



## Viewpoint

## Policy change towards implementing harm reduction in Sub-Saharan Africa



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Opiate use has been documented in 36 countries in Africa, with its prevalence ranging from an estimated 2.3% of the adult population in Seychelles, to 1% in Mauritius, and 0.3% in Kenya (Ministry of Health of Seychelles, 2011; UNODC, 2014). Injecting drug use has been reported in 28 African countries, with increasing evidence of linked HIV epidemics (Bouscailiou, Evanno, Proute, Inwole, & Kanran, 2016; Kurth et al., 2015; Lepretres et al., 2015; Matiko et al., 2014; Nyandindi et al., 2014; Scheibe et al., 2016; Eluwa et al. 2013). Two scenarios characterize the diffusion of HIV among people who inject drugs (PWID) in the Sub-Saharan African region: there are countries, such as Kenya and Tanzania, that have moved from a long-established generalized HIV epidemic to a recent mixed epidemic with high HIV prevalence among key populations, including PWID; and there are concentrated HIV epidemics among PWIDs emerging in low HIV prevalence countries, such as Mauritius, Seychelles and Zanzibar.

There is now wide consensus in the region that the adoption of the comprehensive package of nine evidence-informed interventions recommended by United Nations (WHO, UNODC and UNAIDS, 2012), and the United States President's Emergency Fund for AIDS Relief (PEPFAR) tenth intervention, namely outreach, can help significantly reduce new HIV and hepatitis infections among PWID and their sexual partners. The global evidence in support of combination HIV prevention for PWID is compelling (Degenhardt et al., 2010; MacArthur, Minozzi, & Martin, 2012), and this has framed initiatives supported by PEPFAR in the region since 2010 towards fostering policy change supportive of the development of harm reduction. The combination of interventions promoted includes mutually reinforcing biomedical, behavioural, and structural interventions, which are not only evidence-informed but rights-based as well as community-owned. Countries have begun to endorse and develop a package of HIV prevention intervention for PWIDs, including to varying extent, medically assisted therapies for treating opiate use and addiction, low threshold access to antiretroviral HIV treatment, needle and syringe distribution and exchange, sexual behaviour change communication, and community outreach. There is also a need for structural interventions to address critical social, legal, political, and environmental enablers of HIV risk.

The policy environment for harm reduction has significantly improved in the region over the last five years. This has enabled

more countries to accept and adopt policies, or at least strategies, to reduce new HIV and hepatitis B and C infections among PWID. Mauritius was the first country in Africa to enact drug specific harm reduction legislation, namely the HIV and AIDS Act 2006, which made NSP lawful. Kenya and Tanzania Mainland have adopted harm reduction strategies, including NSP since 2010 in Tanzania and 2013 in Kenya, and opioid substitution treatment (OST) since 2011 in Tanzania and from late 2014 in Kenya (Ratliff, McCurdy, & Mbwanbo, 2013; Rhodes et al., 2015). A noticeable feature of the policy shifts occurring has been the combined efforts of multiple players and stakeholders working at different levels and in different ways to promote harm reduction and the health rights of drug users.

## Policy change through multiple stakeholder engagement

At the continental level, the African Union Plan of Action on Drug Control 2013–2017 was endorsed at the 5th African Union Ministerial Conference in 2012, and strongly committed itself to implement the United Nations comprehensive package of nine interventions on harm reduction (African Union, 2013). The Regional Economic Commissions (RECs) in Africa, specifically the Southern Africa Development Community (SADC) and the Economic Commission of West African States (ECOWAS), have also expressed their support for harm reduction.

At the level of national Government, there is increasing evidence of policy debate being evidence-informed. In Mauritius, the commitment of the top political leadership to harm reduction in 2006 led to a major paradigm shift in policy (Republic of Mauritius, 2012). Recognizing that drug users accounted for almost 70% of prison inmates, the government offered Provider Initiated HIV Testing and Counselling (PITC) upon entry in prisons by the prison health personnel. In 2009, 40% of them tested positive at entry. This decreased to 18.5% in 2013. The OST services were also extended to PWIDs in prisons. To date, of an estimate of 10,000 PWIDs in the country, 5570 are receiving OST and 2300 are receiving NSP services, thus giving a harm reduction coverage of 78%. Kenya, Tanzania Mainland, Zanzibar and Seychelles have introduced harm reduction in their national strategic documents on drug control and HIV prevention. While this has not been followed by national legislation, Kenya and Tanzania Mainland have developed their national protocols for OST and NSP, with services now being implemented, while Zanzibar has just initiated its OST service.

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The role of international agencies has also been key to shaping the policy debate and to fostering momentum towards policy endorsement of HIV prevention for PWID. The United Nations Office of Drugs and Crime (UNODC) and UNAIDS have been vocal advocates of harm reduction policies, including at international fora such as the Commission of Narcotic Drugs and international conferences on AIDS. UNAIDS, UNODC, WHO, UNDP and the Global Fund have published a number of strategic guidance notes to support governments and civil society organizations to adopt harm reduction interventions, including technical guidance for countries on the setting of targets towards universal access to HIV prevention (WHO, UNODC and UNAIDS, 2012). In addition, recent meetings of the International Narcotics Control Board (INCB) and the Commission on Narcotic Drugs (CND) have noted the need for drug control to encompass HIV prevention and the reduction of drug harms (CND, 2009, 2013; INCB, 2014). The Global Fund has also played an important role in voicing support for harm reduction, and in supporting the development of NSP in Kenya.

The support of the United States Government (USG) has been key to securing resources and technical support for harm reduction in East Africa, especially in Kenya, Tanzania Mainland and Zanzibar, and to a lesser extent in South Africa. The published USG/PEPFAR guidance on HIV prevention among PWID brought a fundamental shift in the USG approach to HIV prevention among PWIDs (PEPFAR, 2010). In Kenya, USAID and UNODC have combined to support the country's response on the Coast Counties while the Centre for Disease Control and Prevention (CDC) has played a critical role in establishing OST in Tanzania Mainland and in Nairobi, Kenya.

Several international non-governmental organizations (NGOs) are increasingly engaged in the HIV prevention response in Kenya and Tanzania. These include the International HIV and AIDS Alliance, Harm Reduction International, International Drug Policy Consortium, International Network of People Who Use Drugs, Medecins du Monde, Open Society Institute, Dutch Mainline, and Youth Rise. These NGOs have persistently advocated for the rights of PWIDs to access evidence-informed harm reduction services and have also collaborated with local NGOs to increase their capacity for advocacy, to work with law enforcement agencies and to deliver low-threshold HIV prevention services.

The full engagement of local CSOs in Kenya, Mauritius, Nigeria, South Africa, Tanzania Mainland and Zanzibar, including networks of people who use drugs in advocacy and in the design, implementation, monitoring and evaluation of harm reduction programmes, has made a significant contribution to advancing the rights of drug users and developing evidence-informed services. The CSOs have also played a key role in reaching out to PWIDs in communities, informing and educating them on harm reduction, providing them with clean injecting equipment and condoms, referring them to health services and assisting them with psychosocial support, including linked to early initiation of OST interventions.

### Policy change supporting harm reduction interventions

Despite strong global evidence (Degenhardt et al., 2010; MacArthur et al., 2012), the coverage of harm reduction interventions for PWID is abysmally low. Mathematical models conducted elsewhere suggest that high coverage of combined OST, NSP and ART can reduce new HIV infections among PWIDs by more than 50%, subject to background levels of prevalent HIV infection (Degenhardt et al., 2010). In Mauritius, the introduction, rapid scale up and decentralizing NSP and OST services have led to a dramatic reduction in new HIV infections among PWIDs. This key population accounted for 92% of new HIV infections in 2005. This dropped to 68% in 2011, to 38% in 2013, and 31% in 2014

(Ministry of Health of Mauritius, 2015). It is estimated that a reduction of the unmet need of OST, NSP and ART by 60% during the 2010–2015 could prevent 30% of incident HIV infections in Nairobi, Kenya (Strathdee et al., 2010).

Table 1 lists Sub-Saharan African countries with evidence of harm reduction intervention, though the estimated scale and coverage of these interventions may be largely unknown or is woefully inadequate (*italics* denotes estimated low coverage). While testing for hepatitis B and C is offered in Kenya, Mauritius, Seychelles and Tanzania and hepatitis C testing and diagnosis is affordable, the current estimated costs of treatment of chronic hepatitis C are prohibitive to most resource-constrained settings in sub-Saharan Africa. Several countries have made naloxone available in their emergency rooms or operating theatres as a means of reversing opiate overdose. In Kenya, Mauritius and Tanzania, naloxone is now available at OST clinics or in adjoining health facilities, and has been piloted by outreach workers at street-level in Kenya.

There is a growing realization of the key role that law enforcement officers working at community level can play as agents of positive change, including referral of PWID to health services. In selected countries of Sub-Saharan Africa, advocacy with, and sensitization of, judiciary and law enforcement officers has been conducted during the past five years to enhance their understanding of HIV among PWIDs, to respect the human rights of drug users and to support their diversion from the criminal justice system to health and social services. For instance, in January 2015, drug users accounted for 70% of prisoners in Malindi Prison on the Coast of Kenya, with many of these linked to petty crime rather than directly linked to drug use or distribution. Sensitization trainings with law enforcement officers in Mauritius in 2011, and in Mombasa and Malindi in Kenya, in Dar es Salam, Tanzania and in Zanzibar in 2014, have resulted in officers pledging their support for harm reduction intervention and to assisting drug users in their access to health and HIV services. Mauritius is the first country in the region to start with induction and maintenance of OST for PWIDs in prisons and Kenya and Tanzania Mainland have signified their interest to do likewise.

Intervention development at the community level has also been assisted by the sensitization of a cross-section of key community stakeholders on the benefits of harm reduction. This has been the case, for example, in the early implementation phase of OST in Malindi and Mombasa on the Coast of Kenya, as well as in Dar es Salam and Zanzibar, where sensitization workshops have sought to reduce social stigma linked to drug use and drug users. Community sensitization intervention has been a key ingredient of initiatives designed to create environments enabling of harm reduction in East African countries. Such intervention has afforded opportunity to emphasise the far-reaching as well as indirect benefits of harm reduction in relation to improving the quality of community life,

**Table 1**  
Harm reduction policy and intervention in Sub-Saharan Africa.

Country	HR legislation	HR Policy	NSP	OST	ART	Outreach
Kenya		Yes	Yes	Yes	Yes	Yes
Madagascar		Yes	Yes		Yes	Yes
Mauritius	Yes	Yes	Yes	Yes	Yes	Yes
Nigeria			Yes		Yes	Yes
Seychelles		Yes		Yes	Yes	
South Africa			Yes	Yes	Yes	Yes
Tanzania Mainland		Yes	Yes	Yes	Yes	Yes
Zanzibar		Yes		Yes	Yes	Yes

**Note:**

- A policy constitutes a formal harm reduction policy, a national strategic plan, or an operational plan.
- Italics denote very limited estimated intervention coverage.

reducing crime, and reducing the burden on law enforcement and the criminal justice system, including prisons. Working with media organisations has also been a key stratagem of supporting policy change towards harm reduction. In Kenya, enlisting the support of the media has been a key feature in the national response to building HIV prevention among PWIDs (see also, Rhodes et al., 2016).

## Conclusion

There has been significant recent progress for harm reduction policies and practices in sub-Saharan Africa. The gains have been slow but the momentum is building. All the countries in the region need to review their legislation in order to secure harm reduction interventions under law. While Mauritius has made such major progress in promulgating its HIV and AIDS Act 2006, ambiguity nonetheless persists in its full enforcement vis-à-vis certain provisions of the Dangerous Drug Act of 2000, to the extent that drug users may still be arrested for possession of illicit drugs. South Africa and Nigeria have been identified by the United Nations as high priority countries for HIV prevention among PWIDs. With their large populations, of 50 million and 160 million respectively, high number of new infections annually at 387,000 and 336,000 respectively, and relatively high HIV prevalence among PWIDs, the adoption and rapid scaling up of harm reduction interventions are urgently needed. Both countries can achieve an impressive reduction in new infections among PWIDs by adopting evidence-informed policies and interventions. Both Kenya and Tanzania Mainland need a rapid scaling-up of NSP and OST in all sites where PWIDs are concentrated. Zanzibar initiated its OST programme in January 2015 and NSP needs to start very rapidly. Mauritius has already achieved a high coverage for harm reduction services. Putting all PWIDs on OST and all HIV positive PWIDs on antiretroviral therapy, irrespective of CD4 count, are not insurmountable tasks. Mauritius may very well aspire to be the first country to achieve zero new HIV infection among PWIDs in the next five years. The Seychelles will need to scale up and decentralize its OST programme and to start NSP as soon as possible.

Time is of the essence. The time for small pilot harm reduction programmes in priority countries in Africa, and elsewhere, has gone. The virus is not waiting. It is imperative for countries to rapidly mobilize both their core resources and partners' funding and adopt a systematic public health approach for large, high volume and low threshold harm reduction programmes for HIV prevention as against small, low volume and high threshold ones.

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