



Commentary

Drug policy and harm reduction in the Middle East and North Africa: The role of civil society



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ABSTRACT

Civil society organizations (CSOs) in Middle East and North Africa (MENA) are the principal partners of government in scaling up the response to HIV and in implementing national policies. In return, CSOs expect endorsement of their work by the governments. Some CSOs face weaknesses and need capacity-building in order for them to reach the level of response required for reducing drug-related harm in this region. Substance use and the transmission of HIV are increasing in the MENA region. The limited data available on drug use show that there are approximately 630,000 people who inject drugs (PWID) across the region. The HIV epidemic remains concentrated among PWID and other key populations in the region. Comprehensive harm reduction programs which include prevention, care, and HIV treatment for PWID are being implemented by CSOs. This could not happen without the presence of a conducive environment which has been facilitated by the CSOs, and which aims to lead to a positive response in health policies, and thus to harm reduction programs in some countries in the region. However, based on the international data, antiretroviral therapy (ART) coverage remains low in these countries, even if the number of people living with HIV (PLHIV) receiving ART is increasing. This increase can sometimes mask important challenges in equity: in several countries PWID are the most likely to be infected with HIV while being the least likely to be receiving care and ART. Therefore, concentrated efforts need to continue toward the goal of having mainstream harm reduction approaches in region.

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According to the Global report on HIV (WHO, 2006), civil society initiatives were the foundations on which the national response has been built in most countries. Civil society remains at the forefront of prevention, care and support programs, particularly among the most vulnerable and hard-to-reach populations. Over the years, civil society has also helped to influence scientific research and has played a key role in challenging restrictive drug patents and bringing down the cost of HIV treatment. “Civil society” is essentially made up of citizens who organize themselves outside of government to address specific needs and concerns that current governmental process cannot address by itself, with the belief that societies function more effectively when the State and its citizens engage openly on how policies are formulated and implemented.

In the context of HIV/AIDS, many different individuals and organizations participate actively in the epidemic response outside of government structures. The most active members of civil society are often those with personal experience of the epidemic, either as

people living with HIV or members of marginalized and vulnerable populations, such as people who inject drugs (PWID). They are present at every level of the response, in associations and networks of people living with HIV (PLHIV), community organizations or as members of other HIV/AIDS-related organizations.

Civil society groups have engaged in advocacy to influence a range of policy objectives since the beginning of the AIDS epidemic, including better access to health care and less expensive drugs. For example, in 1987 the members of the AIDS Coalition to Unleash Power in New York drew attention to their claim that excessive profits earned by pharmaceutical companies on AIDS medications limited access to treatment and slowed the process of drug approval, thus placing lives unnecessarily at risk. The Coalition also campaigned for public education on the epidemic and an end to AIDS-related discrimination. This early activism helped create the foundation for more affordable treatment initiatives (WHO, 2006).

In the past 10 years, similar examples of civil society organizations (CSOs) in the Middle East and North Africa (MENA) have demonstrated their success in scaling up HIV preventive national policies in a number of countries. This work was based mainly on advocacy, as well as on partnering with governments, despite the lack of technical and financial support.

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CSOs and policy development in the Middle East and North Africa

Civil society organizations (CSOs) in the Middle East and North Africa (MENA) have played an active role in advocating for harm reduction approaches and people who use drugs' (PWUD) rights, and to include them in health and development policies. The Middle East and North Africa Association (MENAHA) is the umbrella organization for harm reduction CSOs in the region. In addition to advocating with policymakers and government officials, advocating with religious leaders to promote acceptance of harm reduction programs is often central to increasing tolerance of harm reduction in the region. MENAHA and a group of religious leaders issued a guide on harm reduction and religion aiming to fight stigma against PWUD and to ensure their social reintegration (MENAHA, 2015a).

In November 2013, MENAHA held its 2nd Regional Conference on Harm Reduction in Beirut. Hosted by the Lebanese Ministry of Public Health, the event brought delegates from 24 countries to discuss, debate and advocate for harm reduction policies and practices. A pre-conference donors' meeting highlighted MENA's harm reduction needs, ensuring that the region remains an integral part of donors' agendas (HRI, 2015). MENA also has a community-led organization, Middle East and North Africa Network of People who Use Drugs (MENANPUD), which was formed at the Harm Reduction International Conference in Beirut in 2011 and its main mission is to advocate for the rights of PWUD.

The Global State on Harm reduction (HRI, 2015) showed that although monitoring of injecting drug use has improved slightly in the region, many MENA countries still make no explicit mention of harm reduction in their national strategies. Algeria's national strategic plan does not refer to harm reduction, which is also absent from Bahrain's national strategy. In Oman and Kuwait, there is no mention of harm reduction, but there are plans to revise these documents to include key populations including PWID. In Jordan and Saudi Arabia, the need to strengthen HIV prevention for key populations is acknowledged but PWID are not. However, Egypt, Iran, Morocco, Syria and Tunisia all refer to harm reduction in their national strategic plans (HRI, 2015).

Currently, harm reduction policies and programs exist in Afghanistan, Iran, Lebanon, Morocco, Pakistan, and Syria due to a number of advocacy actions that defended the efficiency of these policies and programs: these actions were mainly conducted by civil society organizations in most of these countries (MENAHA, 2013a).

In November 2012, a technical meeting to develop an Arab AIDS strategy took place in Riyadh. The meeting was organized by the League of Arab States in coordination with the United Nations Joint Program on HIV/AIDS (UNAIDS). It served as a technical forum for facilitating the development and implementation of the strategy. The Council of Arab Ministers of Health endorsed the Arab AIDS Strategy (2014–2020) during its session at the League of Arab States. The strategy urges the need to scale up HIV testing and harm reduction programs as part of an integrated package of services for PWID.

In the same scope of harm reduction strategies, as stated by many resources and in the Global State of Harm Reduction report (HRI, 2015), civil society played a leading role in securing important reductions in the cost of hepatitis C (HCV) medications. According to the Economics Times civil society actions contributed to adding ten new countries by Gilead for its Sovaldi access program, Tunisia and Libya were among these 10 countries (Economic Times, 2015).

All the advocacy for policy development by CSOs were mainly based on direct contacts with policy makers, in addition to scoping missions, sensitization sessions, working with the media, and

organizing communication campaigns, including partnering with key stakeholders such as religious leaders and policy makers.

Current situation and barriers

Several developments have happened in the MENA region since the first situation assessment on harm reduction conducted by MENAHA in 2008. Morocco and Lebanon adopted a harm reduction policy on Opioid Substitution Therapy (OST); Bahrain, Egypt, Jordan and Syria included PWID as a target group for HIV prevention in their National Aids Strategic Plan (NASP); OST was started in Afghanistan, Lebanon and Morocco and scaled up in Iran; Needle and Syringe Programs (NSP) were scaled up in ten countries – Afghanistan, Egypt, Iran, Jordan, Lebanon, Morocco, Oman, Pakistan, Palestine and Tunisia (MENAHA, 2012). However, these changes were reached very slowly due to a number of security crises, political, social and financial barriers in MENA, which resulted in a need to reach additional stakeholders and conduct further advocacy efforts.

MENA – the political and security crisis

MENA countries have experienced an influx of refugees due to on-going conflicts in countries in the region, including Afghanistan, Iraq, Libya, Syria, and Yemen. The conflict in Syria, in particular, has placed a burden on neighboring countries including Lebanon and Jordan, as well as Egypt to a lesser extent (UNHCR, 2015).

Heroin is the most commonly reported injectable drug by countries in the region (MENAHA, 2012). Substance use, including injecting drug use among refugee and migrant populations, is a neglected area of public health although it has been recognized as an important risk environment for substance-related harms, including HIV (Strathdee et al., 2010). Limited research has been conducted on harm reduction approaches in refugee and migrant settings worldwide. Unpublished data from 2014–2015 highlights the emergent need to consider harm reduction and HIV prevention among refugees in primary health care provisions.

While HIV infection is spreading in MENA, with the highest number of new cases reported each year worldwide, the consequences of the wars have decreased governments' commitments to the HIV response.

Access to continuum of care, treatment and services

In June 2012, the World Health Organization (WHO) released the first consolidated guidelines for the use of antiretroviral (ARV) drugs to prevent and treat HIV infection, which brought together clinical, operational, and programmatic guidance for all populations across the continuum of HIV services. As such, WHO recommends the use of ARV drugs, particularly for people exposed to HIV risk, including those with higher-risk behaviors.

A recent population size estimation study, conducted by MENAHA with men who have sex with men (MSM) and PWID in Lebanon, found a high prevalence of hepatitis C among PWID which was associated with sharing needles (MENAHA, 2015b). The results of this study as well as other research and data have informed that new harm reduction policies and programs are needed, and are currently piloted in Lebanon by the Ministry of Public Health in partnership with MENAHA.

HIV testing and counseling (HTC) is an integral component of HIV prevention programs and, CSOs have been advocating for this service since its start-up. However, there is still very limited access to HTC throughout the region. Some progress has been made through the integration of HTC with other health services, which contributed to increased access to this service. Moreover, based on Global Fund reports the numbers of voluntary HTC centers have

increased in the past seven years across the region because many governments of MENA countries have taken major steps towards the prevention of HIV including this service. However, the fact that injecting drug use remains the primary route of HIV transmission emphasizes the need for further scale up and legalization of these types of prevention initiatives.

Gender specific services and women injecting drugs

In 2010, women comprised an estimated 44–45% of people living with HIV in the MENA. The vast majority of women in the region, who are HIV-positive, acquired their infection from their husbands or partners who practice high-risk behavior.

Injecting drug use among women is growing worldwide ([European Monitoring Centre for Drugs and Drug Addiction, 2006](#)). Although the actual proportion of women who inject drugs in the MENA region is unknown, anecdotal data implies similar growing trends in injecting drug use among women as elsewhere in the world ([WHO, 2014](#)).

Although the evidence is that female injecting drug users have different experiences from their male counterparts and limited access to harm reduction services, gender sensitive interventions are rarely integrated into harm reduction programs. An operational research study was conducted in 2013 by MENAHRA in five countries (Afghanistan, Egypt, Lebanon, Morocco and Tunisia) to better understand the context of drug use among women who inject drugs and the factors that hinder or facilitate access to harm reduction services. The study found a number of problems related to gender-based norms and domestic abuse which lead to drug use. For example, women from Egypt, Lebanon, Morocco, and Tunisia identified factors that contributed to their initiation into drug use, including a history of family problems, sexual relations outside marriage, being left by their partners, unwanted pregnancies, and abortions. In addition, domestic abuse, including verbal and physical abuse as well as other unjust treatment from family members, was believed to make women vulnerable to drug use. The study findings also highlighted the underlying gender-specific determinants of needle sharing. Women tended to use the syringe after their partner and were therefore more likely than their partners to use contaminated needles. The findings were concordant with available data from the region and elsewhere ([MENAHRA, 2013b](#); [Rafiey, 2009](#)).

Women in MENA face important health hazards associated with gender, and have difficulties accessing healthcare services. Sexually transmitted infections, HIV, and hepatitis B and C infections were found to be common among female injectors, particularly those who engage in commercial sex. Unsafe sexual practices among women who inject drugs are shaped by gender determinants and infections.

Interventions to reduce harm associated with drug use should therefore take into consideration the social determinants that expose women to injecting drug-related hazards. Efforts should be focused on improving women's education, ensuring their economic independence, and increasing their awareness of their rights. Harm-reduction approaches should prioritize women in all their activities. More financial and human resources within existing programs should be dedicated to reaching out to women who inject drugs and responding to their health and social needs.

Repressive laws and social stigma

The criminalization of sex work, drug use, and same-sex relations in MENA countries mean that many people from key populations are incarcerated at some point in their lives. Discriminatory legislation, stigma, and violence in many countries pose major barriers to providing HIV services and limit the use of

the existing ones, unless a paradigm shift would transform these legislation to public health policies, similarly to the situation that Malaysia underwent in 2015, where the government adopted needle exchange, opiate substitution and other harm-reduction measures.

Globally, according to WHO, there are 83 countries that have repressive laws that pose barriers to HIV responses. Furthermore 33 countries and territories still include the death penalty for drug offences, including 10 in which the sentence is mandatory. 16 among the 33 concerned countries are located in MENA; varying from high applications states (Iran, Saudi Arabia) to low applications states (Kuwait, Pakistan, Egypt), or symbolic applications states (Oman, Qatar, United Arab Emirates, Bahrain, Palestinian Territories, South Sudan). Some countries have insufficient data on any further details (Libya, Sudan, Iraq, Syria, Yemen). In the past year, hundreds of people have been executed for drug offences in violation of international law in a small minority of states that continue to operate at the fringes of international consensus ([Gallahue & Lines, 2015](#)).

Strengthening the role of CSOs to scale up HIV and HR responses

Based on the above, CSOs have demonstrated a strong influencing role in harm reduction policy development; however there is a need for CSOs to be strengthened in order to partner with stakeholders and advocate with policy makers in their countries. For a long time, the role of the key population communities and PLHIV was underestimated and they were considered beneficiaries and not key partners of the HIV response. MENAHRA, for instance, established close partnerships with PWID and their networks since its inception. Additionally, key populations and CSOs are not usually engaged as part of monitoring the quality of services provided, including documenting rights violation cases. One of the factors contributing to this situation is the limited capacity of these communities and their representative organizations. The strengthening needs would include capacity to organize engagement as well as technical capacities such as management and service related-knowledge and skills.

Most notably, in 2014, the endorsement of the League of Arab States' (LAS) HIV strategy by the Ministers of Public Health gave hope that after 33 years of the HIV epidemic, MENA CSOs now have a strategy to fight HIV. However, CSOs must continue to push national governments and UN agencies to implement this strategy, translate it into law and cement its funding within country's budgets.

The Regional/Arab Network against AIDS (RANAA) is another leading CSO organization which is active in the region. It covers 25 countries in MENA and is a network of national networks of CSOs working on HIV as well as support groups of people living with HIV (PLHIV) in the MENA. In 2014, RANAA signed a Memorandum of Understanding with the League of Arab States to implement the HIV strategy throughout the MENA region.

Research and evidence from MENA are very rare and there is a need to provide support to research institutions and to work with these institutions to compile regional data in order to better understand the epidemic.

As key players, CSOs suffer from a serious lack of resources. The Global Fund's new eligibility criteria give the impression that the Fund is withdrawing from the MENA region. Currently, the Global Fund is the largest funder of HIV services in the world and only six to seven countries of the MENA region are eligible to receive its funding. The reason for this is that MENA countries are being classified as middle to high-income countries. Yet a high-income level does not necessarily mean an adequate government response to HIV. In most countries, HIV is not even recognized as an issue. As such, CSOs and sometimes governments are seeking support from

international organizations. The MENA CSOs that assist in filling the gap between the services provided by the government and the needs of people necessitate financial support to sustain and implement their programs.

Conclusion

In MENA, there are several CSOs that are making a real change in policies, and having an impact on service delivery and community progress. Regional networks are being created, including RANAA, MENAHRA, MENAROSA, ITPC and two newly established networks, MENANPUD and M. Coalition, to address HIV among key populations. MENANPUD, M. Coalition and MENAROSA are considered to be a real revolution in CSOs in this part of the world. They are networks of community members who want to defend their rights. MENAROSA is working with women living with HIV. M. Coalition is a beacon of hope for MSM rights and support. MENANPUD is the network of PWUD who advocate for their rights, promote their right to health and harm reduction in spite of all the challenges, mainly related to criminalization and repressive laws.

The visibility of PWUD in the region is crucial for change. They must be involved in decisions or policy making that will address their health rights and access to services. While many CSOs are working on advocacy for access to Anti-Retroviral Treatment, these efforts need to be coordinated, and strategized with existing networks and CSOs. A regional platform is being initiated for this purpose and if CSOs can work together, they can make their voice heard loud and clear and thus together will succeed strongly in advocating for integrated policies.

Despite benefiting from many grants, CSOs in MENA need urgent support to sustain their efforts, to advocate for harm reduction policies and to improve their services. The MENA region is treading a line between low drug use and HIV prevalence and an overwhelming wave of new cases, and all the indicators point to the same inevitable outcome. Government, funders, academia, all other stakeholders, and UN agencies working together will help

curb drug use prevalence and the harms associated with the current regional situation.

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