2021

Substance Use Atlas

World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

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Designed by Punto Grafico

Contents

Acronyms and abbreviations

ATS	Amphetamine-type stimulant
CBT	Cognitive behavioural therapy
DALY	Disability-adjusted life year
GHC	General health care
HIV	Human immunodeficiency virus
MHC	Mental health care centre
MNS	Mental health, neurological and substance use disorders
NA	Narcotics Anonymous
NGO	Nongovernmental organization
NPS	New psychoactive substance
OAMT	Opioid agonist maintenance treatment
PHC	Primary health care
PWID	People who inject drugs
PWSUD	People with substance use disorder
SBI	Screening and brief intervention
SUDs	Substance use disorders
SDGs	Sustainable Development Goals
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Executive summary

The ministers of health of Member States in the Eastern Mediterranean Region adopted the regional framework for action to strengthen the public health response to substance use in 2019 at the 66th session of the Regional Committee.[1] Following the endorsement of the regional framework, the Regional Committee mandated World Health Organization (WHO) to monitor and report biennially on its implementation. The mental, neurological and substance use disorders programme has developed the current regional report, Substance use atlas 2021, to report on progress made in the implementation of the regional framework. The atlas maps the resources and capacities of the countries of the Region to respond to the problems of substance use. It also highlights challenges and gaps and identifies areas where public health response to substance use problems needs to be strengthened. The atlas provides aggregated regional information and individual country profiles, with detailed information on available resources and capacities at the country level.

1. Governance

Policy

- All the responding countries reported that they had a policy or plan for the prevention of substance use and/or treatment of substance use disorders (SUDs), either as a stand-alone policy or as a policy integrated into other policies/plans.
- Close to 70% of responding countries reported that they had a government unit or government official at the national level who was responsible for the implementation of policy regarding the treatment of SUDs.
- 81% of responding countries reported that they had a policy/plan that had been updated in the past five years.

Financing

- 81% of responding countries reported having a specific budget for the prevention of substance use and/or treatment of SUDs.
- For all treatment modalities, government financing was the most frequently reported financing method in public and private settings.

Legislation

- 75% of responding countries reported that they had a stand-alone law for the prevention and management of SUDs.
- 81% of responding countries reported that their current legislation included provisions for voluntary or compulsory treatment as an alternative or in addition to criminal sanctions.
- 50% of responding countries reported that they had a drug court system.
- 25% of responding countries reported that they had provisions for depenalization and 31% of responding countries reported that they had provisions for decriminalization.

2. Health sector response

Settings, sectors and services

- Opioids were the main class of drugs reported at the entry point to treatment, by 50% of responding countries; this was double the percentage reported in the 2015 atlas.
- For all treatment modalities, the public health sector is the main provider of treatment services for SUDs.
- Stand-alone treatment facilities are the main provider of treatment services for SUDs, reported by 62% of responding countries.
- All responding countries reported that they had publicly funded specialized treatment facilities for SUDs, either in the capital city or in other major cities and areas.
- The median number of beds available for patients with SUDs per 100 000 adult population was 1.13 in public mental health services and 0.68 in public specialized centres for SUDs.

Special treatment programmes for specific populations

- 56% of responding countries reported that they had special treatment programmes for women, and 25% reported having such facilities for pregnant women.

[1] World Health Organization. Report of the 66th Session of the WHO Regional Committee for the Eastern Mediterranean. Tehran: WHO; 2019. http://www.emro.who.int/about-who/rc66/documentation.html

- 56% of responding countries reported that they had special treatment programmes for children and adolescents.

Accessibility and coverage of treatment services for people with substance use disorders

- On average and across the three substance groups of opioids, cannabis and amphetamines, around 60% of responding countries reported on the proportions of people who seek treatment for substance dependence and who receive such treatment; of these, about 50% reported this proportion to be "substantial" or "high".
- For countries where data were available, treatment contact coverage was generally reported as being "limited" or "very limited" for all three substances. Treatment contact coverage was generally higher among men compared with women.

Treatment interventions

Pharmacological treatment for people with substance use disorders

- 69% of responding countries reported that they had at least one opioid agonist agent for pharmacotherapy.
- 56% of responding countries reported that they used at least one opioid agonist agent for detoxification, and 50% of responding countries reported that they used at least one opioid agonist agent for opioid agonist maintenance treatment (OAMT).
- None of the responding countries reported that naloxone was widely available, though 11 reported that naloxone was registered in the country.
- About 75% of responding countries reported that screening and brief interventions were provided in health services.

Psychosocial treatment programmes for people with substance use disorders

- 87% of responding countries reported that psychosocial treatment programmes were available for people with SUDs.

Open access and harm reduction interventions

- Between 12% and 37% of responding countries reported that different harm reduction interventions were available, depending on the specific intervention.
- 25% of responding countries reported that they had needle and syringe exchange programmes and low-threshold and community outreach services.
- Between 12% and 37% of responding countries reported that different open access interventions were available, depending on the specific intervention.

Rehabilitation programmes

- 87% of responding countries reported that they had rehabilitation programmes for people with SUDs (PWSUD) at the country level or as stand-alone initiatives by leading national institutions/research programmes.
- 56% of responding countries reported the availability of Narcotic Anonymous (NA) groups and 19% reported that family support groups were available.

Screening and brief intervention programmes

- 73% of responding countries reported that screening and brief intervention (SBI) services were provided in health services in the country.
- Five countries reported that SBI tools were available in primary health care (PHC) services – two more countries than in the 2015 atlas survey.

Health workforce

- The number of health workers, in all professional groups, available for the treatment of SUDs per 100 000 adult population was generally less than one.
- The median number of professionals available per 100 000 adult population was lowest for addiction medicine specialists/narcologists (0.12) and highest for nurses not specialized in psychiatry (0.58).

3. Promotion and prevention programmes

- 94% of responding countries reported that they had interventions/programmes in place for the prevention of substance use.
  - Targeted multimedia campaigns were the most frequently implemented type of prevention intervention, reported by 94% of responding countries, and workplace prevention programmes were the least frequently implemented, reported by 31% of responding countries.
  - 56% of responding countries reported that they had specific prevention programmes and/or interventions for children, adolescents and young adults.

4. Monitoring and surveillance

- 62% of responding countries reported that they had a national system for epidemiological data collection on psychoactive substance use.
- 31% of responding countries reported that they had a national system for epidemiological data collection on substance use among children and adolescents.
  - 69% of responding countries publish data collected by the national system for epidemiological data collection on substance use periodically; of these, 45% reported that these data are publicly available.

5. International cooperation

- 75% of responding countries reported that they have adopted various international prevention and treatment standards/guidelines.
- 69% of responding countries reported that they have adopted United Nations Office on Drugs and Crime (UNODC)/WHO substance use prevention standards.
- 62% of responding countries reported that they have adopted UNODC/WHO treatment standards for SUDs.
- 69% of responding countries reported that they have national centres or networks that actively collaborate with regional or international centres/networks.

Introduction

According to the *World Drug Report 2021* by the UNODC, globally an estimated 275 million people aged 15–64, or one in every 18 people, had used substances at least once in the previous year.[1] It is estimated that among those who used drugs in the past year, 13% suffered from SUDs. It is projected that by 2030 the population of people using drugs will increase globally by 11%. A bigger increase is expected in developing countries due to factors such as faster population growth, younger populations and rapid urbanization.[2]

The *World Drug Report 2021* estimates that substance use caused 494 000 deaths and 30.9 million years of disability-adjusted life years (DALYs) in the previous year. Opioids were responsible for more than 70% of deaths and DALYs. Globally, 62 million people, or 1.2% (range 0.7% to 1.6%) of the population aged 15–64, were estimated to have used opioids (i.e. opiates and pharmaceutical and/or synthetic opioids) for non-medical reasons. The risk of acquiring human immunodeficiency virus (HIV) infection is 29 times higher among people who inject drugs compared with those who do not, and one in eight people who inject drugs (PWID) lives with HIV. The estimated prevalence of hepatitis C among PWID is 50.2% and for hepatitis B it is 8.7%.

The prevalence of opioid use among the population aged 15–64 years in some countries of the Eastern Mediterranean Region is about 2.5 times higher than the global level (3.2% versus 1.2%).[3] The non-medical use of pharmaceutical opioids such as tramadol is reported as a major concern in many countries of the Region.[4] There are an estimated 930 000 PWID in the Region,[5] the majority of whom reportedly use opioids as their main drug. It is also estimated that 43% of all new adult HIV infections in the Region are among PWID.[6]

Globally, only one in eight people who need treatment receives it, while in countries of the Region only one in 13 receives treatment.[7] The COVID-19 pandemic has disrupted the delivery of essential services, particularly for the most vulnerable populations such as people with SUDs (PWSUD), which were already inadequate in the Region. A rapid survey of service delivery for mental, neurological and substance use (MNS) disorders during the COVID-19 pandemic in 2021 showed that about 40% of opioid agonist maintenance treatment (OAMT) and overdose prevention and management programmes were completely or partially disrupted in countries of the Region.[8]

The ministers of health of WHO's Member States in the Region adopted the regional framework for action to strengthen the public health response to substance use in 2019 at the 66th session of the Regional Committee.[9] The regional framework was built on the momentum generated by the high-level commitments articulated at the 2016 special session of the United Nations General Assembly on the world drug problem and the inclusion of a specific target (Target 3.5[10]) on strengthening the prevention and treatment of substance abuse under Sustainable Development Goal (SDG) 3. The regional framework proposes cost-effective, affordable and feasible strategic interventions across the five domains of governance, health sector response, promotion and prevention, monitoring and surveillance, and international cooperation, and suggests indicators for monitoring the progress of its implementation.

Following its endorsement of the regional framework, the Regional Committee mandated WHO to monitor and report biennially on its implementation. The MNS programme has developed the current regional report,

[1] In this atlas, the term "substance" refers to all psychoactive substances, licit and illicit, but does not cover the use of alcohol and tobacco.

[2] United Nations Office on Drugs and Crime. World Drug Report 2021. UNODC; 2021. https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html.
In the World Drug Report, countries of the Eastern Mediterranean Region are categorized as follows:
North Africa subregion: Egypt, Algeria, Tunisia and Morocco;
South-West Asia: Afghanistan, Iran (Islamic Republic of) and Pakistan;
Near and Middle East: Bahrain, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, State of Palestine, Syrian Arab Republic, United Arab Emirates and Yemen.

[3] United Nations Office on Drugs and Crime. World Drug Report 2021. UNODC; 2021. https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html. The high prevalence of opioid use in some countries of the Eastern Mediterranean Region refers to countries in UNODC's South-West Asia region category.

[4] United Nations Office on Drugs and Crime. World Drug Report 2021. UNODC; 2021. https://www.unodc.org/unodc/en/data-and-analysis/wdr2021.html.

[5] Based on joint UNODC/WHO/UNAIDS/World Bank estimates of PWID presented in the World Drug Report 2020; recalculated for the WHO Eastern Mediterranean Region.

[6] UNAIDS. Global AIDS Update 2020: Seizing the Moment – Tackling Entrenched Inequalities to End Epidemics. This figure relates to the Middle East and North Africa Region. https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf.

[7] Regional framework for action to strengthen the public health response to substance use. Regional Committee for the Eastern Mediterranean. Sixty-sixth session. https://applications.emro.who.int/docs/RC_Technical_Papers_2019_8_en.pdf?ua=1.

[8] World Health Organization. Regional Office for the Eastern Mediterranean. The impact of COVID-19 on mental, neurological and substance use services in the Eastern Mediterranean Region: results of a rapid assessment. https://applications.emro.who.int/docs/9789290223658-eng.pdf?ua=1.

[9] http://www.emro.who.int/about-who/rc66/documentation.html.

[10] *Target 3.5:* Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

Substance use atlas 2021, to monitor the progress made in implementing the framework. The atlas has been aligned with the regional framework to map the resources and capacities of countries, to highlight challenges and gaps and identify areas for the strengthening of the public health response to the problem of substance use.

Survey methods

To collect data, the MNS programme developed a questionnaire based on the previous questionnaires used for the 2012 and 2015 editions of the *Substance use atlas*. The questionnaire included items from the two previous exercises and was complemented by additional items to report on the indicators identified in the regional framework and to assess the process of enforcement and implementation of substance use-related policies, legislation and programmes (and was thus not restricted just to the existence of such policies and programmes). The data collected by the atlas questionnaire were supplemented by information extracted from a survey conducted in 2019[1] to monitor the progress of Member States in meeting SDG Target 3.5.[2]

To facilitate the data collection exercise, the MNS programme provided countries with the option to fill out the questionnaire online or using Microsoft Word/PDF formats. The atlas survey was shared with the designated country focal points at the ministries of health of all 22 countries and territories[3]. Seventeen countries responded to the questionnaire, which represents an 80% response rate. The countries participating in the atlas survey were Afghanistan, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Pakistan, occupied Palestinian territory, Morocco, Oman, Qatar, Saudi Arabia, Sudan, United Arab Emirates and Yemen. In the final analysis, 16 countries were included.

The data are presented either as the number of the countries of the Region responding to a particular question or the percentage of responding countries. When the results are presented as "percentage of responding countries" the denominator is 16 (countries) for the atlas survey and 15 (countries) for the SDG survey. For figures, the source is indicated each time – either the atlas survey 2021 or the SDG survey 2019.

Wherever feasible, comparisons are made with the previous edition of the atlas (2015, published in 2017),[4] though the data collected are not comparable for all questions. The atlas questionnaire for 2021 used different phrasing for some questions and made changes in some indicators used in the *Substance use atlas 2015* to accommodate the requirements of the regional framework. It is advisable to exercise caution in drawing any firm conclusions from comparisons.

In this report, the results of the survey are presented in five sections reflecting the five domains of the regional framework for action to strengthen the public health response to substance use:

1. Governance
2. Health sector response
3. Promotion and prevention
4. Monitoring and surveillance
5. International cooperation.

In this atlas, the term "substance" refers to all psychoactive substances, licit and illicit, but does not cover the use of alcohol and tobacco.

[1] The results of the 2019 SDG survey have not yet been published.

[2] SDG Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

[3] Afghanistan, Bahrain, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, occupied Palestinian territory, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates, Yemen.

[4] World Health Organization. Atlas: substance use in the Eastern Mediterranean Region 2015. WHO Regional Office for the Eastern Mediterranean; 2017. https://apps.who.int/iris/handle/10665/254675.

1. Governance

1.1 Policy

Policy or plan regarding prevention of substance use and/or treatment of substance use disorders

Background

Respondents were asked about the existence of a policy or plan regarding the prevention of substance use and/or treatment of SUDs, either stand-alone or integrated into mental health, general health or other policies and plans within the health sector or other sectors.

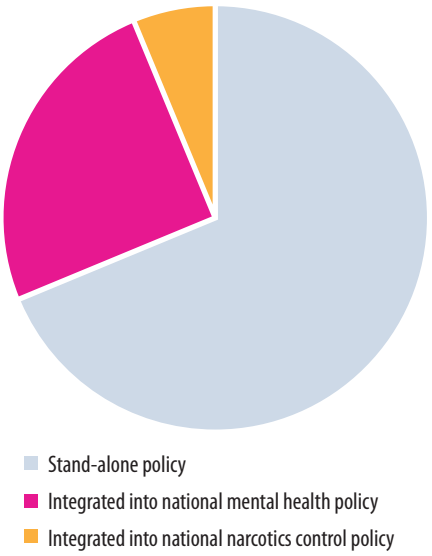
Findings

All responding countries reported that they had a policy or plan for the prevention of substance use and/or treatment of SUDs, either a stand-alone policy or a policy integrated into other policies/plans.

Of the five countries reporting that their substance use policies were integrated into other policies and plans, four reported that these policies/plans were integrated into national mental health policies and one that it was integrated into a national narcotics control policy. Additionally, two countries reported that they had both a stand-alone policy and policies integrated into other policies/plans. (Fig. 1.1)

This question was not asked in the 2015 atlas survey.

Fig. 1.1. Existence of a policy/plan regarding the prevention of substance use and/or treatment of SUDs



Source: Substance use atlas survey 2021.

Estimates of human/financial resources for the implementation of substance use policy/plan

Background

Respondents were asked if their substance use policy/plan included an estimate of human and financial resources needed to implement it, and whether resources were allocated in line with these estimates to enable implementation of the policy/plan.

Findings

Of the countries that reported that they had estimates for the human and financial resources required, seven out of nine countries (77%) indicated that they had allocated resources for human resources in line with estimates to enable implementation of the policy/plan, and six out of eight countries (75%) reported that they had allocated financial resources in this way. (Fig. 2.2)

Specific indicators or targets to monitor the implementation of substance use policy/plan

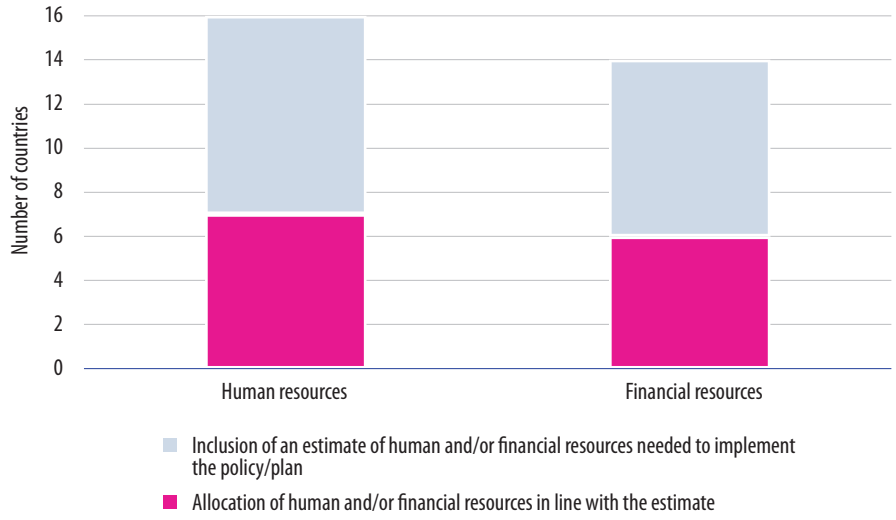
Background

Respondents were asked if the substance use policy/plan contained specified indicators or targets to monitor its implementation.

Findings

Thirteen countries reported that their substance use policy/plan contained specified indicators or targets to monitor its implementation. Of these, 46% reported they had used these indicators and targets in the past two years for the monitoring and evaluation of the implementation of their substance use policy/plan. (Fig. 1.3)

Fig. 1.2. Estimates and allocation of required human and/or financial resources for the implementation of substance use policy/plan



Source: Substance use atlas survey 2021

Update of substance use policy/plan and its compliance with international covenants, conventions and human rights instruments

Background

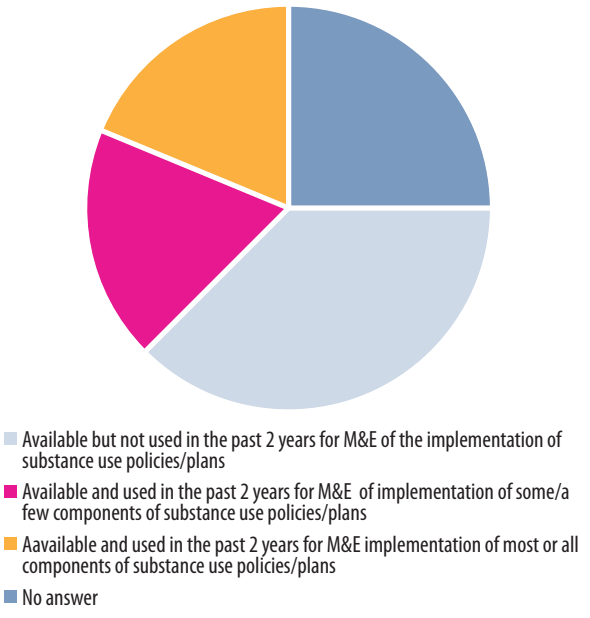
Respondents were asked if their substance use policy or plan had been updated since the last iteration of the regional *Substance use atlas*. They were also asked if their current substance use policy/plan had been developed in consultation with stakeholders and if it met the following specifications:

- includes provisions to promote respect for the human rights of PWSUD;
- promotes a full range of services;
- supports PWSUD to live independently and be included in the community;
- promotes community-based services for PWSUD.[1]

Findings

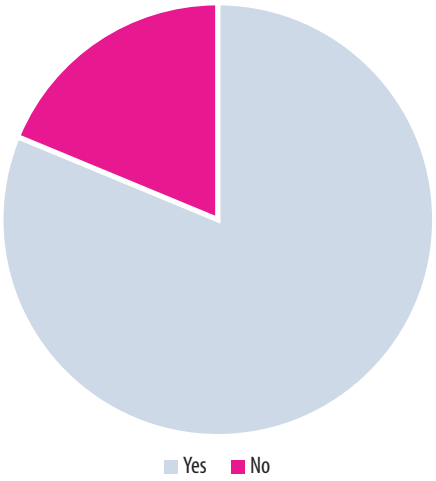
Thirteen countries (81% of responding countries) reported that they had updated their substance use policy/plan since last the atlas survey in 2015(Fig. 1.4).

Fig. 1.3. Existence and use of indicators for M&E of implementation of current substance use policy/plan



Source: Substance use atlas survey 2021.

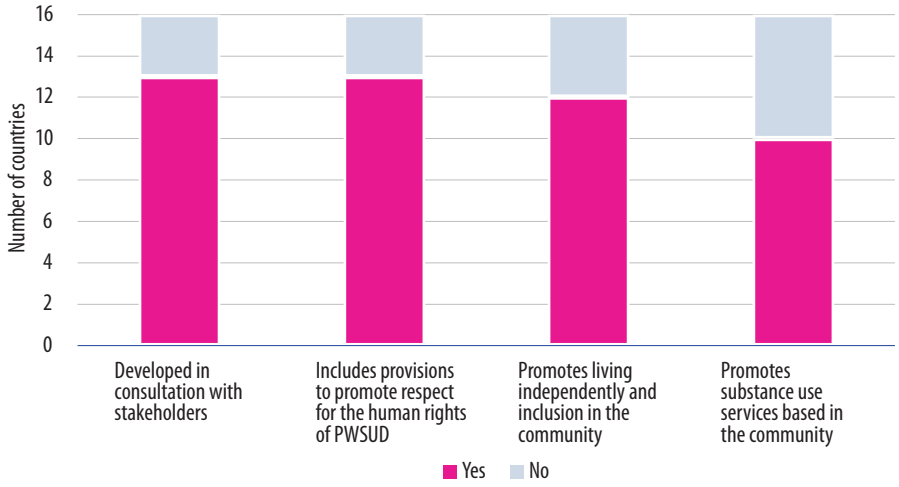
Fig.1.4. Substance use policy/plan has been updated since 2014



Source: Substance use atlas survey 2021.

[1] Substance use services that are integrated into general hospitals and primary care.

Fig. 1.5. Compliance of substance use policy/plan with international covenants, conventions and human rights instruments



Source: Substance use atlas survey 2021.

Between 62% and 81% of responding countries reported that their substance use policy/plan was compliant in different ways with international covenants, conventions and human rights instruments (Fig. 1.5).

In the atlas survey for 2021, 81% of responding countries reported that their current substance use policy/plan had been developed in consultation with stakeholders; this represents an increase of around 15 percentage points compared with figures for the 2015 atlas.

There was no question about the compliance of substance use policies/plans with international covenants, conventions and human rights instruments in the 2015 atlas.

Ministry/office with primary responsibility for implementation of substance use policy/plan

Background

Respondents were asked about the ministry/office that has primary responsibility for the implementation of the substance use policy/plan.

Findings

Eleven countries (69% of responding countries) reported that the ministry of health was primarily responsible for the implementation of their substance use policy/plan. (Fig. 1.6)

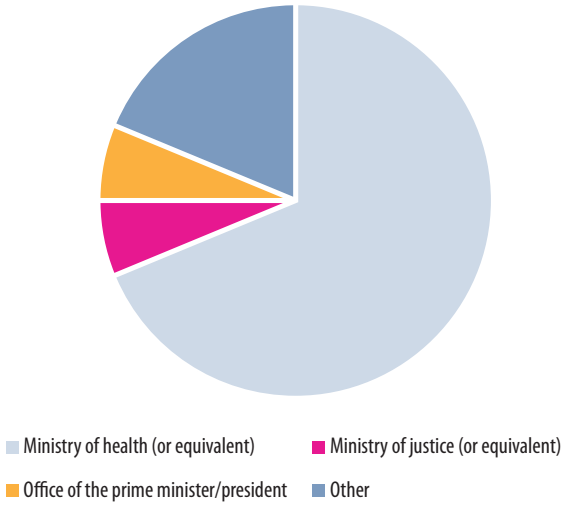
Compared with the 2015 atlas, a lower percentage of responding countries reported that the Ministry took primary responsibility for the prevention and/or treatment of SUDs (69% in the 2021 atlas compared with 95% in the 2015 atlas). This percentage represents 11 out of 16 countries in the 2021 atlas survey, compared with 19 out of 20 countries in the 2015 atlas. This reduction can be attributed partly to the lower response rate to the 2021 survey and partly to the different wording used for this question.

Intersectoral/interministerial coordinating mechanism/body/entity

Background

Respondents were asked if there was a formal intersectoral or interministerial coordination mechanism between the ministry/office that has the main responsibility for the implementation of the substance use policy/plan and other ministries and sectors, and about the level and modality of this collaboration.

Fig. 1.6. Ministry/office with primary responsibility for implementation of substance use policies/plans



Source: Substance use atlas survey 2021.

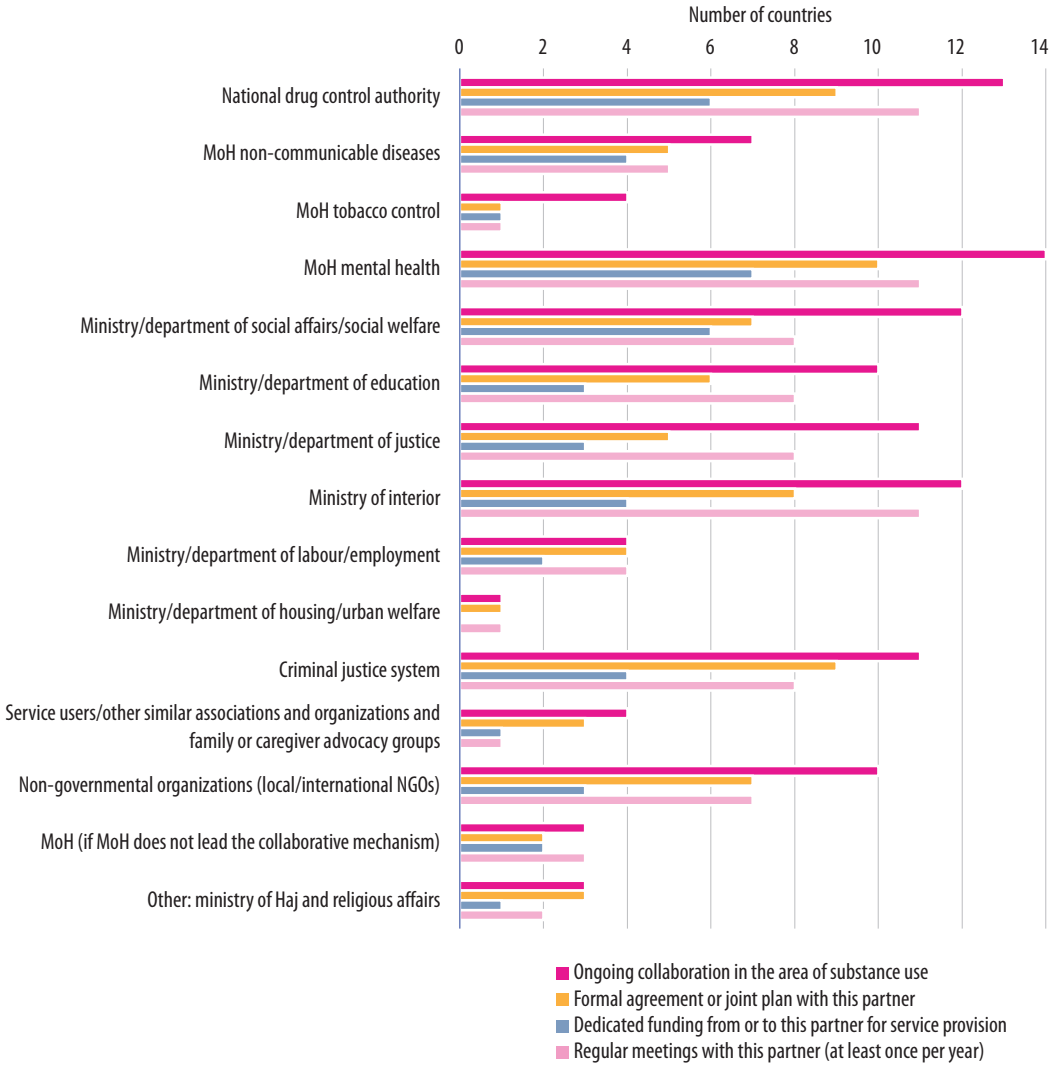
Findings

Fourteen countries (87% of responding countries) reported that they had a formal coordination mechanism in place.

The most commonly reported entities with which a formal intersectoral/interministerial coordination mechanism was in place were mental health units and the national drug control authority. Ongoing collaboration[1] was the method most commonly reported by respondents as being used in the coordination mechanism, followed by regular formal meetings (Fig. 1.7).

This question was not asked in the 2015 atlas survey.

Fig. 1.7. Collaboration between stakeholders and ministry/office with primary responsibility for implementation of substance use policy/plan



Source: Substance use atlas survey 2021

[1] Defined as continuous collaboration without a formal arrangement.

1.2 Financing

Ministries/offices with specific budget line(s) for the prevention of substance use and/or treatment of substance use disorders

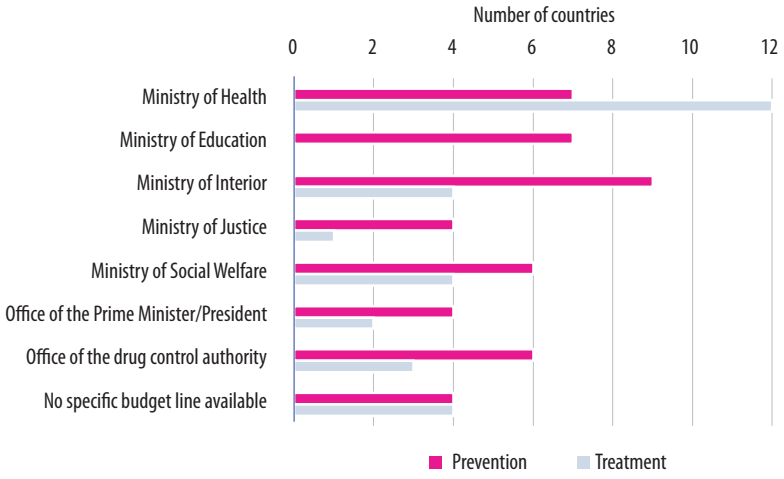
Background

Respondents were asked about ministries/offices that have specific budget line(s) for the prevention of substance use and/or the treatment of SUDs. They were asked if the Ministry of Health had a specific budget line(s) for the prevention of substance use and treatment of SUDs.

Findings

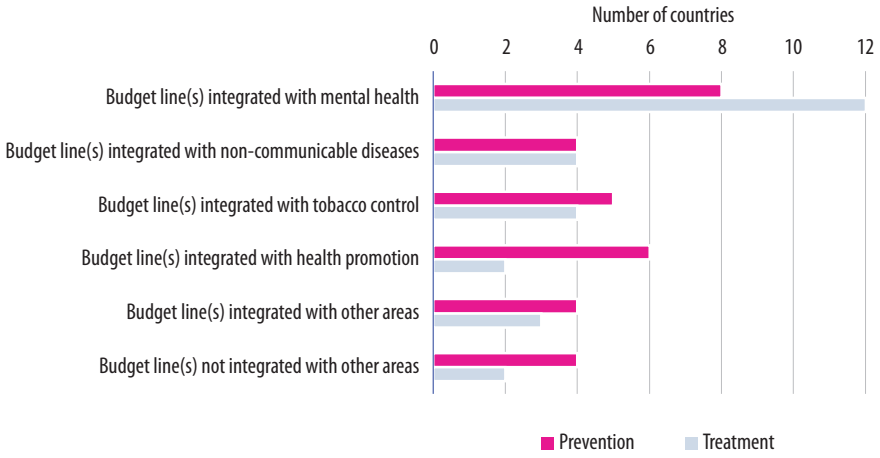
Thirteen countries (81% of responding countries) reported that they had a specific budget for the prevention of substance use and/or the treatment of SUDs. Three countries reported that they had no specific budget line for prevention or treatment, which was comparable with the results of the 2015 atlas. Of

Fig. 1.8. Countries with ministries/offices with specific budget line(s) for prevention of substance use and/or treatment of SUDs



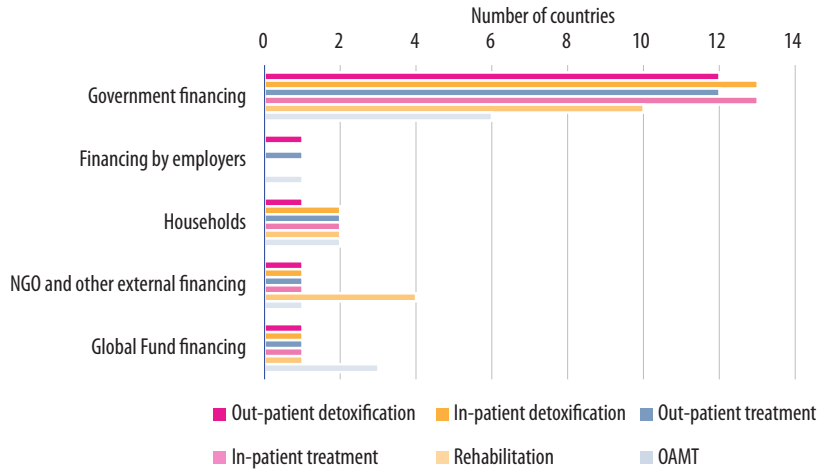
Source: Substance use atlas survey 2021.
Note: Respondents could choose to include budgets in more than one area.

Fig. 1.9. Integration of specific budget line(s) for prevention of substance use and treatment of SUDs into other areas



Source: Substance use atlas survey 2021.

Fig. 1.10. Financing of services for SUDs in different treatment settings



Source: Substance use atlas survey 2021.

the responding countries, 25% reported that they had a specific budget line for the prevention of substance use that was not integrated into other areas, and 12% reported that they had a specific budget line for the treatment of SUDs that was not integrated into other areas (Fig. 1.8).

It appears that ministries other than ministries of health have started to make specific allocations for the prevention and management of substance use over the past few years. For example, 45% of responding countries in the 2021 atlas survey reported that the ministry of interior had a specific budget for the prevention of substance use, three times the percentage reporting that was the case in the 2015 atlas (Fig. 1.9).

Financing services for SUDs in public or private treatment settings

Background

Respondents were asked how different services for SUDs were financed in public and private treatment settings.

Findings

For all treatment modalities, government financing was the most commonly reported financing method. However, two countries reported individuals/families as the main financing method for SUDs treatment services (Fig.10).

In general, there was no significant change in financing modalities for services for SUDs since the 2015 atlas survey.

1.3 Legislation

Legal provisions related to drug demand reduction and stand-alone drug laws

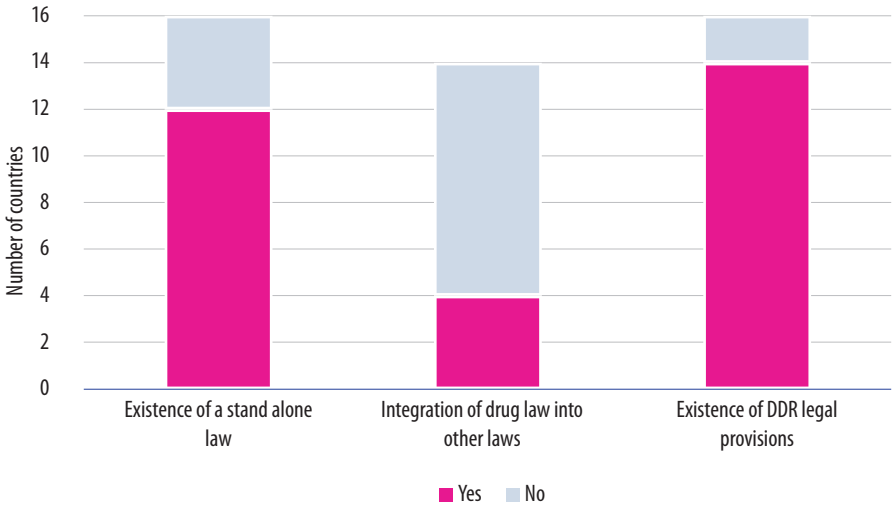
Background

Respondents were asked if their country had a stand-alone drug law, or whether legal provisions on drug use were incorporated into other laws. They were also asked in which year drug laws or legal provisions on drug use were enacted. The other question in this section was about the availability of legal provisions related to drug demand reduction (DDR),[1] aimed at minimizing adverse public health and social consequences.

Findings

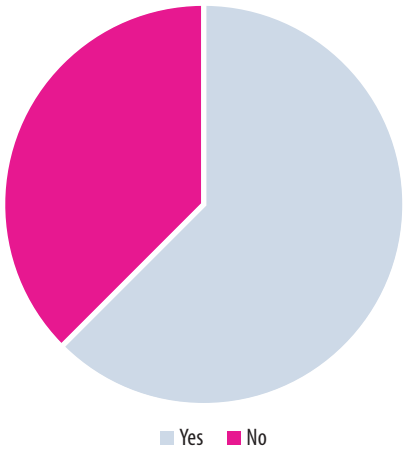
Twelve countries (75% of responding countries) reported that they had stand-alone drug use laws, and two countries reported having both stand-alone laws and laws integrated into other laws. Fourteen countries (87% of responding countries) reported that they had legal provisions related to DDR. Two countries reported that they had no drug laws, either stand-alone or integrated into other laws (Fig. 1.11). In most countries, drug laws were enacted between 2015 and 2021.

Fig. 1.11. Existence of legal provisions on substance use



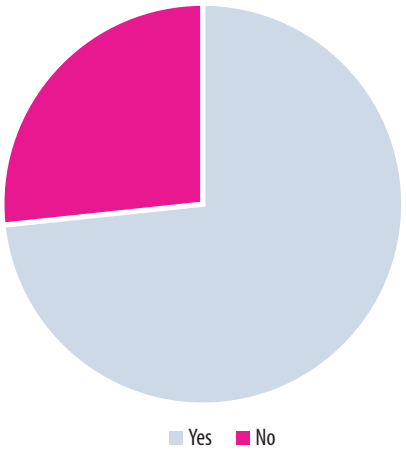
Source: Substance use atlas survey 2021.

Fig. 1.12. Existence of legislation that promotes the rights of people with substance use-related problems



Source: Substance use atlas survey 2021.

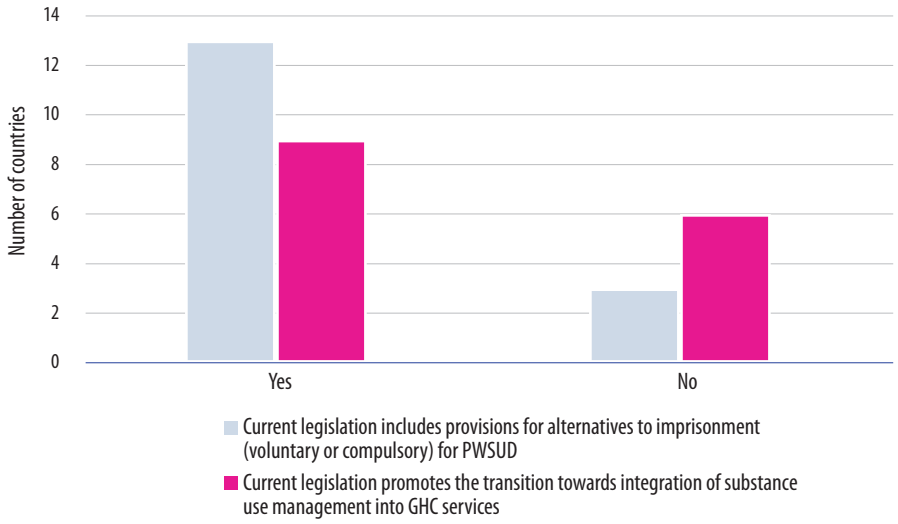
Fig. 1.13. Existence of a national law or legal regulation to protect people in treatment for SUDs



Source: SDG survey, 2019.

[1] Including prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration measures.

Fig. 1.14. Legal provisions and measures to facilitate alternatives to imprisonment for PWSUD



Source: Substance use atlas survey 2021.

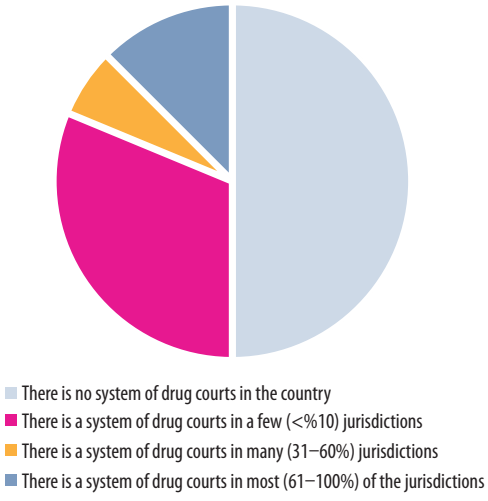
Legislation and regulations to promote the rights of people with substance use disorders

Background

Respondents were asked if their country's current legislation promoted the rights of people with substance use-related problems and protected people in treatment for SUDs.

Information related to the existence of a national law or a legal regulation to protect people in treatment for SUDs is derived from the survey conducted in 2019 on progress towards the realization of SDG Target 3.5.

Fig. 1.15. Drug court systems and their estimated coverage



Source: Substance use atlas survey 2021.

Findings

Ten countries (62% of responding countries) reported that their current legislation promoted the rights of people with substance use-related problems (Fig. 1.12). Eleven countries (73% of responding countries) reported that they had a law or legal regulation on protecting people in treatment for SUDs (Fig. 1.1.3).

National legislation and measures facilitating the provision of alternatives to imprisonment for people with SUDs

Background

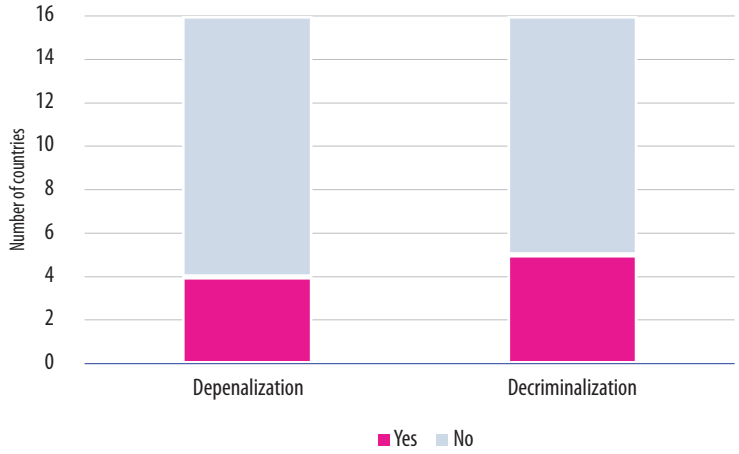
Respondents were asked if current legislation in their country promoted a transition towards the integration of substance use management into general health care (GHC) settings. They were also asked if the current legislation included provisions for the diversion of PWSUD from the criminal justice system to the health care system (Fig. 1.14).

Findings

Thirteen countries (81% of responding countries) reported that their current legislation included provisions for voluntary or compulsory treatment as an alternative or in addition to criminal sanctions. Nine countries (56% of responding countries) reported that their current legislation promoted a transition towards the integration of substance use management into GHC settings.

The percentage of responding countries reporting the availability of legal provisions for voluntary or compulsory treatment as an alternative or in addition to criminal sanctions has increased compared with the 2015 atlas survey, from around 60% to 81% of countries.

Fig. 1.16. Depenalization and decriminalization of drug use



Source: Substance use atlas survey 2021.

There was no question in the 2015 atlas survey about the availability of legislation to promote the transition towards integration of drug use management into GHC services.

Drug court systems

Background

Respondents were asked if there was a drug court system[1] in their country and, if coverage estimates were available .

Findings

Eight countries (50% of responding countries) reported that they had a drug court system, with varying rates of coverage. Of these countries, four reported that the use of drug courts had increased.

Compared with the 2015 atlas survey, the percentage of responding countries reporting that they had a drug court system increased by 37 percentage points (from 13% to 50%) (Fig. 1.15)..

Provisions for decriminalization and depenalization

Background

Respondents were asked about the existence of legal provisions for the decriminalization and depenalization of drug use.[2]

Findings

Four countries (25% of responding countries) reported that they had provisions for depenalization, and five countries (31% of responding countries) reported that they had provisions for decriminalization (Fig. 1.16).

This question was not asked in the 2015 atlas survey.

[1] For a glossary of specialist terms, see Annex 2.

[2] See Annex 2.

2. Health sector response

2.1 Sectors, services and settings

Main drug at entry point to treatment

Background

Respondents were asked about the main drug being used at the entry point to treatment. They could rank five substances as the main drugs at treatment entry point, from a list provided.[1]

Findings

The main class of drugs reported at the treatment entry point was opioids (eight countries), followed by cannabinoids (four countries), sedatives, anxiolytics and sleeping pills (two countries) and amphetamine-type stimulants (ATS) (one country). Most countries did not rank a fifth main drug at entry to treatment (Fig. 2.1).

The percentage of responding countries that ranked opioids as the main drug at entry to treatment almost doubled in 2021 compared with the 2015 atlas. There was no significant change in the percentage of countries that reported cannabinoids as the main drug at entry to treatment.

Main sectors providing treatment services for people with substance use disorders

Background

Respondents were asked about the sector in which most people received treatment services for SUDs. They were asked to select only one sector for each treatment service.

Findings

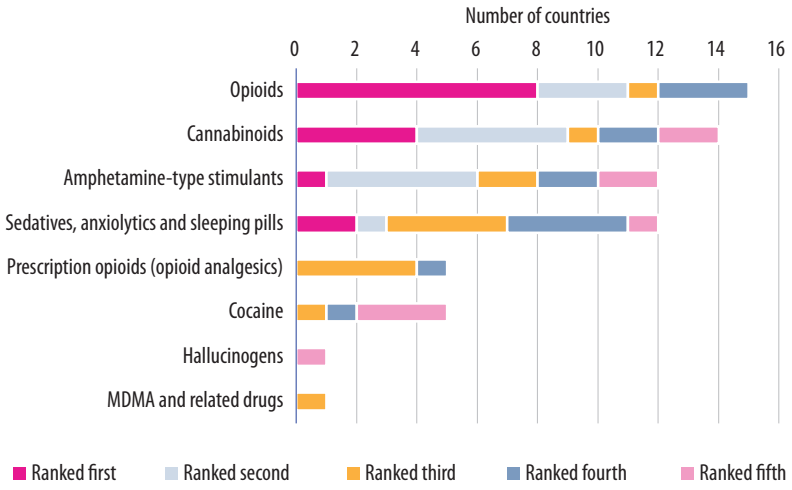
For all treatment modalities, the public health sector was the main provider of treatment services for SUDs, similar to the findings of the 2015 atlas survey (Fig. 2.2).

Main providers of treatment services for substance use disorders

Background

Respondents were asked to rank the five main providers of treatment services for SUDs.

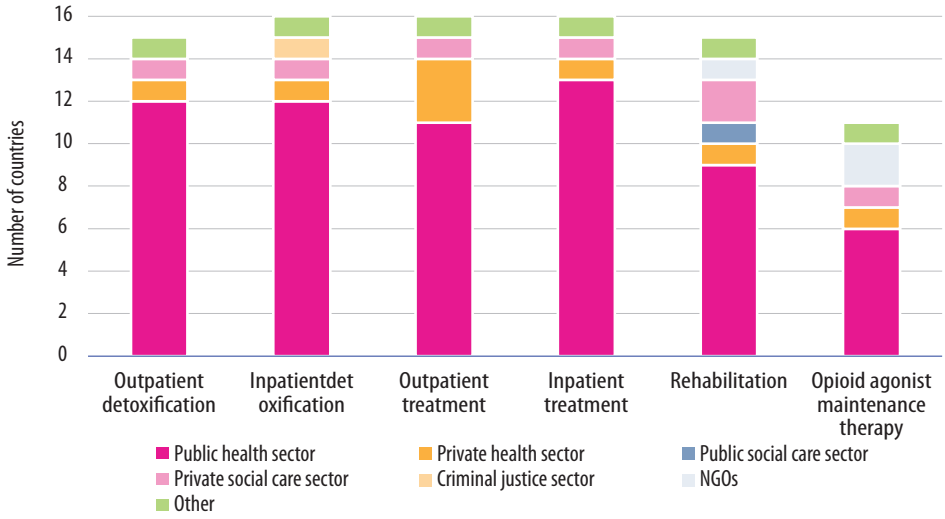
Fig. 2.1. Substances reported as main drug at entry to treatment



Source: Substance use atlas survey 2021.

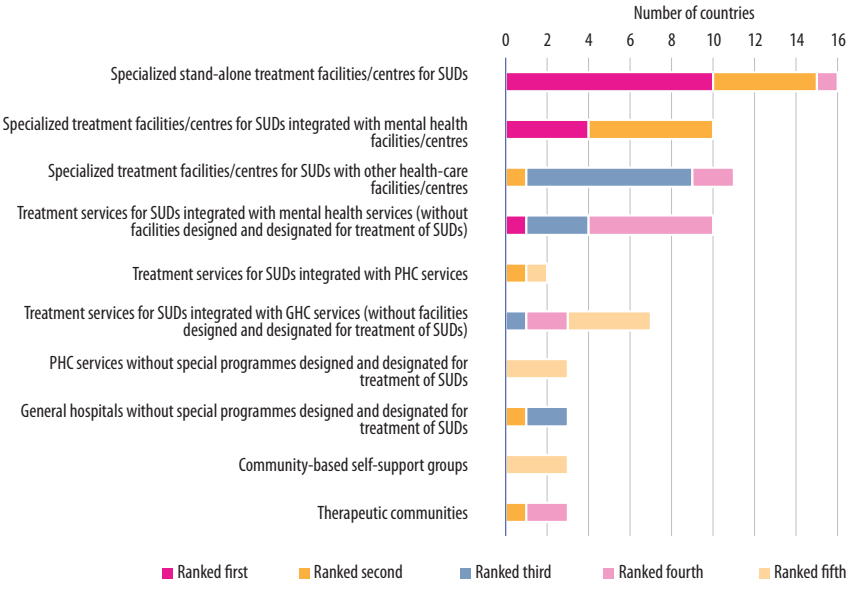
[1] The list included: amphetamine-type stimulants (speed, etc.), cannabinoids, cocaine (including crack cocaine), hallucinogens, ketamine, MDMA and related drugs, opioids (heroin, etc.), PCP and other dissociative drugs, prescription opioids (opioid analgesics, methadone, buprenorphine), sedatives, anxiolytics and sleeping pills, and volatile inhalants.

Fig. 2.2. Main sectors providing treatment services for SUDs



Source: Substance use atlas survey 2021.

Fig. 2.3. Main providers of treatment services for SUDs



Source: Substance use atlas survey 2021.

Findings

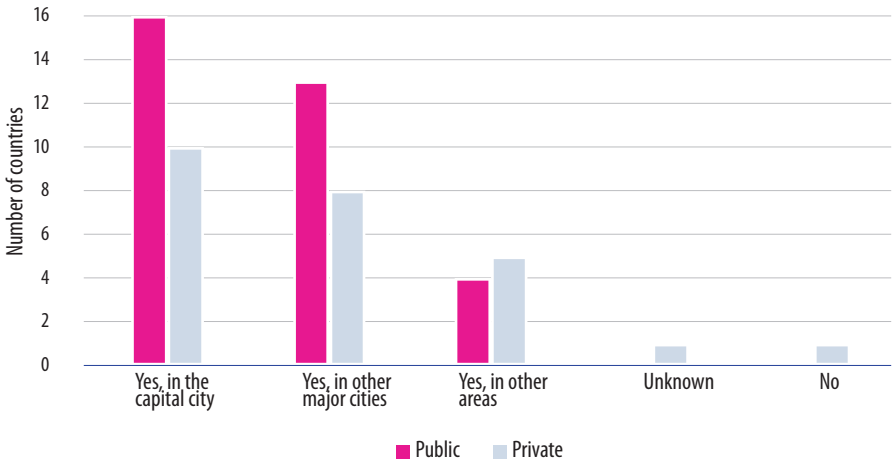
Stand-alone treatment facilities were reported by 10 countries (62% of responding countries) as the main providers of treatment services for SUDs, followed by services integrated within mental health facilities and GHC services, each reported by four countries (Fig. 2.3).

Specialized treatment services for people with substance use disorders

Background

Respondents were asked about the availability of specialized treatment facilities, publicly or privately

Fig. 2.4. Availability and geographic distribution of specialized treatment facilities for SUDs



Source: Substance use atlas survey 2021.

funded, for SUDs and their geographical distribution.

Findings

All the responding countries reported that they had publicly funded specialized treatment facilities for SUDs, either in the capital city or in other major cities and areas. Generally, specialized treatment facilities were less widely available in rural areas (Fig. 2.4).

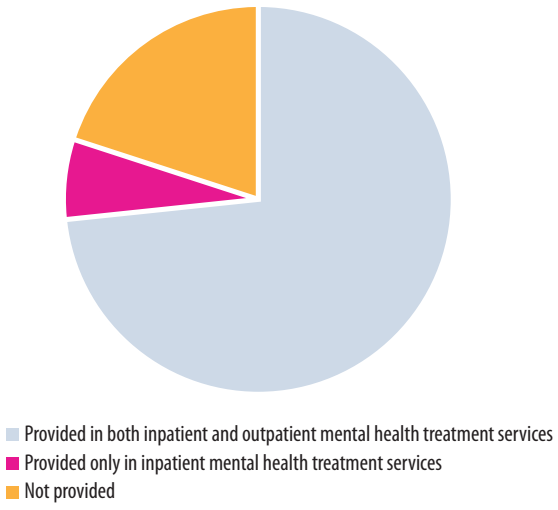
There was an increase of about 35 percentage points in the number of responding countries reporting that they had publicly funded specialized treatment facilities for SUDs in their capital city.

Providing specialized treatment services for people with SUDs in mental health treatment services

Background

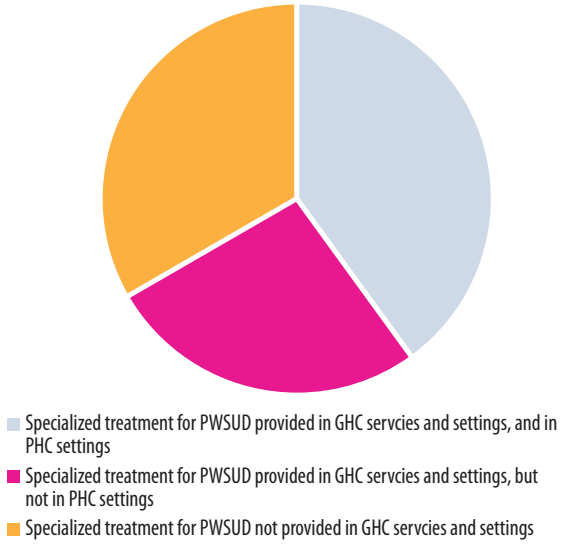
This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the availability of

Fig. 2.5. Mental health treatment settings providing specialized treatment services for PWSUD



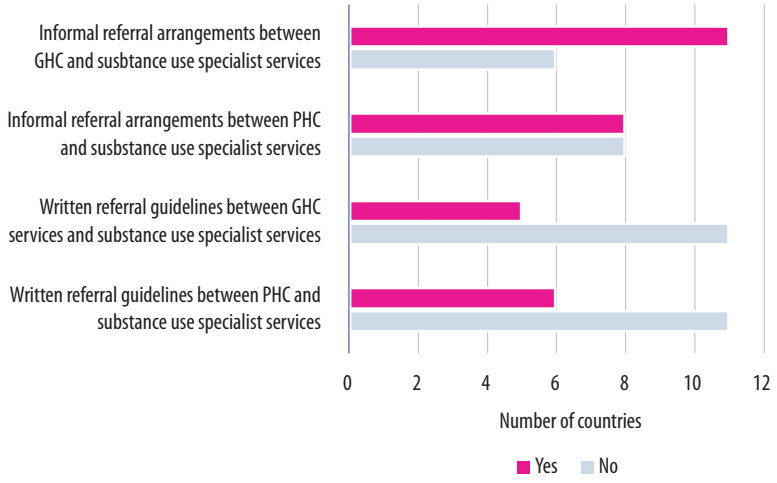
Source: SDG survey, 2019.

Fig. 2.6. Provision of specialized treatment for PWSUD in GHC and PHC services and settings



Source: SDG survey, 2019.

Fig. 2.7. Existence of referral guidelines/pathways between PHC/GHC services and specialist services



Source: Substance use atlas survey 2021.

specialized treatment services for PWSUD in mental health treatment services and their availability in inpatient, outpatient or both settings.

Findings

Twelve countries (80% of responding countries) reported that they provided specialized services for PWSUD in mental health treatment services in either inpatient or outpatient treatment settings.

Provision of specialized treatment for people with SUDs in general health care services and settings

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the availability of specialized treatment for PWSUD in GHC services and settings (such as district hospitals or outpatient clinics) and in PHC settings.

Findings

Six countries (40% of responding countries) reported that they provided specialized treatment for PWSUD in both GHC and PHC settings.

Availability of referral guidelines and pathways between primary/GHC services and specialist services

Background

Respondents were asked if there were referral guidelines and pathways in place between primary/general health care services and specialist services for people with substance use problems.

Findings

Five countries (31% of responding countries) reported that written referral guidelines between GHC and substance use specialist services existed and were used, and six countries (37% of responding countries) reported that such guidelines existed and were used between PHC services and substance use specialist services (Fig. 2.7).

This question was not asked in the 2015 atlas survey.

Total number of facilities providing services for SUDs

Total number of specialized facilities

Background

Respondents were asked about the total number of specialized facilities for SUDs and, out of this number, how many had provided OAMT for opioid dependence, HIV and hepatitis testing, counselling and treatment during the past 12 months.

Findings

Fourteen countries (87% of responding countries) provided the number of specialized facilities they had for the treatment of SUDs. The average number of such facilities per 100 000 adult population was 0.19. Twelve countries reported that they had provided HIV and hepatitis testing, counselling and treatment services and five countries reported that they had provided OAMT during the past 12 months in specialized facilities for the treatment of SUDs (Fig. 2.1).

Table 2.1. Total number of specialized facilities, and specialized facilities providing OAMT, HIV and hepatitis services

Country	Number of specialized facilities	Facilities per 100 000 adult population	Number of specialized facilities providing these services during the past 12 months					
			OAMT	HIV testing and counselling	Antiretroviral treatment (ART)	HCV testing and counselling	Hepatitis vaccination	Hepatitis treatment
Afghanistan	81	0.38	–	–	–	–	–	–
Iran (Islamic Republic of)	100	0.17	100	100	100	100	100	100
Iraq	5	0.02	NA	0	0	0	0	0
Jordan	32	0.49	NA	19	19	19	19	19
Kuwait	1	0.03	1	1	0	1	0	1
Morocco	18	0.07	7	7	–	7	0	0
Oman	32	0.83	0	32	32	32	-	32
Occupied Palestinian territory	15	0.5	12	2	0	2	0	0
Pakistan	20	0.01	0	0	0	0	0	0
Qatar	1	0.04	1	1	1	1	1	1
Sudan	1	0.004	–	–	–	–	–	–
Saudi Arabia	32	0.13	0	19	19	19	19	19
United Arab Emirates	2	0.02	–	0	0	1	1	1
Yemen	1	0.006	0	1	1	1	1	1

Source: Substance use atlas survey 2021.

Table 2.2. Number and percentage of PHC services providing SBIs

County	PHC services		
	Number of services	PHC services implementing SBI	
		Number	Percentage
Iran (Islamic Republic of)[1]	27 319	100	0.36%
Iraq	21	–	–
Jordan	370	93	25%
Kuwait	–	–	–
Lebanon	220	50	22%
Morocco	538	–	–
Oman	21	–	–
Occupied Palestinian territory	250	12	4.8%
Pakistan	1184	300	25%
Qatar	28	0	0%
Saudi Arabia	2325	1037	44.6%
United Arab Emirates	–	–	–
Yemen	0	0	0

Source: Substance use atlas survey 2021.

[1] The Islamic Republic of Iran has the largest programme for the treatment of SUDs in the Eastern Mediterranean Region.

Table 2.3. Total number of mental health facilities and number/percentage providing SUD services during the past 12 months

Countries	Mental health facilities		
	Number of MH facilities	Providing services for SUDs during past 12 months	
		Number	Percentage
Iran (Islamic Republic of)	14 241	100	0.7%
Iraq	34	16	47%
Jordan	3	–	–
Kuwait	2	1	50%
Lebanon	109	–	100%
Morocco	119	53	44%
Oman	11	11	100%
Occupied Palestinian territory	12	3	25%
Pakistan	1002	348	35%
Qatar	5	0	0%
Saudi Arabia	32	32	100%
United Arab Emirates	1	1	100%
Yemen	7	1	15%

Source: Substance use atlas survey 2021.

Total number of mental health and PHC facilities providing services for substance use disorders

Background

Respondents were asked about the total number of mental health facilities and services and the number of these services that had provided treatment for SUDs during the past 12 months.

They were also asked about the total number of PHC services and the number of these services that had implemented screening and brief interventions (SBIs) for harmful and hazardous substance use at the national level during the past 12 months.

Findings

Thirteen countries (81% of responding countries) provided information about the number of services and facilities that provided services for SUDs within mental health and PHC settings.

The median percentage of PHC services implementing SBIs during the past 12 months was 22%, and the median percentage of mental health facilities providing services for SUDs during the past 12 months was 47% (Table 2.2).

Total number of beds available for inpatient treatment of substance use disorders

Background

Respondents were asked about the total number of beds available for inpatient treatment of SUDs in publicly and privately funded GHC facilities, mental health care facilities and specialized SUD facilities.

Findings

Thirteen countries (81% of responding countries) provided data about the number of beds available for the treatment of SUDs in GHC, mental health care and specialized SUD centres in the public sector.

The median number of beds available for treatment of SUDs per 100 000 adult population in public mental health services was 1.13 and in public specialized centres for SUDs it was 0.68.

Only three countries provided data about the number of beds available for treatment of SUDs in different private health care centres and facilities (Table 2.4).

Table 2.4. Total number of beds for SUD treatment in GHC, public mental health care centres (MHCs) and public specialized centres for SUDs

Country	Public GHC		Public MHCs		Public specialized centres for SUDs	
	Number of beds for SUD	Per 100 000 adult population	Number of beds for SUD	Per 100 000 adult population	Number of beds for SUD	Per 100 000 adult population
Afghanistan	–	–	–	–	3565	16.5
Egypt	–	–	700	1.13	200	0.32
Iran (Islamic Republic of)	1828	3.17	5498	9.53	190 181	330
Iraq	–	–	143	0.6	70	0.29
Jordan	–	–	–	–	270	0.04
Kuwait	–	–	–	–	–	200
Morocco	–	–	–	–	45	0.18
Oman	6	0.16	44	1.15	40	1.04
Pakistan	3440	2.6	350	0.26	100	0.07
Qatar	–	–	–	–	73	3
Saudi Arabia	–	–	4440	17.76	1739	6.96
United Arab Emirates	–	–	18	0.22	–	–
Yemen	–	–	–	–	14	0.08

Source: Substance use atlas survey 2021.

2.2 Special treatment programmes for specific populations

Treatment programmes for women and pregnant women with substance use disorders

Background

Respondents were asked about the availability of special treatment programmes for women and for pregnant women, and their geographical distribution.

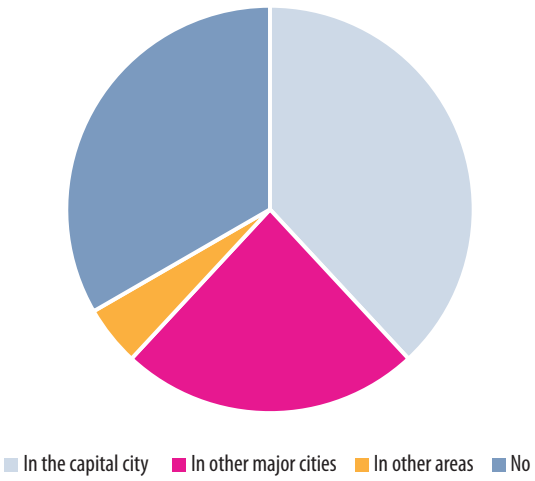
Findings

Nine countries (56% of responding countries) reported that they had special treatment programmes for women with SUDs, and four countries reported that they had specialized programmes for pregnant women with SUDs.

Compared with the 2015 atlas survey, two more countries reported that they had special treatment programmes for women, either in the capital city or in other major cities or other areas (Fig. 2.8).

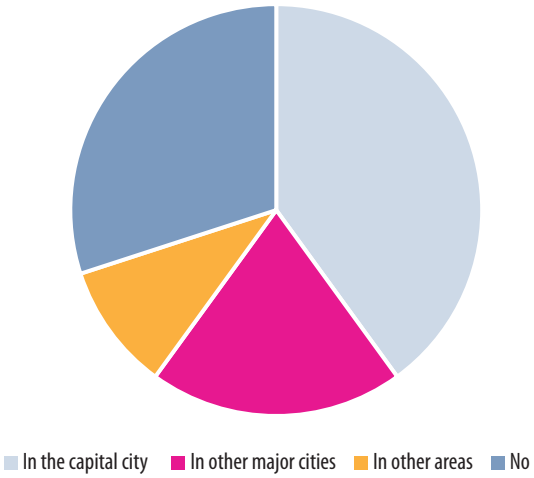
There was no question about special treatment programmes for pregnant women with SUDs in the 2015 atlas survey.

Fig. 2.8. Special treatment programmes for women with SUDs



Source: Substance use atlas survey 2021.

Fig. 2.9. Special treatment programmes for children and adolescents with SUDs



Source: Substance use atlas survey 2021.

Treatment programmes for children and adolescents with substance use disorders

Background

Respondents were asked about the availability of special treatment programmes for children and adolescents with SUDs, and their geographical distribution.

Findings

Nine countries (56% of responding countries) reported that they had special treatment programmes for children and adolescents with SUDs (Fig. 2.9).

As with programmes for women, the availability of special treatment programmes for children and adolescents is very limited in other areas.[1]

Compared with the 2015 atlas survey, four more countries reported that they had special treatment programmes for children and adolescents either in the capital city or in other major cities or other areas.

Special treatment programmes for older people and people with comorbid conditions and disabilities with SUDs

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the availability of specialized programmes for the treatment of SUDs for older people and people with comorbid conditions and disabilities.

Findings

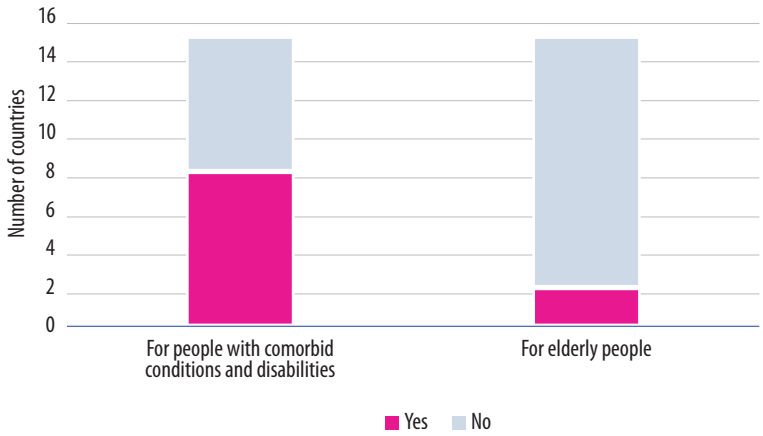
Eight countries (53% of responding countries) reported that they had specialized programmes for people with disabilities and comorbid conditions, while only two countries reported that they had programmes for older people with SUDs (Fig. 2.10).

Treatment services for substance use disorders and related health problems for incarcerated populations

Background

Respondents were asked whether treatment services for SUDs and related health problems were available for incarcerated populations. They were also asked what treatment services for SUDs were available for people in pre-trial detention, in prisons and in post-release phases.

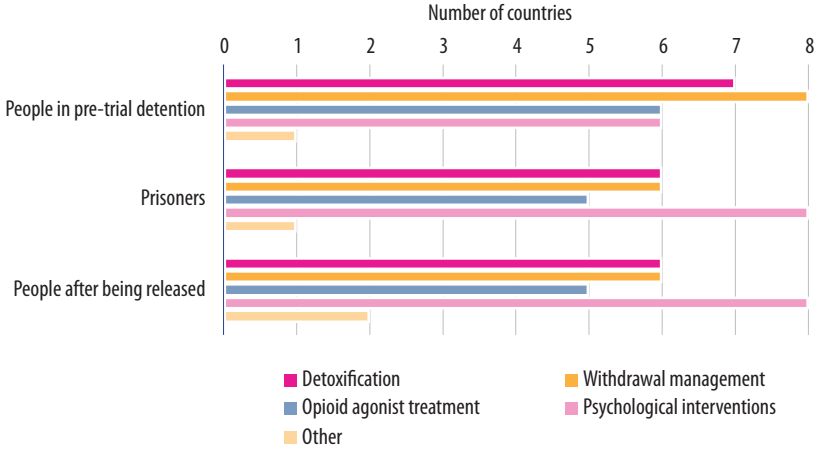
Fig. 2.10. Specialized treatment programmes for people with SUDs in special population groups



Source: SDG survey, 2019.

[1] "Other areas" refers to urban and rural areas outside the capital and major cities.

Fig. 2.11. Treatment services for SUDs for incarcerated populations



Source: Substance use atlas survey 2021.

Findings

Nine countries (56% of responding countries) reported that they had treatment services for SUDs and related health problems available for incarcerated populations.

Ten countries (62% of responding countries) reported that psychological interventions were the treatment services most commonly provided to prisoners and ex-prisoners after release. Withdrawal management was the most common service provided for people in pre-trial detention (Fig. 2.11).

2.3 Accessibility and coverage of treatment services for people with substance use disorders

Proportion of people who seek and receive treatment for drug dependence

Background

Respondents were asked about the proportion of people who seek treatment for substance dependence and who receive such treatment. The question was asked for opioid dependence, cannabinoid dependence and ATS dependence for the whole population and also disaggregated by gender.

Findings

Eleven countries (69% of responding countries) reported on the proportion of people seeking and receiving treatment for opioid use dependence; of these, six countries reported that this proportion was substantial (21–40%) or high (more than 40%) (Fig. 2.12.).

Twelve countries (75% of responding countries) reported on the proportion of people who seek and receive treatment for cannabis use dependence; of these, five countries reported that this proportion was substantial (21–40%) or high (more than 40%) (Fig. 2.13).

Ten countries (62% of responding countries) reported on the proportion of people who seek and receive treatment for amphetamine use dependence; of these, six countries reported that this proportion was substantial (21–40%) or high (more than 40%) (Fig. 2.14).

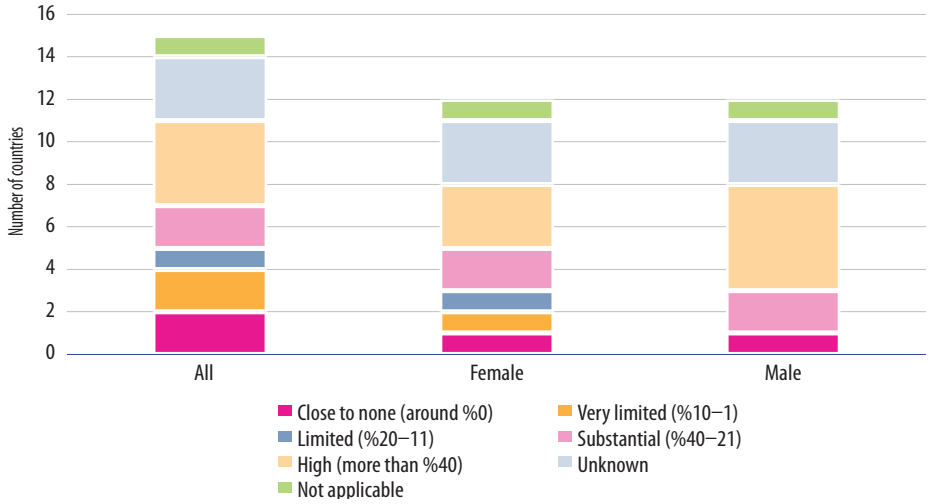
On average and across the three substances (opioids, cannabis and amphetamines), roughly 60% of responding countries reported on the proportion of people who seek treatment for substance dependence and who receive such treatment. Of these, around 50% reported that this proportion was substantial (21–40%) or high (more than 40%).

The proportion of women seeking and receiving treatment for substance dependence was lower than the proportion of men.

Compared with the 2015 atlas survey, there was no significant change in the proportion of people who seek and receive treatment for opioid or cannabis dependence. There has been a decrease in the percentage of responding countries that reported the situation to be "unknown" (a reduction of about 5% for cannabis dependence and 16% for opioid dependence); this may suggest an improvement in data reporting (Fig. 2.15-2.16).

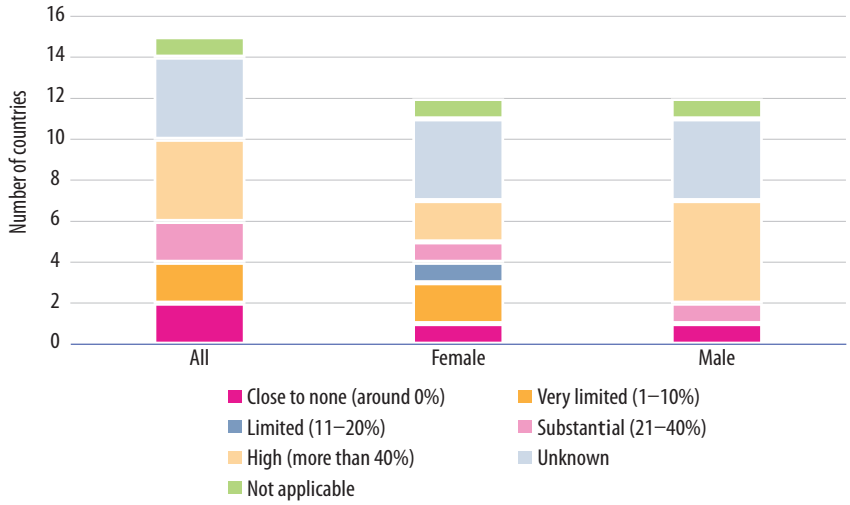
In the 2015 atlas survey, data were not collected on the proportion of people who seek treatment for amphetamine dependence and who receive it, and there was no question on data disaggregated by gender.

Fig. 2.12. Proportion of people seeking and receiving treatment for opioid dependence



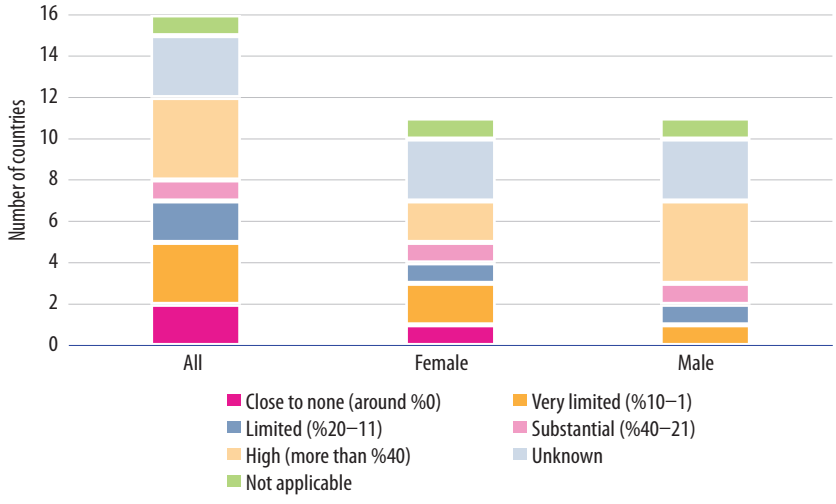
Source: Substance use atlas survey 2021.

Fig. 2.13. Proportion of people seeking and receiving treatment for cannabis dependence



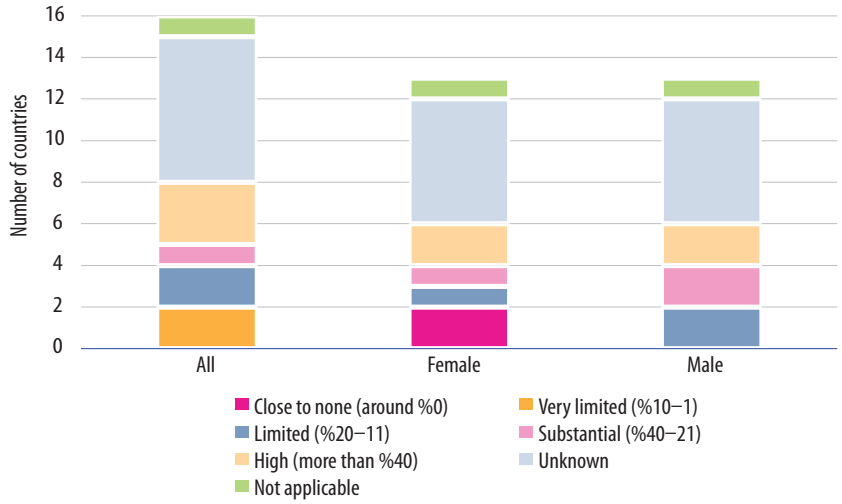
Source: Substance use atlas survey 2021.

Fig. 2.14. Proportion of people seeking and receiving treatment for amphetamine dependence



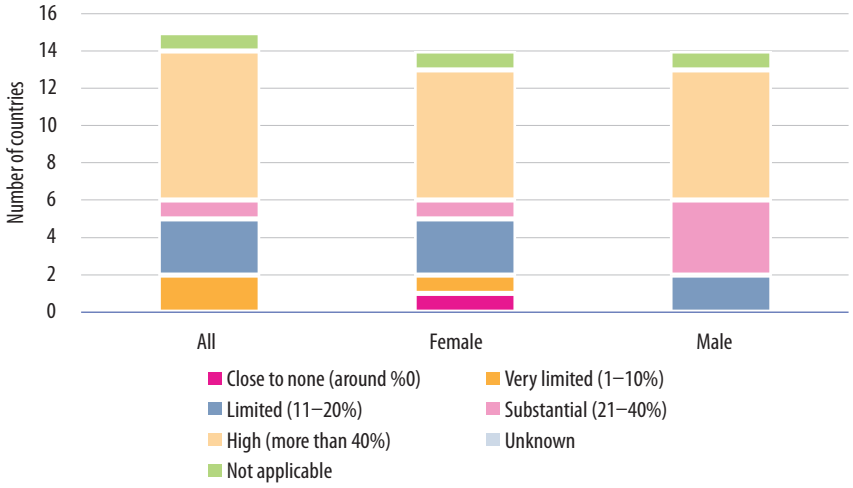
Source: Substance use atlas survey 2021.

Fig. 2.15. Treatment coverage for people with opioid use dependence



Source: Substance use atlas survey 2021.

Fig. 2.16. Treatment coverage for people with cannabis dependence



Source: Substance use atlas survey 2021.

Treatment coverage

Background

Respondents were asked about treatment contact coverage i.e. the proportion of PWSUD who are in contact with treatment services. The question was asked separately for opioid, cannabinoid and ATS dependence, for the whole population and disaggregated by gender.

Findings

For countries that had data available, treatment contact coverage was generally reported as being very limited (1–10%) or limited (11–20%) for all three substances. Treatment contact coverage was generally higher for men than for women.

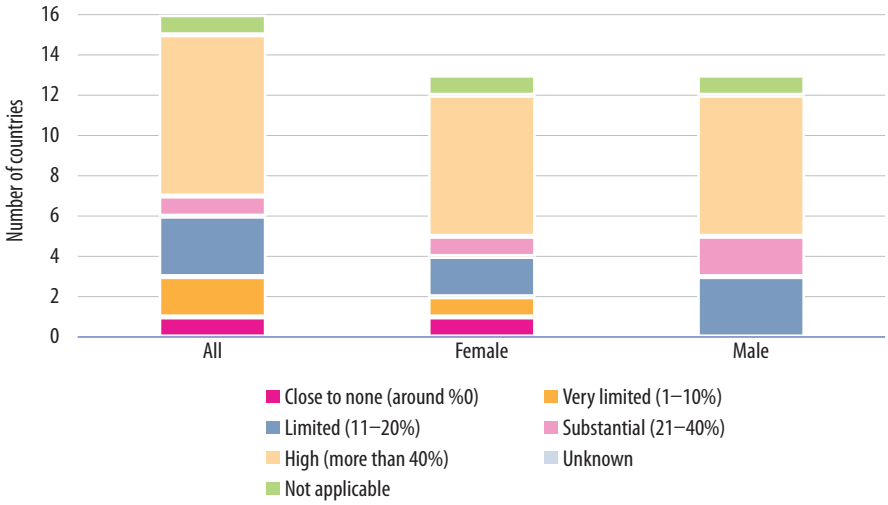
Treatment contact coverage for opioid use dependence was reported as being substantial (21–40%) or high (above 40%) by four countries in total. It was also reported as being very limited (1–10%) or limited (11–20%) by four countries in total (Fig. 2.15).

Treatment contact coverage for cannabis use dependence was reported as being substantial (21–40%) or high (above 40%) by just one country. It was reported as being very limited (1–10%) or limited (11–20%) by five countries (Fig. 2.16).

Treatment contact coverage for ATS use dependence was reported as being substantial (21–40%) by one country. It was reported as being very limited (1–10%) or limited (11–20%) by five countries (Fig. 2.17).

In general, levels of treatment coverage do not show any significant change from the levels reported in the 2015 atlas survey.

Fig. 2.17. Treatment coverage for people with ATS dependence



Source: Substance use atlas survey 2021.

In the 2015 atlas survey, data disaggregated by gender were not collected for this question, and nor were data on treatment coverage for people with ATS dependence.

2.4 Treatment interventions

Pharmacological treatment for people with substance use disorders

Access to medicines: key medicines for treatment of SUDs

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked if the key medicines for the treatment of SUDs were:

- registered in the country
- included in the national drug formulary/essential list
- provided for free in the public sector.

Findings

The registration of methadone was reported by six countries, buprenorphine by three countries, naloxone by 11 countries and naltrexone by five countries (Fig. 2.18).

Five countries reported that methadone was included in the national drug formulary or essential medicine list, three reported that buprenorphine was included, eight that naloxone was included and three that naltrexone was included. (Fig. 2.19).

Three countries reported that methadone was provided free of charge in the public sector, one country buprenorphine and five countries naloxone. No country reported that naltrexone was available free of charge in the public sector (Fig. 2.20).

The most commonly registered medicine was naloxone, which was reported by 11 countries (73% of responding countries), and the least registered was extended-release formulations of opioid agonists, reported by only two countries (13% of responding countries).

Compared with the 2015 atlas survey, two more countries reported that methadone was registered and one more country that naltrexone was registered.

Opioid agonist pharmacotherapy for detoxification and maintenance treatment

Background

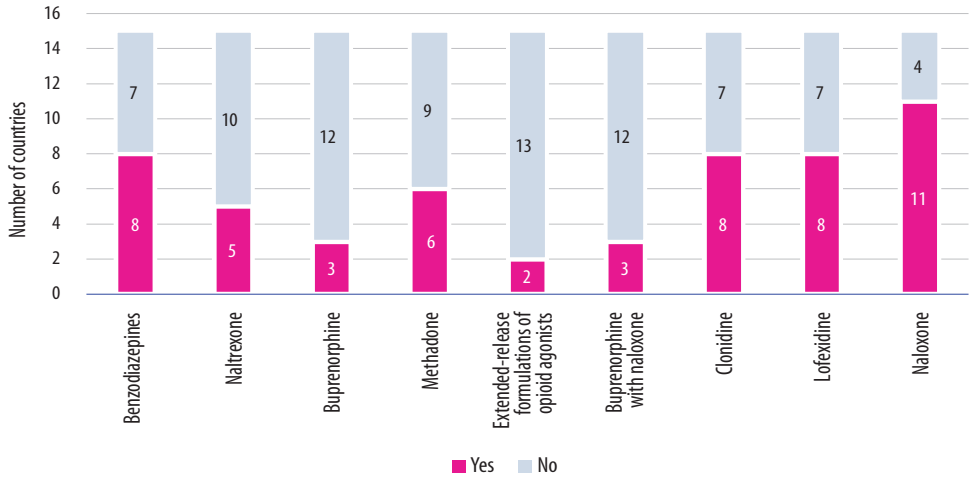
Respondents were asked if opioid agonist pharmacotherapy (such as with methadone, buprenorphine and buprenorphine/naloxone) was used for the treatment (detoxification and/or maintenance treatment) of opioid dependence in their countries.

Findings

Eleven countries (69% of responding countries) reported that they had at least one opioid agonist agent for pharmacotherapy.

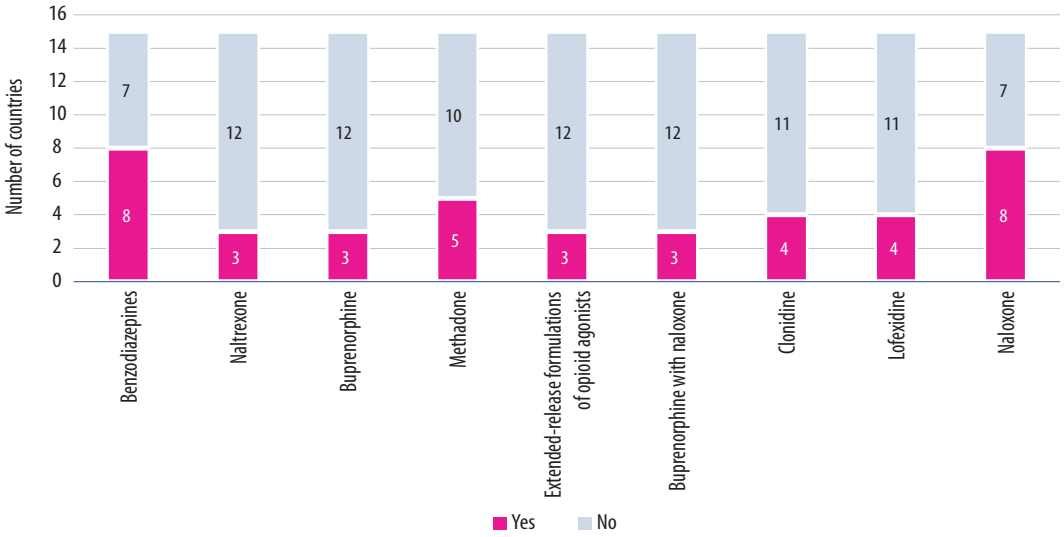
Nine countries (56% of responding countries) reported that they used at least one opioid agonist agent for detoxification and eight countries (50% of responding countries) reported that they used at least one opioid agonist agent for OAMT.

Fig. 2.18. Key medicines for the treatment of SUDs registered in countries



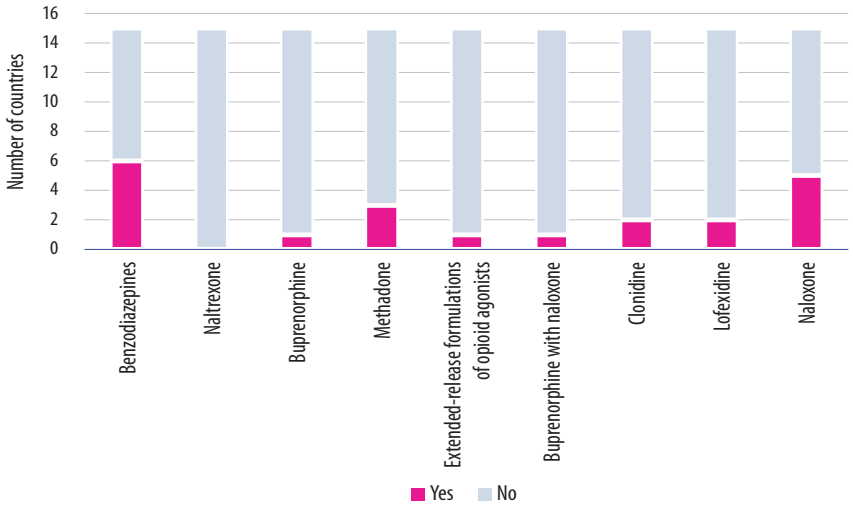
Source: SDG survey, 2019.

Fig. 2.19. Key medicines for the treatment of SUDs included in national drug formularies/essential lists



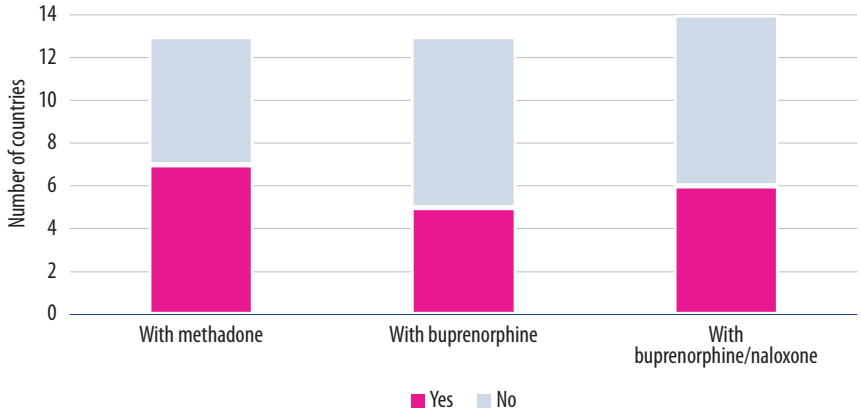
Source: SDG survey, 2019.

Fig. 2.20. Key medicines for the treatment of SUDs provided free of charge in the public sector



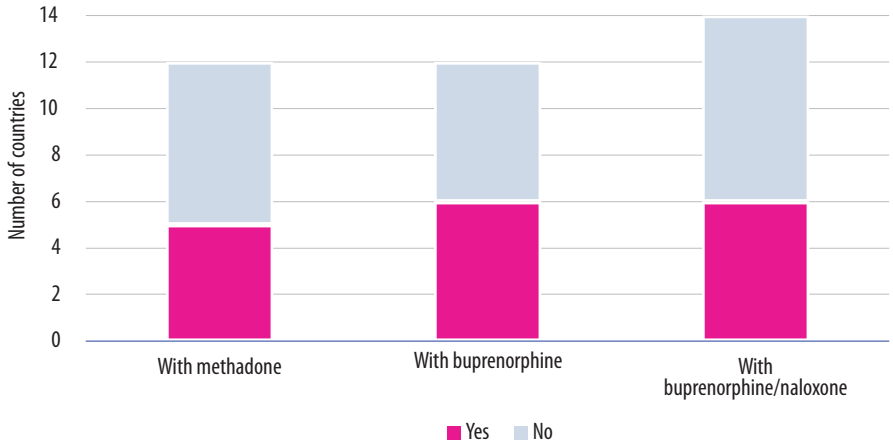
Source: SDG survey, 2019.

Fig. 2.21. Use of opioid agonist pharmacotherapy for detoxification of opioid dependence



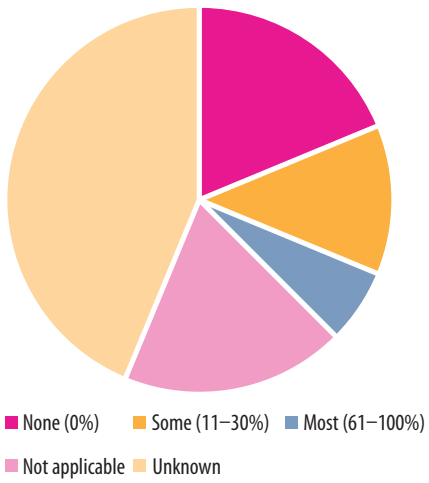
Source: Substance use atlas survey 2021.

Fig. 2.22. Use of opioid agonist pharmacotherapy for maintenance treatment of opioid dependence



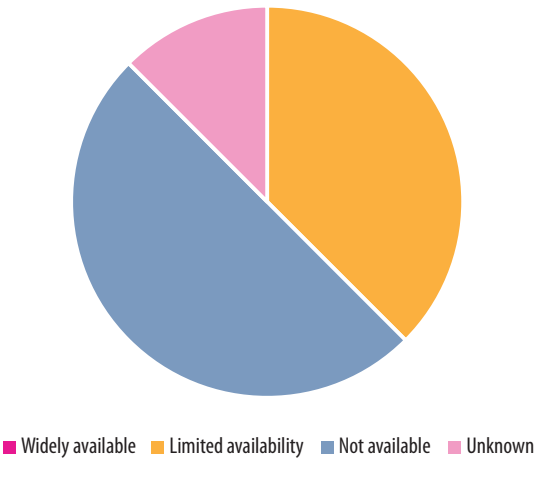
Source: Substance use atlas survey 2021.

Fig. 2.23. Proportion of ambulances that carry naloxone for use in suspected opioid overdoses



Source: Substance use atlas survey 2021.

Fig. 2.24. Availability of take-home naloxone to people at risk of opioid overdose/people likely to witness an overdose



Source: Substance use atlas survey 2021.

Of the eight countries providing OAMT, seven reported that outpatient dosing for OAMT was generally supervised; one reported that OAMT was time-limited while three reported that it was open-ended; two reported that they provided both time-limited and open-ended OAMT; and one reported that the situation was unknown.

Compared with the 2015 atlas survey, two more countries reported that they used methadone for detoxification, but the number of countries using methadone for maintenance treatment has not changed.

One more country reported that it used buprenorphine for detoxification and two more countries reported that they used it for maintenance treatment, compared with the 2015 atlas survey. Meanwhile, two more countries reported that they used buprenorphine/naloxone for detoxification and three more countries that they used it for maintenance treatment, compared with the 2015 atlas survey (Fig. 2.22).

Restrictions on the provision of opioid agonist maintenance treatment

Background

Respondents were asked if opioid agonist pharmacotherapies were available for maintenance treatment and whether there were any restrictions to access, such as age restrictions or restrictions on the duration of opioid dependence prior to treatment, or access being restricted solely to PWID.

Findings

Five countries (25% of responding countries) reported that they had no restrictions on providing OAMT. One country reported that its maintenance treatment was restricted solely to PWID. One country indicated that parental authorization was needed for persons under 18 years of age.

Opioids overdose management

Availability of naloxone in ambulances

Background

Respondents were asked about the proportion of ambulances that carry naloxone for use in suspected cases of opioid overdose.

Findings

The availability of naloxone in ambulances in countries in the Region is very limited, being reported by only three countries (Fig. 2.23).

This question was not asked in the 2015 atlas survey.

Availability of naloxone for take-home use

Background

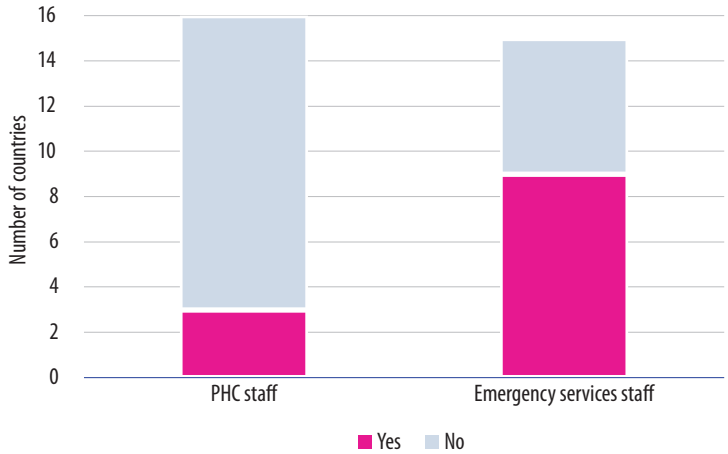
Respondents were asked if naloxone was available for take-home use (either through prescription, distribution or sale in pharmacies) to people at risk of opioid overdose or people likely to witness an overdose, for use in emergency situations.

Findings

None of the responding countries reported that naloxone was available for widespread use in the community. Six countries (37% of responding countries) reported limited availability for take-home use, either through prescription, distribution or sale in pharmacies (Fig. 2.24).

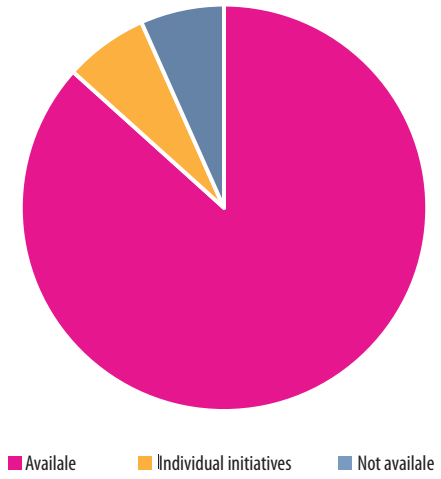
This question was not asked in the 2015 atlas survey.

Fig. 2.25. PHC and emergency services staff trained to manage opioid overdose



Source: ***Substance use atlas*** *survey 2021.*

Fig. 2.26. Availability of psychosocial treatment programmes for people with SUDs



Source: SDG survey, 2019.

Training on delivery of opioid overdose management for primary health care and emergency services staff

Background

Respondents were asked if staff in PHC and emergency services were trained to manage opioid overdose.

Findings

Three countries (19% of responding countries) reported that training on the management of opioid overdose was available for PHC staff, and nine countries (56% of responding countries) reported that such training was available for emergency services staff.

This question was not asked in the 2015 atlas survey.

Psychosocial treatment for people with substance use disorders

Availability of psychosocial treatment programmes

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the availability of psychosocial treatment programmes for PWSUD.

Findings

Fourteen countries (93% of responding countries) reported the availability of psychosocial treatment programmes for PWSUD (Fig. 2.26).

This question was not asked in the 2015 atlas survey.

Elements of psychosocial treatment for the majority of patients entering treatment for SUDs

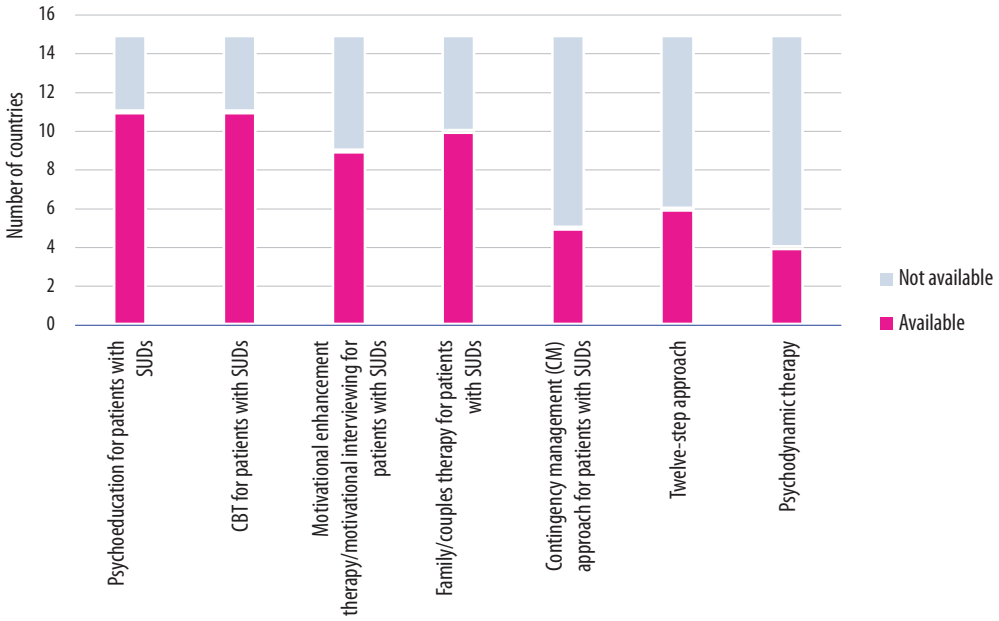
Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Countries were asked about the availability of different psychosocial treatments for PWSUD.

Findings

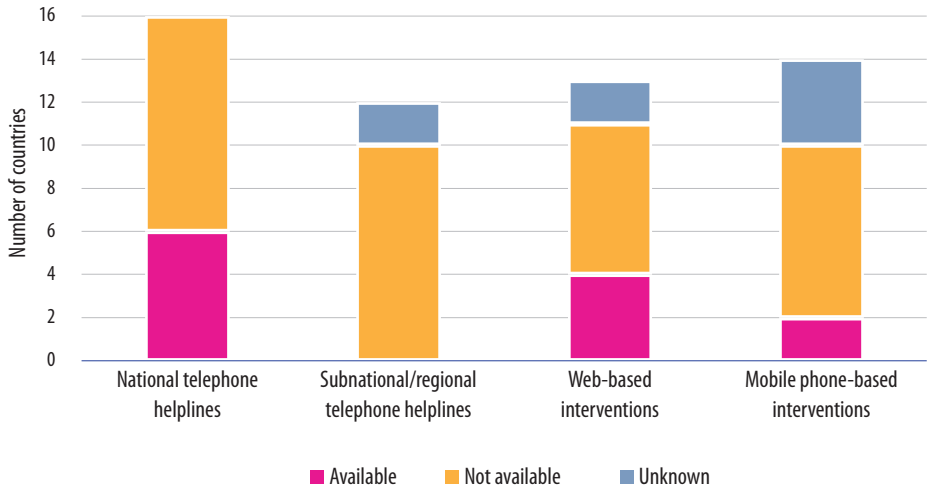
Twelve countries (80% of responding countries) reported on the availability of different types of psychosocial treatment. Psychoeducation and cognitive behavioural therapy (CBT) were the most common psychological treatment modalities for the majority

Fig. 2.27. Availability of psychosocial treatments for the majority of patients entering treatment for SUDs



Source: SDG survey, 2019.

Fig. 2.28. Open access interventions for addressing SUDs



Source: Substance use atlas survey 2021.

of patients entering treatment for SUDs; each was reported by half the countries in the Region (Fig. 2.27).

Note: two countries reporting that they had psychological treatment available for PWSUD did not respond to this question.

Open access and harm reduction interventions

Open access interventions

Background

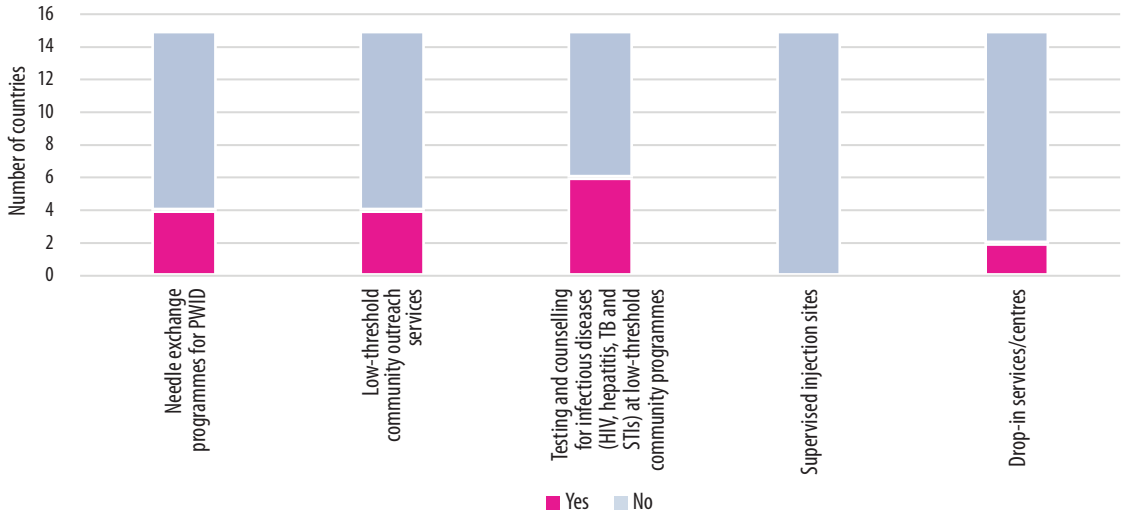
Respondents were asked about the availability of different types of open access intervention, including helplines, web-based interventions and mobile phone-based interventions, at the national or subnational (i.e. regional) level.

Findings

Between 12% and 37% of responding countries reported the availability of different open access interventions, depending on the specific intervention.

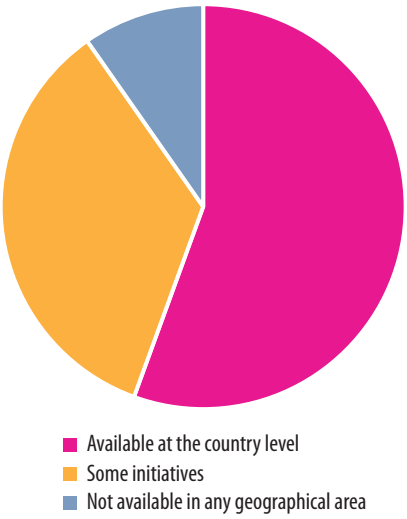
The availability of telephone helplines has not changed significantly since the 2015 atlas survey, though one more country reported that web-based interventions were available. The availability of mobile phone-based interventions among responding countries in 2021 was about half the percentage reported in the 2015 atlas survey. It might have been expected that mobile phone-based interventions would be more widely available considering the increasingly widespread availability of cell phones and their use in providing services, especially during the COVID-19 pandemic; however, this observation might be due to differences in the phrasing used in the atlas surveys in 2015 and 2021.

Fig. 2.29. Availability of harm reduction interventions



Source: SDG survey, 2019.

Fig. 2.30. Availability of rehabilitation programmes for PWSUD



Source: SDG survey, 2019.

Harm reduction interventions

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the availability of different harm reduction interventions for PWSUD.

Findings

Between 13% and 40% of responding countries reported that different harm reduction interventions were available, depending on the specific intervention.

Four countries reported the availability of needle exchange programmes for PWID and low-threshold community outreach services. Supervised injection sites are not available in any country of the Region.

In 2021, one more country reported having a needle exchange programme compared with the 2015 atlas survey. The number of countries reporting that they had low-threshold community outreach services has not changed since the previous atlas.

Rehabilitation

Rehabilitation programmes

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Countries were asked about the availability of rehabilitation programmes for PWSUD.

Findings

Thirteen countries (87% of responding countries) reported that they had rehabilitation programmes for PWSUD at the country level or as stand-alone initiatives by leading national institutions/research programmes (Fig. 2.30).

Special housing and employment for people with substance use disorders

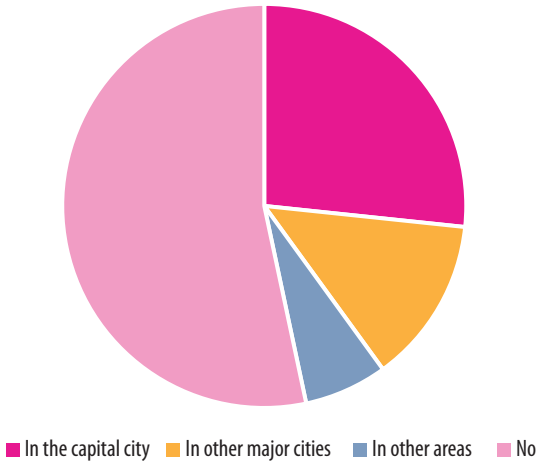
Background

Respondents were asked about the availability of special housing services and of employment for PWSUD as part of the treatment and rehabilitation process.

Findings

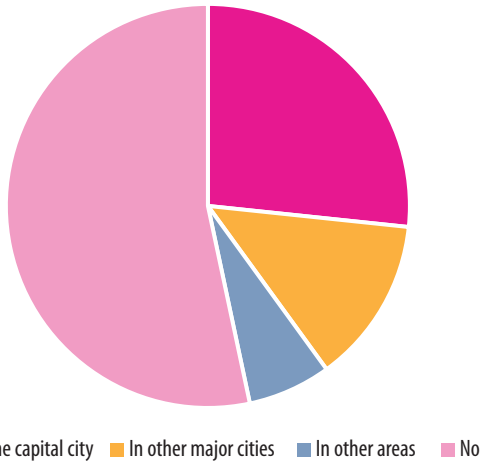
In general, the availability of special housing services and the provision of employment services for PWSUD,

Fig. 2.31. Special housing services for PWSUD



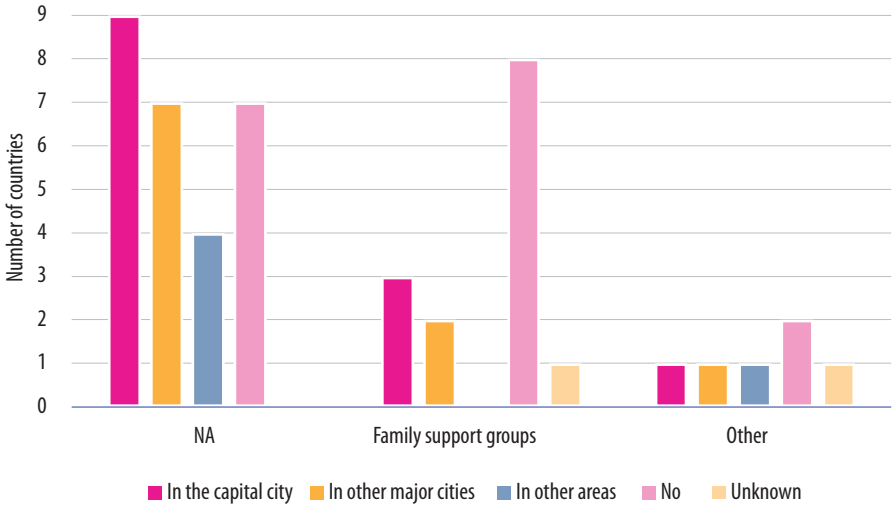
Source: Substance use atlas survey 2021.

Fig. 2.32. Employment services for PWSUD



Source: Substance use atlas survey 2021.

Fig. 2.33. Availability of mutual support/self-help groups and their geographical distribution



Source: Substance use atlas survey 2021.

either in the capital city or in other major cities or other areas,[1] are limited (Fig. 2.31 and 2.32).

Compared with the findings of the 2015 atlas survey, one more country reported having special housing services available and three more countries reported having employment provision for PWSUD.

Mutual support/self-help groups

Background

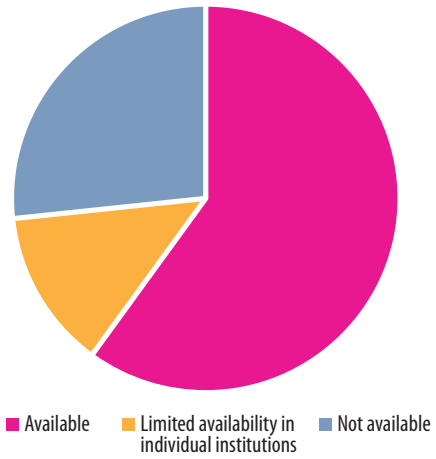
Respondents were asked if mutual support/self-help groups were available in their countries.

Findings

Nine countries (56% of responding countries) reported that they had Narcotics Anonymous (NA) groups and three countries (19% of responding countries) reported that they had family support groups available in the capital city. The availability of mutual support/self-help groups in "other areas" including in rural areas is very limited, reported by fewer than 25% of responding countries (Fig. 2.33).

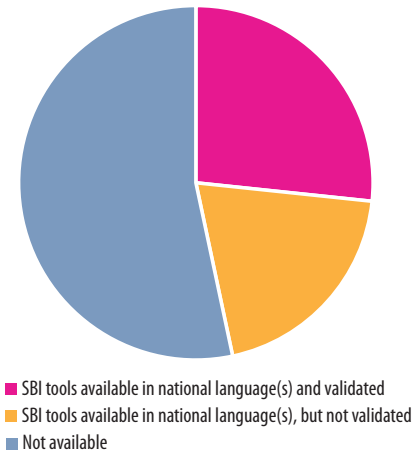
Compared with the 2015 atlas survey, two more countries reported that they had NA groups in the capital city and one more country reported that it had NA groups in other areas.

Fig. 2.34. SBI programmes



Source: SDG survey, 2019.

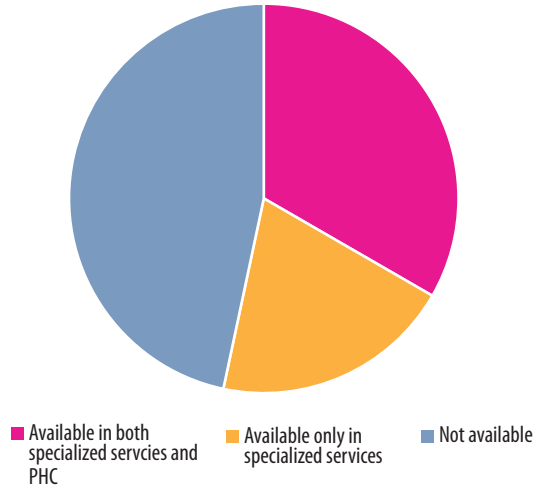
Fig. 2.35. SBI tools in national languages



Source: SDG survey, 2019.

[1] "Other areas" refers to urban and rural areas outside the capital city and other major cities.

Fig 2.36. SBI tools in specialized services with an expected high prevalence of substance use among patients/clients



Source: SDG survey, 2019.

Screening and brief interventions

Screening and brief intervention programmes

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the availability of SBI programmes for harmful and hazardous substance use and whether these tools were available and validated at the national level in national languages.

Findings

Eleven countries (73% of responding countries) reported that SBI programmes are provided in their health services (Fig. 2.34). Seven countries (47% of responding countries) have these tools available in national languages, but only three countries reported that these tools are validated in the national language(s) (Fig. 2.35).

SBI tools in specialized services with expected high prevalence of substance use among patients/clients

Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Countries were asked about the availability of SBI tools in specialized services with an expected high prevalence of substance use among patients/clients (e.g. services for mental health or infectious diseases) and in PHC.

Findings

Eight countries (53% of responding countries) reported that SBI tools were provided in specialized services with an expected high prevalence of substance use among patients/clients, and five countries (33% of responding countries) reported that they had SBI tools available in PHC services.

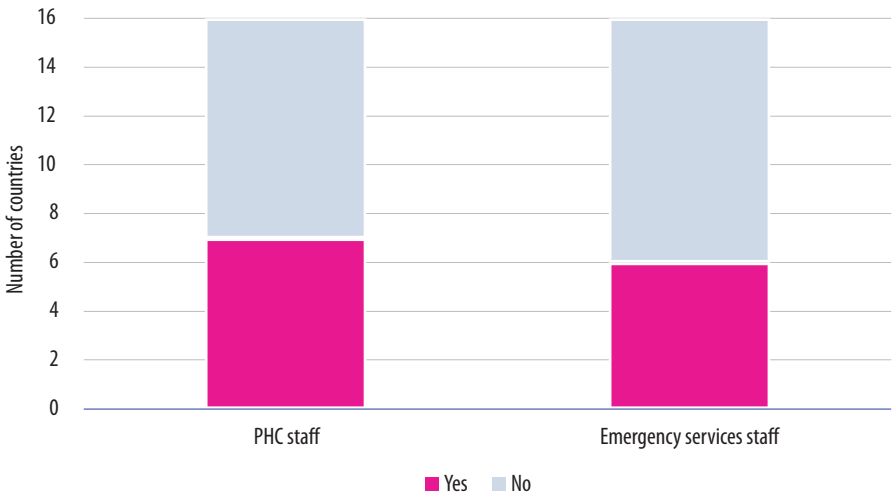
Compared with the 2015 atlas survey, two more counties reported the availability of SBI tools in PHC services.

Training for delivery of screening and brief interventions for primary health care and emergency services staff

Background

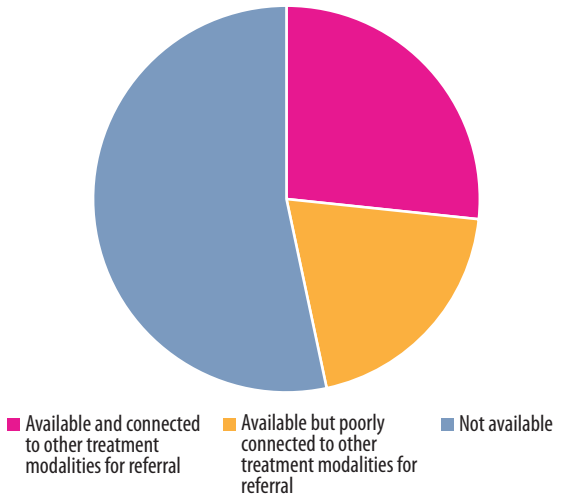
Respondents were asked if staff in PHC and emergency services were trained to deliver screening and brief interventions for SUDs.

Fig. 2.37. Training of PHC and emergency services staff to deliver SBIs for SUDs



Source: Substance use atlas survey 2021.

Fig. 2.38. Brief interventions for most or all patients/clients screened positively in high-prevalence specialized services and PHC services



Source: SDG survey, 2019.

Findings

Seven countries (44% of responding countries) reported that training on the delivery of SBI programmes was available for PHC staff, and six countries (37% of responding countries) reported that such training was available for emergency services staff (Fig. 2.37).

This question was not asked in the 2015 atlas survey.

Brief interventions

Background

Countries were asked if brief interventions were provided to most or all patients/clients screened positively in high-prevalence specialized services and in PHC settings.[1] The WHO screening and brief intervention tool is used for screening: this is a quick and easy test that contains eight questions and is administered by a health worker. People who screen positively are those who have had problems due to using substances and are potentially at risk of developing SUDs. This means that they require a level of intervention, depending on the severity of risk as scored in the screening.

Finding

Seven countries (47% of responding countries) reported that they provided brief interventions for patients/clients who had been screened positively in high-prevalence specialized services and PHC settings (Fig. 2.38).

2.5 Health workforce

Number of health professionals available for treatment of substance use disorders

Background

Respondents were asked about the total numbers of different groups of health professionals available for the treatment of SUDs.

Findings

The number of health workers available for the treatment of SUDs per 100 000 adult population was generally less than one across all professional groups.

Across countries, the median number of professionals available per 100 000 adult population was lowest for addiction medicine specialists/narcologists (0.12) and highest for nurses not specialized in psychiatry (0.58) (Table 2.5).

The numbers of different health professionals available for the treatment of SUDs in the public and private sectors, their total numbers and their relative number per 100 000 population are presented in Tables 2.6 to 2.14, with a summary of findings presented in Table 2.5.

National standards of health care professionals working with people with substance use disorders

Background

Respondents were asked if there were national standards of care developed for different health care professionals working with PWSUD.

Findings

All the responding countries (16 countries) reported that they had national standards of care for psychiatrists. Compared with the 2015 atlas survey, five more countries reported that they had national standards of care for nurses not specialized in psychiatry, three more countries reported that they had national standards of care for addiction counsellors and psychiatric nurses, two more countries reported that they had national standards of care for addiction medicine specialists/narcologists and one more country reported that it had national standards of care for community health workers and outreach/field workers.

In general, there has been an increase in the number of countries reporting the availability of national standards of care for different professional groups.

[1] See WHO. Screening and brief interventions for substance use problems. https://www.who.int/activities/screening-and-brief-interventions-for-substance-use-problems.

Table 2.5. Summary of findings on types and numbers of professionals in countries of the Region

Type of professional health worker	Median number of professionals per 100 000 adult populations	Number of responding countries
Addiction medicine specialists/narcologists	0.12	6
Psychiatrists	0.22	14
Psychologists	0.26	14
Medical doctors not specialized in psychiatry or addiction medicine	0.21	11
Psychiatric nurses	0.43	11
Nurses not specialized in psychiatry	0.58	8
Social workers	0.16	13
Addiction counsellors	0.57	5
Outreach/field workers	0.26	4

Source: Substance use atlas survey 2021.

Table 2.6. Number of addiction medicine specialists/narcologists

Country	Public sector	Private sector	Total	Per 100 000 adult population
Iran (Islamic Republic of)	308	8588	8896	15.42
Kuwait	3	–	–	0.09
Lebanon	–	–	9	0.19
Morocco	64	–	64	0.26
Occupied Palestinian territory	–	1	1	0.03
Oman	4	2	6	0.16
Pakistan	–	100	100	0.07
Qatar	3	–	–	0.12
Sudan	1	1	1	0.004

Source: Substance use atlas survey 2021.

Table 2.7. Number of psychiatrists

Country	Public sector	Private sector	Total	Per 100 000 adult population
Afghanistan	8	–	–	0.04
Egypt	139	–	–	0.22
Iran (Islamic Republic of)	1170	310	1540	2.67
Iraq	130	–	–	0.55
Kuwait	12	–	–	0.37
Lebanon	–	–	26	0.56
Morocco	20	–	20	0.08
Oman	69	3	72	1.88
Occupied Palestinian territory	2	5	7	0.23
Pakistan	200	300	500	0.37
Qatar	4	–	–	0.16
Sudan	26	6	(32)	0.13
United Arab Emirates	5	–	–	0.06
Yemen	4	–	4	0.02

Source: Substance use atlas survey 2021.

Table 2.8. Number of medical doctors not specialized in psychiatry or addiction medicine

Country	Public sector	Private sector	Total	Per 100 000 adult population
Afghanistan	225	–	–	1.04
Egypt	24	–	–	0.39
Iraq	49	–	–	0.21
Lebanon	–	–	14	0.3
Morocco	6	–	6	0.02
Occupied Palestinian territory	7	3	10	0.33
Pakistan	300	400	700	0.52
Qatar	5	–	–	0.2
Sudan	33	2	35	0.14
United Arab Emirates	2	–	–	0.02
Yemen	4	0	4	0.02

Source: Substance use atlas survey 2021.

Table 2.9. Number of psychiatric nurses

Country	Public sector	Private sector	Total	Per 100 000 adult population
Egypt	339	–	–	0.54
Iran (Islamic Republic of)	308	7612	7920	13.72
Iraq	109	–	–	0.46
Kuwait	200	–	–	6.20
Lebanon	–	–	20	0.43
Morocco	54	–	54	0.22
Oman	88	8	96	2.51
Qatar	18	–	–	0.74
Sudan	0	14	14	0.06
United Arab Emirates	14	–	–	0.17
Yemen	4	0	4	0.02

Source: Substance use atlas survey 2021.

Table 2.10. Number of nurses not specialized in psychiatry

Country	Public sector	Private sector	Total	Per 100 000 adult population
Afghanistan	210	–	–	0.97
Lebanon	–	–	30	0.65
Morocco	23	–	23	0.09
Occupied Palestinian territory	11	6	17	0.57
Pakistan	300	500	800	0.59
Qatar	86	–	–	3.5
Sudan	60	0	60	0.24
Yemen	4	0	4	0.02

Source: Substance use atlas survey 2021.

Table 2.11. Number of psychologists

Country	Public sector	Private sector	Total	Per 100 000 adult population
Afghanistan	116	–	116	0.54
Egypt	29	–	–	0.05
Iran (Islamic Republic of)	1892	7632	9781	16.86
Iraq	48	–	48	0.2
Kuwait	20	–	–	0.62
Lebanon	–	–	42	0.91
Morocco	3	–	3	0.01
Oman	4	3	4	0.01
Occupied Palestinian territory	3	5	8	0.27
Pakistan	200	500	700	0.52
Qatar	6	–	–	0.25
Sudan	93	9	102	0.41
United Arab Emirates	3		3	0.04
Yemen	4	0	4	0.02

Source: Substance use atlas survey 2021.

Table 2.12. Number of social workers

Country	Public sector	Private sector	Total	Per 100 000 adult population
Afghanistan	327	–	–	1.51
Egypt	44	–	–	0.07
Iraq	31	–	–	0.13
Kuwait	2	–	–	0.06
Lebanon	–	–	28	0.61
Morocco	14	18	32	0.11
Oman	7	11	18	0.83
Occupied Palestinian territory	3	6	9	0.6
Pakistan	200	500	700	0.52
Qatar	4	–	–	0.16
Sudan	40	8	48	0.19
United Arab Emirates	3	–	–	0.04
Yemen	2	0	2	0.01

Source: Substance use atlas survey 2021.

Table 2.13. Number of addiction counsellors

Country	Public sector	Private sector	Total	Per 100 000 adult population
Afghanistan	175	–	–	0.81
Iran (Islamic Republic of)	1892	7632	9782	16.95
Kuwait	3	–	–	0.09
Oman	14	8	22	0.57
Qatar	14	–	–	0.57

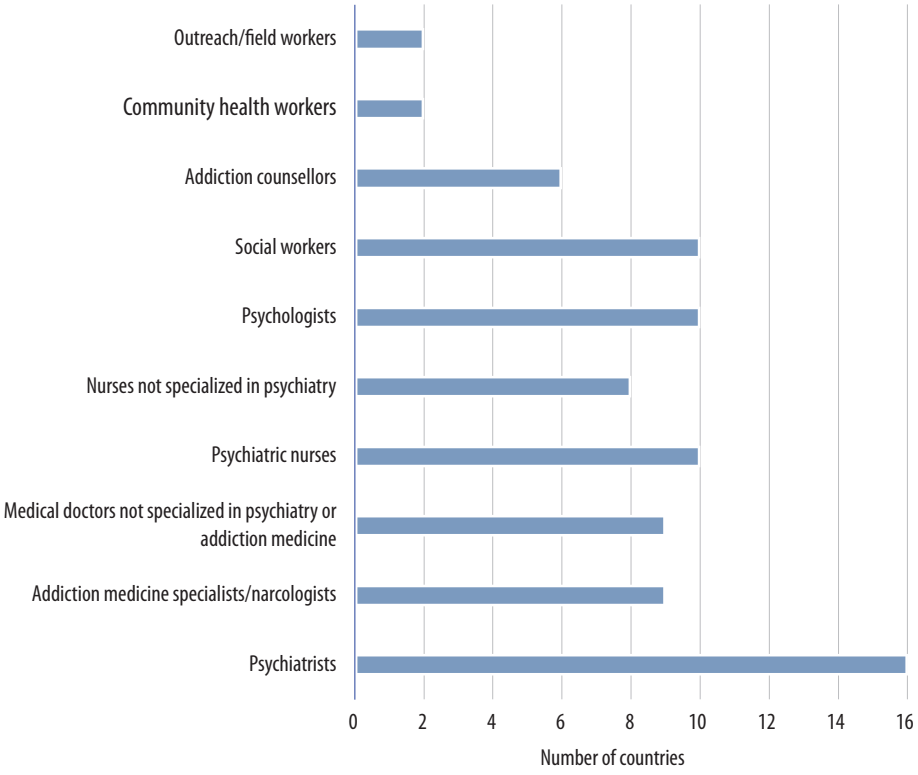
Source: Substance use atlas survey 2021.

Table 2.14. Number of outreach/field workers

Country	Public sector	Private sector	Total	Per 100 000 adult population
Iran (Islamic Republic of)	860	–	860	1.49
Lebanon	–	–	14	0.3
Morocco	–	–	37	0.15
Pakistan	–	–	300	0.22

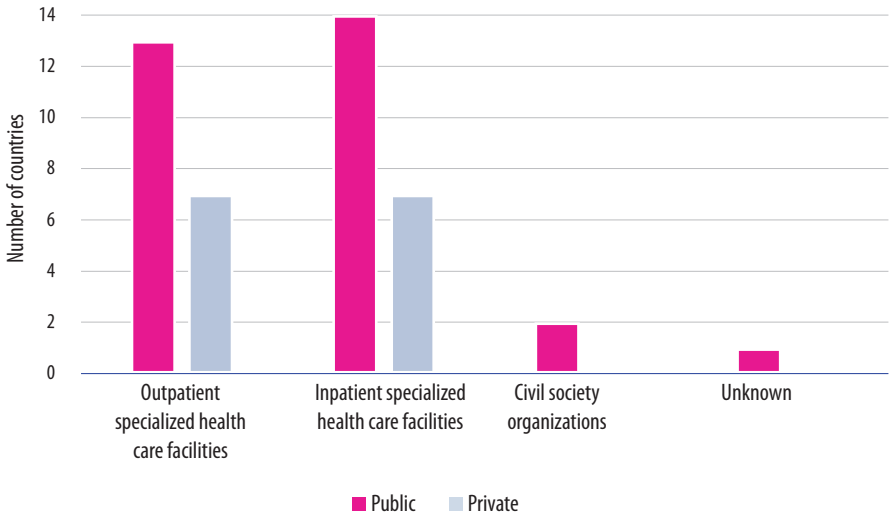
Source: Substance use atlas survey 2021.

Fig. 2.39. National standards of care developed for different health care professionals working with PWSUD



Source: Substance use atlas survey 2021.

Fig. 2.40. Availability of multidisciplinary specialist teams for outpatient/impatient treatment and care of PWSUD



Source: Substance use atlas survey 2021.

Multidisciplinary specialist teams for outpatient and inpatient treatment and care of substance use disorders

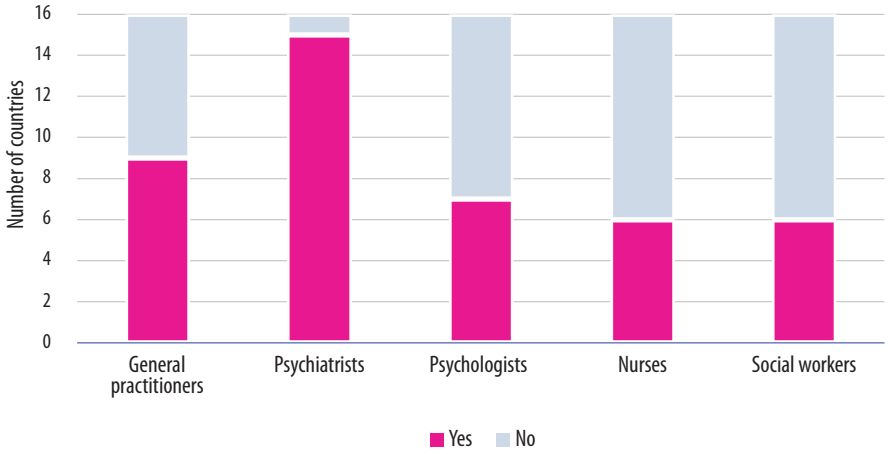
Background

Respondents were asked if they had multidisciplinary specialist teams available to provide outpatient and inpatient treatment and care of PWSUD, including pharmacological and psychosocial interventions.

Findings

Fourteen countries (87% of responding countries) reported that multidisciplinary specialist teams were available for inpatients in public specialized health care facilities and 13 countries (81% of responding countries)

Fig. 2.41. Substance use components integrated into pre-service/in-service education and training programmes for health and social welfare professionals



Source: Substance use atlas survey 2021.

reported that such teams were available for outpatients. Multidisciplinary specialist teams were available in the private sector only half as frequently as in the public sector.

This question was not asked in the 2015 atlas survey.

Integration of substance use into pre-service and in-service education/training programmes

Background

Respondents were asked if there was a substance use component integrated into pre-service and in-service education/training programmes for health and social welfare professionals.

Findings

Fifteen countries (94% of responding countries) reported that they had a training component on substance use integrated into training programmes for psychiatrists. Nine countries reported that they had such a component integrated into training programmes for general practitioners. Seven countries reported that they had a component on substance use integrated into training programmes for psychologists, six countries for nurses and six countries for social workers (Fig. 2.41).

The existence of training components on substance use integrated into training programmes for health and social welfare professionals ranged from 37% to 94%, depending on the professional group.

This question was not asked in the 2015 atlas survey.

Providing supervisory support for the health workforce in the management of substance use disorders

Access to regular supervision

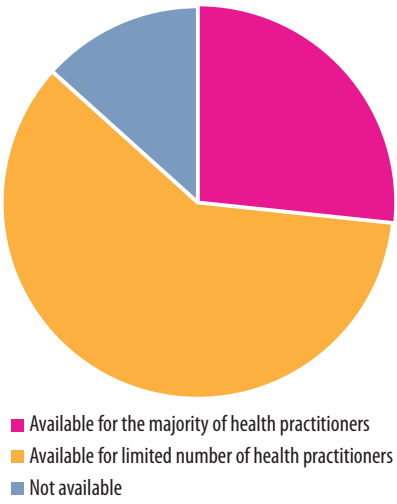
Background

This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Countries were asked if the health workforce had access to regular supervision in the area of SUDs.

Findings

Four countries (27% of responding countries) reported that access to regular supervisions was available for the majority of health practitioners (Fig. 2.42).

Fig. 2.42. Access to regular supervision for health care professionals



Source: SDG survey, 2019.

3. Promotion and prevention programmes

3.1 Interventions/programmes for the prevention of substance use and substance use disorders

Background

Respondents were asked about the existence of interventions/programmes for the prevention of substance use and SUDs.

Findings

All the responding countries except one (15 countries, or 94% of those that responded) reported that they had interventions/programmes in place for the prevention of substance use and SUDs (Fig. 3.1).

3.2 Different interventions/programmes for the prevention of substance use and SUDs and their estimated coverage

Background

Respondents were asked about the existence of different interventions/programmes for the prevention of substance use and SUDs and their estimated coverage.

Findings

Targeted multimedia campaigns were the most frequently implemented prevention intervention, reported by 15 countries of the Region (94% of responding countries), and workplace prevention programmes were the least frequently implemented, reported by five countries (31% of responding countries).

3.3. Prevention programmes and/or interventions targeting specific populations

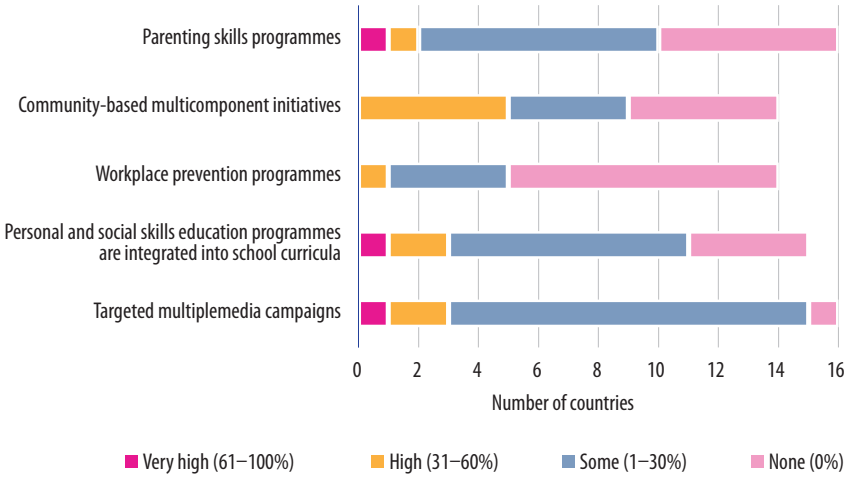
Background

Respondents were asked about the existence of prevention programmes and/or interventions aimed at different population groups.

Findings

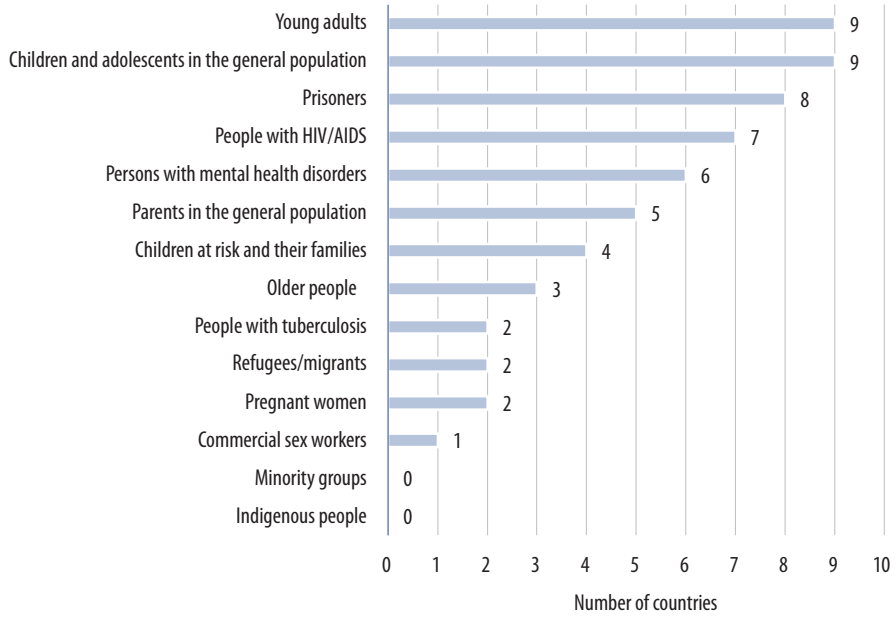
Nine countries (56% of responding countries) reported that they had specific prevention programmes and/or interventions for children, adolescents and young adults. Three countries (19% of responding countries) reported that they had specific prevention programmes for older people.(Fig. 3.2).

Fig. 3.1. Estimated coverage of interventions/programmes for the prevention of substance use/SUDs



Source: Substance use atlas survey 2021.

Fig. 3.2. Specific prevention programmes and/or interventions targeting specific populations



Source: Substance use atlas survey 2021.

3.4 Groups and agencies actively involved in the prevention of SUDs

Background

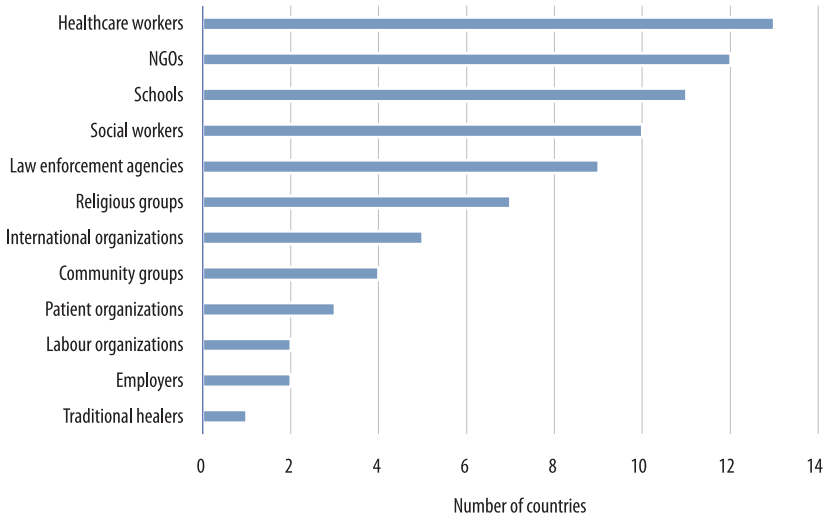
Respondents were asked about groups and agencies that are actively involved in the prevention of SUDs.

Findings

The three groups reported as having the most involvement in the prevention of SUDs were health care workers (13 countries or 81% of responding countries), nongovernmental organizations (NGOs) (12 countries or 75% of responding countries) and schools (11 countries or 69% of responding countries) (Fig. 3.3).

Compared with the 2015 atlas survey, in the 2021 survey health care workers replaced NGOs as the group with the highest involvement in the prevention of SUDs.

Fig. 3.3. Groups and agencies actively involved in the prevention of SUDs



Source: Substance use atlas survey 2021.

4. Monitoring and surveillance

4.1 National systems of epidemiological data collection

Background

Respondents were asked about the existence of a national system of epidemiological data collection for psychoactive substance use (i.e. collecting data on substance use), along with the frequency of data collection, the types of drug on which this system collects data and whether data were disaggregated by age and gender.

Findings

National system of epidemiological data collection and frequency of data collection

Ten countries (62% of responding countries) reported that they had a national system of epidemiological data collection for psychoactive substance use; of these countries, 80% reported that they published results periodically (Fig. 4.1).

Compared with the 2015 atlas survey, two more countries reported that they had a national system of epidemiological data collection for psychoactive substance use.

Collecting data on specific types of drug

Eight countries (50% of responding countries) reported that they had epidemiological data available on the prevalence of use of one or more drugs.

Compared with the 2015 atlas survey, one more country reported that it had epidemiological data available on the prevalence of use of different types of drugs.

Collecting data disaggregated by gender and age

Ten countries (62% of responding countries) reported that their national system of epidemiological data collection for drug use compiled data disaggregated by gender, and eight countries (50% of responding countries) reported that their national system compiled data disaggregated by age.

This question was not asked in the 2015 atlas survey.

National system of epidemiological data collection for substance use among children and adolescents

Background

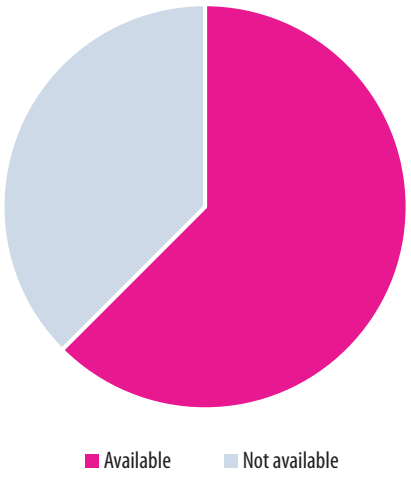
Respondents were asked about the existence of a national system of epidemiological data collection for substance use among children and adolescents (Fig. 4.2-4.5).

Findings

Five countries (31% of responding countries) reported that they had a national system of epidemiological data collection for substance use among children and adolescents. School surveys were reported to be the main method of data collection among this age group.

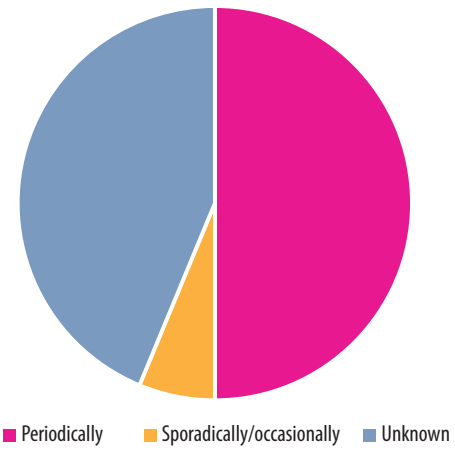
Compared with the 2015 atlas survey, three more countries in 2021 reported that they had a national system of epidemiological data collection for substance use among children and adolescents.

Fig. 4.1. National system of epidemiological data collection for psychoactive substance use



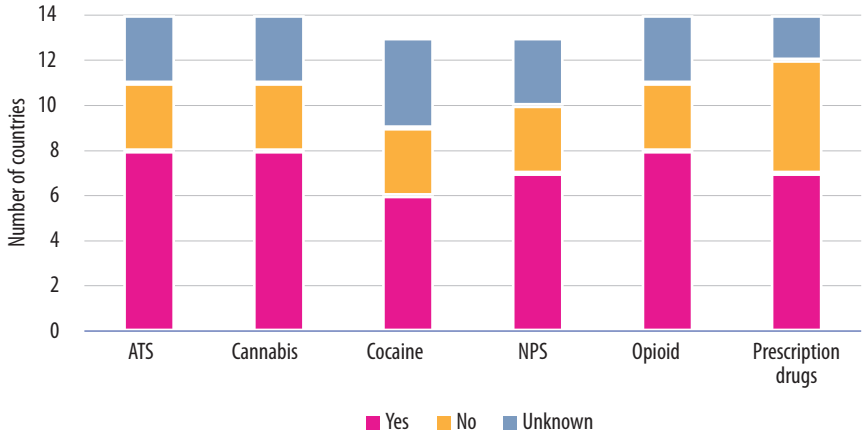
Source: Substance use atlas survey 2021.

Fig. 4.2. Frequency of data collection



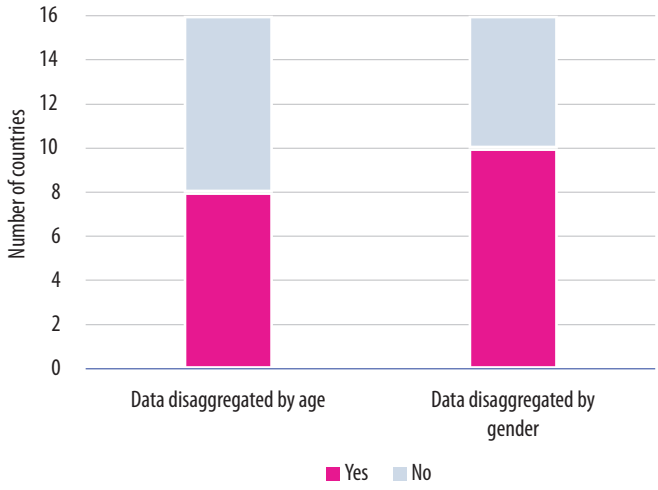
Source: Substance use atlas survey 2021.

Fig. 4.3. Data collected on specific types of drug use



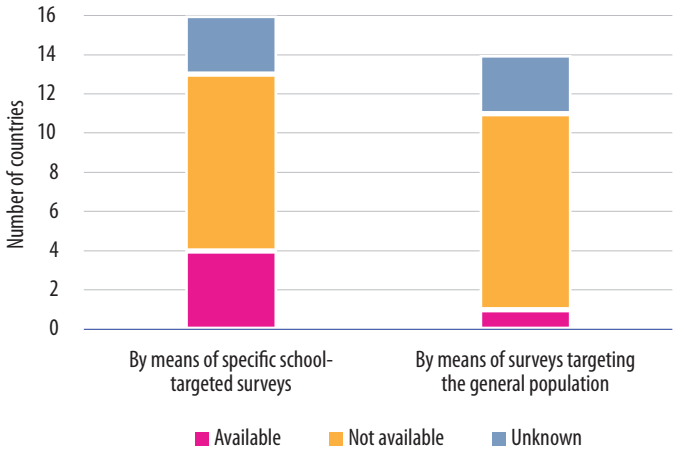
Source: Substance use atlas survey 2021.

Fig. 4.4. Data collected and compiled disaggregated by age and gender



Source: Substance use atlas survey 2021.

Fig. 4.5. National system of epidemiological data collection for substance use among children and adolescents



Source: Substance use atlas survey 2021.

4.2 National systems of data collection on service delivery in treatment of substance use disorders

Background

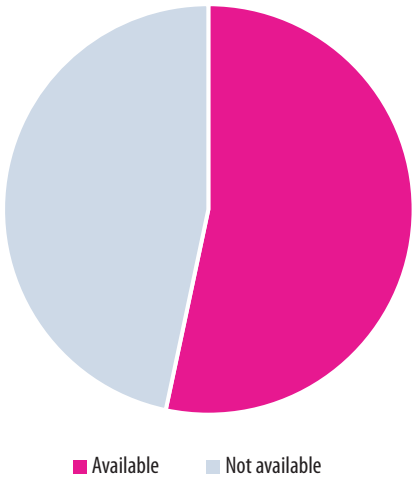
This item is derived from the survey conducted in 2019 on progress towards meeting SDG Target 3.5. Respondents were asked about the existence of a national system for collecting quantitative data on service delivery for the treatment of SUDs and whether these data were nationally representative.

Findings

Eight countries (53% of responding countries) reported that a national system was available for the collection of quantitative data on service provision for the treatment of SUDs; of these, six countries (75%) reported that these data were nationally representative (Fig. 4.6).

Compared with the 2015 atlas survey, one more country reported that it had a data collection system for SUDs based on the delivery of health services.

Fig. 4.6. Availability of a national system for collecting quantitative data on service provision for the treatment of SUDs



Source: SDG survey, 2019.

4.3 Systems for monitoring involvement of drugs in deaths

Existence of a system for monitoring the involvement of drugs in deaths

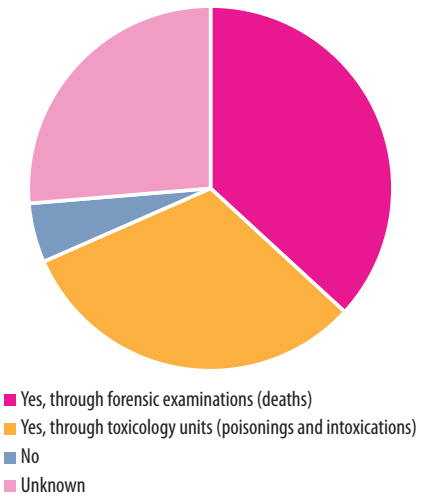
Background

Respondents were asked about the existence of a system for monitoring the involvement of drugs in deaths, either as a direct cause or as an underlying cause.

Findings

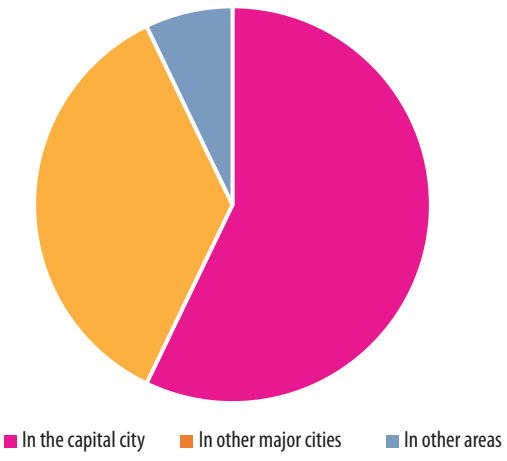
Ten countries (62% of responding countries) reported that they had a system for monitoring the involvement of drugs in deaths, as a direct cause or as an underlying cause, and either through forensic examinations or through toxicology units (Fig. 4.7).

Fig. 4.7. Availability of a system for monitoring the involvement of drugs in deaths



Source: Substance use atlas survey 2021.

Fig. 4.8. Geographical coverage of systems for monitoring the involvement of drugs in deaths



Source: Substance use atlas survey 2021.

Compared with the 2015 atlas survey, there was an increase of 17 percentage points in the number of responding countries reporting that they had a system for monitoring the involvement of drugs in deaths.

System for monitoring opioid overdose mortality

Background

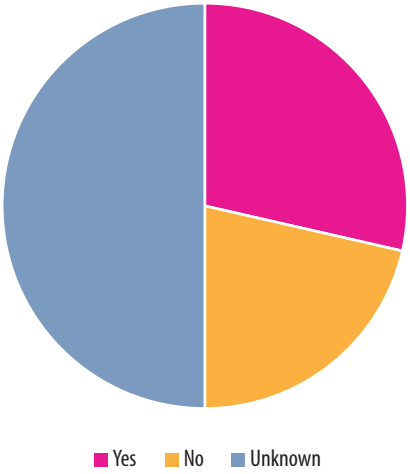
Respondents were asked if there was a system for monitoring opioid overdose mortality.

Findings

Four countries (25% of reporting countries) reported that they had a system for monitoring opioid overdose mortality (Fig. 4.9).

Two more countries reported having a system for monitoring opioid overdose mortality in 2021 than in 2015.

Fig 4.9. System for monitoring opioid overdose mortality



Source: Substance use atlas survey 2021.

4.4 Data collection methods used by national systems for epidemiological data collection

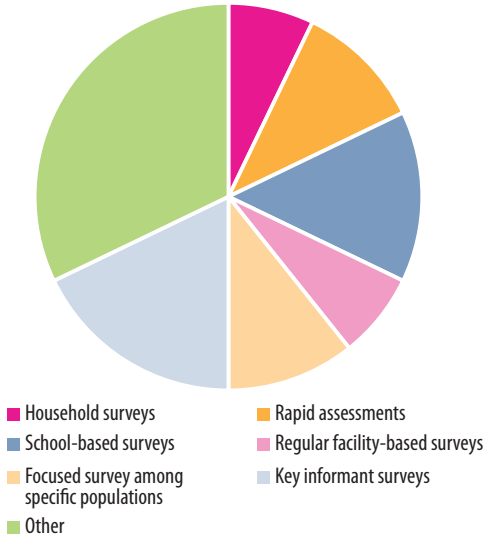
Background

Respondents were asked about the methods used by the national system for epidemiological data collection in collecting data.

Findings

Surveys of key informants were the most common data collection method, reported by five countries of the Region (Fig. 4.10).

Fig. 4.10. Methods used for collecting epidemiological data on substance use



Source: Substance use atlas survey 2021.

4.5 Publishing and reporting data

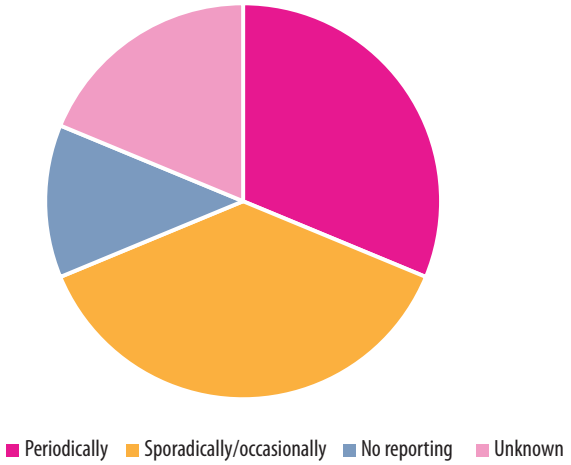
Background

Respondents were asked about the frequency with which the national system for epidemiological data collection for substance use published data, and whether the data published were publicly available.

Findings

Eleven countries of the Region (69% of responding countries) reported that they published data collected by the national system for epidemiological data collection for substance use either periodically or sporadically. Of these, 45% (five countries) reported that these data were publicly available (Fig. 4.11).

Fig. 4.11. Frequency of reporting data on substance use



Source: Substance use atlas survey 2021.

5. International cooperation

5.1 Adopting international prevention and treatment standards/guidelines

Background

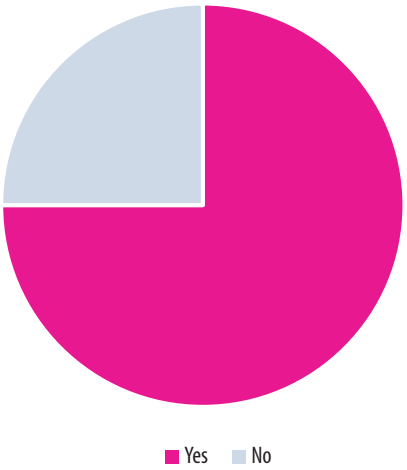
Respondents were asked if they had adopted international substance use prevention and treatment standards and guidelines, UNODC/WHO prevention standards, UNODC/WHO treatment standards or other international prevention and treatment standards/guidelines.

Findings

Twelve countries (75% of responding countries) reported that they had adopted international prevention and treatment standards/guidelines.

Eleven countries (69% of responding countries) reported that they had adopted UNODC/WHO prevention standards and 10 countries (62% of responding countries) (Fig. 5.1) reported that they had adopted UNODC/WHO treatment standards. Additionally, five countries reported that they had adopted other international prevention and treatment standards/guidelines (Fig. 5.2).

Fig. 5.1. Adoption of international prevention and treatment standards/guidelines



Source: Substance use atlas survey 2021.

Fig. 5.2. Adoption of updated UNODC/WHO prevention and treatment standards

Source: Substance use atlas survey 2021.

5.2 National centres/networks that actively collaborate with regional or international centres/networks

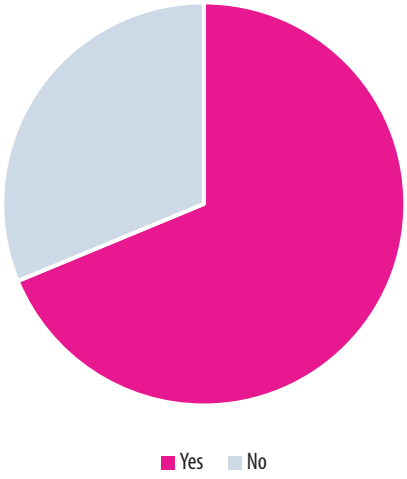
Background

Countries were asked about the existence of national centres and networks that actively collaborate with regional or international centres and networks, and about the areas of collaboration.

Findings

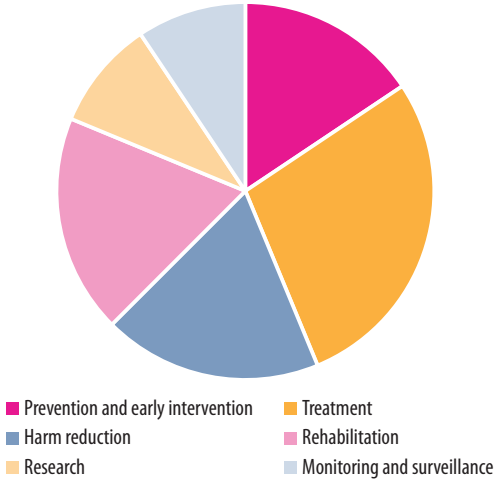
Eleven countries (69% of responding countries) reported that they had national centres or networks that actively collaborate with regional or international centres/networks. Treatment of SUDs was the most common area of collaboration, reported by nine countries (56% of responding countries) (Fig. 5.3-5.4).

Fig. 5.3. National centres/networks actively collaborating with regional/international centres or networks



Source: Substance use atlas survey 2021.

Fig. 5.4. Areas of collaboration with national and regional/international centres or networks



Source: Substance use atlas survey 2021.

Conclusion

The current atlas provides a comprehensive overview of the resources that exist for responding to substance use problems in countries of the Eastern Mediterranean Region, through the lens of the regional framework for action to strengthen the public health response to substance use. Annex 1 provides a snapshot of the overall situation in the Region, summarizing the survey's findings for each country and for the Region as a whole and quantifying these findings against the indicators defined in the regional framework.

As a general conclusion, in the governance and health sector domains on average about 60% of the resources required to provide a comprehensive response to substance use problems currently exist in the Region.

In the domain of governance, all responding countries reported that they had a policy or plan in place for the prevention of substance use and/or the treatment of SUDs, either as a stand-alone policy or a policy integrated into other policies/plans. A majority of responding countries also have drug laws or legal provisions aimed at the reduction of drug demand, most of which have been enacted since the last atlas survey was conducted in 2015. There has been considerable progress in putting in place alternatives to imprisonment, with the provision of voluntary or compulsory treatment as an alternative to or in addition to criminal sanctions and drug courts.

In terms of the health sector, all the responding countries provide specialized services for PWSUD, mostly as stand-alone services. Nevertheless, the number of facilities and the numbers of health professionals for the management of SUDs are still very limited in the Region, particularly in rural areas. The integration of care and treatment services for SUDs into mental health care, GHC and PHC settings have not reached an optimal level, and referral systems between these settings need to be improved.

A major finding of the survey was that opioids have become the main drug at the point of entry to treatment. There has been some progress in providing evidence-based treatment for opioid use disorders. More countries in the Region now have access to different OAMT agents, though these are not necessarily used for maintenance treatment. The availability of essential medicines for the treatment of SUDs and for OAMT remains a challenge. Psychological treatment for the management of SUDs is available in most countries of the Region; however, other treatment interventions such as overdose management, harm reduction, open access services and SBI programmes are not well developed.

There has been progress in providing specialized services for specific population groups. More countries are providing these services for women and for children and adolescents. Treatment services for people in prison settings are available in more than half of the countries of the Region; however, the availability of pharmacological treatment specifically for people with opioid use disorders is limited. The availability of services for pregnant women, people with disabilities and older people also remains limited.

In general, the data reported show stagnation in the accessibility and coverage of services for the management of SUDs since the last atlas report in 2015. The scaling up of services for SUDs calls for the integration of evidence-based and cost-effective interventions in health systems and services, as well as increased allocation of resources to meet the specific needs of populations.

In terms of prevention and promotion programmes, the average availability of resources was 80%. Almost all countries of the Region have prevention programmes; however, the implementation of well-evidenced interventions is not yet at an optimum level. The atlas report indicates greater involvement of health care workers in implementing substance use prevention programmes.

In monitoring and surveillance, according to the summary findings, the average availability of resources was 40%, which suggests slow progress in the implementation of epidemiological and service delivery information systems and the dissemination of information. Additionally, using less structured data collection methods, such as key informant surveys, reduces the reliability and validity of the data collected. There is an urgent need to strengthen substance use information systems in the Region and to accelerate efforts towards the integration of substance use monitoring and surveillance measures into general health surveys.

The COVID-19 pandemic erupted across the globe just three months after the regional framework was adopted in October 2019, and all health resources in countries of the Region were shifted towards COVID-19 control measures. Many mental health and substance use services were disrupted, which created a major impediment to achieving the targets of the regional framework. However, despite this major challenge, the current atlas report highlights positive developments in the provision of services for PWSUD. This report can be used by countries as a baseline for examining their responses to substance use problems and for enhancing their endeavours based on evidence and tailored to their specific contexts and needs in the era to come after COVID-19.

Annex 1. Summary tables

Summary of country scores on indicators of the regional framework for action to strengthen the public health response to substance use

Country	Governance summary score: out of six indicators	Health sector summary score: out of 10 indicators	Promotion and prevention summary score: out of five indicators	Monitoring and surveillance summary score: out of four indicators
Afghanistan	5/6	8/10	5/5	2/4
Egypt	5/6	5/10	3/5	3/4
Iran (Islamic Republic of)	6/6	10/10	4/5	2/4
Iraq	1/6	3/10	5/5	4/4
Jordan	2/6	5/10	3/5	1/4
Kuwait	5/6	8/10	1/5	3/4
Lebanon	1/6	6/10	3/5	1/4
Morocco	3/6	9/10	4/5	2/4
Occupied Palestinian territory	5/6	5/10	4/5	2/4
Oman	6/6	7/10	4/5	3/4
Pakistan	4/6	6/10	2/5	1/4
Qatar	5/6	6/10	3/5	0/4
Saudi Arabia	6/6	4/10	4/5	0/4
Sudan	2/6	1/10	4/5	1/4
United Arab Emirates	4/6	9/10	3/5	1/4
Yemen	1/6	2/10	1/5	0/4
Regional average	3.8/6	5.9/10	3.9/5	1.6/4

Governance

Country	Operational multisectoral public health-oriented substance use policies are endorsed and published	Relevant national legislation is updated in line with international covenants, treaties and conventions	Intersectoral (interministerial) coordinating mechanism is in place reflecting public health leadership	Specified budgetary allocations are in place to cover the prevention, treatment, care and rehabilitation of PWSUD	Depenalization/decriminalization of drug use, and drug courts are available in major cities	Treatment services for SUDs and related health problems are available for incarcerated populations across the continuum of care
Afghanistan	✓	✓	✓	✓	NA	✓
Egypt	✓	✓	✓	✓	✓	NA
Iran (Islamic Republic of)	✓	✓	✓	✓	✓*	✓
Iraq	NA	NA	✓	NA	NA	NA
Jordan	NA	NA	✓	✓	NA	NA
Kuwait	✓	✓	✓	✓	NA	✓
Lebanon	✓	NA	NA	NA	NA	NA
Morocco	✓	NA	✓	NA	NA	✓
Occupied Palestinian territory	✓	✓	✓	NA	✓	✓
Oman	✓	✓	✓	✓	✓	✓
Pakistan	NA	✓	✓	✓	NA	✓
Qatar	✓	✓	✓	✓	NA	✓
Saudi Arabia	✓	✓	✓	✓	✓	✓
Sudan	NA	NA	✓	✓	NA	NA
United Arab Emirates	✓	✓	✓	✓	NA	NA
Yemen	NA	NA	NA	✓	NA	NA

* For decriminalization.

Health sector

Country	PHC and emergency services staff are trained to deliver SBIs for SUDs and to manage opioid overdose		Multidisciplinary specialist teams are available for outpatient and inpatient treatment and care of SUDs, including the provision of pharmacological and psychosocial interventions	Referral guidelines and pathways between primary and specialist services are in place	A comprehensive package of services for HR is in place	Methadone, buprenorphine, naloxone and other medications for detoxification and maintenance treatment are available as part of a comprehensive package for the management of SUDs*	A substance use component is integrated into pre-service and in-service education/training programmes for health and social welfare professionals and in continuing professional education/recertification programmes		Self-help/mutual aid groups are available	United Nations Office on Drugs and Crime (UNODC)/WHO treatment standards for ensuring quality are adopted/adapted
	OD	SBI					In-service	Pre-service		
Afghanistan	✓[em]	✓	✓	NA	NA	✓	✓	✓	✓	✓
Egypt	NA	✓	✓	NA	✓[S]	NA	NA	NA	✓	✓
Iran (Islamic Republic of)	✓ PHC	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iraq	NA	NA	✓[P]	NA	NA	NA	✓	NA	NA	✓
Jordan	✓[em]	✓ PHC	✓[In]	NA	✓	✓	NA	NA	NA	NA
Kuwait	✓	✓	✓[P]	✓		NA	✓	✓	✓	✓
Lebanon	✓[em]	✓[em]	✓[C]	NA		✓	NA	✓	✓	NA
Morocco	NA	✓PHC	✓[P]	✓	✓	✓	✓	✓	✓	✓
Occupied Palestinian territory	✓[em]	NA	✓[P]	NA		✓	✓	NA	NA	✓
Oman	✓	NA	✓	✓	NA	✓	✓	✓	✓	NA
Pakistan	✓[em]	✓	✓	✓	NA	NA	✓	NA	NA	✓
Qatar	✓[em]	NA	✓[P]	NA	NA	✓	✓	NA	✓	✓
Saudi Arabia	NA	NA	✓	NA	NA	NA	✓	✓	✓	NA
Sudan	NA	NA	✓[Pr]	NA	NA	NA	NA	NA	NA	NA
United Arab Emirates	✓[em]	✓[em]	✓[P]	✓		✓	✓	✓	NA	✓
Yemen	NA	NA	✓[P]	NA		✓	NA	NA	NA	NA

[em] For emergency staff only.

[PHC] For PHC staff only.

* Marked available if at least one agonist agent and one opioid antagonist agent are available.

[P] In the public sector only.

[Pr] In the private sector only.

[In] In inpatient settings only.

[C] In civil society organizations only.

[S] Some elements are available.

Promotion and prevention

Country	Multicomponent community intervention programmes are available	Life skills education programmes are integrated into school curricula curricula	Workplace education and intervention programmes are in place	Targeted campaigns are developed using multiple media channels to improve literacy about substance use and SUDs	Updated UNODC/WHO prevention standards for ensuring quality are adopted/ adapted
Afghanistan	✓	✓	✓	✓	✓
Egypt	✓	NA	NA	✓	✓
Iran (Islamic Republic of)	✓	✓	NA	✓	✓
Iraq	✓	✓	✓	✓	✓
Jordan	✓	✓	NA	✓	NA
Kuwait	NA	NA	NA	NA	✓
Lebanon	✓	✓	NA	✓	NA
Morocco	✓	✓	NA	✓	✓
Occupied Palestinian territory	✓	✓	NA	✓	✓
Oman	✓	✓	NA	✓	✓
Pakistan	NA	NA	NA	✓	✓
Qatar	✓	NA	✓	✓	✓
Saudi Arabia	✓	✓	✓	✓	NA
Sudan	✓	✓	✓	✓	NA
United Arab Emirates	NA	✓	NA	✓	✓
Yemen	NA	NA	NA	✓	NA

Monitoring and surveillance

Country	National monitoring and surveillance systems are in place	Regular reports are published and shared with national/international stakeholders and partners using the core set of indicators		Monitoring and registration systems are in place for prescription drugs
		Regular reporting	Sharing reports	
Afghanistan	✓	NA[S/O]	✓	NA
Egypt	✓	✓	NA	✓
Iran (Islamic Republic of)	✓	✓	NA	NA
Iraq	✓	✓	✓	✓
Jordan	✓	NA[S/O]	NA	NA
Kuwait	✓	✓	✓	
Lebanon	NA	NA[S/O]	✓	
Morocco	✓	NA[S/O]	✓	NA
Occupied Palestinian territory	✓	NA	✓	
Oman	✓	✓	✓	NA
Pakistan	NA	NA[S/O]	✓	NA
Qatar	NA	NA	NA	NA
Saudi Arabia	NA	NA	NA	NA
Sudan	NA	NA[S/O]	✓	NA
United Arab Emirates	✓	NA	NA	
Yemen	NA	NA	NA	

[NAS/O] Not available regularly, but available sporadically/occasionally.

Annex 2. Glossary of terms

Action plan: A document that includes detailed strategies and activities for developing services for substance use disorders.

Addiction specialist/narcologist: Medical doctor with a specialization in addiction medicine/narcology.

Addiction counsellor: Professional certified to work as a counsellor for patients with substance use disorders and behavioural addictions after completion of formal training of different intensities. Educational requirements for addiction counsellors vary depending on the type of certification; higher levels of certification may require a bachelor's degree or equivalent level of education.

Budget line: Source of money available and allocated for actions directed towards treatment and prevention of substance use disorders.

Community health worker: Member of a community who is chosen by community members or organizations to provide basic health and medical care to their community. Other names for this type of health care provider include village health worker, community health aide, community health promoter and lay health advisor.

Community-based programme: Community-based initiatives normally have multiple components, taking action in different settings (e.g. schools, families, media, enforcement, etc.). They mobilize efforts to create partnerships, task forces, coalitions, action groups, etc. and bring together different actors in a community to address substance abuse.

Continuing professional development/education: Any certified training activities that are followed by a person after completion of their formal professional training in order to maintain skills and knowledge related to their professional career.

Decriminalization: The removal of criminal penalties for drug law violations (usually possession for personal use).

Depenalization: This usually involves personal consumption as well as small-scale trading and generally signifies the elimination or reduction of custodial penalties, while the conduct or activity still remains a criminal offence.

Detoxification: Refers to a relatively short-term treatment aimed at withdrawing an individual from the effects of a psychoactive substance; it usually involves clinical management of intoxication and/or withdrawal syndrome in a safe and effective manner.

Drug court: A specialized court that aims to stop drug abuse and related criminal activity through court-directed treatment and rehabilitation programmes. Drug courts order the treatment of suitable drug-related offenders as an alternative to prosecution or imprisonment and usually monitor compliance with treatment through court appearances and court-mandated regular tests (e.g. urine tests) or examinations.

Drug demand reduction: Measures as reflected in the outcome document of the 2016 United Nations General Assembly special session on the world drug problem, including drug demand reduction such as prevention, early intervention, treatment, care, recovery, rehabilitation and social reintegration measures, as well as initiatives and measures aimed at minimizing adverse public health and social consequences.

Employer's financing: Social health insurance scheme in which workers and employers are obliged to contribute to health insurance funds.

Facilities: Refers to treatment centres, departments, wards and units designed and designated for treatment of substance use disorders. These facilities can be stand-alone (e.g. national addiction treatment centres, drug treatment centres/clinics, narcological dispensaries) or integrated with other health care centres, clinics or dispensaries (such as GHC or mental health centres or hospitals, HIV clinics, etc.).

Full range of services: This includes evidence-based treatment, rehabilitation and harm reduction services such as opioid agonist maintenance treatment (OAMT) and opioid overdose prevention services, psychological support and treatment services, rehabilitation services, social services, legal services, educational, vocational and employment opportunities, housing services and supports, and so on.

Government financing: National, regional/subnational or local government financing from any tax-based funding, or national health insurance.

Global Fund financing: Financing that comes from the Global Fund, an international financing institution that fights AIDS, tuberculosis and malaria.

Government benefits: Benefits that are provided by the government from public funds for people with disabilities including those with substance use disorders that cause impairment leading to functional limitations.

Benefits can be provided in different ways e.g. as disability pensions, free access to services, housing, personal staff care, etc.

Household payments: Direct out-of-pocket payment for health services.

Inpatient treatment: Refers to different treatment modalities beyond detoxification that are implemented on an inpatient basis, i.e. with formal hospital admission which usually involves an overnight stay, or in residential care when a patient lives in a residential treatment setting rather than in his/her own home or family home.

Major cities: Refers to cities with relatively large populations and with tertiary and higher levels of health care that include highly specialized facilities such as university hospitals or highly specialized treatment centres such as for neurosurgery or radiology.

Multidisciplinary specialist team: A team made up of the following professionals, but not limited to them: psychiatrist, general practitioner, psychologist, social worker, nurse, legal assistant, nutritionist, pharmacist, life coach, support/peer group, counsellor.

Mutual support group: More widely known as a self-help group. A group in which participants support each other in recovering or maintaining recovery from alcohol or drug dependence or problems, or from the effects of another's dependence, without professional therapy or guidance. Examples of mutual support groups include Alcoholics Anonymous, Narcotics Anonymous and Al-Anon/Alateen (for family members of people with alcohol/substance use disorders).

New psychoactive substance (NPS): Novel psychoactive substances are compounds designed to mimic existing established recreational drugs. They can be grouped into four main categories: stimulants, cannabinoids, hallucinogens and depressants. Legislation regarding NPSs varies internationally.

NGO and other external financing: Financing through funds provided by voluntary organizations, charitable groups, service user groups, advocacy groups, professional associations or international organizations.

Non-structured services: These include low-threshold/harm reduction interventions, outreach services, open access interventions (online support, helpline services), unstructured mutual help/peer support groups (e.g. NA, AA), as well as brief engagement and peer counselling.

Policy for service development: An official statement by a government or health authority that provides the overall direction for health development by defining a vision, values, principles and objectives and by establishing a broad model for action to achieve that vision.

Outpatient treatment: Refers to different treatment modalities beyond detoxification that are implemented on an outpatient/ambulatory basis, i.e. without formal hospital admission that usually involves an overnight stay or outside residential care where a patient lives in a treatment facility for a period of treatment.

Parenting skills programmes: These guide parents to provide stimulating and responsive parenting, where parents set rules for acceptable behaviours, closely monitor free time and friendship patterns, help to acquire skills to make informed decisions and are role models for their children.

Personal and social skills education programmes: In these programmes, trained teachers engage children in interactive activities to give them opportunities to learn and practise a range of personal and social skills via a series of structured sessions.

Postgraduate training programme: Training that is pursued after a first degree (such as a bachelor's degree) in a specific field or area.

Rehabilitation: Refers here to a longer term process aimed at enabling people with substance use disorders to achieve an optimal state of health, psychological functioning and social well-being through a combination of approaches, including psychosocial, medical and recovery-oriented interventions implemented on an inpatient and/or outpatient basis as well as in community-based support groups.

Services: Refers to the functions of providing prevention and treatment interventions for substance use disorders by health professionals, but not necessarily implemented in specialized facilities designed and designated for the treatment of SUDs. Examples include the provision of screening and brief interventions for alcohol and drug use by health professionals in emergency rooms or PHC centres, or management of substance use disorders, including pharmacotherapy of substance dependence, by medical doctors or other professionals working in different areas of medicine, psychology and social care (family doctors and nurses, psychiatrists, gastroenterologists, oncologists, social workers, community health workers, etc).

Short-cycle tertiary education: Includes advanced vocational, academic or professional education in specialized areas of education but not reaching the bachelor's degree or equivalent level.

Standard operating procedures (SOPs): A set of step-by-step instructions to help workers carry out complex routine operations.

Specialized treatment facilities for substance use disorders: Specialized facilities designed and designated for treatment of substance use

disorders. This also includes mental health care facilities that offer specialized treatment for SUDs.

Substance use: Refers to the non-medical use of illicit drugs or other psychoactive substances, including prescription drugs. The 2021 atlas survey covers all psychoactive substances, including prescribed medications, but does not cover alcohol and tobacco use.

Substance use disorders (SUDs): A group of conditions related to alcohol or other drug use. In ICD-10, section F10-F19, they are described as "mental and behavioural disorders due to psychoactive substance use" and include a wide variety of disorders of different severity and clinical forms, all having in common the use of one or more psychoactive substance, which may or may not have been medically prescribed.

Supervised opioid agonist maintenance treatment: Refers to medically supervised dispensing of methadone, buprenorphine, buprenorphine/naloxone, diazepam, disulfiram and naltrexone on an outpatient basis. In supervised methadone treatment, for example, patients come each day for their dose at the beginning of treatment until they are assessed as being suitable to receive take-home methadone.

Specialized health care facilities: For the purposes of the 2021 atlas survey, this refers to facilities for substance use disorders only and does not include specialized mental health care facilities that offer specialized treatment for substance use disorders.

System of epidemiological data collection: Refers to an organized epidemiological surveillance system, which usually incorporates the results of regular epidemiological studies/surveys on the prevalence of substance use and substance use disorders, patterns of substance use and similar.

Targeted multimedia campaigns: Media campaigns with a precisely identified target group and messages designed on the basis of strong formative research and strongly connected to other existing drug prevention programmes in the home, school and community. Such campaigns should ensure adequate exposure of the target group for a long period of time. The aim of targeted media campaigns is to change cultural norms around substance use and/or educate people about the consequences of substance use and/or suggest strategies to resist substance use.

Workplace prevention programmes: These typically have multiple components, including prevention elements and policies, as well as counselling and referral to treatment.

The *Substance use atlas 2021* reports on progress made in the implementation of the regional framework for action to strengthen the public health response to substance use, which was endorsed in 2019 at the 66th session of the Regional Committee for the Eastern Mediterranean Region. Following endorsement of the regional framework, the Regional Committee mandated WHO to monitor and report biennially on its implementation. The atlas maps the resources and capacities of the countries of the Region to respond to the problems of substance use. It also highlights challenges and gaps and identifies areas where the public health response to substance use problems needs to be strengthened. The atlas provides aggregated regional information and individual country profiles, with detailed information on available resources and capacities at the country level.