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WORLD HEALTH ORGANIZATION
ORGANISATION MONDIALE DE LA SANTE

ENGLISH ONLY

WHO INTERREGIONAL WORKSHOP ON PREVENTION AND TREATMENT OF DRUG DEPENDENCE

Alexandria
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I Inter-regional Workshop on Prevention and Treatment of Drug Dependence

1. Introduction

The Inter-regional Workshop on Prevention and Treatment of Drug Dependence was held in Alexandria from 16-21 October 1978. Fourteen participants from nine countries belonging to two WHO regions, South East Asia and Eastern Mediterranean, took part in the workshop, along with observers and representatives from other international and non-governmental organizations (the list of participants is attached as Annex II).

The workshop was inaugurated by Dr. M. Shoib, Director Programme Development, who, on behalf of the Regional Director welcomed the participants and representatives. Dr. A.H Taba, Regional Director, although unable to be at the opening session because of other commitments, was present during parts of the workshop and at the closing session. In his message to the participants Dr. Taba stressed the importance of inter-regional meetings which brought together geographically contiguous countries with shared problems. He highlighted the public health perspectives of the problem of drug dependence, and its close link with the socio-economic changes which were taking place in the countries of the regions. He also drew attention to the unsolved problems in this area, such as developing culturally effective treatment modalities, monitoring of data, estimating the magnitude of drug abuse, development of trained manpower and hoped that the deliberations would focus on these issues. (Annex I).

Dr. A. Arif, Senior Medical Officer in charge of the Drug Dependence Programme, Division of Mental Health WHO Hq. and Dr. T. Baasher, Mental Health Advisor, Eastern Mediterranean Region, also welcomed the participants and expressed gratitude to the National Institute on Drug Abuse, USA, for providing financial support.[1] Furthermore, Dr. Arif pointed out the changing concepts of WHO policies relating to programmes of technical cooperation in the field on Mental Health. The World Health Organization will support all efforts to develop self-reliance within a given country and support co-operation between countries with similar geographic and socio-economic conditions. This new concept is particularly well-suited for the treatment and prevention of drug dependence, since this problem goes far beyond any geographical or political boundary and has its roots in the socio-economic level of the community. The inter-regional workshops have been planned to implement this new policy and as a direct response to both WHO and UN General Assembly resolutions.[2,3]

The 1970 World Health Assembly Resolution 23.42 noted, among other items, the extension of the serious public health problems resulting from the self-administration of dependence producing drugs. It expressed the urgent need to promote prevention, treatment and rehabilitation measures at the local, national, regional and international level. It further expressed the need to develop a system for collaborative reporting by selected institutes.

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[1] WHO/NIDA Contract No. 271-78-1301

[2] World Health Assembly Resolution 23.42, 1970

[3] United Nations General Assembly, thirty-second session, December 1977, Resolution 32/124

The UN General Assembly resolution 32/124 passed in 1977 recognized the need to make individuals and governments aware of the dangers of drug abuse and pointed out that increased attention should be given to the field of prevention, treatment and rehabilitation of drug dependent persons. The resolution invited the United Nations Fund for Drug Abuse Control to initiate, in collaboration with WHO and other appropriate agencies, actions to design models for the prevention, treatment and rehabilitation of drug dependent persons having different cultural backgrounds. Furthermore, it is hoped that through these workshops we will increase the awareness of this particular problem, promote the exchange of information, experience, research results and expertise. They will also help in establishing mechanisms for coordination and collaboration between developing countries for a more effective planning and implementation of the prevention, treatment and other intervention programmes in drug dependence

Election of Officers

Dr. I. Siassi, Deputy Minister of Health and Welfare for Mental Health and Rehabilitation, National Iranian Society for Rehabilitation of the Disabled, Teheran, was elected Chairman. Dr A S El-Hakim, Director, Mental Health Department, Ministry of Health, Cairo, was elected Vice-Chairman and Dr. D Mohan, Associate Professor, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, was elected Rapporteur.

2. Objectives of the Workshop

In the light of the above-mentioned Resolutions the objectives of the workshop are as follows·

(i) To discuss and assess the drug dependence problems in the countries of the regions.

(ii) To identify and review measures used in prevention, treatment and rehabilitation and to make recommendations about the most practical approaches to treatment and rehabilitation

(iii) To identify and review practical approaches to manpower development.

(iv) To identify and evaluate the available information needed to plan and operate programmes, to determine what research and information is most needed to improve planning, operation and evaluation of programmes

(v) To discuss and agree on ways and means which would ensure that programmes concerned with the management of drug dependence (and mental health problems linked to those) become part of overall country programmes in the field of health and socio-economic development.

(vi) To examine mechanisms for co-ordination and collaboration within countries and between countries in the region

3 Work of International bodies concerned with Drug Dependence

3 1 World Health Organization (WHO)

The World Health Organization has been actively involved in the problems of alcohol

and drug abuse and has in the past convened several expert committees to examine various aspects of drug dependence.[1-8] The mental health programme of WHO aims at preventing and reducing mental and neurological disorders and psychosocial problems including those related to alcohol and drug dependence More recently, WHO has been involved in developing strategies for mental health programmes in developing countries. The central feature of this effort is that mental health is viewed as an integral part of public health and social welfare programmes rather than a highly specialized set of skills and knowledge that can be applied only in special institutions. The activities concerned with drug dependence are an important part of the WHO mental health programme. These activities should be integrated into the primary health care system within the existing administrative infrastructure of a given country.

Many rural and agricultural areas in developing countries have little or no health services. The fundamental purpose of a primary health care programme is to assist the people in a community to develop its own resources. Implicit in this principle is the acceptance of the fact that different countries would have differing priorities, as the basis of their country health programming. WHO would act as a catalyst in assisting in the development of country health programming. The emphasis of such programmes is placed on the interaction of the health and other relevant sectors, thus placing health in a broad perspective. Country health programming can provide the impetus for drug dependence programme development and the infrastructure to ensure that drug dependence activities are planned and co-ordinated within the existing health and social care delivery systems. Once a country has decided that drug dependence is a serious social-health problem, a national programme should be formulated, based on the best available data and on the assessment of the country's available resources.

In the past, WHO's activities were mainly concerned with providing technical assistance to developing countries. Today, the new strategy of technical co-operation supports the efforts of countries to develop self-reliance in health matters to help the countries help themselves. WHO's drug dependence programmes are therefore designed to help the countries solve their own problems, to develop their own technology and adapt knowledge from other places to their own needs. WHO encourages the utilization of training facilities, consultants and information available from other countries of the same region with similar socio-economic conditions. Drug dependence programmes are of necessity, multisectorial. Law enforcement, crop replacement, treatment and rehabilitation, education, prevention are all important activities and each agency has a role to play. The health role is primarily one of treatment, prevention and rehabilitation.

The implementation of the principles expressed above can be found in the current activities of the country programmes in drug dependence such as the ones initiated in Afghanistan, Burma, Egypt, Iran, Malaysia, Pakistan, Peru, Thailand and Vietnam. At the country level these activities are: a) training of personnel and development of manpower, b) strengthening of the existing services and facilities involved in the prevention, treatment and rehabilitation; c) the introduction and systematic evaluation of treatment programmes; d) engage in epidemiological studies in order to obtain information on the nature, extent and underlying causes of drug dependence.

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[1] WHO Technical Report Series, No 273, 1964, p.9.
[2] WHO Technical Report Series, No 407, 1969
[3] WHO Technical Report Series, No. 437, 1970.
[4] WHO Technical Report Series, No. 460, 1970, p.9.
[5] WHO Technical Report Series, No. 478, 1971
[6] WHO Technical Report Series, No. 516, 1973.
[7] WHO Technical Report Series, No. 526, 1973
[8] WHO Technical Report Series, No. 556, 1974

At the regional level, these activities can be found in the organization of a) seminars, workshops and fellowships, b) promotion of inter-country collaboration through the exchange of information and expertise.

Recognizing the need of international co-ordination to improve the comparability of the epidemiological data, WHO initiated a research and reporting programme on the epidemiology of drug dependence. Data collecting activities are carried out by a network of collaborating institutions, the majority of which are located in developing countries. Presently there are three collaborative data collecting studies to finalize methodologies for. 1) intensive case finding of drug users in target communities; 2) surveys of non-student youth, 3) evaluation of drug dependence treatment methods

WHO has also initiated a study on "Drug Dependence in Socio-Cultural Context". The objective of this study is to produce guidelines for treatment and rehabilitation of drug dependent persons to be used in different countries The Organization has also promoted the establishment of a network of collaborative centers known for their expertise in the field of drug dependence. Through this network the exchange of experiences and information from various sources can be channelled to the countries in need

The Single Convention on Narcotic Drugs as well as the Convention on Psychotropic Substances simplified and unified earlier treaties and continued to assign to WHO the role of evaluating drugs and making recommendations to the UN Commission on Narcotic Drugs.

3.2 International Labour Organization (ILO)

The International Labour Organization in co-operation with other agencies is responsible for that sector of drug abuse control programmes concerned with the reduction of illicit demand. More specifically, ILO aims at providing suitable vocational and rehabilitation opportunities for those who have been through treatment or withdrawal centers. It promotes such activities where ILO regional experts in the field of vocational rehabilitation, co-operation and small scale industry have advised governments and individual rehabilitation facilities on the development of training and work programmes for drug dependent persons

3.3 United Nations Educational, Scientific and Cultural Organization (UNESCO)

The role of education in prevention strategies has been increasingly emphasized and demands have been made from various sectors on UNESCO to develop its programme in this field. From UNESCO's point of view, the term "drug" covers all types of substances whether illegal or not and including therefore the use of alcohol, tobacco, over the counter drugs, as well as cannabis, heroin, etc. 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 It has organized workshops and has produced educational material to be used in the drug dependence programmes in order to give assistance to the countries concerned Upon UNESCO's initiative, drug education programmes have been designed to be used at various school levels

3.4 Colombo Plan Bureau for Technical Co-operation

The Colombo Plan Organization is a 27 member country association for co-operative socio-economic development and technical co-operation in Asia and the Pacific. Its member countries, belong to three regions of WHO Eastern Mediterranean Region, South East Asia Region and Western Pacific Region The Colombo Plan through its Drug Advisory Programme (DAP) established in 1973 a broad scheme aimed at "diminishing

the causes and ameliorating the effects of drug abuse" in member countries of the plan which is basically promotional and complementary in character, operated in close consultation with various member governments and various regional, international agencies as well as non governmental bodies, voluntary organizations interested in the field of drug abuse.

The Drug Advisory programme sponsors a series of National and Regional meetings and conferences, seminars/workshops, bilateral talks; study tours and exchange fellowships, participation grants in all fields of drug abuse, including law enforcement, treatment rehabilitation prevention, education, information and research training.

This organization maintains close links and liaison with the UN bodies and other national, regional international agencies to avoid overlapping of activities and thereby increases its own effectiveness.

3.5 International Council on Alcohol and Addictions

ICAA is an association of organizations and institutions concerned with the prevention and treatment of alcoholism and/or drug dependence. It was formed in 1907, and in 1968 it added the subject of dependence on drugs other than alcohol to its programme in line with recommendations of WHO As a non-governmental organization the ICAA enjoys consultative status category II with the United Nations economic and social Council and is in official relationship with WHO and ILO. It also maintains close co-operation with a number of regional, governmental organizations, including the League of Arab nations, Colombo Plan and Council of Europe The main objectives of this organization is to function as a coordinating agency and information centre; to organize international congresses and symposia

3.6 Arab League for Social Defence

The members of the workshop recognized the important role of the Arab League in combatting the problem of drug abuse and appreciate their collaboration with WHO in the field of drug abuse control.

3.7 The participants also appreciated the activities being undertaken by other international organizations, who were not represented at the workshop, such as UN Division of Narcotic Drugs, the United Nations Fund for Drug Abuse Control and the International Narcotics Control Board. All of these organizations closely collaborate with WHO.

4. Profiles and problems in the regions

4.1 Assessment of the magnitude of the problems

In most of the countries of the regions, the extent of the problem, had not been objectively estimated. In countries of the Indian sub-continent, the commonest sources of data were secondary, e.g. police seizures, amounts of drugs imported, areas of official opium and cannabis cultivation, hospital statistics, opium registers, etc. The shortcomings of such data are obvious and need no elaboration, and they at best are very rough indicators of the total use In India, for example, a sharp rise in the import/manufacture of methaqualone was closely parallelled by increased use, as reflected in the media and reports of cases. Limited surveys in some countries had been carried out, in selected areas of populations, which do not lend themselves to broad generalization The opium use rates may vary within geographical areas

of the same country as has been observed in Afghanistan,[1,2,3] where in Faizabad the rates were 6%, while in Badakshan[4] province (Zebak), the rates were 60% of the adult population. Similar variation was observed in Pakistan, where a UN mission estimated that in certain villages, within the opium producing areas, more than 20% of the male population were opium users. McGlothin et al[5], gave a prevalence rate which was much higher than the UN mission estimates of opium consumption in the cultivated areas, (50% of adult males, and 4%-5% in adult females) An estimate arrived through sales in opium vends gave rates of 0.5%. (Hussain[6], 1972) Finally the guess estimates in Pakistan put prevalence rates of opium use as 1-1.5% of the total population.

In India, more recently studies from localized areas suggest that the problem of opium use in rural areas is likely to be much higher than the official estimates. The studies also suggest that the problem of alcohol use, far exceeds all other drug use in the country and that in time to come it may become a major public health problem. In a study sponsored by the Ministry of Social Welfare and co-ordinated by the All India Institute of Medical Sciences, representative samples of university students were studied by a common questionnaire, in three metropolitan and three non-metropolitan cities The study in contrast to the situation obtained in neighbouring countries, showed a very high non-use rate (excluding alcohol and tobacco), and very low user rates for opiates The commonly abused substances were painkillers, followed by minor tranquillizers and barbiturates-hypnotics. The prevalence rates varied from 2-4.5% Alcohol and tobacco use rates were uniformly high in all the cities[7]. Iran, has systematically attempted data collection on drug use Earlier estimates in 1955 suggested that there were a million and a half opium users (7%) out of a total of 20 million. Azarakhsh[8] in 1972, estimated that users were between 200-300,000 out of a population of 30 million. Iran also had some estimates based on opium registers

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[1]Micuta, W. Report on Mission to Afghanistan. UN Division of Narcotic Drugs. Geneva 1973

[2]O'Keeffe, Charles. Report on Mission to Afghanistan. WHO Geneva, 1975.

[3]de Beus J.G and Davies, M , Mission to Afghanistan United Nations Fund for Drug Abuse, 1976.

[4]Uchtenhagen, A.A Report on Mission to Badakshan. WHO Geneva, November, 1976

[5]McGlothin, W.H. et al. Opium use in two communities of Pakistan, a preliminary comparison of rural and urban patterns, Bulletin of Narcotics, 1979 (in press)

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

[7]Drug Abuse in India. Report of the Committee Drug Controller of India Nirman Bhauan. Ministry of Health, New Delhi, 1977

[8]Azarakhsh, H A The Nature and Extent of Drug Abuse in Iran. Cento Seminar, Teheran. Central Treaty Organization, Ankara, Turkey.

153,613 in 1974 and 170,000 in 1976, which were believed to represent only between 1/3 to 1/2 of the real number of addict population (Mohareri[1]). Fozouni and Siassi[2] (1976) recently examined on a national basis, the characteristics of registered opium users with those who were illicit opium users They observed several differences between the two groups, which were greater across age related variables, such as education and marital status. A significant proportion of illicit opium users were born in Teheran and had also used heroin. The majority of addicts were employed and the female users experimented with opium less often compared to the males The most significant observation was that there was about a 4 year lag between median time of first use and addiction in the 35-54 age groups. The study suggested that the trends in urban and rural areas differed considerably in Iran, and that in urban areas perhaps a new trend of increasing illicit drug use was emerging.

Cannabis use has been fairly common in all the countries represented. In Sudan, a survey of 2,200 individuals from 9 towns showed that approximately 30% of the male population interviewed had used cannabis and more than half of these were still continuing its use for a period varying from one month to four years. In India, the number of cannabis users have been estimated to be 300,000[3] but more recent field studies show that the use may be declining in areas where rapid socio-economic changes have taken place. It has to be kept in mind that in India, the commonest method of cannabis consumption has been cannabis leaf in decoction taken by mouth, a custom which is fairly widespread in some of the northern states, especially on ceremonial occasions No exact estimates are however possible regarding its use, in India.

Common to all the countries was a trend towards increasing use of psychotropic drugs, including minor tranquillizers, hypnotic sedatives and amphetamines. The problem seemed to be more common in urban, semi-urban areas, than rural areas, where traditional drug abuse of opium and cannabis still persisted, and health services with modern medicine were not yet developed

Common to all countries was an increasing concern about acceptance and tolerance of alcohol consumption. In most of the countries, the production, importation and consumption was being doubled almost every year. In India, this has been well documented, it was the commonest drug abused both in rural (where its use exceeded opium and cannabis) and urban areas, as well as specific groups such as students, or industrial workers. Indeed in Iraq, one of the countries represented in the workshop, alcohol use was stated to be the only drug problem.

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[1] Davies, M. Report on WHO/UN/ILO/FAO Mission to Pakistan. Geneva 1974

[2] Iradj Siassi, M.D. Bahman Fozouni, Ph.D , Dilemmas on Iran's Opium Maintenance Programme. an action research for evaluating goal conflicts and policy changes.

[3] R.N Chopra and I.C. Chopra, Drug Addiction with special reference to India, Council of Scientific and Industrial Research, New Delhi, 1965.

Khat (Catha edulis Forsk) is another drug, whose use is specifically confined to some countries in the Eastern Mediterranean Region and the African Region, especially North and South Yemen. Estimates of its use suggest that among males it may reach as high as 80% in major cities and as high as 90% in the villages where Khat was cultivated It has been an issue of concern to the permanent anti-narcotic bureau, League of Arab States as well as the Eastern Mediterranean Regional Office.

Summarizing, though no official or valid scientific estimates regarding the magnitude of the problem were available in the regions, the following broad trends emerge

(i) Opium and cannabis, continue to have widespread usage in most countries Opium, predominantly in Pakistan, Afghanistan, Iran, Bangladesh. Cannabis predominantly in Egypt, Sudan, India, Bangladesh, Pakistan, both opium and cannabis in some of these countries

(ii) Alcohol use shows a rising trend in all the countries.

(iii) Psychotropics use is confined to urban/semi-urban areas, but its use is still not widespread

(iv) The use of opiates like heroin, have appeared in some countries where none was in use before, predominantly in urban areas

(v) It can most commonly be stated that opium and cannabis are mainly used in rural areas, while psychotropic substances are more widely used in urban areas The rise of alcohol consumption was, however, seen in both urban and rural areas, substances like heroin and solvent inhalants remained primarily an urban phenomena There are differences in age, education, marital status between the older rural drug users and the younger urban group. The latter also show patterns of poly drug use

4.2 Policy Developments

The policy development in relation to drug dependence has not occurred at an even pace throughout the countries of the region Usually the policies have developed in response to international conventions and treaties, the two most important of these being the Single Convention on Narcotic Drugs (1961) and the Convention on Psychotropic Substances (1971) The Single Convention does recognize the principles of treatment and rehabilitation, but for most of the countries the legal enforcement measures directed at reducing the supply, took precedence and were developed in a sort of vacuum without taking into account the host, drug and the environment paradigm. The areas within the regions were primarily seen as the growing areas of narcotics and the efforts appeared to be directed more at controlling the flow of these substances to consuming areas primarily in the West The development of policies, their goals, and methods of achieving these goals in the region have to be understood keeping in view the above supply demand model Very few countries have developed integrated policies in the areas of prevention, treatment, including rehabilitation and still fewer integration with legislation enforcement machinery. Sudan, Iraq, India, Iran and Egypt have made efforts at evolving such integrated policies though the administrative infrastructure to implement these policies was in varying stages of evolution These developments were also related to the broad socio-political systems which operate within the countries In countries where there was a strong central government or where the federal government controls its constituent state governments, special agencies emerged e.g Pakistan Narcotics Control Board, National Iranian Society for the Rehabilitation of the Disabled (NISRD) These agencies were vested with executive powers, while in the other countries with different health and social services a lag in integration results, as in India

Since in most of the countries, such policy developments have not occurred, it is perhaps an opportune moment for agencies like WHO to help formulate programmes which take into account the principles enunciated earlier (2 1) Obviously such policy developments would have to fit in with the overall objectives of the country health and welfare systems

4.3 Current efforts at policy developments

In most of the countries, apart from the compliance with the international treaties, ad hoc policy developments have occurred in specific situations, concerned primarily with the control of drug that was being currently abused. The general trend of such ad hoc developments had been to reduce availability; primarily of psychotropic drugs. The import/manufacture of amphetamines and methaqualone has been banned in Iran, amphetamines in Sudan and codeine in Pakistan. In India, for example, importation of LSD has been completely banned under the Sea-Customs Act. It is apparent that instead of integrated policy development, in a large number of countries actions are being initiated which respond to a current crisis situation.

4.4 Responsibility of policy development, goals and objectives

The goals and objectives as well as policy development have had chequered history in the countries in the region. Usually, perhaps due to historical trends, the policy development has been spread over a number of government departments. In many countries opium had been a source of excise and revenue Hence policy development basically retained this point of view and remained within the purview of departments of excise and finance. The smuggling of narcotics, usually brought in departments of interior or law enforcement agencies. Psychotropics, usually remained within the purview of departments of health and drug control organizations as their use was the responsibility of health services. Wherever the problem assumed wide dimensions rapidly, departments of education, social welfare, also became involved Food and agriculture (where crop substitution was being envisaged), or Industries, where alcohol is a problem, also became involved. In this kind of situation, it is apparent that there would be duplication of efforts and lack of co-ordination towards achievement of the goals and objectives. In some countries, there have been attempts to form co-ordinating councils at the highest levels, so as to achieve cohesion in policy development

The major goals of existing drug control policies are aimed at reducing the availability of dependence producing drugs, especially narcotics Almost all the countries have banned the cultivation of opium (except for medicinal purposes, e.g. India) or for domestic consumption e.g. Iran. It was however observed that illegal cultivation still persisted to varying extents in different countries, especially cannabis, which often grew wild, or was grown in remote areas, where administrative controls are difficult to maintain because of lack of access to the area (e.g. in Sudan, Afghanistan, Bangladesh, parts of India and Pakistan)

The overall objectives of these policies in the different countries are : (i) to control non-medical use of drugs (ii) to reduce demand of illicit drugs (iii) to control trafficking (iv) development of manpower in health areas in an integrated manner (v) to develop methods for continuing assessment and monitoring of changing trends in drug use (vi) development of culture specific treatment modalities, which can be evolved within the existing health services framework and (vii) to develop prevention education programmes.

4.5 Co-ordinating mechanisms and models

These are closely related to policy development. In general most of the countries had, either evolved or were in the process of evolving, a co-ordination committee at

the highest level of ministerial functioning presided over by the chief executive This was the first level of co-ordinating mechanism, which also served as a policy making body The second level co-ordination was the creation of an autonomous board/ organization, which was responsible for the implementation of the decisions taken at the highest levels The second level organizations in some countries had further demarcated autonomous areas of functioning such as treatment rehabilitation, prevention education, enforcement/legislation (Iran and Sudan). The above model was particularly suited in those countries which had a strong central form of government An illustrative example of the above organizational co-ordinating mechanism is Iran, which has a cabinet level Drug Abuse Co-ordinating Council, and the second level Narcotics Control Administration, which was independently funded and acted as an overall co-ordinator at the execution level

4.6 Legislative provisions for treatment, rehabilitation and prevention

In the countries represented no specific legislative provisions for prevention, treatment and rehabilitationfor drug dependent individuals were in force. In some countries there are specific legislations which prohibit the sales promotion and advertising of alcoholic beverages. There are also some restrictions about general sales promotion (except to medical personnel) of psychotropics and their availability without prescription. These can be interpreted as measures directed at primary prevention.

None of the countries seemed to favour the concept of compulsory treatment of drug dependents, or making drug dependence an illness akin to psychosis which could have attracted legal restrictive measures for treatment. In some countries there is, however, a provision for compulsory treatment (e.g. following a car accident)

Another variant of legal treatment system was observed in some countries of the region. India, Iran, operated opium maintenance programmes under legal registration. In India, recent registration of users is virtually non-existent and officially closed in 1959, while in Iran, the recent experience suggests that unless properly controlled, it could itself become a source of illicit use. Similar systems, but without monitoring were also seen in Pakistan and Bangladesh (opium vends in the former, and cannabis shops in the latter) In fact, one of the major recommendations flowing out of the Single Convention, (Art. 37) regarding treatment and rehabilitation, largely has remained unimplemented because two different government departments were usually involved, one with the excise and enforcement, and the second health

In the absence of such legislative provisions, the drug dependent individuals were usually treated as voluntary patients, in psychiatric units wherever they were available, or in general hospital systems or specialized centres where they have been created. In this connection, it is interesting to note that in some countries (e g Afghanistan, India and Pakistan), even though opium use is fairly widespread and some treatment facilities are available, very few persons actually request detoxification (Gobar[1]).

A welcome trend observed in some countries was an attempt to develop community out-reaching services which were both preventive and therapeutic, utilizing culturally acceptable situations and resources, such as locating drug centres in mosques as is the case in Egypt

The sources of referral to such treatment facilities varied from self-referral, physicians, family, or with a complication of mental illness (toxic or functional psychosis) In a few countries legislative provisions existed for referral following

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

motor vehicle accidents (India), or through police and court action (Sudan) However, no systematic referral systems seem to be operating in any of the countries.

4 7 Budgetary provisions

In most of the countries, no special budgetary provisions existed for drug dependence services. The budget usually was provided from the overall health budgets and from within the mental health services component, which often ranked quite low in health priorities. A noteable exception was Iran, where by legislation, 80% of the proceeds from the sale of opium to registered addicts and 75% of proceeds from sale of seized narcotics were put at the disposal of the Ministry of Health and Welfare to finance treatment and rehabilitation programmes

4.8 Role of Voluntary bodies

There were a few voluntary organizations with exclusive involvement in the area of drug dependence and their effectiveness varied In India for example, All India Prohibition Council had been actively involved in the area at national level for a long time, while sporadically other organizations had appeared and survived for varying periods of time (such as Alcoholics Anonymous). In Egypt, a central association exists for prevention of use of alcohol, drugs and intoxicants In addition, associations of mental health and social workers had also been active in this area. The tradition of charity was fairly strong in the countries of the region, and it would be worthwhile exploring if some funds could be channelled to this area.

5 Treatment facilities, methods and evaluation

5 1 Existing treatment facilities

In all except two countries, no specific treatment facilities existed for drug dependence. The existing general health services facilities for both in-patients and out-patients were also being utilized presumably by individuals with drug dependence. Iran and Sudan have earmarked specific percentage of in-patients and out-patients services for drug dependence, the former having 1,420 beds and facilities for treating around 34,200 individuals on an out-patient basis, while in Sudan, apart from providing specific beds in psychiatric units, had also provided 1/2-1% of all beds in provincial hospitals for this purpose. Some countries (India) have made provisions for developing specialized training-cum-teaching centres, but visualize no special services for dependence In-patient services in special institutions for treatment of drug dependence have been developed in Iran, Sudan, Egypt and Lebanon, while in other countries they are within the mental health care system, as well as general hospital services Two countries have a specific facility of drug wards in prison systems. The out-patient services are located within the general hospital systems, special centres are in community health centres where they have been developed.

5.2 Existing treatment methods

The existing treatment modalities in the countries were limited. A majority of the countries used tranquillizers and neuroleptics to cover the withdrawal symptoms during detoxification. Methadone substitution or its combination with tranquillizers was used in only two countries (Iran and Bangladesh) Opiate substitute or gradual dosage reduction was used in three countries. Insulin treatment to cover withdrawal was being used in two countries, while an equal number were experimenting with acupuncture. No exclusive methods or pattern during detoxification was seen in any country, except possibly Iran, which systematically used methadone and India which avoided it. Most of the countries used multiple methods Opium maintenance programmes operated in only two countries in the region (Iran and India). There were no systematically organized methods for official after-care of detoxified clients in

any of the countries whether voluntary or state sponsored Therapeutic communities as known in the West operated in none of the countries represented. Two countries attempted to use religious cultural factors towards therapy, Egypt, where clinics were located in mosques and the Sudan, which had therapeutic villages and used religious gatherings in mosques In three countries indigenous systems of medicine also flourished and treated drug dependent individuals, the details of their methods and techniques were not indicated. None of the countries had any immediate plans to try different methods of treatment, with the exception of Iran where methadyl acetate (LAAM) and naloxone might be used in the near future.

5.3 Manpower resources

The manpower resources in almost all the countries are inadequate. Even in India where there is one of the largest reservoirs of manpower, its resources in mental health are inadequate In some countries there is a pool of psychologists and/or social workers as well as practitioners of indigenous systems of medicine who can be involved in the broad field of mental health work as well as drug dependence This obviously is an issue which needs careful planning and evaluation

5.4 Training programmes and facilities

Training facilities for mental health professionals exist in India, Iran and Sudan. This includes facilities for training of social workers and psychologists. Specific training programmes in the area of drug dependence are being attempted by Iran, India and Thailand. The three countries have the potential to train professionals from the region in epidemiology, research methodologies, treatment and rehabilitation.

5 5 Evaluation programmes in prevention, treatment and rehabilitation

Specific treatment evaluation programmes are under way in three countries, Egypt has been evaluating the role of insulin in detoxification Iran has a series of projects on treatment evaluation, e g. out-patients treatment methods, two years follow-up study of rehabilitation of drug dependents and others, as well as evaluating long term vocational training and rehabilitation as well as agricultural rehabilitation programmes Pakistan has recently begun to evaluate out-patient treatment in two different settings, the village based and conventional hospitals In provincial treatment units, activities will be continued in operation research for the evaluation of their existing models

6. Summary and Conclusions

6.1 Factors influencing drug use

On reviewing the nature of drug use in the regions there are some general features that emerge

a) There is a long history of drug use in several countries and none of them are immune to this problem

b) There is considerable quasi-medical use of opium (and its derivatives) which persists as health services have not yet developed extensively in all countries.

c) Traditionally drug use is common in males and the youth is now an exposed vulnerable group.

d) There is a different pattern of drug use in urban, semi-urban, compared to rural populations. Psychotropics, heroin is more common in the former, while opium and cannabis is more common in the latter Alcohol use tends to be common to both and is rising.

6.2 Constraints to programme development

The constraints are as follows.

(i) Lack of integrated policy development

(ii) Lack of accurate baseline statistical data.

(iii) Lack of appropriate culture specific models for prevention treatment and rehabilitation.

(iv) Shortage of trained manpower and lack of formal training programmes suited to local needs.

(v) Lack of general development of health services and within it of mental health services which impedes treatment rehabilitation of drug dependent persons.

(vi) Lack of a central organizational and administrative machinery to co-ordinate activities in the field of drug dependence

(vii) Almost all the countries are a party to the international conventions, or are in the process of ratifying them. They have concentrated more on a legal prevention machinery to reduce availability Enough attention and resources have not been devoted to prevention, treatment and rehabilitation, as well as operational research.

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

7. Recommendations

Keeping the factors and constraints referred to above (5.1 and 5.2), the following recommendations were made.

Recommendation No. 1

The group reviewed the various issues of the policy development in the countries of the region. It felt that although in many countries efforts are being made to evolve integrated national policies, some others have still to initiate programmes towards formulation of their national policies. This would be facilitated by having reliable baseline data on pattern, nature and extent of the problems.

It is recommended that all countries in the region should formulate their national policies within the framework of their traditions and socio-cultural contexts and with regional and inter-regional co-operation.

Recommendation No. 2

The group noted that the data on drug dependence/abuse and its related problems were mainly obtained from indirect sources.

It is recommended that the countries should develop an adequate information collection and dissemination system as part of their national information system, which would not only provide a baseline data in respect to the problems of drug abuse, but also provide an insight into the changing patterns.

Recommendation No 3

The group, while reviewing the individual national policies noted that the way

these policies are formulated could have an impact on the adjoining countries, as also the countries of the regions.

It is recommended that the regional co-ordination can be improved substantially if those who have responsibility for treatment, rehabilitation of prevention, meet annually. The regional offices of WHO should host these meetings

Recommendation No. 4

The group recognized that while drug dependence is an important public health issue in the regions, it does not find adequate place in the teaching/learning schedules of various courses for the health professionals and workers in related fields.

It is recommended that the area of drug dependence and drug abuse should be introduced into the course curriculum of the health and social sciences at all appropriate levels of education

Recommendation No 5

The group fully realized that problems of the drug dependence and abuse are the components of an overall public health problem and considered it appropriate that these problems should be dealt with in the overall concept of total health care

The group recommended that drug abuse policies and programmes be integrated with the general health policies of the countries, and be an integral part of the general health care delivery system

Recommendation No 6

The group appreciated that the problem of drug abuse and dependence is multi-dimensional in nature and requires a close co-ordination and active co-operation of appropriate governmental agencies.

It is recommended that strong national co-ordinating committees, preferably with adequate executive powers be established in each country of the regions

Recommendation No. 7

The group examined various aspects of health manpower development with special regard to health professionals engaged or likely to be engaged in the treatment, prevention and rehabilitation of drug dependence It was felt that the establishment of separate health manpower, cadre and services for drug dependence was neither desirable nor feasible, both for logistic and economic reasons. It was also felt that the region was deficient in the number of training centres where health professionals could be trained

It is recommended that existing manpower resources and facilities be utilized for drug dependence service by providing adequate "in service training" to health professionals and by augmenting the existing facilities. A number of professionals should be trained immediately to provide a nucleus for training others within their countries

Recommendation No. 8

The group considered the existing legal and penal codes of the countries and felt that these should be updated

It is recommended that whenever necessary each country of the regions should set up an appropriate machinery for thorough comprehensive reviews, and an enactment of adequate laws to deal effectively with the problems of drug abuse especially the areas of treatment, prevention and rehabilitation

Recommendation No 9

The group considered in detail various programmes connected with the treatment and rehabilitation of patients in other parts of the world; these need adaptation to this region because of difference in socio-cultural backgrounds

It is recommended that innovative strategies be planned for treatment and rehabilitation of drug dependents, utilizing the existing resources such as family ties, religious, cultural organizations and others, as well as the methods used elsewhere to meet local needs.

Recommendation No 10

The group reviewed and appreciated the work being done by various national and international voluntary non-governmental organizations in the field of drug abuse

It is recommended that a continuous co-operation and co-ordination be maintained with those voluntary organizations active in the countries of the regions in the field of drug abuse and dependence.

Recommendation No. 11

The group also appreciated the work done by specialized UN agencies, Intergovernmental and Non-Governmental, like the Colombo Plan Bureau for Technical Co-operation, the League of Arab States and the International Council on Alcohol and the Addictions

It is recommended that further co-operation between the World Health Organization and the above agencies be maintained and developed.

Recommendation No 12

The group fully appreciates the role that the World Health Organization plays in meeting the health needs of the countries of the regions.

It is recommended that WHO, through its regional offices, continues to collaborate with the countries in order to promote inter-country activities in the field of drug dependence.

ANNEX I

MESSAGE FROM DR A.H. TABA
DIRECTOR
WHO EASTERN MEDITERRANEAN REGION

to the

OPENING SESSION OF THE
WORKSHOP ON PREVENTION AND TREATMENT OF DRUG DEPENDENCE

Alexandria, 16 - 21 October 1978

It is my particular pleasure to welcome you all and to thank you, on behalf of WHO, for your participation at this important Workshop

Though I was planning to be with you, at this meeting, unfortunately, because of other commitments, it was not possible to do so.

Furthermore, I know how keen was the Government of Iran to host this meeting in Teheren, as was previously planned. However, due to the devastating effects of the earthquake and the ensuing emergency situation, the venue of the Workshop had to be shifted to Alexandria.

Historically speaking, since its inception in 1948, the World Health Organization has been increasingly engaged in the field of drug abuse and within its mandatory purview as the directing and coordinating organ of international health its role has been significantly developing.

This meeting as you are aware is one of several activities in the field of drug dependence and there are three important features which characterize this Workshop, which we are happy to hold in this office.

First, this Workshop is the first in a series of five, which are planned to cover wide regional representation.

Second, two WHO regions, namely Eastern Mediterranean and South East Asia, which are closely similar in social and cultural background are represented in this workshop. This as you appreciate will facilitate the exchange of information and promote the sharing of experience

Third, in spirit of cooperation and mutual collaboration, all national participants have actively been involved in extensive collection of information and development of their respective country profiles, with particular emphasis on drug dependence problems, national policies and strategies, available resources and future programmes

I am confident that based on your wide experience and in the light of the available information, you will competently address yourself to the challenging issues of proper planning and effective programming in the complex field of treatment and prevention of drug dependence

I need not remind you that as the nature and extent of drug dependence is continuously changing in the wake of new socio-economic developments that more relevant and more appropriate approaches have to be considered. In this respect I am pleased to point out that several countries in EMR, specially Egypt, Iran, Pakistan and Sudan have recently endeavoured to develop more promising and better therapeutic modalities. However, in spite of the tremendous efforts being made, nationally and internationally, the field of drug dependence is still riddled with many difficulties and suffer from serious deficiencies.

Briefly, there are the familiar difficulties of assessing the magnitude of the drug problems and how and where to obtain essential base-line data. Indeed in the majority of countries shortage of trained manpower form a serious impediment in the provision of necessary treatment and rehabilitation care for drug dependent persons and constitute a practical obstacle in the way of routinely collecting information or possibly being involved in systematic studies and surveys.

Again, while drug abuse is more and more emerging in the forefront in the health field, there are still no efficient models for dealing more effectively with its intriguing problems.

At country level, the need for close integration of the care of drug dependent persons within the total health system and better coordination with other related social services have been generally felt

At regional and international level, serious concern has been recently shown regarding the growing abuse of synthetic psychotropic substances. This as you know has led to the ratification of the 1971 Convention on Psychotropic Substances which aims at ensuring better control of these drugs, nationally as well as internationally. However, there are still several countries which have not acceded to this convention and it is hoped that they very soon join the international community in a global collaboration against the threat of these drugs.

In this connection, I feel that this meeting will provide an excellent opportunity for augmenting national efforts with WHO Headquarters and Regional activities together with other international contribution for working together towards a composite and overall drug dependence programme.

With these ideas in mind, I wish your meeting fruitful deliberations and successful discussions and look forward for the recommendations emanating from your distinguished group, which I trust will be helpful in further developing our joint activities for better programming and more appropriate management of drug dependence.

Thank you.

WORKSHOP ON PREVENTION AND TREATMENT
OF DRUG DEPENDENCE
Alexandria, 16 - 21 October 1978

ANNEX II

LIST OF PARTICIPANTS

TEMPORARY ADVISERS FROM EMR*

AFGHANISTAN

*Dr Z. Zahine
Mental Health Department
Ministry of Health
Kabul

Dr Abdul Razeq
Vice President
Mental Health Department
Ministry of Health
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Dr A S. E.D El-Hakîm
Director, Mental Health Department
Ministry of Health
Cairo (Vice-Chairman)

Dr G.M.A.M. Abou El-Azeyem
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IRAN

Dr I. Siassi
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Professor of Psychiatry
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* Invited but unable to attend: as above and Bahrain

IRAN (cont'ed)	*Dr A,M Shamie Neuropsychiatrist-Psychotherapist 380 Takte Tavoos Teheran
	*Dr M. Niazi Director, Yaftabad Community Health Centre Teheran
IRAQ	Dr S. Al-Karchi Specialist in Mental Health and Psychiatry, Shamaiya Hospital Director, Rushd Hospital Baghdad
LEBANON	Dr A.L Boustany Chief Mental Hygiene Department Social Development Office Beirut
PAKISTAN	Dr M. Shafique Assistant Professor of Psychiatry Khyber Medical College Peshawar
	Dr M.H.Mubbashar Head Department of Psychological Medicine Central Government Hospital Rawalpindi
SUDAN	Dr H El R. Suleiman Director General Mental Health Services Ministry of Health Khartoum

TEMPORARY ADVISERS FROM SEARO

BANGLADESH	Dr A.K.M N Chowdhury Professor of Psychiatry Institute for Postgraduate Medical Research Dacca
INDIA	Dr D.B. Bisht Deputy Director General Health Services, Government of India New Delhi
	Dr V.K Varma Associate Professor of Psychiatry Postgraduate Institute of Medical Education and Research Chandigarh

* Invited but unable to attend

INDIA (Cont'ed)

Dr D. Mohan
Associate Professor
Department of Psychiatry
All India Institute of
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OBSERVERS FROM EGYPT

*Dr Omar El Garem
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Alexandria

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Dr Mustapha Soueif
Professor of Medical Psychology
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Dr Omar Shaheen
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Kasr-el-Eini Faculty of Medicine
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Dr Ahmed Galal
Ministry of Health, Department of Statistics,
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*Dr H Sherbini
Head Family Health Department
High Institute of Public Health
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Dr Helmi Ghali Abdel Messih
Director
Mental Health Hospital
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Dr Kivork Mazloumian
Cairo

Dr Ahmed Okasha
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Ain Shams University
Cairo

* Invited but unable to attend

OBSERVERS FROM THAILAND

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Director
Institute of Health Research
Chulalongkorn University
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Dr V Poshyachinda
Institute of Health Research
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REPRESENTATIVES OF OTHER ORGANIZATIONS

INTERNATIONAL COUNCIL ON ALCOHOL AND ADDICTIONS	Dr E. Tongue Assistant Director International Council on Alcohol and Addictions Case postale 140 1001 Lausanne - SWITZERLAND
LEAGUE OF ARAB STATES	Dr H. Hammonda Department of Health League of Arab States Cairo - EGYPT
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NATIONAL INSTITUTE OF MENTAL HEALTH, ROCKVILLE, USA	Dr H. Tuma Assistant Chief Clinical Research Branch Department of Health Education and Welfare National Institute of Mental Health Rockville - USA
*NATIONAL INSTITUTE ON DRUG ABUSE, ROCKVILLE, USA	Dr J P Smith Assistant Director for International Activities National Institute on Drug Abuse Rockville - USA
COLOMBO PLAN BUREAU FOR TECHNICAL CO-OPERATION	Mr P Abarro Drug Adviser Colombo Plan Countries 12 Melbourne Avenue Colombo - SRI LANKA

* Invited but unable to attend

WHO SECRETARIAT

Dr A.H Taba	Director	Eastern Mediterranean Regional Office. Alexandria
Dr M.O Shoib	Director Programme Management	Eastern Mediterranean Regional Office, Alexandria
Dr A. Arif	Senior Medical Officer in Charge Drug Dependence Programme	Mental Health Division, WHO Headquarters, Geneva, Switzerland (Secretary)
Dr G Rifka	Director Strengthening of Health Services	Eastern Mediterranean Regional Office, Alexandria
Dr T A Baasher	Regional Adviser on Mental Health	Eastern Mediterranean Regional Office, Alexandria
Dr S. Martens	Consultant	Lecturer, Psychiatric Department, University College, Cork, Ireland
Dr E. Senay	Consultant	Professor, Department of Psychiatry University of Chicago, Illinois, USA

ANNEX III

PROGRAMME

MONDAY, 16 October 1978

- Registration of Participants
- Inaugural Message from Dr A H Taba, WHO, Director, Eastern Mediterranean Region to be delivered by Dr M O. Shoib, Director, Programme Management, EMRO
- Election of Officers
- Introduction to Workshop
- Objective of the Workshop
- Approval of Agenda

TUESDAY, 17 October 1978

- Chairman's summary of prevailing situation in the countries
- Presentations by International Organizations
- Presentation of Consultant Paper 1 Public Health Policy Perspective by Dr S. Martens
- Policy Development
- Assessment of Problems
- Definition of Objectives
- Resources (including manpower) and Costs
- Legislations
- National Advisory Boards and Coordination Bodies
- Identification of Ministerial Responsibilities
- Role of non-governmental organizations
- Evaluation
- Constraints
- Future needs
- Discussions

WEDNESDAY, 18 October 1978

- Chairman's summary of highlights of items 5,6 and sub-items discussion
- Presentation of Consultant Background paper No. 2 - Perspectives on Treatment and Rehabilitation by Dr E. Senay
- Future trends

- Treatment objectives
- Integrated approach
- The diagnostic process and its implications for treatment programmes
- Review of Existing Treatment Methods
- New Approaches
- Evaluation
- Constraints

THURSDAY, 19 October 1978

- Presentation of Special Programme (Iranian Drug Dependence Programme, etc)
- Manpower Development

FRIDAY, 20 October 1978

- Prevention in Developing countries
- General discussion

SATURDAY 21 October 1978

- Summary and Recommendations
- Conclusions
- Recommendations
- Closing Session

ANNEX IV

List of Documents

1. WHO's Role, Strategies and Activites in the Drug Dependence Programme with Special Emphasis on Developing Countries - by Dr Awni E. Arif, Senior Medical Officer in Charge of Drug Dependence Programme, Division of Mental Health, WHO, Geneva

2. Objectives and Aims of the Workshop - by Dr Awni E. Arif, Senior Medical Officer in Charge of Drug Dependence Programme, Division of Mental Health, WHO, Geneva

3. The Role of the World Health Organization in the Prevention and Treatment of Drug Abuse - by Dr T.A.Baasher, Regional Adviser on Mental Health, WHO Eastern Mediterranean Region, Alexandria

4. Drug Dependence in Countries of Eastern Mediterranean Region - by Dr T.A.Baasher, Regional Adviser on Mental Health, WHO Eastern Mediterranean Regional Office, Alexandria

5. Public Health and Policy Perspectives - Consultant's Background Paper 1 - by Dr S. Martens, Lecturer in Psychiatry, University College, Cork, Ireland

6. Adapting Western Drug Abuse Treatment Methods in Developing Countries - Consultant's Background Paper 2 - by Dr E.C.Senay, Professor of Psychiatry, University of Chicago, School of Medicine, Chicago, USA

7. Education concerning the problems associated with the use of drugs - Contribution by the United Nations Educational, Scientific and Cultural Organization, Paris

8. The Role of the International Labour Organisation in the Field of Drug Abuse Control - Contribution by the International Labour Organisation, Geneva

9. Socio-Economic Realities and their Implications in the Treatment of Drug Dependent Persons - by Dr Charas Suwanwela et al., Health Research Institute, Chulalongkorn University, Bangkok

10. Primary Health Care in the Hill Tribe Villages - by Dr Charas Suwanwela et al., Health Research Institute, Chulalongkorn University, Bangkok

Background Documents

1. WHO Technical Report Series, No. 460, 1970

2. WHO Technical Report Series, No. 516, 1973

3. WHO Technical Report Series, No. 551, 1974

4. WHO Technical Report Series, No. 618, 1978

5. A Manual on Drug Dependence, World Health Organization, Geneva, 1975

ANNEX V

Country Profiles

1. Bangladesh
2. Egypt
3. India
4. Iran
5. Iraq
6. Lebanon
7. Pakistan
8. Sudan