



Compendium of Good Practices on Drug Use Prevention, Drug Use Disorders Treatment and Harm Reduction



UNODC

United Nations Office on Drugs and Crime



**Compendium of Good Practices on
Drug Use Prevention, Drug Use Disorders
Treatment and Harm Reduction in Africa**





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FOREWORD: AFRICAN UNION

The African Union Commission is proud to present this seminal work showcasing good practices in addressing drug use challenges in Africa. All the articles in this compendium were compiled and submitted by AU Member States Drug Demand Reduction National Focal points. The compendium is published primarily for the purpose of sharing knowledge and enabling countries in Africa to benefit from exchange of experiences and solutions on what works and draw on lessons learnt.

The recommendation of the second session of the African Union Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC-2) in April 2017 to produce a Compendium of Best Practices on Drug Use Prevention, Drug Use Disorders Treatment and Harm Reduction in Africa was timely. Some good things are happening out there. These few articles demonstrate very encouraging steps. Indeed a journey of a thousand miles begins with a single step. Through this publication, and other activities, the African Union will continue to bolster the efforts of hard working Member States, often with limited resources, and in difficult circumstances. In this regard, we would like to thank in a very special way Drug Demand Reduction National focal points who were instrumental in mobilizing national stakeholders to produce the articles.

It is hoped that this publication will encourage all AU Member States and other countries to embrace evidence-informed strategies and interventions to scale up prevention and treatment services where they exist or to calibrate their response to adopt and implement such strategies and interventions where these do not exist.

The production of this compendium was made possible with the support of the United Nations Office on Drugs and Crime (UNODC), Regional Office for Eastern Africa. It is the tangible translation of the spirit of cooperation and partnership between the two organisations in their efforts to address drug control at the continental level with greater efficiencies

H.E. Amira Elfadil
African Union Commissioner for Social Affairs



FOREWORD: UNODC

The Eastern Africa Regional Office of the United Nations Office on Drugs and Crime is pleased to support the production and publication of the first African Union Compendium of Good Practices on Drug Use Prevention, Drug Use Disorders Treatment and Harm Reduction in Africa. This initiative, led by the African Union with the support of Member States, while showcasing the work of only a hand-full of countries, certainly demonstrate the resolve of African States to address comprehensively, and in a balanced manner the continental and national drug problems.

The cases presented in this publication demonstrate the joint efforts of national stakeholders, including government agencies, civil society and community, to cater for the prevention and treatment needs of people in various settings and to ensure no one is left behind as we strive to curb both the drug use and HIV epidemics on the continent. The work presented is both in line with the framework of the African Union Plan of Action on Drug Control (2013-2017) and in the spirit of the global joint commitment to effectively address and counter the world drug problem expressed in the outcome document of the thirtieth Special Session of the General Assembly of April 2016.

The good practices are only a fragment of the significant body of experience on the continent, but they certainly demonstrate that national and external investments are paying off – The efforts poured into capacity building of implementers, such as first-line health officials, teachers, families, civil society organisations service providers and law enforcement officials is saving lives.

The work undertaken towards the development of standards, policies and plans is ensuring that evidence-based service provision is prioritised and that the well-being of Africans is at the heart of the drug responses on the continent. The challenges are complex, but these good practices demonstrate that evidence-based, coordinated, and tailored approaches work.

The road to achieving the Sustainable Development Goals is an ambitious one. In reading this sample of good practices, one can see the determination of Member States and implementers to ensuring that goal 3, Ensure healthy lives and promote wellbeing for all at all ages, is achieved for all by 2030.

I do humbly hope that this publication will foster exchanges among implementers continent-wide and stimulate the scale-up of drug use prevention, drug use disorders treatment and harm reduction programmes and services at the measure required to respond to the needs of to all who can benefit from them.



Amado Philip de Andrés
Regional Representative
Regional Office for Eastern Africa
United Nations Office on Drugs and Crime



BACKGROUND

Africa has made a lot of strides in its efforts to tackle the world drug problem. In January 2013, the African Union Commission launched the African Union Plan of Action on Drug Control (2013-2017) as a comprehensive strategic framework to guide drug policy development in the continent, enabling Member States to galvanize national, regional and international cooperation to address the issue.

The fundamental goal of the of the Plan of Action goal is to improve health, security and socio-economic well-being of people in Africa by reducing illicit drug use, trafficking and associated crimes, with a particular emphasis on implementation of evidence based responses and the ability to assess effectiveness of those interventions.

Like many other regions of the world, Africa has become a major transit route in the global trade in narcotics. An increase in the trafficking of opiates through East Africa and cocaine in North and East Africa, as well growth in illicit manufacturing and trafficking of methamphetamine have been recorded in the region contributing to a surge in abuse of opioids, cannabis, amphetamine type stimulants and cocaine. Cannabis remains the primary drug of concern in the continent, accounting for 57% of people in drug treatment, followed by opioids (24%) and amphetamines (8%).

The 2017 Progress Report on the Implementation the AU Plan of Action on Drug Control (2013-2017) for the period 2014-2016, highlights significant progress achieved with regards to capacities for coordination at the African Union (AU), Regional Economic Communities, especially the Economic Commission for West African States (ECOWAS), and Member States. The 2017 Progress Report also lauded improved research capacity; strides towards a balanced approach to drug control focused on both drug demand and drug supply reduction; enhanced drug dependence treatment capacity in AU Member States; and strengthened legal and policy frameworks to counter drug trafficking and related challenges to human security.

Of significance, drug dependence treatment, including medically assisted treatment has greatly improved in 19 countries. Opiate Substitution Therapy (OST) is now available in six (6) countries -Algeria, Kenya, Mauritius, Senegal, South Africa and Tanzania. In addition, two other Member States are working towards initiating OST.

Several countries are establishing National Drug Observatories to enhance their capacity to monitor and analyse trends and patterns in drug trafficking and use. However, gaps persist. Drug use prevention is scant at best in most countries whilst drug dependence treatment remains far under the required threshold and scale. Both prevention and treatment are severely under resourced and not always evidence-based. In Africa, one in eighteen persons with drug use disorders access treatment, compared to one in six persons worldwide, due to limited availability of such services.

In resonance, the outcome document of United Nations General Assembly Special Session (UNGASS) on the world drug problem held in 2016 recognizes that, 'while tangible progress has been achieved in some fields, the world drug problem continues to present challenges to the health, safety and well-being of all humanity, and we resolve to reinforce our national and international efforts and further increase international cooperation to face those challenges'. The UNGASS outcome document further recognizes that 'transit States continue to face multifaceted challenges, and reaffirm the continuing need for cooperation and support, including the provision of technical assistance to, inter alia, enhance their capacities to effectively address and counter the world drug problem, in conformity with the 1988 Convention'.

In, order to consolidate efforts by the AU, the second session of the African Union Specialized Technical Committee on Health, Population and Drug Control (STC-HPDC-2), April 2017, recommended the publication of a Compendium of Best Practices on Drug Use Prevention, Drug Use Disorders Treatment and Harm Reduction in



Africa. These are components of the AU Plan of Action on Drug Control (2013-2017) under the priority to scale up evidence-based services to address health and social impact of drug use in Member States, and in line with both the Common African Position on UNGASS, and the UNGASS outcome document operational recommendation on drug demand reduction and related measures, including prevention, treatment and other related measures.

Compendium of Best Practices

The compilation of this compendium is an attempt to recognize efforts made by the Member States in Africa to tackle drug control as comprehensively as possible through evidence-informed drug use prevention and drug use disorders treatment. While several countries are still far from reaching the necessary threshold in service delivery to have a meaningful impact at national level, these initiatives and achievements albeit resource-constrained, need to be acknowledged, documented and shared. This will facilitate exchange of experiences and solutions on what works in similar resource-constrained settings and serve as best practice models for other countries to learn, adapt and adopt in their drug control strategies.

A ‘Good Practice’ is commonly defined as ‘**a technique or methodology that, through experience and research, has proven reliably to lead to a desired result**’. A practical definition of a ‘Good Practice’ is ‘knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts’.

The Compendium consists of (15) articles, from AU Member States, describing best practice initiatives in prevention, treatment and harm reduction which were evaluated against the following criteria:

Effectiveness: Is it working and achieving measurable results?

Efficiency: Is it producing results with reasonable resources and time?

Relevance: Is it addressing an important health problem and need in the country?

Ethical: Is it respecting the ethics of dealing with human subjects?

Sustainability: Is it sustainable over time with reasonable resources?

Replicability: Is it replicable elsewhere in the country or in another country in Africa?

Community involvement: Is it involving the active participation of the affected community?

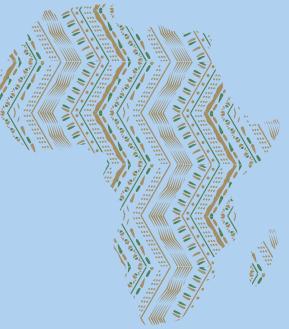
Political commitment: Is it receiving support of the national or local authorities?

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ALGERIE



JEUNESSE SANS DROGUE

Introduction

Suite à un constat amer de la prise de drogue chez les jeunes et malgré tous les efforts des organismes nationaux et internationaux luttant contre ce fléau le problème de la drogue prend toujours de l'ampleur. Notre association est née pour apporter une contribution modeste a la prise en charge de personnes utilisant la drogue.

Après avoir mené plusieurs actions de sensibilisation et de tentatives de récupération de jeunes toxicodépendants vivant une triple exclusions: a savoir, délinquance juvénile, la prise de drogue, démêlé avec la justice, notre travail de proximité nous a permis d'identifier un certain nombre de problématiques spécifiques et de barrières qui ne permettent pas l'issue de vaincre la toxicomanie et une bonne réinsertion professionnelle et sociale.

C'est dans l'objectif d'une réponse efficace à ce besoin que notre association a pensé à mettre en place un projet qui est la concrétisation d'un espace expérimental associatif dédié à cette problématique.
Ceci constitue une première expérience à Oran en Algérie.

Activités :

Première activité : elle a été réalisée par des psychologues spécialistes.

L'entretien motivationnel a été utilisé pour identifier le degré de l'addiction et l'état de motivation de ces personnes pour des soins. Cette intervention nous a permis, soit les suivre à notre niveau pour une prise en charge par la psychologue de l'association pour les motiver pour une réinsertion sociale et ou professionnelle, ou soit pour les orienter vers les structures de soins médicaux appropriés. Dans ces entretiens la psychologue les encourage d'adopter un esprit vers le changement.

Deuxième activité :

Cette activité consiste à la mise en place d'un groupe d'auto-support afin de les aider à développer les compétences potentielles par le biais de théâtre interactif, de jeux de rôle, et autres activités ludiques.



Troisième activité :

Nous avons adopté une approche préconisée par un expert en addictologie « à rentrer en contact avec les usagers qui permet l'intervention précoce, c'est créer une passerelle vers les soins ». C'est le but de notre groupe de thérapie de parole réalisé par une psychothérapeute. Cette activité essentielle a permis aux toxicodépendants de prendre la parole, de s'exprimer dans un cadre amical et de raconter leur récit de vie dans une atmosphère respectueuse et empreint de compréhension dépourvue de stigma et de discrimination.

L'illustration avec les témoignages des usagers permet d'avoir une connaissance approfondie sur les différentes substances utilisées, notamment des médicaments et des nouveaux produits de synthèse. Ceci a permis une bonne appréciation des substances consommées, du contexte dans lequel cette consommation a lieu et qui finalement facilitent une prise en charge thérapeutique réfléchie et basée sur l'évidence.

La psychothérapeute les a aidés à développer l'estime de soi, la confiance et à identifier les barrières à une réinsertion sociale et professionnelle.

Quatrième activité :

Une formation pointue des membres de l'association sur les pratiques d'accompagnement nous a permis d'acquérir de bonnes compétences tout en supportant une meilleure réinsertion socioprofessionnelle des toxicodépendants. Cette activité est réalisée par un spécialiste en addictologie.

Les thèmes abordés lors de cette formation sont des généralités sur les drogues et les caractéristiques des conduites addictives. Les deux leçons importantes se sont dégagées de ces ateliers sont notamment l'accueil des toxicodépendants et l'accompagnement continu qui doit être dispensé.

Le travail en réseau et inter-sectorialité: la réinsertion des toxicodépendants est pluridisciplinaire nécessitant plusieurs acteurs dont l'équipe médicale , les dispositifs de réinsertion , les autorités , les associations et autres acteurs.

Cinquième activité :

La création d'une permanence d'écoute juridique et d'appui dans les procédures aux tribunaux et démarche pour régler le casier judiciaire s'est avérée d'une grande importance. Cette permanence a permis aux personnes utilisant la drogue et en conflit avec la loi, et qui vivent souvent dans une grande précarité, de recevoir des conseils et un appui pour faire face à leurs difficultés d'ordre légales qui étaient une source de stress permanent.

Des journées d'information juridique regroupant les toxicodépendants et leurs parents sur les conséquences de prise de la drogue vis-à-vis de la loi ont aussi été organisées dans la communauté.



RÉSULTATS DE LA MISE EN ŒUVRE

- 30 jeunes toxicodépendants ont bénéficié d'un soutien psychologique individuel et collectif pour le renforcement de la confiance en soi.
- Ils ont tous bénéficié d'un accompagnement personnalisé dans les différents dispositifs professionnels d'auto emploi.
- 8 jeunes toxicodépendants ayant des démêlés avec la justice ont bénéficié d'un suivi juridique.
- Innovation: écoute juridique et l'accompagnement aux tribunaux.

LEÇONS A TIRER

Une approche thérapeutique holistique doit être pluridisciplinaire, notamment réunissant des professionnels qui réunissent les compétences nécessaires pour offrir des services qui comprennent l'aspect sanitaire;

- un soutien psychologique ;
- un appui social ;
- un soutien juridique ;
- et un rappel éducatif et professionnel.

Pour avoir une harmonie entre le soignant et l'usager il faut identifier les résistances afin d'éviter de provoquer les états d'opposition. Les jeunes ont développé les compétences psychosociales qu'il faut maintenir par des séances de psychologie (entretien motivationnel, groupe de parole et prévention de la rechute).

Professionnellement, ils n'ont pas été insérés vu le niveau scolaire bas et la non coopération de certains dispositifs de réinsertion, et ainsi que le niveau socioéconomique bas de la quasi-totalité de nos bénéficiaires. Ces éléments constituent des barrières majeures à la réhabilitation. En plus, la majorité de ces jeunes rejettent l'idée de s'inscrire dans une formation professionnelle. Mais malgré cela nous avons pu inscrire deux jeunes toxicodépendants dans une formation professionnelle. Le reste de l'effectif est en voie de réinsertion suivant leur choix et les barrières rencontrées (amendes non réglées vis-à-vis de la loi, perte de confiance en soi, etc.)

CONCLUSION

La réinsertion socio-professionnelle favorisée par le soin réciproquement l'amélioration de l'état de santé grâce au parcours d'insertion. Tous les bénéficiaires ont participé aux activités réalisées au niveau de l'espace jeunesse sans drogue. Ils ont développé en eux la confiance et l'estime de soi et se sont intégrés socialement (famille, société, etc.). Pour mener une bonne action de prévention et de prise en charge des toxicomanes, Il faut faire une enquête sur la substance prise et le contexte de la prise.

Auteur:

L'association de lutte contre la toxicomanie A.L.T

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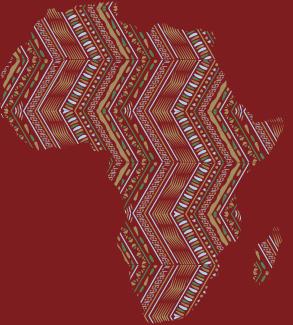


Best Practice

A technique or methodology that, through experience and research, has proven reliably to lead to a desired result.



ANGOLA



DRUG POLICY AND PRACTICES IN ANGOLA

INTRODUCTION

Drug use has become a serious problem for many families in Angola, ranging from the lowest income to the middle and upper classes. As in most African countries, alcoholic beverages and Cannabis Sativa are the most widely consumed due to their easy availability.

Most people do not understand the reasons why they themselves and others become addicted to drugs. Many mistakenly see drug use and addiction as a narrowly social problem. Heredity and genetics are important predisposing factors in the genesis of drug use, while individual personality traits also play a significant role. All these factors need to be analyzed in depth to get a deep insight in drug using behaviours.

This article discusses four fundamental aspects related to drug use in the Angolan society, namely the robustness of the educational sector, the role of the family in addressing drug use, the availability of evidence-based treatment and some reflections on the National Institute for the Fight against Drugs (INALUD) model. The family is the fundamental nucleus of any society where ethical, cultural and moral values are transmitted and where the first notions of democracy are understood.

DEVELOPMENT

In the education sector, the following measures have been taken:

- a) The training of teachers of basic education (teachers working with pupils from 4 to 15 years of age);
- b) The insertion of drug use prevention materials in the school curriculum of basic education;
- c) The creation of the School Safety Units;
- d) The active involvement of the family and the community.



With regard to teacher training and up-to-date curricula, the Angolan government implemented in stages from 2002 to 2015 the second educational reform with which it aimed to solve a fundamental problem of the education and teaching system, namely access to quality education. This has been achieved by a significant expansion of the primary and secondary school network in all provinces, improving the quality of education offered, strengthening the efficiency of the education system and strengthening its equity. These have translated in a substantial increase in the number of students enrolled and the number of teachers recruited.

The education reform has also seen an expansion of professional technical education, with an increase in the number of courses, and a comprehensive restructuring of the drug use prevention programme in schools, through a close collaboration between the Ministry of Education and INALUD.

In order to achieve the major goals defined in the 2013-2017 strategic

development plan, for pre-school, primary and secondary education, the Ministry of Education has been developing the following plans and strategies:

- National Action Plan Education for all 2013-2020. Its enlargement is envisaged until 2030;
- National Training Plan 2013-2020;
- Global Assessment of Educational Reform;
- Strategic Plan for the Prevention and Mitigation of HIV / AIDS its relationship with drugs, Malaria and Tuberculosis, in the Education Sector 2013-2017;
- Diagnostic Studies of the Preschool Education Subsystem.

YEAR	GENERAL	TEACHER TRAINING	PROFESSIONAL TECHNICIAN	YEARLY TOTAL
2013	36,792	11,205	22,700	60,155
2014	38,682	12,360	23,890	63,100
2015	38,682	12,770	24,990	65,025
2017	47,790	14,500	26,793	69,263
TOTAL	166,708	50,835	98,373	315,916



The role of the family

As mentioned earlier, the role of the family and especially the parents, is of paramount importance in preventing drug use. Young people are constantly in the quest for new experiences and sensations and often trying to escape from their daily realities. This especially happens when they undergo important biological transformations during their teen years. The initiation to drug use is even more likely when the young person finds himself or herself in stressful situations, poverty, loneliness and does not receive family support or other form of social support. Suddenly, drug use becomes an attractive alternative. This vulnerability is offset to a certain extent by socially healthy environment and true friendships and positive meaningful relationships.

In interacting with family members and parents, they are taught that it is essential for them to engage with their children and to encourage them to involve in healthy and productive activities that they enjoy, such as the practice of sports, music, theater, etc. These activities are meant to convey to the young people that they have a greater purpose in life and getting involved in using drugs is a serious impediment to fulfilling their potential.

This has been in essence our day-to-day journey with families. As prevention expert Arthur Guerra states, "*Parents should convey security in the message they want to pass; understand that the family is still the nucleus and central for affective decisions; and that example is not only the best way to teach something to someone: it is the only.*"

This work has proved to be effective. Using observation as a method of scientific investigation in our case has shown that, for example, road accidents due to driving under the influence of intoxicants during the last two years have reduced especially during the festive season. This is largely due to the 'Merry Christmas, Christmas without Alcohol' prevention programme, which is implemented every year in November and December with community involvement. These efforts are principled on United Nations Office on Drugs and Crime (UNODC) drug use prevention policies together with national public policies.

In line with the United Nations policy recommendations, the Angolan government considers preventive policies as the fundamental pillar in preventing and reducing addictive behaviors, and thereby creating conditions which are conducive for the reduction of demand and supply of drug use.

In conformity with the macroeconomic vision of Angola, we believe that a focus on 'protection factors' is crucial for public policies to be successful. This implies improving the social conditions of our communities in order to make better use of the information which is disseminated, and to harness the direct relationship between the information transmitted and the way people live. The thrust of our actions is aimed for communities to live in dignified homes, to study in dignified schools, to eradicate social exclusion and to widen opportunities for all without distinction of sex, race or even religion. This will mean that our children, youth and adolescents can get the maximum benefit and protection from our work.

DRUG DEPENDENCE TREATMENT

Regarding drug dependence treatment, two forms of treatment for detoxification are available in Angola. The first one is residential and the second in an outpatient regimen.

The first form of treatment starts in a hospital unit where the patient is admitted and stabilized with the administration of substitute medicines. During this period, the drug dependent person receives counseling and other support services.

The second form of treatment is a reality treatment during which medical treatment and psychosocial support are provided at the patient's home or in the community. This is recognizing that addictive behaviors are the result of biopsychosocial and environmental factors and patients are helped to develop coping skills and progressively strengthen their competencies in order to face the day-to-day pressures effectively.



Patients with substance-induced or severe withdrawal treatment who are most likely to continue using drugs if they remain in the community are treated in a supervised and professional-controlled environment in a short-term residential intervention programme. This approach has not been applied at the national level due to the lack of trained human resources, namely social workers and specialized nurses for effective follow-up.

Patients who are diagnosed with co-morbid conditions are provided with short-term in-patient treatment in psychiatric hospitals.

Rehabilitation is done in an integrated manner in collaboration with other government agencies. The Ministry of Public Administration Labor and Social Security provides professional development opportunities while the Ministry of Education provides vocational training programmes. Commercial banks make credits available for the opening of businesses, thus ensuring the full insertion of the person using drugs.

THE INALUD MODEL

The work of National Anti-Drug Institute (INALUD) ensures that drug prevention and use are carried out following best practice models and reducing juvenile delinquency, working with families who do not offer sufficient protection or social safety nets to their young children. Greater efficiency of this model is achieved by working in close partnership with other State institutions that form the Inter-Ministerial Committee on the Fight against Drugs and with social partners, churches, NGOs and private associations. In taking this approach for our model, we work in close conformity with UNDOC guidelines and also with a view to disseminating information as broadly as possible, and to increasing cooperation at regional and international levels to address a phenomenon which has no boundaries.

CONCLUSION

We conclude by saying, the effective prevention and treatment of drug use, especially in the young population and adolescents requires the full involvement of the various authorities at national levels, together with the active engagement of the family, civil society, and young people themselves; The suppression of drug trafficking will also require the full cooperation of countries at both the regional and international levels.

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BENIN

MON ÉCOLE DIT NON À LA DROGUE

INTRODUCTION

Selon le rapport de 2017 de L'ONUDC, un quart de milliard de personnes dans le monde en 2015 consommaient des stupéfiants ; et parmi eux, 29,5 millions de personnes souffrent de troubles liés à la consommation de stupéfiants, y compris de dépendance¹. Le Bénin, à l'instar de certains pays africains, n'est pas en marge de cette estimation. Il est en effet en proie au phénomène de trafic de drogue. Et pour cause, il constitue une voie de passage pour les stupéfiants transitant par l'Afrique de l'Ouest². La drogue y circule facilement et se consomme sous différentes formes (licite et illicite) en abus. Cette facilité de circulation favorise la consommation au niveau des adolescents qui découvrent et développent de nouveaux modes de consommation tel que la chicha par exemple.

La couche la plus concernée par ce phénomène est essentiellement juvénile, en l'occurrence les jeunes déscolarisés, les élèves et étudiants. En effet, le phénomène de consommation de la drogue sous différentes formes, se développe dans les milieux scolaires et prend une allure vertigineuse avec des conséquences néfastes sur l'avenir des enfants, leur santé (troubles psychologiques, somnolence au cours, détérioration du système nerveux avec difficulté de mémorisation, etc), leurs comportements (agressivité, violence, etc) et surtout sur la sécurité des élèves et enseignants dans les établissements. Ce phénomène est indissociable de celui de l'abandon scolaire. Même si la population scolarisée augmente grâce aux mesures prises par le gouvernement (gratuité de la scolarité et encouragement de la scolarité des filles) au Bénin, les taux d'abandon demeurent encore trop élevés: de 6% en 2004, il est passé à 13,39% en 2012 (INSAE, TBS 2012). En quittant l'école sans diplôme, et n'ayant aucune qualification professionnelle, beaucoup d'entre eux se retrouvent dans une situation de précarité avancée, ce qui les expose à toutes sortes d'exploitation. Lorsqu'ils se retrouvent à gagner leur vie dans la rue précocement, ils deviennent facilement victimes des réseaux de traite de personnes et de trafiquants de drogues.

¹Rapport mondial sur la drogue (2017) de l'Office des Nations Unies contre la Drogue et le Crime (ONUDC),

²Rapport du Département d'Etat des Etats-Unis d'Amérique sur la lutte contre les stupéfiants publié le 4 mars 2002



L'un des axes d'intervention du Centre de Développement Economique Local (CDEL) étant l'« Accompagnement des Jeunes dans leur Insertion Professionnelle », et au regard de l'ampleur de ce fléau sur la couche juvénile, le CDEL a initié et mis en œuvre le projet « Prévention des addictions (dépendances) et l'abandon scolaire auprès des élèves des collèges et lycées de la ville de Cotonou, BENIN » avec l'appui financier du Service de la Solidarité Internationale (SSI) de la République et Canton de Genève.

L'objectif général de ce projet est de « Contribuer à la réduction des dépendances et de l'abandon des classes chez les jeunes élèves (filles et garçons) de la ville de Cotonou ». Spécifiquement, il s'agit d'« Informer et sensibiliser 13,800 jeunes élèves de 10 à 20 ans (filles et garçons) de 5 collèges et lycées de Cotonou » à savoir les CEG DANTOKPA, le NOKOUE, SAINTE RITA, Du LAC et GBEGAMEY.

MISE EN ŒUVRE DE LA PRATIQUE

Le CDEL, pour atteindre lesdits objectifs, a prévu plusieurs activités dont les principales sont :

- La formation des élèves pairs éducateurs ;
- La formation des enseignants relais et autorités administratives;
- La mise en place et la formation des clubs de sensibilisation composés d'élèves pairs éducateurs, enseignants relais, autorités administratives et personnel de soutien chargés de véhiculer les messages de sensibilisation au sein de chaque collège ;
- La rencontre inter clubs de sensibilisation ;
- La mise en place des comités de suivi dans les collèges composés des représentants des élèves, des enseignants, des autorités administratives, des parents d'élèves, du personnel de soutien (gardien, infirmier, bibliothécaire, etc.) chargés de coordonner les activités des clubs ;
- La réalisation des supports de communication : dépliants, flyers, affiches, banderoles, t-shirt, casquettes, etc.

- L'organisation des séances de sensibilisation par les clubs au sein desdits établissements à travers des activités innovantes ;
- L'organisation des caravanes de sensibilisation au cours des journées culturelles dans chaque collège ;
- La conception et la diffusion de spots radio et téte ;
- La réalisation de débats sur les chaînes de radio et télévisions pour conscientiser le public sur la question de la prévention des addictions ;
- La réalisation d'ateliers de capitalisation ;
- L'évaluation interne auprès des bénéficiaires du projet ;
- L'atelier de partage de méthodologie d'intervention et de bonnes pratiques ;

La plupart des activités menées avec les élèves se sont déroulées en tenant compte du calendrier scolaire des collèges. En effet, les différentes formations ont été réalisées aux heures de pause au cours de l'année scolaire. Certaines activités ont connu leur intensité dans les périodes de détente qui sont de grands moments de consommation de stupéfiants. Ainsi, les journées culturelles organisées dans les collèges ont été des occasions de sensibilisation à travers les caravanes aux alentours des collèges bénéficiaires. La diffusion des spots et des débats de sensibilisation sur les chaînes de radio (Radio nationale, ADO fm, Radio Tokpa, Océan fm) et télévisions (Golfe TV, Canal 3 bénin) a été réalisée durant les congés de détente et les vacances, périodes très mouvementées en termes de réjouissances pour nos cibles directes, les élèves.



Les exécutants majeurs des activités sont : le CDEL et ses animateurs, les consultants (psychologue et toxicologues) et les clubs de sensibilisation. Les différentes activités de sensibilisation au sein des établissements sont organisées par les membres des clubs composés de commissions appuyés par les animateurs du projet et les consultants en cas de besoin. Les formations et les séances de sensibilisation grand groupe sont réalisées par les consultants spécialistes de la question ; recrutés par le CDEL. Ce dernier a en effet assuré la coordination de toutes les activités en termes d'organisation, de formation, de suivi, d'appuis-conseils et de lobbying auprès des autres parties prenantes du projet. L'OCERTID (l'Office Central de Répression du Trafic Illicite des Drogues et précurseurs) et le CILAS (Comité Interministériel de Lutte contre l'Abus des Stupéfiants et des substances psychotropes) sont sollicités en tant que partenaires techniques. Le ministère de la santé et la Direction Départementale de l'Enseignement Secondaire, Technique et de la Formation Professionnelle de l'Atlantique-Littoral (DDESTFP/Atl-lit) ont aussi été associés aux activités. Le projet a été financé par le Service de la Solidarité Internationale de la REPUBLIQUE ET CANTON DE GENEVE sous couvert de GENEVE TIERS-MONDE, partenaire privilégié de CDEL.

RÉSULTATS DE LA PRATIQUE – BÉNÉFICES ET RÉSULTATS

Ce projet a permis de former 986 membres des clubs de sensibilisation; de sensibiliser 2345 élèves des collèges pilotes ; de réaliser 7 caravanes de sensibilisation avec une participation de plus de 3600 membres des clubs, et ce, grâce à l'utilisation d'une stratégie participative reposant sur les acteurs eux-mêmes.

Pour apprécier les effets des activités menées auprès des bénéficiaires, une évaluation interne a été commanditée par le CDEL. Elle révèle que:

- Au cours des deux années de mise en œuvre du projet, seulement 02 et 04 cas d'abandon liés aux effets de la drogue, ont été enregistrés respectivement dans les CEG Nokoué et Gbégaméy comparativement aux années antérieures selon les propos des responsables d'établissement.
- Les formations reçues et les sensibilisations ont permis à certains élèves identifiés comme cas suspect de changer de comportement et d'intégrer les clubs de sensibilisation ;
- L'environnement sécuritaire des collèges s'est amélioré : les réseaux de consommation de drogues au sein des collèges ont été démantelés grâce aux activités de sensibilisation;
- Il y a une prise de conscience du problème de la toxicomanie dans les écoles bénéficiaires ;
- L'existence dans les écoles pilotes d'un cadre structurel d'information et d'orientation ;
- Il y a une amélioration des rendements scolaires au niveau des élèves autrefois suspectés d'être consommateurs de drogue.

Par ailleurs, l'évaluation externe est en cours de réalisation.

L'innovation de cette pratique est l'installation des clubs comme outil de pérennisation, regroupant toutes les composantes du système. C'est aussi la sensibilisation par les pairs à travers le mécanisme de Communication pour le Changement de Comportement (CCC). Ce processus interactif et participatif permet l'échange d'informations, d'idées, de connaissances et d'opinions pour favoriser des changements de comportements durables au niveau de l'individu ou la communauté.



ENSEIGNEMENTS DÉGAGÉS

Au cours de la mise en œuvre du projet, certaines pratiques mises en œuvre ont porté ces fruits. Il s'agit de:

- L'échange d'expériences en matière de stratégie de prévention de la consommation de la drogue en milieu scolaire favorisé par la mise en réseau des clubs de sensibilisation;
- La sensibilisation des élèves des collèges bénéficiaires à travers leurs pairs, rendue possible par l'approche participative;
- La capitalisation du projet grâce à l'implication de tous les acteurs.

Pour sa courte durée, bien que le projet ait enregistré des succès notables, les parties prenantes ont identifiées des difficultés et obstacles qui ont été des freins à l'atteinte des résultats et au renversement de la tendance de toxicomanie dans les collèges. On peut citer : le faible niveau d'engagement citoyen de certains acteurs ; la rareté des tranches horaires disponibles dans le calendrier scolaire ; l'environnement des collèges non favorables à une lutte efficace et le faible intérêt porté au fléau de consommation de drogues dans les collèges par les autorités politiques. De même, la production des statistiques liées aux cas de toxicomanie détectés et référencés n'a pas été effective à cause du défaut de communication entre acteurs chargés du référencement et de la prise en charge.

CONCLUSION

Ce projet a eu le mérite d'avoir induit des changements de comportement notables au sein de la communauté scolaire. Les autorités et les enseignants ne sont plus indifférents à la manifestation du phénomène. En termes de profit, on peut reconnaître que l'atmosphère de travail s'est améliorée dans les collèges concernés ; aussi bien entre les élèves eux-mêmes, qu'entre élèves, enseignants et autorités.

Cette intervention peut être considérée comme une « Meilleure pratique » car elle a permis:

- Une synergie d'actions entre les différents acteurs de l'école, ce qui a permis aux élèves d'être au moment habitués aux dynamiques de la vie associative;
- Une implication d'autres acteurs du domaine de lutte contre la consommation de la drogue;
- Aux élèves, bénéficiaires directs du projet, d'être les acteurs de premier plan de l'intervention.

Tout ceci a favorisé l'obtention des résultats et par ricochet de réduire le taux de consommation de drogues et de dépendances au sein des établissements.

Pour reproduire cette pratique, nous recommandons de mettre en place un système intégré de prévention, de lutte, de référencement et de prise en charge des cas détectés. De même, la prise en compte des bénéficiaires comme vecteurs des messages de sensibilisation reste une démarche participative importante pour la réussite de la pratique.

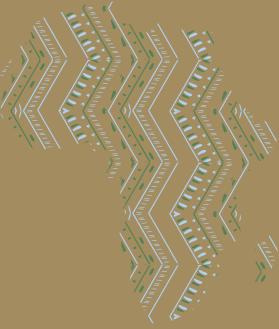
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Cotonou, 8ième arrondissement, quartier Agbondjèdo Ste Rita, 01 BP 4960. C/1073 1èreven à gauche après le feu tricolore Ciné Okpè Oluwa en allant vers la Mairie de Cotonou
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Lecture approfondie

- <https://cdelong.org/cat/programme-daction/projet-prevention/> (Site web de l'ONG CDEL) ;
- <HTTPS://MATINLIBRE.COM/INDEX.PHP/SOCIETE/ITEM/11362-LE-CDEL-ARME-DES-CLUBS-DE-SENSIBILISATION> (CONSOMMATION DE LA DROGUE EN MILIEU SCOLAIRE: LE CDEL, ARME DES CLUBS DE SENSIBILISATION).



PRÉVENTION DE L'USAGE DE DROGUES DANS LES ÉTABLISSEMENTS SCOLAIRES SECONDAIRES À ABIDJAN

INTRODUCTION

L'expérimentation et l'usage de drogues est une réalité au sein de la population scolaire urbaine en Côte d'Ivoire. Cette frange importante des jeunes de 11 à 20 ans est particulièrement vulnérable du fait de son inexpérience, mais aussi à cause du contexte de post crise. L'irruption de la drogue dans l'espace scolaire est régulièrement dénoncée par la presse. Une étude conduite par le PNLTA en 2002, situe la prévalence du tabagisme chez les élèves de 8 à 22 ans à 7,9. Ces chiffres doivent avoir bien évolué avec le temps. Le tabagisme constituant un véritable portail vers l'usage de certaines drogues illicites, les élèves ont été atteints par une toxicomanie juvénile toujours plus présente sur la scène scolaire. La violence, l'indiscipline, l'échec et le décrochage scolaires entre autres se disputent la hiérarchie sur l'échelle des maux de l'école ivoirienne en milieu urbain. Les motifs de consultation du Centre d'Accueil de la Croix Bleue confirment cette tendance avec près de la moitié de ses patients constitués d'élèves. Ceux-ci représentant par ailleurs la plus grande partie de la jeunesse, il nous est apparu décisif de soutenir une action de prévention en direction de celle-ci en ciblant la frange scolaire.

Conscients de l'impact négatif d'un enrôlement massif de la jeunesse scolaire, certains responsables d'établissements se sont engagés dans la mise en place d'une action de prévention de la toxicomanie au sein de leur structure. L'objectif de notre intervention dans un tel projet est de contribuer à informer les acteurs locaux du système éducatif sur les dangers de l'expérimentation des drogues. Les données expérientielles nous ont permis de capitaliser les meilleures pratiques au cours de ces interventions.

Nous rapportons dans cet article l'expérience combinée dans deux écoles secondaires pendant les années scolaires 2015-2016 et 2016-2017 : le Collège Notre Dame d'Afrique (CNDA) de Biétry et le Collège Catholique Saint Jean Bosco (CCSJB) de Treichville.



MISE EN ŒUVRE DE LA STRATÉGIE DE PRÉVENTION

Les activités de l'intervention se sont menées sous trois axes: la sensibilisation de tous les élèves ; la formation des parents d'élèves et des éducateurs de l'école et le référencement des cas de toxicomanie vers la Croix Bleue ou d'autres structures de prise en charge.

La sensibilisation des élèves

L'établissement d'un programme

L'administration établi un programme de sensibilisation pour toutes les classes en tenant compte de l'emploi du temps des élèves, de leur disponibilité et de la capacité d'accueil de la salle de la séance. Chaque groupe d'élèves passait entre 60 et 90 minutes avec l'animateur et les éducateurs pour la sensibilisation qui reposait sur l'enseignement de Compétences de Vie Courante (CVC).

Les Compétences de Vie Courante

Les Compétences de Vie Courante (CVC) sont une stratégie intrapersonnelle de transfert de données relevant du domaine du savoir, de la connaissance vers celui du savoir-être. Autrement dit comment donner des informations nouvelles à un individu et l'amener à reformuler sa conduite en intégrant les éléments issus du savoir nouvellement acquis.

L'enseignement des CVC est un processus pro-actif utilisant des méthodes centrées sur l'élève. Le succès de leur transmission réside dans la capacité de l'animateur à utiliser des méthodes participatives. Leur efficacité dans le domaine de la prévention de la toxicomanie parmi les populations jeunes et homogènes ou à risque n'est plus discuté au sein de la communauté scientifique.

Les séances de prévention avec enseignement de CVC

Vue la difficulté d'organiser plusieurs rencontres pour le même groupe d'élèves, le contenu de chaque séance de sensibilisation avait en trame de fond un enseignement de CVC. En pratique, des situations de la vie quotidienne des élèves étaient exposées et ils étaient invités dans un premier temps à verbaliser la conduite attendue pour cette situation. Puis un jeu de rôle permettait de mettre en scène les comportements adaptés recherchés. L'usage de lunettes de simulation des troubles

visuels sous forte alcoolémie ou après consommation de cannabis est un exemple de mise en scène de la réalité.

Avant la séance, l'administration et les travailleurs sociaux impliqués dans l'organisation des séances rappelaient aux élèves et aux éducateurs l'heure de la séance et en confirmaient la tenue à l'animateur. Des dispositions logistiques étaient prises pour rendre opérationnelle la salle (nettoyage, sonorisation, etc.)

Au début de la séance, le silence et le calme étaient solennellement demandés aux participants. Une liste de présence à signer et permettant de déterminer le nombre exact de participants était mise en circulation. Le contexte de prévention était défini et l'importance de se faire une opinion pour une attitude sanitaire responsable à l'issu du temps d'enseignement était soulignée. Le message portait sur les effets recherchés et les méfaits de différents produits psychoactifs utilisés par les jeunes à savoir l'alcool, le tabac et surtout le cannabis. Les autres drogues (héroïne, cocaïne, hallucinogènes naturels et de nouveaux produits psychotropes...) étaient abordées pour mettre en relief le risque réel d'escalade vers de plus dangereuses formes de toxicomanie. Tout au long de l'exposé, les situations de la vie quotidienne auxquelles l'élève pourrait être confronté sont évoquées afin d'amorcer une préparation personnelle à affronter l'appel des drogues. Un vidéoprojecteur était utilisé pour projeter des images qui servaient d'illustration aux commentaires du formateur. Pour davantage mettre l'accent sur cette relation entre connaissances et vécu quotidien, les élèves étaient invités à :

- Poser des questions libres sur tout sujet abordé ou non concernant les drogues, leurs usages et méfaits.
- Restituer les nouvelles informations apprises au cours de la séance,
- Faire des propositions d'actions à l'administration pour empêcher que la drogue circule au sein du collège,
- Faire des propositions d'actions éducatives aux parents pour que leurs enfants ne touchent pas à la drogue,
- Dire ce que devrait faire chaque élève pour ne pas que la drogue passe par lui,



Toutes les réactions enregistrées étaient consignées dans le rapport de séance du jour. Suite à ce moment d'échange, un court métrage (de 5 minutes) résumant l'histoire naturelle de l'addiction était projeté. Et les dernières paroles étaient celles d'un élève volontaire qui se prêtait à l'exercice de lancer un appel à ses camarades contre l'expérimentation de la drogue.

A la fin de la séance, les contacts (téléphoniques, courriels, etc.) étaient présentés pour permettre de poursuivre éventuellement les échanges soit avec l'animateur, soit avec la permanence des travailleurs sociaux et les éducateurs. Dans la mesure du possible, un support physique d'une page avec présentation de la Croix Bleue, des explications sur les produits utilisés avec des images en couleurs était reproduit et distribué aux participants. Un rapport était rédigé pour consigner les faits particuliers survenus au cours de la séance.

La formation des parents et des éducateurs

Cet axe d'intervention est complémentaire des séances d'enseignement de CVC avec les élèves eu égard aux facteurs impliqués dans la survenue de la toxicomanie. Il s'agit de les former à la (re)connaissance des drogues usuelles, à la détection clinique de leur usage, aux principes d'éducation préventive ainsi qu'aux stratégies de communication avec les enfants et adolescents en cas de soupçon ou non d'usage de drogue. Cette formation est voulue très interactive et participative. Le partage d'expériences des participants est encouragé et orchestré par l'animateur. Ainsi, elle dure entre 6 et 8 heures selon la dynamique du groupe et peut s'étaler sur 2 à 4 séances. Les parents recevaient un support physique de 7 pages portant sur le contenu de la formation, du matériel d'information en version électronique (des fichiers pdf) et surtout des ressources bibliographiques pour orienter les recherches personnelles.

Le référencement

Le référencement pourrait se présenter comme une tâche technique mais l'acquisition de connaissances de base sur les effets des produits, la détection clinique de leur usage et les possibilités et principes de prise en charge en ramènent le processus dans le domaine du couramment possible. Il ne s'agit pas en soi d'une activité thérapeutique mais

de l'amorce d'un projet de prévention de niveau 2 ou 3. C'est une conséquence de la sensibilisation des élèves et de la formation des parents et éducateurs. Le référencement est individuel et peut être proposé par les parents, les éducateurs, les travailleurs sociaux de l'école et même par les élèves.

La mise en œuvre de toutes ces activités a nécessité la participation concertée de l'Administration des écoles, des associations des parents d'élèves, des apprenants eux-mêmes et l'appui technique et organisationnel de la Croix Bleue.

RÉSULTATS DE LA MISE EN ŒUVRE

Les résultats de l'intervention peuvent être observés à plusieurs niveaux:

Les chiffres : Sur un plan quantitatif, et au titre des deux dernières années scolaires, 2 921 élèves de tous les niveaux ont été touchés pour les deux écoles, 42 parents et éducateurs sont engagés dans la formation dont le processus est encore en cours. Le nombre de cas référés reste plus difficile à évaluer vu que certains ont été orientés vers des structures autres que la Croix Bleue.

Les connaissances : Dès la fin de la séance, les participants sont invités à restituer les nouvelles informations acquises. La tendance était toujours à l'accroissement des connaissances. Il est vrai que le changement de comportement qui est le but de l'intervention n'est pas immédiatement observable, mais la qualité des nouvelles informations restituées présageait d'un changement d'attitude imminent.

La perception du phénomène : La circulation de fausses idées et de pratiques dangereuses d'expérimentation de drogues au niveau des élèves s'est nettement estompée selon les travailleurs sociaux. Le fait d'engager une action publique au sein de ces établissements a en outre contribué à briser le silence autour d'un fléau visiblement présent et parfois considéré comme nuisible à l'image de l'école et donc occulté.



L'innovation majeure: Elle se situe à deux niveaux. D'une part le contenu de l'intervention auprès des élèves a été d'équilibrer le message en évoquant les effets recherchés par les jeunes expérimentateurs avant d'exposer les méfaits à moyen et long termes qu'ils connaissent beaucoup moins. L'orientation des séances vers le quotidien des participants est du même ressort. D'autre part, l'implication des acteurs locaux est un paradigme significatif à notre avis. Si le phénomène de la toxicomanie juvénile peut avoir divers déterminants, son traitement devrait également fédérer l'implication d'acteurs divers.

ENSEIGNEMENTS DÉGAGÉS

L'un des points de succès a été la mise en synergie de différents acteurs autour d'une question d'intérêt commun. Avant l'intervention, il existait une tension entre les parents d'élèves et l'Administration de l'un des collèges dès que les cas d'usage de drogues ont commencé à être signalés, chaque partie croyant l'autre au moins en partie responsable du non suivi des élèves. Nous avons contribué à l'harmonisation des points de vu sur la question.

Un autre aspect positif a été d'ébaucher un changement d'attitude et de comportement chez les élèves en une séance unique conçue sur un mode interactif, rompant avec les interventions classiques bâties autour de la simple transmission d'informations. Il n'aurait pas été possible d'atteindre une telle performance sans l'utilisation d'images judicieusement choisies (power point et vidéos) l'adaptation du processus de CVC.

CONCLUSION

La prévention de la toxicomanie en milieu scolaire est une urgence non signalée en Côte d'Ivoire. Le milieu urbain est particulièrement exposé et suite à la décennie de crise, le phénomène tend à prendre d'inquiétantes proportions.

Des acteurs de plus en nombreux ont toujours agit sur la scène scolaire mais les actions menées doivent être repensées en permanence au regard de la progression du fléau. Des années d'expériences et une observation attentive du terrain a montré une faible implication concomitante des acteurs directs. Notre approche met l'accent sur une action concertée et intégrée.

De plus l'intervention prend en compte les trois niveaux de prévention. La prévention primaire s'est faite avec des messages en direction des élèves de classes du 1er cycle pouvant être considérés comme des abstinents primaires. La prévention secondaire visait particulièrement les produits usuels d'expérimentation (tabac, cannabis et autres drogues fumées). Les effets recherchés étaient d'abord mis en exergue avant l'exposé particulièrement étoffé des conséquences non recherchées (méfaits) de manière à faire pencher la balance décisionnelle en faveur d'un retour à l'état d'abstinence. Ce deuxième niveau de prévention visait singulièrement les élèves du second cycle. La prise en charge des cas de toxicomanie au Centre d'Accueil de la Croix Bleue était facilitée par les contacts avec nous et le suivi psycho-éducatif proposé. L'occasion (malencontreuse) nous était donnée au cours du traitement (hospitalier ou ambulatoire) de préparer le jeune patient à une attitude sanitaire personnelle responsable mais surtout à la paire éducation dans son environnement scolaire et social.

La méthodologie de la prévention doit se nourrir de l'analyse de l'évolution des phénomènes de dépendances juvéniles. C'est à notre avis ce qui devrait constituer le fer de lance de la stratégie de réduction de la demande en matière de lutte contre les drogues.

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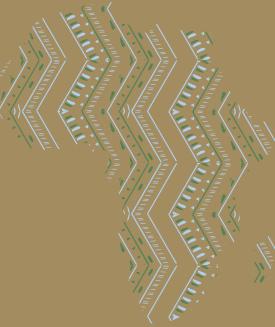
Conseiller Formateur en Toxicomanie

Charge de Projets à la Croix Bleue de Côte d'Ivoire

Responsable du Service social du Centre d'Accueil de la Croix Bleue

Lecture approfondie

- BROU Konan, D. (2016), L'alcool en Côte d'Ivoire, Histoire, usage et signification
- TREAT NET (2008), Volume B Module 1, Compétences de base en conseil et la dépendance aux drogues
- Formation Multinationale IFBC (2010-2014), Prévention



MISE EN PLACE D'UN PROGRAMME COMMUNAUTAIRE DE RÉDUCTION DES RISQUES AUPRÈS DES USAGERS DE DROGUES AU SEIN DES SCÈNES OUVERTES DE CONSOMMATION À ABIDJAN EN CÔTE D'IVOIRE

a) Titre de la “meilleure pratique”

Mise en place d'un programme communautaire de réduction des risques auprès des usagers de drogues au sein des scènes ouvertes de consommation à Abidjan en Côte d'Ivoire.

b) Introduction

Quelle est la nature du problème ?

Selon l'étude réalisée par MdM en 2014 à Abidjan, les produits consommés sont essentiellement la cocaïne (crack) et l'héroïne, mélangés à du cannabis et régulièrement associés à d'autres produits ou médicaments. Une particularité observée en Côte d'Ivoire est que l'héroïne et la cocaïne (crack) sont consommées sous une forme inhalée dans 97% des cas soit moins de 3% d'injecteurs.¹

Autre particularité observée à Abidjan est l'existence de « fumoirs » qui sont des scènes ouvertes de vente et de consommation. Il y en aurait une centaine à Abidjan. Situés dans des endroits difficiles d'accès, ils peuvent être fréquentés par plusieurs centaines de clients par jour. Très organisés autour d'un responsable, de plusieurs revendeurs, de loueur de matériel (pipes), service de sécurité et même parfois d'un petit marché alimentaire. Le « fumoir » constitue pour la plupart des consommateurs un lieu de rencontre où ils viennent passer du temps lorsqu'ils consomment. Pour certains, le fumoir devient un lieu de vie à part entière, dans des conditions sanitaire très précaires et de sécurité (notamment pour les femmes).

¹ Santé des personnes usagères de drogue à Abidjan en Côte d'Ivoire », étude comportementale réalisée par MdM, 2014



Quelles sont les populations touchées ?

Les usagers de drogues (UD) fréquentant les « fumoirs » d'Abidjan seraient entre 6.000 et 10.000. La population est constituée d'hommes à 85%. D'après l'étude réalisée, un tiers des UD avait en 2014 entre 16-25 ans, un autre tiers est constitué de personnes âgées de 25 à 35 ans et le dernier tiers avait plus de 35 ans. Même si le public est très varié, une majorité d'entre eux est sans emploi ou pratique une activité informelle.²

Quel est l'impact du problème sur la population ?

L'impact en matière de santé publique est alarmant. En effet, les prévalences observées pour le VIH étaient plus de deux fois supérieures à la prévalence nationale. De plus, certaines sous populations à risques (travailleurs.euse.s du sexe et hommes ayant des relations sexuelles avec d'autres hommes) présentent des prévalences bien plus élevées (jusqu'à 52,6% pour les HSH TS).

Par ailleurs, l'étude en cours de réalisation sur la prévalence de tuberculose montre une prévalence trente fois supérieure à la population générale.

Ces prévalences sont expliquées essentiellement par les conditions de vie précaires (promiscuité, insalubrité...) associées à des pratiques sexuelles à risque.

Quels sont les objectifs à atteindre ?

Dans le cadre du projet en cours d'exécution par MdM, il s'agit de permettre l'accès des UD aux structures de santé en luttant contre les différentes barrières (financières, stigmatisation,...), en améliorant leurs connaissances en matière de Réduction des Risques (RdR), en limitant la répression à leur encontre des et en améliorant l'accueil des UD dans les structures de soins.

L'approche RdR permet un accompagnement dénué de tout jugement et en fournissant une information claire et des outils qui induisent des changements de comportements.

¹Ibidem

c) Mise en œuvre de la pratique

Quelles sont les principales activités à mener ?

Il s'agit de mettre en place un programme de RdR à base communautaire, programme qui nécessite des étapes fondamentales :

- Connaitre et étudier en profondeur la problématique, le profil des consommateurs, les produits consommés, les lieux et modes de consommation, la taille de la population et les acteurs nationaux pouvant être associés au projet.
- Elaborer le projet en impliquant la population ciblée afin de garantir l'adaptation des projets avec la réalité particulière de chaque terrains.
- Impliquer les UD, les ONGs locales, la société civile ivoirienne, les partenaires techniques et financiers, et les personnes ressources en addictologie tout au long du projet.
- Mener un plaidoyer et un renforcement des capacités constant de toutes les parties concernées afin d'améliorer l'accès aux soins et faire évoluer le regard que porte le pays sur la problématique.
- Amorcer rapidement une stratégie de sortie afin de favoriser la prise de leadership par les acteurs nationaux.

Quand et où ont été menées les activités ?

Le programme RdR mis en œuvre par MdM a démarré en 2015 suite à la réalisation d'une étude bio comportementale en 2014 auprès d'un échantillon de 450 UD d'Abidjan.

Qui étaient les exécutants majeurs et les partenaires ?

Dès le démarrage, MdM a travaillé en étroite collaboration avec :

- Quelques dizaines d'UD ou ex UD qui se sont progressivement structurés en 5 associations communautaires qui mènent des activités sur le terrain (essentiellement de la sensibilisation et éducation en stratégie avancée dans les « fumoirs » mais aussi des actions de plaidoyer auprès des instances de coordination nationale, comme celle du Fonds Mondial).
- Trois partenaires de mise en œuvre (Espace Confiance, La Croix Bleue, ASAPSU) qui ont été formés et accompagnés afin d'assurer la prise en charge médicale des UD (notamment en stratégie avancée).



- Le Ministère de la Santé et de l'Hygiène Publique et le Comité Interministériel de Lutte Anti-Drogue (CILAD) qui ont été associés au pilotage et au financement du projet RdR afin d'en assurer la pérennisation d'une part mais aussi de faire évoluer les politiques et l'approche générale en direction des UD.

La mobilisation et l'engagement de tous ces acteurs a été la clé de voûte de la réussite du projet.

Par la suite, 2 ONG nationales ont également démarré en 2017 des actions en direction des usagers de drogues à Abidjan mais aussi Bouaké et Yamoussoukro.

Quelles étaient les implications en termes de ressources ?

Le projet a été financé sur la période 2015-2017 à hauteur de 1.647.000 Euros. Plusieurs bailleurs soutiennent le projet (Initiative 5%, Agence Française de Développement, Fonds Mondial de Lutte contre le VIH, la Tuberculose et le Paludisme ainsi que MdM).

En terme de moyens humains, l'équipe MdM du projet est composée : 1 coordinateur général, 1 coordinateur médical, 1 coordinateur de programme, 12 staffs programmatiques (dont 2 staffs médicaux, 5 éducateurs pairs, 1 chargé de suivi-évaluation, 1 responsable des activités terrains...) et 7 staffs administratifs et logistique.

Par ailleurs, plusieurs personnes au sein des partenaires sont dédiées au projet et une vingtaine d'éducateurs pairs issus des associations communautaires.

Un bureau est loué à Abidjan, deux véhicules sont dédiés au projet ainsi que du matériel pour les sorties outreach (tentes, bâches...).

d) Résultat de la pratique, bénéfices et résultats

Quels étaient les résultats concrets atteints en termes de bénéfices et de résultats ?

Entre 2015 et 2017, ce programme de RdR a clairement démontré son intérêt :

- L'accès aux fumoirs est garantie grâce au travail des associations communautaires et à l'implication des éducateurs pairs. Une relation de confiance s'est instaurée avec les UD.
- 1 688 UD ont été pris en charge au niveau médical dans le cadre du projet, des centaines d'autres ont eu un accès facilités aux soins.
- Plus de 11 000 UD ont été sensibilisés en vue d'adapter leurs comportements pour limiter les risques liés à leur consommation de drogues.
- Six associations communautaires ont vues le jour et se mobilisent pour améliorer le quotidien de ces personnes vulnérables.
- 6 groupes d'auto-support ont été créés et permettent à une centaine d'usagers de partager leurs expériences et se soutenir mutuellement.
- 2 ONG nationales ont démarré en 2017 des activités en direction des UD à Abidjan et dans d'autres villes du pays.
- Les institutions et programmes nationaux ont maintenant une bonne connaissance de l'approche RdR et de sa plus-value pour la prise en charge de ce type de population.
- Le Fonds Mondial a intégré les usagers de drogues au sein des populations clés.
- Le pays verra prochainement l'ouverture de deux centres de prise en charge incluant les traitements de substitution aux opiacés (déclaration de la Ministre de la Santé début 2017).
- Un projet de révision de la loi concernant l'usage de la drogue est en cours et devrait permettre une approche moins répressive



et plus cohérente à destination des consommateurs.

- Une dynamique régionale est en route, des liens forts ont été créés avec le Sénégal (qui dispose déjà d'une expérience en matière de prise en charge et de traitements de substitutions) et avec 4 pays de la sous-région à travers le programme régional de RdR « PARECO » (Guinée Bissau, Cap Vert, Burkina Faso et Sénégal) mis en œuvre par l'ANCS (Alliance Sénégal) et financé par le Fonds Mondial.

Une évaluation a-t-elle été effectuée de la pratique mise en œuvre ? Si oui, quels étaient les résultats ?

Le suivi-évaluation du programme est réalisé de manière constante à travers les différentes réunions de pilotage (comité de suivi, réunion de coordination ...).

Un travail de capitalisation interne a été mené au premier trimestre 2017 et a permis de tirer les premiers enseignements du programme et de formuler des recommandations.

Une évaluation extérieure du projet par l'un des bailleurs est prévue dans les prochains mois.

Quelle était l'innovation de la pratique?

L'innovation principale est la mise en place d'un programme d'une telle ampleur sur des bases communautaires. L'articulation et le travail conjoint entre deux types de compétences : les compétences en RdR / addictologie et la connaissance du terrain des acteurs communautaires (usagers et ex-usagers) sont essentiels pour mener à bien ce type de programme.

En effet, les connaissances théoriques alliées à la connaissance du terrain permettent d'adapter au mieux les outils, l'approche et l'accompagnement en tenant compte des spécificités de chaque population, de chaque lieu de consommation et de produire une réponse globale, holistique et adaptée à la problématique.

e) Enseignements dégagés

Qu'est ce qui a marché en réalité et pourquoi ?

- L'engagement dès le départ des populations cibles : dès l'étude bio comportementale, pendant la phase de conception et dans la mise en place du programme, des représentants de la communauté des UD ont été impliqués, recrutés et formés. Certains d'entre eux (5) font partie intégrante de l'équipe MdM, d'autres sont recrutés temporairement à certaines phases du projet et la majorité se sont structurée en associations identitaires.
- La mobilisation des partenaires de mise en œuvre (3 ONG nationales : Espace Confiance, Croix Bleue, ASAPU) qui ont accepté d'ouvrir leurs portes aux UD afin d'assurer leur prise en charge.
- Les actions de plaidoyer pour le droit à la santé des plus vulnérables associées aux activités opérationnelles qui permettent de faire évoluer les positionnement et les cadres stratégiques des acteurs nationaux (volonté de changement social).
- L'engagement de la partie nationale ivoirienne (MSHP et CILAD) dans la prise en compte des problématiques des UD assure la pérennité du projet.
- Une dialogue continu et constructif entre tous les acteurs a permis d'affiner l'approche et les messages, d'adapter les outils et les actions pour plus d'efficacité en fonction de l'âge, du profil des bénéficiaires et des lieux de consommation.
- Un travail de capitalisation a permis de rester dans un processus d'auto-évaluation, de dégager les bonnes pratiques et de réorienter ce qui doit l'être.

Qu'est ce qui n'a pas bien marché et pourquoi?

Le volet communautaire n'a pas fonctionné du jour au lendemain, il a fallu un questionnement constant et plusieurs réorientations afin de trouver le modèle adéquat. La gestion de l'argent par exemple, par des personnes usagères actives ont été l'un des enjeux. La difficulté de certains usagers à s'engager dans un processus à long terme doit également être prise en compte.



f) Conclusions

La population a-t-elle tiré profit des résultats ?

Le projet a permis aux UDD d'accéder aux soins de santé, d'être sensibilisés aux risques liés à l'usage de drogues et d'avoir à leur disposition du matériel de prévention adapté (préservatifs, embouts,...)

La communauté est à présent mobilisée et a pleinement pris conscience de l'importance de l'approche RdR. Les associations sont également mobilisées autour d'objectifs de plaidoyer pour un meilleur accès aux soins et pour plus de respect des droits humains en général. Enfin, la partie nationale a une meilleure connaissance des problématiques liés à l'usage de drogues et adhèrent à une approche de RdR.

Pourquoi peut-on considérer l'intervention comme une meilleure pratique ?

Trop de projets sont conçus par des « spécialistes » qui, malgré leurs connaissances, n'ont pas la connaissance du terrain. C'est pourtant du terrain que remontent les informations essentielles à une parfaite adéquation entre l'offre de service et les besoins précis. La création d'un projet à base communautaire en RCI sur ce type de problématique est une pratique innovante qui porte ses fruits et permet un travail efficace et adapté. Cette approche participative est particulièrement pertinente dans ce type de population qui est très éloignée des structures de soins et exclue de la société. Sans cette approche, un tel projet n'aurait pas été possible.

- Recommandations pour ceux qui envisagent d'adopter la "meilleure pratique" documentée ou comment peut-elle aider les populations à plancher sur les mêmes problèmes

Chaque public spécifique doit pouvoir avoir accès à du matériel et des services adaptées (horaires, langage, aspects culturels, type de matériel ...) en fonction de ses caractéristiques propres. Nous recommandons donc d'associer dès la conception d'un projet un maximum d'acteurs afin de garantir cette adéquation de l'offre de service et les caractéristiques du public-cible.

Il est très important de pouvoir assurer un accompagnement des associations communautaires sur le long terme, de leur création jusqu'à leur autonomie. Ce processus prend du temps et nécessite un accompagnement et des renforcements de capacités tout au long du processus

Maintenir l'implication tout au long du processus des communautaires est fondamental. Cette implication demande d'y consacrer du temps et des moyens en termes d'accompagnement et de renforcement de capacités.

Encourager la conduite d'actions de recherche (en matière de diagnostics sanitaires notamment) en collaboration avec les différents programmes de santé nationaux selon les zones d'intervention. Avoir des données chiffrées facilite grandement le travail de plaidoyer notamment.

Mettre en place un processus de capitalisation, modélisation et diffusion des bonnes pratiques.



g) Lecture approfondie

**Veuillez donner une liste de références (six maximum)
qui donne des informations complémentaires sur votre
meilleure pratique**

AUTEUR

Médecins du Monde France en Côte d'Ivoire

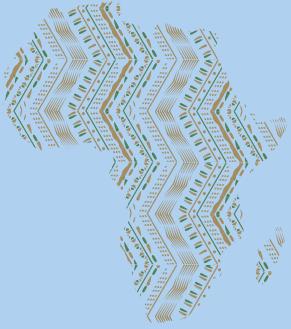
*Siège social : Abidjan Cocody - II Plateaux St Jacques Lot 445, Ilot 50 - 08
BP 4077 Abj 08*

Etude biocomportementale MdM 2014

Présentation du rapport de capitalisation interne Médecins du Monde

Présentation des résultats préliminaire de l'étude Tuberculose

Plaquette de présentation du projet RdR de Médecins du Monde



GENDER RESPONSIVE SERVICES FOR WOMEN WITH SUBSTANCE ABUSE DISORDERS IN EGYPT - A BEST PRACTICE.

INTRODUCTION

Egypt is experiencing a serious drug use problem among women. In order to address this phenomenon, a decision was made to provide gender-specific substance use disorders treatment to this population. A dedicated treatment facility for women was established, gender-sensitive treatment modalities were developed, staff trained and an adapted model was set up. In a short time, treatment uptake by women has significantly increased and impressive results achieved. This is viewed as a model to be replicated on other parts of the country and even for other medical specialities to adopt to respond to the specific needs for women.

In Egypt, women constitute about half of the 104 million population. According to the national addiction survey 2015, the prevalence of substance use in Egyptian women accounts for 9.5% of total morbidity. The overall male:female ratio for substance abuse is 1:7, and 1:10 for dependency. The composite figure for female alcohol and substance dependence is 0.5%.

The number of female patients who received treatment for drug addiction in Egypt over this 7-year period was 2836/110650 i.e. 2.6%. The number of female admissions to governmental hospitals was 271/5156, i.e. 5% of all admissions in the period 2014/2015.

Egyptian society is still far from accepting female addiction and judges such women harshly. This is reflected in the lack of willingness among these women to declare their problem and access treatment, and in the under-development of services for them. There is strong consensus in the international literature that the rates of drug dependence are rising, and that women may succumb to severe forms of the disorder more rapidly than men, that they suffer more complications and that they seek out and receive treatment less often than men. There are specific gender-related issues underlying treatment-seeking behaviour and responses in women.



PROJECT OBJECTIVES

- To build capacity for staff to provide gender-responsive care to women suffering from drug dependence;
- To develop policies and guidelines to establish gender-responsive drug dependence services nationwide;
- To start up and assess a public-domain addiction service for women which serves their specific treatment needs to high standards;
- Implementation of practice

Project phases

Study of the situation of women who use drugs and the services on two levels:

Phase I: Formative assessment: in-depth interviews (IDI) and focus group discussions (FGD) with a random sample of persons from addiction management facilities

Phase II: Quantitative survey: based on the findings of Phase I

Phase III: Pilot Study of women responsive drug dependence treatment service and evaluation.

The project moved into the experimental stage once practical clinical trials had been launched to implement a gender-responsive service.

Establishment of the programme

- Identify a successful programme and adapt it to the Egyptian setting;
 - The present model incorporates features from models identified in Sweden and Pakistan with experiences derived from training in Malta. The most important aspect is that the care programme will rely on findings from previous phases.
- Identify centre location;
 - It was decided to locate this service in an independent building within the current premises of Heliopolis (El Matar) Addiction Hospital in Cairo. This is a renovated, purpose-built facility for treating patients with addiction problems in Egypt. Infrastructural changes were undertaken to enhance

privacy and facilitate access to the service. All gender-responsive requirements were integrated to guarantee client engagement with treatment.

Build up staff capacity to provide gender-sensitive care for women suffering from substance abuse.

To achieve this, we worked on three levels:

1. Developed a therapeutic team integrating colleagues who received training in Malta with others who had not;
2. Held regular meetings with the team: the clinical team met with the project coordinator and research advisor on a bi-weekly basis for development and follow-up.

The meetings included:

- a) Review and modification of the clinical record sheet and adding of gender-sensitive items to the assessment;
- b) Discussion on the scientific background of many gender-related topics:
 - Physiological differences of substance abuse in women;
 - Impact of relationships on the development of substance abuse and the partner effect;
 - Assessment of co-dependency problems;
 - Risk factors, especially trauma, anxiety, depression, eating disorders and sensation seeking;
 - Impact of substance abuse on menstruation, pregnancy, labour and breastfeeding;
 - Correlations between substance abuse, sexuality and violence;
 - Challenges and obstacles faced by women to accessing treatment and compliance management;
- c) Allocating roles to team members for the required activities;
- d) Revising the case management of inpatients, especially those with extreme social difficulties likely to challenge the treatment;



- e) Designing electronic patient files in order to record interventions;
- f) Motivating women to enrol in the programme after assuring them of confidentiality;
- g) Identifying alternative community services following discharge.

3. Programme development

- a) Establishing a treatment programme for inpatients, including daily group therapies: motivational groups, meditation, parenting skills, marital counselling, psycho-educational assistance, support group, physiological feedback and effects of drugs on female hormonal health, in addition to co-dependency issues. Introducing rehabilitation activities including handicrafts, art activities, cooking, reading, gardening, etc.
- b) Reducing the recommended length of the inpatient stay from 6 to 4 weeks. This was based on our observation that long stays were inappropriate for married women and a reason for dropouts;
- c) Conducting trials to make the once weekly day-care programme exclusively for females;
- d) Planning for community-based follow-up for the clients;
- e) Providing outpatient clinics in the morning over 3 days plus 2 afternoon clinics;
- f) Developing a computerised documentation programme;
- g) Developing a system to follow up and motivate patients after their discharge.

EVALUATION OF PRACTICE

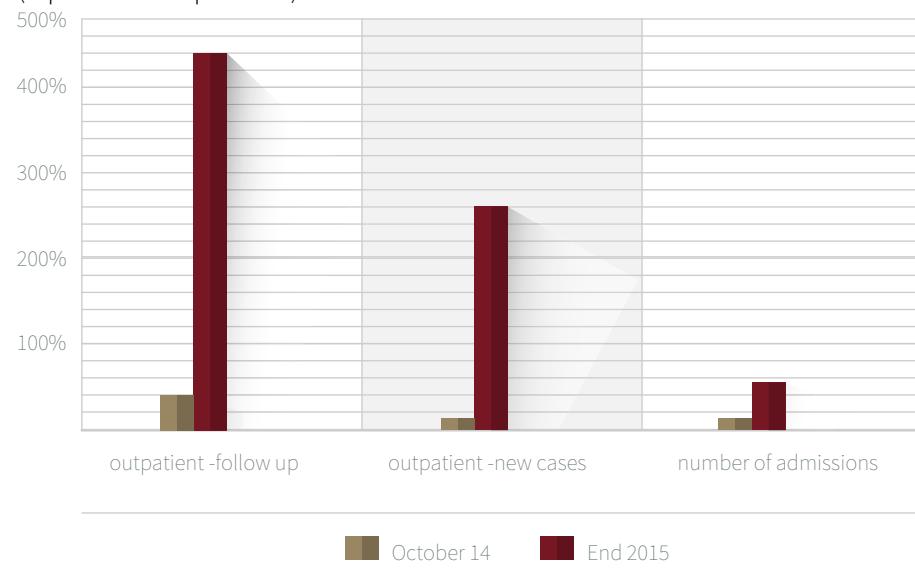
This was done in order to assess and determine how current practices compared to the standards identified in the previous phases. The following results and outcomes were found.

Service progress in numbers

The number of female patients who attended the hospital service from October 2014 until the end of 2015 was as follows:

- New outpatient cases increased from 5 to 249 cases;
- Follow-up outpatient cases increased from 28 to 470 cases;
- Female inpatients with substance abuse problems increased from 7 to 51 cases. (Table 1)

Table 1: Services received by women who used drugs at Heliopolis hospital (inpatients-outpatients) from October 2014 until end 2015.





Therapeutic activities in the inpatient ward (June 2015 – June 2016)

The treatment programme in the inpatient ward was strengthened with a fixed daily schedule in May 2015. Each patient was able to receive individual psychotherapy and to attend group activities. The aim of this daily practice was to boost motivation, overcome obstacles to recovery and promote the treatment decision.

The group therapy programme consisted of various approaches including motivation groups, psychological coaching, cognitive behaviour therapy and emphasis on the here-and-now.

Couple and family counselling

- Counselling and treatment of couples were provided in individual cases;
- Family psychoeducation was performed according to needs;
- Parenting skills and childcare skills were provided according to needs.

Rehabilitation activities included

- Creative art activities including painting, handicrafts and writing were offered once weekly;
- The ward library was improved in order to enhance the reading activity of clients;
- Cooking activities: clients were encouraged to cook their own food the way they liked once weekly. This was a “special” day and clients shared their food with the therapy team.

Social integration with families

- The social workers developed a telephone service in order to communicate with the patients’ families;
- Breakfast parties were held for all patients including recovered ones in order to instil hope and provide role-models for those still under therapy;
- Patients’ families were invited to attend a collective Ramadan breakfast with the patients.

Phone service for patients and their families

- Calls with patients’ families during their inpatient period to ensure that clients completed their therapy;
- Follow-up calls to encourage clients to attend the outpatient clinic and to maintain abstinence;
- Telephone calls to remind regular day-care attenders;
- Tele-counselling of clients and their families in the event of crises.

Evaluation of programme development and team building

This evaluation was designed and performed after work had been done on building clinical skills and considering gender topics in daily practice for 6 months. It also aimed to assess the application of standards relating to gender issues in the service.

These standards included:

1. Recognising the role and significance of personal relationships in a woman’s life;
2. Addressing the unique health concerns of women;
3. Recognising the importance and role of socioeconomic issues;
4. Assembling an integrated and multidisciplinary therapeutic team;
5. Paying attention to the relevance and existence of various caregiver roles assumed by women throughout their lives;
6. Supporting the development of gender competency specific to women’s issues;
7. Adopting a trauma-relief perspective.

The questionnaire

The questionnaire was designed by the project coordinator and revised by 4 independent consultants working in the addiction field. It consisted of 24 questions covering routine practice skills and how gender-related issues had been integrated in practice. The therapists’ self-reflection about the treatment process was evaluated, as well as ethical issues encountered during the patient’s therapeutic journey. The study questionnaire enquired about requirements for a gender-responsive service from the health providers’ perspective.

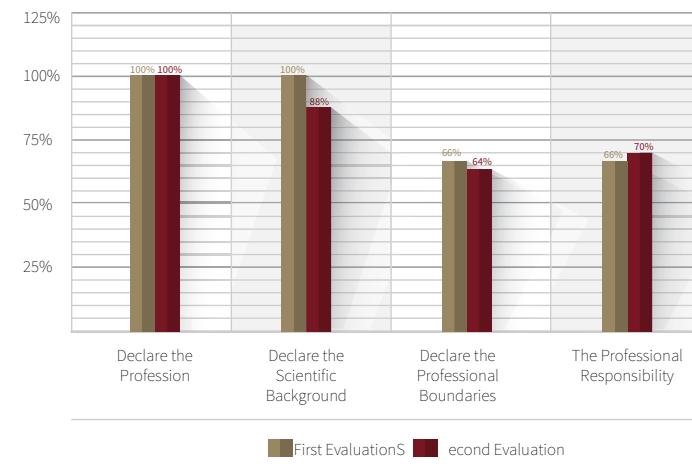


Subjects and Procedure

The evaluation was performed twice (April and November 2015) and followed ethical principles and with clients' consent and in confidentiality. The first evaluation was carried out in April 2015 ; while the second evaluation was done in November 2015, when the programme had become well established.

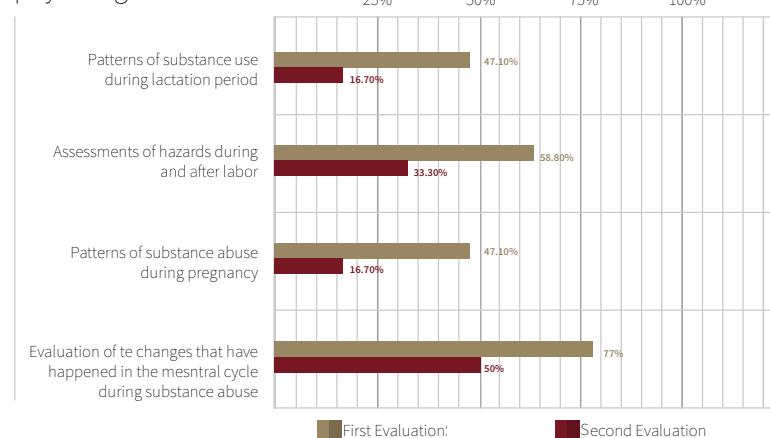
Results and comments

Table 2: Treatment team openness with patients



Incorporating gender issues within the assessment:

Table 3: Assessing how substance use related to female physiological life



($\chi^2 = -0.2$, $p=1.468$ using Mc Nemar's test).

Reports from health providers about the environment in which women who used drugs were introduced to services

Table 4: Environment including site, staff and work programme dedicated to the gender service

Service Description	First evaluation	Second evaluation
Special wards for women	100%	100%
Availability of dedicated team for women	50%	76.6%
Availability of group therapy for women	66%	53%
Availability of child care services	0%	17%
Services related to sexual health	16%	35.6%
Special services related to reproductive health	33%	30%

Table 5: Admission procedures for women who used drugs

	First evaluation	Second evaluation
Parents or husband's consent before admission	66.7%	35.3%
Mandatory pregnancy test	100%	93%
Mandatory HIV and hepatitis screening	50%	59%
Educational material and reproductive and sexual health awareness-raising	66.7%	87.6%



Table 6: Evaluating social obstacles for women to access treatment

	FIRST EVALUATION	SECOND EVALUATION
Confidentiality	100%	100%
Stigma in relation to treatment	88%	80%
Economic and financial problems	83.3%	70%
Motivation to undergo treatment	83.3%	88%
Fear of legal consequences	33%	41%
Balance between treatment and family obligations	50%	63%
Refusal of the guardian to allow treatment	50%	41%
Self-protection against violence	-	23%

CONCLUSIONS

1. This project has received the political commitment of the Ministry of Health and Population and other partners;
2. A gender-sensitive and responsive service for women who use drugs has been created in Egypt which is delivered in an ethical manner and which has proved to be both effective and efficient;
3. In spite of a number of shortcomings, this service has had an impact on all public mental health services in Egypt, creating a cascade of similar services;
4. Its main achievement is that many professionals in various specialities are now sensitized to the specific needs of women in treatment and are prepared to support them;
5. The future challenge will be to maintain collaborative links and interact with similar services worldwide in order to share experience and stimulate further improvements;
6. Statistics provided by the service from its inception indicate that it has an increasing and unique role in providing services for women with substance abuse problems in Egypt;
7. This service needs to be replicated across the country where such services are required and are integrated with community services in order to optimize benefits.

LESSONS LEARNT

- The gender sensitive and responsive service was both adaptable and culturally acceptable to the Egyptian females and effectively addressing their needs;
- Long term psychosocial support, rehabilitation and follow up are recommended;
- Integration of all the stakeholders including the Ministry of Social Solidarity, National Council of Women, National Council of Child and Motherhood and NGOs, is highly recommended for higher impact;
- Inclusion of a special section in the national strategies for gender issues should be clearly articulated for long-term sustainability;
- Amending the legislation regarding child custody and child protection concerning women who use drugs, can open the gate of hope and opportunities for women to be reunited with their children after recovery, is crucial.

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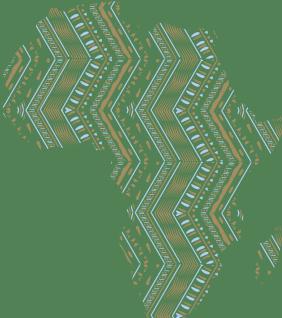
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Acknowledgement

This project is the product of joint collaboration between the General Secretariat of Mental Health & Addiction Treatment, Ministry of Health and Population in Egypt and the MedNet / Pompidou Group of the Council of Europe.

KENYA



Kenya's Medically Assisted Therapy Programme – A Best Practice Model

Introduction

Illicit drug use has been documented in Kenya since 1980 with an estimated 18,327 people who inject drugs (PWID), 50% in Coast region. PWID had significantly higher HIV prevalence compared to general population (18.3% versus 6%), with females who inject drugs disproportionately affected (44.5% versus 16% for male peers). Adverse effects of drug use on society included homelessness, family breakdown, loss of productivity, criminality, higher morbidity and premature death.

An unprecedented heroin crisis in November 2010 in Kenya following the government's crackdown on drug trafficking barons highlighted a weak public health response capacity to PWID, namely congested health facilities, human resource constraints, no medications for opioid withdrawal management, highly mobile clients, and a large proportion of polydrug users.

IMPLEMENTATION OF THE PRACTICE

A unique collaboration between the Ministry of Health and County Governments in Kenya and USAID/PEPFAR, UNODC, University of Maryland, Civil Society Organisations (CSO) and PWID networks was developed for the roll out of Medically Assisted Therapy (MAT) Programme in Nairobi and Coast regions as part of a comprehensive Combination Prevention Programme to prevent HIV among this key population. The implementation method adopted comprised a four-pronged approach, namely:

1. Strategy I: Adopting policies, strategies and guidelines to increase PWID access to evidence-based services and interventions;
2. Strategy II: Increasing access to comprehensive PWID package of HIV Prevention, care and support services;
3. Strategy III: Strengthening policy-makers and community support for PWID HIV prevention interventions;
4. Strategy IV: Improving capacity to monitor and evaluate PWID programmes.



IMPLEMENTATION APPROACH AND RESULTS

Strategy 1: Adopting policies, strategies and guidelines to increase PWID access to evidence-based interventions

- a. Sustained engagement of government and non-governmental partners through regular MOH-led national and county-level technical working groups meetings;
- b. Review and drafting of policies, guidelines and operational plans for MAT programme roll-out;
- c. Study tours of best practice countries for core national and county health authorities and focal persons of targeted facilities;
- d. Training by international MAT experts from Mauritius, Tanzania, United Kingdom and the United States.

Results of Practice:

- Lessons from Mauritius, Spain, UK, Vietnam and Tanzania reinforced the conviction and confidence in Kenya's MAT programme initiation;
- PWID were prioritized in national AIDS strategic plans;
- Supportive policy framework for MAT: A National Policy for HIV Prevention for Key Populations was developed;
- Technical guidelines, standardized operating procedures and road maps assured a smooth roll-out of evidence-based and high impact harm reduction practices;
- Over time, national health authorities, with the support of UNODC, have engaged trained local resource persons for the development and delivery of MAT training packages in recognition of increasing in-house capacity at national and decentralized levels.



Strategy 2: Increasing access to comprehensive PWID package of HIV Prevention, care and support

- a. Structured feasibility assessments of proposed public health facilities and CSOs guided MAT clinic establishment at selected public health facilities;
- b. UNODC/USAID equipped and operationalized new MAT clinics while national and county governments provided health commodities and human resources;
- c. CSOs awarded grants to conduct community outreach to mobilize, refer and follow up enrolled MAT clients;
- d. Practical mentorship of newly recruited MAT clinic staff by twinning with experienced service providers from existing clinics and CSOs;
- e. Eligible opioid dependent persons accessed methadone under direct observation treatment and other MAT-related services; namely psychosocial counseling; treatment for co-morbidities and other infections (depending on baseline screening for HIV, TB, STI and pregnancy results) and individualized treatment plans;
- f. CSO Drop-in-Centres enabled client recovery through: basic social support (hygiene kits, daily meals, shelter), counselling for substance use disorders, non-complaint client follow-up, support groups, securing national identity cards, paralegal aid for PWUD in conflict with the law and family reintegration.
- g. Counties have also established MAT Linkage forums that meet on a quarterly basis. These forums have strengthened and increased uptake of MAT, as well ensured non-complaint client tracing as data, progress and challenges from individual facilities are discussed amongst the staff, community members and CSOs.
- h. The buddy system has been introduced in Kisumu and through this interventions those on MAT have been able to bring and have their peers inducted into the MAT programme.
- i. In an effort to make the programme sustainable, MoH has been able to budget for and procure Methadone for the clients

Results of Practice:

- In December 2014 Kenya became the third sub-Saharan African country to introduce Medically Assisted Therapy (MAT);
- Within 3 years, 6 MAT clinics were functional at public health facilities with CSO linkages in 5 counties (Nairobi, Kilifi, Mombasa, Kisumu and Kwale);
- Cross-county mentorship and periodic MAT meetings facilitated networking and effective client referrals across MAT sites;
- Expanded MAT clinical package addressing special client needs such as: linkage to ART and viral load testing upon diagnosis of MAT clients living with HIV; integration of MAT with PMTCT and MNCH for pregnant and lactating female MAT clients and their infants; HCV treatment for PWUD with confirmed diagnosis at established MAT Clinics and CSO DIC;
- Take-away doses piloted in Mombasa to minimize attrition of bedridden or postpartum clients, those with heavy transport costs, visiting places without MAT services, or security concerns (e.g. during 2017 elections).



Strategy 3: Strengthening policy-makers and community support for PWUD HIV prevention interventions

- a. Conducted advocacy and sensitization meetings with national, county and community stakeholders (policy makers, judiciary law enforcement, media, cleric, opinion leaders, affected family members and the general community); TV and radio broadcast of documentaries on PWUD; awareness campaigns on World AIDS Day and International Day Against Trafficking and Illicit Drugs;
- b. Vocational training needs assessment are underway to sustain recovery, with plans to disseminate findings to local business community and secure support for MAT clients;
- c. Vocational training and entrepreneurship skill building offered by CSO partners for MAT clients;
- d. MAT client groups are formed and linked to relevant government and non-government stakeholders for community development.

Results of Practice

- More tolerant attitudes among general population enabled over 2000 PWID to access MAT services without fear of discrimination or violence in Nairobi and coastal regions;
- More accepting attitudes of law enforcement with fewer swoops in drug using dens, police brutality, harassment and incarceration of PWUD in 2017 compared to previous years;
- Alternate sentencing of MAT clients in conflict with law by a magistrate in Mombasa via diversion to nearby MAT services rather than imprisonment;
- Representation of CSO paralegal staff in Malindi's Court Users Committee to secure probation for PWUD charged with petty crimes (loitering, possession of drugs for personal use or injecting paraphernalia);
- Prison authorities in Mombasa and Malindi organize daily escort to MAT clinics to assure continuity of care for all incarcerated inmates initiated on MAT prior to incarceration;
- Over 10 MAT client groups registered in Mombasa, Malindi and Kwale for advocacy, microcredit and entrepreneurship initiatives; some clients sell handicrafts or snacks around MAT clinics;
- At least 50 MAT clients from Mombasa, Malindi and Kwale engaged as CSOs Peer Educators;
- At least 100 MAT clients gained vocational skills in soap making, driving, tailoring and computer literacy;
- Kwale County government mobilizing resources for vocational and entrepreneurship skills-building and job creation among MAT clients within 2-3 months of MAT initiation rather than after 12 months as in other counties.



Strategy 4: Improving capacity to monitor and evaluate PWUD programmes

- a. Kenya's Ministry of Health and its partners defined a core set of indicators for its first Monitoring & Evaluation (M&E) system for MAT;
- b. Cross-sectional paper-based service delivery and reporting tools developed for work-stations at MAT Clinic and CSO levels. M&E tools were reviewed after 12 and 24 months of programme implementation to improve efficiency in documentation and reporting. Further review at county level is planned to address site-specific needs and capacities;
- c. M&E orientation conducted for clinical and CSO staff at MAT initiation followed by periodic supervision and data quality checks;
- d. Development of Real-Time i-Health Portal to track programme implementation, raise alerts and facilitate regular reporting and on demand;
- e. Progress updates are presented and discussed at monthly MAT staff retreats for clinical and CSO staff, and quarterly county technical working group meetings with other stakeholders;
- f. Practical hands-on mentorship on data analysis and abstract writing was provided for core MAT clinical and CSO teams from Malindi and Mombasa;
- g. Introductory training on Implementation Science for national, county and CSO partners was conducted;
- h. The country has migrated its KP data to the DHIS, including that of MAT. This will enable all MAT sites to report on one platform and it will ease in the analysis and comparison of data among the different counties.

Results of Practice

- Coast MAT sites improved client care and follow-up by consolidating 22 M&E tools into single MAT Client Card;
- MAT Client Card transformed into longitudinal MAT Client Booklet awaiting national endorsement prior to roll out;
- Real-Time AFYA-PWID portal developed and piloted at Kwale at MAT Clinic and CSO levels;
- Malindi and Mombasa MAT Clinics maintaining up-to-date interim Excel-based health records that facilitate monthly data aggregation and reporting;
- Regular data analysis and presentation of service delivery statistics on demand by MAT Clinics and CSO partners;
- Over 40 abstracts submitted for international, regional and local conferences with at least 10 approved for oral, poster or dialogue presentation;
- Kenya's MAT programme visibility significantly enhanced through UNODC/PEPFAR and Swedish sponsorship of over 20 national, county, clinic, CSO representatives and beneficiary clients at global conferences, including 2016 AIDS Conference and 2017 International Harm Reduction Conference;
- Enhanced understanding of preliminary MAT programme effectiveness and outcomes.

NOTE: Kenya's MAT Programme has not been previously evaluated. Reported results in this document are extracted from routine programme reports, and anecdotal reports, donor visits and study tours of project sites by other entities.

What makes this a best practice programme is the strong national and county ownership and leadership; dynamic multi-sectoral partnerships with judiciary, law enforcement, media and communities; substantive domestic contributions and commitments of national and county governments, non-government as well as CSO entities involvement; building on lessons learnt from existing MAT sites; and a client-centered approach at all levels.



LESSONS LEARNT

1. The following features have worked well:

- Strong commitment and partnership between national, county governments, CSO, UNODC and USAID/PEPFAR;
- Existence of MAT champions at national, county and CSO levels facilitated rapid response to emerging issues;
- Low threshold approach assured MAT access for both injecting and non-injecting PWUD;
- One-stop shop model facilitated integration of HIV, TB, HCV screening and treatment;
- Ongoing engagement with law enforcement, judiciary and prison authorities assured a continuum of care;
- Moonlight dispensing during Ramadhan strengthened spirituality and provider-client relations in areas with a high density of Muslim population.

2. The following have not worked well:

- Low service uptake by women who use drugs - despite open-door policy for induction of female clients;
- Human resource constraints at existing MAT clinics compromised MAT access for eligible PWUD and quality of care for enrolled clients and slow down client enrollment;
- Restrictions by regulatory health authorities compromised provision of alternate dispensing options such as mobile vans, take-home as a MAT option;
- Absence of MAT clinic standards led to establishment of low volume facilities, that were overwhelmed within 12 months of programme initiation;
- No dedicated funding for livelihood assistance compromises recovery with many clients perceived as a nuisance to the community due to loitering.

CONCLUSIONS

Kenya's MAT programme is a good practice model as evidenced by strong partnership of government and non-government entities with collaborative shared responsibility and local ownership from program start. A low threshold approach, rapid scale across regions and client-centred approach ensured:

- Over 2000 injecting and non-injecting males and females who use drugs enrolled for Medically Assisted Therapy;
- Of 100% clients who accessed MAT were offered screening for HIV, TB, hepatitis, syphilis and TB on first day of enrollment;
- Enhanced treatment adherence for ART, anti-TB and HCV treatment among MAT clients in Coast region;
- Over 80% clients retained for on MAT for 12 months.

Low and Middle Income Countries (LMIC) with concurrent HIV and drug use epidemics may replicate Kenya's model MAT provided they secure adequate human resources, technical guidelines and resources for sustainable livelihood interventions from programme start for MAT scale up.

Authors

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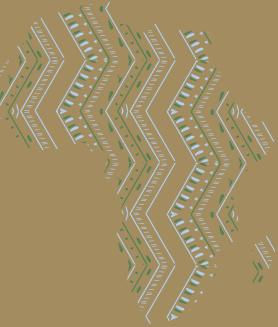
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MAURITIUS



HARM REDUCTION MEASURES OF METHADONE SUBSTITUTION THERAPY AND NEEDLE EXCHANGE PROGRAMME AMONG INJECTING HEROIN USERS IN LIMITING THE SPREAD OF HIV IN MAURITIUS

Introduction

Since the 1980's, Mauritius has experienced a serious injecting drug use problem. Over the years, injecting drug use emerged as the main driver of a concentrated HIV epidemic which culminated in 2005. Harm Reduction measures of methadone substitution therapy and needle exchange programmes were implemented in 2006 following the enactment of the HIV Act, 2006. The effects were felt over the following years with a reduction in the incidence of HIV. However, the rapid induction of methadone to injecting heroin users did not come without problems. There were problems of overcrowding at dispensing sites and loitering in the vicinity of sites with an ensuing public nuisance factor. These, to a certain extent, led to a suspension of methadone induction for 2 years. Methadone induction started again in June 2017.

Mauritius is an island of about 1.3 million inhabitants situated about 800 km off the east coast of Madagascar in the South West Indian Ocean. Injecting drug use has been a serious problem in Mauritius since the 1980's. Integrated Biological and Behavioral Surveillance (IBBS) surveys conducted in 2009 and 2011 estimated the number of People Who Inject Drugs (PWIDs) to be about 10,000.

A further IBBS survey conducted in 2013 estimated that, among the PWIDs, 45% were living with HIV. Of all HIV cases registered till August 2017, 65.0% were detected among PWIDs. Between 2003 and 2005, there was a 4-fold increase in the incidence of HIV in Mauritius. Methadone Substitution Therapy and Needle Exchange Programmes were introduced in Mauritius in 2006, as part of Harm Reduction strategies, in an attempt to limit the spread of HIV/AIDS in the island.



IMPLEMENTATION OF THE PRACTICES

1. Methadone Substitution Therapy (MST)

About 6,800 PWIDs have been induced on the methadone substitution therapy programme since it started in both community and prison settings. The programme temporarily stopped for 2 years between June 2015 and June 2017 because of associated difficulties which included overcrowding at dispensing sites and loitering in the vicinity of dispensing sites. To remedy these problems, decentralization of methadone distribution was effected in 2015 and it achieved its main objectives of reducing overcrowding at sites and loitering near sites.

Non-Government organizations (NGOs) collaborate with the Ministry of Health and Quality of Life (MoHQL) to implement the Methadone Substitution Therapy programme. The NGOs offer individual and group counselling sessions to patients prior to their enrolment in the programme. They also offer support to patient's family and careers.

Prior to 2015, methadone induction was conducted both in daycare and residential settings. Since methadone induction re-started in June 2017, it has been conducted only in daycare settings. Patients attend the daycare centres daily during the induction phase which lasts between one and two weeks. Then, newly induced patients attend out-patient clinic on a weekly basis to further review and adjust their methadone doses during an early stabilization phase which lasts for about 6 weeks.

A later stabilization and maintenance phase follows whereby patients are reviewed at a lesser frequency, usually fortnightly to monthly depending on their level of stabilization. Methadone doses are reviewed and adjusted if necessary. Thereafter, patients are followed up according to their needs at the methadone treatment centres. Patients are encouraged to attend the treatment centres in case of any medical or psychosocial difficulties.

2. Needle Exchange Programme (NEP)

The Needle Exchange Programme (NEP) was launched in 2006. It involves a collaboration between the MoHQL and an NGO. The NEP has been gradually scaled up since it started, and currently, 46 sites are served across the island, especially in areas with a high concentration of PWIDs. In this joint Government/NGO collaboration, the MoHQL covers 35 sites and the NGO covers 11 sites.

Around 6 000 PWIDs have benefitted from the NEP since it started. However, over the recent years, the number of patients have steadily decreased as patients had been shifting to the Methadone Substitution Therapy programme after having been for some years on the Needle Exchange Programme.

Mobile caravans and field workers cover the NEP sites in discreet locations to maximize confidentiality and encourage attendances. The materials provided include clean injecting equipment like syringes, needles and injecting paraphernalia which are exchanged for used needles and syringes. Alcohol swabs are also provided.

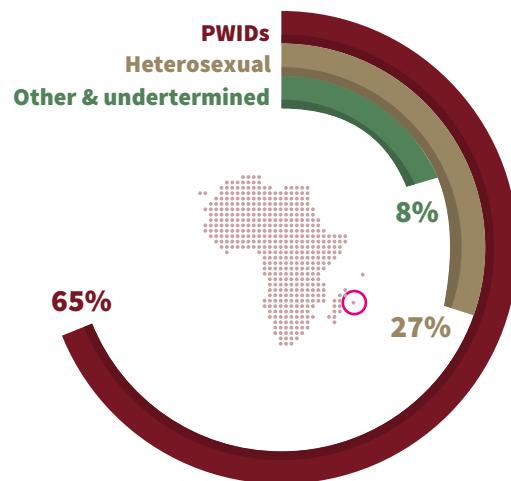
Other facilities offered at the mobile NEP sites include male and female condom distribution and HIV rapid-testing with pre- and post-test counselling.

RESULTS OF THE PRACTICE

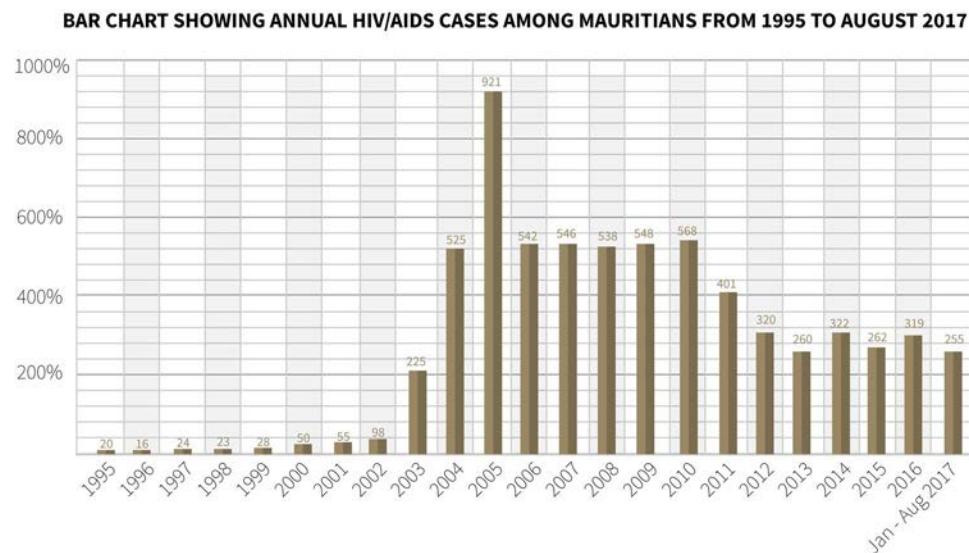
The outcome measure used to assess the benefits of the Harm Reduction programmes is the annual incidence of HIV among different groups in Mauritius. The pie chart shows the respective percentages of HIV cases registered among PWIDs, heterosexuals and "others & undetermined" from 1987 till August 2017.



A chart showing the percentage of HIV/AIDS cases among different groups



The bar chart shows the annual HIV/AIDS cases registered among Mauritians from 1995 to August 2017.



It shows a general reduction in the incidence of HIV in Mauritius since the implementation of harm reduction strategies in 2006. The number of registered cases of HIV stayed more or less the same, varying around 550 cases for about 5 years before starting to drop in 2011. There was a steady decrease in registered HIV cases between 2011 and 2013. The lowest number of cases registered was in 2013 when the number of registered HIV cases was 260. Since 2014 the figures have fluctuated around 300 cases yearly, but remained relatively low compared to the pre-2011 era. It may be too early to assess the impact of withholding methadone induction between June 2015 to June 2017 on the incidence of HIV cases.

Innovative feature about this model of harm reduction:

The innovative features about this model of harm reduction are:

1. It uses a “low threshold, high volume” model of inducting patients on methadone to reach a maximum number of patients whilst maintaining a high level of safety and efficacy.
2. It involves a meticulous level of coordination and collaboration between Government health professionals and NGO programme officers and field workers for both MST and NEP.
3. The Government/NGOs collaboration is not only limited to working in the community but extends to other settings like prison and women-only rehabilitation centres.
4. This model of Harm Reduction encourages a joint medical/psychiatric/social management of patients whilst adopting a holistic approach to treatment.
5. Care delivery is effected by a multi-disciplinary team of health professionals with easy referral to other agencies.
6. Peer educators form an important part of the treatment team and are present at the dispensing sites to offer education and support to patients.

LESSONS LEARNED

This “low threshold, high volume” model of inducting patients on methadone worked well in reaching a sizeable number of patients and thereby contributing in reducing significantly the incidence of HIV in Mauritius.



However, the high volume of patients induced on methadone over a relatively short period of time did not come without problems. As the number of patients attending the methadone dispensing sites across the island increased, it became associated with overcrowding at the dispensing sites and loitering of patients in the vicinity of the sites causing some public nuisance. These problems were overcome through the decentralization of methadone distribution service points whereby the 17 dispensing sites in the community were increased to 40 dispensing sites across the island, each with a maximum capacity of 250 patients. Previously, some sites were serving up to 650 patients.

A further proposed measure to reduce overcrowding at the dispensing sites is the provision of “take-home” doses of methadone for patients with stable occupational and psychosocial functioning.

A few difficulties were encountered with the NEP, namely in getting a reliable list of patients registered on the programme. To encourage attendances at the NEP sites, a level of discretion and confidentiality are offered whereby patients are not required to show their identification (ID) Cards. This has led to difficulties in compiling an accurate register of patients benefitting from the NEP services. However, a process of using a unique identifying number for each patient has been proposed and is being worked upon.

CONCLUSION

This model of Harm Reduction is considered as best practice because its efficacy in reducing illicit drug use and curbing down the incidence of HIV in Mauritius have been proven. It has benefitted the population not only in terms of Harm Reduction services, but it has also helped to reduce crimes. Although the programme requires some level of expertise to implement, help from UNODC Consultants in training medical and paramedical staff has enabled a smooth taking off and running of the programme.

With further planned improvements of the Harm Reduction programme in sight, it is likely to be even more sustainable in the longer term. Given the highly structured nature of the programme, it can be replicated in practices with a drug profile similar to that in Mauritius.

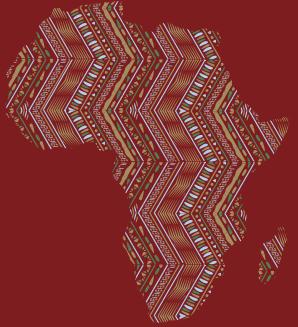
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NAMIBIA



A SUBSTANCE USE PREVENTION MODEL: COALITION ON REDUCTION OF HARMFUL DRINKING (CORD) PROGRAMME

Introduction

The Coalition on Reduction of Harmful Drinking (CORD) programme was initiated in 2004, due to the increased concern of the Government of Namibia about the level of alcohol consumption in Namibia. Due to this worrisome phenomenon, the Ministry of Health and Social Services (MoHSS) initiated the CORD program to prevent the abuse of alcohol. The Knowledge, Attitude and Practice (KAP) Baseline Survey on Alcohol and Drug Use in Namibia (2002) stated that over fifty-five percent (55,6%) of the Namibian adult population consume alcohol and 53% of youth have been /are drinking alcohol on a regular basis. The CORD was established in all the regions in Namibia, using a multi-sectoral approach with stakeholders from various sectors of society, including government, community-based organizations, non-governmental organizations, private sector, development partners and international agencies who play different roles in reducing harmful use of alcohol in Namibia.

Alcohol use plays a prominent role in the cultural, social and economic life in Namibia. Alcohol is also recognized as one of the drivers of the HIV epidemic and was later added to the programme to reduce alcohol-related HIV risks. This initiated the consideration to fund the alcohol programme through Centre of Disease Control (CDC) Namibia from 2010 with an amount of N\$5 million for five years.



Brief Abstract

Alcohol use and sexual risk-taking are strongly associated with HIV transmission. Alcohol drinkers' risks include higher numbers of sex partners, greater frequency of casual sex and decreased condom use, compared with non-drinkers. In Namibia's generalized HIV epidemic, 26% of adults report hazardous drinking, including binge drinking more than 6 drinks per occasion. The CORD Programme to reduce alcohol-related HIV risks was designed to:

- 1) reduce hazardous drinking through structural interventions;
- 2) build healthcare workers' alcohol abuse prevention skills;
- 3) evaluate and expand behavioral interventions;
- 4) develop coalitions working in alcohol risk reduction;
- 5) institutionalize alcohol risk reduction media.

The Model of Intervention:

The CORD, which exists since 2004 is a preventative programme, which focuses on education, information dissemination and awareness raising on the dangers of alcohol abuse.

The CORD Programme has expanded to all the 14 regions in Namibia. Within each region, the CORD served as a forum for health, social, business, civic and law enforcement leaders, as well as representatives from and the alcohol treatment centers to come together to coordinate their response to address excessive alcohol use and alcohol-related harm. The key interventions of the CORD are prevention, legislation enforcement and expanding alcohol treatment options.

CORD prevention activities focus on establishing CORD committees and to have community meetings, school site visits and other activities to emphasize that alcohol drinkers' risk behaviors include higher numbers of sex partners, greater frequency of sex with casual partners and decreased condom use compared with non-drinkers.

The CORD committees increase awareness raising and mobilize communities on the effects of alcohol and drug abuse, dissemination and distribution of information on substance abuse (IEC material) and to make services accessible to the community. To make the program sustainable, the members are trained, amongst others in brickmaking and candle making to create self-employment opportunities and become self-reliant. This program also promotes voluntarism and participation of the community at large.

The regional committees use cultural activities to disseminate information on the dangers of alcohol and drug abuse. The CORD committees established support groups, which meet with social workers to discuss burning issues on alcohol abuse in the community and to find solutions on how to address these problems that ordinary community members are involved in the identification of problems and to come up with solutions for these problems. The CORD Program makes use of volunteers who assist in activities like the discussion of the, Brief Motivational Alcohol Intervention and Alcohol and HIV and AIDS Picture Codes.



The police are part of the CORD committees and are involved in the enforcement of legislation regarding alcohol production, sales and use. The CORD committees identify shebeens and/or bars that sell alcohol that are not licensed or do not keep to trading hours and inform the police accordingly or are selling alcohol products to teenagers. The CORD committees furthermore oppose new applications for licensing to sell alcohol at shebeens or bars, which are near schools or religious places. The police are mapping those areas with bars and shebeens that are prone for crime.

Social Workers guide CORD Committees on how to address issues, such as selling of alcohol at pay points where older persons' grants are received. They educate the elderly on the negative effects of alcohol abuse and encourage them to refrain from using their grants to buy alcohol.

CORD committees and health professionals are trained to screen and refer individuals to support groups (e.g. AA groups) and clients to in-patient treatment centers or to the local social worker for therapeutic interventions.

The model is considered as a best practice based on the following criteria:

The CORD Committees in the 14 regions are working based on a costed annual plan with detailed action steps to reach their planned outputs. Three times a year CORD Cluster Review Meetings are held by MOHSS at National Level as a monitoring tool and a platform for mutual learning. Regions give feedback on the implementation of their action plan.

The communities are actively involved, as many volunteers and ordinary community members are working hand in hand with the local social workers. A few community members are selected from the regions to attend the cluster review meetings and this build their morale and is a motivation for them for further involvement in preventive activities on a voluntarily basis.

Regional and local authorities e.g. regional and town councils have expressed their firm political commitment to this initiative, are actively involved in the activities and are assisting with funding whenever they can. They also take the floor during preventative events and thus motivate the broader community to take part in the CORD activities.

Is there an innovative feature about your model?

The CORD programme has an innovative feature. It has benefits for its members and contribute to improve their living standard and well-being through empowerment and skills development. The programme also contributes to the ultimate goal to create self-employment opportunities and increase self-reliance, while promoting voluntarism and the participation of the community at large.

This model has proven to be successful in Namibia, because community members are trained to screen and identify individuals at an early stage and to refer to social workers for help. CORD Committees are also working on grass roots level and the community accept them because they are part of the community. The CORD Committees serve as a helping hand for social workers. Support groups are also more accessible and available to the members of the community who wants to stop using alcohol or drugs. Some regions are also successfully implementing brickmaking and candle making projects that are sustainable and it benefits the members as well as the community.



Conclusion

The CORD programme has proven itself to be an important tool to reduce alcohol consumption in Namibia while improving the quality of life of the population. It promotes strong community participation and partnership while contributing to enhance the self-reliance of its community members in entrepreneurship and income-generation.

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INTEGRATED COMMUNITY-BASED RESPONSE TO DRUG USE AMONG YOUNG PEOPLE

Introduction

Nigeria, a West African country has in recent times witnessed an increase in availability and use of illicit drugs. This is partly due to the trafficking of drugs through the country and the growing local demand for drugs among the youthful population motivated by several reasons. YouthRISE Nigeria, an NGO, is currently responding to the challenge through the implementation of an ‘Integrated Community-based response to Drug Use Among Young People’. This is a Youth-centered approach that integrate advocacy for policy reform, community-based public health programmes and social integration.

Besides cannabis that is cultivated in the country, several clandestine amphetamine laboratories have also been discovered. YouthRISE Nigeria, an NGO, is one of the leading organizations responding to this growing challenge in the country. The model of intervention used in the programme has been implemented in the Federal Capital Territory (FCT) for the last 3 years (2015-2017).

Description of Model of Intervention

YouthRISE Nigeria implements a Youth-Centred Intervention model that is based on the following principles:

- i. Effective response to any youth-related issue requires meaningful engagement of young people, and meaningful engagement simply means active participation of affected and knowledgeable youths in the design, implementation, monitoring and evaluation of programmes.
- ii. Young people make the best out of their lives when they have the required information and competencies to negotiate their social environment.
- iii. Interventions for young people need to be holistic.

In line with the above principles, YouthRISE implements a three-pronged intervention. These are Youth Engagement in Advocacy and Development of National Drug Policy, Community-Based Outreach Services, and One Stop Shop.



A. Youth Engagement in Advocacy and Development of Evidence-based National Drug policy

Nigeria, like most African countries, has a punitive drug law regime that focuses on punishment for drug use offences. The implementation of this policy for many years has not led to reduction in the scale of drug market and drug misuse in the country. Instead it has disproportionately affected young people in terms of lack of access to comprehensive drug prevention education, and healthcare services (treatment, rehabilitation, & harm reduction). It has also promoted lots of human rights abuses in terms of arbitrary arrest, detention, torture and sexual violations. In order for an effective policy response, YouthRISE Nigeria regularly provides a platform that connects community of young people, including those who use drugs, with policy makers (including law enforcement agents, health workers, educational institutions and other relevant agencies) to discuss better approaches towards effective drug response in Nigeria. The platform mobilizes young people across different regions of the country, allow them to sit in the same room with stakeholders, voice their opinion and contribute to the national discuss. This practice has contributed to many progressive changes in the Nigeria drug control response which include a recent call at the highest level of the Nigeria parliament for the review of the Nigeria drug law to be in tandem with current day reality and a gradual change in perspectives of law enforcement agents from seeing drug use as a criminal offence to a public health issue.

B. Community Based Outreach Services (CBOS):

YouthRISE outreach team takes services to where young people naturally socialize rather than waiting for them to converge at a designated location. Furthermore, the outreach programme acknowledges the heterogeneity of young people at the community level and services are tailored and delivered to meet the need of the different sub-population. In this regards, the following youth sub-populations were identified in relation to drug use:

- Young people who use drugs;
- Young people who inject drugs;
- Young females who use drugs (both injecting and non-injecting);
- Young females who use drugs and also sell sex;
- Young people who have not initiated drug use.

From the above, the targets of the CBOS are the first four sub-populations and the following services are provided:

- i. Drug Misuse Prevention Education: This intervention is based on the understanding that most drug use disorders experienced by young people are a result of lack of adequate knowledge on what drugs are, different types of drugs, how drugs work and how individuals can react differently to the same drug. Here the outreach team interacts with young people who have already initiated drug use by providing them with comprehensive information including harm reduction messages, client-centered counseling and referral to other services. Through this programme, over four thousand (4000) young people who use drugs have been reached directly at the community level. While the goal of this programme is not total abstinence, many young people reached voluntarily expressed their desire to stop using drugs and requested for support services.
- ii. HIV and AIDS and related services: This programme targets young people who inject drugs. HIV infection among people who inject drugs is reported to contribute to 9% of annual new HIV infections in Nigeria. Due to criminalization of drug users, injecting drug use among young people in the country is hidden. This group of people rarely benefit from the general HIV/AIDS programme. To address this situation, YouthRISE has an outreach team of young people who are trained on how to conduct HIV testing and counseling. The team visits locations where these individuals are, conduct HIV testing, and provide information about HIV and AIDS and other related services. Through this model, over 2000 injecting drug users within the Federal Capital Territory have learnt their HIV status for the first time and one hundred and seventy persons who tested HIV positive were linked to antiretroviral treatment services. Other services provided by the team include screening for hepatitis infection and syndromic management of sexually transmitted infections.



iii. Paralegal services: At the community level, people who use drugs are subject of frequent police brutality, arrest and arbitrary detention. In this regard, many drug users have their human rights violated by being detained for a long period without being taken to court and many times denied access to justice. Although the Nigeria law still criminalizes drug use, YouthRISE has a team of trained paralegal officers who can be called anytime an arrest of someone is made on an account of drug use. Once the report is received, the response team visits the police station to determine the case and provides necessary support to the individual. Through this service, cases of prolonged detention, extortion and other human rights violation experienced by drug users have been reduced within the communities where the organization works.

C. One Stop Shop (OSS):

Beside the mobile services provided by the outreach team at the community level, YouthRISE Nigeria has a drop-in-center for drug users where an array of services is provided. Some of these services also include those that are provided at the community level. The idea of the One Stop Shop is to have a center where major health-related services required by drug users are provided in a single place. The other services provided at the centre include:

- i. HIV positive drug users feel reluctant to uptake treatment services at the same centres with the other general population due to fear of stigma based on their drug use habit. Since the commencement of the OSS, being drug user-friendly, there has been an increase in enrolment rate of injecting drug users and their partners who are HIV positive. After enrolment, the individuals are counseled by a trained adherence counselor who is usually HIV positive and from drug using community. This process has improved the rate of treatment adherence at the OSS.
- ii. Brief Intervention: Knowing fully well that many people who use drugs do not have drug use disorders and hence do not necessarily require drug treatment, the center provides brief interventions for drug users in terms of screening to identify current or potential

problems with substance use and motivate the individual to adopt healthy behavior. The brief intervention is carried out by trained medical personnel and social workers. This has shown positive results in having individuals give up injecting drug use or risky injecting practices, reducing their drug intake and some enrolling into care to become drug free.

- iii. Social Integration: A major challenge faced by young people who use drugs or those who have been to a rehabilitation is stigma/isolation and this increases their vulnerability to relapse, problematic drug use, crime, and other risky behaviors. The social integration activities at the OSS focus on family reunion, economic empowerment and access to education. Through this, many youths have reunited with their families and families are educated on drug use and how to relate better with the individual. There are documented cases of individuals who dropped out of school due to their problematic drug use and have now back in school. Others are gainfully employed in other institutions.
- iv. Sexual Reproductive Health Service: This is a service that targets mostly young women who use drugs and/or sell sex. This programme, in addition to drug counseling, provides access to contraceptives to prevent unintended pregnancies. For those who become pregnant, the OSS have developed working relationships with some hospitals where they register for ante-natal care services and ensure they receive required care till delivery. This programme has successfully prevented still birth and delivery complications which are common among women who use drugs in the communities where we work. The mothers are given after-delivery care while they take care of their babies. The organization has collected many success stories in this regard.



What Makes Our Model a Best Practice?

- Peer-Led Model: The key to the success recorded by the above model is based on the strategy of being peer-led programming. It is a model of service where young people are the major actors reaching out to their peers. The outreach components are led by young people who use drugs themselves or have been a drug user and are recruited and trained to deliver services to their peers. The other components of the service are also done by young people who are professionals in the field of healthcare and social works.
- This model is highly efficient given the little resources and time used to make the remarkable achievements.
- Respect for human rights: The interventions are in total compliance with ethical standards of dealing with human subjects. Every client, including personal records, is treated with the highest degree of confidentiality. Consents are requested from programme beneficiaries before asking them to participate in any activity; hence no individual is compelled or forced to uptake a service against his or her wish.
- Services are delivered by trained personnel who are non-judgmental and friendly to the service recipients. A testimony to this is that the center now receives many clients who were referred by other peers who were at one time service beneficiaries of YouthRISE.
- The intervention model of YouthRISE Nigeria is novel, relevant and addressing a major health need in the country.
- The intervention is scalable and can be replicated in resource-limited settings in Nigeria and in other countries.
- YouthRISE Nigeria through its activities has gained recognition from many national institutions in Nigeria, international organizations and was a recipient of the prestigious UNAIDS Red Ribbon Award in 2016.

Innovative Feature

A major innovative feature of this model is the integrated approach to prevention of drug use disorders among young people by young people. It integrates public health services with social-economic development bearing in mind some of the major contributing factors to drug use disorder. Service delivery is also flexible in meeting people where they are with an emphasis on quality (client-centered) and not on numbers. Furthermore, mobilization of young people to contribute to the development of evidence-informed drug policy in order to create an enabling environment for effective and sustainable service provision.

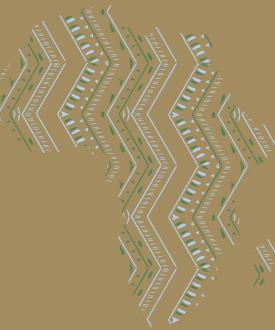
Conclusion

YouthRISE Nigeria is a modest NGO which is making a valuable contribution to address drug use and HIV prevention and care for young people by young people in FCT. It has limited means which it is optimizing for higher impact and results. This model of intervention has received international recognition for its efficacy and needs to be supported for replication in many sites in Nigeria.

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INTEGRATED METHADONE ASSISTED THERAPY PROGRAMME FOR PEOPLE WITH OPIOID USE DISORDERS IN TANZANIA

Introduction

This report summarizes the details of the integrated Methadone Assisted Therapy (MAT) programme for people with opioid use disorders from February 2011 to December 2016 in Dar es salaam, Tanzania. It represents works related before initiation, during implementation, challenges faced and recommended ways forward for scale up of MAT services.

The document contains the qualitative and quantitative measurement, assurance and improvement of MAT services. It also enlightens the status of harm reduction services particularly MAT to people with opioid use disorder. The key areas are outputs, outcomes, challenges, and the proposed way forward for integration of MAT services in Tanzania.

The main aims of the establishment of MAT programme:

- 1) Increase treatment access to people with opioid use disorders to MAT, physical and psychosocial services;
- 2) Reduce drug use and its associated consequences;
- 3) Identify sustainable and satisfactory systems solutions for people with opioid use disorders.

In the six years of implementing MAT programme, a total 3,559 clients, namely people who injected drugs (PWID), were enrolled. The prevalence of HIV and TB was 26% and 7.9% respectively, compared to a prevalence of 5.1% and 0.2% respectively in the general population.

The programme achieved aims 1 and 2 while the last one proved to be more complex. The document revealed key challenges and proposed ways forward to successful implementation of a MAT services in Tanzania.



Illicit drug use is a growing problem posing a significant threat to public health, and the social, political, environmental and economic wellbeing of Tanzania. The problem is more concentrated in urban areas and increasingly spreading to smaller towns. Regions with large number of People Who Use the Drugs (PWUD's) include Dar es Salaam, Tanga, Kilimanjaro, Arusha, Pwani, Mwanza, Morogoro and Mbeya . The use of drugs is mostly among people aged between 15-45 years. There is no reliable national estimate for the number of PWUD's in the country, except for heroin which is estimated to be between 200,000 and 425,000, including 20,000 and 42,500 people who inject the drug countrywide. The most commonly used drug is cannabis followed by khat, heroin, cocaine and inhalants.

INTEGRATED METHADONE ASSISTED THERAPY FOR PEOPLE WITH OPIOID USE DISORDER.

MAT is a medical treatment combined with psychosocial support to people with opioid used disorders particularly those using heroin. The programme gives methadone, medical treatment and psychotherapies. The methadone treatment programme has the following benefits:

- It decreases drug use behaviour and associated morbidity and mortality;
- It reduces criminal activities associated with drug use in the community;
- It lessens HIV risk behaviours and other blood borne infections;
- It improves patients' health status and overall quality of life;
- It facilitates the integration of clients in the health care system;
- It increases screening and treatment of HIV, Hepatitis B and C, TB and other medical and psychiatric co morbidities;
- It contributes to reduced stigma in health care settings and community for PWUDs;
- It minimizes risks of people who use drugs to develop resistance to HIV and TB treatment due to drug interactions between some

ARTs and anti TB medications with heroin;

- It improves pregnancy outcomes for pregnant women with opioid use disorder;
- It serves as a gateway to other medical, social and economic services targeting people who use drugs.

The Goals for MAT services

The goals for MAT are harm reduction, improved quality of life and reduction in drug use.

Target Population

The target population for MAT are PWUD's who fulfil the following criteria:

- Establishment of the diagnosis of opioid use disorder;
- Capability of giving informed consent;
- Signing of the MAT agreement;
- Confirmation of PWUD who is medically manageable with methadone.

Model of MAT services

Model of MAT programme is integrated within the existing hospitals with the following:

1. MAT and other evidence-based drug dependence treatment;
2. HIV testing and counselling;
3. Antiretroviral therapy;
4. Prevention and treatment of sexually transmitted infections (STIs);
5. Condom programmes;
6. Targeted information, education and communication (IEC);
7. Prevention, vaccination, diagnosis and treatment for viral hepatitis;
8. Prevention, diagnosis and treatment of TB;
9. Naloxone for overdose prevention.



Tanzania adopted the UNAIDS, WHO and UNODC recommendations, which are evidence-based interventions for effective prevention of HIV infection among People Who Inject Drugs (PWIDs).

Setting of MAT services

Setting of MAT services involves the following:

I) Community-based services

Community based services in MAT refers to provision of psychosocial services to clients prior and after enrolment to MAT facility services. Services include basic hygiene, education, self-help groups and referral to MAT sites. All the clients have to go through at least two sessions at the community before enrolment to MAT clinic for a period of at least a week.

II) Facility-based services

MAT sites receive clients referred from community-based services ready for enrolment. Eligible clients complete a written informed consent procedure and sign a MAT contract. Services are provided by staff members ranging from medical recorders, assessment nurses, social workers, psychologists and social workers, pharmacists, and clinicians.

The services offered are:

- Registration
- Screening
- Assessment
- Management
- Dispensing

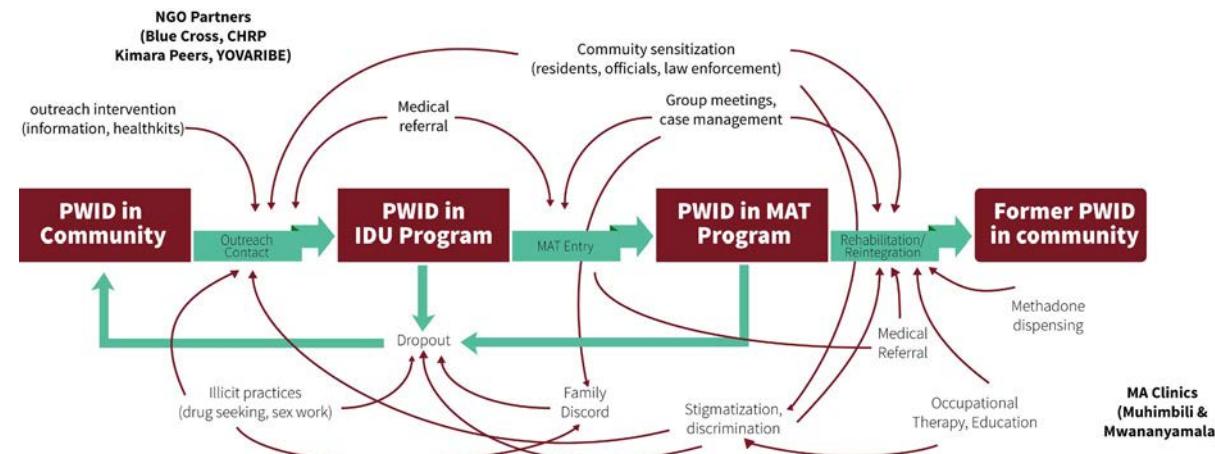
Referral and Access to Additional Services

Additional services, such as legal and specialized medical services, are referred to appropriate service providers. The common referrals include surgical services, emergency medical department, dental, and medical services.

Coordination of Services

Coordination is under Ministry of Health and Drug Control and Enforcement Authority (DCEA) by forming a technical working group in collaboration with service providers. The team would meet at least once a month and assess progress in service provision, identify areas of improvement and make decision for way forward.

Comprehensive MAT services involving both community and facility.





Policy and Guidelines for Provision of Methadone Services

The following guiding documents were developed:

- National Methadone Assisted Therapy Standard Operating Procedures for health care providers in Tanzania;
- National Guideline for Management of People With Opioid Use Disorder in Tanzania;
- Minimum Standard for Establishment of Methadone Assisted Therapy services in Tanzania;
- Guideline for Methadone Assisted Therapy Site Improvement Monitoring Systems.

MAT programme: Outputs and Outcomes.

Data is presented in terms of numbers, proportions and percentages and is submitted to DCEA and Ministry of Health on quarterly basis. This report is a summary of cumulative data gathered from the inception of MAT clinic in February 2011 to end of December 2016 from three sites which are Muhimbili, Mwananyamala and Temeke.

Enrolment, dropout and current number of MAT clients

A total of 3559 clients with males 3228 (90.7%) and females 331 (9.3%) were recruited. MAT Muhimbili contributed to 1273 (35.8%) clients, Mwananyamala recruited 1380 (38.3%), and Temeke 906 (25.5%) clients with age ranging from 15-63 years.

Table 1. Cumulative enrolment

ENROLMENT STATUS BY SITE	MALMUHIE		FEMALE		TOTAL	
	N	%	n	%	N	%
Muhimbili	1198	(93.1%)	75	(5.9%)	*1273	(100)
Mwananyamala	1176	(85.3%)	204	(14.7%)	**1380	(100)
Temeke	854	(94.3%)	52	(5.7%)	***906	(100)
TOTAL	3228	(90.6%)	331	(9.3%)	3559	(100)

Table 2. Cumulative drop out

DROP OUT BY SITE	MALMUHIE		FEMALE		TOTAL	
	N	%	n	%	N	%
Muhimbili	39	(13.7 %)	7	(22.6%)	46	(14.6%)
Mwananyamala	42	(14.7 %)	18	(58.1%)	60	(19.0%)
Temeke	204	(71.6%)	6	(19.4%)	210	(66.4%)
TOTAL	285	(100)	31	(100%)	316	(100)

*A total of 62 males and 14 females drop out due to deaths mainly due to complications of HIV and Tuberculosis, 13 males were expelled from the clinic due to failure to comply with MAT regulations.

Table 3: Cumulative defaulters

DEFALUTERS BY SITE	MALMUHIE		FEMALE		TOTAL	
	N	%	n	%	N	%
Muhimbili	247	(5.0)	23	(12.3)	270	(5.5)
Mwananyamala	225	(86.5)	35	(13.5%)	260	(100)
Temeke	204	(97%)	6	(3%)	210	(100)
TOTAL	676	(91.4%)	64	(8.6%)	740	(100)



Table 4: Cumulative retention

RETENTION BY SITE	MALMUHIE		FEMALE		TOTAL	
	N	%	n	%	N	%
Muhimbili	556	(71.1)	47	(82.5)	603	(71.9 %)
Mwananyamala	849	(80.8%)	143	(81.6%)	992	(80.1%)
Temeke	528	(73%)	32	(81.3%)	560	(75.6%)
TOTAL	1933	(76.8%)	122	(78.9%)	2155	(77.6%)

Table 5: Screening for HIV infection

HIV POSITIVE STATUS BY SITE	MALMUHIE		FEMALE		TOTAL	
	N	%	n	%	N	%
Muhimbili	190	(25.5%)	35	(63.6)	225	(28.1%)
Mwananyamala	64	(14.8%)	74	(50.3)	138	(20.7%)
Temeke	137	(16.0%)	23	(44.2%)	160	(17.7%)
TOTAL	268	(21.2%)	114	(55.07%)	382	(26.0%)

Table 6: Clients received Anti-TB therapy

CLIENTS RECEIVED ANTI-TB THERAPY BY SITE	MALMUHIE		FEMALE		TOTAL	
	N	%	n	%	N	%
Muhimbili	*71	(9.1)	18	(31.6%)	89	(10.6%)
Mwananyamala	**42	(3.7%)	34	(16.7%)	73	(5.3%)
Temeke	***43	(5.0%)	4	(7.7%)	47	(5.2%)
TOTAL	92	(6.6)	35	(16.6)	127	(7.9)

* Multidrug resistant cases were diagnosed; 4 males in Muhimbili (3 died and one is currently sent to Kibong'oto for MDR treatment; 3 cases from Mwananyamala

Provision of psychosocial services

The following psychosocial services were given to PWUDs:

- Psycho-education
- Brief Intervention
- Motivational Enhancement Therapy
- Cognitive Behavioural Therapy
- Individual therapy
- Group therapy
- Family therapy

Service Outcomes

By the end December 2016, there were 3553 clients recruited with 77% retention in MAT. Most of these clients would not have accessed any medical services were it not for services at MAT clinics which acted as an entry point. More than 75% of clients who are HIV positive were not aware of their HIV status until when they were recruited into the MAT clinics. MAT clinics offer most of other services under the same roof thereby significantly improving adherence to ARTs, anti-TB and other treatment modalities.

Research findings show that there is significant improvement on quality of life with clients scoring higher on SF-12 quality of life scale after treatment as compared to prior to initiation of treatment. These findings are consistent on qualitative research, clinical data and on anecdotal reports from various stakeholders including clients, their caretakers, politicians, and other stakeholders in terms of changes in social interactions, economic wellbeing and occupational function.



CHALLENGES AND THE WAY FORWARD

The following are challenges faced in MAT services.

Social challenges

- MAT programme is a new concept with regards to harm reduction in Tanzania. Some people wrongly perceive it as 'a drug replacing another drug';
- High stigma vis-a-vis people who use drugs and drug dependence, people living with HIV, and also those experiencing mental health disorders.

System Challenges

- Monitoring and Evaluation of MAT services are still not linked with the existing M&E system for HIV health related interventions;
- Low access and coverage of MAT services within the country. This results in continuing to use heroin.

Health Care Provider Challenges

- Heavy workload and longer hours by MAT service providers;
- Few service providers specialized in MAT programme.

MAT Client Challenges

- Failure to follow rules and regulations by MAT clients; especially during the early phase of treatment;
- Direct Observed Therapy (DOT) to MAT clients is costly and therefore daily travel to the clinic discourages many clients from engaging in income generating activities.

RECOMMENDATIONS

The following are the recommended ways forward for the fruitful MAT programme:

- To engage more advocacy and sensitization on MAT;
- To scale up MAT services to other regions with high number of heroin users;
- To train more service providers on delivery of MAT services;
- To combine additional programmes aiming at other essential areas like gender-based violence and vocational training to MAT clients;
- To strengthen the M&E system, service audit and supportive supervision to cater for the need of MAT services;
- To envisage MAT take away dose so as to reduce the burden of direct observed therapy.

CONCLUSION

The introduction of MAT has significantly changed the national response to addressing drug use and the treatment of drug use disorders in the country. It has received a high level of political support and is proving to be a key, effective and cost-effective intervention which is easily replicable in other regions in the country.

Author

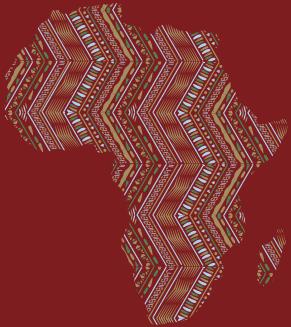
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Assistant Commissioner

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ZANZIBAR



ESTABLISHMENT OF A MEDICALLY ASSISTED TREATMENT (MAT) CLINIC FOR PEOPLE WHO INJECT DRUGS (PWIDS) IN RESOURCE LIMITED SETTINGS IN ZANZIBAR

INTRODUCTION

In the past decade, the Ministry of Health has learnt that drug-related problems are characterized by being complex and multi-faceted in nature, exacerbating crime and posing several challenges to its control. In order to address the illicit drug-related problems holistically, effective and increased national and international cooperation are crucial. It also demands an integrated, multidisciplinary, coordinated, mutually reinforcing and balanced approach between supply and demand reduction as well as harm reduction strategies.

The archipelago nature of the Island of Zanzibar adds to the complexity faced by law enforcement activities to effectively control the influx of drugs. The location of Zanzibar on a drug-trafficking route between Asia, the Middle East and Europe, has greatly contributed to the availability of heroin in the Island. Moreover, increase in drug trafficking activities through East Africa, easier infiltration of drugs, as it is the case in most coastal areas, and the demand for drugs, are other reasons that account for a greater availability of narcotic drugs in the region. Zanzibar trade connections with other countries and its geographical position on a major corridor for drugs trafficked across the Indian Ocean from Asia to Europe and North America make it more vulnerable and potential hub for drug business.

Drug use is mainly found in urban settings and in rural areas around touristic areas on the east coast of Unguja and Pemba. The changing social and economic context, coupled with poverty, has resulted in a growing problem of drug use in the islands. Easy availability and accessibility to drugs and tourism have contributed to Zanzibar youth indulging in drug use. The street price of heroin is very cheap.



It is estimated that 7,000 to 10,000 people are using drugs in Zanzibar, and this includes 3,200 people who are injecting drugs (Ubuguyu et al. 2016)

Methadone maintenance treatment is a key component of a comprehensive treatment and prevention strategy to address opioid dependence and its consequences. A review of the literature indicates that methadone maintenance treatment is considered an effective means of reducing the use of other opioids, the use of other substances, criminal activity, and the mortality rate in this population. Methadone maintenance treatment has also been found to reduce injection-related risk behaviors, other risk behaviors for transmission of human immunodeficiency virus (HIV), sexually transmitted infections (STIs), hepatitis C virus (HCV) and other blood-borne pathogens. Methadone maintenance treatment improves physical and mental health, social functioning, quality of life, and pregnancy outcomes. Methadone maintenance treatment has also been found to increase retention in treatment.

Interventions that effectively treat drug dependence can reduce illicit drug use and, hence, the frequency of injection among PWIDs, as well as improve health and social functioning. For people dependent on opioids, agonist opioid substitution therapy (OST), sometimes referred to as Medically Assisted Treatment (MAT), is highly effective in reducing injecting behaviors that put opioid dependent people at risk for HIV acquisition. OST can reduce opioid use and improve retention in HIV treatment. Access and adherence to OST can improve health outcomes, reduce overdose and resulting mortality, reduce criminal activity, and result in better psychosocial outcomes and decrease risk to pregnant women dependent upon heroin and to their infants. Methadone and buprenorphine, which are on WHO list of essential medicines, are the most commonly used opioid agonists.

IMPLEMENTATION OF THE PRACTICE

In Zanzibar, there is a national regulatory framework for methadone prescription. The Commission for National Coordination and Drug Control works with the Ministry of Health to facilitate access to methadone maintenance treatment. The establishment of Medical Assistant Treatment in Zanzibar was officially initiated in February 2015. Zanzibar uses methadone, a synthetic opioid used to treat heroin and other opioid dependence. It reduces opioid withdrawal symptoms and the euphoric effect when opioids are used. Methadone is taken orally on a daily basis. It is important to ensure that the dose is sufficient (60–120 mg on average) and is given for a sufficient duration. To achieve optimal coverage and treatment outcomes, opioid substitution therapy should be provided free of charge and should be accessible to all those in need. OST should not be compulsory; patients must give informed consent for treatment. OST should be provided as maintenance treatment at adequate doses.

The following interventions were done to facilitate increased access and uptake to methadone treatment:

- **Development of Policy and Guidelines for Key Population in Zanzibar**

In 2013, a package of interventions for key populations (KP) was developed to address a minimum package service for key populations, namely men-having-sex with men (MSM), sex workers (SW), PWID and students in correctional facilities. The package described the kind of services which should be provided to this group. In 2015, a key population strategic plan for 2016- 2022 was developed with UNFPA support. However, these documents do not provide details on how each component of the interventions should be operationalized. In 2016, Zanzibar develops comprehensive guidelines to respond to the current needs and latest evidence in providing care for the KPs. This guideline is intended to be a reference, and it details on Methadone programme and provision.



- Developing guidelines and training for practitioners and health care providers in providing methadone maintenance treatment.**

Methadone can be prescribed only by physicians who have received training and authorized by the Commission for National Coordination for Drug Control in Zanzibar.

- Increasing awareness on MAT to community leaders and members, religious leaders, NGOs and other stakeholders through community outreach and dialogues;
- Increased sensitization of the Office of Director of Prosecution, the Judiciary, Law Enforcement Department; and the Heads of Correctional Facilities and Social Welfare;
- Using the media, drama and cinemas to further sensitize communities on the establishment and use of Methadone services;
- Targeted HIV prevention education to Peoples Who Use/Inject Drug;
- Introduction of Harm Reduction measured, namely the distribution of clean needles and syringes and bleach kits.

INTEGRATED COMPREHENSIVE SERVICES PROVIDED AT METHADONE CLINIC IN ZANZIBAR

1. Medical care

At Methadone Clinic, in addition to MAT services, the practitioners provide management and screening of HIV-related diseases including TB, Hepatitis B&C and STI screening. Overdose management is done using Naloxone for the clients who are in need. The nurses at clinic provide general health services to satisfy the needs of patients, including dressing wounds and ulcers; assisting with general hygiene and infection control.

2. Counseling and Psychosocial support

Counselors provide general counseling on issues of concern to patients. In addition, undertaking motivational interviewing is used with patients to increase their motivation to reduce illicit drug use. The nurse-counselors also provide pre- and post-test counseling for patients seeking an HIV test or for other infectious diseases. The clinic has a psychologist who assists patients suffering from co-morbid mental illnesses and psychiatric problems such as depression, anxiety or post-traumatic stress disorder.

3. Health promotion, disease prevention and education

- Condoms are distributed to patients to avert HIV infection through unprotected sex.
- Information, Education and Communication (IEC) materials were developed and distributed.

4. Linkages with other services and supports

To ensure effective linkage with other services and supports, a Care and Treatment clinic has been integrated within the Methadone Clinic. Escorted referral to and for other services is done and include legal advice and support, correctional facilities and other social services. Linkage and support are also provided for recovery support to drug users including referrals to drop in centers and Sober Houses.

5. Outreach Support Services

In collaboration with NGOs and the MAT Community, MAT Counsellors provide the support services needed to increase adherence and retention to treatment. These services including the provision and dispensing of Methadone at satellite sites, such as in correction facilities and other closed setting, for [patients admitted at hospital for some other medical condition and as well as those who were not able to attend the Clinic for a valid reason.

RESULTS OF THE PRACTICE/WHY CONSIDER AS A BEST PRACTICE

- Since the start of the programme to September 2017, a total of 415 clients were enrolled to the MAT programme. The retention rate is more than 75%. Since July 2016, the numbers of MAT clients have increased by an average of 13 patients monthly. Programme adherence is quite high with 228 patients attending the Clinic daily to take their methadone, with the dosage ranging between 8 mg – 295 mg person per day.
- Close collaborative between Ministry of Health, implementing partners, Drug Control Commission and local community NGOs facilitated MAT services and harm reduction for comprehensive HIV prevention in resource limited settings.
- Successful introduction and provision of comprehensive services at MAT clinic including HIV counseling and testing, ART services, Mental health services, TB screening, hepatitis B&C screening and STI screening and management.



LESSON LEARNED

Establishment of MAT services in a limited resource setting requires the involvement and participation of various related stakeholders including NGOs, and Drug Users Community engagement. Furthermore, the provision of comprehensive MAT services will increase and improve adherence and retention of clients in various health interventions including HIV services.

CONCLUSION

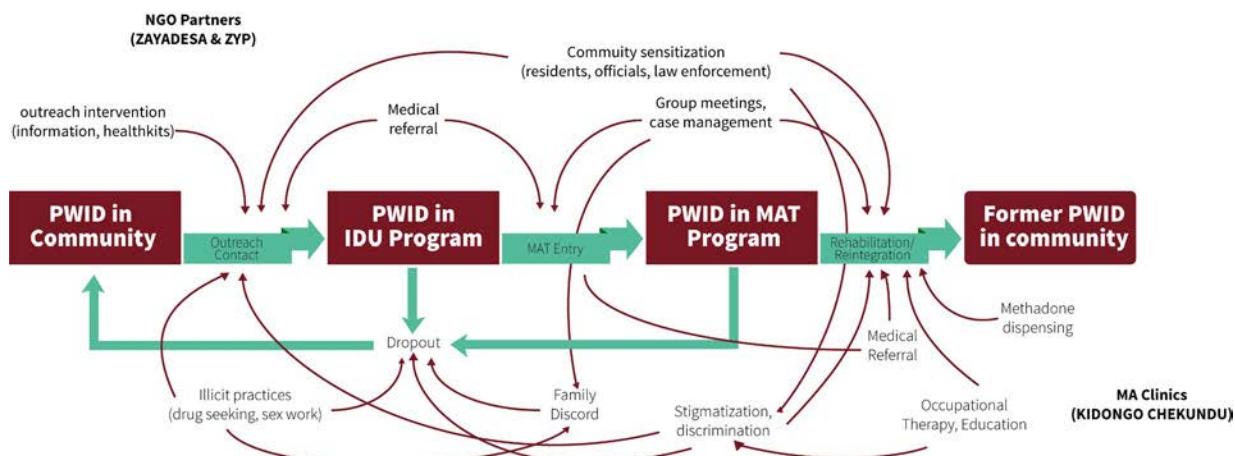
MAT services in Zanzibar have shown good retention in services and results. They provided an opportunity to offer additional benefits attaining productive livelihoods through interventions in collaboration with other stakeholders, including occupational therapy, vocational training and economic empowerment initiatives. In addition, introduction in low resource settings and can cater clients from correction facilities

Author

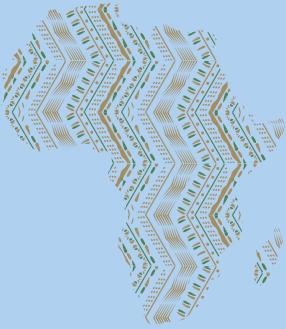
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ZIMBABWE



A SUBSTANCE AND ALCOHOL USE DISORDERS INTERVENTION IN PEOPLE LIVING WITH HIV AT AN HIV CARE CLINIC: PILOT STUDY

INTRODUCTION

Substance and Alcohol Use are associated with risky sexual behavior, poor adherence to HAART, treatment failure and increased physiologic harm. A psychotherapy intervention for HIV infected patients with Substance Use disorders (SUD), developed through adaptation of existing evidence based psychological treatments, and was piloted at a tertiary HIV care clinic in Zimbabwe. The primary outcome measure was the AUDIT. The IHDS, the DUDIT, and the SAMISS were administered to screen for eligibility. CD4 count, viral load, the WHODAS 2.0 and the WHOQoL HIV were secondary outcome measures. Registered general nurses, using a manualised protocol, carried out the intervention. Forty patients were recruited from 8th January 2016 to 28th January 2016 and followed up to 30th April 2016. Outcomes for 31 patients were assessed at three months. The study showed that an intervention for SUD leads to a reduction in substance and drinking in people living with HIV/AIDS and can be administered by nurses.

Substance use disorders(SUDs) and Alcohol Use Disorders (AUDs) are highly prevalent in people living with HIV(PLWH)(Galvan et al., 2002; Maxwell et al., 2006). SUDs and AUDs are associated with increased risk lifestyles and sexually transmitted infections that results to an increase exposure to HIV infection(Maxwell et al., 2006; Mbonye et al., 2013). Besides, SUDs are also associated with poor adherence to HIV treatment, which leads to non-suppression of HIV virus and poor treatment outcomes in HIV treatment (Du Bois & McKirnan, 2012; Tucker, Burnam, Sherbourne, Kung, & Gifford, 2003). Psychosocial interventions are the mainstay of SUDs treatments (Cleary, Hunt, Matheson, Siegfried, & Walter, 2008). Despite the propensity of PLWH to use of substances, there has not been an appropriate response to provide psychosocial treatments to them. This is despite that there is evidence that shows that the psychosocial interventions are effective. This study sought to develop and pilot a SUDs and AUDs intervention in PLWH that is at risk.



METHODS

Design

The study was a randomised controlled trial

Setting

The study was carried out at a tertiary hospital opportunistic infection clinic

Sample size

The study had 40 participants at the beginning and 9 were lost to follow up. The participants were HIV positive patients who were on HIV treatment and attending Harare hospital.

Sampling

The patients who came to the hospital for their usual refill of medication were approached and requested to join the study. Informed consent was sought and received. 102 patients were approached and 40 were eligible.

Randomisation: The participants were randomised to intervention and control by a remote computer in South Africa.

Ethics: Ethical clearance was requested and received from the Medical Research Council of Zimbabwe and Harare Hospital ethics committee.

CONDITIONS

Intervention

This was a blended motivational interviewing developed through adaptation of evidence-based therapies. Trained registered general nurses delivered it.

Control

The control was an adapted World Health Organization mental health GAP intervention guide alcohol use section. The registered general nurses delivered the control.

Training

The registered general nurses were trained over 4 sessions at the HIV care clinic through power point presentation

Quality assurance: The nurses were received supervision from the research teams that included trainers and the delivery deficiencies were corrected

Results

The main outcome measures were the AUDIT score and the CD4. There were statistically significant changes in the intervention and control over time. The CD4 also improved for both the intervention and control

Discussion

The intervention had effects on the main outcomes. This change was in both the intervention and control as both were active treatments



CONCLUSION

The intervention was feasible in terms of recruitment, training and delivery of the intervention. Further, there was change in the main study outcomes.

Model

This intervention is based on the psychosocial management of SUDs. The mainstay of management is the motivational therapies that include motivation interviewing and motivational enhancement therapy. This is combined with elements of Cognitive Behavioural Therapy (CBT). Motivational interviewing is used to engage the patient and the CBT is used to maintain the change so achieved by motivating the patient. The intervention is manualised to allow a uniform delivery of the intervention. As the treatment of the PLWH has been decentralized, the registered general nurses are responsible for day to day running of the clinic, the intervention is delivered by the nurses who receive supportive supervision from the research team.

The model is a best practice

The intervention uses the nurses to deliver the therapy, thereby allowing task sharing. Task sharing has been advocated as the treatment model that is most suitable for resource-constrained settings like most low and middle-income countries. The HIV care programme has significant progress due to decentralization. However, this has not been matched with the availability of the interventions of choice for the collateral conditions such as SUDs. Mental health concerns are a challenge to the HIV care programme and introduction of the SUDs and AUDs interventions may allow expansion of mental health care in HIV.

The model is innovative

Apart from HIV care, this is one of the first interventions that can be done by nurses and other cadres that does not require additional training. This is also a pragmatic intervention as it takes into account the natural settings of the HIV care clinic. Although the intervention uses the motivational therapies and cognitive behaviour therapies as the theoretical underpinnings, these have been adapted to suit the local context. The intervention staff have been the well-trained personnel like psychologists. These cadres are scarce in this environment. The task shifting for an intervention that is usually offered by trained staff is essentially novelty.

SUCCESS OF THE INTERVENTION

The intervention was shown to be efficacious over time. The delivery of the intervention did not require extra effort and resources and is cost-saving. The staff that delivered the intervention acquired new skills. The interventions lead to a reduction in substances use as shown by reduction in the AUDIT score. The CD4 count improved as well. The intervention got support from hospital managers as they participated in the training of the registered general nurses. The nurses indicated it was a feasible intervention.

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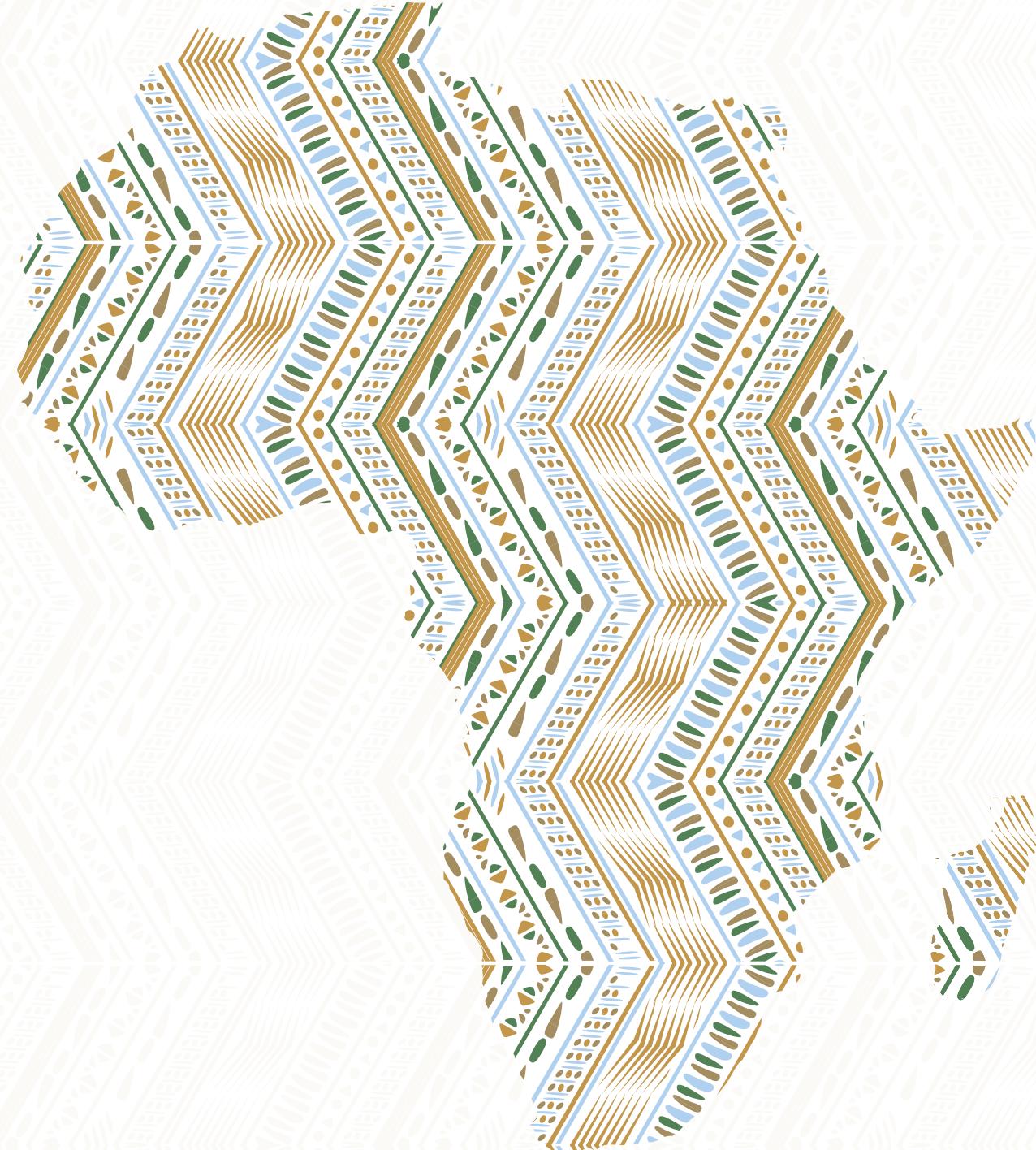


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