



Harm Reduction

Where do we stand?





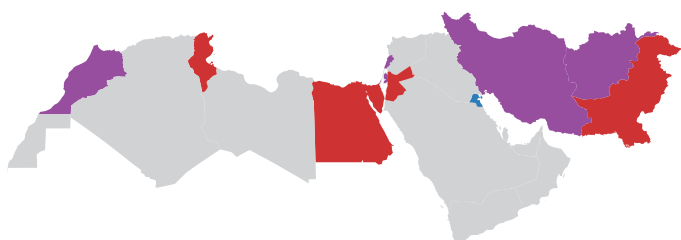
Where do we stand?

In the past decade, national and international interest in harm reduction in the MENA has increased. As a result, there has been an increase in research, improvements in disease surveillance, and establishment of significant health policies throughout the region.



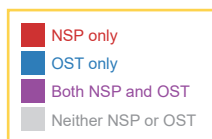
What's the situation regarding harm reduction response?

MAP 1 Availability of Needle/Syringe Programmes (NSP) and Opioid Substitution Therapy (OST) by 2017



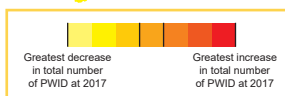
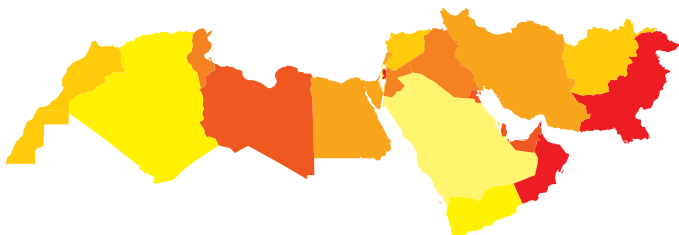
NSP Afghanistan, Egypt, Iran, Jordan, Lebanon, Morocco, Pakistan, Palestine, Tunisia

OST Afghanistan, Iran, Kuwait, Lebanon, Morocco, Palestine, UAE. Planned in Pakistan and Oman.



Here is how the number of PWIDs is changing in each country in the region

MAP 2 Fluctuation in the prevalence of PWIDs from 2012 to 2017





What are the most significant accomplishments so far?

- **Iran** has consistently been scaling up NSP and OST, as well as increasing ART availability. The country is the only one in the region that offers BMT, MMT, and opium tincture as forms of OST. Iran continues to serve as a model country in the region in terms of harm reduction response.
- **Lebanon** is the only country that has scaled up NSP and OST in a comparatively remarkable way, while inputting harm reduction into national policy. Additionally, HBV vaccination is provided to PWID and HCV testing is conducted.
- The amount of **countries with NSPs increased to 9** by 2017: Afghanistan, Egypt, Iran, Jordan, Lebanon, Morocco, Pakistan, Palestine, and Tunisia.
- The amount of **countries with OST available has increased to 7** by 2017: Afghanistan, Iran, Kuwait, Lebanon, Morocco, Palestine, and UAE.
- As of 2017, general **counseling for HIV is available** in Afghanistan, Egypt, Iran, Jordan, Lebanon, Morocco, Pakistan, Palestine, Syria, and Tunisia.

A range of success in implementation of National AIDS Strategic Plans throughout the region:

Country	NASP Years	Addition(s) to NASPs
Iran	2015-2019	Maintenance of HIV prevalence at less than 15% among PWID
Lebanon	2016-2020	OST and NSP added, with Naloxone and methadone maintenance by 2019
Morocco	2012-2016	OST added, Increased HIV education, distribution of syringes and condoms
Pakistan	2015-2020	OST added, PWID acknowledged as vulnerable group, plan to implement BMT
Palestine	2014-2018	Pilot methadone maintenance program
Saudi Arabia	2013-2017	Prioritization of HIV screening, counseling, and treatment
Tunisia	2015-2018	OST and NSP added, plan for HIV prevention and care



What's delaying the process?

Conflict

- o **Political unrest and/or war** – Afghanistan, Bahrain, Egypt, Iraq, Palestine, Libya, Syria, Yemen. Ongoing fighting inhibits these countries from establishing methods of harm reduction response as national resources are allocated towards resolution of the conflicts.
- o **Refugees** – Iran, Jordan, Lebanon, Pakistan. Increasing refugee populations have reflected increased need for harm reduction and health related services. Countries bordering the conflicts in Syria and Afghanistan have exhausted their already limited harm reduction resources to meet increasing needs.

Variation in prioritization of HIV and harm reduction

- o **High-income countries**, like Oman, UAE, Kuwait, Bahrain, Saudi Arabia, and Qatar have relatively developed healthcare systems yet there is a lack of relevant political interest in harm reduction. **These countries have the resources but do not necessarily prioritize HIV as a concern.**
- o **Middle-income countries**, like Iran, Jordan, and Tunisia have the capability to allocate more resources to harm reduction. However there is a significant **lack of political interest and resources are limited.**
- o **Low-income countries**, like Afghanistan, Yemen, Palestine, Iraq, have lesser-developed healthcare systems and fewer resources. As a result they **cannot prioritize HIV and harm reduction response.**

Societal and Cultural Challenges

- o **Traditional and conservative views may be obstacles** in creating or implementing harm reduction responses. This is specifically evident in Afghanistan, Pakistan, Bahrain, and Saudi Arabia.
- o Throughout the MENA region, there is an evident **stigma** against researching HIV, PLHIV, or even acknowledging the presence of HIV. Additionally, there is a stigma when conducting research or acknowledging a presence of alcohol consumption, drug use, and homosexuality. As a result, surveillance of drug use and sexual health issues is inadequate, and implementation of harm reduction practices is limited.

Economic Challenges

- o The availability of funds and resources varies throughout the region. **One standard set of recommendations cannot be used** because each country has a unique developmental and economic situation.
- o There is **understaffing** in Oman, Saudi Arabia, and Syria. As a result these countries have to downsize the harm reduction plans accordingly.
- o Collaboration among research groups, NGOs, the government, and private clinics is insufficient, resulting in **incompleteness of data and limited distribution of harm reduction resources.** This is especially present where there are many groups working without cohesion, like in Afghanistan and Lebanon.
- o There is **poor resource allocation, availability, or mobilization** in Algeria, Afghanistan, Palestine, Lebanon, Kuwait, Yemen, Morocco, and Bahrain. These countries tend to have services concentrated in the largest cities with very low resource penetration in rural areas.
- o The MENA region is highly **dependent on external assistance** – with majority of the harm reduction resources being provided by the Global Fund.

Political Challenges

- o Qatar, Bahrain, UAE, Saudi Arabia, and Kuwait **criminalize** PLHIV and treat deportation as their harm reduction policy. The majority of resources in these countries are used in screening for the presence of HIV or drug use. Qatar, Kuwait, and UAE lack a NASP. Oman and Bahrain have yet to update their elased NASPs.
- o NGO presence within countries varies due to government interest and support of the intervention. Kuwait, Bahrain, Oman, Qatar, Yemen, Iraq, and UAE have **very limited or no active NGOs** working towards harm reduction and HIV control.



What needs to be done?

- **Scale up advocacy and harm reduction practices.** Specifically in countries with a very high prevalence of HIV and large amount of PWIDs, like Egypt, Pakistan and Morocco.
- **Improve data collection and surveillance** by increasing research and/or collaboration among researchers in order to create usable sets of data. Data is most unreliable or unavailable in Yemen, UAE, Qatar, Iraq, Bahrain, Egypt, Libya, Saudi Arabia, Afghanistan, and Pakistan.
- **Scale up surveillance** of HCV, HBV, and tuberculosis among PWIDs. These diseases are highly prevalent in certain areas in the region and data is extremely limited.
- **Improve surveillance of overall HIV** in Afghanistan, Algeria, Iraq, Libya, Pakistan and Palestine, as data after 2012 is largely unavailable for these countries.
- **Support further or initial bio-behavior surveys (BBS)** in Iraq, Bahrain, Kuwait, Libya, Qatar, Saudi Arabia, UAE, and Yemen. BBSs are the most effective ways to study those who are most at risk, so that policies and harm reduction response programs can target specific populations.
- **Attain increased support from religious leaders,** because they have significant influence on the implementation of harm reduction policy.

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Harm Reduction in MENA

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