WORLD HEALTH ORGANIZATION

Regional Office for the Eastern Mediterranean

ORGANISATION MONDIALE DE LA SANTÉ

Bureau régional pour la Méditerranée orientale

WHO Inter-Regional Workshop on
Prevention and Treatment of Drug Dependence

Alexandria, 16 - 21 October 1978

Drug Dependence in Countries of Eastern Mediterranean Region

by

Dr Taha A. Baasher
Regional Adviser on Mental Health
WHO Eastern Mediterranean Regional Office, Alexandria

TABLE OF CONTENTS

The drugs which are commonly abused in countries of the Eastern Mediterranean Region (EMR) can be generally grouped into five major categories namely, opium and its derivatives, cannabis, khat, alcoholic beverages and a variety of synthetic substances.

In general the abuse of these drugs is more than a pharmacological reaction. For it transcends the drug user and is intricately enmeshed in the historical background of the communities under study, the socio-cultural matrix and the prevailing ecological environment. Hence, in discussing the complex problems of drug dependence, due consideration will be given to these inter-related and varied factors.

In this paper an attempt will be made to briefly describe the historical perspective of drug dependence in countries of EMR, outline the nature and extent of the existing problems, define the objectives, and suggest general guidelines for future planning and programming in this complex field.

I. HISTORICAL PERSPECTIVE

1. Origin and Early Use of Drugs

The countries of EMR are among the most ancient in the world and drugs, as shown by recorded history were variously used at different times and places.

The two varieties of opium poppy, Papaver somniferum and Papaer rhoeas for instance, seem to have been known in ancient Egypt and can be clearly recognized from ancient paintings and writings. It is believed that the opium poppy was introduced during the Eighteenth Dynasty into Egypt from Mesopotamia.(1)

Importantly, whatever the origin of opium and its mode of spread into the ancient countries of EMR, it seems to have been essentially used for the relief of pain and induction of sleep. Apparently there is no evidence to indicate that it was abused in these ancient civilizations. It is to be remembered, however, that the healing arts at that time were part of the priest-physician cult and knowledge regarding therapeutic medications of opium poppy were later transmitted through Greece-Roman times to early Islamic physicians.

In contrast to recorded history on opium poppy, there is no evidence to indicate the use of cannabis in ancient Egypt. However, its therapeutic use as an anaesthetic was first reported in an early Chinese treatise on remedies and gradually spread to India, the Tigris and Euphrates Regions, Iran and Arabia.(2) Significantly, cannabis was known to the arabs as Indian herb.

Similar to opium and cannabis, since early times, khat (catha edulis) has been known in some countries of EMR, notably Djibouti, Somalia and Yemen. The first available references date back the cultivation of khat in Ethiopia to the fourteenth century and from there it was reported that in the fifteenth century the plant found its way into the northern part of Yemen.(3)

2. Early Abuse and Prohibition

Over the years the use of these natural drugs was no longer restricted to therapeutic practices and were non-medically abused. The earliest reference to the abuse of opium in countries of EMR was made by Al-Biruni of Khawarizm (973 - 1051 A.D.). He described how people living in hot countries got into the habit of using opium to relieve themselves of the physical distress and secure longer period of sleep.(4) Significantly, he observed that though, at the start, the doses used were small, they were sometimes increased to lethal levels.

In principle, Islamic teachings advocate that the use of any substance which leads to clouding of the mind and causes confusion of thinking should be strictly prohibited. However, as the use of opium and cannabis, unlike alcohol, was not explicitly dealt with in early Islamic doctrines, this might have led to their traditional acceptance.

Along with economic, social and cultural decadence which crept from the tenth century onwards into many countries of EMR, an escalated abuse of opium and cannabis as pleasure-producing substances seemed to have taken place. Interesting accounts in this respect were given by the renowned traveller, Ibn Jubayer(5) of the 12th century and later on by distinguished historians such as Al Maqrizi.(6)

Realizing the harmful effects on society from the wide use of cannabis, early attempts of prohibition in some countries were made by various rulers including Napolean after his conquest to Egypt in 1800.(7)

Alcoholism which seems to have been strikingly prevalent in pre-Islamic era in the Arabian Peninsula, has been exceptionally the focus of attention since the early inception of Islam in the seventh century. Prohibition was gradually introduced and the new religious system had brought about far reaching social and behavioural changes which made Muslim believers readily respond to Islamic teachings. The Holy Koran contains several verses which are concluded as follows "Satan's plan is to excite enmity and hatred among you with intoxicants and gambling, and to hinder you from the remembrance of God and from prayer. Will you not then abstain?" (Sura five,verse 91 Al Maaida).

3. The New Synthetic Substances

In contradistinction to opium, cannabis, khat and alcohol, which have been traditionally abused in countries of EMR, there are the new synthetic substances, which have been posing increasing problems since the turn of this century. With the growing industrial productivity of modern narcotic drugs, closer relationship between countries and faster communication, more and more of these substances have become readily available for public use. It has to be remembered that the hazardous nature of these new narcotics may take some years before they are recognized. Heroin (diacetylmorphine) which was originally therapeutically used as a non-addictive substitute for morphine, provides in this respect an illustrative example. When it was first used towards the end of last century, it was hailed as an effective cure against morphine addiction. It was only by the beginning of this century that its addictive charcteristics were recognized. However, this same drug was soon introduced into some countries of EMR and serious problems ensued. The account given by El Hadka[8] on the "forty years of campaign against narcotic drugs in the United Arab Republic" presents a vivid and informative example. It clearly demonstrates the changing pattern of drug dependence in countries of EMR. For until the beginning of the First World War, the new narcotic substances often referred to as "white drugs" namely cocaine, heroin and morphine were generally unknown. This situation, however, was no longer obtained and the abuse of the new synthetic substances soon became one of the major health problems.

II. NATURE AND EXTENT OF DRUG ABUSE

Accurate statistical data on the nature and extent of drug abuse in countries of EMR are generally lacking. Only rough estimates are available in some countries and hence the need has been felt for organized research and better collection of information. Recently, increasing national and international efforts, including that of WHO, have been directed towards this end and some of the relevant findings will be briefly presented here.

1. Extent of Opium Use and Abuse

As previously stated since the dawn of recorded history opium use as a therapeutic substance has been known in some countries of EMR. Todate there are four countries in this Region namely: Afghanistan, Egypt, Iran and Pakistan, where opium abuse is considered as a major problem in the field of drug dependence.

In Afghanistan, since 1973, various attempts by United Nations agencies have been made to measure this problem.[9,10,11] Despite the paucity of information, preliminary estimates showed that the incidence of opium dependence in the northern areas of the country varies from five per cent (Faizabad) to sixty per cent (Zabak). In Badakhshan Province (population of 500,000), where preliminary study was made, it was roughly estimated that one out of five of the general population was suffering from opium dependence.[12] Other field surveys are now underway to provide more information for dealing more effectively with this problem. The importance of field surveys need no emphasis here. It may be of interest, however, to point out that only few patients with opium dependence report for treatment and that records from the health services reflect rather poorly the magnitude of the problem. For example, while it was estimated that there were 100,000 persons in Badakhshan Province, who were regularly abusing opium, during the ten-year period from 1965 to 1974 only twnety-four opium addicts were admitted into Sanayee Hospital of Kabul University, the only institution with in-patient psychiatric facilities in the country.[13]

Studies were also conducted in other countries. In 1974 an attempt was made to assess the number of persons in Egypt who were dependent on opium and the following two approaches were applied[14]:

(a) official figures of the annual amounts of opium seized by the Narcotic Control of the Egyptian police were used as a basis for estimating the number of regular users.

(b) twelve experienced psychiatrists were asked to provide estimate on the size of the problem.

Based on the figures of supplies of opium and on an average consumption rate of 1.5 to 2 grams per day per individual, it was estimated that there were approximately 25 to 30 thousand persons suffering from opium dependence in Egypt.

Similarly the consensus of medical opinion estimated the chronic abuse of opium in Egypt in the range of 25 to 33 thousand persons, mostly older males who were in the lower socio-economic stratum of the society.

The majority of opium-dependent persons seemed to be concentrated in urban centres, mostly Cairo, where again the consensus of opinion among the clinicians interviewed put the number at approximately 15 000. Though these findings gave a rather rough measuring index, they were still very useful for overall planning and development of appropriate treatment facilities.

In some countries of EMR such as Iran, opium abuse shows a unique historical and social background and is so deeply ingrained in the culture that it is not easy to draw a distinct line between occasional use and sustained dependence. This is clearly one of the problems in case-finding and in the proper assessment of the extent of opium-dependence.

Because of lack of systematic field studies, early estimates of opium abuse in Iran, were rather impressionistic and generally unavailable. In 1955, however, it was estimated that there were a million and half persons using opium out of a population of 20 million. Later on, in 1972 Azaraksh[15] put the figures of opium users between 200 000 and 300 000 out of a population of 30 million. Obviously there is a significant difference between the estimate in 1955 (7.5 per cent) and that of 1972 (one per cent). It has to be recalled that in 1955 the use of opium was prohibited in Iran, and that this measure was superseded in 1969 by a new policy which restricted the use of opium. Furthermore, as the methodology were different it will not be possible to draw any reliable conclusions from the two estimates.

As a rough index of opium dependence in Iran, use has been made of the registration records, which are routinely kept. In 1974, for instance, official records based on ration cards showed that the number of registered opium-dependent persons was 153 613. This figure only shows the number of persons who voluntarily reported for taking rations of opium on medical certification, or because of age - 60 years and over, as stipulated in the law of prohibition. Again in 1976, Moharreri stated that there were over 170 000 officially registered opium addicts and that "this figure.... is believed to represent only between one-third to one-half of the real number of the addict population".[16]

Similar to other countries until very recently there were no available valid data on the extent of opium abuse in Pakistan. In 1974, however, it was reported by a UN Mission that in certain villages within the opium producing areas in Pakistan more than 20 per cent of the male population were dependent on opium. More recently, McGlothlan et al[17] gave a higher prevalence rate in certain opium cultivated areas. In Kuria village (Swat District), for example, opium dependence was estimated as high as 50 per cent among adult persons, including 4 to 5 per cent of adult female population. Furthermore, on systematic interviewing the daily opium users purchasing through the vends in Rawalpindi, it was estimated that "the percentage of the overall population

addicted to opium is about 0.5". In a previous survey, however, the percentage of male opium dependent persons in the city of Lahore was estimated to be 3.7 (Hussin 1972).[18] Due to differences in methodological approaches, comparison between Rawalpindi and Lahore estimates does not seem appropriate and obviously no generalization on national prevalence of opium abuse in Pakistan can be made from available information. However, these preliminary findings provide useful indication for future drug dependence programme and call for extending the current studies to other parts of the country.

In sharp contrast to country-wide opium use as previously described in Afghanistan, Egypt, Iran and Pakistan, there are countries where limited pockets stand out clearly in the epidemiological scene of drug dependence and the socio-cultural study of drug dependent persons in Port Sudan area, is worthy of mentioning in this respect.[19]

2. Cannabis Use and Abuse

Reference has already been made to the use and abuse of cannabis (hashish, bhang, bango, charas etc.) in historical perspective. In recent years special studies on its behavioural[20] and psycho-social aspects[21] were carried out. Though Gobar based on his experience in Afghanistan, stated that "the population of hashish abusers cannot be estimated as they are scattered diffusely throughout the country" in 1974 he reported that 75 cases of "hashish intoxication" which constituted 13 per cent of all psychiatric patients were admitted into Senayee Hospital during the period, 1960 - 1969. It is clear that this is a high rate of admission and the severity of toxic confusional states which may lead to hospitalization is well supported by general observation in this country, as well as in others. Among other features it is calimed that the potency of the Afghan hashish, due to its relatively higher THC-Δ-9 contents, was six to eight times stronger than marijuana. There are no available valid information which permits adequate comparison between the active contents of cannabis in countries of EMR and other regions and organized research studies are indicated to fill up this important information gap.

A promising study is the extensive survey, which covered nine towns in the Sudan and 2200 persons were interviewed to find out the extent of cannabis use and abuse. Analysis of the results showed that approximately 30 per cent of the male population interviewed used cannabis and that more than half of them were still continuing to smoke this substance for a period which varied from one month to four years.[22]

As the selection of the sample was not adequately described, it is difficult to say how far it was representative. Consequently, no generalization on national prevalence can be made from this study. Nonetheless, it clearly indicated the seriousness of cannabis abuse which calls for more effective measures in order to deal more properly with this problem.

3. Studies on Khat

The UN Commission on Narcotic Drugs (1956) and the Permanent Anti-Narcotic Bureau, League of Arab States,[24] were among the first organizations to show interest in systematic studies on khat. The document on "The Question of Khat",[25] submitted to WHO Regional Committee (EMR) gave an all-round statement from the international and national viewpoint. Information regarding the medical aspects of the khat plant (catha edulis Forskal) were fairly well documented in previous publications.[26,27]

Preliminary studies on socio-cultural aspects and on the extent of khat-chewing in Yemen were initiated by EMRO in 1973.[28] More elaborate data were collected by an inter-disciplinary team and the preliminary findings demonstrated that the prevalence of khat-chewing among adult males may reach 80 per cent in major cities and 90 per cent in the villages where khat was cultivated.[29] Concern by certain national authorities has been increasingly shown for more elaborate studies and for practical approaches in the prevention and management of the multi-sided problems of khat-chewing. Co-ordination of national activities with international input is a well-worthy effort in this respect.

4. Abuse of Synthetic Drugs

The abuse of synthetic drugs, has been observed, to a varying extent, in some countries of EMR. A variety of substances ranging from narcotic to stimulant drugs have been reported from several countries.

It has often been observed that whenever the supply of traditional natural drugs is put under control , resort to synthetic substances may take place. The abuse of heroin, in the form of sniffing or inhaling, was believed to have increased in Iran, following the suppression of opium production in 1955. In 1973 for example, it was estimated that there were approximately 20 to 30 000 heroin users among the general population. Though this figure is relatively small when compared to opium users,

those admitted into Vanak Hospital* with heroin dependence formed 55 per cent of the total admissions. As a new subculture, heroin abuse,different from opium dependence, is commonly popular among the youth of higher income group living in major urban centres.

In recent years, the abuse of methaqualone in the form of mandrax, has created, similar to other regions,(30) alarming concern due to its serious complications e.g. escalation to alcoholism, cardiovascular complications, epileptic seizures etc.

In some countries which are undergoing rapid socio-economic changes and where extensive long distance motor-ways have been constructed, such as Saudi Arabia, abuse of amphetamine by truck-drivers has often been reported. Other forms of abuse of stimulant drugs have been popular with the student population.

III. FACTORS INFLUENCING DRUG ABUSE

1. General Features

On reviewing the nature of drug abuse in countries of EMR there are general features which can be clearly delineated as follows:

(a) the long past of the tendancy for drug abuse in several countries.
(b) that no country has been immune to the abuse of drugs.
(c) the variety of drugs abused in different countries.
(d) the change in drug abuse and in the pattern of dependence with change in time, circumstances and place.
(e) the importance of the availability of drugs liable to cause dependence and their social and cultural acceptance.

Traditionally, drug abuse has been popular with the male population and the vulnerability of youth stands out strikingly in all countries. Even in chronic opium users, which is commoner in older people, the first experience with the drug in the majority of cases may be traced to a generally younger age group.

---

* Vanak Hospital was then the only institution in Teheran providing special important facilities for drug dependent persons.

2. A Number of Factors

Apart from social conformity and the influence of tradition, a number of factors can be elicited in the use and abuse of drugs. In certain traditional societies, the abuse of drugs has been wrapped in mythical beliefs, bizarre sexual notions and pleasure-inducing tendencies. As a psycho-social behaviour, several parameters mainly identification, motivation, stimulus and reward effects etc., commonly seen among the peer-groups, are considered important determinant factors in drug abuse. Again, various assumptions have also been advanced, ranging from metabolic[31] to psycho-dynamic disorders[32], to explain the phenomena of drug dependence. However, it is most likely that all depends on an interplay of factors, particularly the personality structure, the psycho-pharmacological effects of the drug and the psycho-social environment.

On the other hand there are the obvious and straight forward causes of drug dependence which are secondary to an underlying illness or being socially induced.

In a country like Afghanistan opium dependence has been attributed to lack of health services and to its traditional use as a medication against diarrhoeal diseases, chronic respiratory conditions etc., and for relief of pain in cases of injury, arthritis, febrile episodes, toothache, pruritis and physical distress during the cold weather.

IV. PROGRAMME DEVELOPMENT IN DRUG DEPENDENCE

It can be concluded from available information that concentrated efforts have to be made, at national, regional and international levels for dealing more effectively with the current overriding issues of drug dependence. Because of increasing awareness and growing nature and complexity of drug abuse, several countries in EMR have expressed keen interest to develop preventive and therapeutic measures in this field.

The policy basis and the role played by WHO in the field of drug dependence have been covered by the same author in another paper.

It seems appropriate, however, to review the general objectives and strategy, define the difficulties besetting programme development to reach these objectives and discuss relevant guidelines for future programming.

1. Objectives and Strategy in Programme Development

The general objectives in programme development in countries of EMR should aim at preventing the occurrance of drug dependence, reducing its disabilities,when they exist, and resolving the problems, with which it is commonly associated.

To achieve these objectives the strategy to be followed should be based on an integrative approach to ensure active collaboration and close coordination between the various authorities concerned and facilitate maxim effectiveness in the mobilization of available resources in respective countries for efficient control of drug abuse and proper management of drug dependent persons.

2. Constraints of Programme Development

There are several difficulties in the field of drug dependence that impede development of satisfactory programmes to meet the needs of countries. In brief these difficulties are:

(a) lack of accurate statistical data, which are so important for proper planning and decision-making.

(b) deficiencies of facilities and lack of good models which can be appropriately developed in preventive, therapeutic and rehabilitative programmes.

(c) shortage of qualified manpower and lack of formal training programmes in all the countries of EMR. In practice, several professionals have been sent to drug dependent centres in technically advanced countries for general orientation and for getting acquainted with current knowledge and skill in this field. The fact that there are no teaching material and no formal academic experience relevant to local conditions and in harmony with the psycho-social background of the trainee, constitute a serious obstacle, in manpower development, particularly with regard to auxilliary and para-professional workers.

(d) in view of the deficiencies of central organizational and administrative machinery, drug dependence programmes in many countries are disjointed and fragmented.

(e) legal regulations and drug laws are often out-moded and out of date with respect to the rapidly changing national and international situations.

(f) some of the countries are still not parties to the International Conventions

on Narcotic Drugs. This will obviously hamper mutual activities between the national and international community.

3. General Guidelines for Programme Development

In principle, the general guidelines formulated by the WHO Expert Committee (1974),[33] form a useful frame work for the development of effective drug dependence programmes. The measures to be used should be primarily directed to deal with three inter-related and basic issues which are:

- limitation of the availability of dependence-producing drugs.
- management of individual and group users of drugs.
- coping with the environment.

(a) Limitation of Availability of Dependence-Producing Drugs

The limitation of the availability of drugs is a crucial issue in the prevention of drug dependence. In some countries, such as Syria and Tunisia, where appropriate measures have been undertaken for the control of narcotic drugs, it has been noted that the incidence of opium and cannabis abuse, for instance, has become generally low.

Again the classical example of the spread of heroin into Egypt indicated the importance of early recognition of dependence-producing drugs and the need for cooperation at the national and international levels to facilitate the exchange of information and ensure world-wide control of illicit trafficking.

At the national level, much efforts are needed for proper monitoring and rational use of narcotic and psychotropic substances. Control of illicit cultivation, production and use of such drugs as opium and cannabis, which are traditionally grown in countries of EMR, have to be considered within the context of socio-economic needs and mutual participation of the communities at risk. Crop substitutions, which have been recently introduced in some countries, show promising results. Still one has to go a long way on this difficult road before successful results can be proclaimed.

(b) Measures Directed at the Individual and the Group

(i) General

Ideally, programme development in drug dependence should aim at a total approach for prevention, treatment and rehabilitation of individuals and groups, who are either potentially at high risk, or actually suffering from drug abuse. This by necessity should involve a range of social institutions and community agencies. Due regards

has to be given to the role of: the family, education, health and social services; religious institution, mass media, political groups, peer-groups etc. The importance of close cooperation between these various agencies need no further emphasis here. The programme, however, should be relevant to the local needs and geared towards the realities of the local conditions.

(ii) Treatment and Rehabilitation Programme

In practically all countries of EMR, difficulties have been encountred in the establishment of treatment facilities and the development of appropriate therapeutic modalities. While the first project in Shiraz for out-patient treatment of opium addicts[34] shows encouraging result, the detoxification programme based on methadone-withdrawal cover, which has been implemented in various parts of Iran, had many drawbacks and failed to make any break-through.[35,36]

However, attempts at establishing community-based centres, such as the Ataba Clinic, Cairo, hold many possibilities for integrative programmes and for the wider utilization of community resources. The site of the clinic in areas known to be exposed to drug dependence problems and the application of a multi-team approach have proved more appropriate to the psycho-social complexity and broad nature of the drug abuse problems. It is envisaged that prospective controlled study of the specific services provided in this Clinic and the follow-up of results may yield useful information which should be helpful in promoting the efficiency of the treatment and rehabilitation programme.

(c) Measures Directed towards the Environment

The close interaction between individuals or groups and their surroundings in cases of drug dependence calls for special attention to be given to socio-economic background, cultural norms, physical conditions etc. The approach to the khat problem, for example, due to unique socio-economic and cultural problems, should be relevant to the prevailing conditions of the target communities. One of the recent measures, for instance, undertaken in Somalia for reducing the use of khat is its prohibition during office work. Such a measure seems appropriate to a special social sector of the community and deals with only one feature of the problem. This action is one of the very early steps. It certainly expresses the official concern of

Somalia regarding this problem. In People's Democratic Republic of Yemen, more broader measures, which restricted the use of khat to week-ends and holidays, were recently enforced. It is difficult to say at this stage what will be the effects of such measures on the use of khat in Somalia and Yemen, however, it is clear that more elaborate action has to be taken in order to get to the roots of the habit and deal with problems of khat abuse as part of an overall socio-economic plan.

An important issue which also needs proper reviewing is the legislation of drug dependence. Detailed information on legislation in Egypt, Iran and Pakistan can be obtained from publications by Dixon, Mclaughlin et al[37] and Khan and Wadud.[38] In many countries of EMR, the laws which are regulating and controlling the use of narcotic drugs and which have far-reaching effects in the social and cultural environment, are inappropriate and generally defective.[39]

More efforts are required to update the existing regulations and render them more relevant to the current needs.

V. SUMMARY

In this paper an attempt has been made to describe the historical perspective of drug abuse in countries of EMR with due reference to its deep psycho-social roots and changing patterns in relation to time and place.

Rough estimates regarding the size of the problem are given and guiding principles with relevant examples to meet the growing needs of countries are provided.

Programme development in all the countries are beset with organizational difficulties, inadequacy of coordination, shortage of trained personnel, defective regulations, inappropriate therapeutic and rehabilitative models etc. Concerted efforts are, therefore, generally needed to effectively deal with centuries-old problems of drug abuse in this Region.

REFERENCES

1. Gebra, S. Papaver Species and Opium through the Ages, Bull. Inst. Egypt, 1956, 37, 39 - 54.

2. Bouquet , J.R. Cannabis, parts I and II, Bull. Narcotic, 2: 14 - 30, 1950.

3. Alles, G.A. et al. Clinical Pharmacology of Catha Edulis. J. of Medicinal Pharmaceutical Chemistry, 3(2), 323 - 352, 1961.

4. Al Biruni, Abu Rayhani, M. Kitab el Sayadanah, edited and translated by Hakim Mohamed Said. Hamdrad National Foundation, Pakistan, 1973.

5. Ibn Jubayr, M.A. Rihalat (Journeys). Saadah Press, Cairo, 1908.

6. Al Maqrizi, Tag el Din. Al Khitat, Al Neel Press, Cairo, 1324, A.H.

7. De Sacy,S. Chrestomathie Arabie. Paris, 1826.

8. El Hadka , A.A. Forty Years of the Campaign Against Narcotic Drugs in the United Arab Republic. Bull. Narcotics 17· 1 - 12, 1965.

9. Micute, W. Report on Mission to Afghanistan. UN Division of Narcotic Drugs. Geneve, 1973.

10. O'Kuffe, Charles. Report on Mission to Afghanistan. WHO Genève, 1975.

11. Beus, J.G. and Davies, M., Mission to Afghanistan. United Nation Fund for Drug Abuse, 1976.

12. Uchtenhagen, A.A. Report on Mission to Badakhshan. WHO Genève, November 1976.

13. Gobar, A.H. Drug Abuse in Afghanistan. Bull. on Narcotics. Vol. XXVIII, No.2, 1976.

14. Tuma, H.A. Treatment of Drug Dependence at the Ataba Clinic, WHO Alexandria, 1974.

15. Azaraksh, H.A. The Nature and Extent of Drug Abuse in Iran. Cento Seminar, Teheran. Central Treaty Organization. Ankara, Turkey.

16. Davies, M. Report on WHO/UN/ILO/FAO Mission to Pakistan. Geneve, 1974.

17. McGlothlan, W.H. et al. Opium Use in Pakistan. 1976. (under publication).

18. Hussein, M. Nature and Extent of Drug Addiction in West Pakistan. Social Science Research Centre, University of Punjab, Lahore, 1972.

19. Abdel Rahim, T. Opium Use in Port Sudan Area. Third Arab International Conference on Alcohol and Drug Dependence. Khartoum, December 1977. (under publication)

20. Soueif, M.I., The Use of Cannabis in Egypt. A Behavioural Study. Bull. Narc., 23: 17 - 28, 1971.

21. Soueif, M.I., Hashish Consumption in Egypt with Special Reference to Psycho-social Aspects. Bull. Narc. 19: 1 - 12, 1967.

22. Sulıman, H. Cannabis Use in Sudan. Third Arab International Conference on Alcohol and Drug Abuse. Khartoum, December 1977. (under publication)

23. UN Commission in Narcotic Drugs. UN Document E/2891. July 1956.

24. WHO EMRO. EM/RC.6/5. July 1956.

25. WHO EMRO. EM/RC.9/13. July 1959.

26. Habbach, H. Medical Aspects of the Chewing of Khat Leaves. Bull. World Health Organization, 47, 21 - 29, 1972.

27. Guedel et al. The Medical and Social Problems of Khat in Djibouti. Bull. on Narcotics 9: 34 - 36, 1957.

28. Abu el Azayem, G.M., WHO Report. EM/MENT/58. Alexandria, 1974.

29. Hughes, H.P. The Epidemiology of Qat Chewing in Yemen. WHO Report, 1973 (unpublished).

30. Darryl, S.A. et al. Methaqualone Abuse. JAMA, Vol. 224, No.11. June, 1973.

31. Dole, W.P. and Nyswander, M.H. Heroin Addiction - A Metabolic Disease. Arch. Int. Med. 120, 19 - 24. July 1967.

32. Glover, H. On the Aetiology of Drug Addiction.
International J. Psycho-anal. 13, 298 - 326, 1932.

33. Wld. Hlth. Org. tec. rep. ser. 1974. 551.

34. Moharreri, M.R. Out-Patient Treatment of Opium Addicts.
Report of a Pilot Project in Shiraz. Bull. Narcotic XXVIII,
No.3, 1976.

35. Baasher, T.A. Report on Mental Health Activities in Iran.
EM/MENT/51. WHO Alexandria, 1973.

36. Baasher, T.A. Report on Psychiatric Services in Meshad, Iran.
EM/MENT/66. WHO Alexandria, 1974.

37. Dixon, W.H., Narcotic Legislation and Islam in Egypt.
Bull. on Narcotics. XXIV, 4, 11 - 18, 1972.

38. McLanghlin, G.T., and T.M. Quinn. Drug Control in Iran.
A Legal and Historical Analysis.
Iowa Law Review. Vol. 59, No. 3, 469 -524, 1974.

39. Khan, I. and K. Abdel Wadud. Drug Abuse in Pakistan.
Bull. on Narcotics, Vol. XXIX, No. 4, 21 - 40, 1977.

Contribution by Unesco to the Workshop on Prevention and Treatment on Drug Dependence (Alexandria, 16 - 21 October 1978)

Education concerning the problems associated with the use of drugs

I. Prevention

1. Introduction

The role of education in prevention strategies has been increasingly emphasized and demands have been made from various sectors (law enforcement, etc.) on Unesco to develop its programme in this field.

"Drug education" has been considered at first as "a luxury", to quote a statement made several years ago in an international United Nations meeting, in the same manner more or less as education itself was at one time considered as a privilege and often a luxury. However, again like education in general, "drug education" was soon to become a need and a right.

After having been considered a superfluous item, it was expected to work wonders and requested to produce "quick and spectacular result". This was forgetting that education deals with the minds and feelings of human beings that hardly ever change overnight. More over, in a field as complex as that of drug use, it must be remembered that there is always "a solution quick, simple and wrong".*

Drug education has sometimes been accused of contributing to the extension of the use of dangerous substances. This statement was based mainly on a number of experiments made at the beginning of the implementation of educational programmes in this field. Just as drugs themselves, drug education and drug information are not good or bad per se but their value depends on how they are used, that is, what methods they utilize, what audiences they are meant for and in what contexts they are situated.

Concerning drug demand and preventive education one should consider on the one hand the facts, which can be measured by epidemiology (extension of the phenomenon, number of occasional, regular, dependent users, etc.), on the other hand, the way in which the situation is perceived. From the point of view of education this perception of the phenomenon is the most important aspect. Indeed, the authorities, the teachers or the parents will not take the same educational steps depending on whether they believe that the problem is not serious or they think there is an epidemic, depending on whether they consider drugs as either good or bad or they think that all drugs have a potential for both good or bad effect.

2. Unesco policy and activities

It should be clarified that from the point of view of Unesco the term "drugs" covers all types of substances whether legal or illegal and includes therefore the use of alcohol, tobacco, over-the-counter drugs, prescription drugs, as well as cannabis, heroin, etc. But the problems associated with the use of drugs are considered less as depending on substances than as

* "Drugs Demystified, Introduction, page 12

psychosocial problems closely linked with the cultural and economic environment of the various countries. Also, contrary to what has been a prevailing attitude in recent years, the Organization has refused to equate drug problems with problems of youth.

In its activities Unesco has tried to bring awareness to Governments about the problems associated with the use of drugs and to educational authorities, parents' organizations, youth groups, etc. about the role that they could play in preventing or solving those problems.

The Organization has endeavoured to define situations relating to drug use, to foster the exchange of experiences of educational material and teaching staff and to support educational approaches adapted to the various situations.

Far from trying to gather on a world level educators from the greatest possible number of countries the Organization has limited participation in its meetings to groups corresponding to certain categories of Member States. Priority has been given first to industrialized countries, then to more limited groups of these countries, and to studies bearing on specific age groups (meeting on Youth and the use of drugs, study on the youth press, study on the rehabilitation of young ex-drug users, etc.) All these activities have formed a basis for the pamphlet : "Drugs Demystified" which, in spite of its general value is first of all based on the situation in highly industrialized countries. The Organization has then tried to give assistance also to countrie in Latin America and the Caribbean, to help them define the problems related with the use of drugs such as they appear in the region, taking into account very substantial differences from one country to another (national studies, overall study by a consultant, regional meeting in Lima, 1976, etc.)

This has been followed by the launching of an experimental project in secondary schools of one Member State in the region (Argentina), and by the convening in the Caribbean of two Workshops for the preparation of education material for teachers, parents, and youth groups. One of those meetings was intended for English speaking Caribbean countries (Kingston, Jamaica) the other for Spanish speaking Caribbean and Central American countries and Mexico (Santo Domingo, Dominican Republic).

In Africa a similar approach has been adopted on a more modest scale. The first step concerned three English speaking and three French speaking countries where national studies were undertaken, consultants provided and an expert meeting organized (Lomé, 1976). This was followed by the granting of fellowships to educators from other French and English speaking countries which will lead to the organization of educational material workshops in 1979.

In Asia a meeting (Penang, Malaysia, 1977) intended for ten countries was again preceded by study tours awarded to educators and by studies on the attitudes of youth towards drugs and drug education.

In the Arab States a survey has been launched on the basis of questionnaires and the visit of a consultant to five of the countries concerned.

3. <u>Existing programmes of education concerning the problems associated with the use of drugs</u>.

The various studies and meetings undertaken by Unesco have shown that educational activities are still comparatively limited as far as problems of drug use are concerned. However, some Member States have taken serious measures to institutionalize it. The first level of intervention has often been the school.

At the school level it is often considered useful to include information and guidance in the curricula for the various levels and types of teaching, in which case the teachers are in charge of this action. Thus : "At the elementary level the pupils can be taught about tobacco, alcohol and, if the question is much to the fore, the use of solvents and other drugs, in connexion with discussions regarding health, body functions, forms of conduct and customs. With well-informed and detailed argumentation school must simultaneously clearly point out the positive value of total abstinence from alcohol and tobacco first of all during the period of growth. Further it must be pointed out that all use of drugs not prescribed by a doctor means danger and is contrary to the existing law."

"At the intermediate and higher levels, education should be directed towards matters that come within the fields of interest, both of sociology and the natural sciences. At the higher level, opportunities will be found to discuss behaviour and the results of scientific surveys on this subject and the role of publicity in shaping attitudes. It is important that the school should cooperate closely with parents and with representatives of the different health institutions and agencies so as to reinforce the elements learned in school."

"All teacher-training colleges now have a compulsory eight-hour course for all teachers, irrespective of the subject they will be teaching." (1) In this case what is considered is health education, education and training to develop certain patterns of behaviour and guidance in relation to traditional customs. It is considered that the school has responsibilities concerning education as well as leisure time.

In a number of countries the existing infrastructure of youth organizations for example, or trade unions is used for the spreading of information and for the establishment of communication with various sectors in the general public. In some cases it is considered that youth groups for example must take responsibility for this action, with a government subvention, because adults lack credibility with young people.

Other experiments show the importance of an overall action. In some countries "national organizations are working hard to stir up communities and get everyone to participate in dealing with the problems of drug addiction. To this end these organizations have initiated information programmes for the general public, programmes in the industrial sector, programmes aimed at parents, teachers, and specialists in education and the treatment of drug addicts, programmes aimed at motorists, and programmes directed at other particular groups." (2)

In the countries where the problem has only been perceived at a recent date, it seems that the first steps in prevention activities have always been inspired by the same reaction , it is considered that a serious danger exists and the risks involved in the use of "drugs" have been given wide publicity, most of the time without distinguishing between the various products and the various types of use.

This type of education or rather biased information usually generates more harm than good and is then followed by an attempt at more efficient methods. Obviously it would be better not to start by stirring up curiosity, rejection or disbelief of the information, all of which contribute to making further activities more difficult. It would be advisable therefore to encourage the states that have not yet undertaken this type of programmes

(1) EPDA/EN/3. Sweden. I.2.1

to first request assistance in order to study the present situation, to train qualified staff and to prepare adequate methods and teaching material or adapt to the local socio-cultural conditions which may be available in other countries. It is equally important to advise the authorities not to undertake large national programmes at the outset but to start by experimenting and evaluating the methods which appear to be best suited to their country.

4. Some requirements for activities of education concerning the problems associated with the use of drugs.

As already stated prevention must first aim at creating an awareness of the problem among the authorities, among people in charge of education and social services as well as among those who are responsible for activities concerning either youth or out of school education for adults.

This awareness must go along with an understanding of the nature of the problem and must result in a sharing of responsibilities between the various groups and services. This allocation of duties must go together with a large measure of cooperation. It is obviously insufficient for educators and parents for example to be well informed if physicians and pharmacists have no concern for the consequences of the use of medical drugs and are not informed of the problems related with the use of illicit or licit drugs, if judges, social workers and the police only know the enforcement legislation or only consider drug use to the extent to which it constitutes a crime.

If cooperation mechanisms are essential it also seems necessary that the bodies set up for that purpose only serve as coordinators. For example, since the responsibility for implementation does not belong to the coordinating agencies or committees but to ministries of education, teachers themselves, parents or leaders of youth organizations it is important for them to contribute to the setting up of the programmes and activities for which they will be executors.

II. Education in treatment and rehabilitation of drug users

Drug users have very frequently only benefited from an incomplete education and have often dropped out of school, whether the use has occurred as a result of abandonment of educational institutions or has preceded it. It is therefore essential that an educational action be undertaken in connection with medical or social treatment.

Education should therefore aim on the one hand at changing the attitudes of the drug users, at giving them general knowledge background and the prerequisites for further schooling of vocational training. It should aim also at strengthening the personality of the individuals and equip them to function as useful and responsible members of society. On the other hand, educational programmes should be directed to the drug users family, to the community and to employers in order to make them aware of their responsibility with regard to former drug users and to encourage them to provide emotional and psychological support as well as opportunities for skills training and job placement.

The problem of education in social reintegration programmes has been mentioned with more and more emphasis in recent meetings organized by Unesco and will be given increased importance in the programmes of the Organization in the next biennium, provided those are approved by the General Conference which will meet in October and November 1978.

In both prevention and rehabilitation education programmes Unesco hopes for a continued and increased cooperation with the other Agencies of the United Nations family and with non-governmental organizations.

Paper prepared for WHO Workshop on
Prevention and Treatment of
Drug Dependence
Teheran, 15-20 October 1978

The Role of the International Labour Organisation in the Field of Drug Abuse Control

Introduction

The ILO in co-operation with other agencies and organisations, is responsible r that sector of drug abuse control programmes concerned with reduction of nand. In particular, the ILO's field of responsibility covers:

- advising on the development and organisation of vocational rehabilitation facilities and programmes in co-ordination with medical treatment and withdrawal centres for drug addicts;
- advising on the vocational guidance, assessment, vocational preparation, placement and resettlement of those discharged from medical treatment and withdrawal centres;
- advising on the need for establishing workshops, co-operatives, rural activities, self-employment schemes, etc., for former addicts;
- advising on the development of follow-up programmes for former addicts to help ensure the success of those placed in employment;
- training the necessary vocational rehabilitation, placement and follow-up staff;
- advising on the development and co-ordination of public information programmes and community involvement aimed at facilitating the reintegration of former addicts into the community;
- research into problems affecting the vocational rehabilitation, reintegration and follow-up of addicts.

Background to the ILO Programme

The ILO has from its outset been concerned with the improvement of social nditions and the protection of workers. Its activities have included attention the employment needs of the handicapped.

With the adoption in 1955 of ILO Recommendation No. 99 concerning the cational rehabilitation of the disabled, comprehensive international guidelines r action were established which still remain relevant in today's world.

Vocational rehabilitation may be described as that part of the continuous and -ordinated process of rehabilitation which involves the provision of vocational rvices, e.g. vocational evaluation, job counselling and guidance, prevocational eparation and vocational training, selective placement and follow-up. These lividualised services are designed to facilitate the securing and retaining of itable work.

Experience has now shown that the methods and techniques of vocational nabilitation are particularly relevant in those joint community efforts aimed the reintegration of drug-dependent persons. Undoubtedly, the absence of such cational services or their inadequate provision and organisation can represent rious limitations to the success of treatment and rehabilitation programmes.

In addition to assisting in the development of such services the ILO can also ay an important role in the creation of job opportunities for the drug dependent

to ensure that employment can be secured. This includes the creation of workshops, co-operatives, small-scale industry and in setting up rural and handicraft activities.

At the official request of the governments involved, ILO can make available the services of regional advisers for short-term consultations on vocational rehabilitation questions. Moreover, the ILO Information and Documentary Service has developed a section on the vocational rehabilitation of drug-dependent persons.

5. ILO Tripartism and Drug Dependence

As the ILO's structure is based on the tripartite system (collaboration between Government, employers' and union representatives) its action in the field of rehabilitation of drug dependents attempts, wherever possible, to encourage the participation of these important sectors.

At the 58th Session (1973) of the International Labour Conference, Geneva, a Resolution concerning alcoholism and drug dependency was submitted by the Workers' Delegations of Canada and the United Kingdom. The Resolution invited ILO member States and workers' and employers' organisations "to do their utmost in their own countries", inter alia "to promote effective tripartite or, appropriate trade union management consultations at all stages of the elaboration and implementation of programmes of treatment and rehabilitation", and "to promote positive attitudes such as the recognition of alcoholism and drug dependence as illness for which there is help and treatment, and to provide the best possible treatment and rehabilitation facilities in all communities."

Presently, however, all too few unions' and employers' organisations are prepared to offer jobs to rehabilitated addicts. Much progress remains to be made in this area. It is certain that prejudice in hiring former drug-dependent persons has contributed to the failure of many a rehabilitation effort and to the former dependents "going back to the habit" out of sheer discouragement. If he believes there is little hope in obtaining work after vocational rehabilitation, it would be difficult to either attract him to such a programme or to expect his wholehearted participation if admitted to it.

Too low a priority, in relation to other action in the field of drug abuse control, has been given to the psycho-social needs of the drug dependent. Yet it is encouraging that attention is increasingly being focussed in this direction. But much more needs to be known about how to improve our effectiveness in offering help to members of this group. Additional experience and knowledge should be sought primarily through programmes of action and not through too heavy a reliance on research findings and survey results.

Suggestions for Future Action

(a) Drug users should not automatically be labelled as drug dependent. With this in mind, the criteria for rehabilitation intervention should be based on the degree to which an individual is capable of relatively stable and responsible (as determined either by himself or his community) functioning with respect to his community.

(b) In the formulation of criteria for the evaluation of rehabilitation outcomes, one should take into account improved psycho-social and economic functioning.

(c) The full co-ordination and continuity of all treatment, rehabilitation and other services necessary to the drug dependent should be assured both on local and national levels. This could best be assured locally by professionals actively involved in treatment and/or rehabilitation programmes; and on national levels by a co-ordinating committee with all relevant representation of ministries and private sectors (including community groups [church, parents, etc.], unions and employers' organisations).

(d) As a general rule, rehabilitation programmes should be non-institutional in nature and not require large financial investments. Wherever feasible, there should be a variety of programmes which will correspond to important differences in the characteristics of the drug-dependent population (such as the need for highly structured as opposed to loosely organised activities; residential programmes as opposed to the availability of short-term assistance as needed, etc.). Rehabilitation programmes should be community-based and should avoid a too high

along with professionals in the rehabilitation process, wherever possible, as they have been found to play a very constructive role.

(e) The full range of vocational services (vocational evaluation and guidance, job preparation, vocational training, selective placement and follow-up) should be made available, all or in part according to needs, as one of the phases of the treatment/rehabilitation continuum. (Relevant documentation and information as well as technical assistance services are available through the ILO.)

(f) Industries and unions should be encouraged to consider alternatives to the outright termination of employees who have been identified as drug dependent. Programmes of employee drug education, counselling and therapeutic assistance should be developed with a view to cut down employee turnover, improve employee job functioning and reduce losses in property damage, accidents and absenteeism.

(g) Industries and unions should be encouraged to offer job try-outs to rehabilitated job applicants. A person should be judged by his present performance and not by his past or by labels that society may have placed upon him.

(h) Professional training schools (e.g. medicine, nursing, social work, pharmacy, police, church, etc.) should be encouraged to include some orientation, wherever relevant, on the range of programmes and services as well as significant problems in vocational rehabilitation of drug-dependent persons.

Annex I

ILO's Work in the Field of Drug Abuse Control Over the Past Year (1977-1978)

The main thrust of the ILO's technical input in the past year has been directed towards the social and vocational rehabilitation component of projects in Pakistan and Burma supported by the UN Fund for Drug Abuse Control. An ILO vocational rehabilitation expert joined the Pakistan project in 1977. A vocational rehabilitation workshop was opened recently in Hyderabad and planning of a second workshop in Karachi is well advanced. Both workshops are closely associated with newly established treatment centres in those two cities. Moreover, vocational rehabilitation activities are being developed within the context of the rural sector of the project in the Buner area.

In Burma, ILO assistance is taking the form of short-term consultancies undertaken by ILO headquarters staff. As a result of the first consultancy, a detailed work plan for the Social Welfare Sector was drawn up which allows for a start to be made on the identification and registration of addicts and the establishing of four vocational training centres. ILO has also assisted in drawing up comprehensive lists of equipment for these centres. A further short-term consultancy visit is envisaged in the near future to help local specialists plan for the expansion of the pilot facilities.

The past year also saw the active involvement of ILO regional experts in the drug abuse control programme. In Bolivia, Malaysia and Thailand, for example, ILO regional experts in the fields of vocational rehabilitation, co-operatives and small-scale industry have advised governments and individual rehabilitation facilities on the development of training and work programmes for drug-dependent persons.

The ILO is also active in supporting the efforts of other agencies and organisations in the field of reduction of demand, including contributions to the study on this subject undertaken by the UN Division of Narcotic Drugs and to WHO meetings on epidemiology of Drug Dependence. In collaboration with WHO the ILO also recently produced a questionnaire for trial field testing in several on-going projects. The aim and purpose of the questionnaire is to obtain basic information to permit an evaluation to be made of the effectiveness of social and vocational rehabilitation.

The need for more attention and higher priority to be given to the question of reduction of demand for drugs was emphasised at the February 1978 Session of the United Nations Commission of Narcotic Drugs. With this important consideration in mind, it seems likely that the call for ILO specialist expertise in the vocational rehabilitation and social reintegration of drug addicts - an important element of programmes concerned with reduction of demand - will increase in the year ahead.

Annex II

An ILO Questionnaire/Inquiry Form Relating to the Entry of Drug-Dependent Persons to Rehabilitation Programmes and Subsequent Follow-up

(This form is currently being field-tested)

Social/Vocational Information Sheet (for drug dependent persons)

[Rehabilitation Programme Entry Form]

Date of Report :

Name : [optional]

Sex · male _____ female _____ age : _____ date of birth : _____

Permanent address : _____

Local current address : _____

Ethnic group . _____

Marital Status :

single (never married)	_____	married	_____	other (specify)
non-licensed marriage	_____	separated	_____	_____
divorced	_____	widowed	_____	

Living with whom :

spouse(s) or family	_____	friend	_____
member s of same		alone	_____
institution (hospital,		other	_____
jail, school, rehab. etc.)	_____		

Referred to rehabilitation service by

self	_____	family	_____	other (specify)
hospital	_____	Police/court	_____	_____

Source of income :

salary, wages	_____	spouse, family	_____	other (specify)
public assistance, charity	_____	friends	_____	_____
etc.				

Number of dependents :

_____ (how many people depend for support)

Have you any family, relatives or friends willing and able to help in some way in your rehabilitation? (who) _____

Education :

illiterate	_____	literate	_____
number of completed years of education		_____	

Job Training ·

has any been received (in a centre, school or from someone)
If yes, specify which type(s) _____
How long did training last _____
Diploma, certificate, license etc. received _____

Work : [List jobs below in chronological order, starting with most recent]

1) last job : duties _____
how long worked : _____ reason for leaving _____

2) job duties : _____
how long worked : _____ reason for leaving _____

How many jobs were held in the last 18 months _____

Longest time that any job lasted during last 18 months _____

List the different types of occupations held during last 18 months

[ENTRY FORM]

arrest(s) in last 12 months (specify) _____

_____ time spent in detention _____

sent legal status _____

es of therapy, services or help previously received ·

medical treatment	_____	legal assistance	_____
(how many times)	_____	housing assistance	_____
individual/group		other(s)	_____
counselling	_____		_____
job guidance	_____		
job training	_____		

* * * * * *

e_____) TERMINATION OF REHABILITATION PROGRAMME

gth of time spent in rehabilitation programme _____

son(s) for leaving programme :

Left to obtain work _____

left for further education or training _____

absconded _____

started taking drugs _____

other (specify) _____

vices and help received while in programme :

medical	_____	individual/group counselling	_____
job guidance	_____	job training	_____
job placement	_____	legal assistance	_____
housing help	_____		
other(s)	_____		

Social/Vocational Rehabilitation Programme for Drug Dependent Persons

(date_____) FOLLOW-UP FORM

One, six, twelve, eighteen months after leaving programme (please circle appropriate number of months)]

Since having left programme, former addict cannot be located :

died _____ moved (no new address) _____
no information _____ other (specify) _____

Employment status :

gainfully employed _____ house responsibilities _____
student or trainee _____ unemployed (seeking work)
other _____

[please give details on items checked] _____

_____

Work : [List jobs below in chronological order, starting with most recent]

1) last job, duties _____
how long worked : _____ reason for leaving : _____

2) job duties : _____
how long worked : _____ reason for leaving : _____

How many jobs were held since leaving rehab. programme or since last follow-up period _____

Longest time that any job lasted during this period _____

List the different types of occupations held during this period _____

_____

Current problems which appear to require special help :

health _____ financial _____
employment _____ family _____
personal _____ drug taking _____
other (specify) _____

[please give details on items checked] _____

_____

Have important changes occurred in his/her life?

working legal status _____
(specify) _____ living arrangement
marital status (specify) _____
(specify) _____ schooling _____
other (specify) _____

Is or will an attempt be made to help former addict to get the assistance he appears to require _____

(specify action recommended and/or to be taken _____

_____

_____

Other relevant comments or suggestions : _____

_____