



## Editorial

# Drug policy and human rights in the Middle East and North Africa: Harm reduction, legal environment and public health



The Middle East and North Africa region is at the centre of many of the burning issues of our globalized and inter-dependent world. When it comes to drug use, infectious diseases and marginalized populations, however, the debate falls short. While the incidence and prevalence rates of drug injection and of related HIV infections remain low compared to other regions of the world, tough drug policies and discrimination against vulnerable populations remain embedded in the social, economic and cultural contexts of the region.

To address the lack of information in the region, the Global Commission on Drug Policy invited researchers from Morocco, Egypt, Lebanon and Iran to contribute to a collection entitled “Drug Policy in the Middle East and North Africa” which aimed at providing an overview of the legal, medical and societal aspects of drugs and drug policies in the region.

A first challenge was to define the region. The Commission on Narcotic Drugs splits the countries of the Middle East and North Africa into two of the United Nations regional groups, the African group and the Asia-Pacific group, whereas the World Health Organization (WHO) defines a Middle East and North Africa regional group for the East Mediterranean also covering Afghanistan and Pakistan, but excluding Algeria. The UN Arab group, representing the membership of the League of Arab States (LAS) recognizes a similar MENA region with the exclusion of Iran. The articles in this issue of the International Journal of Drug Policy consider all countries from Morocco to Afghanistan that are part of the UN, WHO and League of Arab States (LAS) regional groupings. Added to this is the challenge of analysing drug policies in a region where many countries share language and religion, but where the cultural, ethnic, social and economic differences are considerable.

For historical, religious and political reasons, the Middle East and North Africa (MENA) started to be considered as a regional group through the introduction of pan-Arabism and its development with the creation of the LAS in 1945. MENA grew further when other countries, stretching to South East Asia, Central Asia and West Africa joined in to create the “Islamic world”. Such a regional bloc is however heterogeneous outside of shared religion and its sub-regions are more likely to have shared structural drug policy reforms. For example, the Maghreb (Mauritania, Morocco, Algeria, Tunisia and Libya) share the same socio-structural barriers to drug policy reform, and similar drug use patterns in their populations, while they face similar security threats related to drug trafficking. This sub-region, of which countries are intrinsically different from other MENA countries, be it with regard to the

religious practices, country incomes or ethnic groups, suggest that a MENA approach to drug policy is not possible in the current regional framework. More data and research on the similarities of and differences between MENA countries is needed.

One shared characteristic of all countries in the region is Islam as a State religion. Islam states that illicit drugs are prohibited (*haram*). However its principal sources for contemporary policy, the *Qu’ran* or the *Sunnah* (the Prophet’s sayings), allow for the implementation of harm reduction programs and services to preserve human dignity and protect physical and mental health (see for example the arguments by [Kamarulzaman & Saifuddeen, 2010](#)). Iran, Morocco and Lebanon have followed this interpretation of the sacred books vis-à-vis drug use and the rehabilitation of drug users, whereas others such as the Gulf countries and Pakistan focus on drug prohibition and apply a punitive approach derived from the moral purposes of the *Sharia* law.

This special issue reports that drug control policies were regionalized early on, in the pre-UN Convention era. Egypt, for instance, passed the first cannabis prohibition law in the world in 1879 ([UNODC, 2008](#)). The country also led the movement to add the international trade in cannabis to the list of controlled activities under the Geneva Opium Convention in 1925 ([UNODC, 2008](#)). In 1929, Egypt established the world’s first drug control agency, the Central Narcotics Information Bureau, which then became the Anti-Narcotic General Administration in the 1970s ([UNODC, 2005](#)), helped establish the Permanent Anti-Narcotics Bureau of the Arab States League in 1950 ([UNODC, 1980](#)). Moreover, Egypt recommended the creation of a United Nations Anti-Narcotics Bureau for the Middle-East, headquartered in Cairo, to focus on crop eradication and smuggling. The Commission on Narcotic Drugs rejected this program because some States in the region were reluctant to embrace the idea, and others were unwilling to create an international mechanism to deal with a regional situation ([UNODC, 1960](#)).

Although data are relatively limited, the overall estimate is that 630 000 people inject drugs in the region ([Aaraj & Abou Chrouh, 2016](#)). There is evidence that drug use and its adverse health and social consequences are increasing and that drug control policies are not achieving their objectives. Nevertheless, some governments and other stakeholders are implementing harm reduction as a counter-balance to the national supply-oriented drug policies ([Greenfield & Paoli, 2012](#)) in the region. Several articles in this issue cover different aspects of harm reduction, its health and social benefits as well as the barriers its implementation faces. In their

commentary, Himmich and Madani (2016) document the effectiveness of harm reduction, focusing on the Iranian and Moroccan models. The commentary highlights the adverse health effects of drug use and the response given by the two governments to reduce the harms related to the increase in HIV and hepatitis C among people who inject drugs. The positive effects of the Iranian and the Moroccan approaches to harm reduction should be viewed as a first response to the legal, political and social barriers to drug policy reform in MENA. This is mainly related to the fact that most countries in the region have not yet developed a risk environment approach to address the harms related to drug use and to the legal environment in which these responses are shaped (Rhodes, 2002): they continue to rely on measures to eliminate drug use.

Similarly, the policy analysis by El-Khoury, Abbas, Nakhle, and Matar (2016) discusses the Lebanese experience in implementing an Opioid Substitution Therapy (OST) programme in 2011, as the first Arab country to use buprenorphine. Morocco implemented OST using oral methadone in 2010. The OST programme faced several challenges, starting with the lack of training of health workers and service providers, the absence of local prescribing guidelines, the non-existence of OST in prisons and the inadequacy of the services to the needs of women who use drugs. Nevertheless, hepatitis C infection rates among people who inject drugs are decreasing since the implementation of OST, and the programme had a significant impact on clinical practice in a short period. Noting the benefits of the programme, the authors call for the Lebanese example to be rolled-out in the rest of the region (El-Khoury et al., 2016). These findings are similar to the results of the introduction and scale-up of buprenorphine substitution therapy in other regions of the world, with comparable conservative social and political environments, as well as financial constraints (Bruce, Dvoryak, Sylla, & Altice, 2007). In their commentary, Aaraj and Abou Chrouh (2016) show how instrumental the role of civil society organizations and advocates has been in the management of the consequences of drug use and of drug policies. Because the HIV epidemic in the region is concentrated among key populations including people who use drugs, civil society partners are essential in addition to the public sector to help structure the national response to the HIV and hepatitis epidemics. Nevertheless, civil society organizations suffer from insufficient funding and deliver services in difficult legal and cultural environments with little or no political support. The political and financial barriers that civil society faces in its advocacy efforts to change national drug policies have been documented elsewhere (Spicer et al., 2011).

To have a better overview of the legal environment in which drug policy reform and harm reduction can be introduced, the commentary by Tinasti and El-Shazly (2016) discusses how the legal environment has led to the prioritization of repressive approaches, including arrests, conviction and mandatory treatment of people who use drugs in the region. Reviewing 16 national policies, the authors delineate the different provisions of drug control laws on possession, consumption, dependence treatment and the rights of convicted users to confidentiality. National legal frameworks in MENA share the specificity of treating people who use drugs as either “sick people” or criminals.

The Middle East and North Africa is not only a transit region for illicit drugs, but also a producing region for many of them. The commentary by Afsahi and Darwich (2016) focuses on cannabis production and distribution in two of the largest drug cultivation and production localities in the region, the Rif Mountains in Morocco and the Beqaa Valley in Lebanon. These two places are secluded and underdeveloped, and the production and export of cannabis and cannabis resin represents significant economic

income for the local populations. The two localities developed expertise in the production and sale of cannabis, but the market that is now facing competition from domestic production in the traditionally importing/consuming countries particularly in Europe (Decorte & Potter, 2015). The Rif and Beqaa are also confronted with the political and security turmoil that occurs in many countries, and competition with new producers in the region.

Finally, papers in this collection report on the structural barriers to drug policy reform in the region. Some of these barriers of a legal, cultural, social or religious nature can be overcome, as many of the articles report and which are demonstrated by the developments in Morocco, Lebanon and Iran. Nevertheless, countries in the region lack a comprehensive and multidisciplinary approach to drug policy reform. The health sector reforms and the introduction of harm reduction measures do not guarantee people who use drugs protection from a repressive legal environment, and are far from sufficient in the global policy framework. As the Global Commission on Drug Policy reported in 2015, drug policies need to operate within the sustainable development agenda (Tinasti, Bém, Grover, Kazatchkine, & Dreifuss, 2015), and MENA countries – in order to align with the sustainable development elements of justice, dignity and people-centred policies – will need to review their drug policies.

## References

- Aaraj, E., & Abou Chrouh, M. (2016). Drug policy and harm reduction in the Middle East and North Africa: The role of civil society. *International Journal of Drug Policy*, 31, 168–171.
- Afsahi, K., & Darwich, S. (2016). Hashish in Morocco and Lebanon: A comparative study. *International Journal of Drug Policy*, 31, 190–198.
- Bruce, R. D., Dvoryak, S., Sylla, L., & Altice, F. L. (2007). HIV treatment access and scale-up for delivery of opiate substitution therapy with buprenorphine for IDUs in Ukraine—Programme description and policy implications. *International Journal of Drug Policy*, 18(4), 326–328.
- Decorte, T., & Potter, G. R. (2015). The globalisation of cannabis cultivation: A growing challenge. *International Journal of Drug Policy*, 26(3), 221–225.
- El-Khoury, J., Abbas, Z., Nakhle, P. E., & Matar, M. T. (2016). Implementing opioid substitution in the Arab countries: Experience from Lebanon. *International Journal of Drug Policy*, 31, 178–183.
- Greenfield, V. A., & Paoli, L. (2012). If supply-oriented drug policy is broken, can harm reduction help fix it? Melding disciplines and methods to advance international drug-control policy. *International Journal of Drug Policy*, 23(1), 6–15.
- Himmich, H., & Madani, N. (2016). The state of harm reduction in MENA: The focus on Iran and Morocco. *International Journal of Drug Policy*, 31, 184–189.
- Kamarulzaman, A., & Saifuddeen, S. M. (2010). Islam and harm reduction. *International Journal of Drug Policy*, 21(2), 115–118.
- Rhodes, T. (2002). The ‘risk environment’: A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, 13(2), 85–94.
- Spicer, N., Harmer, A., Aleshkina, J., Bogdan, D., Chkhatarashvili, K., Murzalieva, G., et al. (2011). Circus monkeys or change agents? Civil society advocacy for HIV/AIDS in adverse policy environments. *Social Science and Medicine*, 73(12), 1748–1755.
- Tinasti, K., & El-Shazly, F. (2016). Incarceration or mandatory treatment: Drug use and the law in MENA. *International Journal of Drug Policy*, 31, 172–177.
- Tinasti, K., Bém, P., Grover, A., Kazatchkine, M., & Dreifuss, R. (2015). SDGs will not be achieved without drug policy reform. *Lancet*, 386(9999), 1132.
- UNODC (1960). *Bulletin of Narcotics: The Middle East Narcotics Survey Mission (September–October 1959) of the United Nations*. Vienna: Author.
- UNODC (1980). *Bulletin of Narcotics: The role of the General Administration in drug abuse control in Egypt*. Vienna: Faraag SA.
- UNODC (2005). *Egypt: Country profile*. Vienna: Author.
- UNODC (2008). *A century of international drug control*. Vienna: Pietschmann T, Tullis M, Leggett T et al.

Hakima Himmich<sup>a</sup>

Michel D. Kazatchkine<sup>b</sup>

Gerry V. Stimson<sup>a,b,c</sup>

<sup>a</sup>Association de Lutte Contre le Sida, Casablanca, Morocco

<sup>b</sup>Global Commission on Drug Policy, Geneva, Switzerland

<sup>c</sup>Imperial College London, and London School of Hygiene and Tropical Medicine, United Kingdom