IDPC report

First IDPC seminar on drug policy in the Middle East and North Africa

Marie Nougier[1] March 2011

Introduction

In the Middle East and North Africa (MENA), illicit drugs have long been tackled through drug policies mainly focusing on tough law enforcement. As a result, few efforts have been made to assess the nature and the scope of drug use and dependence, and drug users have become increasingly stigmatised. Compared to other regions of the world, the prevalence rates of diseases associated to drug use, such as HIV and hepatitis, are relatively low in MENA. However, some groups have shown to be particularly vulnerable to these diseases, such as drug users, men who have sex with men, youths, migrants, sex workers, prisoners and street children. Injecting drug use is the main driver of the HIV epidemic in Iran, Bahrain and Libya and contributes to the spread of the disease in several other countries in the region.[2] In recent years, some MENA countries have started to recognise that a law enforcement approach to illicit drugs had not addressed drug-related harms and drug dependence and are considering new options of intervention.

In an effort to support this new development, IDPC organised a seminar in collaboration with its local partner, the National Rehabilitation Centre in Abu Dhabi (NRC, www.nrc.ae), in order to generate constructive discussions and share experience on drug policy, in the region and beyond. The seminar was attended by over 150 participants from 12 different countries, including Afghanistan, Egypt, Gaza, Iran, Jordan, Lebanon, Pakistan, Saudi Arabia, Tunisia, the United Arab Emirates, the West Bank and Yemen. The seminar benefited from the participation of policy makers, representatives of international governmental and non-governmental organisations, local NGOs, healthcare providers and law enforcement officers. The goals of the seminar were twofold – to share experience and perspectives on drug policy to get a better understanding of the main issues in MENA, and to discuss possibilities for networking activities in the region. The main sessions focused on four themes, drug prevention, drug dependence treatment, harm reduction and drug laws and enforcement. Each session started with a short presentation on global evidence, followed by presentations on regional examples of good practice, and ended with discussions and a Q&A from the audience. This report highlights the main discussions that took place at the meeting.

[1] Research and Communications Officer, International Drug Policy Consortium
[2] International Harm Reduction Association (2010), *Global state of harm reduction 2010 – Key issues for broadening the response,* http://www.ihra.net/contents/245

Box 1. Setting up definitions

For the purposes of this seminar, IDPC has used the following definitions:

- **'Illicit drugs'**: In general terms, 'illicit drugs' include all controlled substances as listed in the UN Drug Control Conventions. For the purposes of this seminar, however, alcohol was also included in the discussions as an illicit drug, since it is considered illegal in most MENA countries.
- **'Middle East and North Africa'**: For the purposes of this seminar, we decided to include Afghanistan in the MENA region to enable their experience to be shared to the rest of the participants.

Drug prevention

The international experience

A variety of interventions have been developed around the world to prevent, delay or reduce illicit drug use, but few of them have proven to be truly effective. With regards to available evidence, it is therefore useful to assess progress made in terms of prevention for alcohol and tobacco use.

Prevention interventions can consist of mental health promotion activities towards the general public to enhance self-esteem, well-being and social inclusion; universal prevention towards the general population; selective prevention targeting one particularly vulnerable sub-group; and indicated prevention focusing on vulnerable individuals that already show indications of health disorder. These interventions can impact on the individual, his/her community (family, peers, school and media), or a country's laws and policies. They eventually seek to influence the individual's health (i.e. behavioural prevention) or his/her environment and living conditions (i.e. environmental prevention).

In May 2008, The European Monitoring Centre on Drugs and Drug Addiction (EMCDDA) published a report gathering 49 high-quality reviews of drug prevention programmes implemented between 1993 and 2003 within the European Union. The EMCDDA concluded that the most effective prevention programmes were those consisting of interactive school-based programmes.[3] The report found that these interventions were particularly effective when they offered coherent life-skills development through intense contact with the targeted group (greater than three hours a week). Mass-media campaigns were also shown to have preventive effects on consumption behaviours, but only when combined with other prevention interventions. As individuals develop in a particular environmental context (socio-economic conditions, education and employment opportunities, drug use among one's family or community, etc.), it is clear that both behavioural and environmental interventions are useful tools in preventing drug use.

Further studies have demonstrated that prevention interventions need to be culturally aware and adapted to the particular audience they are aiming to reach out to. This is particularly important for young people, who seem to be most vulnerable to drug use.

[3] European Monitoring Centre for Drugs and Drug Addiction (May 2008), *Prevention of substance abuse*, http://www.emcdda.europa.eu/html.cfm/index52388EN.html

Drug prevention in MENA – The experience of the International Federation of the Red Cross and Red Crescent

Recently, many countries in the MENA region have realised that a new approach had to be adopted to tackle the increasing number of harms related to drug use. A number of professional institutions and NGOs began to work on drug prevention, and more studies and research started being undertaken on drug prevention and treatment. The International Federation of the Red Cross and Red Crescent (IFRC), one of the largest global networks present in 186 countries, has developed a set of preventive measures to tackle the issue in the region, including:

- General public awareness: National Societies of the IFRC organise educational sessions and workshops for their staff and volunteers on drug use and dependence. A community-based approach is used to educate the general public on drug-related harms.
- Community-based health and first aid programmes: These measures aim to help minimise the risks caused by drug use, inform people and refer them to services and prevention activities, provide first aid training to drug users' families in case of emergencies linked to drug use, organise the community to address drug use problems, and work with other agencies (including religious and youth organisations) to provide information about drug use. The IFRC also supports harm reduction programmes and treatment options, and seeks to reduce the level of stigma and discrimination attached to drug use in the community.
- HIV/AIDS prevention programmes: The IFRC organises prevention activities on HIV and injecting drug use, disseminates prevention guidelines, provides technical advice and training to its National Societies, and promotes peer education, especially among the youth.
- Psychosocial support programmes: The IFRC offers psychosocial support to both occasional and dependent users and their families.
- School-based health and first aid programmes: This programme, initiated in 2011, aims to promote healthy living habits and safe behaviours among school children.

Based on this experience, the IFRC insisted on the importance of collaborative and cross-cutting work for effective drug prevention. Sharing knowledge and experience of what works best in the field of prevention in a given environment, and engaging with vulnerable groups and their communities, are crucial elements for effective prevention programmes. This should go hand in hand with campaigns to reduce the marginalisation and social stigma attached to drug use. Successful prevention interventions are therefore particularly effective if they are innovative, culturally sensitive, humane and pragmatic.

A comprehensive approach to drug prevention in Tunisia

Drug laws in Tunisia are very strict with regards to drug use, with individuals caught for production, possession and distribution being imprisoned for 6 to 10 years. The association ATUPRET (Association Tunisienne pour la Prévention de la Toxicomanie), an initiative funded by the Global Fund, the Tunisian Ministry of Social Affairs and the Ministry of Health, aims to prevent all types of dependence, minimise the harms related to drug dependence through awareness campaigns, provide treatment and rehabilitation services to dependent users, and strengthen partnerships and social interventions among the public about drug-related harms. In the field of prevention, ATUPRET intervenes in schools, colleges, vocational training centres, trains, at fairs and festivals, and among vulnerable populations (including in prisons and at police stations) to provide people

with information on how to access drug dependence treatment and measures to protect themselves from HIV/AIDS, sometimes through peer education. ATUPRET works particularly with injecting drug users (IDUs) in an effort to minimise drug-related harms through the sharing of information about drug injection harms, the distribution of condoms, peer education, etc. The Association also provides IDUs with guidance on how to access drug dependence and HIV treatment (more information about ATUPRET's treatment programmes is provided in the section below). In 2010 alone, ATUPRET reached 1,271 dependent users in Tunisia. The association provides training to outreach volunteers, and participates in research studies at the local, regional and international level about matters related to illicit drugs.

Participants at the IDPC Seminar in MENA

Drug prevention in Dubai – The police's perspective

In Dubai, United Arab Emirates (UAE), drug use and dependence particularly affect people in their late teens and early twenties. The Dubai Police has therefore decided to intervene among young children. In the UAE, people usually start using drugs because of peer influence, to enhance their sexual experience, or because of lack of education. Although it is difficult to assess what works best between tough law enforcement and more liberal approaches to prevent drug use, it seems clear that a long-term strategy is needed to tackle the issue. This is the approach adopted by the Dubai Police. The programme targets 12 year-olds through 77 hours of interventions in schools on various topics related to drugs and drug dependence. The goal of the strategy is raise awareness among students about the problems related to drug use. The interventions include the development of websites and cartoons on 'How to say no to drugs', sports, etc. 'Big brothers' and 'big sisters' are key players to guide the children towards healthier lifestyles. Parents are also involved in the campaigns. Minimising drop-out rates from school and raising academic results is seen as an important part of the programme, since dependence is often linked to low education. Cooperation among different government departments is also crucial to the success of the campaign. Similar prevention programmes are now being used in other MENA countries.

Gaps and challenges for drug prevention in Gaza and the West Bank

In Gaza, 80% of the population falls below the poverty line of US$ 2.00 per day, and the unemployment level stands at approximately 50%. Gaza has also been subject to military occupation for decades, causing significant psychological trauma among the population, particularly among children. In the past decades, the level of tobacco and drug dependence has increased steadily in Palestinian Territories, becoming a major issue among young people, especially in East Jerusalem. It was reported that tobacco use and dependence often leads to other drug use. Although very little data is available on the prevalence of drug use and dependence, much research has been conducted about the factors that push people to use drugs. Some of the most common push factors related to tobacco use include: having a smoking mother, peer influence, violence and bullying, a child's school experience and his/her teachers' attitudes towards smoking.

Only a limited number of prevention programmes has been developed in Palestinian Territories. For example, the Palestinian National Committee for Drug Prevention, established in 1996, publishes leaflets and is involved in preparing an academic training programme aimed at educational moderators in the Ministry of Education and social workers in schools. The Ministry of Youth and Sports also publishes leaflets and pamphlets on drug prevention.

Discussions and conclusions

A number of conclusions can be drawn from these experiences and the discussions that followed the presentations. First of all, considering the limited data available on drug prevention, it is necessary to increase the level of research and share evidence-based experience from the region and other parts of the world. The issue of peer influence has been particularly under-researched. The experience gained from tobacco prevention should be taken into account for illicit drug prevention.

Prevention programmes should only be developed after an assessment of the characteristics of the targeted group(s), and should be culturally sensitive. They also need to be based on long-term cooperative efforts between different governmental and non-governmental actors across a variety of sectors (health, law enforcement, education, etc.).

Each prevention programme should be properly followed up and evaluated in order to assess their long-term impacts on drug use prevalence.

Drug dependence treatment

The international experience

Drug dependence treatment has evolved considerably over the past sixty years. Prior to the 1950s, there were only pockets of drug treatment programmes developed within wider mental health programmes, except in Britain, where substitution therapy has been used since the 1920s. After World War II, a more structured approach to treatment was adopted, and abstinence-based programmes were offered in residential settings or within the community through a 12-step or a therapeutic communities approach. In the 1960s and 1970s, these approaches were supplemented by substitution treatment – a doctor-led process aiming to stabilise the patient's dependent

behaviour. In the 1980s and 1990s, drug treatment programmes expanded, and other services started being offered to the patients, including harm reduction, public health and family interventions, as well as practical services including education, training, housing and employment.

The key learning from this experience is that drug dependence *can* be successfully treated, and it *is* possible to manage drug users' behaviour while they are still dependent. Evidence also shows that effective drug treatment needs to be flexible and multi-faceted to respond to the needs of each patient – this necessitates a range of models and intensities of treatment. It has been largely proven that when treatment is delivered well, to the right people, and in the right circumstances, it can improve health, reduce crime and strengthen communities in a cost-effective way.

An 'integrated treatment system' entails that each government identifies the nature of drug use in their own country in order to prioritise the target group that will most benefit from drug treatment. A menu of integrated and flexible treatment services should then be available that combines different settings and levels of intensity. For those who cannot, or will not, become abstinent straight away, a number of public health services should be developed to minimise the harms associated with drug use. Finally, reintegrating drug users as family members, students and workers within their communities constitute an important part of the treatment.

In 2008, the United Nations Office on Drugs and Crime (UNODC) and the World Health Organisation (WHO) published a report providing a set of principles on drug dependence treatment.[4] The report defines drug dependence as a 'multi-factorial health disorder', hence recognising the biological, mental health and social problems involved in drug dependence. The report also emphasizes the importance of complying with human rights standards, such as the principle of self-determination and the right to be free from cruel and inhuman punishment.

Tunisia's drug treatment approach – The experience of ATUPRET

In October 2007, the Tunisian organisation ATUPRET opened a drug dependence centre with the support of the Ministry of Social Affairs and Solidarity and Tunisians Abroad. The treatment facilities consist of a large park, a reception area, a multi-functional area and sports facilities, and are run by a doctor, a psychiatrist, a psychologist, nurses, social workers, social advisors and animators. The centre can accommodate up to 28 men, 10 women and 6 children. The main goal of the treatment is to provide care for young dependent users and change their behaviour through the provision of information, education, life-skill training, sports and artistic activities. The treatment centre complies with the principles of professionalism, confidentiality, freedom, equality and social responsibility. The treatment operates in four stages: 1- withdrawal (for 10 to 15 days), 2- behaviour change (for 4 weeks), 3- Preparing to leave the programme (for 2 weeks), 4- post-treatment social reintegration and follow up, involving the family, follow-up visits and phone calls. Social reintegration is facilitated by partnerships with governmental and non-governmental agencies. Today, the main barrier to reintegration efforts in Tunisia is the high level of unemployment among the population, which is particularly high among current and former drug users.

[4] United Nations Office on Drugs and Crime & World Health Organisation (March 2008), *Discussion paper - Principles of drug dependence treatment*, http://www.unodc.org/documents/drug-treatment/UNODC-WHO-Principles-of-Drug-Dependence-Treatment-March08.pdf

According to data collected from ATUPRET, most patients admitted at the centre were unmarried men, with a low educational background (only 5.6% have a higher education). 80% of the patients were treated for dependence to Subutex (usually used by injection). With regards to infectious diseases, 3% of the patients were infected by HIV, 8% by hepatitis C and 1.5% by hepatitis B. Since November 2010, the Centre has been offering voluntary testing and counselling services to the patients in order to prevent and treat these infectious diseases.

Between 2007 and 2010, 528 dependent users underwent treatment. However, there is a long waiting list of IDUs wishing to access treatment. ATUPRET is currently in the process of expanding the capacity and services of the centre, especially for women and children.

New developments and remaining challenges in Egypt

Drug dependence is a very old problem in Egypt. For a long time, drug users used to be arrested and sent to compulsory treatment for unlimited periods of time. Gradually, drug treatment became a business and compulsory treatment centres started opening in many areas of the country. In September 2008, a mother brought a complaint against a private treatment facility, claiming that her son had been detained illegally. This judicial case led the government to pass the 2009 Mental Health Act, in which, for the first time, dependent users became considered as mental health patients. A set of rules were established concerning dependent users' admission into treatment – these included the voluntary basis for drug treatment (except when the users represent a danger to themselves or others), a time limit for the length of the treatment, regular clinical assessments of the patient, etc. Since then, and because of the new voluntary nature of drug treatment, doctors no longer have the authority to force a dependent user into treatment. It is now up to the police, the family and the community to exercise pressure on the dependent user to attend a treatment programme.

One of the main issues was the strong belief among the Egyptian population that if a person were attending a treatment, they would automatically be cured of their dependence. Not only did this create disillusionment towards the effectiveness of drug treatment, this belief also had repercussions on Egyptian laws which only allow a judge to send a dependent user to treatment once – if re-arrested, the user is automatically sent to prison. This goes against widespread scientific evidence according to which drug dependence is a chronic relapsing condition that often requires multiple episodes of treatment. The length of the referral process to treatment services is another issue. When a person is arrested for drug dependence, they only appear before a judge after about a year after arrest, which means that a long period of time passes before dependent users receive treatment. There are also instances where the referral process is dysfunctional. For instance, when a dependent user commits a crime, they go to prison automatically, without being offered treatment. This last issue may soon be resolved since Egypt is currently working on a programme to provide drug dependence treatment in prisons.

Efforts to standardise effective drug dependence treatment in Gaza and the West Bank

Before 1990, dependent drug users living in Palestinian Territories used to be treated in private clinics and psychiatric hospitals. The Gaza Community Mental Health Programme was established in 1990 to provide safe detoxification, using a combination of anti-psychotics, benzodiazepine and

antidepressants, psychological support and social rehabilitation. In the West Bank, the Al-Sadig Al-Taieb Association opened a drug dependence treatment centre in May 1991, which now provides detoxification, individual and group psychotherapy, awareness-raising workshops and seminars on illicit drugs. Despite these positive developments, there is a great need for independent and comprehensive drug dependence treatment and rehabilitation centres in Palestinian Territories.

In order to facilitate the provision of drug treatment in Gaza and the West Bank, two professors from the Al Quds University in Jerusalem have translated a standardised manual on drug treatment into Arabic that was originally developed by the Matrix Institution in the USA. The manual, entitled "Validation of manualised substance abuse programme for treatment of drug addicts", will be used by therapists throughout the Gaza strip and the West Bank. The manual is accompanied by some translation notes to clarify its content in a culturally sensitive manner, and includes some guidance on how to use it in practice. When translated, the manual was evaluated during two workshops with health professionals. Trainings are now taking place on how to use the manual. A master's programme also opened at the Al Quds University for mental health experts on the issue of drugs and drug dependence. The challenge now rests on the availability of resources for the good implementation of the manual, which will involve opening necessary healthcare facilities and rehabilitation centres, and training relevant staff. Studies will be conducted on how efficient the use of the manual is for different institutions dealing with dependent drug users.

Effective approaches to drug treatment and rehabilitation in Saudi Arabia

Since 1995, Saudi Arabia has developed a comprehensive drug dependence treatment system, including detoxification, rehabilitation and follow up mechanisms. Mental health and drug dependence are both dealt with in hospitals. A rehabilitation programme was also set up in a military air-base, where the patients follow the programme four days a week, and then less and less as the months go by (once a week, then twice a month, then once a month, and so forth). This process has been shown to increase the patients' attendance to, and follow up after, the programme. Other examples of good practice in terms of follow up mechanisms in Saudi Arabia include half-way houses, where patients stay from one to two years after their treatment is over.

Discussions and conclusions

According to UNODC, only 10% of drug users have a clinical dependence to illicit drugs. This means that a clear distinction should be made between occasional and dependent users so that drug treatment is provided to those most in need. Healthcare providers, police and judges need to be trained to be able to make that distinction.

During the session, many participants recognised that compulsory treatment, while it might work in certain isolated cases, should be avoided. However, considerable discussions took place as to whether dependent users should be coerced into treatment, although global evidence demonstrates that treatment outcomes are more likely to be positive if the patient decides to undergo the treatment for themselves. It was made clear that more research needed to be undertaken in the region about evidence-based drug dependence treatment in order to bridge the gap between evidence and practice. Substitution therapy was rarely mentioned during the presentations and the discussions, and many participants seemed wary of its use, despite a large range of evidence of its effectiveness.

Finally, a comprehensive approach is needed for effective drug treatment, which entails the setting up of necessary legislation, policies and practices, the training of healthcare professionals, the development of efficient referral processes from judicial courts to drug treatment programmes, campaigns to raise awareness about drug dependence among families and communities, and the participation of drug users in the discussions that affect them. Drug treatment services also need to be tailored to the particular needs of women and children/teenagers, and they should be available in prisons.

Harm reduction

The international experience

Despite the strongest efforts to prevent drug demand and supply, there will always be some level of drug use within a given society. It is therefore necessary to minimise the vulnerability of this particular group to health problems, such as overdoses and blood-borne infections (including HIV and hepatitis B and C) transmitted through the sharing of injecting equipment or unprotected sex. The term “harm reduction” refers to pragmatic policies and programmes that aim primarily to reduce the adverse health, social and economic consequences of illicit drugs. Harm reduction may sometimes seem controversial because it does not, in itself, aim to reduce drug use. The main challenge in the domain of drug policy consists in striking a balance between minimising drug use and minimising drug-related harms. Harm reduction is now widely recognised by UN agencies and national governments.

Since every country will be affected by different types of drug use and related problems, no single approach exists to effectively prevent drug-related harms. This is why the WHO, UNODC and the Joint UN Programme on HIV and AIDS (UNAIDS) propose a ‘comprehensive package’ of evidence-based and cost-effective interventions that include needle and syringe exchange programmes (NSPs); opioid substitution therapy (OST) and other forms of drug dependence treatment; HIV testing and counselling; antiretroviral therapy; prevention and treatment of sexually transmitted infections; targeted information, education and communication to IDUs and their sexual partners; and vaccination, diagnosis and treatment of viral hepatitis and tuberculosis.

As young people are particularly affected by drug use, it is necessary for governments to reduce the existing stigma attached to drug use and remove existing barriers (parental consent to access services, fear of criminalisation, inappropriate information, etc.) that prevent young people’s access to harm reduction services. Young people should be involved in the design and implementation of these programmes to ensure that they are appropriate to their particular needs.

Governments need to assess the nature and scope of drug-related problems in their country before deciding which interventions should be implemented locally, taking into account the political and cultural contexts at hand. Some interventions may have to be accompanied by awareness campaigns among community members, government agencies, NGOs, law enforcement and public health officials and the general population. Harm reduction services can be delivered through a variety of sources, including the general healthcare system, drug rehabilitation centres or NGOs. Law enforcement agencies can contribute efficiently to identifying and referring dependent users to appropriate services. It is also necessary to develop harm reduction services in prisons, since large groups among the prison population use drugs.

Iranian harm reduction policies – A model for the region

Iran is an interesting regional example of how drug use and its related harms have been managed by the government. Due to its geographical location – on the trafficking route of opium from Afghanistan to Turkey and Europe – Iran has had an extensive history of drug use. Following the Islamic revolution in 1979, a large number of people started using drugs in order to cope with the associated trauma. A large urban drug market started to develop in the 1970s and 1980s, while the patterns of use shifted from smoking to injecting. In 2005, 200,000 people were injecting drugs in Iran. In 2002, it was estimated that 30% of IDUs were infected with HIV, while over 60% of new infections were caused by drug injection.

During the 20 years that followed the revolution, Iran became known for the harshness of its drug policy, consisting mainly of arresting and imprisoning dealers and consumers. Locking large numbers of drug users in Iranian prisons largely contributed to the spread of the HIV epidemic. In the late 1990s, the government started to consider alternative ways of handling the drugs problem, and adopted two main policies – to divert dependent users into treatment, and to develop harm reduction services. As a result, OST and NSPs rapidly expanded in Iran. Today, over 200,000 opioid users are undergoing substitution therapy. Iran also realised that the drugs issue could only be tackled effectively if public health services were introduced in prisons. In terms of the public acceptance of the government's policies, in January 2005, the Iranian government released a position statement proclaiming the compliance of its harm reduction policies with Islamic principles. This government intervention is particularly important for MENA, since most countries in the region operate under Islamic laws. In terms of effectiveness, a scientific study is currently being conducted by Iranian universities. In 2010, it was reported that no new HIV infections had occurred through injecting drug use.

Harm reduction efforts in Afghanistan

Afghanistan is renowned for opium production and armed conflicts. However, we must keep in mind that, some years ago, the country was almost free of opium, a substance that was only being used as traditional medicine. Today, 1.7 million Afghans are involved in the illicit drug market. This constitutes a huge labour force, and peasants make generous profits out of opium production thanks to the high increase in the price of farm-gate dry opium over the past few years. The government's drug policy has varied significantly over the years. When the Taleban were in power, people believed to be involved in drug production and trade were subject to extrajudicial killings. More recently, the government has adopted a more humane drug strategy, consisting in offering

cash to the farmers to make them stop producing illicit crops. This approach, unfortunately, is not sustainable in the long term.

There are over 1.5 million dependent users in Afghanistan, with three people dying every day of drug-related problems. However, there are only 40 drug rehabilitation centres in the country, and only few of them comply with international human rights standards. There has also been a recent escalation in the number of regular drug users, and the prevalence of drug use has also largely increased among the police. With regards to health problems, it was estimated in 2010 that about 10% of IDUs in Kabul were living with HIV and 15% were infected by hepatitis C.

The response to the drugs problem in Afghanistan is managed co-jointly by the Ministry of Health, the Ministry of Interior and the Ministry of Justice (for prison matters), and the Ministry of Social Care (for issues related to rehabilitation centres). However, there is an urgent need to improve the communication channels between service providers and policy makers, to provide more evidence-based drug dependence treatment, to emphasize a public health based approach for drug dependence, and to promote a regional approach to the drugs problem.

Médecins du Monde (MDM) has been striving for over 5 years to gather evidence of the effectiveness of harm reduction in Afghanistan. In 2006, MDM developed a comprehensive harm reduction programme in Kabul, which provides NSPs, OST, voluntary testing and counselling for HIV, hepatitis C and sexually transmitted infections, anti-retroviral therapy, psychiatric care and overdose prevention. The services also include an economic and social component – Afghanistan being the second last ranking country in the UN development index, it is essential to address social and economic issues in parallel with providing drug treatment and other harm reduction services. The centres will soon provide treatment for hepatitis C. While the programme was first set up as a MDM project, it was slowly 'localised' to adapt to the Afghan context. In order to ensure continuity, the programme provides theoretical and practical training to local professionals and police staff. The centre is now endorsed by the Afghan Ministry of Health. The original goal of this programme was to demonstrate that harm reduction was feasible, efficient and acceptable. The programme is now considered to be an example of best practice by the Afghan Ministry of Health and will be applied in the rest of the region. The main issue is the scale up of the programme to reach every person in Afghanistan in need of those services without compromising the quality of the programme.

Discussions and conclusions

Several conclusions were drawn from the discussions that took place after the presentations above. First, it was made clear that governments should recognise the value of harm reduction. Even if resources are scarce, governments would gain much by allocating resources to harm reduction interventions, first by undertaking small steps (for example, self help and peer support programmes), and then by developing and expanding other harm reduction programmes from the bottom up. The main challenge is to expand the scope and reach of these programmes without affecting their quality.

Since drug use and dependence particularly affect youth, it is necessary to consider young people as a key force to influence their peers on issues related to illicit drugs. Youth involvement should therefore be encouraged in the design and implementation of harm reduction programmes.

Drug laws and enforcement

The international experience

We are now reaching 100 years of international drug control, with the adoption of the Hague Convention in 1912. The current international system of drug control is based on three international treaties – the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Substances and the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The objective of these treaties is to control the production, distribution and possession of controlled substances, while facilitating their availability for medical and scientific purposes. The logic behind the conventions is that illicit drugs should be controlled through law enforcement at three levels: 1- actions against wholesale drug traffickers to limit the availability of drugs; 2- actions against street dealers to reduce the retail market; and 3- actions against drug users to deter them from using drugs.

The ultimate objective of this strategy – the eradication of the global illicit drug market – has not been achieved. Instead, the problem has become more complex with the globalisation and moving nature of drug markets, and law enforcement agencies have tended to focus their resources on arresting and punishing low-level and easily replaceable offenders, rather than those that have a real control over the drug market. This strategy has also had serious negative consequences, for example the rapid transmission of HIV among drug users. Today, it is essential that law enforcement agencies balance their activities with public health, social and developmental activities. In order to do so, governments need to change their measure of success. Up until now, governments have measured their success in combating illicit drugs according to the amount of illicit drugs were seized and the number of drug users and dealers arrested. In reality, the ultimate goals to be reached are more complex. A new set of objectives should be established to measure the extent to which governments have successfully diverted drug users to health services, reduced the violence associated with drug markets, etc. These achievable goals are currently being considered in many political circles around the world.

Law enforcement remains a key element of this new framework – since a large number of occasional and dependent drug users come in contact with law enforcement authorities, the latter should be able to refer them to the services they need. For example, diversion into drug treatment services can happen upon arrest at the police station; in court, when the judge decides to refer a dependent user to treatment; or in prison, where prisoners can be diverted to drug treatment in certain conditions, or sent to a treatment programme within the prison facility. Partnerships between health, social and law enforcement agencies are necessary for the good functioning of these referral mechanisms.

Drug law reform in the United Arab Emirates – ‘Dependent users are patients, not criminals’

Drug laws and enforcement play a major role when it relates to illicit drugs. In 2005, the UAE law on the control of narcotic drugs was amended and now considers dependent drug users as patients, rather than criminals. This law reform denotes that health services need to be developed in order to provide dependent users with appropriate treatment. Several countries around the world have decided to lower the intensity of law enforcement activities towards drug users to encourage them to access drug dependence treatment and other health services. This is the case, for example, in

Portugal, Germany and the Netherlands. In MENA, Lebanon has been a pioneer in considering drug dependence as a health problem rather than a crime.

On the basis of the principle that dependent drug users are patients, rather than criminals, the UAE President adopted a new piece of legislation that established the National Rehabilitation Centre of Abu Dhabi (NRC), which now serves as the point of reference for the provision of drug dependence treatment, and for conducting research on illicit drugs in the UAE and the wider region. While the NRC was, at first, established to provide drug treatment and rehabilitation, it expanded its mandate to provide post-treatment follow up services. The Centre is also habilitated to propose legislations and policies in the field of drug prevention and treatment and get involved in legislative processes on related matters. This new prerogative was officially announced by the Ministry of Health at the IDPC Seminar. During the Seminar, the NRC was also officially mandated to receive drug offenders for treatment as an alternative to custody. This represents a very positive move towards a public health approach in the country.

From left to right: Dr. Hatem Ali (UNODC), H.E. Dr. Farouk Elarabi (UAE Ministry of Justice), Hamad Al Ghaferi (NRC) and Mike Trace (IDPC)

Discussions and conclusions

Each speaker at this session recognised the value of drug laws and their enforcement to address the drug problem and provide drug treatment and harm reduction services for those in need. In order to ensure that these laws are efficient and do not have negative effects, it is necessary that a variety of actors intervene in their design and implementation. These notably include health officials, harm reduction providers, civil society, and those most affected by drug laws and policies – young people, drug users, people undergoing drug dependence treatment, etc. Too often, these groups are denied access to the legislative process and drug policy debates.

In addition, in order to make the most out of available resources, it is necessary to differentiate between the different groups involved in the illicit drug market – by order of priority, high-level

traffickers, low-level dealers, dependent users and occasional users. The bulk of available resources should be aimed at those having the most influence over the overall market (i.e. high-level drug traffickers), while occasional and dependent users should be encouraged to access harm reduction and treatment services. This distinction means that judges and police officers are trained to differentiate between the different groups with whom they come into contact, that drug treatment and other health services are available to those seeking to access them, and that efficient referral mechanisms are in place to divert consumers to appropriate services.

The development of a MENA regional network

The last session of the seminar consisted of a meeting with a smaller group of participants from the region, who gathered to discuss opportunities for setting up an IDPC regional structure in MENA. IDPC has already developed similar structures in Latin America and South East Europe. The overall objective of these regional networks is threefold: 1- to establish communication mechanisms between relevant stakeholders in the region; 2- to connect the region with other areas of the world; and 3- to influence national and regional drug policies and programmes.

The proposal of developing a MENA regional network was warmly welcomed by the participants. Regarding the scope of the network's activities, the participants identified several areas of interest, including increasing research and analysis on drug policy in the region; organising country visits and sharing experiences about what works best in the region and in other parts of the world; produce briefing papers and reports on examples of best practice on drug prevention, treatment, harm reduction and drug policy reform in the region; encouraging and facilitating trainings for judges, healthcare providers and law enforcement officers on drug use and dependence; and facilitating communication among MENA network members through existing IDPC communications channels (IDPC website and monthly alerts), and new mechanisms, such as a blog where interested parties would be able to ask questions and share ideas on drug policy. Finally, some governments remain quite reluctant to support NGO involvement in the drug policy field; therefore, it was felt that intensive advocacy work will be necessary to promote open and constructive dialogue between policy makers and other stakeholders, including local and foreign NGOs.

Discussions also focused on the structure of the network. Considering the specificities of MENA and the limited number of NGOs working in the drug policy field in the region, it seemed useful to open membership to the network both to NGO representatives and other interested organisations or individuals, such as health professionals. Other key stakeholders should also include drug users, former consumers, associations of users, people undergoing treatment, harm reduction service providers, etc. in order to ensure that the network's activities are as pragmatic and efficient as possible. Represented NGOs were encouraged to consider applying for IDPC membership in order to use existing mechanisms within the Consortium. For the time being, the coordination and administration of the network will be done from the IDPC Secretariat and the NRC. However, the participants raised the idea of creating a working group or a board that would be responsible for taking decisions and leading on the organisation of future events.

One of the main difficulties highlighted in the discussions was that of financial support to ensure the sustainability of the network. Although several local, regional and international partners already showed willingness to support the activities of the network, the issue of funding will have to be explored further in future meetings.

The participants agreed to meet again at the margins of the International Harm Reduction Conference in Beirut in April 2011 to keep the momentum going around the regional network, and to agree on next steps and activities for the coming months. It was also suggested that the network would meet again in Tunisia, where ATUPRET agreed to host the next network meeting. For the time being, IDPC and the NRC will be drafting a regional work plan that will be distributed to the participants at the Beirut meeting for comments and feedback, while the participants will be responsible for identifying other partners from the region to gain better geographical and expert representation.

Conclusions and the way forward

This first IDPC seminar in MENA was an opportunity to share ideas and expertise on drug policy in the region. Over this two-day seminar, IDPC was pleased by the level of interest and participation in the discussions throughout the sessions, showing a true potential for engagement in the region. The last session constituted a successful first step in establishing a regional network, and IDPC will work in the next year to develop a dynamic and functional regional network in MENA.[5]

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[5] If you, or your organisation is based in the Middle East and North Africa and you wish to get involved in IDPC's activities, please contact IDPC at contact@idpc.net