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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.

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 (MENAHRA) 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. MENAHRA 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 (MENAHRA, 2015a).

In November 2013, MENAHRA 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 (MENAHRA, 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 MENAHRA 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 (MENAHRA, 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 (MENAHRA, 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 MENAHRA 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 (MENAHRA, 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 MENAHRA.

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