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Agenda item 10(b)

Technical Paper

ABUSE OF NARCOTICS AND PSYCHOACTIVE DRUGS

CONTENTS

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Summary

The abuse of drugs and other substances has many dimensions, of which drug dependence represents only one. Drug dependence is more than a health problem. The problem is pandemic, and almost no country or territory in the world can be regarded as drug free. As such, it is a cause of concern for many countries, including many countries in the Eastern Mediterranean Region (EMR). Not only are many substances and drugs abused in the Region, but the EMR is also one of the most important transit routes in the world, and is becoming increasingly more vulnerable to drug-related problems of all kinds.

The history of combating drug abuse is not a successful story. Many different approaches used in the past have failed to stop or even slow-down the spread of drugs. Therefore, the problem now is grave as it has ever been at any time in recent decades. This is not a justification for losing hope, but a good reason for re-examination of the problem in search of solutions and required action. Supply and demand for drugs are dependent on so many variables, that it is impossible for one social sector, like health, to draw workable plans of action for different aspects of drug abuse problems.

Due to the largely illicit nature of the activity, reliable and valid data on drug abuse is always difficult to obtain. The absence of reliable data is particularly striking in EMR Member States. To plan effectively for drug abuse control, a certain minimum data base and a reliable mechanism for monitoring are essential at national and regional levels.

It is simplistic to speak of the etiology of complex problems like drug abuse. A combination of dynamically interactive factors can be the cause of, or can contribute to drug dependency in an individual, as well as the extent of drug abuse problems in society in general. These factors may have biological, psychological or socio-environmental sources.

Available resources to combat drug abuse are many, and can be utilized to work in a dynamically interactive system to achieve some results. The most important of these resources include religion and faith, the family, schools, working places, the community, national will, existing health infrastructure, academic community, law enforcement, the media, medical and psychiatric facilities, and nongovernmental and international organizations.

To develop a workable strategy to combat drug abuse, it is necessary first to examine the experiences of the past. Then there is the need to

get information that promises to promote effective action. Therefore, epidemiological data that only show the extent of the problem need to be replaced, or supplemented by data showing for what percentage of the problem a solution may exist. To combat drug abuse, one cannot easily start from the *causes*, because they are so varied and interlocked with so many unreachable factors. Instead, one should rely on resources. An analysis of resources should also be done with the aim of identifying those upon which meaningful interventions can be built. Then, each resource should be connected to a concrete plan of action with realistic aims. The primary health care (PHC) system is the most reliable resource in all health-related issues concerning alcohol and drug abuse. There is a need to empower the community and to develop a system for intersectoral coordination. The development of adequate health services, with the resulting improvement of health and well-being of individuals and the community, will be one of the most effective barriers against drug abuse. Health can become the most significant contribution to influence the market forces of supply and demand.

This paper identifies some of these resources and suggests ways to use them to build programmes within existing health and social infrastructures. It also identifies some measures that national, regional and international bodies can consider for developing plans of action to facilitate achieving targets and goals of controlling alcohol and drug-related problems. These actions encompass a wide range of subprogrammes, such as prevention, education, promotion of healthy life-styles, training, diagnosis, treatment and rehabilitation.

1. Introduction

The use of psychoactive substances has many dimensions, of which health consequences, including drug dependency, represent the most significant aspect. Other dimensions deal with different aspects of production, marketing, legislation, law enforcement, provision of drugs for medical use, etc.

Drug abuse is more than a health problem, it is a formidable social challenge as well. The magnitude of the problem is pandemic, and virtually no country or territory can be regarded as drug free. It is difficult to give an accurate estimate of the extent of drug abuse, but it can be said that what is seen and reported is not more than just the "tip of the iceberg" (**Table 1**).

The United Nations General Assembly has proclaimed the decade of 1991-2000 as "the Decade to Combat Drug Abuse". The Forty-third World Health Assembly passed resolution WHA43.11, requesting Member States and the Director-General to take clear steps in areas of demand reduction, treatment, rehabilitation and research to combat drug abuse. This was preceded by other related resolutions (WHA37.23, WHA33.27) echoing concern and calling for coherent and concerted action.

Historically, the recreational or ceremonial consumption of substances with psychoactive properties goes back to the beginning of civilization. Man has used almost all sources of carbohydrates from camel's milk to grapes and sugarcane to produce alcohol. The opium poppy was used as a medication by the Mesopotamians and the ancient Egyptians. Indications of the presence of the poppy seed in Turkish archaeological sites go back several thousands years. The use of cannabis is reported in Hindu literature from 1400 B.C. In Iranian classical poetry from the 10th to the 15th centuries A.D., there are more than accidental references to opium. And cocaine and tobacco are believed to have originated on the American continent.

The Eastern Mediterranean Region (EMR) is hard hit by drug abuse problems. Abuse of both narcotics and psychotropics is common. The Region is also one of the most important transit routes for drugs in the world and, as such, is increasingly vulnerable to drug-related health, social and economic problems. In general, it can be said that drug abuse is among the major social and health problems in the Region, and its uncontrolled spread is, needless to say, contrary to the goal of the health for all by the year 2000.

Health and other problems related to drug abuse are numerous. Drug use increases accidents and injuries on the road, in the workplace and in the home. It is associated with suicide and violence, as well as with absenteeism and decreased work productivity. If consumed during pregnancy, psychoactive substances can affect the fetus. It can also shorten life by increasing a person's susceptibility to cancer and cardiovascular, respiratory, infectious and immune system diseases, particularly acquired immunodeficiency syndrome (AIDS). It induces fundamental changes in personality, makes a person susceptible to psychiatric illnesses, breaks down families, drains the family's and society's economic resources,

Table 1

Drug abuse reported to the United Nations, by selected countries or areas (1988)

Country/Area	Rate per 100 000 population		
	Cocaine	Heroin	Opium
Argentina	626.4	--	--
Chile	119.7	--	--
Ecuador	283.0	--	--
Mexico	108.4	32.3	--
Hong Kong	--	--	57.0
Malaysia	--	--	145.0
Myanmar (Burma)	--	95.8	--
Philippines	0.3	--	39.6
Singapore	--	336.6	16.8
Sri Lanka	--	206.0	--
Thailand	--	100.3	108.7
Iran, Islamic Republic of	--	273.3	911.0
Pakistan	--	378.7	210.4
Austria	--	35.0	55.0
Canada	40.8	3.9	11.5
Italy	0.5	349.1	--
Spain	103.6	146.2	--
United Kingdom	1.6	29.6	1.2
United States of America	5,012.3	202.2	--
U.S.S.R.	--	0.7	10.8

Source: Commission on Narcotic Drugs, E/CN.7/1990/14, 2 January 1990.

deludes people out of participation in social development, and, hence, reduces quality of life. Moreover, there is a direct relationship between crime and drug abuse. Drug traffickers commit many criminal acts against the State and individuals, and addicts are capable of committing any wrongdoing to satisfy their drug addiction.

A brief review of the history of an addict's life can demonstrate the gravity of the problem as well as the opportunities for positive intervention. Although physical and psychic dependency have different manifestations according to the type of drug used, the individual addict is a person whose life is dependent on regular consumption of a chemical. This is an end result of a long process that starts with experimenting with drugs. Drug taking starts for many reasons, and in the initial stages cannot be regarded as drug dependence. It usually takes a long time, from several weeks to several years, before it fully develops into dependence. This period is a time when preventive activities can stop the full development of drug dependency or alcoholism.

It is only after a period of experimenting--which differs from substance to substance--that the symptoms of dependence occur, and still it takes a longer time for the development of full-scale addiction, with craving and withdrawal symptoms, social isolation and participation in semi-clandestine groups to find drugs. Most people who experiment with drugs do not become addicts, and the sterotyped terminal *skid-row* (social outcast) addict is an extreme example who does not represent the majority of persons who have experimented, on occasion, with drugs.

In spite of all sincere, well-intentioned activities through many national, international and nongovernmental organizations (NGOs) to combat drug abuse, the problem of drugs has continued and indeed has even worsened. New, innovative approaches, through the use of existing community resources and health infrastructure, combined with wise, strong and steady measures against supply, can help to decrease this grave danger. This paper addresses these issues with special reference to the Region, and, through an analysis of previous experiences, causes of drug abuse and available resources, and tries to suggest realistic strategies to combat this problem.

2. Objectives

The objectives of this paper are:

- to provide basic facts regarding the problem of drug abuse at the global level and to examine the conditions and status in the countries of the Region, highlighting constraints, issues and opportunities;

- to examine the background and the reasons for supply and demand, and, in the light of existing conditions, suggest strategies and innovative approaches with community-based actions and primary health care to combat the problem; and

- to review institutional arrangements at the national level, as well as with international and nongovernmental organizations, and international conventions and treaties regarding drugs and drug abuse.

3. Some common terms used in the context of substance abuse

Although there are hundreds of terms related to substance abuse, for the purpose of this paper, it is important to clarify the following terms and concepts.

3.1 Supply

Supply deals with all aspects related to the availability of a drug. These may include production, marketing, smuggling, laws and law enforcement, quotas of some drugs for medical use, monitoring techniques, customs regulations, etc. Supply reduction mainly falls on legislation, law enforcement bodies and economic and developmental measures to ensure legitimate income to replace the income generated by drugs.

3.2 Demand

Demand deals with all aspects related to the availability of a drug. These may include availability of the drug, individual, family and socio-economic factors, psychosocial or environmental factors, such as stress, cultural attitudes, social norms, religious influences, youth conditions, etc.

There are no sharp lines separating supply and demand sides. It is best to look at the problem as an open system, with two major interacting subsystems.

3.3 Narcotic drugs

Narcotic drugs refer to any drug that dulls the senses, relieves pain, produces a sense of well-being in small doses, and causes insensibility, and even stupor, and, in large doses, death. The term has been in use for over a hundred years and has acquired many shades of meaning. It is often used loosely by non-medical persons to refer to all types of illicit dependence-producing drugs. Most of the pharmacologists, however, restrict its use to only those drugs that relieve pain and induce deep sleep, thus limiting this term for (a) opium, (b) opium derivatives (opiates) (e.g., morphine, codeine and heroin), and (c) synthetic compounds resembling opiates (opioids) (e.g., meperidine, methadone, etc.). However, for historical reasons, the term "narcotic" in the international treaty entitled, "Single Convention on Narcotic Drugs, 1961", is used in a wider sense, and apart from opium products, it covers cannabis and coca leaf products also, though cannabis and cocaine, strictly speaking, are not true narcotics. (See section 8 on "International Treaties" for further details.)

3.4 Psychotropic substances

The term psychotropic substances is sometimes used to cover all psychoactive substances; more commonly in pharmacology, it is used to refer to psychotherapeutic drugs (drugs used for the treatment of mental disorders). In the international treaty "Convention on Psychotropic Substances, 1971", the term "Psychotropic" is used in a wider sense to cover all psychoactive substances that have a potential for dependence.

3.5 Psychoactive substances

The term "psychoactive substances" is gradually replacing the terms "psychotropic" and "narcotic" in medical usage. It is wider in scope and refers to all substances, including drugs that affect the central nervous system and alter mood, perception and consciousness. As pointed out before, the term "narcotic" and "psychotropic" have historically evolved over a long period of time, and they continue to be used in two major international treaties, namely "The Single Convention of Narcotic Drugs, 1961" and the "Convention on Psychotropic Substances, 1971". However, for medical purposes and for health records, WHO has preferred the more comprehensive term "psychoactive substances" as listed in its publication, *International Statistical Classification of Diseases and Related Health Problems* (ICD-10).

3.6 Classification of psychoactive substances

According to the ICD-10, the use of the following groups of psychoactive substances can produce mental and behavioural disorders, including dependence:

- alcohol
- opioids
- cannabinoids (cannabis and its derivatives)
- sedatives and hypnotics
- cocaine
- other stimulants (e.g., amphetamines, *khat*, caffeine)
- hallucinogens (e.g., lysergic acid diethylamide--LSD)
- tobacco
- volatile solvents
- multiple drug use and other nonspecified substances.

3.7 Mental and behavioural disorders caused by psychoactive substances

The following are the major syndromes produced by psychoactive substances, as described in the ICD-10.

1. Acute intoxication. It is generally dose related. There are disturbances in the level of consciousness, cognition, perception, mood and behaviour. It is usually accompanied by changes in psychophysiological functions.

2. Harmful use. This term is applied when the use of psychoactive substances produces physical and/or psychological damage to health not amounting to dependency, withdrawal state or psychotic

disorder. This term is important for listing health damage due to excessive use of tobacco, alcohol, etc.

3. Dependence syndrome. In the medical literature, the previously popular terms, such as "addiction", "habituation", etc., have been gradually replaced by the more standardized term "dependence". A classical dependence syndrome has the following features:

   - a strong desire or a sense of compulsion to take the substance/drug;
   - difficulty in controlling drug-taking behaviour in terms of onset, termination or level of use;
   - a physiological withdrawal state when the substance use is stopped or reduced;
   - evidence of tolerance (i.e., increased dose is required to produce the same effect);
   - progressive neglect of alternative pleasures and interests; and
   - persisting with substance abuse despite evidence of harmful consequences.

4. Withdrawal state. In this state, a person develops various physical and psychological symptoms of varying severity following the total or partial withdrawal of a psychoactive substance after heavy or prolonged use. The type of withdrawal symptom varies with different substances (e.g., opium, alcohol, tobacco).

Psychoactive substances differ greatly in their potential to produce dependence and withdrawal symptoms. For example, alcohol, opium, heroin, cocaine are known to have a stronger tendency to produce dependency compared with many other substances. Furthermore, individual reactions vary greatly due to different bio-psycho-social factors in each case. Hence, even by taking the same drug, the end-result may be different in different individuals.

4. The magnitude of the problem

4.1 Some sources for obtaining data on drug abuse

Due to the illicit nature of the activity, valid data about the prevalence, incidence and health consequences of drug abuse are not easily available. Assessment of drug dependency problems often has to be based on secondary sources of data. For assessing the magnitude of the problem, the following sources of data are usually employed:

1. From the Departments of Police, Excise, Law, etc. Most countries have information on the amount of seizure of illicit substances, the number of persons arrested, tried in court, etc. Yearly data on these items can provide a good information base on the increase, decrease or changes in drug abuse patterns in a country, but they totally lack the health aspects of the problem.

2. From the records of health services. Direct information can be collected from special hospitals and clinics for the treatment of

drug-dependent persons or from general psychiatric hospitals and out-patient services in the countries. Such information is useful to estimate the number of drug dependent persons who use such services and the type of drugs being used. The usefulness of such information is, however, limited because only very heavily dependent persons seek such help, and due to the illicit nature of the activity, drug-dependent persons do not disclose true and complete information. Indirect information from general medical services, such as the number of cases of cirrhosis, can also be useful in knowing about the prevalence of drugs like alcohol.

3. From epidemiological surveys. Good information can be obtained by conducting epidemiological surveys of the general population and of high-risk groups (e.g., students and non-student youths, industrial workers, street children, truck drivers, etc.). These surveys can also be supplemented by laboratory examination of body fluids for various psychoactive substances. However, such surveys are costly, time consuming and require trained human resources, such as doctors, psychologists, statisticians, social workers, etc. Furthermore, to be really useful, these surveys need to be repeated with similar populations and monitored over time with standardized instruments every few years to assess the changes in the pattern of drug abuse in the community. Over the years, WHO has produced a number of questionnaires and guidelines for use in epidemiological drug abuse surveys for different types of populations, which can be very helpful for those who want to organize such epidemiological surveys.

4.2 Prevalence of substance use

The following description of prevalence is according to the grouping of psychoactive substances as listed in the ICD-10.

Alcohol

Alcohol is the most widely used mind-altering substance in the world. The harmful effects of alcohol on the individual and on society have been known for a long time. Earlier, alcohol-related problems were mainly confined to countries in Europe and the Americas, but today its use has spread to most of the countries in Asia and Africa. Fortunately, due to the strong religious traditions and strict laws against alcohol, the problem is still relatively minor in EMR Member States.

Opioids

This group includes opium and its alkaloids (e.g., morphine, codeine and heroin) and similar synthetic compounds (e.g., meperidine, methadone, pentazocine, etc.). Opium has been traditionally used, both for medicinal and recreational purposes, in many countries of Asia and Africa. Occasionally, such use also has led to dependency, but somehow this has not posed a very serious problem for these countries until recently.

The problem of opioids abuse has changed dramatically with the appearance of heroin on the illicit market. *In the countries of the*

Eastern Mediterranean Region, at present, heroin is perhaps the most widely used illicit drug with high potential for drug dependence. It is a semi-synthetic derivative of opium, and is available as a brown or white powder. It is usually inhaled by sniffing, or sometimes it is also injected intravenously. It has many street slang names, including "Brown Sugar", "Smack", etc.

The use of heroin is now widespread in Egypt, the Islamic Republic of Iran and Pakistan, and in many other countries in the Region. The rise in its use has been very dramatic. For example, before 1982 there were hardly any cases of heroin abuse treated at the psychiatric hospital in Alexandria, Egypt. During 1983, 26 cases were admitted for treatment. By 1987, the number of heroin dependent cases had increased to more than 600.[1/] Since then, the number has steadied a little or even declined. Pakistan has also reported a dramatic increase in heroin addicts since 1980. In 1986, a survey by the Pakistan Narcotic Control Board estimated the number of heroin addicts in Pakistan at 657 000. The number probably has gone up since then.

Many authorities have compared the dramatic rise in heroin abuse during the 1970s and 1980s to an "epidemic", which reached its peak in the 1970s and 1980s and is now levelling off. However, no one can afford to be complacent about drug abuse. Many times, a reduction in the use of one drug is replaced by the use of other drugs, which may be more dangerous. There are already indications that with the reduced supply of heroin, many addicts are turning to the intravenous route to get a stronger effect (or "high") and, in the process, are more exposed to the additional danger of contracting acquired immunodeficiency syndrome (AIDS).

Cannabinoids

Cannabis is a plant that grows in many countries in Asia and Africa. In EMR Member States it is mainly used for smoking as "hashish", which is the resin obtained from its leaves and flowers. Earlier, its use was widespread in many countries of the Region, including Egypt, Morocco, Lebanon, and other Arab countries, especially in rural areas. Its dependence-producing potential is relatively less than opioids.

Sedatives and hypnotics

These psychoactive substances, synthetically produced in the laboratory, are a product of the twentieth century. While barbiturates, bromides, chloral hydrate, etc., were available during the first half of this century, the market has been flooded with many more products since 1950. The best known are various kinds of **benzodiazepines** (e.g., diazepam, lorazepam, etc.). These drugs, when used medically, relieve anxiety and tension and induce sleep. All the benzodiazepines, especially short-acting ones, have a potential for producing dependency when taken in large quantities and for prolonged periods. Methaqualone (Mandarax) is another sedative-hypnotic drug, which has a strong tendency for producing

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[1/] Document EM/RC35/15 of 1986.

dependency. Many newer anti-anxiety drugs keep appearing on the market every year, and the drug control authorities in a country have to be vigilant in monitoring their risk-benefit ratio. WHO Expert Committees regularly review such newer drugs and advise the countries as per the terms of the Convention on Psychotropic Substances, 1971.

However, all psychotropic drugs are not habit forming. Many of them are very useful for the treatment of mental patients. In this connection, a special mention must be made of **antipsychotic** drugs (e.g., Chlorpromazine, Haloperidol) and **anti-depressant** drugs (Imipramine, Amitriptyline). *These are not sedative-hypnotic drugs, nor are they habit-forming or dependence-producing drugs.* Accordingly, they are not included in the ICD-10. Both lay persons and health professionals need to be educated in this regard.

Cocaine

Cocaine is the active alkaloid from the coca leaf. The coca bush grows widely in mountainous regions of Central and South America. Coca leaves (not to be confused with the cacao plant that produces cocoa, which is the ingredient of chocolate!) have been chewed for centuries by the mountain people of Peru and Bolivia for a variety of medicinal, social and religious purposes. Cocaine is mainly a stimulant of the central nervous system and also a local anaesthetic. It has a strong potential for producing dependence. For the last few years, the use of cocaine has greatly increased in the United States of America. Its popularity is relatively less in Europe. Fortunately, at present, the use of cocaine, except occasional cases, is not common in EMR countries.

Other stimulants

Amphetamines and certain appetite suppressants belong to the group of stimulant drugs. Amphetamines have a strong potential for dependence. Their prolonged use can also lead to acute mental symptoms. **Caffeine**, which is the main alkaloid in tea and coffee, is also a stimulant, but with a relatively mild potential for dependence.

The active alkaloids of *khat* also belong to the group of stimulant drugs. The chewing of *khat* leaves is widespread in Djibouti, Somalia and Yemen, and is also prevalent in Ethiopia, Kenya and other neighbouring countries. *Khat* has a potential for producing dependence though not as marked as with opioids or cocaine. A number of EMRO publications have discussed the various health and social issues related to the use of *khat* (e.g., EMR reports of an intercountry meeting in 1982 in Mogadishu, and of a national meeting in 1984 in Djibouti).

Hallucinogens

Hallucinogens are a group of drugs that produce an alteration in consciousness and perception, with vivid visual and auditory hallucinations. The best known drug of this type is LSD. Such drugs are not commonly available in the Region.

Tobacco

Tobacco is one of most widely used psychoactive substances. Its active alkaloid is **nicotine.** Its use definitely produces dependence. Its health-damaging effects are now very widely known. The Regional Committee for the Eastern Mediterranean has already discussed this subject a number of times and, hence, it is not discussed here in detail.

Volatile solvents

Volatile solvents are generally not medical substances, but are used in industry as polishes, glues, adhesives, etc. Substances like gasoline and ether also belong to this group. Their vapours, when sniffed or inhaled, produce temporary euphoria, and with greater intake, they can cause delirium and damage to the cardiovascular system. Their use is reportedly increasing in many parts of the world, including EMR countries, especially among street children and youth.

Multiple drugs

It is quite common among drug addicts to use more than one drug, such as hashish and alcohol or heroin, with other sedatives or stimulants. Such a combination of drugs makes the problem of dependence and its management more complicated.

4.3 Conclusions on the prevalence of drug abuse in EMR Member States

Traditional substances such as opium, cannabis (hashish) and *khat* are still used in many countries of the Region. Among the newer substances, the most health-damaging and dependence-producing is **heroin.** Its use has rapidly spread to many countries and has assumed epidemic proportions. The use of hypnotic-sedatives, stimulants and volatile solvents are the other substances that are causing concern. **Table 2** includes information on drug abuse based on answers received from various EMR Member States in response to a recent EMRO questionnaire. A quick look at the Table confirms that, despite increased awareness and heightened public concern, reliable and valid data on drug abuse are generally lacking from most EMR Member States. This situation needs to be remedied urgently. It is important to organize national groups to monitor the drug abuse trends in various countries. Such monitoring groups can collect information from various sources, as listed previously, and make it available for national planning in the field of drug abuse. The activities of such national groups can further be coordinated at the regional level. WHO can help in the establishment of such national and regional groups by providing the necessary technical input.

5. Causes of drug abuse

There are as many speculations and hypotheses about the causes of drug abuse as there are suggestions for treatment methods. The fact is that it is oversimplistic to look for a single etiological factor for a condition that has so many systemic and interdependent dimensions.

Table 2

Drug scene in some EMR Member States based on answers received from government authorities

Country	Main agent(s) of abuse	Estimated number of dependents	Supply routes	Demand trend	Treatment facilities	Preventive measures
Afghanistan*	Heroin Opium	1 000 000	Domestic production	Increas-ing	--	--
Bahrain	Heroin Opium	1806**	Transit route	--	In-patient Out-patient	Media Sports Training
Cyprus						
Djibouti	Khat	Many	Domestic production	--	Some	--
Egypt*	Heroin Cannabis Psychotropics					
Iran, Islamic Republic of	Opium Heroin	600 000	Transit route	Decreas-ing	Rehabili-tation and Judiciary system	Media Religion Sports Education
Iraq	Non-existent	None	--	--	--	--
Jordan						
Kuwait						
Lebanon						
Libyan Arab Jamahiriya						
Morocco						
Pakistan	Opium Heroin Cannabis	2 000 000	Domestic production	Increas-ing	Exist	Media Schools Religion
Oman	Heroin Opium Psychotropic medicine	Few	Transit		Present	Media Sports Religion Education
Qatar						
Saudi Arabia						
Somalia						
Sudan	Cannabis Benzodiazepines	Many	Domestic production	--	Some	Religion Schools Media
Syrian Arab Republic	Narcotics Psychotropics	Few	Medically prescribed Small illicit portion	--	Some	Media Schools
Tunisia	Narcotics Cannabis	Few	Transit Medically prescribed	--	Few	Media Schools
United Arab Emirates						
Yemen						

* Non-official information.
** These are hospital statistics, the Government believes the extent of the problem is more.

At least three groups of causes have been proposed for drug abuse: biological, individual (psychological) and sociocultural. All these causes can be viewed in a public health model consisting of the drug (as agent), the host (individual) and the environment (social factors).

5.1 Host factors

Genetic predisposition

The presence of a genetic predisposition has long been postulated for drug dependence. It is mainly in relation to alcoholism that such an inherited predisposition has been studied most. There are also suggestions of possible genetic disposition to narcotic abuse based on the biology of endogenous morphines. Undoubtedly, the environmental factors influence the expression of the intended predisposition of any kind.

Molecular biology

The presence of specific opioid receptors led to the discovery of morphine-like substances in the brain. These substances have a possible role to play in the etiology of opioid dependency. There are speculations about the role of these substances in alcoholism as well. There are numerous alcohol-metabolising enzymes in the body, and their effects cause the individual's differences (inter-individual and intra-individual) in alcohol metabolism determining the susceptibility to alcoholism. Receptors for benzodiazepines also have etiological significance, some blocking agents have been identified which, instead of working centrally, have peripheral effects. Their effect on the autonomic nervous system provides some clues to the etiology of drug abuse.

The presence of physical illness or complaint

For years, drugs, particularly opium, have been used to alleviate pain and physical complaints related to different illnesses. This practice still continues, particularly in areas with poor access to health facilities, and has become a cause of drug dependence.

Individual psychological factors

Most of the studies in this area focus on alcohol and opioid dependence. One problem is that nobody can say whether the psychopathological and personality changes seen in drug-dependent individuals are a cause or an effect of their drug dependence. However, it is generally believed that some types of personality are more prone to drug dependence. These include hostile dependency, high level of anxiety in interpersonal relations, low frustration tolerance, low self-esteem, etc.

Although psychological studies, based on learning theory, have shed some light on different aspects of the problem, they are unable to describe a phenomenon with so many dimensions.

5.2 Agent

An agent is a pharmacologically active chemical compound--with or without a recognized, scientific medical use--which is consumed for its psychoactive properties. Pharmacological effects of different agents differ. They may be stimulants or depressants of the central nervous system. They may be absorbed easily or with difficulty, and they have different routes of administration. Susceptibility to an agent may have many reasons, including biologic and genetic ones.

Although it appears that all statements regarding the influence of biological and environmental factors become invalid in the absence of an agent, certain conditions can make the ground so fertile for drug abuse that despite all measures, the agent finds its way to the scene sooner or later. Classically, the factors related to the agent (or drug) are availability, cost, legislation, and the like.

Availability

The simple formula that the more a drug is available, the greater becomes the number of dependents, is generally true, but it hides very complex issues regarding supply and demand. One aspect of the complexity that needs to be studied is the question of cross-availability, meaning the impact the prohibition of one substance may have on demand for other substances. It is also necessary to study the impact of different aspects of demand and availability. Availability of licit, medically prescribed substances depend on prescribing practices, control measures on pharmaceuticals, etc.

The relationship between cost, availability and dependency is also a complex one. It is certain that increased law enforcement and seizure of more illict drugs causes increased price for substances like opioids, and this in turn decreases the number of addicts. The market analysis is usually not good enough to explain some of the health problems related to drug use. For example, it has been observed in some countries that a successful police crack-down on drug dealers and street drugs may cause undesirable effects, such as an increase of drugs injected and the spread of the human immunodeficiency virus (HIV) among those users who go "underground" and try to obtain the maximum effect from drugs with an increased street price.

Laws and regulations

Laws and regulations can aim to punish the drug dealers, drug-dependent individuals and/or regulate production and distribution of drugs used medically. The harsh measures against addicts have rarely proved to be effective. These measures should take into account the characteristics of the addicts involved. Laws against drug traffickers should also be seen with enough understanding of the country involved. For example, in a society with a long tradition of opium or cannabis abuse, harsh measures may indirectly increase the abuse of other more powerful and damaging drugs.

5.3 Social/environmental factors

No etiological explanation will be complete if it does not take into account social-environmental factors. Society at large, as the main habitat of the human race, determines both supply and demand for drugs, and sets norms of behaviour which are important in understanding the trends and patterns regarding the use and abuse of drugs. It is not easy to quantify and measure the effects of many complex interacting forces which together make up society. But, nevertheless, the most important of them are as follows.

Breakdown of accustomed life structures

Depopulation of villages, increased migration and the resulting enlargement of shanty towns around large cities are important social factors that increase the demand for drugs and provide a fertile ground for drug suppliers.

One special problem noted in many EMR Member States is the migration of male members of the family to richer countries in search of better work opportunities, leaving behind family members. The absence of a father figure, along with easy availability of money sent from abroad, may encourage adolescents left at home towards a more promiscuous life-style, including use of illicit drugs.

Economic factors

Apparent or hidden unemployment, non-profitable farming or enterprises, and lack of incentive to initiate new enterprises are among the conditions that make drug trafficking desirable. Despite all the laws, drug trafficking is among the most profitable transactions in the world, and a complex network of people are involved in it.

Culture

Different cultures deal with drug-related problems in different ways. The attitude of a particular culture may differ towards different drugs, and cultural attitudes towards drugs also change with time. Cultural attitudes towards a drug can take different forms, as shown in **Table 3.**

Table 3

Examples of cultural influences on drug-taking habits

Attitude	Example
Complete abstinence	Alcohol in Muslim societies
Ritualistic-ceremonial use	Use of cannabis or alcohol in some ceremonies
Connivial use	Use of opium in some societies or alcohol on social occasions

Family

Parents and siblings can function as role models. Parental attitudes towards drug-taking sets the emotional and moral attitude of the family regarding particular drugs. Parental absence, either through separation or divorce, or by death, brings a higher risk of many emotional, personality problems, including drug abuse. Absence of love, affection and positive family interaction can also contribute to problems, which, in turn, may lead to drug dependence.

Group pressure

It is not quite clear if peer groups are the cause or the effect of substance abuse. They probably are important in the initiation of drug abuse, but are less important in maintaining it.

The social setting of drug abuse

The social setting, which includes special physical arrangements and participation of particular people, may reinforce a continuation of the habit. In some societies there are distinct groups of addicts who may even enjoy good social status, and drug taking is a part of their "membership" to a semi-respected, semi-clandestine group of friends, which functions like a club, in which non-participation means disloyalty.

6. Resources against drug and alcohol-related problems

Resources to combat drug- and alcohol-related problems are many. Some have been tried frequently, but without much success, while some others show more promise. This paper does not focus on those resources that are effective in reducing the supply of drugs, instead the main focus will be on demand.

Identifying available resources is an important task. Combating drug dependence by identifying hypothetical causes that are very complex does not seem to be a wise strategy. Instead, by identifying resources and making an estimation of their usefulness, realistic attainable flexible goals can be set to be achieved in accordance with each particular drug, and each country. These resources can be summarized as follows.

6.1 Religion and faith

Faith is among the most influential factors affecting human behaviour. Religious beliefs and allegiances are among the most enduring of all human value systems. All religions preach harmony, brotherhood, subservience to God, and are opposed to many behaviours that cause health hazards.

Almost all the countries of the EMR are Muslim countries and many Islamic laws and principles oppose drug abuse. The consumption of alcohol is strictly prohibited in Islam, and the use of other mind-altering drugs is also strongly discouraged or even prohibited. One of the sayings of the Prophet, peace be upon Him, reads: "Strictly forbidden is whatever intoxicates or narcotizes; whatever intoxicates when taken in large doses is forbidden to be taken in small doses; verily, whatever obscures the intellect is strictly prohibited."

Religious teaching and the influence of religious leaders can be utilized to combat drug abuse. This should be done with very careful planning and as an integrated part of a comprehensive programme. Special training is necessary and trainers' attitudes should get adjusted to the specifications of each given community and group of religious leaders.

The following lines quoted from an EMRO document, "Healthy Life-styles" (EM/RC36/Tech.Disc./1, 1989), seem very relevant in this context:

> In Islam, the responsibility for individual behaviour lies first with the individual himself/herself. However, social groups also play a very significant role in Islamic tradition. In Islamic societies an individual's allegiance remains veering between the family or the local community and the idea of a universal *Umma*, or Islamic nation. In the Islamic *Umma* there is no difference between individuals except on the basis of the degree of piety and good deeds. The individual in Islamic culture paradoxically combines a constricted sense of family (or small local group) allegiance and a wider sense of universalism. In both cases the emphasis on the individual as an agent of change remains secondary to that of the group. Indeed a Koranic pronouncement about change is that God will not change a people [rather than individuals] until they change themselves. (The Holy Koran: Sura XIII, Verse 11: 'Allah will not change the condition of a people until they first change themselves').
>
> Hence, what is regarded mistakenly by Western thinkers as fatalism in Islam culture is really a renuciation of individualism in favour of group consciousness. The individual tends to comply with the group rather than deviate from it or attempt to divert it from its traditional course. Therefore, in addressing alteration of life-styles, it is important to take into account the group organization and its leadership along with the call to individual to change.

6.2 Family

The family is the cornerstone of social life. It has strong emotional, economic, religious and judicial significance. It is probably the oldest and most enduring of human institutions. As pointed out before, parents are role models, and greatly contribute to their offsprings' value system. The way they treat their children, both individually and as a group, has a great impact on the way children view themselves and their world.

The proclamation by the United Nations of the year 1994 as "The year of the Family" points to the recognition of the ever-increasing importance of the family in all human activities. The renewal of interest in the role the family can play comes after decades of uncertainty and even doubt about its importance. This calls for new, innovative approaches to use this strong institution more effectively for promotive and preventive health purposes, particularly in complex areas such as drug abuse.

6.3 Schools and universities

Schools are social institutions with great importance. Every educated member of the society has a vested interest in the school system at some time in his or her life. Everything related to a school, its physical structure, the curriculum, teacher job-satisfaction and teacher-parent associations, has a tremendous impact on the society as a whole.

Until recently, school health programmes have been rather passive, mainly providing some diagnostic-therapeutic services. This attitude has not allowed for schools to be used as a promotive and preventive resource.

It is important to look for new ways of using schools to combat drug abuse. It should be remembered that school children are also very vulnerable to dangers of drug abuse, and any preventive programme involving schools can function as a "double-edge sword" by increasing children's curiosity. Perhaps schools can best be used as model communities for learning a healthy life-style. With the support of WHO, a number of EMR Member States (e.g., Egypt, Islamic Republic of Iran, Pakistan) have already started school mental health programmes, emphasizing a healthy life-style, including prevention of drug abuse.

6.4 Employment

Employment means, among other things, economic certainty and hope for the future, less stress, better self-esteem, strong family life and a disciplined work schedule. The workplace, being most often an office or factory, a farm or a school, is an important social system. People develop emotional attachment to their work. Their habits are formed and changed by their work. The workplace is a great resource to help combat drug abuse, particularly in helping to promote a healthy life-style.

6.5 Culture

National customs and beliefs, the heritage of a people, arts and literature of the past and present, are strong social forces. Some of the most influential people in society are the ones who describe people's lives and experiences in forms of stories, poems, paintings, or essays. The core of all national cultures and heritage is human and noble, and many of the people involved in cultural work are among best resources, particularly for health promotion and protection.

6.6 National will

Without any exception, the national will of all countries is opposed to drug abuse. There is a need to solidify this will through the media, legislation and government action.

6.7 Media

In relation to drug abuse, the media is a "double-edge sword". On one hand, it is an indispensable means of relaying information, on the other hand it can become a medium for increasing curiosity and even desire for drugs. On balance, perhaps, the advantages of the media in the campaign against drug abuse outweigh the disadvantages.

6.8 The existing health infrastructure

The existing health infrastructure is an important resource for prevention, promotion, treatment and rehabilitation. It should be utilized according to each country's health policies and structure. The idea of separating drug and alcohol-related problems from the rest of the health system has not worked well in most places. In countries and areas where mental health is integrated into the primary health care (PHC) system, drug prevention, treatment and rehabilitation of drug-dependent persons should become a part of the PHC system, as far as possible.

6.9 Academic community

Health professionals and social scientists can contribute by training and conducting research in the area of drug abuse, and can also serve as role models.

The academic community is influential and in direct contact with youth. Medical schools, other health-related schools, law schools, etc., are important ones in this regard.

6.10 Medical and psychiatric facilities

Medical and psychiatric facilities of the public and private sectors are among the assets that can be utilized in all areas related to substance abuse, particularly in areas of acute intoxication, detoxication and prevention of relapse. They can also be involved in training and research.

6.11 Nongovernmental organizations

Nongovernmental organizations (NGOs) cover a wide range of religious, charitable, commercial, community-based groups, which form the venue for many activities that can affect varied areas of supply and demand. Their activities need to be given clear objectives and directed towards concrete results in the framework of comprehensive, nationwide programmes. Their assets can be utilized in many areas of prevention, treatment and rehabilitation, such as establishing treatment centres, finding employment for ex-addicts, helping families to cope with drug-related problems, providing the youth with activities in their spare time, etc.

6.12 International organizations

Many international organizations are active in different drug-related problem areas. The United Nations General Assembly has declared the 1990s as the "Decade to Combat Drug Abuse". This is also a decade to promote family values and a healthy life-style.

Annex 1 lists the United Nations agencies that deal with drugs and the role each of them plays in this regard.

6.13 Law enforcement

Enforcement agencies are involved with different aspects of the abuse of narcotic and psychotropic drugs. The training of different levels of law enforcement personnel is of utmost importance in the control of drug abuse. This training should not be limited to police-excise-judicial subjects, but must also include subjects related to bio-psycho-social aspects of drug abuse as well.

7. Development of a strategy for action

By reviewing different health-related aspects of substance abuse, it is evident that:

a) Causes of drug abuse are complex, interconnected and at times unreachable. Many of these are related to factors beyond the boundaries of the health sector alone. Therefore, the strategic approach based on the causes alone lacks a good chance for success.

b) It is unwise to induce high expectations by suggesting grandiose, unrealistic goals and approaches in as complex an area as drug abuse. Workable strategies should stay away from rhetoric and concentrate on what are possible plans of action, and activities should be well defined and have clear objectives.

c) The causes of drug abuse are diverse and are completely interwoven, but so are the resources to combat it. Identifying these resources and building plans and programmes upon them seems more promising.

d) A regional programme should take into consideration the similarities and differences that exist in different countries of the Region regarding questions like the type of drugs being abused, administrative arrangements, health policies, cultural background, etc. The programme should be flexible enough to allow for all these considerations.

e) One of the most effective and important elements of the health infrastructure that can be utilized in programmes to combat drug abuse is the existing national mental health policy and programme in each country of the Region. In countries where mental health services are already integrated into the health system, this may be done by the inclusion of some preventive, diagnostic, therapeutic and rehabilitative measures regarding drug abuse, to be carried out by PHC personnel at different levels. Additional approaches, linked with urban and school mental health programmes, can also be initiated in countries with existing programmes in these areas. In some countries, some preventive and therapeutic services can be offered in conjunction with noncommunicable disease programmes and programmes for maternal and child health or healthy life-styles.

7.1 Strategies for action

Based on the above analysis, the following strategies seem particularly relevant for the control of drug abuse in EMR Member States, as already identified in the Technical Paper, "Promotion and Protection of Mental Health" (EM/RC35/15 of 1988):

- development of clear national policies and programmes linked with national health plans, covering both supply and demand aspects;
- coordination of various sectors dealing with drug abuse problems, e.g., health education, social welfare, police, law and justice, religious groups, NGOs, etc.;
- stressing the promotion of healthy life-styles and the prevention of drug abuse, through health education;
- reinforcing religious teachings that support healthy life-styles and thereby reducing the demand for drugs;
- including tobacco in drug abuse control programmes and using anti-smoking campaigns as an indirect approach to drug abuse in general; and
- developing drug-dependence treatment services integrated into mental health and general health services and not isolated from the general health care system.

Table 4 lists other examples of some approaches based on the resources available in the Region.

Table 4

Examples of some approaches based on resources

Resource	Approach supported	Programme activities
Religion and faith	Involve religious institutions and use religious teachings in health education.	Convene a consultation. Prepare educational material.
Family	Support families with a member who abuses drugs or alcohol.	Develop materials for health education.
	Identify and help families with multiple problems to prevent occurrence of drug or alcohol abuse.	Produce training materials to complement training of health personnel with relevant inputs about psychosocial matters.

Table 4 (cont'd)

Resource	Approach supported	Programme activities
Schools	Use schools actively in mental health and drug abuse prevention programmes. Promote healthy life-styles in the school setting.	Organize consultation on school mental health. Prepare education material to be used in training courses for teachers and school health personnel. Involve school principals in national mental health programmes.
Work	Identify professional and organizational settings likely to increase the risk of alcohol and drug abuse in the Region.	Approach employers and unions to work out common strategies of prevention and help (example, ILO/WHO joint project on drug abuse in factories).
Community	Use occasions provided by tradition and community leaders in the promotion of healthy life-styles.	Carryout an ethnographic exploration of countries to identify ways of strengthening community resistance to drug and alcohol abuse.
Existing health structure	Use existing health structure to help people with problems related to drug and alcohol use.	Produce specific training modules and guidelines that will help health care agents to deal with alcohol and drug problems. Organize an intercountry meeting on mental health services in the Region, with specific reference to the role of these services in the fight against alcohol and drug problems.

Table 4 (cont'd)

Resource	Approach supported	Programme activities
Academic community	Involve research institutions in investigating problems related to alcohol and drug abuse at national and regional levels, and in research on treatment, rehabilitation and prevention methods.	Organize training course on research methodology (with particular emphasis on needs assessment).
Law enforcement	Revise legislation to facilitate implementation of health programmes to deal with problems related to alcohol and drug abuse.	Organize consultation on legislation relevant to mental health and psychosocial problems.
Media	Involve the media in campaigns to combat drug abuse.	Provide regular press releases containing information about alcohol and drug-related problems, about their solutions and possibilities for prevention.
Regional resources	Provide opportunity for exchange of experiences at regional level.	Organize regional consultation meetings for focal points on health aspects of drug abuse.
WHO and other organizations	Participate in the elaboration of national and regional strategies and plans to combat alcohol and drug problems.	Produce relevant inputs in the course of WHO missions and planning exercises with countries. Involve other intergovernmental (e.g., the Arab League) and non-governmental organizations (e.g., the World Psychiatric Association) in regional and country programmes.

8. International treaties for the control of drug abuse

8.1 The Single Convention on Narcotic Drugs, 1961

Since the beginning of this century, efforts have been made to develop international control on opium and other dependence-producing drugs. The first International Opium Convention was signed at The Hague (the Netherlands) in 1912. During the next fifty years, eight more international "Conventions", "Agreements" or "Protocols" were signed to control opium, and other narcotic drugs. Finally, under the guidance of the United Nations, a **Single Convention on Narcotic Drugs** was drawn up in 1961. This Convention terminated all previous treaties. This treaty regulates the production, medical use, international trade and all other related aspects for the national and international control of opium, cannabis, coca leaf and their by-products. With the experience gained, the Convention was amended by a protocol in 1972, to make it a comprehensive instrument for covering all aspects of narcotic drugs.

8.2 Convention on Psychotropic Substances, 1971

Though the Single Convention of 1961 well covered various aspects related to the control of the so-called "narcotic" drugs, many countries started becoming aware of the new danger posed by the sudden explosion of knowledge in the field of psychopharmacology. Since 1950, hundreds of psychotherapeutic drugs and other psychoactive compounds have appeared on the market in all countries. Many of them have a great potential for producing dependency and causing other health damage. While the narcotic substances controlled by the Single Convention, namely, opium, cannabis, and coca leaves, were all naturally grown vegetable products, mostly from developing countries of Asia, Africa and South America, the new psychotropic substances were synthetically produced, mainly in the laboratories of developed countries in Europe and North America.

Responding to pressure from Member States, the United Nations drew up an additional Convention on Psychotropic Substances, which was adopted in Vienna in 1971. One significant feature of this new Convention is that, according to the potential harmful nature and its medicinal use, all psychotropic substances have been divided into four schedules: ranging from Schedule I drugs needing maximum control, to Schedule IV drugs needing minimum control. There is a mechanism for WHO to regularly review these drugs, and to make recommendations for additions, deletions or changes of schedule category, which are finalized by the United Nations Commission on Narcotic Drugs.

The latest list of countries that are signatories to different conventions are listed in **Annex 2.**

9. Recommendations

It is recommended that:

1. Member States should develop clear national policies and programmes for the control of drug abuse.

   Such national programmes:

   1.1 should be multisectoral and headed by the highest possible authorities in the country, involving sectors concerned with health, along with sectors concerned with law enforcement, education, social services and nongovernmental organizations;

   1.2 should cover both aspects of supply and demand;

   1.3 should identify available resources to combat drug abuse and work on finding the best possible ways of using these resources in a harmonious, concerted way, avoiding parallel action;

   1.4 should emphasize the prevention of drug abuse by promoting healthy life-styles, through the involvement of religious and community leaders, cultural activities, sports, the school system, the media, and the family; and

   1.5 should develop treatment programmes that are comprehensive, i.e., offer follow-up along with detoxification, rehabilitation, counselling and, when necessary, social re integration into the community.

2. In countries where drug abuse is a major problem, national groups should be developed to collect data regularly and to monitor trends in drug abuse. An EMRO consultation can initiate such a process and provide technical support for such groups. With the support of country groups, a regional consultative group may be formed.

3. At least one academic centre should be upgraded with WHO support in three or four countries where drug abuse constitutes a major problem. The function of such centres would be to:

   3.1 collect appropriate data and monitor trends in drug abuse in the country;

   3.2 train health and other professionals who are involved in the control of drug abuse;

   3.3 carry out needs-based research;

   3.4 develop community programmes for the prevention of drug abuse; and

   3.5 develop model services for the prevention of drug abuse.

Annex 1

UNITED NATIONS SYSTEM AND DRUG CONTROL

General Assembly

The General Assembly is the body through which the United Nations adopts resolutions, conventions and protocols, approves funds and serves as the forum through which individual governments express their views.

Economic and Social Council (ECOSOC)

The 54-member ECOSOC is responsible for formulating overall United Nations policies in the field of drug abuse control, coordinating drug control activities with the full range of economic and social programmes of the United Nations and making relevant recommendations to governments. In this work, it is assisted and advised by one of its functional commissions, the Commission on Narcotic Drugs, for which it acts as the parent body.

Commission on Narcotic Drugs (CND)

The 53-member CND is one of ECOSOC's six functional commissions. It is the central policy-making body in the United Nations system for dealing with all questions related to drug abuse control. The three drug control conventions also assign important functions to CND. It assists ECOSOC in supervising the application of international conventions and agreements dealing with narcotic drugs and psychotropic substances, considers any changes that may be required in the existing machinery for the international control of such drugs and may prepare new conventions and international instruments.

International Narcotics Control Board (INCB)

INCB was established by the Single Convention on Narcotic Drugs, 1961. It is composed of 13 individual members elected in their personal capacity by ECOSOC. Three of the 13 members are elected from a list of candidates nominated by WHO for their medical, pharmacological or pharmaceutical experience. INCB has a quasi-judicial function to monitor and promote compliance with the drug control conventions. To achieve this, it investigates all stages in the licit movement of drugs, takes measures to ensure the execution of treaty provisions (consultation with governments over cases of non-compliance, public announcement of such cases as required, etc.), publishes an annual report together with technical supplements, and administers estimates and statistical returns systems for narcotic drugs.

United Nations Secretariat

United Nations International Drug Control Programme (UNDCP)

UNDCP was established within the UN secretariat in Vienna, Austria, in 1991, by integrating therein the three former UN drug units, i.e., the Division of Narcotic Drugs, the United Nations Fund for Drug Abuse Control, and the secretariat of INCB. UNDCP is entrusted with the responsibility for coordinating and providing effective leadership for all United Nations drug control activities.

Centre for Social Development and Humanitarian Affairs (CSDHA)

CSDHA, a part of the Department of International Economic and Social Affairs, is concerned with the adverse effects of drug abuse on social development, including social disintegration and increasing criminality.

United Nations Interregional Crime and Justice Research Institute (UNICRI)

UNICRI, formerly the United Nations Social Defence Research Institute, established under the aegis of CSDHA, conducts studies on the interaction between criminal behaviour and drug abuse and control measures.

Specialized Agencies

World Health Organization (WHO)

WHO carries out the responsibilities assigned to it by the international drug control conventions on narcotic drugs and psychotropic substances by reviewing these substances and making recommendations to the United Nations concerning their international control. Although final decisions are to be taken by the United Nations (CND and ECOSOC), WHO's assessment is to be considered as "determinative" as to medical and scientific matters.

In addition to this convention-based role, WHO, as the specialized United Nations agency responsible for international health, plays a role in health-related demand reduction activities such as prevention, treatment and rehabilitation of drug-dependent persons.

International Labour Organisation (ILO)

ILO's drug control activities relate to the question of employment and the well-being of workers, focusing on drug-related problems in the workplace and on the areas of vocational rehabilitation of drug-dependent persons.

United Nations Educational, Scientific and Cultural Organization (UNESCO)

UNESCO's drug-related activities are focused on the prevention of drug abuse through school education and public awareness.

International Maritime Organization (IMO)

IMO's drug control activities relate to the prevention of drug smuggling on ships engaged in international traffic.

International Civil Aviation Organization (ICAO)

ICAO is seeking ways to counteract illicit drug traffic by air.

Universal Postal Union (UPU)

UPU promotes international collaboration for the prevention of illicit transmission of drugs by mail.

Food and Agriculture Organization (FAO)

FAO has been involved in projects aimed at raising the income level of farmers and reducing the incentive to cultivate narcotic crops.

United Nations Industrial Development Organization (UNIDO)

UNIDO ensures that its industry-promoting technical cooperation projects are consistent with the requirements of the international drug control conventions.

United Nations programmes

United Nations Development Programme (UNDP)

UNDP seeks to incorporate drug abuse control programmes in the context of overall development.

United Nations Children's Fund (UNICEF)

UNICEF works to improve life within the community, principally through strengthening the family and provision of services to children in need, including "street children".

World Food Programme (WFP)

WFP provides food assistance in support of some rural development projects which aim at the substitution of other agricultural products for the illicitly grown opium poppy.

Other international organizations

Customs Cooperation Council (CCC)

CCC promotes technical cooperation to strengthen enforcement coordination among the customs authorities for the control of drug smuggling.

International Criminal Police Organization (ICPO/Interpol)

ICPO/Interpol promotes international cooperation among law enforcement agencies for the control of illicit trafficking in drugs.

Annex 2

LIST OF COUNTRIES THAT ARE SIGNATORIES TO DIFFERENT CONVENTIONS (as of 15 July 1993)

The Convention on Narcotic Drugs, 1961[1] as amended by the 1972 Protocol[2]

The following 137 States are Parties to either 1961 Convention only or 1961 Convention and 1961 Convention as amended by the 1972 Protocol; of these 137 States, 24 (underlined) are Parties to 1961 Convention only:

Afghanistan; Algeria; Antigua and Barbuda; Argentina; Australia; Austria; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Benin; Bolivia; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cameroon; Canada; Cape Verde; Chad; Chile; China; Colombia; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; Denmark; Dominican Republic; Ecuador; Egypt; Ethiopia; Federated States of Micronesia; Fiji; Finland; France; Gabon; Germany; Ghana; Greece; Guatemala; Guinea; Haiti; Holy See; Honduras; Hungary; Iceland; India; Indonesia; Iran; Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kenya; Kuwait; Lao People's Democratic Republic; Lebanon; Lesotho; Liberia; Libya; Liechtenstein; Luxembourg; Madagascar; Malawi; Malaysia; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Monaco; Mongolia; Morocco; Myanmar; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Romania; Russian Federation; Rwanda; Saint Lucia; Saudi Arabia; Senegal; Seychelles; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; Spain; Sri Lanka; Sudan; Suriname; Sweden; Switzerland; Syria; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Uganda; Ukraine; United Arab Emirates; United Kingdom; United States of America; Uruguay; Venezuela; Yugoslavia; Zaire; Zambia.

The Convention on Psychotropic Substances, 1971[3]

The following 117 States are Parties to the Convention:

Afghanistan; Algeria; Antigua and Barbuda; Argentina; Australia; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Benin; Bolivia; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cameroon; Canada; Cape Verde; Chile; China; Colombia; Costa Rica; Côte d'Ivoire; Cuba; Cyprus; Denmark; Dominican Republic; Ecuador; Egypt; Ethiopia; Federated States of Micronesia; Fiji; Finland; France; Gabon; Germany; Ghana; Greece; Grenada; Guatemala; Guinea; Guyana; Holy See; Hungary; Iceland; India; Iraq; Ireland; Israel[4]; Italy; Jamaica; Japan; Jordan; Kuwait; Lesotho; Libya;

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[1] Entry into force: 13 December 1964

[2] Entry into force: 8 August 1975

[3] Entry into force: 16 August 1976

[4] With effect from 9 September 1993

1971 Convention (cont'd)

Luxembourg; Madagascar; Malawi; Malaysia; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Monaco; Morocco; New Zealand; Nicaragua; Niger; Nigeria; Norway; Pakistan; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Protugal; Qatar; Republic of Korea; Romania; Russian Federation; Rwanda; Saudi Arabia; Senegal; Seychelles; Singapore; Slovaka[5]; Slovenia; Somalia; South Africa; Spain; Sri Lanka; Suriname; Sweden; Syria; Thailand; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Uganda; Ukraine; United Arab Emirates; United Kingdom; United States of America; Uruguay; Venezuela; Yugoslavia; Zaire; Zambia[6]

The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988[7]

The following 82 States are Parties to the Convention:

Afghanistan; Antigua and Barbuda; Argentina[8]; Australia; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Bhutan; Bolivia; Brazil; Bulgaria; Burkina Faso; Burundi; Cameroon; Canada; Chile; China; Costa Rica; Côte d'Ivoire; Cyprus; Denmark; Dominica[9]; Ecuador; Egypt; El Salvador[10]; Fiji; France; Ghana; Greece; Grenada; Guatemala; Guinea; Guyana; Honduras; India; Iran; Italy; Japan; Jordan; Kenya; Luxembourg; Madagascar; Malaysia[11]; Mauritania[12]; Mexico; Monaco; Morocco; Myanmar; Nepal; Nicaragua; Niger; Nigeria; Oman; Pakistan; Paraguay; Peru; Portugal; Qatar; Romania; Russian Federation; Saudi Arabia; Senegal; Seychelles; Slovakia[13]; Slovenia; Spain; Sri Lanka; Suriname; Sweden; Syria; Togo; Tunisia; Uganda; Ukraine; United Arab Emirates; United Kingdom; United States of America; Venezuela; Yugoslavia; Zambia[14].

On 31 December 1990 the European Economic Community deposited its instrument of formal confirmation to the Convention (Extent of competence: Article 12).

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[5] With effect from 25 August 1993

[6] With effect from 26 August 1993

[7] Entry into force: 11 November 1990

[8] With effect from 8 September 1993

[9] With effect from 28 September

[10] With effect from 19 August 1993

[11] With effect from 9 August 1993

[12] With effect from 29 September 1993

[13] With effect from 26 August 1993

[14] With effect from 26 August 1993

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

EM/RC40/8
October 1993

Fortieth Session

ORIGINAL: ARABIC

Agenda item 10(b)

ABUSE OF NARCOTICS AND PSYCHOACTIVE DRUGS

Summary of Recommendations

1. It is recommended that Member States develop clear national policies and programmes for the control of drug abuse. Such national programmes should:

   1.1 be multisectoral and headed by the highest possible authorities of the country, and involve health and related sectors, along with sectors concerned with law enforcement, education, social services, and religious affairs and nongovernmental organizations;

   1.2 cover aspects of both supply and demand;

   1.3 identify available resources to combat drug abuse and work on finding the best possible ways of using these resources in a harmonious, concerted way, avoiding duplication of effort;

   1.4 emphasize prevention of drug abuse by promoting healthy life-styles through the involvement of religious and community leaders, cultural activities and sports, the school system, the media, and the family; and

   1.5 develop treatment programmes that are comprehensive, i.e. offer follow-up along with detoxification, rehabilitation, counselling and, when necessary, social integration into the community.

2. In countries where drug abuse is a major problem, national groups should be developed to collect data regularly and monitor trends on drug abuse. An EMRO consultation can initiate such a process and provide technical support for such groups. With support of country groups, a regional consultative group may be formed.

3. At least one academic centre each should be upgraded for the purposes of this programme, with WHO support, in three or four countries where drug abuse constitutes a major problem. The functions of such centres will be to:

   3.1 collect appropriate data and monitor trends in drug abuse in the country;

   3.2 train health and other professionals who are involved in the control of drug abuse;

   3.3 carry out needs based research;

   3.4 develop community programmes for the prevention of drug abuse; and

   3.5 develop model services for the prevention of drug abuse.

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

EM/RC40/8
October 1993

Fortieth Session

ORIGINAL: ARABIC

Agenda item 18(b)

ABUSE OF NARCOTICS AND PSYCHOACTIVE DRUGS

Summary for the Report

The abuse of narcotics and psychotropic drugs constitutes a major health, social and economic problem. The countries of the Eastern Mediterranean Region are among the hardest hit by this menace.

Many factors contribute to drug abuse: the causes are complex and interwoven. Therefore, it is not prudent to try to control drug abuse by focusing on causes. Instead, it seems relevant to use the available social resources for prevention, treatment and rehabilitation. These resources are many and include religion, culture, media, schools, promotion of healthy life-styles and the use of the primary health care system.

The presentation described global and regional drug-related problems, identified different causes, as well as resources that help to deal with the problems at national and regional levels. It is suggested a strategy to combat drug abuse based on identified resources and provided information about international organizations that were engaged in dealing with the problem.

DRAFT RESOLUTION

REGIONAL COMMITTEE FOR THE EASTERN MEDITERRANEAN

EM/RC40/R.
October 1993

Fortieth Session

ORIGINAL: ARABIC

Agenda item 10(b)

ABUSE OF NARCOTICS AND PSYCHOACTIVE DRUGS

The Regional Committee,

Having reviewed the Regional Director's report* on "Abuse of Narcotics and Psychoactive Drugs";

Considering the magnitude of the problem and recognizing that continued efforts are required for the prevention and control of this grave health, social and economic problem in the Region;

1. **URGES** Member States:

1.1 to provide the necessary commitment and support to a comprehensive, multisectoral programme for the prevention and control of drug abuse, using religious, cultural, educational and other resources for promoting healthy life-styles;

1.2 to establish reliable, up-to-date systems for collecting information about drugs; and

1.3 to share among themselves and with WHO information, technical expertise and experience on different aspects of supply, demand, treatment and rehabilitation.

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* Document EM/RC40/8.

2. **URGES** the Regional Director:

2.1 to support Member States in developing regular data-collection mechanisms, thereby facilitating exchange of information and experience among themselves and between them and WHO; and

2.2 to support the establishment and upgrading of reference centres in countries where drug abuse is a severe problem.

REGIONAL COMMITTEE FOR THE
EASTERN MEDITERRANEAN

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Fortieth Session

ORIGINAL: ARABIC

Agenda item 10(b)

ABUSE OF NARCOTICS AND PSYCHOACTIVE DRUGS

Introductory Paragraph

The abuse of narcotics and psychotropic drugs is a major health and social problem that arouses justifiable concern among the countries of the Eastern Mediterranean Region, where there is considerable abuse of many substances and drugs. This Region is also one of the most important drug-transit routes of the world, which is itself becoming increasingly vulnerable to drug-related problems.

Owing to the largely illicit nature of drug abuse, reliable and valid data are difficult to obtain, and this is particularly true for this Region.

In order to draw up a workable strategy for combating drug abuse, it is necessary to rely mainly on information that promises to be of use for positive action. Drug abuse control cannot start from the causes, but by a reliance on resources--the primary health care system, family and social resources, religious and moral resources are among them. Through analysis, it is possible to identify those resources upon which meaningful interventions can be built.

This technical paper gives basic information on the subject, so as to identify some of these resources and suggest measures that national, regional and international agencies can consider in drawing up plans of action that would facilitate achieving targets and goals for controlling alcohol and drug-related problems.