

IDPC Briefing Paper

HIV prevention among people who use drugs in East Africa

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Introduction

There is a well-developed drug market across Sub-Saharan Africa¹ which, as in other parts of the world, is associated with increased criminal activities and corruption, as well as drug use, dependence and related health problems.² Most alarmingly, this includes emerging injecting-related HIV and hepatitis epidemics³ in a region that already bears the brunt of the global HIV epidemic (Sub-Saharan Africa accounts for approximately two-thirds of all people living with HIV).⁴

Much international attention has been given to the perceived increase in drug trafficking and supply through Western Africa, but notably less focus has been applied to drug use and related harms in other parts of the continent – particularly in East African countries. Many Sub-Saharan African governments have developed national strategies that seek to contain drug markets; however, these strategies are far from reflecting a balanced approach to drug control that can respond effectively to drug supply, drug demand and drug-related harms, and which also meet international human rights standards. Experience, debate and scientific evidence on harm reduction from other parts of the world are helpful to inform some government responses to drugs and HIV in Africa.

So far, most governments in the region have focused their drug policies and programmes on the criminalisation of drug possession and use. Evidence from around the world shows that such strategies have not only failed to reduce the prevalence of drug use,⁵ but they have also resulted in a number of negative consequences. These include the development of a huge criminal black market, corruption, increases in violence, the stigmatisation of people who use drugs, and the expansion of drug-related health harms such as HIV.⁶

The high rates of HIV in most Sub-Saharan African countries are primarily driven by heterosexual transmission, but injecting drug use is playing an increasingly significant role in some countries such as Kenya, Tanzania, Mauritius, Mozambique and South Africa, especially among young people.⁷ Yet there is evidence to show that HIV transmission among people who inject drugs can be avoided by adopting a package of proven HIV prevention measures.⁸ To date, only Tanzania and Kenya in East Africa, Mauritius in the Indian Ocean, Senegal in West Africa, and South Africa have started to provide key harm reduction interventions for people who use drugs – albeit in a limited way in most cases.⁹ The coverage of these interventions across the region remains

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incredibly poor: it has been estimated that less than 1 per cent of people who inject drugs in sub-Saharan Africa have access to NSPs and/or OST.¹⁰ In addition, less than 1 per cent of eligible people who inject drugs are receiving antiretroviral therapy (ART).¹¹

This briefing paper summarises the findings of a literature review and scoping exercise¹² commissioned by Harm Reduction

International (HRI) and the International Drug Policy Consortium (IDPC) in 2012. It aims to establish the current state of drug policy and harm reduction services in four East African countries – Kenya, Ethiopia, Uganda and Tanzania.¹³ The paper analyses the barriers and opportunities for harm reduction, and provides recommendations to improve access to services in these four countries.

Box 1. The African Union Plan of Action on Drug Control for 2013-2017

In October 2012, the African Union (AU) – the continental body representing 54 African Member States – held its 5th Conference of Ministers of Drug Control in Addis Ababa¹⁴. At this meeting, AU Member States discussed and adopted a new Plan of Action on Drug Control for 2013-2017.

Previous AU strategies have focused almost exclusively on supply reduction and a punitive, law-enforcement led approach to drug policy. The new Plan of Action therefore represented a significant turning point for the continent – providing instead a balanced approach that comprises supply reduction, demand reduction and harm reduction measures. Although familiar politics meant that the term ‘harm reduction’ did not make it into the document, reference is made to the need for ‘comprehensive, accessible, evidence-informed, ethical and human rights based drug use prevention, dependence, treatment and aftercare services’,¹⁵ and the accompanying ‘Implementation Matrix’ calls on Member States to provide the ‘comprehensive package on HIV prevention, treatment and care among injecting and non injecting drug users’.¹⁶

The Plan of Action 2013-2017 focuses on four ‘priority areas’: management and oversight; evidence-based health and social services for people who use drugs; countering drug trafficking and security threats; and capacity building and research. Although not a legally binding instrument, it does request that Member States conduct baseline studies on drug use, deliver policy advocacy campaigns, and provide alternatives to incarceration. At the Conference of Ministers, the delegation from Tanzania presented their own established harm reduction programmes – including needle and syringe programmes (NSPs) and opioid substitution therapy (OST) – as an example of best practice in the region. This had a clear impact on the final documents. At the same meeting, the AU Member States also adopted a set of ‘Continental Minimum Standards for Treatment of Drug Dependence’, as well as an ‘African Common Position on Access to Pain Management Drugs’. These documents all provide a useful advocacy platform for harm reduction and drug policy, and represent a positive development in the region.¹⁷

Country overview: Kenya

Trends in drug use

The use of cannabis (*bhang*) and khat (also known as *Miraa*, a legal substance in Kenya) is widespread across the country. Heroin and cocaine use has also been reported in the country since the 1980s.¹⁸ Heroin injecting has risen since the late-1990s due to the increased availability of white heroin powder (the 'salt' form of the drug which readily dissolves in water and is therefore easier to inject) replacing the previously prominent 'brown' heroin, as a result of changing drug trafficking patterns.¹⁹ Heroin injection has spread from the coastal areas of Mombasa, Malindi and Lamu to the rest of the country, especially the capital Nairobi.²⁰ Recent years have seen attempts to address the dearth of population-based studies among people who inject drugs with bio-behavioural surveillance projects in Nairobi and Mombasa. According to a 2013 consensus consultation report produced by the Kenyan National AIDS and STIs Control Programme (NAS COP) and informed by various population size estimates (conducted between 2005 and 2013) there are 18,327 people who inject drugs in Kenya.²¹

HIV among people who use drugs

A 2008 modelling exercise estimated that there were 1.5 million adults living with HIV in Kenya, 3.8 per cent of whom are people who inject drugs.²² HIV prevalence among people who inject drugs has been estimated to be 18.3 per cent.²⁴ A study conducted among 336 people who use drugs in Nairobi found that

44.9 per cent had injected their drugs at some stage. Of the 101 people injecting drugs at the time of the study, more than half were living with HIV (compared to a prevalence rate of 13.5 per cent among other heroin users).²⁵

Laws and policies on drugs and HIV

The national response to HIV in Kenya is coordinated by the National AIDS Control Council (NACC), while the National Authority for Campaign against Alcohol and Drug Abuse (NACADA) is the agency responsible for drug control. Until recently, HIV prevention and drug control efforts have been conducted independently from one another, rather than as a coordinated strategy. Efforts are continuing at the central government level to better harmonise laws and policies and ensure that drug control efforts do not hinder HIV prevention measures amongst people who use drugs.

While the latest Kenyan National Strategic Plan for AIDS (KNASP III) calls for the development of HIV interventions targeting people who inject drugs, including NSPs and OST, the overall policy environment toward people who use drugs remains harsh. For example, drug use and possession in Kenya continue to be criminalised. National drug laws also criminalise the possession of 'any pipe or other utensil for use in connection with the smoking, inhaling or sniffing or otherwise using of opium, cannabis, heroin or cocaine or any utensil used in connection with the preparation of opium or any other drug' – an offence which can

Box 2. Estimating drug use and supply in Sub-Saharan Africa

Our understanding of drug use and its related harms in some parts of the region remain hindered by a lack of research. This is seen most profoundly in Central and West Africa, where population size estimates of the numbers of people who inject drugs in particular are extremely limited. While limited data must not delay efforts to reach people who inject drugs with harm reduction interventions, they are necessary for informing coverage and resource needs calculations and evaluating national responses.²³

lead to up to ten years of imprisonment and/or a fine of 250,000 Kenyan Shillings (US\$ 2,850).²⁶ A study of people who inject drugs found that nearly one-third had been arrested by the police or had their injecting equipment confiscated in the previous six months.²⁷

Nonetheless, significant progress was made in 2012 to develop 'Standard Operating Procedures' for NSP and OST in Kenya. Although these documents still present challenges (for example, they include an unnecessary level of detail – even dictating how many rooms an OST service must have), they represent a major break-through for harm reduction in the country. OST has been included in the Kenyan Ministry of Medical Services' drug dependence treatment protocol (currently awaiting ratification by Parliament), and the Kenyan Government is also developing a new stand-alone policy focusing on vulnerable groups, including people who use drugs.

In 2010, Kenya adopted a new constitution which included a Bill of Rights. Article 43.1 states that 'Every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care'.²⁸ This provision is an important advocacy tool for people who use drugs, and potentially provides for legal challenges to some existing policies that impede service delivery in the country, such as the criminalisation of drug use and of the possession of injecting equipment.

Existing HIV prevention services for people who use drugs

A number of international donors and NGOs have been working in Kenya to promote and deliver harm reduction services and to create an enabling environment for their implementation. Funding and/or support are currently available from:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria, via a Round 10 HIV grant managed by the Kenyan Red Cross.²⁹ However, the planned implementation of NSPs through this grant has been delayed, and the grant is being reviewed and re-negotiated this year
- Médecins du Monde are implementing a comprehensive harm reduction project in Nairobi to empower people who use drugs and conduct outreach to deliver a wide range of harm reduction interventions (such as clean needles, condoms, OST, overdose prevention, HIV, TB and hepatitis diagnosis, treatment and care, etc.)
- The Dutch Government are supporting two programmes – the Bridging the Gaps project led by the Dutch NGO Mainline,³⁰ and the Community Action on Harm Reduction project led by the International HIV/AIDS Alliance (see Box 3)
- The French Agency for Development
- Open Society Foundations
- The German Overseas Aid Agency
- The US President's Emergency Plan for AIDS Relief (PEPFAR) are in discussions to begin the roll-out of community-based OST services across Kenya
- The Joint UN Programme on HIV and AIDS (UNAIDS) and the United Nations Office on Drugs and Crime (UNODC) (the latter through their Regional Office for Eastern Africa, located in Nairobi) have worked with the Kenyan Government to develop capacity, provide harm reduction training, and develop the Standard Operating Procedures for NSP and OST.

Box 3. The Community Action on Harm Reduction (CAHR) project in Kenya

CAHR is an ambitious project that aims to expand harm reduction services to more than 180,000 people who inject drugs, their partners and their children in China, India, Indonesia, Kenya and Malaysia.³¹ The project is managed by the International HIV/AIDS Alliance, with programmes being implemented by a consortium of linking organisations – including the Kenya AIDS NGOs Consortium (KANCO) in Kenya. In addition, technical expertise and global advocacy support are being provided by IDPC, HRI and the International Network of People who Use Drugs (INPUD), among others.

In Kenya, KANCO is implementing the CAHR project by focusing its work in Nairobi and the East coast, where HIV prevalence rates among people who inject drugs are the highest. The project aims to develop and deliver OST and NSP services in these regions, and to facilitate the creation of an enabling political environment for the scale up of harm reduction programmes.³²

NSPs began to operate in late 2012 through several community-based NGOs participating in the CAHR project. Their launch was significantly delayed by strong resistance from religious and cultural groups following high-profile media coverage of the proposed interventions. Ironically, this stemmed from an informal media event that was designed to sensitise journalists and address their questions and concerns. However, existing programmes, while a welcome breakthrough, are falling far short of the required coverage and remain under-resourced. As a result, previous

reports of sharing needles and syringes are likely to continue until NSPs are able to meet the demand.³³ To date, OST is only available to a small number of individuals through private clinics, at a significant cost.

Government-run facilities predominantly provide abstinence-based drug dependence treatment. The Mathare Hospital in Nairobi and the Coastal General Hospital in Mombasa are the two main governmental mental health hospitals that offer treatment to people who use drugs through in-patient and out-patient rehabilitation centres. A number of private and community-based rehabilitation centres

have also been established, mainly in Nairobi and Mombasa. However, these facilities lack financial resources and many do not operate under internationally agreed standards. As for access to HIV treatment and care, only 38 people who inject drugs were receiving ARVs in Kenya in 2008.³⁴

As is familiar in many countries, people who use drugs in Kenya reported that fear of arrest and high levels of stigma are major barriers to accessing government-run services – either because people are reluctant to access services and admit their drug use, or because they are refused care when they seek help in general healthcare services.³⁵ Community-based NGOs therefore have an important role to play in reaching out to these individuals – and groups such as KANCO, NOSET Maisha, Reach Out, the Omari Project, Teenswatch, and Support for Addiction Prevention and Treatment in Africa (SAPTA) have all begun to provide harm reduction interventions and training programmes in Nairobi and/or the Coastal region. The Kenya Network of People Who Use Drugs (see Box 4) and the Kenya Harm Reduction Network are also important voices in promoting harm reduction services and the human rights of people who use drugs.

Box 4. Networks of People Who Use Drugs in Kenya and Tanzania

With support and guidance from the International Network of People Who Use Drugs (INPUD), the Kenyan Network of People who Use Drugs (KeNPUD) and the Tanzanian Network of People who Use Drugs (TaNPUD) have both recently been established to promote the engagement of this population in policy discussions and service design and implementation – in line with the spirit of ‘nothing about us, without us’. In the words of John Kimani, the Chair of KeNPUD: ‘People who use drugs should not be seen as the problem... but as the cornerstone of the solution’.³⁶

The two organisations have been able to draw strength and experiences from one another, as they build representative platforms for direct engagement with policy makers at national, regional and international levels. For example, in October 2012, KeNPUD representatives attended the 5th AU Conference of Ministers of Drug Control in Addis Ababa to represent the voice of people who use drugs. Plans are also underway for the first East African Drug User Activist Conference later in 2013.

Country overview: Ethiopia

Trends in drug use

Information about drug use in Ethiopia is very limited. Khat is reportedly widely used across the country and has great significance in Ethiopian culture and traditions. The drug (which is legal in Ethiopia) is also an important part of the country's economy.³⁷ In 2008, the annual prevalence of cannabis use was estimated to be 2.6 per cent of people aged 15 to 64, with 0.3 per cent using amphetamine and 0.05 per cent using opiates.³⁸ However, Ethiopia's location on major trafficking routes into Europe makes it likely that the consumption of these substances may have increased since then and may continue to do so in the future.³⁹

UNODC reported that drug dependence was mainly concentrated among socially and economically marginalised groups in the country. For instance, 50 per cent of the 553 people arrested for drug use in Ethiopia between 1993 and 1997 were unemployed.⁴⁰ A high prevalence of drug use has also been reported among sex workers.⁴¹ There is little information on the prevalence of drug injection in the country.

HIV among people who use drugs

Ethiopia has a generalised epidemic affecting more than 1 per cent of the general population – an estimated 1.1 million people – with marked regional variations.⁴² There has so far been limited research into HIV transmission through unsafe drug injection in the country – despite the fact that drug trafficking routes passing through Ethiopia may have significant implications for drug use and the HIV epidemic.⁴³ Several studies have also reported a link between khat use and the sexual transmission of HIV, although more research is needed to better understand this link.⁴⁴

Laws and policies on drugs and HIV

Ethiopia has adopted a repressive drug policy and applied strong punitive measures towards drug traffickers and people who use drugs. Under the law, drug use and the possession of even small amounts of drugs are criminal offences – and no distinction is made between possession and trafficking offences. Article 525 of the revised Criminal Code (Proclamation No.2004) of Ethiopia stipulates that ‘Whoever plants, buys, receives, makes, possesses, sells or delivers [drugs] to be privately used by himself or another; or uses or causes to be used one of these substances without medical

prescription or in any other unlawful manner, is punishable with rigorous imprisonment not exceeding seven years, and fine not exceeding fifty thousand Birr' (approximately US\$ 4,800).⁴⁵ It is also an offence to be in possession of injection paraphernalia such as needles and syringes.⁴⁶

The National Drug Control Master Plan (2009-2014) is a comprehensive national programme on drug control, which also includes HIV prevention efforts.⁴⁷ An inter-ministerial coordination committee on drug control was established to oversee the implementation of the Master Plan, providing policy advice, monitoring the compliance of Ethiopia with the international drug control treaties, and providing guidance on drug prevention strategies.⁴⁸ To date, the committee has not made any move towards promoting harm reduction service provision in Ethiopia.

UNODC has supported the government in developing drug prevention, treatment, rehabilitation and social inclusion programmes, and various protocols have been ratified on drug prevention and treatment. However, despite the National Drug Control Master Plan, Ethiopia fails to adequately address HIV prevention, treatment and care among people who use drugs.

The Ethiopian HIV response is guided by the Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia 2009–2014 (SPM II).⁴⁹ This Plan seeks to create an enabling environment for the HIV response through capacity building, community involvement, HIV prevention, treatment and care, and information gathering. The document describes drug injection and drug dependence as 'emerging behaviors that make individuals and communities more at risk of acquiring and transmitting HIV infection in the country'. However, the plan does not outline any specific interventions to prevent HIV among people who use drugs.

Existing HIV prevention services for people who use drugs

Harm reduction programming remains alarmingly underdeveloped in the country. Available services are limited to abstinence-based drug dependence treatment facilities, such as the Emmanuel Psychiatric Hospital and the psychiatric department at St Paul's Hospital, both based in Addis Ababa. These facilities handle cases of tobacco, cannabis, khat and alcohol use. However, they reportedly provide limited and generally inadequate support for people who use drugs.

Only one civil society organisation – the Ethiopian Public Health Association (EPHA) – provides drug and HIV prevention and education services to people who use drugs, but these are mainly focused on 'just say no' messages.⁵⁰ The national network responsible for coordinating the HIV response in Ethiopia is the Non-Communicable Diseases Consortium, but it is unclear to what extent this network focuses on people who use drugs.

Country overview: Tanzania

Trends in drug use

National data on the prevalence of drug use do not currently exist for the United Republic of Tanzania. However it has been estimated that there are between 25,000 and 50,000 people who inject drugs⁵¹ in Dar es Salaam alone (see Box 2 on data estimates).

A rapid situational assessment conducted in 2001 in Tanzania's large urban centres found significant levels of heroin use in Arusha, Dar es Salaam and Zanzibar, and emergent patterns of use in Mwanza. Injecting drug use was reported in all the study sites where heroin was being used. However, it is envisaged that more nuanced data on injecting drug use will emerge as more organisations continue to invest in research.⁵² Other types of drugs used

in Tanzania include cannabis, khat, cocaine and morphine.

HIV among people who use drugs

While HIV transmission in Tanzania is predominantly driven by sexual transmission, since 2000 the number of infections through injecting drug use has been increasing. It has been estimated that 42 per cent of people who inject drugs in Dar es Salaam are living with HIV, while 22.2 per cent are living with hepatitis C.⁵³ Women who inject drugs seem to be particularly vulnerable to HIV – a small 2006 survey conducted among 319 men and 98 women who injected drugs in Dar es Salaam found that 58 per cent of women were infected by HIV, compared to 27 per cent of men.⁵⁴ High-risk injecting practices are reported across Tanzania – such as ‘flash-blood’, where one person injects heroin and then fills a syringe with his or her blood to give to a friend who cannot afford their own drugs.⁵⁵

Laws and policies on drugs and HIV

The government’s current stance on drug policy is embedded in both supply and demand reduction. Significant progress has recently been made in national legislation and policies to create an enabling environment for harm reduction service provision. For example, harm reduction is explicitly mentioned in the Tanzanian National Strategy for Non-Communicable Diseases 2009-2015.⁵⁶ The Drug Control Commission (DCC) in Tanzania has also launched guidelines on brief interventions for people who use drugs, OST and outreach services for people who use drugs – reflecting the progress being made in service delivery.

However, despite the recent introduction of NSPs, the possession of needles and syringes remains illegal under Tanzanian laws.⁵⁷ Moreover, law enforcement practices have been reported to pose obstacles for people

who use drugs when accessing services (including outreach), particularly through the fear of arrest and harassment.

Existing HIV prevention services for people who use drugs

Tanzania constitutes a success story in the region for introducing and starting to scale up harm reduction service delivery. It is currently the fourth African country to implement both OST and NSPs (the others being Mauritius, South Africa and, as of 2013, Kenya).⁵⁸ Médecins du Monde initiated the first NSP in 2010, in the Temeke district of Dar es Salaam. Within a year, this service had reached out to over 3,000 people who inject drugs, distributing around 25,000 needles and syringes per month.⁵⁹

Another one of the successes in Tanzania has been the government-run OST programme in Dar es Salaam, funded by PEPFAR. This service began operating in February 2011 at the Muhimbili National Hospital and is currently being expanded to several additional sites, making it one of the largest methadone programmes in Sub-Saharan Africa. The programme has been widely lauded as a model of best practice, and officials have hosted study visits from neighbouring countries such as Kenya and Uganda. The Tanzania AIDS Prevention Programme (TAPP), a network of outreach NGOs, helps to identify people dependent on drugs and support them to enter and stay on the programme. Once enrolled, patients receive social support, regular monitoring, any other medications they need (such as treatment and care for HIV, tuberculosis and dental conditions), and even occupational therapy to help reduce the stigma associated with drug injection and support patient’s social integration.⁶⁰

Outside of Dar es Salaam, the coverage of services is significantly lower, although outreach, education and abstinence-based

rehabilitation services are available on the island of Zanzibar and elsewhere. Although there remains much to be done, Tanzania represents a major harm reduction success story for Sub-Saharan Africa through the commitment of both NGOs and the government.

Country overview: Uganda

There is extremely limited information available on people who use drugs in Uganda, as for most-at-risk populations in general. As a result, this country overview is notably shorter than the others. Yet Uganda is a key country in East Africa in terms of drug policy and harm reduction.

The most common drugs used include cocaine, heroin, alcohol and cannabis.⁶¹ HIV prevalence amongst people who use drugs is unknown, although a small-scale study of 67 sex workers who use drugs found a HIV prevalence rate of 34 per cent.⁶² Effective interventions to prevent HIV among people who use drugs (such as NSPs and OST) do not currently exist in the country.

Uganda does not currently have a drug law, although a national drug policy has been in development since 2005.⁶³ The National HIV Prevention Strategy 2011-2015 does not include the provision of harm reduction services for people who use drugs – rather it merely states: ‘It is globally acknowledged that IDU and MSM play a major role in HIV transmission. However, in Uganda we do not have sufficient information on these population groups... It will be important to keep an eye on these population groups’.⁶⁴ Nevertheless, the Strategy does commit to ‘ongoing surveillance of risk behaviours among IDUs’.⁶⁵

The Ugandan Harm Reduction Network (UHRN) is currently the only organisation focusing specifically on harm reduction and the rights

of people who use drugs in Uganda. Formed in January 2011, UHRN is a national non-profit organisation based in Kampala. It works to promote the health and human rights of individuals and communities affected by drug use across the country, and seeks to act as a coordinating body for associations and individuals working on harm reduction in the country.⁶⁶

Addressing barriers to preventing HIV transmission among people who use drugs

There are several common barriers that prevent the development, uptake and/or scale up of harm reduction services across the four East African countries studied in this paper.

Policy and institutional barriers

Global experience has shown that harm reduction services are most effective when they operate in a conducive policy environment – i.e. one where people who use drugs are not targeted and persecuted by law enforcement. While Kenya and Tanzania have begun to implement proven harm reduction services, legal and policy barriers still exist – most notably drug use and drug possession for personal use, but also the possession of needles and syringes, remain an enforced criminal offence which can lead to years of imprisonment. Police harassment of both service providers and people who use drugs has also been identified as a major issue in both countries.

In Uganda and Ethiopia, the lack of harm reduction services reflects a lack of political will to even acknowledge the existence of injecting drug use. If people who use drugs are not recognised as a population in need of services, they will not be mentioned in the key policy documents. This can be a major barrier to implementation.

Across all four countries, support from political and community leaders is essential. Although harm reduction services in Tanzania have benefited from such support, opposition from community and religious leaders in Kenya for the implementation of these services remains problematic, while political and community support in Ethiopia and Uganda remains non-existent.

Information barriers

Across the region, the lack of reliable data and information about drug use (see Box 2) is a major impediment to policy change. With the exception of recent situational assessments in Kenya and Tanzania, there is insufficient information available on drug using populations, the impact of drug injection on HIV transmission, and on other harms such as hepatitis and overdose. Advocates in Ethiopia and Uganda are struggling to have their voice heard in the absence of these data. The urgency of adopting adequate policies and implementing harm reduction programmes is also undermined by lack of compelling data showing that a response is indeed needed.

Nonetheless, the absence of detailed data should not be a barrier to the start-up of harm reduction services – especially through pilot programmes – where the experience of NGOs on the ground indicates an unmet need. The absence of data requires bravery and strong leadership from policy makers and community leaders. In this regard, Tanzania represents a good model of how implementation was started *alongside* (rather than after) improved research efforts.

To help address this major issue, the AU Plan of Action on Drug Control 2013-2017 (see Box 1) requests that Member States conduct baseline studies and other research into the issues of drug use, HIV prevalence and other harms.⁶⁷

Technical barriers

Governments and civil society organisations in Sub-Saharan Africa often have a limited understanding of the concept of harm reduction, and there is a particular lack of technical expertise on interventions such as NSP and OST. In Kenya, the start-up of harm reduction services was accompanied by a long series of capacity-building trainings and workshops to support NGOs, several of whom had previously only focused on abstinence-based approaches. In Tanzania, study visits are being coordinated for delegations from other African countries to visit the services, learn about their development and implementation, and hopefully to promote this model as best practice across the region. Recent developments in the AU approach to drugs (see Box 1) will hopefully further fill the knowledge gap.

Financial barriers

As in many regions of the world, financial constraints have often been cited as one of the main barriers for harm reduction provision. Between 2009 and 2011, Sub-Saharan Africa accounted for 57 per cent of the HIV/AIDS funding from international donors.⁶⁸ Yet very little of this funding is targeted at people who inject drugs – although the region accounts for more than half of the Global Fund's HIV portfolio,⁶⁹ it received less than 5 per cent of the funding provided for harm reduction from Round 1 (2002) to Round 9 (2009).⁷⁰

Yet a strong financial case has been made for harm reduction in Sub-Saharan Africa, and the examples of Kenya and Tanzania demonstrate how international donors are interested in supporting these programmes. In order to ensure greater domestic support for harm reduction, policy makers need to be convinced that money spent on harm reduction (through services such as NSPs and OST) can lead to significant savings on the treatment of HIV and other health issues. Similarly, the promotion of alternatives to incarceration for people who

use drugs (as included in the current AU Plan of Action on Drugs) can reduce the significant public costs associated with prisons and other closed settings.⁷¹

Ideological barriers

Drug use remains highly stigmatised across East Africa, both within government institutions and among the general public. In all four countries highlighted in this briefing, drug use is heavily criminalised with hugely disproportionate sentences in place. The detrimental effect that this approach has on service access, human rights and public health has been accepted by many governments outside of Sub-Saharan Africa, and there are now numerous examples of countries across the world that have depenalised⁷² or decriminalised⁷³ drug use and possession for personal use.⁷⁴ In Kenya, however, recent attempts to decriminalise drug use were met with considerable resistance by the general public and community and religious leaders.

The impact of these ideological barriers is that, in Kenya for example, people who use drugs have reportedly been excluded from accessing government-run medical facilities.⁷⁵ In addition, because of the stigma they experience, many people who use drugs were reported to be living away from their friends and family in order to conceal their drug use.⁷⁶ This further increases their vulnerability and marginalisation, making them even less likely to access any social or health support. The work of networks of people who use drugs constitutes a key tool for empowering this population and promoting their human rights in public forums.

Conclusion and recommendations

East Africa is at an important chapter of its drug policy development, with countries such as Kenya and Tanzania pushing forward with evidence-based approaches to tackle the health problems related to injecting drug use. It is important that services in these countries are delivered at the required scale to impact on the HIV epidemic, and that this impact is diligently evaluated and reported. Action in the following five areas is recommended in order to strengthen HIV prevention among people who use drugs in East Africa:

1. Development of supportive policy environments

In order to enable the start-up, and maximise the effectiveness, of sustainable harm reduction approaches, the policy environment needs to be changed to mitigate any legislative or regulatory gaps and barriers. This could be achieved through the formulation of 'stand-alone' harm reduction policies in each country, or by amending and adapting existing HIV and drug control strategies. Countries must resolve any conflicts between policies – for example, decriminalising drug use, or removing penalties against the possession of needles and syringes in order to improve the uptake of NSPs. This requires collaboration with, and trainings for, law enforcement and public health officials.

2. Investment in data collection and research

Comprehensive data collection is needed across Sub-Saharan Africa in order to understand the situation and plan effective responses that meet the needs of people who use drugs. This requires the attention and leadership from governments and international donors, as well as capacity building throughout the region. Partnerships with existing data collection agencies and mechanisms, such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), should be utilised.

3. Advocacy for harm reduction

Ongoing advocacy efforts are essential across East Africa to ensure that the media, policy makers, community leaders and the general public understand and appreciate the value of harm reduction. This will enable more open and objective discussions of issues related to drug use and drug policy reform. Government efforts in this regard – such as the adoption of the Kenyan Bill of Rights in 2010 or the inclusion of the concept of harm reduction in national strategies in Tanzania – are crucial, as is the emergence of networks of people who use drugs and of harm reduction activists (see Box 4). Such advocacy efforts need to be carefully planned and delivered, as drug use remains a divisive and emotive topic in the region.

4. Strengthened civil society

Around the world, civil society organisations have played a pivotal role in the promotion and delivery of effective harm reduction services. This has also been the case in Kenya and Tanzania. Across East Africa, however, NGOs need further support in order to deliver and advocate for these interventions, both in terms of their technical and resource capacity. Where governments and donors are investing in harm reduction, they need to do so through or alongside these NGOs, and with the necessary support built in to ensure success.

5. Resource mobilisation

There is an urgent need to scale up investments for effective harm reduction services across

East Africa – both from international and domestic sources. For as long as programmes rely on international grants and projects (such as in Kenya), their long-term sustainability can never be guaranteed. Governments should ensure that people who use drugs are routinely included within HIV strategies, action plans and budgets, and that harm reduction interventions are sufficiently resourced to achieve the levels of coverage needed for success.

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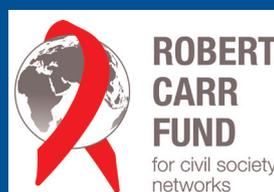
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The International Drug Policy Consortium (IDPC) is a global network of NGOs and professional networks that promotes objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug -related harms. IDPC members have a wide range of experience and expertise in the analysis of drug problems and policies, and contribute to national and international policy debates. IDPC offers specialist advice through the dissemination of written materials, presentations at conferences, meetings with key policy makers and study tours. IDPC also provides capacity building and advocacy training for civil society organisations.

This briefing paper summarises the findings of a literature review and scoping exercise commissioned by Harm Reduction International (HRI) and the International Drug Policy Consortium (IDPC) in 2012. It aims to establish the current state of drug policy and harm reduction services in Kenya, Ethiopia, Uganda and Tanzania, and to analyse the barriers and opportunities to improve access to harm reduction services in these four countries.

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