3 years and a fine. Judge may avoid imprisonment under law and impose a minimum fine for consumption.

Mandatory treatment: court may order admission to treatment centers instead of criminal sanctions. Mandated treatment period is 3 months to one year.



WHAT IS BEING DONE IN HARM REDUCTION?

- ✗ No mention of harm reduction or PWID in national policy documents
- ✗ OAT unavailable
- ✗ NSPs unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Qatar yet and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs

NGOs have no role in the fields of HIV and key populations

⁸ Al-Shazly & Tinasti, 2016

Generation of data on key populations as well as HIV and HCV prevalence in Qatar in an evidence-based manner is crucial to determine the way roadmap of the HIV and harm reduction response



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continue to support inclusion of harm reduction policies and PWID as key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use, death penalty for drug offences, and mandatory treatment

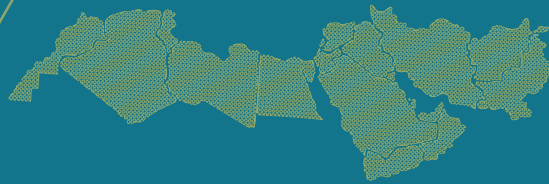
Harm reduction and treatment services and programming:

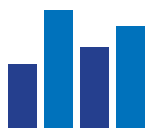
- Continued support for voluntary HIV and HCV testing and counseling in the community
- Advocate for and sensitize for a range of harm reduction policies and programs spanning community and prisons settings. Support for feasibility studies
- Focus efforts on tackling opioids and cannabis use

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Advocate to support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM REDUCTION ADVOCACY BRIEF FOR SAUDI ARABIA





WHAT IS THE CURRENT SITUATION IN SAUDI ARABIA



DRUG USE

Saudi Arabia has an estimated total population of 34,269,000¹ with an estimated number of 16,800 (11,336-22,264) PWID².

The average age profile of PWID population is reported to be 40 years in Saudi Arabia³, however, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Cannabis
- Amphetamines

Primary drugs of abuse among people in treatment: ATS, cannabis, benzodiazepines, opioids, solvents and inhalants

Data on type and prevalence of injecting drug use in Saudi Arabia is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV was 8,000 in 2016, with an estimated 6,744 who know their status⁴

Updated data is unavailable on the estimated number of PLHIV, and the different indicators that measure PLHIV who know their status, PLHIV who are virally suppressed, and PWID who know their HIV status→indicating a need to re-engage HIV surveillance and reporting

HIV prevalence among PWID is estimated at 9.8%⁵

HCV prevalence among PWID is estimated at 58.3%⁶ indicating a concentrated epidemic

Estimated 6,566 (1,636-13,734) PWID⁷ that are chronically infected with HCV

HIV prevalence among prisoners is estimated at 0.2%⁸

Estimated HIV and HCV prevalence among other KPs is not available⁹

Routine HIV testing occurs in STI patients, prisoners and PWID in drug rehabilitation centers

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS, 2018

5 Larney et al., 2020

6 Grebeley et al., 2018

7 Mahmud et al., 2020

8 UNAIDS Info, 2019

9 UNAIDS Info, 2019



LAW ENFORCEMENT

Punitive legislation: law against drug possession for personal consumption punishable by imprisonment of 6 months to 2 years¹⁰

Anti-drug law specifies confidential treatment of identity and information related to convicted PWUD

Saudi Arabia was responsible for the most confirmed drug-related executions globally in 2018, with at least 59 executions (of which 29 were foreign nationals)¹¹



WHAT IS BEING DONE IN HARM REDUCTION?

- ✗ No mention of harm reduction or PWID in national policy documents
- ✗ OAT unavailable
- ✗ NSPs unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Saudi Arabia yet and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs, and especially HCV

NGOs and CSOs contribute relatively strongly to IEC prevention programs and operate half-way houses for drug treatment and support.

¹⁰ Al-Shazly & Tinasti, 2016

¹¹ Girelli, 2019

Generation of data on key populations as well as HIV and HCV prevalence in Saudi Arabia in an evidence-based manner is crucial to determine the way roadmap of the harm reduction response



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continue to support inclusion of harm reduction policies and PWID as key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use, corporal punishment and death penalty for drug offences

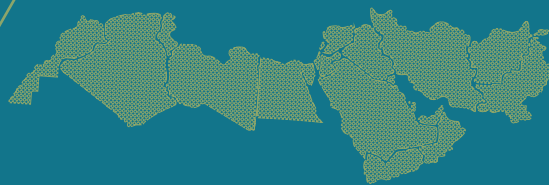
Harm reduction and treatment services and programming:

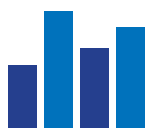
- Advocate for voluntary HIV and HCV testing and counseling in the community
- Advocate for and sensitize for a range of harm reduction policies and programs spanning community and prisons settings. Support for feasibility studies
- Focus efforts on tackling opioids, ATS, khat, pharmaceutical drug and cannabis use

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Advocate to support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

**HARM
REDUCTION
ADVOCACY
BRIEF
FOR SYRIA**





WHAT IS THE CURRENT SITUATION IN SYRIA



DRUG USE

Syria has an estimated total population of 17,070,000¹ with an estimated number of 8,000 (5,750-10,250) PWID².

Young PWID aged under 25 years account for 24.4% of the population with an average age of 32 years³!

Main drugs of use:

- Heroin
- Prescription opioids
- Captagon

Primary drugs of abuse among people in treatment: Opioids, tranquilizers, cocaine, cannabis

Injecting drug use:

- Common drugs injected are heroin and cocaine
- An estimated 4,500 (2,500-7,000) PWID inject on a daily basis, while another estimated 8,500 (4,500-12,500) inject less frequently⁴



PLHIV AND KEY POPULATIONS

Estimated 660 (590-720) PLHIV, and the percentage of PLHIV that are aware of their status is **unknown**⁵

Updated data is unavailable on the different indicators that measure PLHIV who know their status, PLHIV who are virally suppressed, and PWID who know their HIV status indicating a need to re-engage HIV surveillance and reporting

HIV prevalence among PWID is estimated at 0%⁶

Estimated HBV prevalence of 0.5% among PWID in 2014⁷

HCV prevalence among PWID is estimated at 2.5%⁸

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 Colledge et al., 2020

5 UNAIDS Info, 2019

6 Larney et al., 2020

7 World Drug Report – UNODC, 2020

8 Grebeley et al., 2018

Estimated **2,231** (283-3,3738) PWID⁹ that are chronically infected with **HCV**

HIV prevalence among **prisoners** is estimated at **0%**¹⁰, while **HCV** prevalence among **prisoners** is estimated at **1.5%**¹¹

Estimated **HIV and HCV** prevalence among other KPs is not available¹²

Access to HIV testing and counseling has been compromised due to security situations in conflict zones

Significant scale up is warranted in both health surveillance and in HIV testing, particularly in opposition-controlled areas



LAW ENFORCEMENT

No information regarding punitive legislation or mandatory drug treatment is available¹³



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID are noted as an important key population in the country NASP (not updated since 2015)
- ✗ OAT unavailable
- ✗ NSPs unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Syria yet and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs, and especially HCV

NGOs are active in awareness raising and advocacy (updating of national plans) related to HIV/AIDS prevention..

⁹ Mahmud et al, 2020

¹⁰ UNAIDS Info, 2019

¹¹ Heijnen et al., 2016

¹² UNAIDS Info, 2019

¹³ Al-Shazly & Tinasti, 2016

Introduction of harm reduction services in Syria in an evidence-based manner, coupled with increased generation of data and information, in collaboration with civil society and community actors presents an important opportunity in developing model programs in the HIV and harm reduction response



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continue to support inclusion of PWID as key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and death penalty for drug offences

Harm reduction and treatment services and programming:

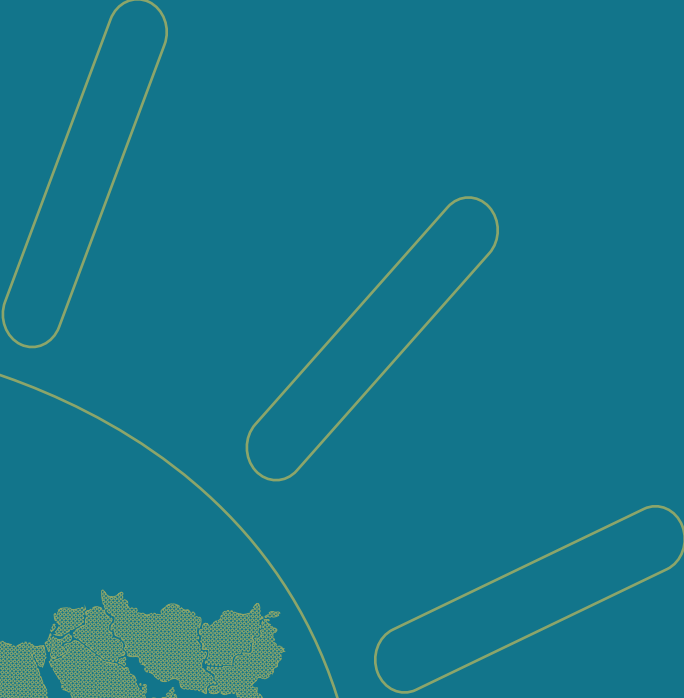
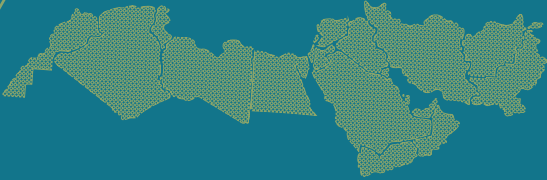
- Reinforce HIV testing and counseling in the community, and introduce HCV testing
- Advocate for and sensitize for a range of harm reduction policies and programs spanning community and prisons settings. Support for feasibility studies
- Focus efforts on tackling Captagon, opioids, heroin, cocaine, pharmaceutical drug and cannabis use

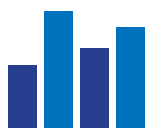
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Advocate to support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR TUNISIA





WHAT IS THE CURRENT SITUATION IN TUNISIA



DRUG USE

Tunisia has an estimated total population of 11,695,000¹ with an estimated number of 11,000 (8,462-13,750) PWID².

Young PWID aged under 25 years account for 14.6% of the population with an average age of 34.6 years³

Main drugs of use:

- Alcohol
- Psychotropic drugs
- Cannabis
- Cocaine

Injecting drug use:

- Prevalence of injecting drug use is **unknown**⁴
- 90.9% of PWID reported the use of sterile injecting equipment during their last injection in 2017⁵

Data on type and prevalence of injecting drug use in Yemen is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated 2,800 (1,700-4,400) PLHIV, with an estimated 20% (14-29) PLHIV only aware of their status⁶, and an estimated 28.6% of PWID know their HIV status⁷

HIV testing and counseling is widely available throughout the country, including in 6 prisons; maintenance of testing centers is crucial to maintain knowledge of status

HIV prevalence among PWID is estimated at 3.5% indicating a concentrated epidemic⁸

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 Larney et al., 2020

5 UNAIDS Info, 2019

6 UNAIDS Info, 2019

7 UNAIDS Info, 2019

8 Larney et al., 2020

Estimated HIV prevalence among MSM at 9.1% also indicates a concentrated epidemic, while prevalence among SW is less concentrated at 1.2%⁹

Estimated HBV prevalence of 3% among PWID in 2016¹⁰

Estimated HCV prevalence of 21.8% among PWID¹¹

Estimated 1,681 (292-3,738) PWID¹² that are chronically infected with HCV

Needle/Syringe programming need to be introduced into prisons and scaled up in the community to ensure high reported use of sterile injecting equipment to translate in the long run to decreased BBV among PWID



LAW ENFORCEMENT¹³

Drug Legislation: law punishes consumption or possession of drugs with imprisonment between 1 and 5 years, and a fine. Law also prohibits use of mitigating factors in sentencing

Mandatory treatment: court may order detoxification at a public hospital. If refused, offender can be forced by the court. Treatment period not specified by court – follows expert committee decision

There has been an amendment to an old law known as Law 53 which gives judges the opportunity to reduce/to minimize the sentence for the new cannabis users. With this law 53, the number of drug users in prisons has decreased significantly.



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ PWID noted as an important key population in the country NASP
- ✓ NSPs available with estimated 49 needles/syringes distributed per PWID in 2019¹⁴
- ✗ OAT unavailable
- ✗ NSPs unavailable in prisons
- ✗ Naloxone community distribution unavailable
- ✗ DCRs unavailable

Introduction of OAT, and scale up of NSPs can contribute largely to increase number of needles/syringes distributed per PWID and provide OAT coverage – as comprehensive combined services

A few NGOs (ATL MST/SIDA, ATIOST, ATUPRET) provide HIV prevention services to key populations, including PWID, but with low capacity and inadequate political support

⁹ UNAIDS Info, 2019

¹⁰ World Drug Report – UNODC, 2020

¹¹ Mahmud et al, 2020

¹² Mahmud et al, 2020

¹³ Al-Shazly & Tinasti, 2016

¹⁴ UNAIDS Info, 2019

Introduction of combined harm reduction interventions, including HCV services and community naloxone distribution, with focus on increasing coverage of HIV testing services in collaboration with civil society and community actors in Tunisia can enhance the HIV and harm reduction response in line with the 2018-2022 Tunisian NASP



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Continue to support the inclusion of PWID as a key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and mandatory treatment
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

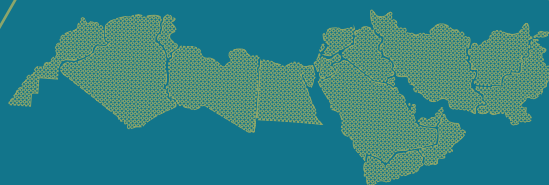
Harm reduction and treatment services and programming:

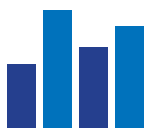
- Initiate sensitization on HCV and overdose within harm reduction programming
- Scale up HIV voluntary testing and counseling in the community and through mobile campaigns in coordination with NGOs
- Sensitize and advocate for a range of harm reduction measures in the community and prisons
- Continued support for the availability and scale up of NSP, with dedicated advocacy and measures to support the scale up of needles and syringes distributed per person who injected (currently 49/person; 2019).
- Focus efforts on tackling psychotropic drug use, pharmaceutical drugs, cannabis, and cocaine
- When planning or during scale up of harm reduction programs ensure to include not only PWID/PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Include dual diagnosis support within drug treatment modalities, and support the planning to initiate OAT

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

HARM
REDUCTION
ADVOCACY
BRIEF
FOR
UNITED
ARAB
EMIRATES





WHAT IS THE CURRENT SITUATION IN UAE



DRUG USE

The UAE has an estimated total population of 9,771,000¹ with an estimated number of 4,800 (3,200-6,400) PWID².

The average age profile of PWID population is not known in the UAE³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Alcohol
- Cannabis
- Heroin
- Captagon
- Anticholinergics
- Benzodiazepines
- Opioid analgesics/syrups
- Barbiturates
- Crystal methamphetamine
- Synthetic cannabinoids
- Prescription medication

Primary drugs of abuse among people in treatment: opioids and cannabis

Data on type and prevalence of injecting drug use in the UAE is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated number of PLHIV is unknown, and there is a lack of data on the progress towards the 90-90-90 targets⁴

A significant lack of data available is noted the different indicators that measure PLHIV who know their status, PLHIV on treatment, PLHIV who are virally suppressed, and PWID who know their HIV status → indicating a great need for support in HIV surveillance and reporting

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

HIV prevalence among PWID is **unknown**⁵

HIV prevalence among **prisoners** is estimated at **1.5%**⁶

Estimated **1,666** (1,001-2,438) PWID⁷ that are chronically infected with **HCV**

Estimated **HIV and HCV** prevalence among other KPs is not available⁸

There is reliance on case find in PWID when arrested, on intake to prison or drug treatment, and there is a need to introduce voluntary counseling and testing in the community



LAW ENFORCEMENT⁹

Punitive legislation: law punishes consumption of drugs and sanctions vary according to drug type with imprisonment between 1-4 years and a fine. Criminalization of consumption of medical drugs without prescription

Mandatory treatment: voluntary request for treatment terminates criminal lawsuit, but mandated rehabilitation treatment is specified for a period of maximum of 3 years



WHAT IS BEING DONE IN HARM REDUCTION?

- ✓ BMT and MMT as integrated treatment program available
- ✗ No mention of harm reduction or PWID in national policy documents
- ✗ NSPs unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No comprehensive harm reduction services are available in the UAE yet and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs

NGOs do not have a role in the fields of HIV and key populations

Introduction of comprehensive and combined harm reduction services in the UAE in an evidence-based manner, coupled with increased generation of data and information, presents an important opportunity in developing model programs to prevent the spread of BBVs among KPs in general and PWID in specific

⁵ Larney et al., 2020

⁶ UNAIDS Info, 2019

⁷ Mahmud et al, 2020

⁸ UNAIDS Info, 2019

⁹ Al-Shazly & Tinasti, 2016



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Advocate to include PWID as key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use and mandatory treatment
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

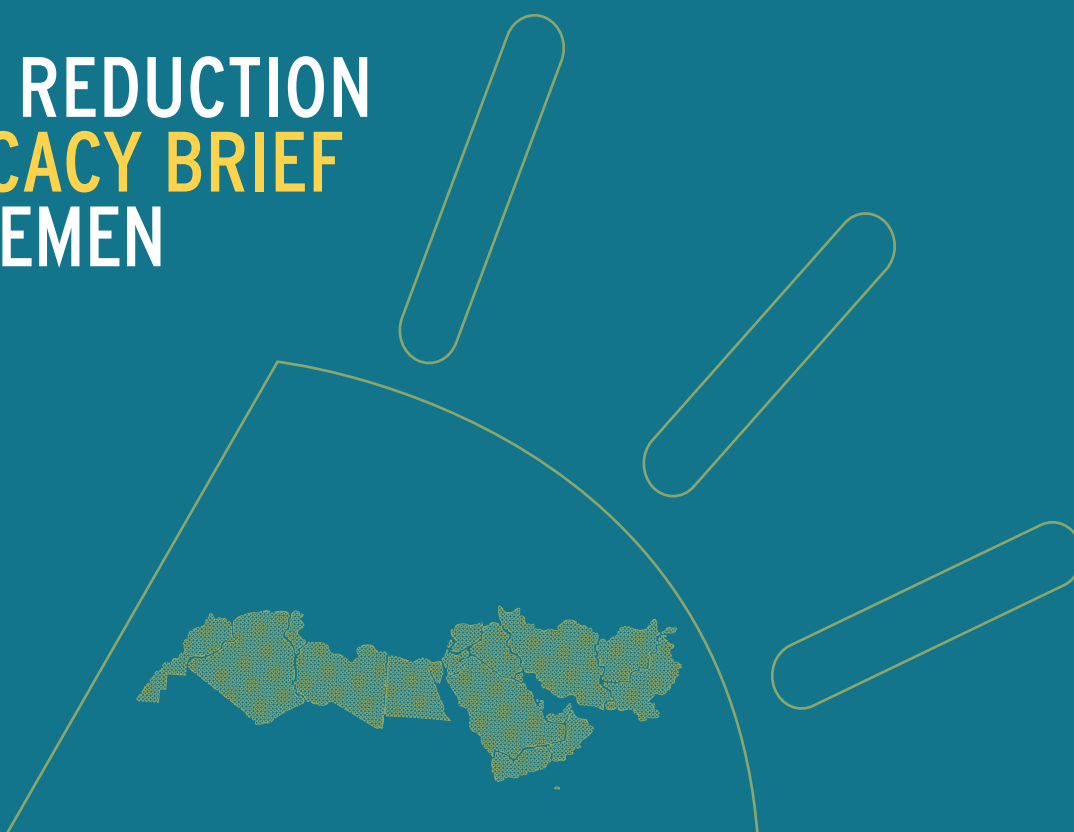
- Initiate sensitization on HCV within HIV and harm reduction programming
- Introduction of voluntary HIV testing and counseling in the community
- Sensitize and advocate for a range of harm reduction measures in the community and prisons
- Focus efforts on tackling psychotropic drug use, synthetic cannabinoids, pharmaceutical drugs, cannabis, and cocaine
- When planning or during scale up of harm reduction programs ensure to include not only PWID/ PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons.
- Include dual diagnosis support within drug treatment modalities, including OAT

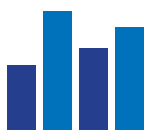
Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continued support for regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOS in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings



HARM REDUCTION ADVOCACY BRIEF FOR YEMEN





WHAT IS THE CURRENT SITUATION IN YEMEN



DRUG USE

Yemen has an estimated total population of 29,162,000¹ with an estimated number of 19,770 (12,710-26,830) PWID².

The average age profile of PWID population is not known in Yemen³, more research is needed to determine the characteristics of this population for informed programming

Main drugs of use:

- Khat
- Pharmaceutical drugs (tramadol, alprazolam, ketoprofen)

Data on type and prevalence of injecting drug use in Yemen is lacking and more data generation and evidence is crucial to estimate the size of the issue and inform the response!



PLHIV AND KEY POPULATIONS

Estimated 11,000 (6,500-18,000) PLHIV, and the percentage of PLHIV that are aware of their status is unknown⁴

Updated data is unavailable on the different indicators that measure PLHIV who know their status, PLHIV who are virally suppressed, and PWID who know their HIV status→ indicating a need to re-engage HIV surveillance and reporting

HIV and HCV prevalence among PWID is unknown^{5, 6}

Estimated 6,864 (3,974-10,221) PWID⁷ that are chronically infected with HCV

HIV prevalence among SWs is reported to be 0%, while HIV prevalence among MSM is estimated at 5.9%, indicating a concentrated epidemic⁸

Estimated HIV and HCV prevalence among other KPs is not available⁹

HIV is driven mainly through sexual transmission in high-risk populations, especially FSW and their clients, and MSM. PWID are not indicated as a priority and more research is needed to determine nature and extent of injecting drug use

The NAP provides HIV testing initiates testing and counseling services at 36 sites in several governorates, however most of country's expenditure has been redirected to relieve the humanitarian crisis

1 UN population division, 2019

2 Mahmud et al., 2020

3 Hines et al., 2020

4 UNAIDS Info, 2019

5 Larney et al., 2020

6 Grebeley et al., 2018

7 Mahmud et al, 2020

8 UNAIDS Info, 2019

9 UNAIDS Info, 2019



LAW ENFORCEMENT¹⁰

Punitive legislation: law punishes possession, purchase, procurement or purchase of drugs for personal consumption with imprisonment for 5 years

Mandatory treatment: voluntary request for treatment terminates criminal lawsuit. Period of stay at treatment center specified between 6 months and 2 years



WHAT IS BEING DONE IN HARM REDUCTION?

- ✗ No mention of harm reduction or PWID as a key population in national policy documents
- ✗ OAT unavailable
- ✗ NSPs unavailable
- ✗ Naloxone through community/peer distribution unavailable
- ✗ DCRs unavailable

No harm reduction services are available in Yemen yet and there is an eminent need to introduce them in an effort to provide PWUD and PWID with targeted programs to prevent transmission of BBVs, and especially HCV

The role and support needs of CSOs in their engagement with Key Populations need to be scaled up

HIV prevention activities have been largely funded by the Global Fund, however increased financial support for HIV prevention in Yemen is urgently needed, alongside sensitization, advocacy, de-stigmatization and support legislation for PLHIV

Introduction of harm reduction services in Yemen in an evidence-based manner, coupled with increased generation of data and information, in collaboration with civil society and community actors presents an important opportunity in developing model programs in the HIV and harm reduction response

¹⁰ Al-Shazly & Tinasti, 2016



WHAT SHOULD BE ADVOCATED FOR IMPROVE THE HARM REDUCTION RESPONSE?



KEY PRIORITIZED ADVOCACY ACTIONS FOR SUPPORT:

Political support, national policies and law, and multi-stakeholder engagement:

- Advocate for the inclusion of harm reduction policies and PWID as a key population in the country NASP
- Continued promotion of national drug demand reduction and harm reduction strategies in communities and prisons, and with a strong coalition of national NGOs/CSOs to advocate on revisions of the penalization of drug use
- Advocate for, and scale-up the role of NGOs in the harm reduction response, by strengthening further the coordination of existing collaborations and partnerships formed and explore new opportunities for collaboration and networking including collaborations, partnerships with key stakeholders in countries, the Global Fund, Regional CSOs, UNAIDS, UNODC and WHO

Harm reduction and treatment services and programming:

- Reinforce HIV testing and counseling in the community, and introduce HCV testing
- Sensitize and advocate for a range of harm reduction measures in the community and in prisons
- Focus efforts on tackling khat and pharmaceutical drugs
- When planning or during scale up of harm reduction programs ensure to include not only PWID/PWUD but also those most vulnerable for example women, juveniles, MSM, CSW and refugees to achieve equitable utilization of non-stigmatizing non-discriminatory services to all as part of human rights and right to health, and with equivalence of testing, treatment and care spanning community, humanitarian setting and prisons
- Include dual diagnosis support within drug treatment modalities

Data generation and evidence:

- Encourage and support regularly updating of the Global AIDS reporting
- Updated population size estimations for PWID and other KPs to properly inform evidence and programming
- Continue to support regular implementation of BBS, rapid assessment and service needs assessments so as to provide regular routine monitoring of drug type and risk characteristics, BBV, STIs trends across overlapping key populations. Use a collaborative approach between community and prison health clinics, health ministries and NGOs/CSOs in addressing issues of PWUD health by centralizing data collection, improving referral systems and data surveillance in the community, in prisons and in humanitarian settings

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