

**Middle East and North Africa  
Harm Reduction Association**



# Harm reduction services in MENA region: Assessment of the situation and response by MENAHRA

Elie Aaraj – Executive Director

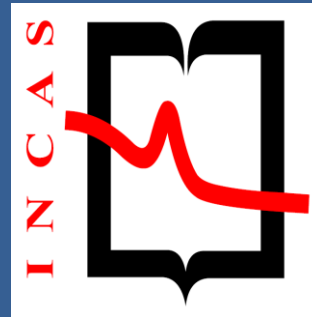
Lisbon Addictions

2019

# Authors



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## Assessment of "Situation and Response to Drug Use and its Harms in MENA"

- First assessment: **2008**
- Second assessment: **2012** Data produced since 2005
- Third assessment: **2016** Data produced since 2010



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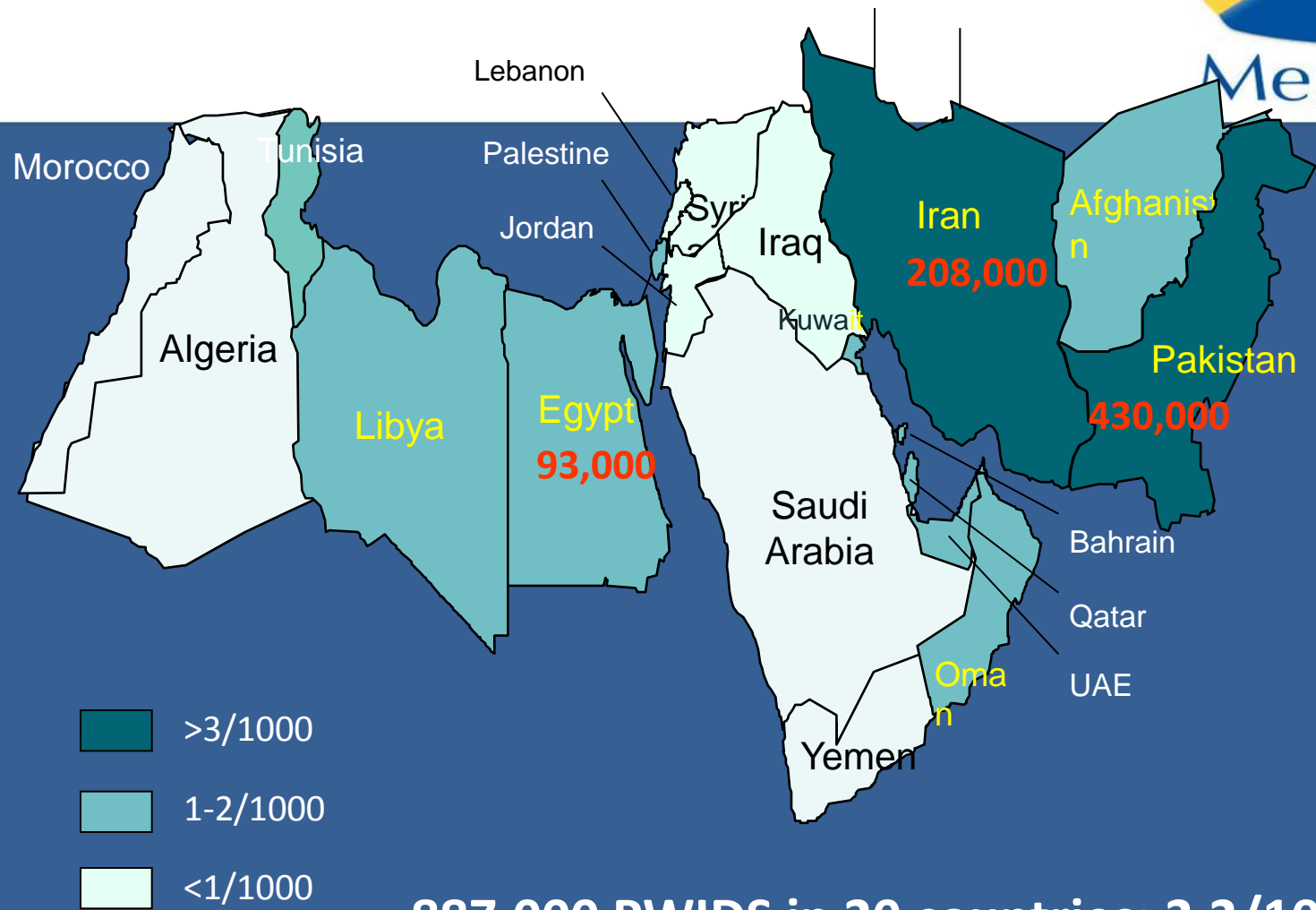
# Most common drug of use



- **Cannabis** in 11 countries
- **Opioids** in Afghanistan and Iran
- **Tramadol** in Egypt
- **Prescription drugs** in Iraq and Tunisia
- **Khat** in Yemen
  
- In Saudi Arabia, both **amphetamine and cannabis**

Other drugs of use in the region include amphetamine-type stimulants and cocaine.

# Estimations on prevalence of PWID in population 15-64



**887,000 PWIDS in 20 countries; 2.2/1000**

# Drugs of injection



- Data from 15 countries
- **Heroin** is the main drug of injection in 11 countries and injected by the vast majority of PWID.
- **Buprenorphine** is the main drug of injection in several countries, like Libya and Tunisia; it has also been reported to be injected in Iran and Pakistan.
- **Other opioids** like opium, morphine, methadone, and other prescription opioids are also injected.
- **Other:** Amphetamine-type stimulants (in Bahrain, Iran, and Palestine), cocaine (in Bahrain, Morocco, Palestine, and Syria), and prescription drugs like benzodiazepines and anti-histamines

# Socio-Demographic Characteristics of PWID



Data from 22 studies in 10 countries:

The studies provide information on 19,743 PWID

- Predominantly **male**
- Mean age of **30 to 40** years
- Around one third, married
- One- to two-thirds, uneducated or education of less than 5 years.
- More than two-thirds have history of **incarceration**.



# Bio-behavioral surveys on PWIDs



Ten countries have conducted a total of 21 BBS, since 2010.

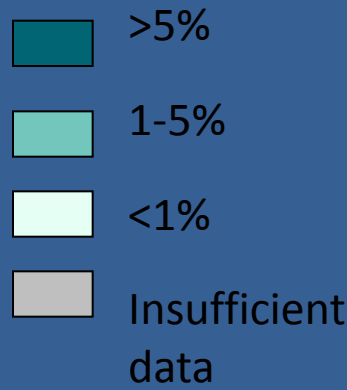
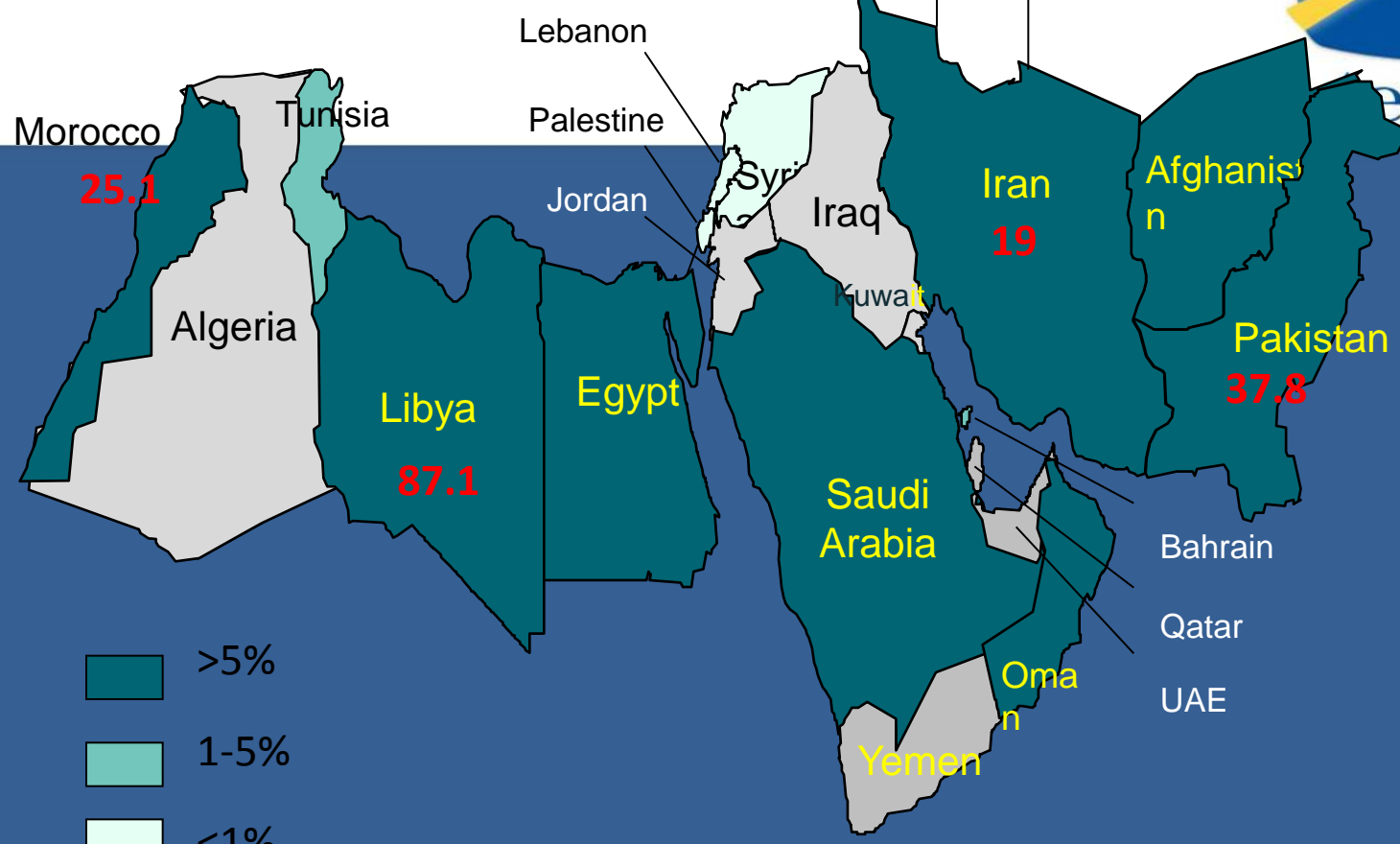
- Total number of 20,636 PWID
- Sample sizes from 42 to 4,956
- 364 (1.8%) were female
- Mainly in large cities
- Mainly conducted in communities, using the Respondent-Driven Sampling (RDS) method; few in treatment and harm reduction centers

# HIV Prevalence among PWID



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# HIV Prevalence among PWID



# HCV in PWID



Information on 19 studies from 9 countries (5,138 PWID ):

- Afghanistan, Iran, Lebanon, Libya, Morocco, Palestine, Pakistan, and Saudi Arabia, Syria
- High HCV in 8 countries
- HCV infection was from **3.3%** in Syria, up to **94.2%** in Libya
- Most between 20% and 56%

# Unsafe injection



Sharing injection equipment (10 countries):

- “Shared needles or syringes in the last month” in 5% to 36%
- “Used non-sterile needles and syringes in last injection” in 5 to 35% of PWID

The main reasons:

- Difficulty in accessing new syringes at the time of need for a quick injection
- Belief of the safety of injection with a trusted partner

# Opioid substitution treatment (OST)



OST exists in seven countries:

- MMT (4 countries): Afghanistan, Iran, Morocco, and Palestine
- BMT (4 countries): Iran, Kuwait, Lebanon, and the UAE
- Opium tincture: only Iran

Iran has a large OST program: >7,000 centers and several prisons, providing OST to >650,000 opioid dependents.

Morocco and Lebanon have expanded their OST services in recent years.

Oman and Pakistan are also currently planning to initiate OST.

# Needle Syringe Program (NSP)



Started 15 years ago

Nine countries provide NSP:

- Iran and Pakistan have large NSP services
- Afghanistan, Lebanon, Morocco, Palestine, and Tunisia have extensive programs.
- Existed in Egypt and Oman for some time.

Main challenges: availability of funding, political commitment and support, long bureaucratic process of getting approval, and security problems

# Major barriers



- Inadequate HIV preventive interventions for the most-at-risk populations.
- Injecting drug use is not recognized as a significant threat to the health of the drug users and communities.
- Inadequate political support in health sector, in drug-control structures, and in other policy-making bodies.
- High risk behaviours are extremely stigmatized and criminalized, which jeopardize recognition of the problem in the overall planning.
- NGOs and CBOs are not actively involved in the health needs of the vulnerable groups.
- A proper surveillance mechanism is missing.
- Inadequate technical human resources and research capacity





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***National body***

**Civil Society Organizations**

**Main elements**

***Academic and research centers***

**External assistance**

***Data production***

**Advocacy**

**Main actions**

***Policy making***

**Service development**



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Assessment



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**THANK YOU**

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**#sdp**