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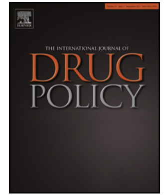

Commentary

The state of harm reduction in the Middle East and North Africa: A focus on Iran and Morocco

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ABSTRACT

HIV/AIDS and hepatitis C among people who inject drugs are on the rise in the Middle East and North Africa (MENA) region. But the regional response to the epidemic falls short both in terms of the quality and scale of response. From the threat of the death sentence for drug offenses to the burden of refugees fleeing conflict, there are many legal, political and social barriers that hinder the introduction and expansion of harm reduction in the region. However Iran and Morocco are two pioneering countries and over the last decade they have been providing evidence that harm reduction is feasible and acceptable in MENA. Using different approaches, these two countries have overcome various obstacles and encouraged discussion and collaboration among stakeholders, including government, health professionals, civil society and community-based organizations. In so doing they have created an enabling environment to endorse a national harm strategy.

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MENA, drug use, and harm reduction

Illicit drug use is on the rise in the Middle East and North Africa (MENA).[1] Evidence suggests that over half a million people inject drugs in the region (Harm Reduction International, 2014; Mumtaz et al., 2014a). Regional conflicts and the location of the Balkan trafficking route, from Afghanistan to Europe, have been associated with drug consumption and dependence in the eastern part of the region (International Drug Policy Consortium (IDPC), 2014). Further, northern Africa is the end point of the West African and Sahel Region transit route for illicit drugs going to Europe (West African Commission on Drugs (WACD), 2014). Opiates (heroin and opium) and cannabis have been the primary drugs of use in MENA, although the use of amphetamine-type stimulants, prescription drugs and new psychoactive substances is increasing (INCB, 2014). In many countries of the region, people who inject drugs (PWIDs) are among the most at-risk groups for blood-borne virus infections. There is evidence of an HIV epidemic occurring among PWIDs in at least one-third of MENA countries, most of which are facing emerging, concentrated epidemics. HIV prevalence among PWIDs ranges between 10% and 15% (Mumtaz, Weiss, & Abu Raddad, 2014). HCV prevalence is higher, with at least half of PWIDs being HCV-infected5. In some countries, and amongst some groups, prevalence has reached some of the highest worldwide levels – for example, Tripoli, in Libya has reported rates as high as 87% for HIV and 94% for HCV (Mirzoyan et al., 2013).

The response to the epidemic in MENA falls short both in terms of the quality and scale of response (UNAIDS, 2011). To date, MENA is one of the most underserved regions regarding harm reduction interventions, alongside the sub-Saharan African region. The current state of harm reduction may be roughly assessed via the ease of access to two essential harm reduction services, as defined by UN guidelines: Needle and Syringe Programs (NSPs) and Opium Substitution Therapy (OST) (WHO, UNODC & UNAIDS, 2013). Only three of the 20 countries of the MENA region have implemented this effective combination of services: Iran (2000), Morocco (2010), and Afghanistan (2010). Only NSP or only OST have been

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[1] There are 20 countries included in the definition of MENA for the purposes of this article: Afghanistan, Algeria, Bahrain, The Arab Republic of Egypt, The Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Syrian Republic, Tunisia, United Arab Emirates, West Bank, Gaza (Occupied Palestinian Territories), and Republic of Yemen.

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implemented in six and two countries respectively (Harm Reduction International, 2014). Methadone Maintenance Treatment (MMT) is the most common OST and(Rahimi-Movaghar et al., 2013) access to these essential HIV prevention interventions is limited except in Iran.

Structural barriers to harm reduction in MENA

MENA countries face common structural barriers that hinder harm reduction. The first is a largely punitive policy and legal environment. For example, 14 of the 20 MENA countries have legislation allowing for the death sentence for drug offenses – not only for trafficking, but also for drug possession. This means that drug users can be sentenced to death in more than two-thirds of MENA countries; this is true for less than one in six countries worldwide (33 of 193) (Harm Reduction International, 2012). Executions for drug offenses in certain countries accounted for 42% of all official executions in 2014 (Amnesty International, 2015). Beyond the death penalty, severe drug law enforcement in the region leads to high numbers of prisoners. A 2005 study in Morocco found that 46% of PWIDs had been incarcerated for drug use (Kouyoumjian et al., 2013). In Bahrain, not only is NSP banned but also people who use drugs may be arrested for possession of syringes (IDPC, 2014).

The second barrier is public health systems. In keeping with the social and institutional structure of most MENA countries, public health policy is driven mainly by a top-down approach (Razaghi & Binazadeh, 2015). Furthermore, drug use is commonly seen in the public and official mind as being associated with mental health disorders; as a consequence, the public health response to tackling drug use takes a mental health approach, requiring involvement of psychiatrists and physicians specialized in addiction treatment. For example, in Morocco, emerging harm reduction interventions have been devised under the umbrella of the mental health directorate in the ministry of health. It is worthwhile noting that the criminalization of drug users on a judicial level in MENA (and elsewhere) mirrors the approach to mental illness on a health level in that interventions to reduce and mitigate drug use, addiction, and associated harm have a basis in social control. This is some way from a genuine approach to harm reduction, where community involvement and "life experience" are highly valuable for devising and implementing harm reduction interventions (eds. Maguet, Debaulieu, & Luhmann, 2013). This depiction of the policy environment is evidenced by the fact that only six MENA countries refer to "harm reduction" in their national strategic plans. Furthermore, in other MENA countries, the types of health services available to people who use drugs are associated with rehabilitation and/or mandatory treatment – which is against the principles of harm reduction (Harm Reduction International, 2014). This social and institutional layout is not sufficiently challenged by the relatively weak commitment of civil society, including community-based organizations that seek to help drug users. But beyond local specificities, as in Morocco and Iran, there is a nascent movement to support MENA civil society, mainly through The Middle East and North Africa Harm Reduction Association (MENAHRA) set up in 2007, and The Middle East and North Africa Association of People Using Drugs (MENAPUD) launched at the 2011 Beirut International Harm Reduction Conference.

The last barrier has more recently originated from the geopolitical regional setting. Since the 1980s, Afghanistan and neighboring Iran and Pakistan have been places of concern with respect to refugees and displaced people. But since 2011 many other countries in the region have been facing state breakdown and armed conflict. These conflicts and crises have led to a massive increase in the number of displaced people and refugees, with Syria being at the top of the list, comprising 3.7 million refugees, mostly fleeing to neighboring Jordan and Lebanon, and 7.6 million internally displaced people. In northern Africa, Libya's failed state is another example of this new ever-evolving structural setting, with 400,000 displaced people and 37,000 refugees (UNHCR, 2015). To date, more than half of the world's refugees are located in MENA countries – Pakistan, Iran, Jordan, and Lebanon – constituting a main structural constraint, affecting national, regional and global priorities. A further issue is that the MENA region encompasses some of the most important worldwide production areas and trafficking routes for illicit drugs. Such settings encourage involvement in illicit activity, including wider access to illicit drugs, and draws the focus of international concern to drug control and counternarcotic. This nexus jeopardizes the development of a drug policy based on human rights and public health and fosters an unstable environment that is hostile to the implementation of harm reduction. This MENA specific environmental difficulties add to the more usual reluctance regarding harm reduction.

Strategies for improving harm reduction

As discussed, the development and implementation of harm reduction interventions in MENA are hindered by legal, political and social barriers. However, there is some hope coming from the boundaries of the region. Iran in the east and Morocco at the western edge are the two countries pioneering the introduction and expansion of harm reduction initiatives. They provide two different models of intervention that have been proved feasible in the MENA setting. This paves the way for other MENA countries to choose the most appropriate model of intervention for their local setting. On one side, Iran has adopted a top-down approach, while Morocco has implemented a more bottom-up approach. Focusing on the strategies adopted by Iran and Morocco will help learning about what can be applied throughout the MENA region.

Iran

Iran has the highest rate of opiate use in the region, with 2.3% of people aged 15–64 years misusing opiates (UNODC, 2013). While opium use has been a traditional practice among an older generation, heroin consumption and injection among young people aged 15–40 years has been a cause of worry for almost two decades (Alam-Mehrjerdi et al., 2015). Before 1999, government-run residential centers for heroin users, "Narcotics Anonymous" support groups, and short detoxification programs in outpatient clinics were the only available treatment programs in Iran. In the late 1990s, at a time when the country was struggling to find more effective treatment for drug use, the high prevalence of HIV among PWIDs drew the attention of policy makers to the harm reduction approach (Nassirimanesh, Trace, & Roberts, 2005).

The first opiate maintenance treatment and other fledgling harm reduction initiatives in the late 1990s and early 2000s were provided through the non-governmental sector; findings of concurrent academic research studies about rates of HIV prevalence in prisons had led to action from the Ministry of Health (MOH) and the first triangular clinic (TC) was established in the central prison of Kermanshah and then in other prisons. Methadone maintenance treatment (MMT) guidelines were developed, and drop-in centers providing outreach/out-patient services were expanded throughout the country (Alam-Mehrjerdi et al., 2015; Asl et al., 2013; Nassirimanesh et al., 2005; Razaghi et al., 2006). Of note, was the positive interaction between health, academic, governmental, and judicial sectors in recognition of drug use as a health concern, leading to the establishment of the harm reduction programs in Iran in the 2000s.

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