

## **THE SOCIAL CONTEXT OF INJECTION DRUG USE AND HARM REDUCTION PROGRAMMES IN SUB-SAHARAN AFRICA**

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### **ABSTRACT**

Sub-Saharan Africa has a documented significant burden of heroin and cocaine injection, and HIV transmission. But the region is behind in the implementation and scaling up of harm reduction measures such as syringe exchange programmes and opiate substitution therapy, due to political preference for the control of drug supply through legal prohibition. Though the policy environment is changing and small-scale programmes are emerging in some countries, large-scale programmes needed to stem HIV epidemic among people who inject drugs are bedevilled by social, cultural and political barriers. For example, current models of harm reduction are problematic in sub-Saharan Africa because they elevate the individual and his or her rights above the society and its needs, and they focus on behavioural changes and do not take into account the social factors that predispose people to drug harms. There is need to align harm reduction programmes with the realities of local contexts in order to guarantee local acceptance as well as increase the potentials for sustainability.

**Key words:** Harm reduction, public health, drug policy, sub-Saharan Africa

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### **INTRODUCTION**

There is significant disillusionment in many parts of the world with the dominant, prohibitionist approach to illicit drugs control. The approach, which rests on the three international conventions, namely the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances, and the 1988

Convention against Illegal Traffic in Narcotic Drugs and Psychotropic Substances, attempt to control the supply and use of illicit drugs by means of legal prohibition. After roughly six decades of attempting to control the use of drugs by suppressing production and distribution, it is now widely acknowledged that the approach is of limited effectiveness. Production and trafficking have been suppressed in some

places, but they have ballooned elsewhere. Demand for cocaine, heroin and new synthetic drugs are on the increase globally (UNODC, 2012).

Across the world, counter-narcotic operations have engendered political instability, violence, corruption, mass incarceration, and violations of the human rights of people who use drugs (PWUDs), including the right to health (Pollack & Reuter, 2014; WACD, 2014), which has been influential in undermining support for the global drug control regime, and strengthening the momentum for policy shift towards public health and harm reduction. A vast body of evidence suggests that harm reduction measures are effective in preventing HIV infection among people who use illicit drugs; such that these programs are considered an important factor in the prevention of HIV among people who inject drugs (PWIDs) (see the review by Csete et. al., 2016).

Consider, for example, syringe exchange and opioid substitution therapy. The former has been proven to be effective in reducing risk behaviour and the incidence of HIV and Hepatitis C (Des Jarlais et. al., 1996; Hagan et. al., 1995). It does not lead to increase in drug use, but is associated with substantial reduction in healthcare expenditures (Fisher et. al., 2003; Normand et. al., 1995). An international study revealed that cities with syringe exchange programs have 5.8% decline in HIV prevalence per year, while HIV prevalence increased by 5.9% in cities without such programs (Hurley et. al., 1997). Opioid substitution therapy (such as methadone) is associated with reduction in, and elimination of, illicit opiate use, reduction in risk behaviour, reduction in the transmission of HIV and viral Hepatitis, and in mortality

rates (MacAurthur et. al., 2014; Turner et. al., 2011).

Despite this evidence of effectiveness, harm reduction measures remain controversial and highly contested in many places, including Sri Lanka, Turkey, North Africa, Eastern Europe and Russia. They are unpopular among African countries, renowned for political preference for the prohibitionist approach to illicit drugs, which is due in part to political pressure from the United States. Although the policy environment is changing, and small-scale programs have emerged in some countries, large-scale implementation of harm reduction measures, which is needed to arrest the epidemic of HIV and viral Hepatitis among people who inject drugs (PWIDs), is faced with many obstacles including government opposition and/or indifference, stigma and discrimination of PWIDs, public discomfort, and socio-cultural and religious barriers (Klein, 2011; Kelly et al., 2006; McCurdy et al., 2007). This paper examines the socio-cultural context of harm reduction in Africa with a view to charting the way forward.

### **Epidemiology of injection drug use**

Injection drug use (IDU) is a growing problem in Sub-Saharan Africa (SSA). SSA countries such as Kenya, Tanzania, Cote d'Ivoire, Mauritius, Morocco, Nigeria, Egypt, Mozambique, South Africa, Ghana, and Congo have a documented growing burden of injection drug use (Harm Reduction International, 2015). There are about 1,778,500 people who inject drugs (PWIDs) in the region, and about 221,000 of these people may be living with HIV (Mathers et. al., 2008). Most PWIDs in SSA are male, ranging from 66% in northern Nigeria to 93% in Nairobi, Kenya (DesJarlais, Perlis, Stimson & Poznyak,

2006; Aceijas et al., 2006). There is a high prevalence of IDU among sex workers, ranging up to 74% in Mauritius, where a quarter of PWIDs are sex workers (Reid, 2009). HIV prevalence among PWIDs in SSA ranges from 22.9% to 50% in Kenya, 19.4% in South Africa, 8.9% in Nigeria to less than 1% in Zambia (Mathers et al., 2008). There is a significant problem of drug injecting without sterile injection equipment, and high risk practices such as the sharing of blood with other users who cannot afford the drug (a practise known as 'flash blood') (Atkinson et al., 2011; McCurdy et al., 2007).

The most common drug injected in SSA is heroin, followed by cocaine and speedball, a combination of heroin and cocaine (Adelekan & Lawal, 2006). Heroin and cocaine were introduced to Africa in the 1980s through international trafficking in psychoactive drugs to European and North American drug markets from Southeast Asia in the case of heroin and South America in the case of cocaine (Akyeampong, 2005; Ellis, 2009). West African countries, especially Nigeria and Ghana, served as the major staging posts in the trafficking of these drugs, triggering growth in the domestic availability and consumption of the drugs. In 2006, an estimated 0.2% of adults in Africa were using heroin, approximating the global average (Dewing, Pluddemann, Myers & Parry, 2006).

Patterns of heroin use ranges from intermittent use among most Nigerian PWIDs to regular binging in Dar es Salaam, Tanzania (Adelekan & Lawal, 2006; Ross et al., 2008). Among young heroin users, the pattern varies from non-injecting in coastal Kenya to widespread injecting in open-air youth hangouts and private settings in Tanzania (Beckerleg,

2005; Dewing, Pluddemann, Myers & Parry, 2006). IDU is common and particularly dangerous among street children. A study conducted among a small sample of street children in the Great Lakes region show that 43.5% reported sharing syringes and other drug injecting instruments (Leshabari & Kaaya, 2005). The age of onset of IDU ranges from 20 in South Africa to 25 in Kenya and Tanzania (DesJarlais, Perlis, Stimson & Poznyak, 2006; Ross et al., 2008). In Nigeria, an estimated 2.4% of students of tertiary institutions had ever injected heroin, and student heroin use dates back to the 1980s (Obot, Karuri & Ibanga, 2003).

PWIDs in SSA live in precarious conditions characterized by homelessness and destitution. The majority of PWIDs hold temporary jobs, while others rely on begging and crime to support their drug use habits (DesJarlais, Perlis, Stimson & Poznyak, 2006; Dewing, Pluddemann, Myers & Parry, 2006). Knowledge of the risk of HIV transmission through sharing of needles is limited among the growing population of PWIDs in SSA, and many AIDS prevention programs in the region have discountenanced injection risks in their public awareness communications, perceiving IDU to be uncommon. A large proportion of PWIDs regularly share syringes, and in Nigeria only 25% of PWIDs report knowing that sharing of syringes carries the risk of HIV transmission (Reid, 2009).

### **Harm reduction programmes**

Drug use is criminalized in most SSA countries, and drug users are the target of spirited law enforcement operations. Government policies on psychoactive drugs reflect a political preference for controlling drug supply, with limited

resources devoted to demand reduction (Reid, 2009). National and regional drug policies, influenced by the US and the international conventions which are contradictory, often limit resources for harm reduction on the grounds that they condone drug use (Parry & Pluddemann, 2004).

Sub-Sahara Africa is behind in the global efforts to implement and scale up harm reduction measures. Only a few countries in the region have implemented harm reduction programmes. For example, Needle and syringe exchange programmes (NSPs) exists only in Mauritius, Tanzania and South Africa, while Opioid Substitution Therapy (OST) are available only in Tanzania, South Africa, Kenya, Mauritius, and Senegal (HRI, 2012). Mauritius has the greatest coverage of NST in the region with 83.8% of people who inject drugs using sterile injecting equipment in 2013 (Government of Mauritius, cited in Reid, 2009). The 2006 HIV & AIDS Act of Mauritius established the first needle exchange and methadone maintenance program in Africa in reaction to explosive HIV transmission among PWIDs in an otherwise low-prevalence population (Kilonzo & Simmons, 2005).

Most of these programmes are limited in scale and are far below estimates required to reverse the HIV epidemic among PWIDs in the region (Harm Reduction International, 2015). The services are mostly provided by CSOs, and there is limited government support for and involvement in the provision of harm reduction services. This has contributed in no small way to the exacerbation of unsafe injection practices and HIV transmission among PWIDs (Reid, 2009; Wolf & Csete, 2010). There has been intense advocacy for the adoption of harm reduction in SSA (Abdool,

2016; Tammi, 2004). The policy environment is slowly changing, with the spread of HIV and HCV among PWIDs stimulating domestic support for harm reduction programmes such as NSP and OST.

In 2007 the Sub-Saharan Africa Harm Reduction Network (SAHRN) was formed, and NGOs, researchers and UN representatives from eleven African countries met to deliberate on drug policies (IHRA, cited in Reid, 2009). The tempo of advocacy for harm reduction has increased and the policy environment is gradually changing. But barriers still exists, especially those related to moral panic and other socio-cultural factors which make current models of harm reduction programs problematic in SSA. We examine two of these 'conundrums' in the succeeding sections.

### **'Rights talk' and the individual/society conundrum**

The provision of harm reduction services is an aspect of a public health response to drug addiction, understood as a chronic, relapsing brain disease. This approach is premised on a medical model of human behaviour where drug addiction is 'the result of disturbance in the proper functioning of neurological communication' (Perez & Esposito, 2010: 94). According to this perspective, although the drug user is regarded as an active agent in initial drug experimentation and use, addiction is thought to develop from factors that are largely independent of the actor's purposeful action (Ibid). According to Tatarsky, '[t]he disease is believed to have a life of its own, separable from the complex of issues that influence the life of the user. The disease is deemed a permanent, lifelong condition...' (2002: 19). For this reason, medical intervention to minimize the harms associated with

this ‘permanent, lifelong condition’ is not only a rational response, but also the ‘right’ of the individual who is addicted to drugs. Failure to provide these services is regarded as a denial of the health right of the individual.

The concept of human rights underlying harm reduction is rooted in liberal political theory. It reflects an atomistic and individualistic cultural ethos, where the rights of the individual are in perpetual conflict with the needs of the society. It “presupposes a society of people who are conscious of their separateness and their particular interests and are anxious to realize them” (Ake, 1987: 83). In this context, human rights are a “claim which the individual may make against the other members of society, and simultaneously an obligation on the part of society to uphold this claim” (Ibid). This concept emerged from the historical context of the western world as a measure to check the invasive and abusive modern state, leading to the “sacralisation of the individual and the supremacy of the jurisprudence of individual rights” (Mutua, 2013:71).

Claims about their universality notwithstanding, human rights are context-specific. Indeed, as Langlois (2009: 20) points out, “the reasoning from which the universality derives is a very particular way of thinking about what it is to be human, which might not legitimately apply to all human persons”. Human rights concepts reflect the social context from which they emerged; they do not align with African cultures values. They are an essentially western concept, one at odds with the cultural and philosophical traditions of African peoples (Goodhart, 2009: 4). As Waters (1996: 593) puts it, “human rights is an institution that is specific to cultural and historical context just like any

other and... its very universality is itself a human creation”.

Liberal human rights ascribe abstract rights to individuals (Ake, 1987), which are hardly realizable in non-western contexts. In African societies, only those who possess the power to actualize these rights enjoy them. Therefore, PWUDs do not enjoy liberal human rights because they do not have the means to realize them. Neither can the state be relied on to actualize human rights. It is common knowledge that the state is a major culprit in the violation of human rights in Africa, especially the rights of marginalized groups such as drug users. The abuse of drug users’ rights is part of an abysmal record of human rights protection in most developing countries (Takahashi, 2009).

For the majority of drug users, human rights are vague, elusive and irrelevant because they are not realizable. For example, the right to health presupposes the availability of healthcare services. But in most countries of SSA, healthcare is either unavailable or unevenly distributed. PWUDs suffers double disadvantage because of stigma and discrimination. Health right is abstract and elusive for PWUDs in SSA because prevailing conditions render them implausible. This confirms Short’s (2009: 93) argument that “‘rights’ are not simply givens, or necessarily beneficial to right holders; rather they are the products of social and political manipulation”.

Furthermore, African societies exhibit what has been described as a ‘collective value system’ (Herskovits, cited in Goodhart, 2009), which place the group above the individual (Menkiti, 1990). The individual receives identity and status from his/her membership in the group. The individual is not granted any right that undermines the needs of the society.

African traditional cultures place premium on harmony and cooperation above competition and conflict. They emphasize the individual obligation to society above the rights he/she can claim against society (Ake, 1987). Individual entitlements are valid to the extent that they do not infringe on the rights of the group, and they are curtailed when they threaten the latter. The collective value system of African societies may be one of the reasons why African states prefer approaches to drug problems that address the concerns of the society to those that prioritize individual rights.

Moreover, in traditional African societies individuals are endowed with rights as well as obligations. The individual has rights by virtue of his or her membership in the group. The right is a claim to be exercised under specific conditions, and the society is expected to provide the conditions necessary for the realization of such rights. On the other hand, the obligations of the individual to the society are the duties he or she is expected to perform to enable the realization of the rights of other members of the society. As Cobbah (in Mutua, 2013: 83) has contended, “the right of one kinship member is the duty of the other and the duty of the other kinship member is the right of another”. The rights and obligations of group members constitute the basis of kinship system in African societies.

Liberal human rights are problematic in the African context because they divorce the rights of the individual from his or her obligation and responsibility to the society, including that of protecting the honour, safety and well-being of the family and community. This is part of the reason why harm reduction measures are unpopular in Africa. They perceived

as encouraging a behaviour that violates group values. They are at odds with African cultural values, which elevate the group above the individual (Mutua, 2013: 71). Harm reduction programs must reflect the collective value system of African societies in order to generate local acceptance.

### **‘Social suffering’ and the behaviour/structure conundrum**

Harm reduction is conventionally regarded as a set of interventions aimed at reducing harms associated with the use of illicit drugs (Obot, 2007). It assesses actual harms resulting from the use of particular substances and proposes pragmatic and morally-neutral measures for minimizing them. Harm reduction is popular because it fosters improved understanding of drug use behaviour and supports the adoption of specific strategies to address them. But it also has an ideological component, which is the object of enormous criticisms.

It has been argued that harm reduction functions as a form of ‘governmentality’ (Foucault, 1979) or a way of exercising state power in late modernity (Gordon, 1991; Dean, 1999; Beck, 2000). It reflects the neoliberal shift from direct state intervention to the devolution of power throughout social institutions (Roe, 2005). In this context, government operates through non-governmental bodies such that all citizens play a role in the governance of self and others (Ibid, 246). Harm reduction therefore features as an approach to addressing drug-related harms that relies on self-regulation. Drug-related harms are minimized by means of individual behavioural adjustments as proposed by different harm reduction measures.

Harm reduction has also been labelled ‘surveillance medicine’ (Miller, 2001; Petersen & Lupton, 1996), where patients’ monitor their life-styles for indicators of deviation from responsible citizenship, and conformity is enforced through medicalization (Tammi, 2004). This has the unintended consequence of diverting attention away from the culpability of the state in the creation of a ‘risk environment’ for drug-related harms. But reliance on behavioural adjustments, including the use of sterile injecting equipment and substitute drugs, while neglecting the risk environment for drug-related harms is disingenuous.

Current models of harm reduction, with its focus on behaviour, often overlooks the fact that human behaviour takes place within specific social contexts, and that behavioural changes without corresponding changes in the social context will produce no lasting results. The individual-centered, behaviourist paradigm of harm reduction does not adequately address the fact that the choices and actions of drug users are influenced by complex social factors. As Buchanan et. al. (2002: 40) pointed out, drug use behaviours are “largely symptom of deeper social structural inequalities and... efforts to eliminate illegal narcotics use are, and will continue to be, futile until we as a society address these fundamental antecedent political-economic problems”.

From the perspective of political economy, it is socio-economic conditions that render particular sectors of the population vulnerable to drug use and harms. This includes socially marginalized groups such as youths, slum dwellers and commercial sex workers. Drug use and harms is therefore a “feature of the political

economy of social suffering” (Rhodes, 2009: 196). It is, in Singer’s words, an ‘oppression illness’ (2004: 17), which is the “product of the impact of suffering from ‘social mistreatment’; a type of stress disorder, where the source of the stress is ‘being the object of widespread and enduring discrimination, degradation, structural violence and abusive derision; whether overt or hidden” (Ibid: 17). It is “a process through which an oppressive environment is incorporated into the everyday practices of those subjected to multiple subordinations” (Friedman et. al., 1998).

Sub-Sahara Africa is faced with numerous political economic problems, including poverty, unemployment, political instability and social conflicts. The growth of human population is not paralleled by economic growth and equitable distribution of income. The state in Africa operates like a criminal syndicate plundering public resources for private enrichment (Bayart, Ellis & Hibou, 1999), and relies on violence to curb threats to its existence. The populace live in precarious conditions characterized by scarcity of basic social services such as sanitation, clean water, healthcare and housing. The bulk of the population earn a living by manoeuvring a poorly regulated and squalid informal sector, where the lines between the licit and illicit are blurred (Klein, 2009).

Social suffering is a major explanation for illicit drugs use and harms in SSA. It has been hinted that psychoactive substances may be used as self-medication (Ibid), by individuals to treat the psychological symptoms from which they suffer (West, 2006). Living conditions in SSA are so traumatizing that “any substance helping to alleviate or control aggressive

impulses could be argued to be playing an important social function” (Ibid, 385). Singer suggests that drug use is a form of ‘self-medication’ for oppression illness (Singer, 2004: 17). Elsewhere he argues that oppression illness ‘pressures sufferers to seek relief’ through drug use, which is an ‘action-oriented culture’ emphasising ‘gratification’, ‘pain intolerance’, ‘chemical intervention’ and a ‘solution’ (Singer, 2001: 205).

Harm reduction programs incorporate this risk environment for drug harms. According to Ezard (2001), harm reduction must include not just reduction of harm and/or risk, but also the reduction of vulnerability and the ‘complex of underlying factors’ at the individual, community and societal level that ‘constrain choices and limit agency’ and thereby predispose one to the risk of drug-related harm. As noted by Elliot et. al. (2005: 119), this highlights the need for “positive action by states to address economic and social rights as part of the response to drug use in order to reduce vulnerability to, and risk of, harm”. Any approach that divorces drug harms from the social context from which they arise will fail to improve the condition of PWUDs in a realistic way.

### CONCLUSION

Although harm reduction programs present potentials for minimizing drug-related harms such as the transmission of HIV and viral hepatitis among PWIDs, current models are unpopular in SSA because they elevate individual rights above groups needs and neglect the risk environment for drug harms. They have to be adapted to the context through a contingent and variable construction of

rights claims that reflects the values of the societies, including values of social justice and collective good. Furthermore, harm reduction programs should be implemented as part of a broad-based response to drug use and related harms which incorporates the risk environment for drug harms in SSA. The good news is that the concept of harm reduction is adaptable to local situations to the effect that it is formulated not as “broad ‘top-down’ policies, but rather as specific, localized programmes” (Reuter & MacCoun, 1995).

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