

Atlas: substance use in the Eastern Mediterranean Region 2012



**World Health
Organization**

Regional Office for the Eastern Mediterranean

Atlas: substance use in the Eastern Mediterranean Region 2012



**World Health
Organization**

Regional Office for the Eastern Mediterranean

WHO Library Cataloguing in Publication Data

World Health Organization. Regional Office for the Eastern Mediterranean

Atlas: substance use in the Eastern Mediterranean Region 2012 / World Health Organization. Regional Office for the Eastern Mediterranean

p. - (EMRO Technical Publications Series; 42)

ISBN: 978-92-9021-953-8

ISBN: 978-92-9021-954-5 (online)

ISSN: 1020-0428

I. Substance-Related Disorders - prevention & control 2. Substance-Related Disorders – drug therapy 3. Substance-Related Disorders - epidemiology - Eastern Mediterranean Region 4. Health Services 5. Substance-Related Disorders – rehabilitation 6. Health Policy I. Title II. Regional Office for the Eastern Mediterranean III. Series
(NLM Classification: WM 270)

© World Health Organization 2013

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Health Publications, Production and Dissemination World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 2670 2535, fax: +202 2670 2492; email: HPD@emro.who.int). Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: WAP@emro.who.int.

Design, layout and printing by WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt

Contents

Executive summary	5
1. Introduction	9
2. Methodology	10
2.1 Data collection.....	10
2.2 Validating the data.....	10
2.3 Limitations	10
3. Demographic characteristics	11
4. Substance use epidemiology	12
4.1 General information	12
4.2. Most commonly used substances	13
4.3 Trends and patterns	13
4.4 Monitoring and surveillance.....	14
4.5 Conclusion.....	15
5. Policy and legislation	16
6. Health services	17
6.1 Administration and financing.....	17
6.2 Treatment services	18
6.3 Treatment setting and specialized services.....	20
6.4 Pharmacotherapy of substance use disorders	21
6.5 Human resources	22
7. Prevention and harm reduction	24
7.1 Groups and agencies	24
7.2 Prevention services.....	24
7.3 Prevention programmes for specific populations	25
7.4 Screening, brief interventions and harm reduction programmes.....	26
References	27
Country fact sheets: substance use disorders	29
Abbreviations	30
Afghanistan	31
Bahrain	34
Egypt	37
Islamic Republic of Iran.....	40
Iraq	44
Jordan.....	46

Morocco 49
Oman 52
Pakistan..... 55
Saudi Arabia 58
Somalia..... 61
Sudan..... 63
Syrian Arab Republic 65
Tunisia 68

Executive summary

Background

This report provides information on the magnitude of substance use disorders in the countries of the Eastern Mediterranean Region of the World Health Organization and the available resources and infrastructure at country level for prevention, treatment and rehabilitation of those suffering from substance use disorders.

The report is based on data collected as part of the development of the *Atlas on substance use 2010* published by WHO, for which a questionnaire was developed and sent to all countries. The questionnaire was used to measure resources available to prevent and treat substance use disorders. From the Eastern Mediterranean Region 14 countries, representing 92% of the Region's population, responded to the questionnaire (1). To develop the present report, the information from the atlas was updated, complemented by a literature review and feedback from the focal points appointed in ministries of health in countries of the Region. Specifically, extra information on demographic characteristics and substance use epidemiology were added to make the current report. The report comprises five major areas:

- demographic characteristics
- epidemiology of substance use
- policy and legislation as related to substance use disorders
- health services
- prevention and harm reduction resources.

Demographic characteristics

- The Eastern Mediterranean Region has a young population with high annual population growth rate which is second highest of all WHO regions.
- The rate of literacy in the region is low: the Region is ranked fifth among all the WHO regions with regard to literacy rate among adults aged 15 years and over.
- General government expenditure on health as a percentage of total government expenditure is low, which put the Region fifth among all WHO regions.

Substance use epidemiology

General information

- The number of age-standardized deaths per 100 000 population in the Region attributable to illicit substance is 9 with a median rate of 5.3.
- The number of age-standardized disability-adjusted life years (DALYs) lost per 100 000 population due to substance use is 400 with a median rate of 175
- The median rate of prevalence of substance use disorders among the population aged 15 years and over for males is 0.53% and for females is 0.1%.

Most commonly used substances

- Cannabis is the most prevalent substance of use.
- Opiates are the main substance of use among persons treated for substance use disorders in most countries.

Trends and patterns

- Heroin is the main substance used for injection.
- The prevalence estimates for HIV infection among injecting drug users ranges from 0.31% to 27.2% with a median of 5.1%.
- Data on prevalence of substance use among women and young people is scarce.

Monitoring and surveillance

- The rates for the presence of epidemiological and national substance use treatment data collection systems in the countries are 35.7% and 44.5% respectively, which are comparable with the global rates.
- Annual government reports on the situation of psychoactive substance use and health resources for prevention and treatment of related disorders are published by only one-fifth of the countries.

Policy and legislation

- Written national policy for substance use and special legislation for treatment and rehabilitation of substance use are available in 78.6% of the countries, which is higher than the global rate.
- Drug courts and special programmes diverting clients from the criminal justice system towards treatment are available in 28.6% and 57% of the countries respectively, which are higher than the global rates.

Health services

Administration and financing

- A drug unit is present in most countries. However, in terms of having a specific budget for management of substance use disorders, the Eastern Mediterranean Region is ranked fifth among all the WHO regions.
- Out-of-pocket payment is the most common method for financing substance use disorders treatment.

Treatment services

- Inpatient detoxification services are available in over 90% of countries.
- Outpatient treatment services are available in 64% of countries.
- Opioid substitution treatment (OST) is available in 14.3% of countries, which is about one-third of the global rate.

Treatment settings and specialized services

- Mental health care setting is the most common setting used for providing substance use disorders treatment services in countries (50%).
- Substance use disorders treatment services are rarely provided in general health care and primary health care settings.
- Specialized services for the treatment of substance use disorders for young people and pregnant women are scarce or unavailable.
- More than half of the countries have treatment services for injecting drug users and for injecting drug users with HIV/AIDS.

Pharmacotherapy of substance use disorders

- Treatment policy document and treatment guidelines are available in about half of the countries, which is comparable to the global rate.
- The rate of availability of methadone (21.4%) is half of the global rate. The rate of availability of methadone maintenance treatment is 7.1%, which is less than one-quarter of the global rate.

Human resources

- Psychiatrists are the main professional group involved in providing substance use treatment services in 42.9% of countries with a rate higher than the global rate.
- The presence of nongovernmental organizations involved in prevention, treatment and rehabilitation is the lowest among all WHO regions.

Prevention and harm reduction

Prevention programmes

- Community-based prevention services and programmes are available in 61.5% of countries, which is comparable with other WHO regions.
- Groups and agencies that are mostly involved in prevention programmes are religious groups, schools, health care workers and law enforcement agencies.
- Prevention programmes for people living with HIV are available in 21.4% of countries, which is half of the global rate; there are no prevention programmes for pregnant women.

Screening, brief interventions and harm reduction programmes

- Screening and brief intervention programmes are available only in one-fifth of countries, which is the lowest among all WHO regions.
- The rate of availability of community-based needle and syringe programmes is comparable with the global rate, and the Eastern Mediterranean Region is one of two WHO regions in which in-prison needle and syringe programmes exist.

I. Introduction

Substance use is a complex phenomenon caused by an intricate web of biological, psychological, social, economic and cultural factors. It is a chronic mental disorder, characterized by remissions and relapses and frequently accompanied by other mental conditions, such as depression and anxiety disorders, and physical conditions such as blood-borne infections (HIV, hepatitis B and C) and tuberculosis.

Given the complexity of substance use, management of its health and social consequences involves a range of prevention, treatment and rehabilitation approaches and settings. Several treatment modalities with proven efficiency have been developed so far, including pharmacological, psychological and social interventions. These interventions are mostly provided in specialized and mental health settings. Recently, there have been efforts to get the general health care and primary health care more involved in providing health services to patients with substance use disorders.

In the Eastern Mediterranean Region substance use disorders account for a loss of four disability-adjusted life years (DALYs)¹ per 1000 of population and nine deaths per 100 000 population, compared with the loss of two DALYs per 1000 of population and four deaths per 100 000 population globally (1). There is evidence of a concentrated HIV epidemic among injecting drug users in some countries of the Region (see Country fact sheets).

The results of a study on mental health systems in the Region have shown that the resources for mental, neurological and substance use disorders are scarce. Inadequate financial and

human resources, shortage of health facilities, unavailability of required medications and improper distribution of services are among the identified shortcomings (2).

The objective of the current report is to compile, analyse and disseminate the available information on substance use in the Region. It maps the existing prevention, treatment and rehabilitation resources addressing the needs of persons with and/or at risk of substance use disorders.

The report is organized into the following sections:

- demographic characteristics
- substance use epidemiology
- policy and legislation
- health services
- prevention and harm reduction.

Each section comprises:

- a brief introduction
- collected data
- key findings
- conclusions and recommendations.

Detailed information on the situation of substance use in individual countries of the Region that participated in development of the *Atlas on substance use 2010* is presented in the final section.

¹ "Disability-adjusted life years" is a single measurement to quantify the number of years of life lost as a result of both premature death and disability.

2. Methodology

2.1 Data collection

The starting point of this report is the data collected for the development of the *Atlas on substance use 2010* published by WHO. To collect the data for the current Atlas a questionnaire was sent to countries of the Region covering the following areas:

- epidemiology and burden of disease of psychoactive substance use
- health services
- pharmacological treatment
- human resources
- policy and legislation
- prevention.

From the Eastern Mediterranean Region, 14 countries provided data for the Atlas:

- Afghanistan
- Bahrain
- Egypt
- Jordan
- Islamic Republic of Iran
- Iraq
- Morocco
- Oman
- Pakistan
- Saudi Arabia
- Somalia
- Sudan²
- Syrian Arab Republic
- Tunisia.

In addition to data collected for the Atlas through its questionnaire, additional data were collected from articles in peer-reviewed journals and published national surveys and assessment reports. Designated focal points in ministries of health were also asked to validate and update the data. Data were also extracted from the Regional Office for the Eastern

Mediterranean data repository, the WHO headquarters data repository and United Nations agencies, namely United Nations Office on Drugs and Crime (UNODC) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) including UNODC world drug reports and United Nations General Assembly Special Session (UNGASS) country reports.

2.2 Validating the data

The collected data for each country were validated in two phases.

1. A country factsheet was developed and shared with the national focal points for validating the data and providing missing information for specific sections.
2. Country profiles on substance use were developed and shared for a second time with the national focal points for final verification.

2.3 Limitations

- From the Eastern Mediterranean Region, only 14 countries participated in development of the Atlas. Thus only these countries are considered in the current report. However, these 14 countries represent 67% of the Region's Member States and 92% of the Region's population.
- Most of the data presented in this report are based on expert opinion, the designated focal points in ministries of health in consultation with related experts having provided the data for development of the Atlas. However, for the epidemiological section, the data were extracted from available surveys and assessments at national, regional and international levels.
- Scarcity of information was the major challenge in compiling the report, especially for the section on substance use epidemiology. The data for commonly

² The country assessments that inform this report were conducted in 2010, before South Sudan became an independent Member State in the Region in September 2011. Thus, the information contained in the report does not provide disaggregated data for Sudan and South Sudan. As of June 2013 South Sudan is a Member State of the WHO African Region.

used substances are extracted from different assessments and studies that were conducted at different times using different methodologies. Thus, this serious shortfall has to be taken into account when making comparisons.

- A few components that are essential for a comprehensive treatment package for substance use disorders, namely structured psychosocial interventions, were not surveyed in development of the Atlas and therefore the related data are missing in the current report.

3. Demographic characteristics

Table 1 provides a brief overview on demographic and socioeconomic statistics of the countries of the Region represented in this report (3).

Findings

- In terms of total population, the Eastern Mediterranean Region has the least population among the six WHO regions. However, in terms of proportion of population 15 years and under and the annual population growth rate, the Region ranks second.
- In terms of population living in urban areas, the Region ranks third among all WHO regions jointly with the Western Pacific Region.

- The Region is ranked third among all regions on life expectancy at birth.
- The Region is in fifth place among the six WHO regions on adult literacy rate (15 years and over).
- Figures from WHO regions on general government expenditure on health as a percentage of total government expenditure put the Region in fifth place (4).

Conclusion

- Those aged 15 years and under comprise a significant proportion of the Region's population. This has implications for planning for prevention, early recognition and treatment of substance use disorders considering that early onset of substance use especially during or even before adolescence, contributes to development of substance dependence during later stages of life (5).
- Allocation of health resources for substance use disorders needs to be tailored to the needs of the population, particularly with the rapid urbanization that has been taken place in the Region.
- The level of literacy among adults is relatively low in the Region. Illiteracy coexists with and exacerbates poverty, a contributing factor to substance use. The level of literacy also affects the communication methods for conveying health messages to the target population.

Table 1. Demographic and socioeconomic statistics, Eastern Mediterranean Region

Indicator	Lowest level	Highest level	Median
Total population (000s)	1 235	177 100	27 438
Population ≤ 15 years (%)	20	46	34
Annual population growth rate (%)	1.1	5.8	3
Population living in urban areas (%)	23	100	62
Life expectancy at birth (years)	50	76.4	73
Adult literacy rate (%) aged ≥ 15 years	25	93.5	74
General government expenditure on health as % of total government expenditure	0	19	7

- Government expenditure on health as a percentage of total government expenditure is low in the Region which translates into low expenditure on mental health and substance use disorders.

4. Substance use epidemiology

4.1 General information

The global burden of disease project provides estimates for the burden of diseases including substance use disorders. The burden is expressed as disability-adjusted life years (DALYs) and numbers of deaths attributable to substance use. The figures reported here are extracted from the global burden of disease report, 2004 update (6).

Substance use disorders included in the global burden analysis include opioid dependence and harmful use of opioids, and cocaine dependence and harmful use of cocaine (7). The prevalence estimates for substance use disorders show the point prevalence of “problematic drug use”, which in this context

comprises dependence on and harmful use of a substance. These estimates are standardized and comparable across countries and regions of the world. Prevalence data are taken from the Global Burden of Disease study 2004 (8). The definitions of substance use disorders are based on the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) (9).

Table 2 presents burden and prevalence estimates of substance use disorders.

Findings

- The median rate of age-standardized deaths per 100 000 population attributable to illicit substance use is 5.3. This indicates that the death rate attributable to illicit drug use in more than half of the countries of the Region is over 5.3.
- The median rate of age-standardized DALYs lost per 100 000 population in the Region due to substance use is 175. This indicates that in more than half of the countries in the Region more than 175 DALYs per 100 000 population are lost due to substance use.

Table 2. Burden and prevalence estimates of substance use disorders in the Eastern Mediterranean Region

Substance use epidemiology	Lowest level (%)	Highest level (%)	Median (%)
Age-standardized death rates for substance use disorders per 100 000 population	0.2	33.1	5.3
Age-standardized DALYs for substance use disorders per 100 000 population ^a	6	865	175
Prevalence estimates for substance use disorders among adult males (%) (15 years and over) ^b	0.01	3.32	0.53
Prevalence estimates for substance use disorders among adult females (%) (15 years and over) ^c	0.00	0.55	0.1

^a The figures related to burden are age-standardized. Age-weighting and time discounting are included in the measurement. Three per cent discounting and non-uniform age weighting were used; resulting in less weight given to years lived at young and older ages.

^b The prevalence estimates of substance use disorders among adult males (%) range from lowest level to highest level as follows: lowest level: < 0.4; middle levels: 0.4–0.7; 0.8–1.5; highest level: ≥ 1.6%

^c The prevalence estimates of substance use disorders among adult females (%) range from lowest level to highest level as follows: lowest level: < 0.1; middle levels: 0.1; 0.2–0.3; highest level: ≥ 0.4

- Global prevalence rates of substance use disorders were estimated to range from 0% to 3%, with the highest prevalence rates found in some countries of the Eastern Mediterranean Region. The median rate of prevalence of substance use disorders in the Region is 0.53% for males and 0.1% for females.

4.2. Most commonly used substances

The data provided in this section are mainly extracted from the world drug reports published every year by UNODC. These reports are based on the UNODC annual report questionnaire, UNODC estimates and in some cases governments' national reports. All prevalence estimates indicate the annual prevalence of use.

Findings

Prevalence estimates of most commonly used substances

Prevalence estimates of the most commonly used substances in the Region are as follows.

- Opiates³: 12-month prevalence estimates of opiates use among the population aged 15–64 years range from 0.02% to 2.0% with a median of 0.16%. The highest rate of opiate use in the world is seen in two countries of the Region.
- Cannabis⁴: 12-month prevalence estimates of cannabis use among the population aged 15–64 years range from 0.01% to 6.2% with a median of 3.2%.
- Amphetamine-type stimulants (ATS):⁵ 12-month prevalence estimates of ATS use among the population aged 15–64 years range from 0.10% to 0.50% with a median of 0.4%.

³ Estimates available for 12 countries.

⁴ Estimates available for 10 countries.

⁵ Estimates available for six countries.

- ATS use is perceived to be on the rise in two countries of the Region.
- *Khat* use is perceived to be on the rise in one country of the Region.⁶
- Cocaine: cocaine use is reported in four countries with the prevalence estimated at less than 0.10%. Two countries have reported a perceived increasing trend of cocaine use.

Primary drug of use among persons treated for substance use problems⁷

All the countries reported opiates among the substances used by persons seeking treatment; but as the leading substance responsible for treatment seeking, opiates are reported in 50% countries of the Region. Cannabis and ATS each were reported as the main substance used by persons seeking treatment in 25% of countries.

4.3 Trends and patterns

Drug injection is the most harmful pattern of substance use with major health consequences. Data on injecting drug use, prevalence of HIV and hepatitis C among injecting drug users, and the rate of contribution of injecting drug use in transmission of HIV are presented in this section.

Additionally, information on the trend and pattern of substance use among specific population groups, namely women and young people, are reported.

Findings

Injection and related hazards

- Heroin is the main substance used for injection⁸ followed by morphine⁹ and

⁶ *Khat* is not considered an amphetamine-type stimulant. However its chemical structure is more similar to this group of substances.

⁷ Data available for eight countries.

⁸ Data available for six countries.

⁹ Data available for two countries.

ATS.¹⁰ Tranquillizers/painkillers¹¹, buprenorphine¹² and cocaine¹³ are also used for injection.

- The prevalence estimates of HIV among injecting drug users ranges from 0.31% to 27.2% with a median of 7.1%.¹⁴
- The prevalence estimates of hepatitis C among drug users ranges from 11% to 63% with a median of 45%.¹⁵
- The prevalence estimates on contribution of drug injection in transmission of HIV among all routes of transmission ranges from 2.4% to 69.8% with a median of 28.30%.¹⁶
- Data on prevalence of tuberculosis among injecting drug users is scarce. The prevalence estimate of tuberculosis among injecting drug users is reported as 18% in one country in the Region.

Young people

Very limited data are available on the situation of substance use among young people¹⁷ in the Region.

- A decreasing trend of the age of first substance use is reported from a few countries of the Region. There are reports of starting substance use before 14 years and even at 11 years.¹⁸
- Cannabis is reported as the main substance used by young people aged between 15 and 25 years.¹⁹
- Heroin use among adolescents has been reported in three countries of the Region. The prevalence estimates of heroin use in

15–16 year olds were 0.09% and 3% in two countries of the Region.²⁰

Women

- Information on the situation of female drug users in the Region is scarce. In three countries an increasing trend of substance use among female drug users has been reported; however no reliable estimate is available.
- Opiates and pharmaceutical drugs like tranquillizers and painkillers are reported as the main substances of use by female drug users.

4.4 Monitoring and surveillance

The presence of national data collection systems is reported in this section. These systems are as follows.

1. *Epidemiological data collection system* refers to an organized epidemiological surveillance/monitoring system and/or data repository, which incorporate information from epidemiological studies and surveys on the prevalence of substance use and substance use disorders, and patterns of substance use (8).
2. *National service delivery data collection system* is the source for obtaining treatment data on inpatient and outpatient admissions and contacts (8).

In addition to data collection systems, the availability of national annual reports is also presented. An annual national report is a written report issued on a yearly basis by the government including information and data on psychoactive substance use, health or social services use, availability of resources for substance use disorders, and economic and any

¹⁰ Data available for two countries.

¹¹ Data available for two countries.

¹² Data available for one country.

¹³ Data available for one country.

¹⁴ Data available for nine countries.

¹⁵ Data available for seven countries.

¹⁶ Data available for six countries.

¹⁷ In the current report: people aged 25 years and younger

¹⁸ Data available for three countries.

¹⁹ Data available for four countries.

²⁰ Heroin use at least once during the preceding year.

Table 3. Existence of substance use monitoring and surveillance systems

Substance use monitoring and surveillance	Region (%)	World (%)
Epidemiological data collection system (%)	35.7	44.5
National substance use treatment data collection system (%)	42.9	49.0
National surveys on substance use among adolescences (%)	21.4	42.2
Annual reports	21.4	N/A

N/A: not available

other important information which is related to psychoactive substance use (8).

Table 3 summarizes data on monitoring and surveillance systems.

Findings

- In terms of having a national epidemiological data collection system, the Eastern Mediterranean Region and Western Pacific Region are jointly in third place among the six WHO regions.
- On presence of a national substance use treatment data collection system, the Region is ranked fifth among all WHO regions.
- The Region is ranked in fourth place with regard to conducting and publishing the results of national surveys on substance use among adolescents. The rate for the Region is about half of the global rates.
- Annual reports are published only by three countries (21.4%) of the countries of the Region examined in the report. Two of these three countries have national epidemiologic data collection systems and national substance use treatment data collection systems, but the data collected are not reported and published regularly.
- Major substances of use in the Region are cannabis, opioids and ATS. Opioids are particularly important as they contribute greatly to demand for treatment of substance use disorders in many countries of the Region. In addition to opioids, cannabis and ATS use also contribute significantly in treatment demands for substance use disorders. Any comprehensive planning for enhancing health services for drug users should consider these three substances and their specific treatment requirements.
- Data on the prevalence of drug injection is scarce. However, it has led to significant health hazards among drug users, including HIV and hepatitis C infection. Specialized services are required to meet the needs of drug users with a concomitant blood-borne infection.
- Scattered and scarce data are available on the situation of substance use among young people and women. Conducting surveys and studies on substance use among women is specifically challenging as it is a hidden phenomenon in many communities.
- Less than half of the countries of the Region have a system for collecting data on substance use disorders. Dissemination of information on substance use in the form of national reports is even less frequent. All efforts to collect data on substance use disorders need to be guided in a systematic way in order to generate core information for health interventions.

4.5 Conclusion

- The burden of substance use disorders is higher in the Eastern Mediterranean Region as compared to the other regions. This high burden highlights the importance of considering substance use disorders in health policy and planning for the countries of the Region.

5. Policy and legislation

A substance use policy refers to a written organized set of values, principles and objectives for reducing the burden attributable to substance use and substance use disorders in the population. This can be in the form of a separate policy for substance use, combined with an alcohol policy, or a component of mental health, alcohol and substance use policy (8).

A legislative provision that pertains to treatment and rehabilitation for persons with substance use disorders can serve a number of purposes, namely to regulate controlled substances that are used in treatment of substance use disorders such as methadone, to facilitate the referral of people from the criminal justice system to the treatment system and to provide for the structure of the treatment system. It can be in the form of a legislative provision for drug treatment and rehabilitation in mental health legislation, social care legislation or general health legislation (8).

Drug courts aim to stop drug abuse and related criminal activity of offenders through court-directed treatment and rehabilitation programmes. A judge manages the treatment programme for eligible participants to undergo treatment and rehabilitation programmes. Instead of traditional sanctions such as imprisonment, compliance to treatment is objectively monitored by frequent substance-abuse testing. Compliance is rewarded and non-compliance is sanctioned. There are also

other programmes that divert clients away from the criminal justice system into treatment (10).

Table 4 summarizes the data on policy and legislation.

Findings

The Eastern Mediterranean Region ranks third among the six WHO regions in having a written policy for substance use. Most of the countries have reported the existence of a written policy for substance use disorders.

- Special legislation for treatment and rehabilitation of substance use disorders exists in most countries of the Region, placing it second among all WHO regions.
- Legislation for compulsory treatment of substance use disorders is available in half of the countries of the Region, which is more than the global rate. The Region ranks fourth among all WHO regions with regard to this indicator.
- Presence of programmes diverting clients from the criminal justice system towards treatment is reported from more than half of the countries in the Region, which is higher than the global rate. The Region ranks third among all the WHO regions with regard to this indicator.
- The rate of presence of drug courts reported in the Region is higher than the global rate and all other regions.

Table 4. Availability of substance use policy and specific legislation on substance use

Policy and legislation	Region (%)	World (%)
Written policy for substance use	78.6	68.0
Presence of special legislation for the treatment and rehabilitation of substance use disorders	71.4	55.2
Legislation for compulsory treatment of substance use disorders	50.0	42.5
Programmes diverting clients from the criminal justice system towards treatment	57.0	52.5
Presence of drug courts	28.6	20.5

Conclusion

- The existence of drug policies in most countries is an asset. Regular review and update of these policies can create proper grounds for substance use disorders quality services with observance of the rights of patients.
- Special legislation for treatment and rehabilitation of substance use disorders can contribute to protecting the rights of drug users. Nonetheless, as substance use is considered a criminal act in most countries, legislation on compulsory treatments needs to be reviewed carefully to prevent breaches of the rights of drug users (11).
- The high rate of presence of drug courts and programmes diverting clients from the criminal justice system towards treatment should be interpreted with caution. Drug courts with standard criteria as defined by UNODC are less likely to be prevalent in the Region. Health professionals might not be very familiar with the definition and function of drug courts and it is possible that other judicial procedures related to drug users may have been reported as drug courts by the focal points that provided data for the Atlas.

6. Health services

Information on the organization and structure of the health services for substance use disorders are presented in this section. It shows how treatment services for clients with substance use disorders are organized and financed. Major components of health services reported in this section include:

- administration and financing
- treatment services
- treatment setting
- pharmacotherapy of substance use disorders
- human resources.

6.1 Administration and financing

In this section information on the presence of drug units, a specific budget line for substance use disorders treatment and the main financing methods for treating substance use disorders is presented.

A drug unit is a government unit responsible for policies, plans and programmes related to substance use disorders care and treatment services at national level. In this context, treatment services refer to both inpatient and outpatient treatment services (8).

A budget line allocated for management of substance use disorders is a regular source of funds available in the annual budget of the government which is allocated for actions directed towards care and treatment services for substance use disorders (8).

The main financing method for financing substance use disorders treatment refers to the most important financing method for patients to pay for substance use disorders care and treatment services, i.e. tax-based funding, hypothecated taxes, out-of-pocket payments, social health insurance, private insurance, financing by nongovernmental organizations, external grant or any other financing method which results in the highest treatment coverage of the population at the national level.

Table 5 summarizes the data on administration and financing.

Findings

- Most countries of the Region have a drug unit or an official dealing with substance use disorders. The rate reported for the Region on this indicator is higher than the global rate and comparable to the highest rates reported from other WHO regions.
- Globally, less than half of the countries have a budget line specifically for management of substance use disorders.

Table 5. Existence of a drug unit, specific budget line for substance use disorders, and financing method for management of substance use disorders

Administration and financing method	Region (%)	World (%)
Presence of a drug unit ^a	78.6	66.2
A budget line allocated for management of substance use disorders	42.8	45.8
Main financing method for financing substance use disorders treatment:		
out-of-pocket payment	45.5	26.2
tax-based funding	18.2	37.7
social health insurance	9.1	18.5
other methods ^b	27.3	9.2

^a Two (14%) countries reported that a mental health unit covers substance use disorders as well.

^b E.g. subsidizing treatment services by the government.

The rate for the Region is less than the global rate; it ranks fifth among all WHO regions on this indicator.

- Out-of-pocket payment is the most common method for financing treatment of substance use disorders in the Region. The share of out-of-pocket payment in financing substance use disorders treatment in the Region is higher than in all other WHO regions.
- The rate of countries in the Region which use tax-based funding is almost half of the global rate, and this method is least used in the Region compared to other WHO regions.
- In the Region, the share of social health insurance as a financing method for substance use disorders treatment services is low yet comparable to the other WHO regions.

Conclusion

- The presence of drug units in most countries of the Region could be an opportunity for promoting evidence-based substance use disorders policies and plans. It is also crucial to strengthen the technical capacity of these units based on the latest developments in the areas of policy and legislation for substance use treatment and rehabilitation.
- Despite the high rate of presence of drug units in the Region, the absence of a

budget line for substance use disorders might undermine the units' endeavours in planning and programming for treatment services.

- Out-of-pocket payment as the main method of financing substance use disorders treatment in the Region might restrict the access to treatment services due to their high cost for service users.

6.2 Treatment services

The rate of presence of treatment services for substance use disorders in the Region and the respective global rate are presented in this section. The section also presents the most important sectors responsible for providing each service. Treatment services can be either on an inpatient or outpatient basis or long-term residential rehabilitation services.

In the context of substance use disorders, services may offer detoxification treatment and opioid substitution treatment, which is also called opioid agonist maintenance therapy.

Few studies are available about the coverage of substance use disorders treatment services in the Region. However, the results of assessments in two countries of the Region indicate a 90% treatment gap for substance use disorders and even higher for female drug users (12,13).

Table 6 summarizes the data on treatment services.

Table 6. Treatment services and sectors for substance use disorders

Treatment services	Region (%)	World (%)	Treatment sector			
			Public health (%)	Social care (%)	Private (%)	Nongovernmental organizations (%)
Inpatient medical detoxification	92.8	90.5	78.5	7.0	7.0	–
Outpatient treatment	64.0	72.4	50.0	7.0	7.0	–
OST ^{a,b}	14.3	44.6	7.1	–	7.1	–
Long-term rehabilitation	35.7	59.3	28.5	–	7.1	7.1

^a Two countries in the Region have reported launching OST as pilot projects.

^b Figures indicating the rates in community; however OST is available in prison setting in one country.

Table 7 presents figures about the number of inpatient and outpatient treatment beds and slots for clients with substance use disorders and the median of average stay of patients in inpatient detoxification services.

Findings

- Inpatient detoxification services in the Region are similar to almost all other regions of WHO and are available in over 90% of countries.
- Outpatient treatment, mostly abstinence-oriented, is less prevalent than inpatient treatment in all WHO regions including the Eastern Mediterranean Region. The Region ranks fourth among all the regions in this indicator.
- The rate for presence of opioid substitution treatment programmes in the Region is about one-third of the global rate, which puts the Region in fifth place.
- The availability of long-term residential rehabilitation services in the Region is less than in other WHO regions.
- The rate of availability of treatment beds in the Region is about one-third of the

global rate which puts the Region in the fifth place among all WHO regions.

- The median length of stay for inpatient detoxification is 10.5 days, which is less than the global rate and the shortest among all WHO regions.

Conclusion

- Inpatient treatment for substance use disorders is much more frequent than outpatient treatment in the Region. There is hardly any evidence in favour of inpatient treatment over outpatient treatment for substance use disorders. The high cost of inpatient treatment limits the access to treatment services for many drug users (14).
- The rate of availability of treatment beds for substance use disorders in the Region is less than in other WHO regions. This can contribute to the low rate of coverage of existing substance use disorders treatment services.
- The rate of presence of opioid substitution treatment programmes in the Region is low. Robust evidence supports opioid substitution treatment

Table 7. Treatment beds and slots for substance use disorders

Treatment slots and beds	Region (%)	World (%)
Treatment slots (median) ^a	0.1	N/A
Treatment beds (median) ^b	0.6	1.7
Median length of stay for inpatient detoxification (days)	10.5	14

^a Treatment slots per 10 000 population. The figure is for substance use disorders and alcohol use disorders.

^b Treatment beds per 100 000 population. The figure is for substance use disorders and alcohol use disorders.

N/A: not available

as an essential element of substance use disorders treatment services. It is highly recommended to include opioid substitution treatment in substance use disorders treatment packages (15).

- The rate of presence of long-term residential rehabilitation services for rehabilitation of drug users is low in the Region. It is evident that drug users who especially have severe drug use problems benefit from these services (16,17). Expansion of these services should be considered while programming for substance use disorders treatment services.

6.3 Treatment setting and specialized services

This section presents the most common settings for providing substance use disorders treatment and the specialized treatment services for patients with both substance use disorders/HIV and substance use disorders/tuberculosis. In the context of this report these settings are categorized as: specialized, general health care, mental health care and primary health care.

In the context of this report services specialized for populations with specific needs and/or for people difficult to reach are reported separately.

The data on treatment settings and specialized services are summarized in Tables 8 and 9.

Findings

Treatment setting

- The main setting reported by the countries of the Region for providing substance use disorders treatment services is mental health care services. The rate for the Region is higher than the global rate.
- Specialized services are the most common setting for providing substance use disorders treatment services in 50% of countries globally, which is about twice the reported rate from the Region.
- Providing services in a general health care setting is not widespread globally. The rate in the Region is about twice the global rate.
- No country in the Region has reported providing substance use treatment services in a primary health care setting.

Table 8. Treatment settings providing services for substance use disorders

Treatment setting	Region (%)	World (%)
Integrated into mental health care	50.0	32.4
Specialized	28.6	51.5
Integrated into general health care	14.3	7.4
Integrated into public health care	0.0	6.6
Other	7.1	2.2

Table 9. Presence of specialized treatment services for special populations

Specialized services	Region (%)	World (%)
Pregnant women	7.7	31.0
Young people	23.1	47.6
Indigenous people	7.7	11.0
Prisoners	53.8	55.9
Injecting drug users	38.5	40.0
Commercial sex workers	15.4	25.5
Substance use disorders and HIV/AIDS	57.1	43.2
Substance use disorders and tuberculosis	28.6	24.6

Specialized treatment services

- The Region is ranked last among all WHO regions in terms of having specialized substance use disorders treatment services for:
 - pregnant women; the rate for the Region is about one-quarter of the global rate
 - young people; the rate for the Region is about half of the global rate
 - commercial sex workers.
- The Region ranks fifth among all WHO regions in having specialized services for indigenous people; nevertheless the rate is comparable to the global rate.
- The Region is ranked fourth among all WHO regions in terms of having specialized substance use disorders treatment services for:
 - prisoners; these services are available in more than half of the reporting countries in the Region, which is close to the global rate.
 - injecting drug users; the rate of the availability of these services is close to the global rate.
- The Region ranks third among all WHO regions in terms of having specialized treatment services for the following persons. The reported rate for the Region for both is more than the global rate:
 - persons with both substance use disorders and HIV/AIDS (available in more than half of the countries of the Region)
 - persons with both substance use disorders and tuberculosis (available in about one-third of the countries of the Region).

Conclusion

- Mental health care and specialized settings are the main settings for providing substance use disorders treatment

services. Some challenges underscore the importance of integration of substance use treatment services into general and primary health care in the Region including: high burdens caused by substance use, a huge treatment gap for substance use disorders, and having out-of-pocket payment as the main financing method for substance use treatment services.

- Treatment services for people with special needs, vulnerable groups and marginalized people are not adequate in the Region. This shortfall is particularly grave for young people and pregnant women, who are much more vulnerable to long-term consequences of substance use.
- Commercial sex workers are the other group who are deprived of substance use disorders treatment services, probably because of the highly stigmatized nature of sex work.

6.4 Pharmacotherapy of substance use disorders

Information on the medicines used for opioid detoxification, opioid substitution treatment and treatment of withdrawal syndrome, and also availability of policy guidelines and framework for the pharmacotherapy of substance use disorders are presented here.

A policy framework and document are necessary to regulate medicines with the potential of abuse; some of them are used in treatment of substance use disorders, including opioid agonists and benzodiazepines (8).

A guideline on the pharmacological treatment of substance use disorders refers to a document guiding decisions and setting criteria for diagnosis, management and treatment of persons with substance use disorders (8).

Table 10 summarizes the data on pharmacotherapy.

Table 10. Availability of policy guideline and framework for pharmacotherapy and the medications used for treatment of substance use disorders

Pharmacotherapy	Region (%)	World (%)
Policy guideline and framework		
Treatment policy document	42.9	40.2
Treatment guidelines	50	51.8
Medicines		
Availability of methadone	21.4	41.6
Methadone for treatment of opioid withdrawal	14.3	33.3
Methadone for maintenance treatment (syrup) ^a	7.1	30.6
Buprenorphine	14.3	27.7
Buprenorphine/naloxane	0.00	20.8
Naloxane/naltroxane	21.4	N/A
Benzodiazepines	57.1	N/A
Antidepressants	14.3	N/A

^a Two countries have started prescription of methadone for maintenance treatment as pilot projects.

Findings

- The proportion of countries in the Region having treatment policy documents is higher than the global rate which places the Region in the second rank on this indicator.
- Guidelines on the pharmacological treatment of substance use disorders exist in half of the countries of the Region. This rate is close to the global rate and places the Region in fourth place jointly with the WHO South-East Asia Region.
- The rate for availability of methadone for treatment of opioid dependence is half of the global rate and less than most other regions. The Region is in fifth place among all WHO regions.
- In the Region the rate of availability of methadone for maintenance treatment is less than one-quarter and for treatment of opioid withdrawal is less than half of the global rates.
- The rate for availability of buprenorphine for treatment of opioid dependence is about half of the global rate. The Region is in fourth place among all WHO regions.
- More than half of the countries in the Region use benzodiazepines for management of withdrawal symptoms. A

few countries use antidepressants for this purpose.

Conclusion

- The presence of treatment policy documents and guidelines in many countries in the Region provide an opportunity to enhance the quality of services. It is crucial to review and update these documents regularly to ensure availability of most effective and evidence-based treatment options for substance users.
- Opioid agonists, either methadone or buprenorphine, are not available in most countries of the region, which is a major problem.
- The absence of buprenorphine/naloxone for the pharmacotherapy of substance use disorders is another shortcoming of the treatment systems in the Region. There is also no information on the availability of α_2 adrenergic agonists like clonidine which are listed as the treatment of choice in the WHO guideline for opioid withdrawal symptoms (15).

6.5 Human resources

Health workers involved in treating persons with substance use disorders have different

professional backgrounds. The level of involvement of each professional category in providing treatment services varies between different countries. Table 11 shows the rate of presence of each professional category in the Region, but does not indicate the level of involvement of each professional category in providing treatment services.

The information on nongovernmental organizations and self-help groups working in areas of treatment, prevention and rehabilitation of substance use disorders is also presented in this section. Nongovernmental organizations can have a major role in strengthening the response of countries to substance use disorders, especially in prevention and rehabilitation and to some extent in treatment.

With regard to self-help groups, the data for Narcotics Anonymous are presented in this section. Self-help groups can have a major impact in maintaining long-lasting recovery for persons with substance use disorders.

Tables 11–13 summarize the data on human resources.

Findings

- Psychiatrists and addictologists/narcologists have a major role in providing treatment services for substance use disorders in the Region, which is similar to the global pattern.
- General practitioners are less involved in substance use disorders treatment services compared to global rates.
- The presence of nongovernmental organizations in areas of treatment, prevention and rehabilitation is less prominent in the Region than in other WHO regions. In the Region nongovernmental organizations are more involved in prevention than treatment and rehabilitation activities.

Table 11. Health professionals involved in treatment of substance use disorders

Health professionals	Percentage
Psychiatrists	71.4
Psychologists	50.0
General practitioners	35.7
Addictologists/narcologists	28.6
Social workers	28.6
Psychiatric nurses	21.4
Primary health care workers	14.3
Addiction counsellors	7.1
Other ^a	7.1

^a Major involvement of religious leaders and traditional healers in providing treatment services is reported from one country.

Table 12. Front line health professionals involved in treatment of substance use disorders

Front line professionals in treatment of substance use disorders	Region (%)	World (%)
Psychiatrists	42.8	35
Addictologists/narcologists	28.6	10
General practitioners	7.1	10

Table 13. Nongovernmental organizations and self-help groups involved in treatment of substance use disorders

Nongovernmental organizations and self-help groups	Region (%)	World (%)
Involved in treatment services only	42.9	59.9
Involved in prevention only	71.4	81.8
Involved in rehabilitation only	57.1	70.7
Self-help group (Narcotics Anonymous)	42.9	56.7

Conclusion

- The health workers involved in treatment of substance use disorders in the Region are mostly mental health specialists. Considering the huge treatment gap for substance use disorders, with proper training and supervision, general practitioners and other groups of health care workers can contribute much more in providing treatment services for substance use disorders and bridging the treatment gap.

- The involvement of nongovernmental organizations and self-help groups in care and treatment for substance use disorders is low in the Region. The countries of the Region may wish to consider strengthening the role of nongovernmental organizations while planning for health services for substance use disorders. With appropriate support and guidance, these entities can collaborate effectively with other health services in reducing the treatment gap.

7. Prevention and harm reduction

7.1 Groups and agencies

Different groups and agencies such as religious groups, traditional healers, social workers, schools, community groups, employers, labour organizations, health care workers, law enforcement agencies and international organizations are involved in the prevention activities for substance use in the countries of the Region.

Table 14 summarizes the data on groups and sectors involved in prevention programmes.

Table 14. Presence of groups and sectors involved in substance use prevention programmes

Groups and sectors involved in prevention programmes	Region (%)	World (%)
Religious groups	71.4	N/A
Traditional healers	28.6	N/A
Social workers	35.7	N/A
Schools	71.4	78.1
Community groups	35.7	49.3
Employers	7.1	29.5
Labour organizations	0.0	19.2
Health care workers	71.4	N/A
Law enforcement agencies	57.4	68.5
International organizations	50.0	56.8

Findings

- Groups and agencies with most involvement in prevention programmes in the Eastern Mediterranean Region are religious groups, schools, health care workers and law enforcement agencies.
- Compared to the other WHO regions, law enforcement agencies are less involved in prevention activities in the Region.
- The rate of presence of international organizations in prevention programmes across WHO regions, including the Eastern Mediterranean Region, is around 50% except for the South-East Asia Region (90%).
- Labour organizations are not involved in prevention programmes in the Region.
- The presence of employers in prevention activities in the Region is lowest among all WHO regions.

Conclusion

- Different groups and agencies are involved in prevention programmes in the Region. The approaches being followed are not documented and assessed and it is not clear whether these approaches are evidence-based.

7.2 Prevention services

The presence of three major prevention programmes, school-based programmes, community-based programmes and workplace programmes, are reported in this section.

Table 15 summarizes the data on major prevention services.

Table 15. Presence of major prevention services

Prevention services	Region (%)	World (%)
School-based programme	76.9	77.9
Community-based programme	61.5	68.5
Work-place programmes	46.2	58.6

Findings

- Except for the African Region, the proportion of countries with school-based programmes for prevention of substance use disorders in all WHO regions, including the Eastern Mediterranean Region, is about 80%.
- The Region is in the fifth place among all WHO regions in terms of having community-based programmes for prevention of substance use disorders.
- Work-place programmes exist in less than half countries of the Region; a rate that is less than all WHO regions.

Conclusion

- School-based prevention programmes need to be focused on and evaluated with special concern. Without an evidence-informed approach and systematic evaluation, these programmes can be ineffective or even counterproductive.
- Evidence-based work-place and community-based programmes need to be promoted in the Region.

7.3 Prevention programmes for specific populations

The main target for prevention programmes is the general population. However, there are certain population groups with specific needs that are equally important from a public health perspective as often either the mainstream services are not easily accessible for them or do not address their needs. The presence of specific prevention programme for these groups is reported in this section.

Table 16 summarizes the data on such prevention programmes.

Findings

- Prevention programmes for prisoners and children and adolescents are the most reported programmes in the Region.

Table 16. Presence of substance use prevention programmes for specific populations

Prevention programmes for specific populations	Region (%)	World (%)
People living with HIV/AIDS	21.4	41.1
Prisoners	42.9	43.2
Indigenous populations	14.3	N/A
Commercial sex workers	21.4	29.5
Children and families at risk	14.3	45.2
Minority groups	7.1	17.8
Refugees	7.1	N/A
Children and adolescents	57.1	N/A
Pregnant women	0	32.2

- The reported rate of presence of prevention programmes for prisoners places the Region in third place among all WHO regions.
- Globally, the proportion of countries that have prevention programmes for commercial sex-workers is low. The reported rate for the Region puts it in fifth place among all WHO regions.
- Prevention programmes for people living with HIV in the Region is about half of the global rate, which places it last among all WHO regions.
- The rate of prevention programmes for minority groups and children and families at risk is low in the Region, which puts it in sixth place among all WHO regions.
- There are no prevention programmes aimed at pregnant women in the Region.

Conclusion

- Prevention programmes for specific populations, representing most-at-risk and vulnerable groups, are limited in the Eastern Mediterranean Region. Prevention programmes need to be tailored to the needs of these populations.
- The high rate of contribution of drug injection in spreading HIV infection in the Region calls for the development of prevention programmes tailored to the

needs of people living with HIV, which seems inadequate now.

7.4 Screening, brief interventions and harm reduction programmes

Screening and brief intervention programmes are recommended in WHO guidelines as effective interventions in reducing substance use and its associated harms (5).

Harm reduction programmes for injecting drug users in a country can be provided both in community and in prison settings. These programmes include: needle and syringe exchange programmes in the community, needle and syringe exchange programmes in prisons, supervised injection facilities, outreach services, naloxone distribution, bleach distribution in the community or bleach distribution in prisons. Opioid substitution treatment is also considered as a harm reduction measure, implemented at community and prison level.²¹ In this report the related information on opioid substitution treatment is presented in the treatment services and pharmacotherapy for substance use disorders sections.

Table 17 summarizes the data on harm reduction programmes.

Findings

- Only three countries in the Region (21.4%) reported using screening and brief intervention programmes, which is the lowest level among all the WHO regions. The global rate for implementation of screening and brief intervention programmes is 46.2%.
- The reported rate of the availability of community-based needle and syringe programmes is higher than the global rate. The Region is in third place on this

²¹ In-prison medical treatment of substance use disorders including methadone maintenance treatment and detoxification is available in one country.

Table 17. Presence of harm reduction programmes in community and prison setting

Harm reduction programmes	Region (%)	World (%)
Community-based needle and syringe programme ^a	42.8	41.1
In-prison needle and syringe programme	14.3	6.6
Outreach services	14.3	N/A

^a Pharmacies are the major source for injecting drug users to obtain their syringes in one country.

indicator. The Eastern Mediterranean Region and European Regions are the only WHO regions that reported having in-prison needle and syringe programmes.

Conclusion

- Screening and brief intervention programmes are implemented on a limited scale in the Region. The Region could benefit from extension of these interventions into primary health care. These programmes can be implemented with low costs and by minimum training of health care workers within the primary health care setting. Adopting screening and brief interventions programme by the primary health care system can be the first step in the region for integrating the services for substance use. This approach could also be beneficial in increasing the access of all population groups to substance use disorders treatment services and reducing the treatment gap (5).
- Needle and syringe programmes are present in almost half of the reporting countries of the Region. This creates a good opportunity for all the countries of the Region to develop similar programmes by adopting the existing models of services in the Region.
- Prison inmates are especially vulnerable to the consequences of substance use including HIV infection through sharing paraphernalia for injections. Harm

reduction programmes in a prison setting, including needle and syringe programmes and opioid substitution treatment, can be effective in reducing HIV infection

among prisoners and subsequently in the larger community. However, it should be taken into account that provision of these services in prison settings requires specific legislation and reforms in the judiciary system (18).

References

1. *Atlas on substance use 2010. Resources for the prevention and treatment of substance use disorders*. Geneva, World Health Organization, 2010.
2. *Mental health systems in the Eastern Mediterranean Region*. Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2010.
3. *Regional health observatory [online database]*. Cairo, Health Organization, Regional Office for the Eastern Mediterranean, 2012. (<http://rho.emro.who.int/rhodata/>)
4. *World health statistics 2012*. Geneva, World Health Organization, 2012.
5. *Screening and brief intervention for hazardous and harmful substance use*. Geneva, World Health Organization, 2010.
6. *The global burden of disease 2004 update*. Geneva, World Health Organization, 2008.
7. *Global health risks: mortality and burden of disease attributable to selected major risks*. Geneva, World Health Organization, 2009.
8. *Global health observatory, data repository. Resources for substance use disorders [online database]*. Geneva, World Health Organization, 2012. (<http://apps.who.int/gho/data/node.main.RSUD?lang=en>)
9. *International Statistical Classification of Diseases and Related Health Problems 10th Revision*. Geneva, World Health Organization, 2010. (Available at: <http://apps.who.int/classifications/icd10/browse/2010/en>)
10. *UNODC and drug treatment courts (drug courts)*. Vienna, United Nations Office on Drugs and Crime, 2009. (http://www.thinkers.sa.gov.au/lib/pdf/Hora/Hora_UNODC_and_Drug_Treatment_Courts.pdf. Accessed 24 April 2013.)
11. *Assessment of compulsory treatment of people who use drugs in Cambodia, China, Malaysia and Viet Nam: an application of selected human rights principles*. Manila, World Health Organization, Regional Office for the Western Pacific, 2009.
12. *Drug use survey in Afghanistan: 2009 survey*. United Nations Office on Drug and Crime, 2009.
13. *Substance use and dependence*. Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2005. Technical paper presented to the Fifty-second session of the Region Committee for the Eastern Mediterranean (document no. EM/RC52/R.5).
14. Day E, Strang J. Outpatient versus inpatient opioid detoxification: a randomized controlled trial. *Journal of substance abuse treatment*, 2011, 40(1):56–66.
15. *Guidelines for the psychosocially assisted pharmacological treatment of opioid dependence*. Geneva, World Health Organization, 2009.

16. *Treatment approaches for drug addiction*. Bethesda, Maryland, National Institutes of Drug Abuse (NIDA), 2009. (http://www.drugabuse.gov/sites/default/files/if_treatment_approaches_2009_to_nida_92209.pdf. Accessed 23 April 2013.)
17. *Contemporary drug abuse treatment. A review of the evidence base*. Vienna, United Nations Office on Drugs and Crime, 2002.
18. *HIV/AIDS prevention, care, treatment and support in prison settings: a framework for an effective national response*. Geneva, World Health Organization and the Joint United Nations Programme on HIV/AIDS, 2006.

**Country fact sheets:
substance use disorders**

Abbreviations

ATS	amphetamine-type stimulant
DALY	disability-adjusted life year
HCV	hepatitis C virus
HIV	human immunodeficiency virus
IDU	injecting drug use
MMT	methadone maintenance treatment
OST	opioid substitution treatment
SUD	substance use disorder

Afghanistan

I. Demographic information	Year of report		
Total population (000s)	2010	26 500 ¹	
Population ≤ 15 years (%)	2010	46 ¹	
Annual population growth rate (%)	2000–2010	2.6 ¹	
Population living in urban areas (%)	2010	23 ¹	
Life expectancy at birth (years)	2009	63 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005	27 ¹	
General government expenditure on health as % of total government expenditure	2009	2 ¹	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	33.1 ²	
Age-standardized DALYs for SUD per 100 000	2008	865 ²	
Prevalence estimates for SUD, point prevalence (%), > 15 years	2004	Males	Females
		0.92	0.10 ²
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> The annual prevalence of regular opiate use is estimated to be 2.7% of the adult population (between 290 000 and 360 000 persons).³ Opium is by far the most commonly used opiate with an estimated prevalence of about 1.9% of the adult population.³ The number of heroin users has increased almost 2.5 times between 2005 and 2009.³ The percentage of drug users who give opium to family members is about 15%; and the percentage of drug users who give opium to children is about 30%.³ 			
Cannabis			
<ul style="list-style-type: none"> Cannabis is the most commonly used illicit substance in the country.³ Around 60% of all drug users have used cannabis in their lifetime.³ The annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 4.3%.⁴ 			
Cocaine			
<ul style="list-style-type: none"> The annual prevalence of cocaine use as a percentage of the population aged 15–64 years is estimated to be less than 0.1%.⁴ 			
Amphetamines			
<ul style="list-style-type: none"> The annual prevalence of amphetamine-type stimulant use as a percentage of the population aged 15–64 years is estimated to be less than 0.1%.⁴ 			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	Heroin and morphine ³		
Drug users who have injected at least once during their lifetime (%)	6 ³		
Drug users who have shared injection paraphernalia (%)	87 ³		
HIV prevalence among IDUs (%)	7 ⁵		
HCV prevalence among IDUs (%)	36.6 ⁶		
II. Young people			
<ul style="list-style-type: none"> Compared to other substances, people start using cannabis at a much earlier age, typically around 18 or 19 years. In comparison, the mean age for first heroin use is 24 years.³ The substances most commonly used among adolescents are cannabis, opium and heroin.³ The substances commonly used among children are opium, tranquilizers and cannabis.³ 			
III. Women			
<ul style="list-style-type: none"> Substances most commonly used among women are opium, tranquilizers and opioids (painkillers).³ The prevalence of substance use has increased among female population from 2.1% percent in 2005 to 3% in 2009.³ Use of unprescribed tranquilizers is twice as likely among female drug users as male drug users, and most female users are daily users.³ 			

D. Monitoring and surveillance		
National data collection system	Epidemiological and service delivery data collection system ²	
National surveys on substance use among adolescents	Yes ²	
Annual reports	Yes ²	
3. Policy and legislation		
Substance use policy	Yes ²	
• The policy was initially formulated in 1988. A new policy on drug demand reduction was formulated in 2002. ⁷		
Special legislative provision		
• Treatment and rehabilitation for people with SUD	Yes ²	
• Compulsory treatment for people with SUD	No ²	
Presence of drug courts in the country	No ²	
Availability of programmes which divert clients away from the criminal justice system towards treatment	No ²	
• The coordination and legislation body for substance use is the Ministry of Counter Narcotics. ⁸		
• The last approved drug control legislation in Afghanistan was enacted in 1970 and considered a drug addict a criminal and subjected a person to imprisonment and monetary fines. The legislation also has provisions for treatment and prevention of substance abuse. ⁹		
4. Health services		
A. Administration and financing		
Government unit responsible for prevention and treatment services for SUD	Yes, in the Ministry of Public Health ²	
Budget line in annual budget of government for SUD prevention and treatment services	Yes ²	
Most important financing method for treatment services	Out-of-pocket payment ²	
B. Treatment sectors and services		
I. Treatment services		
	Availability	Sector
Inpatient medical detoxification	Yes	Public health ²
Outpatient medical detoxification	No	–
Substitution maintenance therapy of opioid dependence	Opioid substitution treatment started as a pilot project in 2010 with evidenced effective outcomes. ¹¹	
Long-term rehabilitation	–	–
Implementation of screening/brief intervention in primary care	No ²	
II. Treatment system		
Availability of treatment policy document and guidelines:	Yes ²	
A standard treatment guideline was developed in 2006 and currently it is under review. ⁸		
Treatment system for SUD	Specialized treatment system ²	
Specialized services for:		
• SUD and HIV/AIDS	Yes ²	
• SUD and tuberculosis	No ²	
Treatment slots		
• Outpatient treatment slots (per 10 000)	–	
• Hospital beds (per 100 000)	–	
• Length of stay for inpatient detoxification (days)	–	
• About 90% of drug users do not receive any treatment. ³		
• Only 4% of female drug users and their partners have access to treatment services. ³		

C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		Minor tranquilizers Naloxane Antidepressants ⁸	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: As a pilot project ¹¹	–	✓	–
• Buprenorphine: No	–	–	–
D. Human resources			
Health professionals		Psychiatrists Social workers (Psychiatric) nurses ¹⁰	
Health professionals mostly involved in treatment of SUD		Psychiatrists ²	
Nongovernmental organizations for treatment		Yes ²	
Nongovernmental organizations for prevention		Yes ²	
Nongovernmental organizations for rehabilitation		Yes ²	
Self-help groups for SUD: Narcotics Anonymous		No ²	
Specific trainings are provided for professionals on detoxification, counselling, after care services, rehabilitation and occupational therapy. ⁸			
Minimum standards of care are under development by Ministry of Counter Narcotics and Ministry of Public Health. ⁸			
5. Prevention and harm reduction			
A. Prevention			
Groups and sectors involved in prevention programmes		Religious groups Traditional healers Social workers Schools Health care workers Law enforcement agencies International organizations ²	
Programmes for specific populations		Children and adolescents ²	
B. Harm reduction programmes			
Availability		Yes ²	
Services		Needle and syringe exchange programmes in the community Needle and syringe exchange programmes in prisons ²	

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *Drug use survey in Afghanistan: 2009 survey*. New York, United Nations Office on Drug and Crime, 2009.

⁴ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁵ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. Ministry of Public Health, Communicable Disease Directorate (CDC), 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁶ Todd SC et al. HIV, hepatitis C, and hepatitis B infections and associated risk behavior in injection drug users, Kabul, Afghanistan. *Emerging infectious diseases*, 2007, 13(9):1327–31.

⁷ *Mental health in the Eastern Mediterranean Region: reaching the unreached*. Cairo, Regional Office for the Eastern Mediterranean, World Health Organization, 2006.

⁸ National focal point at the Afghan Ministry of Public Health (Personal communication 2012).

⁹ *Islamic Republic of Afghanistan Counter Narcotics Drug Law*, [Afghanistan], 2005. <http://www.unhcr.org/refworld/docid/4c1f343b2.html>. Accessed 25 April 2013.

¹⁰ *HIV-AIDS Coordinating Committee of Afghanistan (HACCA) newsletter*. National AIDS Control Programme, April 2011, issue 16.

Bahrain

I. Demographic information		Year of report	
Total population (000s)	2010	1 235 ¹	
Population ≤ 15 years (%)	2010	20 ¹	
Annual population growth rate (%)	2000–2010	5.8 ¹	
Population living in urban areas (%)	2010	100 ¹	
Life expectancy at birth (years)	2009	76.4 ¹	
Adult literacy rate (%) aged ≥15 years	2005–2010	93.5 ¹	
General government expenditure on health as % of total government expenditure	2009	11 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	0.5 ²	
Age-standardized DALYs for SUD per 100 000	2008	78 ²	
Prevalence estimates for SUD, point prevalence (%), > 15 years	2004	Males	Females
		0.44	0.07 ²
<ul style="list-style-type: none"> A situation analysis conducted by UNDP in 2006 estimated the total number of drug users in Bahrain to be 20 000–30 000³ 			
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> The annual prevalence of opiate use is estimated to be 0.3% of the population aged 15–64 years.⁴ Opiates are the primary substance of use for almost 100% of patients treated for SUD.⁴ Opiates are the main cause of substance use related deaths (44.3 deaths per million people aged 15–64 years).⁵ 			
Cannabis			
<ul style="list-style-type: none"> The extent of cannabis use is considerable and the trend is rising. The annual prevalence of cannabis abuse is estimated to be 0.4% of the population aged 15–64 years.⁴ 			
Cocaine			
<ul style="list-style-type: none"> The annual prevalence of cocaine use as a percentage of the population aged 15–64 years is estimated to be less than 0.1%.⁴ 			
Amphetamines			
<ul style="list-style-type: none"> The annual prevalence of amphetamine use is estimated to be 0.1% of the population aged 15–64 years.⁴ 			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	Heroin (the most prevalent), amphetamine-type stimulants and cocaine		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	–		
HCV prevalence among IDUs (%)	–		
<ul style="list-style-type: none"> The primary mode of HIV transmission is injecting drug use, accounting for 58.1% of the total identified cases.³ The prevalence of HIV on mandatory screening for admission of drug users for rehabilitation was 3.3% in 2010; however, these data are not representative of the total population of IDUs.³ 			
II. Young people			
III. Women			
D. Monitoring and surveillance			
National data collection system	No ²		
National surveys on substance use among adolescents	No ²		
Annual reports	Yes ²		

3. Policy and legislation			
Substance use policy			Yes ²
Special legislative provision			
• Treatment and rehabilitation for people with SUD			Yes ²
• Compulsory treatment for people with SUD			Yes ²
Presence of drug courts in the country			No ²
Availability of programmes which divert clients away from the criminal justice system towards treatment			No ²
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	No ²		
Most important financing method for treatment services	Other ²		
B. Treatment sectors and services			
I. Treatment services	Availability	Sector	
Inpatient medical detoxification	Yes	Public health ²	
Outpatient medical detoxification	Yes	Public health ²	
Substitution maintenance therapy of opioid dependence	No ²	–	
Long-term rehabilitation	No ²	–	
Implementation of screening/brief intervention in primary care	No ²		
II. Treatment system			
Availability of treatment policy document and guidelines:	Yes ²		
Treatment system for SUD	Specialized treatment system for alcohol and substance use disorders integrated in mental health care ⁷		
Specialized services for:			
• SUD and HIV/AIDS	No ²		
• SUD and tuberculosis	No ²		
Treatment slots			
• Outpatient treatment slots (per 10 000)	2.5 ²		
• Hospital beds (per 100 000)	3.4 ²		
• Length of stay for inpatient detoxification (days)	30 ²		
C. Pharmacotherapy of substance use disorders			
Essential list of medicines	Yes ²		
Pharmacotherapy for opioids detoxification	Methadone Benzodiazepines (diazepam) Antipsychotics/neuroleptics (haloperidol) ⁶		
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: Yes ²	✓	–	Tablet
• Buprenorphine: No ²	–	–	–
D. Human resources			
Health professionals	–		
Health professionals mostly involved in treatment of SUD	–		
Nongovernmental organizations for treatment	No ²		
Nongovernmental organizations for prevention	No ²		
Nongovernmental organizations for rehabilitation	No ²		
Self-help groups for SUD: Narcotics Anonymous	Yes ²		

5. Prevention and harm reduction	
A. Prevention	
Groups and sectors involved in prevention programmes	Religious groups Schools Health care workers Law enforcement agencies ²
Programmes for specific populations	People living with HIV/AIDS Children and adolescents ²
B. Harm reduction programmes	
Availability	No ²
Services	–

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. National Committee for the Prevention of AIDS (NACP), Bahrain, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁴ *World drug report 2007*. Vienna, United Nations Office on Drugs and Crime, 2007.

⁵ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.

⁶ *Atlas on substance use resources for the prevention and treatment of substance use disorders: Bahrain*. World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/bahrain.pdf

Egypt

I. Demographic information		Year of report	
Total population (000s)	2010	80 410 ¹	
Population ≤ 15 years (%)	2010	32 ¹	
Annual population growth rate (%)	2000–2010	2.4 ¹	
Population living in urban areas (%)	2010	42.9 ¹	
Life expectancy at birth (years)	2009	73.2 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	70.4 ¹	
General government expenditure on health as % of total government expenditure	2009	6 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	13.5 ²	
Age-standardized DALYs for SUD per 100 000	2008	503 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		1.30	0.46 ²
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> The main African country to have reported opium consumption is Egypt.³ There are no reports or data to indicate that the opium consumed in Egypt is trafficked from another country. This may suggest the existence of illicit cultivation in Egypt.³ The annual prevalence of opiate use as a percentage of the population aged 15–64 years is estimated to be 0.44%.³ 			
Cannabis			
<ul style="list-style-type: none"> The annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 6.2%.³ 			
Cocaine			
<ul style="list-style-type: none"> The annual prevalence of cocaine use as a percentage of the population aged 15–64 years is estimated to be less than 0.1%.³ 			
Amphetamines			
<ul style="list-style-type: none"> The annual prevalence of amphetamine use among the population aged 15–64 years is estimated to be 0.5%.³ 			
Primary substances of use among patients treated for SUD are cannabis (50.1%), opiates (42.7%) and ATS (7.2%). ⁴			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	Sharing needles during the past 30 days among a sample of IDUs in Cairo and Alexandria was estimated to be 22.9% and 40.5% respectively (BBSS 2010). ⁵		
HIV prevalence among IDUs (%)	Cairo: 7.7, Alexandria: 6.7 ⁵		
HCV prevalence among IDUs (%)	63 (among drug users) ⁶		
<ul style="list-style-type: none"> HIV transmission through injecting drug use accounts for 28.3% of all reported infections.⁵ 			
II. Young people			
<ul style="list-style-type: none"> Percentage of adolescents aged 15 years who have ever used cannabis is estimated to be 18.9%.⁴ 			
III. Women			
D. Monitoring and surveillance			
National data collection system	No ²		
National surveys on substance use among adolescents	No ²		
Annual reports	No ²		

3. Policy and legislation			
Substance use policy			Yes ²
Special legislative provision			
• Treatment and rehabilitation for people with SUD			Yes ²
• Compulsory treatment for people with SUD			Yes ²
Presence of drug courts in the country			No ²
Availability of programmes which divert clients away from the criminal justice system towards treatment			No ²
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	Yes ²		
Most important financing method for treatment services			Tax-based funding ²
B. Treatment sectors and services			
I. Treatment services	Availability	Sector	
Inpatient medical detoxification	Yes	Public health ²	
Outpatient medical detoxification	No ⁷	–	
Substitution maintenance therapy of opioid dependence	No ²	–	
Long-term rehabilitation	Yes	Public health ²	
Implementation of screening/brief intervention in primary care	No ²		
II. Treatment system			
Availability of treatment policy document and guidelines:	No ²		
Treatment system for SUD		Integrated into mental health care ²	
Specialized services for:			
• SUD and HIV/AIDS	Yes ²		
• SUD and tuberculosis	No ²		
Treatment slots			
• Outpatient treatment slots (per 10 000)	0.5 ²		
• Hospital beds (per 100 000)	1.8 ²		
• Length of stay for inpatient detoxification (days)	7-14 ²		
• A recent study from the greater Cairo area revealed that only 12% of substance-dependent persons receive treatment at any time. ⁸			
C. Pharmacotherapy of substance use disorders			
Essential list of medicines			Yes ²
Pharmacotherapy for opioid detoxification			• Naltrexone • Benzodiazepines ²
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No ²	–	–	–
• Buprenorphine: No ²	–	–	–
D. Human resources			
Health professionals			Psychiatrists Psychologists Addictologists/narcologists ⁷
Health professionals mostly involved in treatment of SUD			Psychiatrists ²
Nongovernmental organizations for treatment			Yes ²
Nongovernmental organizations for prevention			Yes ²
Nongovernmental organizations for rehabilitation			Yes ²
Self-help groups for SUD: Narcotics Anonymous			Yes ²
• Only 30% of substance users are treated by general practitioners or psychiatrists. Religious and traditional healers are widely involved in drug use treatment, especially in southern Egypt. ⁹			

5. Prevention and harm reduction

A. Prevention

Groups and sectors involved in prevention programmes	Religious groups Traditional leaders Community groups Law enforcement agencies International organizations ²
Programmes for specific populations	People living with HIV/AIDS Prisoners Indigenous populations Children and adolescents ²

B. Harm reduction programmes

Availability	No ²
Services	–

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁵ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*, Cairo, National AIDS Programme, Egypt, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁶ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. Cairo, National AIDS Programme, Egypt, 2010. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/>

⁷ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Egypt*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/egypt.pdf

⁸ *Substance use and dependence*. Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2005. Technical paper presented to the Fifty-second session of the Region Committee for the Eastern Mediterranean.

⁹ *Second meeting of the Regional Advisory Panel on Impacts of Drug Abuse (RAPID)*. Cairo, World Health Organization, Regional Office for the Eastern Mediterranean, 2003.

Islamic Republic of Iran

I. Demographic information	Year of report		
Total population (000s)	2010	75 801 ¹	
Population ≤ 15 years (%)	2010	23 ¹	
Annual population growth rate (%)	2000–2010	1.5 ¹	
Population living in urban areas (%)	2010	72.5 ¹	
Life expectancy at birth (years)	2009	72.1 ¹	
Adult literacy rate (%) aged ≥15 years	2005–2010	83.2 ¹	
General government expenditure on health as % of total government expenditure	2009	11 ¹	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	11.1 ²	
Age-standardized DALYs for SUD per 100 000	2008	698 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		3.32	0.55 ²
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> The prevalence of opiate use is estimated to be 2.8% of the population aged 15–64 years.³ 42% of the global opium that is not converted into heroin is consumed in Islamic Republic of Iran.³ 40% of the estimated opiate users consume opium, and the rest mainly consume heroin.⁴ The majority of drug-related deaths in Islamic Republic of Iran is related to opiate use.⁴ 			
Cannabis			
<ul style="list-style-type: none"> Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 4.2%.³ 			
Amphetamines			
<ul style="list-style-type: none"> Iran has reported yearly increases in methamphetamine seizures, suggesting that availability is increasing.⁵ The results of research undertaken in Iran, as reported by its Drug Control Headquarters, indicate that the use of methamphetamine has increased.³ Iran's recent rapid situation assessment of drug users in treatment centres, prisons, and of homeless persons found that approximately 3.6% of these groups primarily used crystalline methamphetamine, whereas no use was reported in 2004–05.⁵ 			
The primary substances of use among patients treated for SUD are opiates (83.4%), ATS (2.6%), cannabis (1.7%) and ecstasy (0.1%). ⁵			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	Heroin, amphetamine type stimulants, buprenorphine ⁶		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	91.72% of all drug users has reported the use of sterile injecting equipment the last time they injected. ⁷		
HIV prevalence among IDUs (%)	15 ⁶		
HCV prevalence among IDUs (%)	38–46.6 ^{6,8}		
<ul style="list-style-type: none"> It is estimated that there are between 170 000 and 230 000 IDUs in Iran.⁷ The most prevalent mean of HIV transmission is through drug injection. Injecting drug use is the reason for HIV transmission in 69.8% cases which have been registered since 1986.⁷ 			
II. Young people			
III. Women			
D. Monitoring and surveillance			
National data collection system	Yes ²		
National surveys on substance use among adolescents	No ²		
Annual reports	Yes ²		

3. Policy and legislation

Substance use policy	Yes ²
Special legislative provision	
• Treatment and rehabilitation for people with SUD	Yes ²
• Compulsory treatment for people with SUD	Yes ²
Presence of drug courts in the country	No ²
Availability of programmes which divert clients away from the criminal justice system towards treatment	Yes ²
• The Drug Control Law (endorsed by Council of Expediency in 1997) provides legal framework for substance abuse treatment services. According to article 648 of Islamic Penal Law, confidentiality of patients' data is mandatory for physician and other health care providers. ⁹	
• Referring to the article 15 of the Iranian Anti-narcotics Law, addiction is a crime, but each addict is entitled to refer to licensed centres identified by the Ministry of Health and Medical Education for treatment and rehabilitation. The article further recognises that all addicts are exempted from penalty of addiction for two years during their treatment and rehabilitation process. ⁹	
• In 2005 the head of the Iranian Judiciary officially recommended to apply a harm reduction oriented interpretation of the article 15 of the Iranian Anti-narcotics law, which exempts drug users under treatment from prosecution. ⁹	

4. Health services

A. Administration and financing

Government unit responsible for prevention and treatment services for SUD	Yes ²
Budget line in annual budget of government for SUD prevention and treatment services	Yes ²
Most important financing method for treatment services	Out-of-pocket payment ²

B. Treatment sectors and services

I. Treatment services	Availability	Sector
Inpatient medical detoxification	Yes	Private ²
Outpatient medical detoxification	Yes	Private ²
Substitution maintenance therapy of opioid dependence	Yes	Private ²
Long-term rehabilitation	Yes	Nongovernmental organizations ²
Implementation of screening/brief intervention in primary care	Yes ¹¹	

II. Treatment system

Availability of treatment policy document and guidelines:	Yes ²
Treatment system for SUD	Specialized treatment system ²
Specialized services for:	
• SUD and HIV/AIDS	Yes ²
• SUD and tuberculosis	Yes ¹¹
Treatment slots	
• Outpatient treatment slots (per 10 000)	–
• Hospital beds (per 100 000)	0.7 ²
• Length of stay for inpatient detoxification (days)	7 ²
• In the Islamic Republic of Iran, 83% of treatment admissions in 2009 were for opiate use. ⁴	
• About 80% of those receiving treatment for substance use disorders use private settings. ¹⁰	
• Inpatient treatment (up to 2 months) for drug dependence is uncommon in Iran. Some patients who have co-morbid psychiatric disorders receive such treatment, usually in public hospitals. ¹⁰	

C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		Benzodiazepines Clonidine Naltrexone Naloxane Methadone Buprenorphine ¹⁰	
Opioid agonist pharmacotherapy	Detoxification	Maintenance ²	Formulation ²
• Methadone: Yes	✓	✓	Syrup and tablet
• Buprenorphine: Yes	✓	✓	Tablet
<ul style="list-style-type: none"> • Opioid substitution treatment (OST) programmes are available both in community and in prison. Iran has provided outpatient models, so no hospitalization is required.¹⁰ • Opium tincture maintenance treatment has been delivered as a pilot project during 2008–10. Trial results suggest it to be effective for certain categories of drug user who are not suitable candidates for MMT.⁵ 			
D. Human resources			
Health professionals		Psychiatrists General practitioners Psychologists Social workers Narcologists ¹⁰	
Health professionals mostly involved in treatment of SUD		Psychiatrists General practitioners ¹¹	
Nongovernmental organizations for treatment		Yes ²	
Nongovernmental organizations for prevention		Yes ²	
Nongovernmental organizations for rehabilitation		Yes ²	
Self-help groups for SUD: Narcotics Anonymous		Yes ²	
<ul style="list-style-type: none"> • Each substance abuse treatment centre must have at least a medical doctor who special training for addiction treatment, a nurse and a clinical psychologist.⁹ • Training is mandatory for physicians before certifying for provision of OST.⁹ 			
5. Prevention and harm reduction			
A. Prevention			
Groups and sectors involved in prevention programmes		Religious groups Social workers Schools/universities Employers Health care workers Law enforcement agencies International organizations Community groups ²	
Programmes for specific populations		Families and children at risk Children and adolescents ²	
B. Harm reduction programmes			
Availability		Yes ²	
Services		Needle exchange programmes in community Needle exchange programmes in prisons Bleach distribution in prisons Outreach programmes ²	
<ul style="list-style-type: none"> • Pharmacies are major source for obtaining syringes among IDUs. According to a survey, close to 50% of those who had injected drugs over the preceding month had bought their syringes from a pharmacy.⁶ • Substance use treatment and harm reduction programmes are available in prisons including detoxification with clonidine and tranquilizers, and maintenance therapies with methadone (as a low-threshold methadone maintenance treatment¹¹) and naltrexone.¹⁰ 			

- ¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.
- ² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.
- ³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.
- ⁴ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.
- ⁵ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.
- ⁶ *A rapid situational analysis (RSA) on substance abuse in Iran*. Tehran, Iranian Drug Control Headquarters, 2007. <http://dchq.ir/html/>. Accessed 25 April 2013.
- ⁷ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. Islamic Republic of Iran., Ministry of Health and Medical Education, National AIDS Committee Secretariat, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>
- ⁸ Alavian SJ. Hepatitis C infection in Iran: a review article. *Iranian journal of clinical infectious diseases*, 2009, 4(1):47–59.
- ⁹ *Report on Regional Seminar on Reducing Harms of Drug Use in Middle East, West and Central Asia*. Tehran, United Nations Office on Drugs and Crime/ Iranian Drug Control Headquarters, 2008.
- ¹⁰ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Iran (Islamic Republic of)*. World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/iran.pdf
- ¹¹ National focal point at Ministry of Health and Medical Education. (Personal communication, 2012).

Iraq

I. Demographic information		Year of report	
Total population (000s)	2010	33 227 ¹	
Population ≤ 15 years (%)	2010	43 ¹	
Annual population growth rate (%)	2000–2010	3.5 ¹	
Population living in urban areas (%)	2010	66 ¹	
Life expectancy at birth (years)	2009	72.7 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	65 ¹	
General government expenditure on health as % of total government expenditure	2009	9 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	6.9 ²	
Age-standardized DALYs for SUD per 100 000	2008	253 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		0.66	0.24 ²
B. Most commonly used substances			
There are no data on the prevalence of different illicit drugs in the country, but it seems that the number of patients using substances is slowly increasing (sniffed, inhaled and injected). ³			
C. Trends and patterns			
I. Injection and related health hazards			
Drug injection is very limited in the country. ³			
II. Young people			
In 2011 ³			
<ul style="list-style-type: none"> The number of registered male patients under 17 years with drug and alcohol use problems was 322. The number of registered female patients under 17 years with drug and alcohol use problems was 106. 			
III. Women			
In 2011, the number of registered female patients over 17 years with drug and alcohol use problems was 395. ³			
D. Monitoring and surveillance			
National data collection system	No ²		
National surveys on substance use among adolescents	No ²		
Annual reports	No ²		
3. Policy and legislation			
Substance use policy (the policy is under review ³)	Yes ²		
Special legislative provision			
<ul style="list-style-type: none"> Treatment and rehabilitation for people with SUD Compulsory treatment for people with SUD New legislation on drug use and abuse has been developed which is under discussion in parliament.³ 	No ² No ²		
Presence of drug courts in the country	No ²		
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	No ²		
Most important financing method for treatment services	Other ²		

B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes	Public health ²
Outpatient medical detoxification		Yes	Public health ²
Substitution maintenance therapy of opioid dependence		No ²	–
Long-term rehabilitation		–	–
Implementation of screening/brief intervention in primary care		Yes ² (rarely)	
II. Treatment system			
Availability of treatment policy document and guidelines:		No ²	
Treatment system for SUD		Integrated into mental health care ²	
Specialized services for:			
• SUD and HIV/AIDS		No ²	
• SUD and tuberculosis		No ²	
Treatment slots			
• Outpatient treatment slots (per 10 000)		0.1 ²	
• Hospital beds (per 100 000)		0.1 ²	
• Length of stay for inpatient detoxification (days)		15 ²	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		–	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No ²	–	–	–
• Buprenorphine: No ²	–	–	–
D. Human resources			
Health professionals		Psychiatrists General practitioners Psychologists ⁴	
Health professionals mostly involved in treatment of SUD		Psychiatrists ²	
Nongovernmental organizations for treatment		No ²	
Nongovernmental organizations for prevention		Yes ²	
Nongovernmental organizations for rehabilitation		No ²	
Self-help groups for SUD: Narcotics Anonymous		No ²	
5. Prevention and harm reduction			
A. Prevention			
Groups and sectors involved in prevention programmes		Religious groups Traditional healers Schools Health care workers International organizations ²	
Programmes for specific populations		Secondary schools Universities ³	
B. Harm reduction programmes			
Availability		No ²	
Services		–	

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ National focal point at the Ministry of Health. (Personal communication 2012).

⁴ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Iraq*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/iraq.pdf

Jordan

I. Demographic information		Year of report	
Total population (000s)	2010	6 113 ¹	
Population ≤ 15 years (%)	2010	38 ¹	
Annual population growth rate (%)	2000–2010	2.2 ¹	
Population living in urban areas (%)	2010	82.6 ¹	
Life expectancy at birth (years)	2009	73 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	93.3 ¹	
General government expenditure on health as % of total government expenditure	2009	19 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	1.7 ²	
Age-standardized DALYs for SUD per 100 000	2008	125 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		0.63	0.10 ²
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> Annual prevalence of opiates use as a percentage of the population aged 15–64 years is estimated to be 0.17%.³ Morphine and heroin were responsible for 36.4% and 15.9% drug related deaths as studied during a five-year period (2000–04).⁴ 			
Cannabis			
<ul style="list-style-type: none"> Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 2.1% (2001).³ There has been a significant increase in using hashish during the past two years (report in 2011).⁵ 			
Amphetamines			
<ul style="list-style-type: none"> The annual prevalence of amphetamine use is estimated to be 0.4% of the population aged 15–64 years.³ There has been a perceived increase in the use of amphetamine-type stimulants (ATS) over the past years.⁶ 			
Primary drugs of abuse among patients treated for SUD was reported as ATS (45.2%), opiates (21.4%), and inhalants (6%). ⁷			
An increased use of synthetic and prescription drugs has been reported in Jordan. ⁶			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	Heroin ⁵		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	Sharing injection paraphernalia is reported by two-thirds (62%) of participants in a bio-behavioral study during the last time they had drug injection. ⁵		
HIV prevalence among IDUs (%)	–		
HCV prevalence among IDUs (%)	–		
<ul style="list-style-type: none"> There has been a decrease in injecting drug use during the past two years (report in 2011).⁵ Addiction to heroin constituted 23% of all drug abuse admissions in the past two years; among them 58% inject the drug.⁵ Injection marks were reported in 56.8% of drug use death related cases as studied during a five-year period (2000–04).⁴ Among all HIV positive cases, 2.4% percent are attributed to drug injection.⁵ 			
II. Young people			
<ul style="list-style-type: none"> Percentage of adolescents aged 15–16 years who used at least once heroin in the past year was 0.9% (ARQ 2001).⁷ Percentage of young people aged 18–25 years who used at least once cannabis in the past year was 2.5% (ARQ 2001).⁷ Percentage of young people aged 18–25 years who used at least once ATS in the past year was 2.6% (ARQ 2001).⁷ 			
III. Women			
D. Monitoring and surveillance			
National data collection system	No ²		
National surveys on substance use among adolescents	No ²		
Annual reports	No ²		

3. Policy and legislation			
Substance use policy			No ²
Special legislative provision			Yes ²
• Treatment and rehabilitation for people with SUD			Yes ²
• Compulsory treatment for people with SUD			Yes ²
Presence of drug courts in the country			Yes ²
Availability of programmes which divert clients away from the criminal justice system towards treatment			Yes ²
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	No ²		
Most important financing method for treatment services		Social health insurance ²	
B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes	Public health ²
Outpatient medical detoxification		Yes	Public health ⁸
Substitution maintenance therapy of opioid dependence		–	–
Long-term rehabilitation		–	–
Implementation of screening/brief intervention in primary care		No ²	
II. Treatment system			
Availability of treatment policy document and guidelines:		No ²	
Treatment system for SUD		Integrated into general health care ²	
Specialized services for:			
• SUD and HIV/AIDS		Yes ²	
• SUD and tuberculosis		No ²	
Treatment slots			
• Outpatient treatment slots (per 10 000)		–	
• Hospital beds (per 100 000)		–	
• Length of stay for inpatient detoxification (days)		14 ²	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		Benzodiazepines ²	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No	–	–	–
• Buprenorphine: No	–	–	–
D. Human resources			
Health professionals		Addictologists/narcologists	
		Psychiatrists	
		(Psychiatric) nurses ⁸	
Health professionals mostly involved in treatment of SUD		Addictologists ²	
Nongovernmental organizations for treatment		No ²	
Nongovernmental organizations for prevention		Yes ²	
Nongovernmental organizations for rehabilitation		No ²	
Self-help groups for SUD: Narcotics Anonymous		Yes ²	

5. Prevention and harm reduction	
A. Prevention	
Groups and sectors involved in prevention programmes	Health care workers Law enforcement agencies ²
Programmes for specific populations	Prisoners Commercial sex workers ²
B. Harm reduction programmes	
Availability	No ²
Services	–

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ Hadidi MS, Ibrahim MI, Abdallat IM, Hadidi KA. Current trends in drug abuse associated fatalities—Jordan, 2000–2004. *Forensic science international*, 2009, 186:44–7.

⁵ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. National AIDS Programme, Jordan, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁶ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.

⁷ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁸ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Jordan*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/jordan.pdf

Morocco

I. Demographic information	Year of report		
Total population (000s)	2010	32 245 ¹	
Population ≤ 15 years (%)	2010	28 ¹	
Annual population growth rate (%)	2000–2010	1.1 ¹	
Population living in urban areas (%)	2010	58.3 ¹	
Life expectancy at birth (years)	2009	74.8 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	56.1 ¹	
General government expenditure on health as % of total government expenditure	2009	7 ¹	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	8 ²	
Age-standardized DALYs for SUD per 100 000	2008	276 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		0.61	0.22 ²
B. Most commonly used substances			
Opiates			
• Annual prevalence of opiates use as a percentage of the population aged 15–64 years is estimated to be 0.02%. ³			
Cannabis			
• Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 4.2%. ³			
Amphetamines			
• Annual prevalence of amphetamine-type stimulants (ATS) use is estimated to be less than 0.1% of the population aged 15–64 years. ³			
• Annual prevalence of ecstasy use is estimated to be less than 0.1% of the population aged 15–64 years (Annual Report Questionnaire, 2003) ³ . Morocco has seen an increase in ecstasy use according to expert opinion. ⁴			
Cocaine			
• Annual prevalence of cocaine use as a percentage of the population aged 15–64 years is estimated to be less than 0.1%. ³			
• Morocco has reported apparent increases in cocaine use. ⁴			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	12% (biological-behavioural surveillance survey, 2012) ⁵		
HCV prevalence among IDUs (%)	74% ⁵		
• The estimated number of IDUs in Morocco is 18 500. ⁶			
II. Young people			
• The age of first substance use is decreasing. In a study conducted in 2006 in the capital region, the age of the first consumption was 11 years. ⁵			
• Percentage of adolescences at the age group of 15–17 who ever used cannabis is estimated to be 6.6%. ⁷			
• Percentage of adolescences at the age group of 15–17 who used cannabis at least once during past year is estimated to be 4.6%. ⁷			
• Among students (13–15 years) who ever used drugs, 84.4% used drugs for the first time before 14 years. ⁸			
III. Women			
It is perceived that substance use prevalence is increasing among women. ⁶			
D. Monitoring and surveillance			
National data collection system	Yes, service delivery data collection system ²		
National surveys on substance use among adolescents	Yes (Medspad 2008) ⁵		
Annual reports	No ²		

3. Policy and legislation			
Substance use policy	Yes ² ; the policy was initially formulated in 1974. ⁶		
Special legislative provision			
• Treatment and rehabilitation for people with SUD	Yes ²		
• Compulsory treatment for people with SUD	No ²		
Presence of drug courts in the country	No ²		
Availability of programmes which divert clients away from the criminal justice system towards treatment	Yes ²		
There is a specific law on disposition of drug users which diverts clients away from the criminal justice system towards treatment. ⁵			
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	No; but the mental health unit in Ministry of Health covers SUD ⁹		
Budget line in annual budget of government for SUD prevention and treatment services	No ²		
Most important financing method for treatment services	Out-of-pocket payment ²		
B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes	Public health ²
Outpatient medical detoxification		Yes	Public health ⁷
Substitution maintenance therapy of opioid dependence		–	–
Opiate substitution treatment has been introduced in 2010 in three pilot sites in Morocco. The programme will be scaled up during 2012–16 with the expectation of recruiting 8000 IDUs by the end of 2016. ⁵			
Long-term rehabilitation		–	–
Implementation of screening/brief intervention in primary care		No ²	
II. Treatment system			
Availability of treatment policy document and guidelines:		Yes ²	
Treatment system for SUD: There is a combination of different treatment systems in Morocco; outpatient and inpatient treatment are provided by the mental health care system. The general health care system, which includes primary health care, provides only outpatient treatment. There are also some specialized inpatient and outpatient treatment units for drug use disorders. ⁹			
Specialized services for:			
• SUD and HIV/AIDS		Yes ²	
• SUD and tuberculosis		Yes ⁵	
Treatment slots			
• Outpatient treatment slots (per 10 000)		0.1 ²	
• Hospital beds (per 100 000)		0.6 ²	
• Length of stay for inpatient detoxification (days)		1–2 ²	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		Benzodiazepine Antidepressants Mood regulators Methadone ⁵	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: Yes (pilot project) ⁵	–	✓	–
• Buprenorphine: No	–	–	–

D. Human resources	
Health professionals	Psychiatrists Psychologists General practitioners ⁹
Health professionals mostly involved in treatment of SUD	Psychiatrists ²
Nongovernmental organizations for treatment	No ²
Nongovernmental organizations for prevention	Yes ²
Nongovernmental organizations for rehabilitation	Yes ²
Self-help groups for SUD: Narcotics Anonymous	No ²
5. Prevention and harm reduction	
A. Prevention	
Groups and sectors involved in prevention programmes	Social workers Schools Community groups Health care workers International organizations
Programmes for specific populations	Prisoners Commercial sex workers Children and adolescents ²
B. Harm reduction programmes	
Availability	Yes ²
Services	Outreach services for IDUs Drop-in centres Needle and syringe programme MMT (pilot project) ⁵

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.

⁵ National focal point at Ministry of Health. (Personal communication, 2012).

⁶ Mumtaz G et al. *HIV modes of transmission analysis in Morocco*. Morocco, Ministry of Health, Department of Epidemiology and Disease Control, National STI/AIDS Programme, 2010.

⁷ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁸ *Global school-based student health survey: fact sheet for Morocco*. Geneva, World Health Organization, 2010.

⁹ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Morocco*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/morocco.pdf

Oman

I. Demographic information		Year of report	
Total population (000s)	2010	3 174 ¹	
Population ≤ 15 years (%)	2010	27 ¹	
Annual population growth rate (%)	2000–2010	2.7 ¹	
Population living in urban areas (%)	2010	72 ¹	
Life expectancy at birth (years)	2009	72.7 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005	86 ¹	
General government expenditure on health as % of total government expenditure	2009	6 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	0.2 ²	
Age-standardized DALYs for SUD per 100 000	2008	8 ²	
Prevalence estimates for SUD, point prevalence (%), > 15 years	2004	Males	Females
		0.02	0.00 ²
A central registry receives notification about all new cases of SUD. ³			
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> Annual prevalence of opiates use as a percentage of the population aged 15–64 years is estimated to be 0.09.⁴ Heroin and prescription opioids are reported as the primary substances used by patients seeking treatment for SUD (100% of cases).⁵ 			
Cannabis			
<ul style="list-style-type: none"> Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 0.01.⁴ There is a moderate and stable use of cannabis in Oman. 			
Amphetamines			
<ul style="list-style-type: none"> Use of amphetamine-type stimulants (ATS) is very rare in Oman.³ Use of khat (an amphetamine-based substance) has increased, especially in the south of Oman (report in 2012).³ 			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	Heroin Morphine Combination of heroin and morphine ⁶		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	1.4 ⁶		
HCV prevalence among IDUs (%)	48 ⁶		
<p>Injecting drug use is a major problem in the country, and the official registered number of injecting drug users (IDUs) is 2036. The number of new reported cases of IDUs in 2011 was 359.³</p> <p>The results of a rapid assessment among IDUs conducted in 2006–07 showed that more than 90% of respondents admitted sharing of injection equipment, with an average of 2–4 times in the month before the survey.⁶</p>			
II. Young people			
<p>The trend of substance use among young people has been increased during the past five years (report in 2012).³</p> <p>The percentage of adolescents in the age group of 15–16 years who used heroin at least once in the past year is estimated to be 3% (report in 2002).⁵</p>			
III. Women			
In the past five years, the trend of substance use among women has increased (report in 2012). ³			
D. Monitoring and surveillance			
National data collection system	Yes ²		
National surveys on substance use among adolescents	No ²		
Annual reports	Yes, National Drug Abuse Registry ²		

3. Policy and legislation			
Substance use policy			Yes ²
Special legislative provision			
• Treatment and rehabilitation for people with SUD			Yes ²
• Compulsory treatment for people with SUD			Yes ²
Presence of drug courts in the country			Yes ²
Availability of programmes which divert clients away from the criminal justice system towards treatment			Not available; limited services only ³
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	Yes ²		
Most important financing method for treatment services			Free of charge (treatment services are subsidized by the government) ³
B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes ²	Psychiatric hospital ³
Outpatient medical detoxification		Yes ²	Psychiatric hospital ³
Substitution maintenance therapy of opioid dependence		–	–
Long-term rehabilitation		–	–
Implementation of screening/brief intervention in primary care		No ²	–
II. Treatment system			
Availability of treatment policy document and guidelines:		Yes (treatment guidelines) ²	
Treatment system for SUD		Integrated into mental health care ²	
Specialized services for:			
• SUD and HIV/AIDS		No – Separate services ³	
• SUD and tuberculosis		No – Separate services ³	
Treatment slots			
• Outpatient treatment slots (per 10 000)		0.2 ²	
• Hospital beds (per 100 000)		0.4 ² ; number of beds (20) to be increased to 50 beds (planned in 2012) ³	
• Length of stay for inpatient detoxification (days)		21 ²	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		Methadone Naloxane Benzodiazepines ²	
Opioid agonist pharmacotherapy		Detoxification	Maintenance
• Methadone: Yes		✓	–
• Buprenorphine: No ²		–	–
			Formulation
			–
			–
D. Human resources			
Health professionals		Addiction counsellor Psychiatrists (Psychiatric) nurses ⁷	
Health professionals mostly involved in treatment of SUD		Addictologists	
Nongovernmental organizations for treatment		–	
Nongovernmental organizations for prevention		Yes; Al-Hayat Association ³	
Nongovernmental organizations for rehabilitation		–	
Self-help groups for SUD: Narcotics Anonymous		Yes ²	

5. Prevention and harm reduction	
A. Prevention	
Groups and sectors involved in prevention programmes	Religious groups Schools Community groups Health care workers ²
Programmes for specific populations	Yes; nongovernmental organizations (peer drug abuse education) ³
B. Harm reduction programmes	
Availability	Yes; limited services ³
Services	Bleach distribution in community Needle and syringe programme in community ²

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ National focal point at the Ministry of Health. (Personal communication, 2012).

⁴ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁵ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁶ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. National AIDS Programme (NAP), Sultanate of Oman, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁷ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Oman*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/oman.pdf

Pakistan

I. Demographic information	Year of report		
Total population (000s)	2010	177 100 ¹	
Population ≤ 15 years (%)	2010	35 ¹	
Annual population growth rate (%)	2000–2010	2.1 ¹	
Population living in urban areas (%)	2010	34.7 ¹	
Life expectancy at birth (years)	2009	66 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	55 ¹	
General government expenditure on health as % of total government expenditure	2009	4 ¹	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	6 ²	
Age-standardized DALYs for SUD per 100 000	2008	234 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
6.48 million people have SUD, of whom 1 25 000 are injecting drug users.		0.84	0.09 ²
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> Globally, of the opium that is not converted into heroin, 7% is consumed in Pakistan.⁴ The annual prevalence of opiate use as a percentage of the population aged 15–64 years is estimated to be 0.70%.⁴ There are 628 000 opiate users, of whom around 482 000 (77%) are heroin users.⁵ 			
Cannabis			
<ul style="list-style-type: none"> Cannabis is the most commonly used substance and the “drug of choice” given its low price and easy availability.⁵ Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 3.9% (2000).⁴ 			
Cocaine			
<ul style="list-style-type: none"> Pakistan has seen an increase in cocaine use according to expert opinion.⁶ 			
Amphetamines			
<ul style="list-style-type: none"> Pakistan has seen an increase in ecstasy use according to expert opinion.⁴ Pakistan has reported an increase in the use of amphetamine-type stimulants (ATS) in recent years.⁶ 			
Primary substances of use among patients treated for SUD in Pakistan are cannabis (37%) and opiates (49%). ⁷			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	Heroin Other opiates Benzodiazepines A combination of these substances ⁵		
Drug users who have injected at least once during their lifetime (%)	29% of opiate users ⁵		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	27.2 ⁸		
HCV prevalence among IDUs (%)	11 ⁵		
Prevalence of tuberculosis among IDUs is estimated to be 18%.			
II. Young people			
The use of ecstasy in parties organized mainly by young men and women aged 16–25 years, usually from the upper or upper middle class, is on the increase in major urban centres. ³			
III. Women			
<ul style="list-style-type: none"> Substance use is mostly a hidden and individual activity for female drug users (FDU) unlike male drug users, who congregate and use drugs with others.⁹ The most common drugs of use among FDUs are charas (28%), bhang (14.2%), heroin (13.6%), and pharmaceutical drugs (12.6%).⁹ Injection is not a common route of drug intake among FDU. It is estimated that injecting drugs occur among 1.5% of FDU.⁹ 			

D. Monitoring and surveillance			
National data collection system		Yes ²	
National surveys on substance use among adolescents		Yes ²	
Annual reports		No ²	
3. Policy and legislation			
Substance use policy		Yes ²	
Special legislative provision			
• Treatment and rehabilitation for people with SUD		Yes ²	
• Compulsory treatment for people with SUD		No ²	
Presence of drug courts in the country		Yes ²	
Availability of programmes which divert clients away from the criminal justice system towards treatment		No ²	
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD		Yes ²	
Budget line in annual budget of government for SUD prevention and treatment services		Yes ²	
Most important financing method for treatment services		Out-of-pocket payment ²	
B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes	Public health ²
Outpatient medical detoxification		Yes	Public health ²
Substitution maintenance therapy of opioid dependence		Yes	Public health ²
Long-term rehabilitation		Yes	Public health ²
Implementation of screening/brief intervention in primary care		Yes, but rarely ²	
II. Treatment system			
Availability of treatment policy document and guidelines:		Yes ²	
Treatment system for SUD		Integrated into mental health care ²	
Specialized services for:			
• SUD and HIV/AIDS		Yes ²	
• SUD and tuberculosis		Yes ²	
Treatment slots			
• Outpatient treatment slots (per 10 000)		–	
• Hospital beds (per 100 000)		–	
• Length of stay for inpatient detoxification (days)		7-10 ²	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioid detoxification		• Buprenorphine • Benzodiazepines ²	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No	–	–	–
• Buprenorphine: Yes	✓	✓	–

D. Human resources	
Health professionals	General practitioners Primary health care workers Social workers ³
Health professionals mostly involved in treatment of SUD	General practitioners ²
Nongovernmental organizations for treatment	Yes ²
Nongovernmental organizations for prevention	Yes ²
Nongovernmental organizations for rehabilitation	Yes ²
Self-help groups for SUD: Narcotics Anonymous	Yes ²
5. Prevention and harm reduction	
A. Prevention	
Groups and sectors involved in prevention programmes	Religious groups Social workers Schools Community groups Health care workers Law enforcement agencies International organizations ²
Programmes for specific populations	–
B. Harm reduction programmes	
Availability	Yes ²
Services	Needle and syringe programme in the community ²
Pakistan has implemented an HIV prevention programme for families of IDUs as a pilot project. ⁵	

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Pakistan*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/pakistan.pdf

⁴ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁵ *Illicit drug trends in Pakistan*. United Nations Office on Drugs and Crime, Country Office Pakistan, 2008.

⁶ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.

⁷ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁸ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. National AIDS Control Programme, Ministry of Inter-Provincial Coordination, Pakistan, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁹ *Female drug use in Pakistan. Mapping estimates, ethnographic results & behavioural [sic] assessment*. United Nations Office on Drugs and Crime, Country Office Pakistan, 2010.

Saudi Arabia

I. Demographic information	Year of report		
Total population (000s)	2010	28 376 ¹	
Population ≤ 15 years (%)	2010	30 ¹	
Annual population growth rate (%)	2000–2010	3.2 ¹	
Population living in urban areas (%)	2010	85 ¹	
Life expectancy at birth (years)	2009	73.8 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	88 ¹	
General government expenditure on health as % of total government expenditure	2009	7 ¹	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	0.2 ²	
Age-standardized DALYs for SUD per 100 000	2008	6 ²	
Prevalence estimates for SUD, point prevalence (%), > 15 years	2004	Males	Females
		0.01	0.00 ²
B. Most commonly used substances			
Opiates			
• Annual prevalence of opiates use as a percentage of the population aged 15–64 years is estimated to be 0.06%. ³			
Cannabis			
• Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 0.3%. ³			
Amphetamines			
• The annual prevalence of amphetamine-type stimulants (ATS) use as a percentage of the population aged 15–64 years is estimated to be 0.4%. ³			
• Saudi Arabia has a significant consumer market for Captagon tablets (amphetamine, often mixed with caffeine). ⁴			
Major substances of use among persons treated for SUD in Saudi Arabia are: ATS 72.8%, cannabis 55.8%, opiates 7.5% and sedatives (5.5%). ⁵			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	–		
HCV prevalence among IDUs (%)	–		
• The mode of transmission for HIV in Saudi Arabia is attributable to drug injection in 1.3% to 2% of cases. ⁶			
II. Young people			
• A study conducted among medical students in Riyadh, Saudi Arabia, regarding alcohol and substance abuse in the community showed that they perceive alcohol and substance abuse as a common problem in the community, especially among young adult males. ⁷			
III. Women			
D. Monitoring and surveillance			
National data collection system	No ²		
National surveys on substance use among adolescents	No ²		
Annual reports	No ²		

3. Policy and legislation			
Substance use policy			Yes ²
Special legislative provision			
• Treatment and rehabilitation for people with SUD			Yes ²
• Compulsory treatment for people with SUD			Yes ²
Presence of drug courts in the country			No ²
Availability of programmes which divert clients away from the criminal justice system towards treatment			Yes ²
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD		Yes ²	
Budget line in annual budget of government for SUD prevention and treatment services		No ²	
Most important financing method for treatment services			Tax-based funding ²
B. Treatment sectors and services			
I. Treatment services	Availability	Sector	
Inpatient medical detoxification	Yes	Public health ²	
Outpatient medical detoxification	Yes	Public health ²	
Substitution maintenance therapy of opioid dependence	–	–	
Long-term rehabilitation	Yes	Public health ²	
Implementation of screening/brief intervention in primary care	–		
II. Treatment system			
Availability of treatment policy document and guidelines:		Yes ²	
Treatment system for SUD			Specialized treatment system ²
Specialized services for:			
• SUD and HIV/AIDS		Yes ²	
• SUD and tuberculosis		Yes ²	
Treatment slots			
• Outpatient treatment slots (per 10 000)		0.1 ²	
• Hospital beds (per 100 000)		2.4 ²	
• Length of stay for inpatient detoxification (days)		7 ²	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines			Yes ²
Pharmacotherapy for opioid detoxification			–
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No	–	–	–
• Buprenorphine: No	–	–	–
D. Human resources			
Health professionals			Addictologists/narcologists Psychologists Psychiatrists ⁸
Health professionals mostly involved in treatment of SUD			Addictologists ²
Nongovernmental organizations for treatment			Yes ²
Nongovernmental organizations for prevention			Yes ²
Nongovernmental organizations for rehabilitation			Yes ²
Self-help groups for SUD: Narcotics Anonymous			No ²

5. Prevention and harm reduction	
A. Prevention	
Groups and sectors involved in prevention programmes	Religious groups Social workers Schools Health care workers Law enforcement agencies ²
Programmes for specific populations	Prisoners Children and adolescents ²
B. Harm reduction programmes	
Availability	No ²
Services	–

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.

⁵ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. Kingdom of Saudi Arabia, 2010. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁶ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁷ Al-Haqwi Al. Perception among medical students in Riyadh, Saudi Arabia, regarding alcohol and substance abuse in the community: a cross-sectional survey. *Substance abuse treatment, prevention, and policy*, 2010, 5:2.

⁸ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Saudi Arabia*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/saudi_arabia.pdf

Somalia

I. Demographic information	Year of report		
Total population (000s)	2010	8 698 ¹	
Population ≤ 15 years (%)	2010	45 ¹	
Annual population growth rate (%)	2000–2010	2.6 ¹	
Population living in urban areas (%)	2010	37 ¹	
Life expectancy at birth (years)	2009	50 ¹	
Adult literacy rate (%) aged ≥ 15 years	2000–2006	25 ¹	
General government expenditure on health as % of total government expenditure	–	–	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	6.4 ²	
Age-standardized DALYs for SUD per 100 000	2008	210 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		0.45	0.15 ²
B. Most commonly used substances			
Opiates			
Annual prevalence of opiate use as a percentage of the population aged 15–64 years is estimated to be 0.16%. ³			
Cannabis			
Annual prevalence of cannabis use as a percentage of the population aged 15–64 years is estimated to be 2.5%. ³			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	–		
HCV prevalence among IDUs (%)	–		
II. Young people			
III. Women			
D. Monitoring and surveillance			
National data collection system	–		
National surveys on substance use among adolescents	–		
Annual reports	–		
3. Policy and legislation			
Substance use policy	–		
Special legislative provision	–		
• Treatment and rehabilitation for people with SUD	–		
• Compulsory treatment for people with SUD	–		
Presence of drug courts in the country	–		
Availability of programmes which divert clients away from the criminal justice system towards treatment	–		
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	–		
Budget line in annual budget of government for SUD prevention and treatment services	–		
Most important financing method for treatment services	Out-of-pocket payment ²		

B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		–	–
Outpatient medical detoxification		–	–
Substitution maintenance therapy of opioid dependence		–	–
Long-term rehabilitation		–	–
Implementation of screening/brief intervention in primary care		–	
II. Treatment system			
Availability of treatment policy document and guidelines:		–	
Treatment system for SUD		Integrated into general health care ²	
Specialized services for:			
• SUD and HIV/AIDS		–	
• SUD and tuberculosis		–	
Treatment slots			
• Outpatient treatment slots (per 10 000)		–	
• Hospital beds (per 100 000)		–	
• Length of stay for inpatient detoxification (days)		–	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		–	
Pharmacotherapy for opioid detoxification		–	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No	–	–	–
• Buprenorphine: No	–	–	–
D. Human resources			
Health professionals		Primary health care workers ⁴	
Health professionals mostly involved in treatment of SUD		–	
Nongovernmental organizations for treatment		–	
Nongovernmental organizations for prevention		–	
Nongovernmental organizations for rehabilitation		–	
Self-help groups for SUD: Narcotics Anonymous		–	
5. Prevention and harm reduction			
A. Prevention			
Groups and sectors involved in prevention programmes		–	
Programmes for specific populations		–	
B. Harm reduction programmes			
Availability		–	
Services		–	

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Somalia*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/somalia.pdf

Sudan

I. Demographic information		Year of report	
Total population (000s)	2010	32 671 ¹	
Population ≤ 15 years (%)	2010	40 ¹	
Annual population growth rate (%)	2000–2010	2.8 ¹	
Population living in urban areas (%)	2010	32.9 ¹	
Life expectancy at birth (years)	2009	59.8 ¹	
Adult literacy rate (%) aged ≥ 15 years	2000–2006	55.7 ¹	
General government expenditure on health as % of total government expenditure	2009	10 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	3.5 ²	
Age-standardized DALYs for SUD per 100 000	2008	140 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		0.41	0.13 ²
B. Most commonly used substances			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	–		
HCV prevalence among IDUs (%)	–		
II. Young people			
III. Women			
D. Monitoring and surveillance			
National data collection system	–		
National surveys on substance use among adolescents	–		
Annual reports	–		
3. Policy and legislation			
Substance use policy	–		
Special legislative provision	–		
• Treatment and rehabilitation for people with SUD	–		
• Compulsory treatment for people with SUD	–		
Presence of drug courts in the country	–		
Availability of programmes which divert clients away from the criminal justice system towards treatment	–		
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	A mental health unit in Ministry of Interior covers SUD ³		
Budget line in annual budget of government for SUD prevention and treatment services	–		
Most important financing method for treatment services	–		

B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes	Public health ²
Outpatient medical detoxification		Yes	Mental health services ³
Substitution maintenance therapy of opioid dependence		–	–
Long-term rehabilitation		–	–
Implementation of screening/brief intervention in primary care		–	
II. Treatment system			
Availability of treatment policy document and guidelines:		–	
Treatment system for SUD		Integrated into mental health care ²	
Specialized services for:			
• SUD and HIV/AIDS		–	
• SUD and tuberculosis		–	
Treatment slots			
• Outpatient treatment slots (per 10 000)		–	
• Hospital beds (per 100 000)		–	
• Length of stay for inpatient detoxification (days)		–	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioids detoxification		–	
Opioid agonist pharmacotherapy		Detoxification	Maintenance Formulation
• Methadone: No		–	–
• Buprenorphine: No		–	–
D. Human resources			
Health professionals		Psychiatrists Psychologists Social workers ³	
Health professionals mostly involved in treatment of SUD		–	
Nongovernmental organizations for treatment		Yes ²	
Nongovernmental organizations for prevention		Yes ²	
Nongovernmental organizations for rehabilitation		Yes ²	
Self-help groups for SUD: Narcotics Anonymous		No ²	
5. Prevention and harm reduction			
A. Prevention			
Groups and sectors involved in prevention programmes		Religious groups Law enforcement agencies ²	
Programmes for specific populations		People living with HIV/AIDS Prisoners Indigenous populations Commercial sex workers Minority groups Refugees Children and adolescents ²	
B. Harm reduction programmes			
Availability		–	
Services		–	

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Sudan*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/sudan.pdf

Syrian Arab Republic

I. Demographic information	Year of report		
Total population (000s)	2010	21 124 ¹	
Population ≤ 15 years (%)	2010	37 ¹	
Annual population growth rate (%)	2000–2010	2.5 ¹	
Population living in urban areas (%)	2010	53.5 ¹	
Life expectancy at birth (years)	2009	73.1 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	85.8 ¹	
General government expenditure on health as % of total government expenditure	2009	6 ¹	
2. Substance use epidemiology	Year of report		
A. General information			
Age-standardized death rates for SUD per 100 000	2008	2.9 ²	
Age-standardized DALYs for SUD per 100 000	2008	63 ²	
Prevalence estimates for SUD, point prevalence (%), > 15 years	2004	Males	Females
		0.03	0.00 ²
B. Most commonly used substances			
Opiates			
<ul style="list-style-type: none"> Annual prevalence of opiate use as a percentage of the population aged 15–64 years is estimated to be 0.02%³; however, it seems that prevalence of SUD is increasing.⁴ Heroin and prescription opioids are reported as the primary substances of use by 95% of patients seeking treatment.⁵ 			
Cocaine			
<ul style="list-style-type: none"> Annual prevalence of cocaine use as a percentage of the population aged 15–64 years is estimated to be less than 0.01%.³ An increasing trend in cocaine use was perceived in 2008, but the trend was stable in 2009.⁵ 			
Inhalants			
1% of the total admitted patients in national observatory use inhalants. ⁴			
Primary substances of use among patients treated for SUD are opiates (94.9%), sedatives (4.1%) and cocaine (0.9%). ⁶			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	0.31 ⁷		
HCV prevalence among IDUs (%)	60 ⁸		
II. Young people			
III. Women			
D. Monitoring and surveillance			
National data collection system	No ²		
National surveys on substance use among adolescents	Yes ²		
Annual reports	No ²		
3. Policy and legislation			
Substance use policy	Yes ²		
Special legislative provision			
<ul style="list-style-type: none"> Treatment and rehabilitation for people with SUD Compulsory treatment for people with SUD 	Yes ² No ²		
Presence of drug courts in the country	Yes ²		
Availability of programmes which divert clients away from the criminal justice system towards treatment	Yes ²		

4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	Yes ²		
Most important financing method for treatment services	Ministry of Health ⁸		
B. Treatment sectors and services			
I. Treatment services	Availability	Sector	
Inpatient medical detoxification	Yes	Social care ²	
Outpatient medical detoxification	Yes	Social care ²	
Substitution maintenance therapy of opioid dependence	–	–	
Long-term rehabilitation	–	–	
Implementation of screening/brief intervention in primary care ²	–	–	
II. Treatment system			
Availability of treatment policy document and guidelines:	Yes (treatment guidelines) ²		
Treatment system for SUD	Specialized system ²		
Specialized services for:			
• SUD and HIV/AIDS	No ²		
• SUD and tuberculosis	No ²		
Treatment slots			
• Outpatient treatment slots (per 10 000)	0.1 ²		
• Hospital beds (per 100 000)	0.4 ²		
• Length of stay for inpatient detoxification (days)	10 ²		
C. Pharmacotherapy of substance use disorders			
Essential list of medicines	No ²		
Pharmacotherapy for opioid detoxification	Symptomatic treatment ⁸		
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone:	–	–	–
• Buprenorphine:	–	–	–
D. Human resources			
Health professionals	General practitioners Psychiatrists Physiotherapists Psychologists Social workers ^{4,9}		
Health professionals mostly involved in treatment of SUD	Psychiatrists ²		
Nongovernmental organizations for treatment	No ²		
Nongovernmental organizations for prevention	No ²		
Nongovernmental organizations for rehabilitation	No ²		
Self-help groups for SUD: Narcotics Anonymous	No ²		
5. Prevention and harm reduction			

A. Prevention	
Groups and sectors involved in prevention programmes	Religious groups Traditional healers Schools Health care workers International organizations ²
Programmes for specific populations	–
B. Harm reduction programmes	
Availability	No ²
Services	–

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ National focal point at Ministry of Health (Personal communication, 2012).

⁵ *World drug report 2011*. Vienna, United Nations Office on Drugs and Crime, 2011.

⁶ *World drug report 2009*. Vienna, United Nations Office on Drugs and Crime, 2009.

⁷ *Country progress report on monitoring of the United Nations General Assembly Special Session on HIV and AIDS*. Damascus, National AIDS Programme, Syrian Arab Republic, 2010. Available at: https://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2010countries/syrianarabpublic_2010_country_progress_report_en.pdf

⁸ National focal point at Ministry of Health (Personal communication, 2012).

⁹ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Syrian Arab Republic*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/syrian_arab_republic.pdf

Tunisia

I. Demographic information		Year of report	
Total population (000s)	2010	10 549 ¹	
Population ≤ 15 years (%)	2010	23 ¹	
Annual population growth rate (%)	2000–2010	1.3 ¹	
Population living in urban areas (%)	2010	66 ¹	
Life expectancy at birth (years)	2009	74.7 ¹	
Adult literacy rate (%) aged ≥ 15 years	2005–2010	77.7 ¹	
General government expenditure on health as % of total government expenditure	2009	11 ¹	
2. Substance use epidemiology		Year of report	
A. General information			
Age-standardized death rates for SUD per 100 000	2008	4.6 ²	
Age-standardized DALYs for SUD per 100 000	2008	137 ²	
Prevalence estimates for SUD, point prevalence (%), >15 years	2004	Males	Females
		0.22	0.04 ²
B. Most commonly used substances			
Opiates			
• Annual prevalence of opiate use as a percentage of the population aged 15–64 years is estimated to be 0.09%. ³			
C. Trends and patterns			
I. Injection and related health hazards			
Substances used for injection	–		
Drug users who have injected at least once during their lifetime (%)	–		
Drug users who have shared injection paraphernalia (%)	–		
HIV prevalence among IDUs (%)	2.42 ⁴		
HCV prevalence among IDUs (%)	40–50 ⁵		
The estimated number of injecting drug users (IDUs) is 9000. ⁴			
II. Young people			
3.8% of students aged 13–15 years have used drugs one or more times during their life. ⁶			
III. Women			
D. Monitoring and surveillance			
National data collection system	Yes ²		
National surveys on substance use among adolescents	No ²		
Annual reports	No ²		
3. Policy and legislation			
Substance use policy	Yes ²		
Special legislative provision			
• Treatment and rehabilitation for people with SUD	Yes ²		
• Compulsory treatment for people with SUD	Yes ²		
Presence of drug courts in the country	No ²		
Availability of programmes which divert clients away from the criminal justice system towards treatment	Yes ²		
4. Health services			
A. Administration and financing			
Government unit responsible for prevention and treatment services for SUD	Yes ²		
Budget line in annual budget of government for SUD prevention and treatment services	No ²		
Most important financing method for treatment services	–		

B. Treatment sectors and services			
I. Treatment services		Availability	Sector
Inpatient medical detoxification		Yes ²	Public health ²
Outpatient medical detoxification		–	–
Substitution maintenance therapy of opioid dependence		–	–
Long-term rehabilitation		Yes	Public health ²
Implementation of screening/brief intervention in primary care		Yes, but rarely ²	
II. Treatment system			
Availability of treatment policy document and guidelines:		Yes, policy documents ²	
Treatment system for SUD		–	
Specialized services for:			
• SUD and HIV/AIDS		Yes ²	
• SUD and tuberculosis		Yes ²	
Treatment slots			
• Outpatient treatment slots (per 10 000)		–	
• Hospital beds (per 100 000)		0.3 ²	
• Length of stay for inpatient detoxification (days)		–	
C. Pharmacotherapy of substance use disorders			
Essential list of medicines		Yes ²	
Pharmacotherapy for opioids detoxification		–	
Opioid agonist pharmacotherapy	Detoxification	Maintenance	Formulation
• Methadone: No	–	–	–
• Buprenorphine: No	–	–	–
D. Human resources			
Health professionals		–	
Health professionals mostly involved in treatment of SUD		–	
Nongovernmental organizations for treatment		No ²	
Nongovernmental organizations for prevention		Yes ²	
Nongovernmental organizations for rehabilitation		Yes ²	
Self-help groups for SUD: Narcotics Anonymous		No ²	
5. Prevention and harm reduction			
A. Prevention			
Groups and sectors involved in prevention programmes		Schools ²	
Programmes for specific populations		Prisoners Children and families at risk Children and adolescents ²	
B. Harm reduction programmes			
Availability		–	
Services		–	

¹ *Regional health observatory* [online database]. Cairo, World Health Organization, 2012. <http://rho.emro.who.int/rhodata>. Accessed 25 April 2013.

² *Global health observatory data repository* [online database]. Geneva, World Health Organization, 2012 <http://apps.who.int/ghodata/>. Accessed 25 April 2013.

³ *World drug report 2010*. Vienna, United Nations Office on Drugs and Crime, 2010.

⁴ *Rapport d'activité sur la riposte au sida—Tunisie*. Tunis, Direction des Soins de Santé de Base, 2012. Available at: <http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/>

⁵ *Atlas on substance use resources for the prevention and treatment of substance use disorders: country profile: Tunisia*. Geneva, World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/publications/atlas_report/profiles/tunisia.pdf

⁶ *Global school-based student health survey; Tunisia fact sheet*. World Health Organization, 2008.

This report provides information on the magnitude of substance use disorders in the countries of the Eastern Mediterranean Region of the World Health Organization and the available resources and infrastructure at country level for prevention, treatment and rehabilitation of those suffering from substance use disorders. The report is based on data collected as part of the development of the Atlas on substance use 2010 published by WHO.